(In)FERTILE CITIZENS

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EDITORS

(In)Fertile Citizens

Anthropological and Legal Challenges of Assisted Reproduction Technologies

(In)FERCIT

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VENETIA KANTSA

Preface

The present book draws on the international conference *(In)Fertile Citizens. Anthropological and Legal Challenges of Assisted Reproduction Technologies* which was organized by the Lab of Family and Kinship Studies, Department of Social Anthropology and History in Mytilene, Lesvos, 28-30 May 2015. The conference was held in the context of the research program (In)FERCIT[1] and focused on assisted reproduction technologies from an anthropological and legal perspective.

The idea for (In)FERCIT was actually born on a boat. During summer vacations in 2011 I was reading the book edited (two year earlier in 2009) by Daphna Birenbaum Carmeli and Marcia Inhorn *Assisting Reproduction, Testing Genes: Global Encounters With New Biotechnologies*. By that time a significant number of anthropological studies on ART had focused on comparisons between countries in relation to kinship concepts, gender differences, legal context, religious practices, and ethnic backgrounds. Comparative approaches adopted a global perspective (Birenbaum-Carmeli and Inhorn 2009), focused on Islamic countries (Inhorn 2008) or looked into European countries (Edwards and Salazar 2009). A significant body of work examined differences in legal systems between Eu-

1. (In)FERCIT, ((In)Fertile Citizens: On the Concepts, Practices, Politics and Technologies of Assisted Reproduction in Greece. An Interdisciplinary and Comparative Approach), is a three year research program (September 2012 to September 2015), funded by the European Social Fund and the General Secretariat of Research and Technology, Greece (PI Venetia Kantsa). The research project focuses on the detailed, multisided ethnographic account of assisted reproduction concepts, practices, politics, and technologies in Greece, relating them to legal issues and human rights on (in)fertility and reproduction, and providing a comparative perspective that will associate the Greek project with similar research conducted in selected European and non-European countries: Spain, Italy, Bulgaria, Turkey, Cyprus, and Lebanon. See www.in-fercit.gr/en

ropean countries and how they urged or enabled a growing number of people to move across European borders in search of more friendly reproductive environments (Sorenson 2006, Shenfield 2010). However, what struck me at that point was the relative absence of a substantial body of comparative research into European countries and beyond. Due to the significance of different legal systems that lead to "cross-border" reproduction care among European countries, comparison of European countries with their non-European neighbors had been so far quite neglected (for an exception see Inhorn et al 2010). (In)FERCIT aimed to adopt a comparative approach that would draw together research results in neighbouring countries that differ in terms of religion (Eastern Orthodox, Catholic, Muslim), reproductive laws, and assisted reproduction technology. The overall objective of the research project was to provide an account which will move beyond permissive vs restrictive discourses on reproductive citizenship and which draws, on the one hand, on notions of reproductive autonomy and the right to choose, and on the other, on ideas about human dignity and the moral majority. This required a reconsideration of the specific cultural contexts in which such discourses emerge, particularly local-global exchanges and social-technological networks.

The conference drew on these considerations. During the 3-day conference forty-five scholars working on European and non-European countries –Spain, Italy, Bulgaria, Cyprus, Turkey, Greece, Malta, Denmark, Sweden Poland, Ukraine, Iran, UK-, experts in their respective fields, have joined together to reconsider topics of *reproductive citizenship* in relation to the specific cultural contexts, local/global exchanges and social/ technological networks they emerge from and engaged in passionate, fruitful, productive discussions.[2]

The present book follows the same path. The regulation of Assisted Reproductive Technologies (ART) varies significantly between different European countries. The outcome of such legal diversity is that an ever-growing number of people may travel within Europe, searching for reproduction possibilities, because they do not have access to feasible ART in their own countries due to legal, economic, practical, technological or religious reasons. Current discussions on assisted reproduction and cross-border reproduction focus on a permissive vs.

2. Apart from the authors of the present book the following colleagues participated in the conference either as presenters or discussants: Stine Willum Adrian, Annalisa Agius, Sarah Ahmed, Alexandra Bakalaki, Andrea Büchler, Costas Canakis, Ulrika Dahl, Jeanette Edwards, Sarah Franklin, Eugenia Georges, Trudie Gerrits, Zeynep Gürtin, Tatyana Kotzeva, Charlotte Kroløkke, Anna Krawczak, Joanna Mizielinska, Ewa Maciejewska-Mroczek, Eirini Papadaki, Jenny Gunnarsson Payne, Heather Paxson, Manuela Perrotta, Enric Porqueres, Agatha Stasińska, Erica van der Sijpt, Deanna Trakas, Theodoros Trokanas.

restrictive discourse that draws on notions of reproductive autonomy, free will, right to choose on the one hand and protection of life, human dignity, public acceptance, moral views of the majority, "adequate protection from the state", on the other (Blyth and Farrand 2005). The current proliferation of ART on European and global level necessitates that research, moves beyond liberal/libertarian vs. restrictive dichotomies and reconsiders topics of *reproductive citizenship* in relation to the specific cultural contexts, local/ global exchanges and social/ technological networks they emerge from.

(In)Fertile Citizens aims to explore these issues adopting two axes of research. The first one (Part I and II) calls for cooperation between anthropological and legal studies and aims at exploring its potentialities in the field of reproductive rights and ART. Papers by Joan Bestard, Judit Sándor, Lina Papadopoulou, Enrica Bracchi, Vasiliki Kokota, Anna Carastathis, Michael Nebeling Petersen, Aspa Chalkidou and Despina Naziri closely examine issues of politics, citizenship and human rights such as: (i) politics of reproduction and exclusions/inclusions in terms of age, gender, sexuality, economic background, (ii) subtle social mechanisms leading to exclusion of (in)fertile citizens, especially women, (iii) human rights concerns and laws that define who is eligible to become parent and who is not, (iv) the socially constructed value of "having children from one's own genetic material" and how this is being informed by the legal framework, (v) the medicalisation of conception as both an opportunity and a threat for personal autonomy, (vi) the ways in which reproductive "freedom" as a manifestation of one's autonomy is transformed into a "right" to assisted reproduction, (vii) which kinship units are to be valued and supported according to the local cultural-legal-religious contexts (the couple, the mother or father to be, single mothers, "other" parents, the child, the nuclear family, the extended family, etc).

A second axis of interest (Part III and IV) invites to reflect upon the ethnographic and analytical value of comparison, by investigating ART implementation in different neighbouring European and non-European countries and transnational reproductive networks emerging within, across and beyond them. Papers by Lia Lombardi, Christodoulos Bellas and Albert Dicran Matossian, Ivi Daskalaki, Aigli Chatjouli, Giula Zanini, Polina Vlasenko, Burcu Mutlu, Sven Bergmann examine the availability of infertility treatments and of specific techniques and procedures in each national context. Individual responses to ART are the result of a number of factors including the way in which people experience infertility and reproductive expectations, the understandings they display of different techniques and the practical, legal and moral accessibility of treatments both locally and translocally.

An underlying concern of many papers is the notion of reproductive citizenship as rights and access to ART treatment, exclusions and inclusions, but also "as obligation, duty and of not having any choice" (as Sarah Franklin 2008 has remarked). As we have demonstrated elsewhere (Chatjouli, Daskalaki, Kantsa 2015), local attitudes towards conjugal childlessness, beliefs about difficulty to reproduce, and gendered subjectivities forms a reference point of the emerging (in)fertile citizenship, highlighting what is g/locally at stake.

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PART I

Kinship, Bioethics, Law

JOAN BESTARD

New reproductive technologies and the anthropology of kinship

What I would like to discuss first in this paper is what we mean by "kinship" in social anthropology. To do that, I will use Marshal Sahlins' definition of kinship in *What kinship is...And is not* (2013). As it is well known, he defines kinship as "mutuality of being: kinfolk are members one of another, intrinsic to each other's identity and existence" (2013: 62). Ethnographers of kinship in different cultures have described the peculiarities of kinship in terms of "inter-subjective relations of being" and "mutual persons", noting that "families consider themselves to be people who belong to one another". Briefly, these ethnographic descriptions present a notion of personhood in which kinship is not simply added to a bounded self, but rather in which relatives are perceived as intrinsic to the self.

One of the best definitions of kinship, as Sahlins says (2013: 20), is the one Aristotle gives in the *Nicomachean Ethics*: "Parents love children as being themselves (...), children [love] parents as being what they have grown from, and brothers [love] each other by virtue of their having grown from the same sources: for the selfsameness of their relation to *those* produces the same with each other (...). They are, then, the same entity in a way, even though in discrete subjects..." (Aristotle: VIII.1161a–1162b, emphasis in original 2009, Book VIII, 12, "relatives", p. 369-70).

For Aristotle, relatives are people who participate in each other. The person is not initially "individual" in the sense of an autonomous being separate from the others. Rather he or she is fundamentally "dividual", in the sense that relationships are what the person is. As Marilyn Strathern (1988: 13) defines the notion of person in Melanesia, "Far from being regarded as unique entities, Melanesian

persons are as dividually as individually conceived. They contain a generalized sociality within. Indeed, persons are frequently constructed as the plural and composite site of the relationships that produce them. The singular person can be imagined as a social microcosm". In the context of kinship, one is intimately involved in the lives of others.

Social anthropologists have stressed the participatory aspect of the person. Kinship has been defined in terms of "alliance", "amicitia", "diffuse solidarity", "care", "continuous identity" or "mutuality of being". All these definitions emphasize the principle of reciprocity as the defining quality of kinship. The human subject is constituted in relation to others; it is not a bounded self, but rather enters into relations of obligation and debt to others, as Marcel Mauss reminded us in his essay *The Gift*. A person gives and receives. The debt of the gift expresses the special nature of the mutual involvement of persons in each others' lives. This sharing is part of the human condition.

For Sahlins, in the non-naturalistic ontological regime of mutuality of being, what is given is the kinship system of each society, not the natural facts of human reproduction. Nature is not separate from culture. Kinship is not a literal copy of biological kinship ties. On the contrary, the "local biology" of human reproduction is subsumed in the symbolic kinship system. Hence the variability of kinship terms that surprised the first ethnographers. I present some classic examples: a "mother" may be "daughter" (Inuit); the "mother's brother" is "male mother" (South Africa); a woman can be "father" (Lovedu); a "brother" can claim to be the "father of sister's son" (Madagascar). In addition, kinship status is not necessarily given at conception and birth. There are ways of making kinship beyond birth: commensality, reincarnation, co-residence, shared memories, shared work on the land, friendship, adoption, shared suffering. In short, nature and culture are not separate entities. They form a continuum. This is the lesson of recent kinship theory.

What happens when we distinguish between the biological facts of reproduction and the symbolic construction of kinship, as happens in the Euro-American kinship system? While we operate in this way, we are a minority in the ethnographic record. As Sahlins mentions (2013: 77), "Few or no people other than the Euro-American understand themselves to be constructed upon –and in fundamental ways, against– some biological-corporeal substratum. For many, their kinship is already given in their flesh".

What, then, has been our kinship model in Europe and North America? Schematically, the Euro-American model has overlapped both social and biological elements, even if they can be thought of as separate. In the Euro-American family

there are symbols that come from the marriage alliance and descent (the social register) as well as from procreation and sexuality (the biological register). That is, there are three aspects in the construction of Euro-American kinship:

a) *A nexus between sexuality and descent*. This connection is about the continuum between conception, birth and parenting. The facts of "conception", "being born" and "being cared for" in a family are the foundations for self-understanding and action. So far as the person is the subject of its actions, it needs a reference that goes beyond the framework of its interactions. For modernist thinkers, this starting point is "birth", a "given" from which social identity is built through relations. As Hannah Arendt said in *The Human Condition* (1998: 9), "Action has the closest connection with the human condition of natality; the new beginning inherent in birth can make itself felt in the world only because the newcomer possesses the capacity of beginning something anew, that is, of acting".

b) *Different parental figures*. Upon being named, the child is inserted into a kinship network. The link is bilateral and it provides the basis for establishing physical and psychological similarities with different parental figures. The kinship system produces people through descent and alliance. The person is not an isolated entity that pre-exists relationships. The crossing of two stories of descent produces biographies and personal stories. To be told, a life story beginning at birth needs not only a protagonist but also a listener. A feature of modernity is that these stories are unique, new and pluralistic. As shown by Strathern (1992), individuality and diversity are the two facts of Euro-American relationships.

c) *A specific way to organize gender differences in the family*. This way of understanding gender difference has come into tension with principles of justice concerning the equality of women, the equality of children as future citizens, and ultimately, the value of the family in ensuring the consistent production and reproduction of society from one generation to another.

In recent years there have been significant changes in this model of kinship. I am referring mainly to the separation of sexuality and procreation through birth control, which has led to non-procreative sexuality, as well as the separation of sexuality and conception through assisted reproduction by donor. At the same time, reconstituted families with overlapping parental figures have separated descent from alliance. And when sexuality is separate from procreation, homo-parental families become possible. Assisted reproduction has developed in the context of demographic changes, mainly, a decline in the marriage and birth rates, a rise in the divorce rate and average parental age at the birth of the first child, and a shift in attitudes toward homosexuality and illegitimacy.

New forms of ethical thinking independent of religious doctrines about human reproduction have created more flexible thinking around kinship and the moral foundations of family. The second demographic transition of the late 20th century, as demographers call it, entails delayed childbearing and declining fertility. In Catalonia, for example, the population of reproductive age has shrunk. Also, the ratio of births to women over 35 years old has grown. It has been estimated that between 8 and 15% of couples are infertile and that more than a half of these will use assisted reproductive techniques (ART) in order to have a child (Crespo Mirasol 2015). Additionally, the dramatic decline of the birth rate has converged with the new mobility of capital, people and information. This process has made possible the rapid dissemination of new medical reproductive technologies.

In this context, new reproductive technologies have resulted in the disentangling of the biological and care components of parenthood. In reproductive clinics, kinship links can be created through desire and care, as well as biology and genetics. New reproductive technologies have opened a new way of thinking about the different elements of the 'bio-genetic substance' of Euro-American kinship. In some contexts, the genetic link is activated, while in others, what is activated is gestational biology or intention and desire. Assisted reproduction makes possible various permutations for bringing together what have been described as the social and biological aspects of kinship. One effect of having separated the different parts of biogenetic substance is that we need contextual information in order to know the exact meaning of the "kinning" process in descent. Another effect it is that the context can change and/or be contested. The indeterminacy of fatherhood and motherhood is solved not by the recursivity of descent, but by reference to other compartments of knowledge. As Strathern (2014: 56) has said recently, motherhood and fatherhood need context in order to be determined.

Let me explain these contexts with an ethnographic vignette from a Barcelona assisted reproduction clinic. This material comes from Giulia Zanini's (2013) dissertation about cross-border reproductive care. Zanini spoke with an Italian couple that travelled to Barcelona in order to undergo IVF with donor gametes, treatment that they thought should have been available in Italy. "It makes us sad to think about our country", they said, showing distress over "the idea that you have to go abroad to do something normal". They felt dissatisfied with their country because, despite cultural similarities between Italy and Spain, the former has a very restrictive assisted reproduction law and the latter a very liberal one. They didn't understand why such similar countries had different norms for gamete donation. "So it is even more distressing to me", says the wife. "This (Spain) is a coun-

try…yes we have the Vatican, but here, it is a country with a Catholic tradition, a Mediterranean country…they can do it. Why can't we do the same? It is very disagreeable", she concludes.

Reproductive technologies travel, but the results are very uneven, as the differences between Italian and Spanish law demonstrate. The Italian couple points out similarities in terms of a shared Mediterranean culture and Catholic religion. But this knowledge is not enough for solving the Italian puzzle. They need to explore other domains of knowledge to understand their situation as Italian (in) fertile citizens. The issue of gamete donation leads to questions about cultural and religious similarities and differences between countries, as well as moral feelings about the legitimacy of their decisions despite their country's laws. In this case, kinship knowledge is not the recognition of the facts of nature, but a device that brings divergent domains of life into interaction with each other. The couple uses culture, religion, politics and law to understand their reproductive situation. A gamete received in a foreign country has different meaning when associated with parenthood. The gamete links disparate fields of knowledge about the world.

Finally, I want to present another ethnographic vignette to point out changes in the context of descent by assisted reproduction. This example comes from research I conducted over 10 years ago with Jeanette Edwards, Enric Porqueres, Judith Sándor and others (see Edwards and Salazar 2009).

I was struck by the thoughts of a woman whose doctors recommended oocyte donation. Since the waiting list was very long and at that time the vitrification technique was not available, they had suggested that she supply a donor in order to shorten the waiting list. The donation would remain anonymous because this donor would assist another person. However, the intended mother, who was from a small town, understood the donation in Maussians terms. She would be indebted to the donor and the gift would participate in the identity of the donor. Her motherhood would be interpreted in the context of concrete relations in their small town. She preferred the anonymity of the city, where there would be no debt and no shared identity. She accepted the longer waiting time rather than providing a donor.

Anonymous donations have been contested and debated in recent years, and standpoints have changed. Not only parents but also children define descent. From this point of view genetic background is not incompatible with gestational or social kinship. A woman at a reproductive clinic in Barcelona took this position. She imagined a special relationship to her egg donor, giving her a place in the descent process, even though she knew that Spanish law forbade her from meeting the donor.

"The genetic mother has her place and so does the pregnant woman. It's a child that several people have had. The child has three parents, well, two mothers and a father. This seems to me a privilege and something very special. Somehow, I have a relationship with the donor. I can't clarify whether it is emotional, sexual or something that can't be defined, but it's clear to me. Perhaps, it would be good to meet her, but this isn't legally possible here" (couple subject 28. Dissertation Thesis Esther Crespo Mirasol, 2015*)*.

This is the sheer inventiveness of anonymous donation. Anonymous donation is a gift without debt, a way of enjoying something without sharing it. It also interconnects different areas of nature and society. Without information about the donation, the construction of self-identity seems difficult. Once again, relatives, even if they are just genetic, become 'intrinsic to the self' (Sahlins 2013: 20). The child is inserted in a network of parental meanings. She is introduced into the "mutuality of being", the key element in establishing a relationship between identity and difference. This is what NRT families teach us about the experience of kinship.

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JUDIT SÁNDOR

Consistency of the regulation on assisted reproduction: Is it a missing element of reproductive justice?

1. Introduction

My objective in this paper is to investigate a possible test that the majority of politicians and legislators, even scholars and academics have frequently neglected when reflecting on new reproductive technologies. I would like to examine the current legislative policies of assisted reproduction by looking into the *consistency* of the existing regulations. Examining consistency can offer a better vision on the consequences of biotechnological and genetic advances for the perceptions of fundamental rights. Since consistency is an important element of justice and, therefore, also of reproductive justice, mapping policies on what is allowed and what is forbidden or restricted will outline a general picture on how reproduction is seen by society. In seeking for consistent regulatory approaches to assisted reproduction, the questions of who will benefit from it and what roles gender differences play in it, will inevitably arise.

One can say that consistency of the regulation may seem obvious. Indeed it dictates that we treat similar cases similarly, we apply the same regulation to the similar cases and there is coherence within the rule. John Coons summarized this consistency as a maxim that "prescribes like treatment for successive cases governed by the same rule of law or morality".[1] Coons defends inconsistency in his article but when he analyzes examples then his cases stem from concrete medical decisions, which is different from setting guiding principles to legal rules. Judicial independence provides in itself a possibility of inconsistency. "Inconsistency is

1. John E. Coons, 1987, «Consistency». *California Law Review*, 75, 1: 59–113, at 60.

the legitimation under one rule of a plurality of results that would be recognized by different deciders of like cases as being in moral conflict."[2] It is important to note that Coons' examples encompass different judicial interpretations of the same rule.

I will examine consistency of the regulation through judicial cases in which reproductive regulation was challenged. I will not reflect on different judicial interpretations on the same matters in the same jurisdiction but cases from different jurisdiction where the regulation was challenged on the ground that it results in inequality or injustice to the parties. Here I will refer to cases where the courts had to decide on a particular IVF technology and I would like to demonstrate that in the lack of clear and unanimously held moral guidelines the courts often have nothing else to rely on but to see if the regulation of a new technology provides a consistent or inconsistent legal approach to the same regulatory situation.

The other obvious question that has to be raised here is the following; what do we seek to find consistency with? Should various forms of infertility treatment, assisted reproduction technologies be consistent with the rights and opportunities available in case of natural reproduction? At the beginning of reproductive technologies legislators and regulators wanted to make sure that there is nothing new and they simply wanted to offer the same rights to the infertile couples with the ones who naturally procreate. But today the answer to these questions is far from being consistent. First of all, the use of these technologies is no longer tied to infertility. When gamete donors participate in the application of a reproductive technology, there is a possibility of genetic screening to make sure that the child to be born would have better health. However, a similar practice in the case of natural reproduction would often contradict with human rights principles as an interference with the rights to privacy and reproductive freedoms. Another difficult question of consistency is whether gender differences should be reflected, annulled, or compensated in the field of regulating assisted reproduction. We shall analyze examples to all of these approaches.

Regulators often see their mission to preserve existing differences in gender, for example by providing different rules to sperm and egg donation, to sperm freezing and egg freezing. There is still a frequent claim that *mater semper certa est,* which dictates that the mother has to be certain in the reproductive procedures. In my view, this follows from the regulatory intent to create consistency with natural reproduction rather than providing consistence and coherence within the realm of regulating various forms of assisted reproduction. Other more recent

2. *Ibid.*, 70.

regulations acknowledge that we can offer new possibilities and we do not have to preserve the previous status of the gender relations within assisted reproduction. The technique can serve also compensatory purposes or can contribute to eliminate gender inequalities.[3]

I would rather look at certain regulatory models and I will examine consistency and inconsistency on this level. Some inconsistencies may be corrected by judicial interpretation but many others could not be. Of course, different judicial interpretations within the same jurisdiction on a similar matter may also seem inconsistent but this is not the field of my current discussion. One may also add that consistency is expected within one particular sphere of law that regulates similar issues. For instance, if patients are to be informed about the risks of a minor medical intervention then they should also be informed about the risks of an operation. This principle may seem self-evident, but I will suggest a reason to doubt both its perspicuity and its soundness.

2. A donor or a parent? Should consistency or difference govern the regulation on gamete donation?

It seems that one can have very different expectations towards her own body and towards biological specimens, cells, tissues, organs borrowed, used, bought, or received from others. While dignity and privacy with regard to our own body indicates the unity of the person and the body, the cases of using surrogate mothers, egg and semen donors, embryos, or embryonic stem cell products suggest a property-like treatment of the human body. Studies that examine concepts of parenthood across countries often emphasize the divergent nature of regulation.[4]

In the case *Johnson v. Superior Court of Los Angeles County,*[5] the plaintiffs, Diana and Ronald Johnson bought sperm from the California sperm bank Cryobank. A successful insemination led to the birth of their daughter (Brittany) who, six years later, was diagnosed with a severe form of autosomal dominant polycystic kidney disease (ADPKD). ADPKD is a disease of which the Johnsons had no family history, they suspected that the disease was transferred to their daughter from the sperm donor. After long legal proceedings, it was eventually revealed that Cryobank's personnel, who interviewed the donor, knew that he had a family

3. Such as ROPA (reception of oocyte from the partner in Lesbian couples) in Spain.

4. See, for example, Brigitte Feuillet-Liger, Thérese Callus, and Kristina Orfali, 2014 *Reproductive Technology and Changing Perceptions of the Parenthood around the World.* Brussels: Bruylant.

5. *Johnson et al. v. the Superior of Los Angeles County*, 2000, 80 Cal.App.4th 1050.

medical history that indicated the existence of ADPKD. But despite this knowledge Cryobank accepted him as a donor without further investigation to determine whether he might indeed carry the ADPKD gene, and later sold his sperm to the Johnsons without warning them about the possible genetic risks involved.

The Johnsons sued Cryobank and its employees for failing to disclose that the sperm they had used came from a donor with a family history of ADPKD, fraud, breach of contract and, later, also filed a motion to amend their complaint to add a claim for punitive damages. The trial court rejected the Johnsons' fraud claim, held that Brittany was not entitled to recover general damages or damages for lost earnings, and denied the Johnsons' motion to add punitive damages to their claim.

On appeal, while acknowledging that there were substantial policy reasons in favor of allowing for punitive damages, the California Court of Appeals affirmed the trial court's denial of the Johnsons' motion to add punitive damages to their claim. Most importantly, the California Court of Appeals subscribed to the trial court's characterization of Brittany's claim as one for 'wrongful life' and thus held that under California Supreme Court case law she was not entitled to recover general damages or damages for lost earnings. Eventually, the Court of Appeals remanded the case for further proceedings addressing only the Johnsons' negligence and fraud claims. And after almost another ten months of procedural complications, and almost seven years after the Johnsons filed their original claim, the parties finally settled the case for $ 1,250,000.[6]

In cases where such negligence can be observed it is apparent that the artificial intervention constitutes liability. Selecting sperm donor pose the burden of certain quality assessment similar than in product liability cases. This legal framework indicates that regulation treats donors and parents differently. Donors are subject to screening and the failure to perform good selection may result in legal proceedings.

In *S. H. and Others v. Austria*,[7] the European Court of Human Rights had to examine a case in which two couples, both in need of gamete donation, challenged the Austrian law on grounds of preventing gamete donation inconsistently. The applicants complained that the prohibition of heterologous artificial procreation techniques for *in vitro* fertilization laid down by Section 3(1) and 3(2) of the Artificial Procreation Act had violated their rights under Article 8 of the Con-

6. See Jenna H. Bauman, 2001 «Discovering Donors: Legal Rights to Access Information about Anonymous Sperm Donors Given to Children of Artificial Insemination in Johnson v. Superior Court of Los Angeles County». *Golden Gate University Law Review* 31, 2: 193–218.

7. *S. H. and Others v. Austria*; ECtHR, application no. 57813/00, judgment of April 1, 2010; judgment of November 3, 2011.

vention. It was apparent that the Austrian legislature was guided by the idea that medically assisted procreation should take place similarly to natural procreation, and in particular that the basic principle of civil law –*mater semper certa est*– should be maintained by avoiding the possibility that two persons could claim to be the biological mother of one and the same child and to avoid disputes between a biological and a genetic mother in the wider sense.

The Court concluded that neither in respect of the prohibition of ovum donation for the purposes of artificial procreation nor in respect of the prohibition of sperm donation for *in vitro* fertilization under section 3 of the Artificial Procreation Act, the Austrian legislature, at the relevant time, exceeded the margin of appreciation. As a result the Court stated that there has been no breach of Article 8 of the Convention with regard to all of the applicants. However, the Court noted that the Austrian parliament has not, until now, undertaken a thorough assessment of the rules governing artificial procreation, taking into account the dynamic developments in science and society noted above. The Court also noted that the Austrian Constitutional Court, when finding that the legislature had complied with the principle of proportionality under Article 8(2) of the Convention, adding that the principle adopted by the legislature to permit homologous methods of artificial procreation as a rule and insemination using donor sperm as an exception reflected the then current state of medical science and the consensus in society. This, however, did not mean that these criteria would not be subject to developments which the legislature would have to take into account in the future.

3. The status of the in vitro embryo: Future offspring, property or research subject?

The mere possibility of *extra corporal* reproduction resulted in numerous legal problems, such as *post mortem* reproduction, custodial rights over the embryo, right to identity and medical secrecy. In *Hecht v. Superior Court*[8] the issue was whether a partner of the deceased man could have an access to the sperms stored by her partner (for the purposes of reproduction). In other terms whether the right to procreation based on privacy encompasses the right to postmortem insemination. In the last will of the deceased partner Ms. Hecht was named as the executor of his last will. However the California Cryobank refused to release the specimens based on the protest of the two children of the deceased partner. Ms Hecht argued that the destruction of the sperms would be a violation of her rights to privacy un-

8. *Hecht v. Superior Court*, 20 Cal. Rptr. 2d 275, 287 (Ct. App. 1993).

der the Federal and under the California Constitution. The Court did not find any public policy that would prohibit or deny postmortem insemination. They granted the access as the late partner clearly expressed his wish before his death.

The European Court of Human Rights had already faced several times the questions on how to interpret regulatory restrictions on the decisions over the human embryo. The first important case was the *Evans v. the United Kingdom* case,[9] in which the applicant claimed that her privacy rights were infringed by granting a legal possibility to destroy her embryos based on the partner's request. While access to many forms of *in vitro* fertilization is accepted as a rule,[10] the issue here was the *conflict between the rights of the prospective mother and the male producer of the embryo*. It is the *in vitro* procedure and *ex utero* storage that creates disruption between the phases of human reproduction. The legal contradiction here is while assisted reproduction was developed with the aim of helping to ensure the rights of the infertile and to grant them privacy and health service that would eliminate the pain of being childless, the disruption of the procedure created an opportunity to invade privacy and right to family life than in the regular cases of reproduction.

As the *Evans* case[11] shows, the procreative liberties recognized as negative liberties (so women should not be prevented to carry on their pregnancy) but this liberty is not applicable in cases of in vitro treatment when the court recognized that here the fathers' right not to become a parent should prevail over her interest to become a mother. This case may have many different interpretations. The Court took into account the assessment of the new reproductive technologies when it recognized the disruption of procreation and pregnancy in case of the in vitro treatment.

The main ethical dilemma of the *Evans* case therefore was whether biological differences in gamete donation could be taken into account in assessing rights of the male and female donors. Furthermore, the court missed the opportunity to recognize the difference between preventing someone to become a parent and the denial of the right to change opinion on biological parenthood.[12]

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9. *Evans v. the United Kingdom*; ECtHR, application no. 6339/05, judgment of March 7, 2006; judgment of April 10, 2007, nyr.

10. In *Dickson v. the United Kingdom* (ECtHR, application no. 44362/04, judgment of December 4, 2007) the European Court of Human Rights had to examine the refusal of facilities for artificial insemination to the applicants, a prisoner and his wife. The Court found that Article 8 was applicable as the Article encompasses the respect for the individual's decision to become a genetic parent.

11. *Evans v. the United Kingdom*, *op. cit.*, para. 71.

12. A different solution was made in the Hungarian legislation since in such cases the law

In the case of *Parrillo v. Italy*[13] the Italian applicant after several unsuccessful attempts to have her own child asked to release the five cryopreserved embryos for stem cell research. Since 2004 (based on the Law no. 40 of 19 February 2004) it was forbidden to do research on the human embryo the IVF center did not allow to donate the embryos for such a purpose. After trying to challenge this in front of the Italian court she applied to the European Court of Human Rights. The court had to decide whether the Italian law's restriction on the individual donor's intent violates the Article 8 of the Convention. In other words whether it is consistent to allow cryopreservation without any specific reasons while embryos cannot be donated even if the embryo's "parent" decide so. It may seem inconsistent that cryopreservation is allowed even without any particular purpose while the donor cannot decide to offer it to a specific purpose. Another basis of comparison could be with a case of a donor who offers her eggs or embryo directly for the purposes of research even without preliminary cryopreservation. Since 2004 the Italian law has been clear on the prohibition of research conducted on embryos. Although the law has been criticized for taking a conservative approach to reproductive technologies, this position was still consistent within the Italian regulation. This can explain that at the end the Court held, by sixteen votes to one, that there has been no violation of Article 8 of the Convention.

4. Is there any difference between an embryo and a fetus?

In the *Costa* case[14] applicant stated that their private and family life was violated by the Italian law that although abortion of a fetus was allowed the selection of an embryo was forbidden. Particularly because in their case there was an inherited condition in the family that could have been screened out and thus saving the mother of abortions and repeated unsuccessful pregnancies. As a result of the prohibition on preimplantation genetic testing and diagnosis they claimed that their right to privacy was violated by Italian law. In Italian law assisted reproduction was available only to infertile couples and in cases when the man is a carrier of a sexually transmissible disease.

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permits the continuation of the procedure, by giving preference to the woman's wish. Naturally, the man is informed prior to entering the in vitro program in the first place, and, at that stage, he may exclude the possibility of continuation for such cases, but may not decide so later when the treatment is already being performed.

13. *Parrillo v. Italy*; ECtHR, application no. 46470/11, judgment of August 27, 2015.

14. *Costa and Pavan v. Italy*; ECtHR, application no. 54270/10, judgment of August 28, 2012.

In the judgment the Court explicitly referred to inconsistencies in the Italian law. As the Court noted, the government failed to explain how the risk of eugenic selection and dignity and freedom of conscience of the medical professions would be averted in the event of an abortion being carried out on similar medical grounds. Furthermore, the Court stated that the inconsistency in Italian legislation on PGD which constitutes an interference with the applicants' rights to respect for their private and family life, was disproportionate. Therefore it has been a violation of Article 8 of the Convention. Here in this case the Court pointed out correctly the inconsistency in the Italian regulation between the possibility of abortion and the ban on preimplantation diagnosis for the same condition that can be in a later stage of pregnancy result in abortion.

5. Should new technologies be distributed and accessible without any discrimination?

While *in vitro* fertilization procedures were introduced to "cure infertility", very soon after the first application of these techniques concerns regarding the quality of gametes used in the procedure emerged. If infertile couples (or persons) pay for reproduction services could they claim higher standards of therapy, or at least the prescreening of certain serious medical conditions of the gamete donors? Would it transform the procedure from "personal donation" to a kind of "product liability" case?

Looking at the practice of the courts in the United States it seems that couples have higher expectations once they undergo the complicated and often painful IVF treatment and in case of inheritable condition on the side of donor they sue clinics for wrongful life.

In the *Paretta v. Medical Offices for Human Reproduction* case[15] the plaintiffs were a husband and wife who filed a medical malpractice action in their own right and on behalf of their daughter. In 1998, Josephine and Gerard Paretta requested fertility treatment and their physician recommended that Mrs. Paretta undergo *in vitro* fertilization using an ovum donor at the Center for Women's Reproductive Care at Columbia University. The couple agreed on this and they were provided with detailed information about the potential oocyte donor, specifically, that she was white, a second-time donor, a heterosexual, an only child of an Irish father and English mother, a Protestant, that she was five feet six inches tall, that she had

15. *Paretta Med. v. Offices for Human Reproduction*, 2004 N.Y. App. Div. LEXIS 4556 (N.Y. App. Div. 1st Dep't, Apr. 13, 2004).

dark brown hair and brown eyes, was long necked with small eyes and ears, that she had a short thin nose, dimples and high cheekbones, and that she did not have freckles. After hearing about these features of the potential donor, the Parettas decided to use her ova. The routine practice was to inform the patients if the potential donor was a carrier of cystic fibrosis. But in this case no one told the Parettas that the available donor was a carrier of the disease. Mrs Paretta became pregnant and gave birth to a child, but soon after her birth it turned out that the child had cystic fibrosis. The husband and wife submitted an action alleging that the doctors and organizations were negligent because they did not screen the ovum donor to determine if she was a carrier of cystic fibrosis. The trial court however held that the husband and wife's child did not have a fundamental right to be born free of disease, and case law precluded the child from recovering damages from the doctors and organizations that helped her parents conceive. Moreover, the case law did not preclude the husband and wife's action seeking damages for expenses they incurred to raise a child with cystic fibrosis, but it did preclude their claim for emotional distress.

Naturally born children do not have a fundamental right to be born free of genetic defects. According to the court, ova donation will not make a difference. Similarly, plaintiffs cannot recover damages for the emotional distress they experienced as a result of having a child with a genetic disease. The emotional distress suffered by parents as a result of the birth of a genetically diseased child after *in vitro* fertilization cannot be treated any differently from that sustained by other parents. However, plaintiffs state a cause of action for the pecuniary expense arising from the heightened care and treatment of their sick child, including claims for compensation related to the plaintiff mother's decision to leave her job so that she could care for her child on a full-time basis. Furthermore, plaintiffs state a cause of action for punitive damages based on allegations of the defendants' grossly negligent or reckless conduct.

In the field of debates on choosing children with specific traits Joan Rothschild points out that "the growing ability to identify genetic conditions through sequencing research combines with refinements and advances in detecting techniques to extend the list of 'defects".[16]

In 2011 in the case of *R.R. v. Poland*,[17] the European Court of Human Rights (ECtHR) dealt with the complaint of a young Polish mother of several children who

16. Joan Rothschild, 2005, *The Dream of the Perfect Child.* Bloomington: Indiana University Press, p. 91.

17. *R.R. v. Poland*; ECtHR, application no. 27617/04, judgment of May 26, 2011.

had to travel from one medical institution to another between Łódź and Kraków to confirm or dismiss the possibility of a severe fetal disorder, suspected at a previous ultrasound exam, and consequently allow her to request an abortion. In a number of cases her request was denied because genetic exams would require a special doctor's referral. After long delays, the genetic test that finally took place in April 2002 confirmed that the fetus did in fact suffer from Turner syndrome and, in accordance with a 1993 Polish law, the request for abortion could be granted. But then fulfillment of her request was now denied on the grounds that her pregnancy was way too far ahead. Thus, on July 11, 2002, the plaintiff gave birth to a girl diagnosed with Turner syndrome. The young woman went to several Polish courts and in her claim she wanted recognition that her doctors prevented her from the timely completion of the genetic test and an application for abortion based on Polish laws.

The peculiarity of the case is that the European Court of Human Rights not only found the violation of privacy rights based on information restraint, involuntary pregnancy, and living in fear, but also ruled that the inhuman and degrading treatment shown towards the complainant violated Article 3 of the European Convention on Human Rights (ECHR) on the Prohibition of torture.[18] One of the inconsistencies within the Polish regulation can be found between the restrictive abortion laws and the availability of prenatal genetic examination. Prenatal genetic testing may constitute new grounds for "health" indications in abortion. However, uncertainty on how to achieve consistency in this particular case between the availability of genetic tests and the legal restrictions on abortion led to repeated referrals and deliberate delays which resulted in the violation of the rights of the pregnant woman.

6. Should international and national surrogacy agreements have identical legal policies?

Surrogacy is controversial and often debated subject in the field of assisted reproduction and therefore it can be used to demonstrate various legal inconsistencies. For instance, if a woman who does not have eggs or eggs that are capable of fertilization seeks an egg donor, then donation in this case is allowed in most of the countries where assisted reproduction is being practiced. However, if a woman lost her uterus because of an operation but she still has her eggs she would need

18. "No one shall be subjected to torture or to inhuman or degrading treatment or punishment." Official English title of the Convention: *European Convention of Human Rights*; full text available at echr.coe.int/Documents/Convention_ENG.pdf, last accessed on September 15, 2015.

a surrogate mother, but surrogacy is forbidden in many countries. In other words, a woman can be a surrogate herself by carrying someone else's genetic embryo while she cannot seek out the same service from another woman even in case of similar medical needs.

Someone may say that perhaps the regulation of surrogacy would have been completely different had it not been for the famous *Baby M.* case of 1987.[19] In the often quoted story later adopted to the big screen, Mary Beth Whitehead was not only a surrogate mother but, since *in vitro* (extracorporeal) fertilization was seldom used at the time, also the genetic mother of the baby mentioned only as M. in the court proceedings. After the child was born, lengthy court proceedings ensued between the genetic father and his wife, who were paying for the surrogacy, and the surrogate mother as to who should win custody over the child.

The key moral issue regarding surrogacy is that it turns motherhood into a business enterprise and is coupled with defenselessness, as the biological mother may be deprived of her rights. Surrogacy may be problematic also when the parents "placing the order" have special wishes or change their minds.

Even though the procedure is expensive, and the legal, traveling, and administrative costs are further increased by the fee paid to the surrogate mother and, in special cases, the egg donor, the United States is often chosen as the site for surrogacy due to the high level of organization and the favorable legal environment. Although India is less expensive and a number of private clinics have specialized in recruiting surrogate mothers, these women are more exposed to miscarriage or many other health complications. As they do not even speak the same language as the buyers, they can be more easily deceived. In a patriarchal society, another frequently quoted issue is that a woman becomes a surrogate mother not on her own free will but because her family would like to generate some extra income. The first case of surrogacy in India was registered in 1994, when the surrogate mother was paid 50,000 rupees and she used the money to have her paralyzed husband treated. Other parents travel to Thailand, Mexico or Ukraine.

Low price is just one of the aspects to consider. The legal background is even more important to the clients, as most of them only travel to such distant countries because surrogacy agreements are illegal in most of Europe, with some countries even threatening to apply criminal law to the parties involved, and in some other countries the invalidity and the unenforceability of the contract is considered a risk factor. The proliferation of international surrogacy raises another legal issue: if the surrogacy agreement is concluded abroad, can the child be acknowledged

19. *Baby M* case, 109 N.J. 396, 447–49, 537 A. 2d 1227, 1253–54 (1988).

under the law of a country that does not recognize or actually bans surrogacy agreements? Here the issue cannot be settled as simply as with an illegal action under the law of the specific country, as the child would suffer severe legal consequences if he or she could not be granted citizenship in the parents' home country and would have to be smuggled across the border while being sedated with drugs.

In the context of new reproductive technologies the access to IVF treatment seemed to pose different kinds of legal problems in the U.S. than in Europe.[20] The validity of surrogacy agreement served the basis of several Court decisions, such as in the *Baby M.* case.[21] In the *Johnson v. Calvert* case,[22] the California Supreme Court rejected a claim by the gestational (surrogate) mother that she can be recognized as the mother of the IVF child. Although birth may establish maternity (*mater est quam gestation demonstrate*) however, the Court developed a different standard by referring to genetic consanguinity and intention expressed by the genetic parents to raise the child. The recognition of family based on genetic ties rather than on marriage had influenced also paternity rights, which is demonstrated in numerous cases, such as *Michael H. v. Gerald D.*[23] Justice Scalia defended the "unitary family" which is accorded traditional respect in western societies.

On the other hand, the notion of surrogacy is hard to reconcile with the legal system in a number of European countries. We might add that surrogate mothers in India or Ukraine are even more defenseless against the heterosexual or homosexual parents from richer countries than in those cases where the operation and the child rearing occur in the same country. If, for instance, the surrogate mother needs medical attention, she would most likely not have access to the same level of medical care in those countries as in the country of the parents. Another important aspect is that same-sex couples have to go through complicated procedures to adopt a child while surrogacy may offer an easy way out to them. The rights of surrogate mothers may be curtailed in countries where information services and patient rights are not so advanced.

Although preparations seem complicated, it is only after the child's birth that real legal difficulties begin. The father signs a voluntary paternity acknowledgement form and the father's wife usually adopts the newborn child. Even if they

20. Richard F. Storrow, 2007 «The Bioethics of Prospective Parenthood: In Pursuit of the Proper Standard for Gatekeeping in Infertility Clinics». *Cardozo Law Review* 28, 5: 2283–2320, at 2291.

21. In *Baby M*, 109 N.J. 396, 447–49, 537 A. 2d 1227, 1253–54 (1988).

22. *Johnson v. Calvert*, 851 P.2d 776 (Cal. 1993).

23. *Michael H. v. Gerald D*. 491 U.S. 110, 115 (1989).

have a birth certificate, they are required to have their child recognized by the legal system of their home country after their return from abroad.

In June 2014, the European Court of Human Rights issued rulings in two cases (*Labassee v. France*[24] and *Mennesson v. France*[25]) concerning the recognition of the family status of children born as a result of surrogacy agreements. In the first case, the French couple residing in Toulouse had concluded a surrogacy agreement in Minnesota, where the daughter named Juliette was born in 2001 after the egg of an anonymous donor was fertilized with the father's sperm and the embryo was implanted in the surrogate mother's uterus. The other French couple in Maisons-Alfort followed the same path in California, where twins were born. Upon their return to France, the parents encountered difficulties when trying to obtain a birth certificate and citizenship for their children. The local court of guardians, then the court of second instance in Lille, and finally the court of appeal all declared the surrogacy agreement null and void as being contrary to French law, under which the carrying surrogate mother is considered the child's mother. The applicants, however, argued before the Strasbourg court that failure to recognize the child's status was in violation of the New York United Convention on the Rights of the Child and Article 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms and that it had already been raised in the *Genovese v. Malta* case that citizenship was an integral part of personal identity. The court ruled that Article 8 was, indeed, violated in both cases and concluded that the child's origin is an important element of privacy rights, which were damaged by the French authorities' failure to recognize the child's relationship with the parents. The increasing number of international surrogacy cases raises the issue whether inconsistency across various jurisdictions could be maintained with regard to the status of children born as a result of surrogacy.

7. Should commercial and non-commercial surrogacy be treated similarly by regulation?

An old but never fully answered question in the field of surrogacy is whether a regulation can differentiate between commercial and non-commercial form of surrogacy. Hungarian legislation established a good, although not lasting, rule on this issue in 1997 when surrogacy for money was banned but altruistic surrogacy between relatives was permitted. The legislator was in an easy situation, as the

24. *Labassee v. France*; ECtHR, application no. 65941/11, judgment of June 26, 2014.
25. *Mennesson v. France*; ECtHR, application no. 65192/11, judgment of June 26, 2014.

Hungarian language actually uses two different terms for these two types of surrogacy: *béranyaság* (literally "rented motherhood") for the one that refers to money paid to a non-family member and *dajkaterhesség* (literally "nanny pregnancy") where only family members are involved.[26] The first one incorporates the possibility of exploitation and damage to health and the key moral issue is the disputed status of the child ordered from a distance, with a chance that these "orders" can be occasionally withdrawn or cancelled.

However, if we accept that *in vitro* fertilization, including egg donation, is technically and legally possible, then this should logically lead to the conclusion that some forms of surrogacy must be authorized as well. This is so because the surrogate mother actually (in the genetic sense) carries another person's pregnancy in the form of the donated egg, with all the health and psychological consequences involved. As such, if we accept these procedures, why is it that a woman who loses her uterus cannot be considered as the mother whereas someone who loses her egg, and thereby the chance for genetic motherhood, is already acknowledged as the mother?

With an increase in the number of foreign cases of surrogacy, the regulations are expected to change, not to mention that surrogacy is, in fact, already permitted in a few European countries.

8. Conclusions

As we have seen in the examination of legal cases and the contemporary legal discourse on them, the law in this field had to react very quickly to several new technologies one after the other leaving no time to reconsider inconsistencies. The hasty interpretation of scientific discoveries and new technological possibilities has many traps. Human rights analysis is not necessarily based on an accurate assessment of scientific developments, and these interpretations sometimes misread the effects of applying new biotechnologies. Moreover, normative interpretations may also be distorted due to factors that are entirely independent from scientific research.

One can easily see a shift in the consistency standard. In the twentieth century examination of consistency was based on a comparison of the similarity between "natural" reproduction and assisted reproductive technologies. In the twenty-first

26. Judit Sándor, 2014, «Reconciling Traditional families with In Vitro Assistance: the Hungaain Legal framework on Kinship in the Light of Biomedical Intervention». In Brigitte Feuillet-Liger, Thérese Callus, and Kristina Orfali (eds.) *Reproductive Technology and Changing Perceptions of the Parenthood around the World:* 156–157. Brussels: Bruylant.

century when new technologies offer services to a much broader group of individuals –not only to the heterosexual infertile, but also to the fertile couples with genetic diseases, to single parents, to childless couples, and to new familie– the comparison between "natural" and assisted reproduction is no longer sufficient. Therefore, consistency analyses would provide a better outcome of reproductive justice if they are performed within the realm of regulating these new technologies and do not necessarily insist on examining their similarity with "natural" reproduction. Indeed, reproductive technologies have developed their own regulatory scope, which should be checked for its own consistency from time to time, but we can see now how far we have moved from the intention to merely "mimic" natural reproduction. As a consequence, judicial interpretation has to analyze scientific activities in a complex way and have to examine also previous laws regulating a similar scientific field. Consistency of a regulation is not just a technical matter: it is a very important and constitutive element of the rule of law and, in this case, of reproductive justice.

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LINA PAPADOPOULOU

Is there a "right to reproduce" through MAR techniques?

1. Introduction

Modern assisted reproduction technologies (ART), by gradually enlarging the boundaries of the "scientifically possible" in the field of reproduction, have improved everyone's chances to become a parent and rear children, leading as such to a "reproductive revolution" (Robertson 1994: 6). This "new reproduction", based on technology, allows for the separation of genetic and gestational motherhood, while social developments permit the separation of the first two from social and legal parenting. Thus, talking about reproduction today one should necessarily include Medically Assisted Reproduction (MAR). Starting from the premise that engaging in reproductive intercourse used to be considered as a fundamental right, the legal question posed nowadays is whether this right to reproductive autonomy includes also MAR, i.e. non-coital or collaborative reproduction (that is, with the participation of a gamete donor or gestator who is not one's spouse) through ART. An initial question is the one focusing on the legitimate, in an ethical sense, grounding of extending in this way the right to reproduce.

This paper discusses this theme and tries to explore the question whether there is a constitutionally –at a national, European or global level– entrenched right of an access to ART. It also examines the access to infertility treatment from the subject's point of view, placing emphasis on the prospective or potential parents rather than on the "best interest" of the child. This methodological pre-choice is due, firstly, to the belief that there is no objective knowledge to draw from in order to judge the "best interest" of an unborn child, if one excludes the intended

physical exploitation. Secondly, even if a competent authority was to specify the minimum requirements for a decent life of the child-to-be-born, the state would still need to justify why it sets such standards to private actors when reproduction is collaborative, involving a doctor or other reproductive technicians, donors and surrogates, and not when the collaboration stays between two heterosexual persons having sexual intercourse leading to pregnancy and birth. Deviations are possible but need to be justified, especially if one does not want to undermine the consistency of legal regulation and thus the principle of equal treatment of similar situations as well as the principle of neutrality of the state towards different ways of life, in other words an expression of liberalism in its classical sense.

2. Reproductive authonomy and MAR

i. The interference of a "negative right" to use ART

The question posed above is being elaborated as to which extend and on what context we could use the language of rights to describe the wish to have a child through MAR. In other words, the question is whether there exists, as a human liberty, a "right to reproduce" not only naturally, before and even outside the law, recognised by the latter, covering natural sexual intercourse, but also if this natural liberty covers also the use of ART, that is of a particular kind of treatment/technology. In this form, the right to reproduce extends the right to use ART, and it is primarily a "negative right" which means that it requires nothing more than restraint or "negative action" from the State towards all agents engaging in this project. The duty of the state would thus only be a non-prohibitive policy, in other words, the right would so mean freedom from coercion.

According to John Robertson (1994, 1983: 405), a scholar who defended the right to procreate in a long series of articles, procreative liberty is the freedom to either have children or to avoid having them. This liberty goes back to the general individual liberty and the free development of one's personality. Henceforth, natural reproduction and MAR are the two sides of the same negative right towards reproductive autonomy. As such this right does not necessarily result into a positive right, i.e. does not produce an obligation to anyone and especially the state to provide real opportunities for reproduction.

As said by Robertson, the right to reproduce "in the genetic sense", is the something "which may also include rearing or not". It thus covers the right of couples to avoid procreation as a correlative to the right to procreate, whereas the unregulated freedom of married couples to coitally procreate also means a freedom to do so noncoitally. The foundation of such a right is obviously liberty (or

freedom), even if the writer terms it as the interest of anyone in liberty and autonomy (Quigley 2010: 405). The main argument in favour of equalizing natural and medically assisted reproduction is that infertility, as a consequence of the natural lottery, ought not to prevent someone from pursuing what has been recognized as of value or justified interest to all.

ii. Possible limitations of the right to reproduce through ART

Obviously even if there was such a right to use ART, it would not be unlimited but it would undergo specific limitations. Limitations, different than those applicable to "natural" procreation (such as physical abuse, age, incest etc), should be based on the differences between coital and non-coital reproduction. The collaborative nature of MAR resulting to distinction between genetic, gestational, and social/legal parents, the involvement of professional reproductive technicians and the commercialisation of ART, may offer solid grounds to introduce further limitations. Yet, any of the latter should be specifically and thoroughly justified on sound grounding and respect the core of the right to reproduce.

Limitations are closely linked with the question who should have access to allowed services. If there is a fundamental right to assisted reproduction then the exclusions of such service, based on considerations of common interest that should be thought to supersede the fundamental right, should be strongly and firmly justified. On the contrary, if MAR is (or should be conceived as) a therapeutical treatment, so that we talk about "patients", then the right to have access to MAR techniques would require very specific health-related requirements, i.e. biological and not social infertility. On the other hand, if one accepted the view that it is just a technological development, to which everybody should have access, then everybody and not only biologically or socially infertile couples, should have free access to it.

iii. Extending the right to singles and non-heterosexual couples

Yet, the above mentioned argument does not extend to social infertility, i.e. to single women and homosexuals, especially if homosexuality is perceived as a choice. Nevertheless, there is no sound moral ground to distinguish between them and heterosexual couples if one accepts the fundamental nature of the right to have a family, to bear and/or rear children, i.e. the right to have a family. If everyone should be free to raise a family and if having a family is essentially valuable for a human being, the state should not intervene with people's life, irrespective of whether the creation of a family rests upon natural procedures or technical means.

There is thus a continuum in the discussion concerning on the first hand, the "natural" procreation by two heterosexual married and fertile persons, which seems to be the biologically and socially privileged reproductive schema, and on the other, the consecutive adoption by a same sex second parent. Stepping from one model to another is an exercise of consistency and equality/non-discrimination considerations, without this necessarily meaning that no ideological or other socially burdened evaluations may disrupt this continuum. So, the extension of the right to procreate may be easier defended if one thinks gradually: a heterosexual infertile couple should not be discriminated against the others, due to the natural lottery which caused them the biological incapacity to procreate. Nevertheless, they should have a fundamental right to access MAR and use their own genetic material. Equally, the natural lottery should not mean harm to those couples lacking suitable genetic material, thus heterologous insemination should equally be considered as part of the fundamental right to procreate. But what if one knows that his/her heterosexual partner is infertile and still chooses her/him? Do they then lose their right because their infertility might have resulted from their choice? Obviously not, since the opposite would interfere with one's personal autonomy and the freedom to choose their own partners.

If this is valid, however, then choosing a partner of the same sex should equally not be considered a valid reason to miss your right to procreate through MAR techniques, even if homosexuality is considered a choice and not a biological imperative (which would then again link up to natural lottery). Last, but not least, if choice –as opposed to biology or natural lottery– is not an adequate factor to undermine the character of reproduction as fundamental right, then singleness should equally not exclude this same right, as long as this is technically possible through voluntarily collaboration (donation of gametes) without another person's coercion.

Conversely, even if one adopts an interest based theory of rights (Raz 1985), reproduction may easily perceived to represent a strong aspect of well-being for some people, either married heterosexual or single and/or homosexual. It does so only if we connect reproduction with rearing a child, one's own child, even though it may not be genetically connected with them. This brings us then also closer to adoption as a way to have and rear children. The belief that underpins this remark is that the main valid interest that lies behind the recognition of reproduction as a fundamental right is not the transfer of one's own genes to the next generations but the actual rearing of one's own child (Quigley 2010: 406). However if this interest is accepted as a foundational grounding –and not as an interest allowing a

choice– then a right to reproduce would be intimately linked to the *ability* to raise a child (Quigley 2010: 407).[1]

iv. From the negative to a positive right?

(a) Distinguishing negative liberty from positive liberty

The question arises to which extent conceiving the right to reproduce as a freedom implies that someone has a corresponding duty to provide for that right, or, at least, to provide the necessary environment for this right to be exercised freely and effectively, since a right is "a sufficient reason for holding some other person(s) to be under a duty" (Raz 1985: 195). If so, then who would be the recipient of such a duty? Selected national regulations concerning limited access to such treatment are measured against the answers to the previous questions which may also be formed as follows: Does this right entitle every person(s) who chooses and is allowed to reproduce through ART to have access to public resources?

The positive answer, implying that a negative right presupposes and implies also a positive right, rests on the reasoning that it is profoundly inadequate to determine privacy as a basis for reproductive and sexual freedom in a solely negative way, since such a conception "perpetuates the myth that the ability to effectuate one's choices rests exclusively on the individual, rather than acknowledging that choices are facilitated, hindered or entirely frustrated by social conditions". Adopting a solely negative privacy theory would thus mean that we exempt the state from the responsibility to contribute to the material conditions and form such social relations that would not impede, and conversely, could encourage autonomous decision-making (Copelon 1991: 46). On the contrary, "a person would effectively be prevented from exercising their right to choose because the opportunity to implement the relevant choice has been taken away from them" (Quigley 2010: 408).

However, the opposite view seems more convincing, especially if one keeps the limited resources problem in mind. This means that funding the infertility services would necessarily mean that there are less healthcare resources available in other areas (Quigley 2010: 410). That's why, the state has a meaningful basis to make choices and set priorities. Consequently, it may be induced that an affirmation of a negative right, does not necessarily mean that the State should provide all persons with the necessary resources to use ART. On the contrary,

1. The same author reports that in the UK, the Human Fertilization and Embryology Authority (HFEA) have produced a set of guidelines in order to assess the suitability of the prospective parents and the expected welfare of the child to be born. Thus prospective parents must be screened before any infertility treatment can take place.

the state could limit them to those rendered infertile and thus it could –unproblematically at first sight– consider ART as any other technology, imposing so only proportional and well founded limitations and prohibitions to access it, and consider it as a medical treatment requiring a medical problem, i.e. infertility, when it comes to finance it.

There is also another, stronger, argument in favour of the distinction between the negative and positive side of the same right: if one sees both sides as inseparable, one could easier argue against extending the negative right to more categories. In other words, extending protection may result to restricted freedom. It is thus preferable to theoretically distinguish and then try to reconcile rather than unbreakably connect and run the danger of losing all because you cannot provide the appropriate services to all.

(b) Non discrimination and social infertility

The rupture to the above consideration starts from the principle of equality and consistency of the law. It is easy to defend the discrimination between a fertile and an infertile heterosexual couple. Since the former can reproduce without causing public expenses, one could find a legitimising reason for that. The problem starts when one considers social infertility. This mainly refers to lesbians, for whom it should be considered an inhuman or degrading treatment to be obliged to have sexual intercourse with a male partner in order to become biological mothers, something also true for singles not wishing to have sexual intercourse or not being able to find an (adequate) partner. Confining their opportunities to use ART through their own resources could possibly lead, under the circumstances, to their real inability to exercise their negative right to reproduce.

Obviously, the State could set criteria on who deserves public assistance, but these criteria should be gender neutral and relevant to the distributed good. Thus, income based criteria could be set to all infertile couples/singles or fertile singles measured in a proportionate manner respecting the core of the negative right to reproduce.

3. The judicial (non)recognition of a fundamental right to reproduce through ART

i. No fundamental right to use MAR is recognised by the European Courts

If the above holds at a theoretical –philosophical and/or normative– level, the question follows to which extent such a fundamental right has been judicially recognised by the European legislator and/or Courts. Focusing mainly on the

European Court of Human Rights (ECtHR) will provide us with an overall picture, since this Court bases its findings concerning violations of the European Convention on Human Rights and Freedoms (ECHR) on common European tendencies.

It may be argued that such a fundamental right could be based on article 8 ECHR[2] or Article 7 and 9 of the Charter of Fundamental Rights of the European Union.[3] There are already judgments of the European Court of Human Rights which show tendencies to that direction but neither an international law instrument,[4] nor an international Court (for example ECtHR or other), nor the Court of Justice of the European Union (CJEU) have recognised such a right yet.

So, at a European level there is not yet recognition –according to the prevailing view– of a fundamental right to reproduce through ART, without further requirements, meaning that any interested person may have the opportunity to have access to all technically available methods and techniques. Neither may all those who have become parents through MAR enjoy exactly the same rights or privileges with the "natural" parents.[5]

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2. Article 8 – Right to respect for private and family life: "Everyone has the right to respect for his private and family life, his home and his correspondence.There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others".

3. Article 7 – Respect for private and family life: "Everyone has the right to respect for his or her private and family life, home and communications". Article 9 - Right to marry and right to found a family: "The right to marry and the right to found a family shall be guaranteed in accordance with the national laws governing the exercise of these rights".

4. There are however some non-binding international human rights instruments making an express reference to reproductive freedom in general, such as the "Cairo Programme of Action8" (1994), the "Beijing Declaration and Platform of Action" (adopted at the Fourth World Conference on Women in 1995) etc.

5. See the recent decision of the Court of Justice of the European Union (CJEU), Case C-167/12, *C. D. v. S. T.*, Judgment of 18.3.2014, according to which the Court denied that a woman who became mother through surrogacy had the same right to get maternity leave with a mother who gave birth herself to her child. The Court declared that Member States are not required to provide maternity leave pursuant to Article 8 of that directive to a female worker who as a commissioning mother has had a baby through a surrogacy arrangement, even in circumstances where she may breastfeed the baby following the birth or where she does breastfeed the baby and that an employer's refusal to provide maternity leave to a commissioning mother who has had a baby through a surrogacy arrangement does not constitute discrimination on grounds of sex.

ii. The ambivalence of the Strasbourg case law

(a) Relevant case law

In the *Evans v. the United Kingdom*[6] judgment the ECtHR accepted that article 8 ECHR also covers the right of everybody –in this case the sperm giver and prospective father– to decide whether they wish to acquire or not a biological child through MAR. By the same token, in the *Dickson v. the United Kingdom*[7] judgment the ECtHR recognized that the right of someone to become genetic parent through MAR using his own genetic material, when he is factually, not only medically, incapable of succeeding that coitally (in this case because he was a prisoner) falls under the protection of private and family life of Article 8 par 1 ECHR.

In the famous *S. H. and others v. Austria*[8] case two couples of Austrians took recourse to the Court complaining for the restriction of their private and family life, because the national legislation contained prohibition concerning the use of donor's genetic material (sperm, ova and embryos). Before taking recourse to the ECtHR the applicants had already challenged, without success obviously, before the Austrian Constitutional Court, the constitutionality of the national regulation prohibiting the use of donated genetic material, obliging them to move to other countries where heterologous fertilisation was allowed. Although the First Section of the ECtHR found (Application no 57813/00, judgment of 01.04.2010) that there was a violation of Article 8 in combination with Article 14, the Grand Chamber reversed that judgment and adjudicated that the prohibition of heterologous insemination did not violate Article 8 ECHR. By adopting a quantitative approach (Penasa 2012: 172), the Court based its judgment on the lack of consensus between the Member States of the Council of Europe concerning the use of third persons' genetic material, which allowed a wide margin of appreciation to the national legislator to evaluate the situation and choose to adopt the one or the other solution, given the fact that such a prohibition was valid in more Member States. On the contrary, according to the dissenting opinion of four judges, the applicants' argument that this prohibition is a violation of Article 8 ECHR, since it restricts the right of the interested parts to acquire a child through MAR and more concretely through this specific method of heterologous insemination, was valid.

6. ECtHR, Judgment of 10th April 2007 (application No 6339/05). See also R (on the Application of Mellor) v Secretary for State for the Home Department, [2001] 3 WLR 533, C.A. and Dickson v The United Kingdom, ECtHR. Judgment of 4 December 2007 (Grand Chamber), Application No. 44362/04.

7. Judgment of 4th December 2007 (application No 44362/04).

8. Judgment of 3rd November 2011 (application No 57813/00).

In the case *Costa and Pavan v. Italy*[9] an Italian couple applied, on 20th September 2010, to the ECtHR alleging that the Italian legislation (Law No. 40/2004) allowing for medically-assisted reproduction only to sterile or infertile couples or where the man had a sexually transmissible viral disease, and prohibiting embryo screening (pre-implantation genetic diagnosis - PGD) breached their right to private and family life. More specifically the ban prevented them, as healthy carriers of cystic fibrosis, from screening their embryos for in vitro fertilisation, despite the existence of the right to therapeutic abortion in domestic law. The applicants claimed that the Italian legislation violated both Article 8 and Article 14 ECHR. They alleged that Law No. 40/2004 violated their right to private life, as the woman, in order to have healthy babies, would be obliged to become pregnant in a natural way and in case the prenatal testing showed the foetus to be infected from cystic fibrosis, which she was a healthy carrier, to have an abortion, as she had already done before. Moreover they claimed that they were discriminated when compared to couples for which MAR was permitted. This ban put the embryo's health in danger and caused a severe psychological distress to the prospective parents and the prospective mother to physical danger because of repeated abortions. Since the couple Costa and Pavan was not infertile –they had already acquired a child suffering from cystic fibrosis before– they could not use MAR. The Court unanimously accepted the applicants' allegations and found that Italy violated Article 8 ECHR. It based this verdict on its finding that the Italian legislation lacked "consistency" since it prohibited PGD on the one hand, but allowed abortion on medical grounds on the other, and this combination could only be found in three countries, Austria, Switzerland and Italy, while Switzerland had already taken necessary steps to change its relevant legislation.

Summing up, while there is not a fundamental right to reproduction through MAR techniques expressly recognized as such by the European Court of Human Rights, partial bans imposed by national legislation of the Member States concerning either the subjects or the objects of MAR may, nevertheless, violate the private and family life protected by the Convention.

(b) Some methodological remarks

In adjudicating such cases the ECtHR takes into consideration the legislation in force in all the Member States in order to come up with a kind of "human rights acquisition" in most of them. In this context, the ECtHR starts from the acceptances of a wide margin of appreciation recognized by the national legislator.

9. Judgment of August 28th, 2012 (Appl. No. 54270/10).

Only in such a case, that an expression of a human right has already been accepted by the majority of the Member States with an equivalent legislative background like the one involved in the case, does the Court proceed to establish the same dimension of the specific right at European level. Although this seems to be an objective procedure, involving a quantitative evaluation, it is more than that.

First of all this kind of adjudication presupposes that the Court sets down the criteria needed to establish the "sameness" between the State involved in the case and the rest of the states. This mental procedure of the evaluative comparison implies more than a mere objective exhibition of the facts. It sets the necessary background against which the legal question is measured. Secondly, a criterion used by the ECtHR is the consistency the national legislation must exhibit in order to set the limitations to a specific right, i.e. in regard to reproductive rights, the right to private and family life should be tolerated by the Court. "Consistency" may be another way to take equality consideration into account. And it certainly includes not only legal but also ethical evaluations and interpretations, not necessarily independent from the judges' pre-hermeneutical beliefs. The sensitive character of this kind of cases explains and to some extent makes such considerations unavoidable. At the same time, however, they render these judgments ethically and socially burdened and susceptible to critique.

(iii) A progressive Spanish legislative and judicial decision

The previous remark reveals on the one hand, the unbreakable interconnection between legal –legislative and judicial– treatment of MAR with social and thus national sensitivities on the other. It is thus of no surprise that Courts meet different decisions in different social contexts. Unable to adequately and deeply explore the landscape of legal treatment of MAR all over Europe, we prefer to focus on a characteristic Spanish case, which might show a way forward for the whole Europe, as it represents one of the most protective stances towards the right to reproduce as civil and social right. This judgment seems to be exemplarily setting the scene for what the issue is today concerning the access to MAR.

In 2013, the Spanish Ministry of Health, aiming at cutting some €7 billion from the public health budget, issued an administrative decision that banned women from accessing reproductive technologies paid by the public health system unless they were infertile or had attempted to conceive through "vaginal coitus" in the last twelve months. Through that decision the conservative government tried to negate the clear equality required by a Spanish law (passed during the previous socialist government) and introduce a French-style ban on women

without male partners receiving donor insemination. This exclusion of female couples and single women from access to assisted reproduction techniques in the public health system was decided by the government when it reviewed the portfolio of common services of the National Health System (the list of procedures in all communities should be covered by public health), although the Law 14/2006[10] on Assisted Human Reproduction does allow access by all women to these techniques, guaranteeing that "all women over 18 years old with full capacity to act may be receiving or use the techniques regulated by this law" […] "regardless of marital status and sexual orientation".

Consequently, two women in a same-sex relationship were denied access to this kind of technologies. The couple considered that their fundamental rights to equality, non-discrimination, dignity, private and family life and protection of reproductive health were violated. With the help of an NGO, Women's Link Worldwide, they took this case to the courts, purporting that reproduction through ART is a fundamental right that has to be exercised without discrimination. The "Juzgado de lo Social" No 18 (Social Court) in Madrid condemned in October 2015 the actions of both the public hospital "Fundación Jiménez Díaz" and the Local Health Authority, for discrimination in denying the treatment and its funding respectively. In its judgment, the Court considered that what was violated was the fundamental right of the couple not to be discriminated because of their sexual orientation. The Superior Court of Madrid has condemned the hospital and the Community of Madrid to pay 4,875 euros in compensation for moral and economic damage caused through the suspending an assisted reproduction treatment to the lesbian couple due to discrimination based on sexual orientation.[11]

The interesting element in this case is that access to MAR has been reaffirmed not only as a civil right, as freedom, but also as a social right, in the form of access to public health system, based on its connection with the non-discrimination principle. Using the latter in order to establish the access of single women or lesbian couples to MAR on equal terms with heterosexual couples clearly shows that in Spain MAR is not considered a health cure for (biological) infertility alone. Or otherwise perceived, biological infertility is equalized with social infertility and both must receive the same treatment by the state within the framework of the national health system. Accordingly, therapies for assisted reproduction paid for

10. Ley 14/2006, de 26 de mayo, sobre técnicas de reproducción humana asistida, available in Spanish at: http://noticias.juridicas.com/base_datos/Admin/l14-2006.html#a3 (last access October 5th, 2015).

11. See: http://politica.elpais.com/politica/2015/10/05/actualidad/1444034240_566720.html (last access October 5th, 2015).

by the public health system should be open to all women across Spain regardless of their personal situations. To this end the Spanish judge did not improvise but followed the Spanish legislator.

4. The philosophical questions posed

Leaving the ground of positivist legal adjudication and moving to its ethical and philosophical underpinnings, the main questions posed when one theorises on the issue of access to MAR techniques and associates this access with a fundamental right is to what extend access to artificial reproduction techniques is different than "natural" reproduction. In other words, it is asked if the individual right, that is the natural liberty to engage in coital reproduction equally applies when it comes to non-coital medically assisted reproduction. Philosophically speaking, and if one stays at the level of a fundamental individual right and does not talk about a social right to have free access to such kind of services (like in the Spanish case mentioned above), one could hardly find any ground to base substantive differences. If the law allows for a single woman to become legal mother after sexual intercourse with a man who does not want to undertake the legal and social role of the father, how could a legal order justify in ethico-legal terms the exclusion of single women from access to MAR?

It is obvious that the question whether the reproductive autonomy also covers MAR may be answered in all possible ways. This relativity reveals the subjective nature of the notion of human rights, which is not a product of rationality or dogmatically sound foundations solely but subject not only to different social and cultural underpinnings but also to emotionally, ethically and ideologically charged beliefs. These subjectivities meet in the field of legal regulation and produce a social negotiation, often formed through specific economic interests such as those of the fertility clinics. As outcome of this social and political negotiation, the law intervenes in the social reality and tries to shape and frame the factually and technologically possible. However, its boundaries are narrow, since the latter, the technological possible often escapes the legal framework either through an "illegal" action or through the trespassing of national borders, especially in today's globalised world or, even easier, in the European Union context.

This inherent relativity is partially undermined and rationalised through mental instruments such as the principle of consistency, as opposite to arbitrariness, closely connected with the fundamental value of our culture, the omnipotent and eternally absent equality principle. Equal treatment of sameness and

unequal treatment of difference may equally well result in all different modes of dealing with a specific issue if one changes the sameness/difference criteria. Yet, and despite this vagueness and openness of equality, which transposes it to the most used principle in public dialogue –in normal or judicial politics alike– considerations of equal treatment may not only be used as ethical and legal weapons by those expelled from the favourable regulation but also lead political reformations and case law to a different, more inclusive framing of the reproductive politics.

Equally, when one agrees that no limitations should be set to the use of MAR –at least no more than those valid for the "natural" way of conceiving– which would mean no (hyper)regulation of clinics and kinship attribution, the next question would be if we then allow for MAR to become a commercial venture. This being true, however, is this consideration ethically strong enough to stop heterosexual fertile couples, rich enough to fund the project, from preferring artificial methods than coital reproduction and save the sexual intercourse for the fun of it (*cf* Benagiano, Carrara, Filippi 2010: 97)?

5. Epilogue

Recognising a right to reproduction on equal terms no matter if it is coital or medically assisted is the other side of the coin of reproductive autonomy. The first side was the struggles to secure access and information concerning contraceptive measures and the legalisation of abortion. Nowadays, the demand is to expand the reproductive possibilities rather than to avoid them. From a feminist point of view, this marks a return to traditional roles even if they are to be served by women with a non traditional marital status, such as singles or lesbians.

In such a context it is vital to keep in mind that technology is at the same time both a facilitator of decisions and coercion. Being able to have an abortion often turns your decision to something socially –or individually, e.g. by your male partner– expected. By the same token, allowing to biologically or socially infertile woman unrestricted access to MAR could equally mean that you are expected to make use of them. In both cases you need to justify the "normal" development of things, i.e. keeping the baby or not having a baby. This is not a defence of conservatism, thus of a stance that things should only follow their own course, or anti-liberalism, in the sense of narrowing the options and finally one's own autonomy. It is rather a reminder that oppression may be hidden in ideologies and cultural expectations, in family structures and social encounters, not only in legal

regulations. Under these considerations paying attention to the social context of personal choices is an expression of a renewed feminism (Ryan 1990: 6).

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"Saying ART": A terminological and comparative reflection about legal texts on assisted reproduction

1. Introduction

This article aims to explore and examine how laws, through the use of specific language, deal with Assisted Reproductive Technologies (hereinafter referred to as: ARTs). The purpose is to explain whether legal language, embedded in a given social and political environment, is able or unable, or even "wants" or "doesn't want" to translate and transfer changes and upheavals characterising the new ways (manners, habits, etc.) children are "made".

I will describe the terminologies used to talk about ART, which is an important legal issue and a very controversial area. Finally, in a comparative perspective, I will present some examples of law articles concerning ART.

2. ART terminologies

Language is often the vector of concepts and understandings within the society in which it is used and spoken. Language can reveal contradictions, denials or acceptances of new social and societal realities. The law regulates these realities using specific language to name and define them. That is why legal terminology can be considered as a mirror and a magnifying lens reflecting trends and variations and boosting contrasts on contemporary issues and ingrained habits that are influenced by religion, history and politics (Bracchi 2014).

Legal texts related to medically assisted reproduction (hereinafter referred to as: MAR), constitute a very controversial matter and are influenced by a wide range of factors –cultural, ethical, legal, political, religious, scientific, etc.– (Atkin 2005: 82).

It is a fact that doctors and legal experts in the field of reproductive medicine work with sensitive concepts, morally encumbered relationships –affiliation, kinship, fatherhood, motherhood, homosexual/heterosexual/transsexual/single parenthood, etc.– as well as ethical issues. Moreover, ART strongly influence public discourse about the risks connected to the reproduction of human beings.

As pointed out by the Italian comparative lawyer and jurilinguist Rodolfo Sacco "Language and law are connected in many ways" (2005: 1). Moreover, Rodolfo Sacco asserts that "The transfer of legal knowledge is entrusted to written or spoken language. That which is written or spoken is most assuredly formulated in a language" (2005: 4). Unlike physicians, engineers or scientists that have different instruments for their research, for legal experts the only way of accessing legal knowledge is legal language (Charrow, Charrow, Crandal 1982: 181).

ART terminology is distinguished by the cohabitation of two different techni-co-scientific languages –the legal and the medical one– with specific characteristics. Moreover, we can observe a cross-linguistic influence and language transfer between those two professional jargons, also called professional sublanguages.

"Abetting the human reproduction is [first of all] a medical act" (Androulidakis-Dimitriadis: 2005) and the terminologies used belong to gynaecology and reproductive medicine. Therefore, the legislation on ART pays special attention to the informing of the abetted people about legal or illegal techniques, the procedures, possible dangers, costs or sanctions.

In ART, "law and medicine are in a logical conjugation" (Androulidakis-Dimitriadis: 2005) and their connection is especially intense: "[…] medicine has consequences not only on the patient, but it also influences the family relations. It interferes with the creation of a new life, where nature on its own fails to create it. So, […] medical science interferes with the legal order, thus forcing the legislator to regulate with provisions of basic law, what medicine is allowed to practice and what not" (Androulidakis-Dimitriadis: 2005).

To know, to understand, to speak and to process the language of gynaecology and reproductive medicine one does not, in general, have to know the language of law. In ART legal texts, however, these sublanguages can or must function together (Hiź 1982: 206). Doctors define "a problem in medical terms by using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to "treat it" (Conrad 1992: 211). As to reproductive medicine, it has a normative character and legal texts on ART have "consequences for the broader social arena", (Czech Science Foundation project). This includes "taboo[s] –sexuality, newly defined forms of kinship, for example

in the case of surrogate motherhood, etc., or the latent and manifested dictates of hetero-normative reproduction", (Czech Science Foundation project).

As medical terms and expressions are used in the text of a law, a code, then, as such, those terms and expressions acquire also a legal meaning. Doctors and patients are subjected to a legislation that can vary according to the different legal systems even if ART are medically possible. Moreover, as in any area of rapidly developing technology, the law has been slow in catching up with scientific and cultural progress.

3. ART: A legal issue

As we can read in the Warnock report "people generally want *some principles or other*[1] to govern the development and use of the new techniques. There must be *some* barriers that are not to be crossed, *some* limits fixed, beyond which people must not be allowed to go" (1982: 2)". What is the function of the law? How can the law fix those limits and create certain barriers?

As the (In)FERCIT research project provides a comparative perspective on ART in different European and non-European countries, I decided to focus on the most recent versions of the French, Greek, Italian and Spanish laws about assisted human reproduction.

First of all, I analysed the latest version of the French law on bioethics (*Loi n° 2011-814 du 7 juillet 2011 relative à la bioéthique*; hereinafter referred to as: French Law 814/2011), number 2011-814, dating 7th July 2011 (last modification on 9th July 2011), that changes the French Health Code (*Code de la santé publique*; hereinafter referred to as: French Health Code) and the Civil Code. Secondly, the Italian law (*Legge 19 febbraio 2004, n. 40. "Norme in materia di procreazione medicalmente assistita"*; hereinafter referred to as: Italian Law 40/2014), number 40/2004, about medically assisted procreation, based on the Italian Constitutional Court judgment number 162/2014 about the unconstitutionality of Article 4, subsection 4 that prohibited heterologous fertilization. Then the Spanish law (*Ley 14/2006, de 26 de mayo, sobre técnicas de reproducción humana asistida*; hereinafter referred to as: Spanish Law 14/2006), number 14/2006, 26th May, about human assisted reproduction techniques (consolidated version of 2nd August 2011). Finally, the Greek law (*Εφαρμογή της Ιατρικώς Υποβοηθούμενης Αναπαραγωγής* – Implementation of Medically Assisted Reproduction; hereinafter referred to as: Greek Law 3305/2005), number 3305/2005, came into force after a first law in

1. In the original text, some words are in bold and italic characters.

2002 (number 3089), with Chapter 3 (Regulations for Medically Assisted Reproduction) recently modified by law number 4272/2014.

I chose those four countries because they have some cultural similarities, close historical antecedents and they all apply the Civil Law[2] legal system: French and Napoleonic influence for France, Italy and Spain and German influence for Greece. Nevertheless, their positions about ART vary significantly.

For this study, I decided to follow a comparative and synchronic approach to analyse legal texts on ART.

There are many political and ethical questions surrounding assisted reproductive technology that countries try to regulate through various means "from laissez faire to highly controlled and restricted, with other models in between" laws (Atkin 2005: 82, Simpson 1998).

In my research corpus, the Italian law is the strictest as opposed to the Greek one that is the most lenient. The French law is an "in between model" and in the Spanish one it is explicitly written in the statement of motives (part II) that the new law follows a more open model according to the state of science and of clinical practice in enumerating ART. However, the legislation prevents the petrifaction of the law and allows health authorities to approve experimental techniques, once their scientific and clinical evidence has been proven:

> La nueva Ley sigue un criterio mucho más abierto al enumerar las técnicas que, según el estado de la ciencia y la práctica clínica, pueden realizarse hoy día. Sin embargo, evita la petrificación normativa, y habilita a la autoridad sanitaria correspondiente para autorizar, previo informe de la Comisión Nacional de Reproducción Humana Asistida, la práctica provisional y tutelada como técnica experimental de una nueva técnica; una vez constatada su evidencia científica y clínica, el Gobierno, mediante real decreto, puede actualizar la lista de técnicas autorizadas. (Spanish Law 14/2006)[3]

According to the different States, the legislation has been short or long in gestation and slow or fast in catching up with scientific progress. For example, in

2. It is also sometimes known as "Continental European law". The central source of this law, recognized as authoritative, contains codifications in a constitution or statute that are passed by legislature to amend a code.

3. The new law follows a model that is much more open and operates in accordance with the latest scientific developments and clinical practice, enumerating the techniques that nowadays can be realized. However, the law prevents the petrifaction of the legislation and allows the relevant health authorities to approve provisional and supervised practice as an experimental technique of a new method. This also depends on the report of the National Commission on Assisted Human Reproduction. Once proven their scientific and clinical evidence, the government, through a Royal Decree, may update the list of approved methods. (Our translation)

Italy, it took at least fifteen years before the law n. 40 of 2004 came into effect. In Greece, until 2002 there had been no special legislation although "medically familiar methods of assisted human reproduction had been practised for many years" (Androulidakis-Dimitriadis: 2005).

4. ART: A controversial area

I analyzed the legal texts composing my corpus focusing mainly on the most fundamental ethical and legal questions concerning ART. Controversy concerning access and resort to ART often focuses on heterologous fertilization and surrogacy. Disagreement stems from matters concerning the access to ART for members of same sex couples, single women or men and women who have passed their natural child-bearing age.

Moreover, the parentage of children born as a result of ART is a crucial matter: which are the parents' and/or donors' rights and responsibilities towards those children? What are the family relationships for children of ART? Which is the legal status for those children?

Record keeping and disclosure of identifying information about the donors is another subject of concern, as it is the storage and destruction of embryos, eggs and sperm as well as the status of the frozen biological material. Related to that, embryo experimentation, research and posthumous use of human products constitute three other very controversial questions.

Finally, legal texts can regulate the costs associated with ART and establish sanctions in case of violation of some articles of the law.

Out of the multiple factors involved in ART, I decided to focus my attention solely on articles concerning people's access and resort to ART. The main reason for this decision is that the degree of openness or reticence of a society towards regulating assisted human reproduction is widely evident in articles concerning the individuals who wish to resort to or participate in MAR techniques.

5. Terminological and comparative reflection on ART laws

In the French Article 152-2 (French Law 814/2011) modifying Article L2141-2 (French Health Code) in force till 9th July 2011, we can read the objective of MAR was first of all to answer to a *demande parentale*/parental requests from a couple. Then MAR techniques had to be used as a remedy to infertility as well as to avoid the transmission to the future child acute diseases:

Art.152-2

> L'assistance médicale à la procréation est destinée à répondre à la demande parentale d'un couple. Elle a pour objet de remédier à l'infertilité dont le caractère pathologique a été médicalement diagnostiqué. Elle peut aussi avoir pour objet d'éviter la transmission à l'enfant d'une maladie d'une particulière gravité. […] (French Law 814/2011)[4]

On 9th July 2011, Article L2141-2 was changed as follows:

Article L2141-2

> L'assistance médicale à la procréation a pour objet de remédier à l'infertilité d'un couple ou d'éviter la transmission à l'enfant ou à un membre du couple d'une maladie d'une particulière gravité. […] (French Health Code) [5]

In the new article, MAR objectives are two: to remedy a couple's infertility and to prevent disease transmission to the child to be born or to the other member of the couple.

As to the Greek law, the first article entitled [*Γενικές αρχές*] General principles, stresses the fact that the methods of assisted reproduction are to be applied in a way that will safeguard the respect of [ελευθερίας του ατόμου] individual freedom and the satisfaction of one's [επιθυμίας για απόκτηση απογόνων] desire to procreate. These principles should follow the practices of medicine and biology and the principles of bioethics:

Άρθρο 1 – Γενικές αρχές

> 1. Οι μέθοδοι της ιατρικώς υποβοηθούμενης αναπαραγωγής (Ι.Υ.Α.) εφαρμόζονται με τρόπο που εξασφαλίζει το σεβασμό της ελευθερίας του ατόμου και του δικαιώματος της προσωπικότητας και την ικανοποίηση της επιθυμίας για απόκτηση απογόνων, με βάση τα δεδομένα της ιατρικής και της βιολογίας, καθώς και τις αρχές της βιοηθικής. (Greek Law 3305/2005)[6]

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4. Article152-2: Medically assisted reproduction aims at responding to a couple's parental requests. The purpose is to remedy infertility when its pathological nature has been medically diagnosed. It can also have the objective of preventing the transmission of a particularly severe disease to the child. [...] (Our translation)

5. Article L2141-2: Medically assisted reproduction aims to remedy a couple's infertility or to prevent the transmission of a particularly severe disease to the child or to one of the members of the couple. […] (Our translation)

6. Article 1 – General Principles. 1.The methods of medically assisted reproduction (M.A.R) are to be applied in a way that safeguards the respect of individual freedom, the right to personality and the satisfaction of one's desire to procreate, based on the practices of medicine and biology and abiding by the principles of bioethics. […] (English translation: George Fasoulakis officially accredited interpreter of the European Union (SCIC-AICI) - Translator, Editor: Re-

References to medical problems that can incite future parents to have recourse to ART only appear in Article 4. Besides, medical investigation before MAR treatments is obligatory to detect some diseases such as immunodeficiency viruses, hepatitis or syphilis:

Άρθρο 4 – Προϋποθέσεις εφαρμογής των μεθόδων Ι.Υ.Α.

[...] 2. Πριν από την υποβολή σε μεθόδους Ι.Υ.Α. διενεργείται υποχρεωτικώς έλεγχος ιδίως για τους ιούς της ανθρώπινης ανοσοανεπάρκειας (HIV1, HIV2), ηπατίτιδα Β και C και σύφιλη. (Greek Law 3305/2005)[7]

The Greek legal experts seem to stress the personal choice rather than the health issue, according to Article 5 of the Greek Constitution concerning the development of people's personality that is also possible through the foundation of a family.

In the Italian law, access and resort to ART is mentioned at least five times, in three different articles. First of all, assisted reproduction represents the solution of reproductive problems if there is no other therapeutic method:

Articolo 1 – Finalità

1. Al fine di favorire la soluzione dei problemi riproduttivi derivanti dalla sterilità o dalla infertilità umana è consentito il ricorso alla procreazione medicalmente assistita, alle condizioni e secondo le modalità previste dalla presente legge, che assicura i diritti di tutti i soggetti coinvolti, compreso il concepito.

2. Il ricorso alla procreazione medicalmente assistita è consentito qualora non vi siano altri metodi terapeutici efficaci per rimuovere le cause di sterilità o infertilità.

Articolo 4 – Accesso alle tecniche

1. Il ricorso alle tecniche di procreazione medicalmente assistita è consentito solo quando sia accertata l'impossibilità di rimuovere altrimenti le cause impeditive della procreazione ed è comunque circoscritto ai casi di sterilità o di infertilità inspiegate documentate da atto medico nonché ai casi di sterilità o di infertilità da causa accertata e certificata da atto medico. [....] (Italian Law 40/2014)[8]

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search Group of the Research Programme of AUTH – EXCELLENCE II *Assisted reproduction and protection of the embryo in vitro*)

7. Article 4 – Conditions for the application of M.A.R methods. […] 2. Before subjecting one to MAR methods it is obligatory that a medical investigation be performed, especially for the detection of human immunodeficiency viruses (HIV1, HIV 2), Hepatitis B and C, and syphilis. (English translation: George Fasoulakis, *Ibid.*)

8. Article 1 – Purpose. 1. In order to facilitate the resolution of reproductive problems arising from human sterility or infertility the use of medically assisted procreation is allowed, in accordance with the terms and conditions stated by this law, in order to ensure respect of the

This condition is recalled in Article 4 entitled *Accesso alle tecniche*/Access to techniques; the same article recommends on principle the use of *principio della minore invasività*/ the least invasive procedures as possible:

> Articolo 4 – Accesso alle tecniche
>
> [...] 2. Le tecniche di procreazione medicalmente assistita sono applicate in base ai seguenti princípi:
>
> a) gradualità, al fine di evitare il ricorso ad interventi aventi un grado di invasività tecnico e psicologico più gravoso per i destinatari, ispirandosi al principio della minore invasività;
>
> b) consenso informato, da realizzare ai sensi dell'articolo 6. [...] (Italian Law 40/2014)[9]

That reference seems to stress the fact that medicine and techniques violate the very private field of human reproduction. The proposed techniques have to be the least possible traumatic experience, both physically and psychologically.

Finally, according to the Italian law, future parents must be informed about other ways to became mothers and fathers, particularly through adoption or foster care (Article 5 subsection 1), even if those two solutions are completely different from an ART procedure. Adoption allows a couple to "have" a child, but not to "make" one, whereas foster care is only a temporary way of "having" a child:

> Articolo 6 – Consenso informato
>
> 1. [...] Alla coppia deve essere prospettata la possibilità di ricorrere a procedure di adozione o di affidamento ai sensi della legge 4 maggio 1983, n. 184, e successive modificazioni, come alternativa alla procreazione medicalmente assistita. [...] (Italian Law 40/2014)[10]

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rights of all individuals involved, even those of the conceived child. 2. The resort to medically assisted reproduction is allowed if there are no other effective therapeutic methods to remove the causes of sterility or infertility. Article 4 – Access to techniques 1. The resort to medically assisted reproduction is only allowed when it is impossible to remove any impediments that prevent procreation. In any case, it is limited to unexplained sterility or infertility documented by a medical procedure, in addition to sterility or infertility due to an established and certified by a medical procedure cause. (Our translation)

9. Article 4 – Access to techniques [...] 2. Assisted reproduction techniques are applied on the following principles: a) gradualness, in order to avoid very invasive interventions, both technical and psychological, for recipients, based on the principle of the least possible invasive procedures; b) informed consent, to be implemented within the meaning of Article 6. [...] (Our translation)

10. Article 6 – Informed Consent. 1. [...] The possibility of using processes of adoption or foster care under the law n. 184 of 4th May 1983 has to be proposed to the couple as an alternative solution to medically assisted procreation. [...] (Our translation)

The Italian law seems to persuade (future) parents to abstain from an "artificial" way of "making" a child. Even the Greek law establishes that patients have to be informed about *εναλλακτικές λύσεις*/alternative solutions to ART, but without any references as to what these solutions could be.

Άρθρο 5 – Ενημέρωση και συναινέσεις

1. Τα πρόσωπα που επιθυμούν να προσφύγουν ή να συμμετάσχουν στις μεθόδους Ι.Υ.Α. ενημερώνονται από το επιστημονικό προσωπικό των Μ.Ι.Υ.Α., λεπτομερώς και με τρόπο κατανοητό, ως προς τη διαδικασία, τις εναλλακτικές λύσεις, τα αναμενόμενα αποτελέσματα και τους πιθανούς κινδύνους από την εφαρμογή των μεθόδων αυτών. Η ενημέρωση αυτή καλύπτει επίσης τις κοινωνικές, ηθικές, νομικές και οικονομικές συνέπειες της εφαρμογής των μεθόδων Ι.Υ.Α.. […] (Greek Law 3305/2005)[11]

For the Spanish legislation, legal ART are used to prevent and treat genetic diseases, if sufficient diagnoses and therapeutic guarantees exist. Even if the ART are medically feasible, they can only be realized if there are reasonable chances of success and if there is no risk for the physical or psychological health of the woman and the conceived and born child:

Artículo 1. Objeto y ámbito de aplicación de la Ley.

b) Regular la aplicación de las técnicas de reproducción humana asistida en la prevención y tratamiento de enfermedades de origen genético, siempre que existan las garantías diagnósticas y terapéuticas suficientes y sean debidamente autorizadas en los términos previstos en esta Ley.

Artículo 3. Condiciones personales de la aplicación de las técnicas.

1. Las técnicas de reproducción asistida se realizarán solamente cuando haya posibilidades razonables de éxito, no supongan riesgo grave para la salud, física o psíquica, de la mujer o la posible descendencia y previa aceptación libre y consciente de su aplicación por parte de la mujer, que deberá haber sido anterior y debidamente informada de sus posibilidades de éxito, así como de sus riesgos y de las condiciones de dicha aplicación. […] (Spanish Law 14/2006)[12]

11. Article 5 – Informed consent. 1. The individuals who wish to resort to or participate in MAR techniques are to be informed by the scientific personnel of the MARC in detail and in a way they understand in what concerns the procedure, the alternative solutions, the expected results and the possible risks that emanate from the application of these methods. This information should also regard the social, legal and economic consequences related to the application of MAR methods. […] (English translation: George Fasoulakis, *op. cit.*)

12. Article 3 – Personal conditions of application of the techniques. 1. ART will be carried out only when there are reasonable chances of success, when they do not pose as great a threat

In France and Italy, the laws are very explicit about people to whom ART methods can be applied:

Article 152-2

> L'homme et la femme formant le couple doivent être vivants, en âge de procréer, mariés ou en mesure d'apporter la preuve d'une vie commune d'au moins deux ans […]. (French Law 814/2011) [13]

Articolo 5 – Requisiti soggettivi

> [...] possono accedere alle tecniche di procreazione medicalmente assistita coppie di maggiorenni di sesso diverso, coniugate o conviventi, in età potenzialmente fertile, entrambi viventi. (Italian Law 40/2014)[14]

This case refers to heterosexual couples where both partners are alive. In the French Article 152-2 (French Law 814/2011) modifying Article L2141-2 (French Health Code) in force till 9th July 2011 we could read *homme et femme*/man and woman; in the Italian Article 5 – *Requisiti soggettivi*/Personal conditions, the legislator used the expression *di sesso diverso*/of a different sex. The couple has to be married (*marié* in French and *coniugate* in Italian) or able to prove that they have been living together for some years. It should be stressed that in Italian the adjective *coniugate*/married implies that they are one man and one woman, since same-sex marriage is forbidden in the Peninsula. In the new version of the French Article L2141-2 (French Health Code; 9th July 2011) the adjective married disappeared: "*L'homme et la femme formant le couple doivent être vivants, en âge de procréer […]*"[15]; in France, homosexual marriage is now allowed (*Loi n° 2013-404 du 17 mai 2013 ouvrant le mariage aux couples de personnes de même sexe*) but ART are forbidden for same-sex couples.

Both in France and in Italy, the law defines that the couple has to be in their natural reproductive age which, of course, is quite vague. What determines this limit?

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to the woman's or her offspring's physical or mental health, and only under the woman's free and conscious consent of their implementation. The woman should have been previously and duly informed about the likelihood of success as well as the risks and conditions of such application. (Our translation)

13. Article 152-2. Both the man and woman forming the couple must be alive, in their natural reproductive age, married or able to prove that they have been living together for at least two years [...]. (Our translation)

14. Article 5 – Personal conditions [...] adult, living and heterosexual couples, married or living together and in their natural reproductive age can have access to medically assisted reproduction techniques. (Our translation)

15. Both the man and woman forming the couple must be alive, in their natural reproductive age [...]. (Our translation)

It is up to assisted reproduction centres or to the national health system to decide. However, this freedom of choice can create discriminations among patients.

In Greece adult persons can have access to MARs treatments; for persons under age is exceptionally permitted. If the assisted person is a woman, the limit of the natural reproductive age is fixed to 50 years old (article 4.1). This according to Greek statistics on Greek women fertility:

Άρθρο 4 – Προϋποθέσεις εφαρμογής των μεθόδων Ι.Υ.Α.

1. Οι μέθοδοι Ι.Υ.Α. εφαρμόζονται σε ενήλικα πρόσωπα μέχρι την ηλικία φυσικής ικανότητας αναπαραγωγής του υποβοηθούμενου προσώπου. Σε περίπτωση που το υποβοηθούμενο πρόσωπο είναι γυναίκα, ως ηλικία φυσικής ικανότητας αναπαραγωγής νοείται το πεντηκοστό έτος.

Η εφαρμογή τους σε ανήλικα πρόσωπα επιτρέπεται κατ εξαίρεση λόγω σοβαρού νοσήματος που επισύρει κίνδυνο στειρότητας, για να εξασφαλιστεί η δυνατότητα τεκνοποίησης. Στην περίπτωση αυτή εφαρμόζονται οι όροι του άρθρου 7. [...] (Greek Law 3305/2005)[16]

What about the phenomenon where the mother is closer to being a grandmother and the ensuing risks for the woman and the child to be born?

Regarding the risks, the Spanish law does not fix an age limit for MARs methods contrary to the Greek text. However, the law requires that the woman has to be informed about the dangers of a pregnancy at a clinically inadequate age.

Artículo 6. Usuarios de las técnicas.

1. Toda mujer mayor de 18 años y con plena capacidad de obrar podrá ser receptora o usuaria de las técnicas reguladas en esta Ley, siempre que haya prestado su consentimiento escrito a su utilización de manera libre, consciente y expresa.

La mujer podrá ser usuaria o receptora de las técnicas reguladas en esta Ley con independencia de su estado civil y orientación sexual.

2. Entre la información proporcionada a la mujer, de manera previa a la firma de su consentimiento, para la aplicación de estas técnicas se incluirá, en todo caso, la de los posibles riesgos, para ella misma durante el tratamiento y el

16. Article 4 – Conditions for the application of M.A.R methods.1. MAR methods are to be applied to adult persons up to the end of the natural reproductive age of the medically assisted person. If the person to be assisted is a woman, the natural reproductive age is considered to be up to fifty years old. The use of the above techniques for persons under age is permitted exceptionally only in the case of serious disease likely to engender sterility, so as to safeguard one's ability to procreate. In this case the conditions of Article 7 are applicable. (English translation: George Fasoulakis, *op. cit.*)

> embarazo y para la descendencia, que se puedan derivar de la maternidad a una edad clínicamente inadecuada. (Spanish Law 14/2006)[17]

In the Greek law, the term referring to people that can have access to MARs methods is a neutral one: persons (πρόσωπα), without any reference to his/her gender, his/her marital status or even his/her sexual orientation. The only requisite is to be an adult, as said before.

We can find the same conditions in the Spanish law: the woman, older than 18 years of age, may be receiver or user of MAR techniques, regardless of her marital status or sexual orientation. The Spanish legislation adds that the woman has to have full capacity to act. It is interesting to note that the Spanish law only talks about the age, the marital status, and everything else related to the woman and seems to forget the man.

6. Conclusion

What I wanted to show through these examples, is how terms can acquire a legal meaning and a legal force in a transdisciplinary domain such as ART. A domain characterised by three levels of assessment.

First of all, the medical assessment: clinical and therapeutic techniques allow or do not allow a person or a couple to "make" a child, because of a physical or pathological condition of the future mother and/or father.

The law permits or does not permit people to have access to MARs methods, in conformity with national (Constitution, laws, civil code...) or supranational law (conventions, laws...). The law defines if a medical technique must or must not be applied, despite the technical possibility, and is sometimes influenced by society, religion as well as by cultural aspects of the country where it is used. The interpretation of jurisprudence can modify the laws and adapt them to the evolution of society, despite customs and strong beliefs. This is for example the case of heterologous fertilisation which has been eventually possible in Italy, after a decision by the Constitutional Court in 2014.

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17. Article 6. Users of the techniques. 1. Any woman eighteen or older and of sound mind may be recipient or user of the techniques regulated by the present law, provided that she has freely, knowingly and expressly given her written consent for the use of these techniques. The woman may be the user or recipient of the techniques regulated by this law independently of her marital status and her sexual orientation. 2. The information given to the woman, prior to the signature of her consent, for the application/implementation of those techniques, should in all cases include, the possible risks to herself during the treatment and pregnancy and to her offspring, which may derive from motherhood at a clinically inadequate age. (Our translation)

The technologies available to infertile couples are constantly increasing. In the process of assisted reproduction, patients are not only subjected to medical practices and legal limitations, but also to society's judgment. The criticism and the judgment of those close to the medically assisted future parents and of society is very powerful: as it turns out, public opinion bears an influence on very private issues.

As a conclusion, Warnock report asserts "it would be idle to pretend that there is not a wide diversity in moral feelings, whether these arise from religious, philosophical or humanist beliefs" (Warnock 1984: 2). As this paper demonstrates, the legal tradition and position should also be added to this list. Moreover, legal tradition and position sometimes are conveyed by terminological choices made by legislators, influenced by political, social and societal factors. Law has to conform to ART evolutionary process reflecting on the terms used and their harmonisation, where their clear definitions should be a major concern in order to avoid misunderstandings among legal experts, doctors, patients, and everyone involved. A good example of this is Article 3 – **Ορισμοί/**Definitions of the Greek law that is entirely dedicated to defining legal terms.

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VASILIKI KOKOTA

The influence of religion on the legal framework concerning medically assisted reproduction

1. Introduction

The paper focuses on the six countries which were under study during the (In) FERCIT Research Programme of the Lab of Family and Kinship Studies at the University of Aegean: four of these countries (that is Italy, Spain, Greece and Turkey) had specific legislation concerning Medically Assisted Reproduction (hereinafter: MAR), while in the other two (that is in Republic of Cyprus and Lebanon) there was a lack of legal framework (in fact, in Republic of Cyprus a law draft about MAR was under discussion during the study). In this paper it is argued that, in some of the above mentioned countries, religion played an important role in the legislation process concerning MAR, while it still does in some others. However, religion's influence on MAR is combined with other factors, such as culture, ethical values and moral prejudices.

In order to support this argument, this paper refers to Christian tradition, both Catholic and Orthodox, which regards the nature of the embryo as equivalent to a human being: the conception of a child through MAR techniques appears, from that point of view, unacceptable, whereas, at the same time, childlessness is deemed either a bless or even a test sent by God. On the other hand, in the strongly pronatalist Muslim world, the key issue is not the embryo, but heritage and kinship. The latter is established through the father's lineage, since only the biological father is identified as the legal father of a child, while the use of genetic material of third-party donors is, according to the Islamic tradition, equivalent to adultery.

However, countries with similar religious doctrine (e.g. the Catholic Spain and the Catholic Italy, the Orthodox Greece and the Orthodox Cyprus) do not necessarily adopt similar legal framework: on the contrary, Spain and Greece present the most permissive legislation within the European Union, while Italy's legislation and Republic of Cyprus' regulatory framework appear to be very restrictive. At the same time, the example of (Sunni) Turkey compared to the (multisectarian, but Shia-dominant) Lebanon shows that, although religion remains crucial, at the end of the day it is the legal and medical scholars who have the last word as far as MAR is concerned. After all, it can be concluded that, although religious concerns are often taken into consideration when legislating in the area of MAR, other factors may equally influence the regulatory outcome.

2. The position of the Orthodox Christian Church on MAR

The main concern in the Orthodox Christian Church's tradition is the *status* and *nature* of the embryo[1]. For the Orthodox Church,[2] from the very beginning of the conception process, the embryo is not simply a fertilized egg but a perfect human being.[3] This is explained by the perception of *soul* which can be found in the Orthodox Christian tradition, in which every human being has an immortal soul which is closely connected to his body. The human soul comes into being along with the body and it remains immortal after the physical death of the body. In that sense, for the Orthodox Christian Church, every human being has a beginning, which coincides with the time of conception, though it has no end, since the soul is immortal. However, the exact moment human life begins is unknown.

As regards the perception of motherhood and fatherhood, for the Orthodox Christian Church the basic function of the female body is oriented towards motherhood, that is the woman exists physically and emotionally for the embryo, the pregnancy and later the childbearing. At the same time, fatherhood is equally im-

1. By using the word "embryo" we refer both to the fertilized egg of the first days as well as the fetus of the consequent days.

2. For more details about the position of the Orthodox Christian Church on MAR, see, among others**,** Metropolitan Nikolaos of Mesogaia and Lavreotiki, 2008, «The Greek Orthodox position on the ethics of Assisted Reproduction», *Reprod. BioMed. Online* 17: 25-33 (especially pp. 26-28).

3. More specifically, for the Orthodox Church, a human being at all stages of its development –namely as zygote, blastocyst, few-weeks-old embryo, 9-month fetus, newborn infant, young child, teenager, adult, elderly– has the same perfect human identity: it is a complete and perfect human being, according to Metropolitan Nikolaos of Mesogaia and Lavreotiki, op.cit., p. 27.

portant, since children should be conceived and then brought up by a couple that is married (ideally, in the traditional Orthodox marriage ritual). However, for the Orthodox Christian Church, childlessness is not a problem to be solved, but it can be seen either as a bless or even as a test sent by God who wishes to try his adherents' loyalty. Couples who cannot have children because of infertility problems can be productive, in the Orthodox Church's opinion, in other areas of social and spiritual life, as this can be seen as God' s will.[4]

Consequently, the Orthodox Christian Church opposes, among other things, asexual conception, that is through MAR methods and techniques, gamete donation and surrogacy, surplus embryo and multiple embryo transfer, pregnancy of post-menopausal women, single parenthood and homosexual parenting.

3. The position of the Catholic Christian Church on MAR

Regarding the status and nature of the embryo, the Catholic Church embraces the same position with the Orthodox Church. To be more specific, for the Catholic Church the embryo is a perfect and complete human being from the very moment of its conception, that is from the moment of the fertilization of the egg.[5] Contrary to the Orthodox Church, the Catholic Church strictly defines the time of the beginning of human life, arguing that this coincides with the very moment of the fertilization of the egg which takes place during sexual intercourse. As a result, the Catholic Church morally opposes abortion, which is, from that point of view, equivalent to murder. Moreover, the Catholic Church rejects methods of human procreation that do not involve sexual intercourse, namely the techniques of MAR which are, in that sense, asexual.

The Catholic Church's view on the embryo and human life can be better understood if it is placed in the broader context of how the Church embraces matters such as family and sexuality: For the Catholic Church, the only option for a child to be considered legal is to be the product of the sexual union of a married heterosexual couple. The institution of marriage is so important to the Catholic Church that divorce in Italy was not only morally unacceptable, but it was also illegal according to the Italian legislation until the 1980's. Again, as it is also true for the Orthodox Church, medically assisted reproduction, pre-marital sex, con-

4. Metropolitan Nikolaos of Mesogaia and Lavreotiki, op.cit., p. 26.

5. For a thorough analysis of the position of the Catholic Christian Church on MAR see M. Rodgers Bundren, 2013, «The Influence of Catholicism, Islam and Judaism on the Assisted Reproductive Technologies (ART). Bioethical and Legal Debate: A Comparative Survey of ART in Italy, Egypt and Israel». *U.Det.Mercy L. Rev.* 715: 1-29 (p. 7 ff).

traception, single parenthood and homosexual parenting are prohibited from the Catholic Church, because this kind of human behaviour is supposed to alienate human beings from God.

The Catholic Church's view on MAR took formal type in 1987, when the Catholic Church in Vatican published the infamous religious instruction with the name *Donum Vitae*. *Donum Vitae* is by all means a political statement, since it is a declaration with normative aspirations derived from the Pope and the Catholic Church instead of the democratically legitimized Italian legislator. With *Donum Vitae* the Catholic Church specifically condemned procreation outside of marriage, as well as prohibiting a married couple from using donated gametes or embryos.[6]

Comparing the two aspects of the Christian tradition, it is understood that the position of the Catholic Church on MAR appears to be stricter than the one of the Orthodox Church and it took written form with the Instruction *Donum Vitae,* composed by the Congregation of the Doctrine of the Faith, which remains in force until today. On the other hand, the Orthodox Church, although it embraces the same notions concerning the status and nature of the embryo, the type of family and the kind of sexuality it recognizes, abstains from expressing its opinion formally and rather prefers to invoke ecclesiastical texts as well as the general Christian Orthodox tradition for the religious reasoning of its view.

4. The Islamic perception of MAR

It is well known that Muslim countries are considered strongly pronatalist*,* that is children are highly desired. As a result, childlessness is not a matter of free choice for Muslims,[7] whereas, at the same time, the institution of adoption is unknown to the Islamic world (in fact, there is only a kind of "fostering" of orphans that is allowed according to the Islamic tradition and as "orphans" are characterised these children whose father is not alive any more). There is only one father recognized, the biological one, since the distinction between social, genetic and biological parents is equally unacceptable for Muslims. Thus, the only solution for Muslim

6. The Instruction equally condemns techniques of assisted reproduction that permit a married couple to contribute their own gametes and gestation to the process of creating a child and it also refers to cryopreservation of embryos as a method that is not allowed by the Catholic Church.

7. On the contrary, it is culturally mandatory, according to M. Inhorn / Z. Gürtin, 2012, «Infertility and Assisted Reproduction in the Muslim Middle East: Social, Religious, and Resource Considerations». *FVV IN OBGYN*: 24-29 (p. 25).

couples who face infertility problems of any kind is to have children through MAR methods and techniques.

In this context, the key question "what is the role of religion in the Muslim world?" rises and it should be answered as a prerequisite, before the issue of the (acceptable) use of MAR methods and techniques from the Muslim couples.

In an attempt to give an answer to this question, we could make a first distinction by dividing the Muslim countries into those with state secularism (that is the Muslim countries where there is a religious neutrality from the part of the state, since the state neither recognizes nor promotes a certain religion as the official one) and the others where legal norms are, more or less, based on religion. Considering the Muslim countries under study, Turkey appears to be secular since there is no reference to religion in the state legislation,[8] while in Lebanon some issues regarding the personal and social status of the citizens tend to be influenced by the official religion(s).[9]

Another distinction would be between Sunni-Muslim countries, that is the dominant form of Islam, and Shia-Muslim countries. With regard to the Muslim countries under study, Turkey is a Sunni country (at a percentage that reaches up to 85-90% of the whole population), while in Lebanon there are more than 18 different religious communities, where the Shiite-Muslim community reaches up to 35% of the population, the Sunni Muslims to about 25% of the population and the Maronite Catholics to about 20% of the population.

Contrary to the Christian tradition, where the "public standing" of the religious authorities towards certain issues (not only religious issues but social issues as well) derives from the official Church, either the Orthodox Church or the Catholic Church, the formal religious guidelines in the Islamic tradition come from religion scholars through written proclamations known as *fatwa.*[10] In general, the position of Muslim religious authorities towards the use of MAR methods and techniques can be explained by the Islamic perception of family relations, sexual morality and heritage. All these three issues are interrelated: for Muslims, heritage

8. See Z. Gürtin, 2012, «Assisted Reproduction in Secular Turkey: Regulation, Rhetoric and the role of Religion» in: M. Inhorn / S. Tremayne (eds), *Islam and Assisted Reproduction: Sunni and Shia perspectives*: 285-311 (p. 294 ff). New York: Berghahn.

9. According to M. Clarke, 2008, «New Kinship, Islam, and the Liberal Tradition: Sexual Morality and New Reproductive Technology in Lebanon». *Journal of the Royal Anthropological Institute* 14: 153-169, Lebanese citizens have to be members of one or other of the official communities and they are subject to the laws and tribunals of their community in matters of personal status, such as marriage, divorce, filiation and inheritance or, in short, kinship. In all other legal domains, civil law prevails and appears to be common to all Lebanese citizens (p. 157).

10. Inhorn / Gürtin, op.cit., p. 25 f.

is established through the father's lineage, while the role of the mother appears to be less important (in fact, we should not forget that polygamy, in the form of marriage between one husband and more wives, is still acceptable, according to the Islamic tradition, though it is not allowed in secular Turkey). Consequently, the use of genetic material of third-party donors is thought to confuse kinship relations and, in that sense, is equivalent to adultery.

From that point of view, the use of MAR methods and techniques appears to be rather problematic for Muslims. However, there is a different approach between the Sunni Muslims and the Shiite Muslims. More specifically:

(i) The Sunni perception

As far as the official Sunni Islamic position on MAR is concerned, that position was outlined in a *fatwa* issued by the Grand Sheikh of Al Azhar University of Egypt in 1980. According to that *fatwa*, only artificial insemination of the wife with her husband's sperm is allowed and the resulting child is the legal offspring of the married couple. IVF of an egg from the wife with the sperm of her husband is also allowed, provided that there is a medical reason and that the surplus of fertilized embryos can be frozen through cryopreservation. Pregnancy in post-menopausal women is allowed using the woman's own cryopreserved embryos. Selective reduction is also allowed in case of multiple pregnancies and when the health or the life of the mother-to-be is in jeopardy. PGD is allowed and even encouraged, as a medical method to avoid pregnancy terminations.

All of the Sunni-majority countries in the Muslim Middle East practice MAR as stated by these religious guidelines, including (secular) Turkey.

(ii) The Shia perception

The Shia-Muslim authorities appeared to be more liberal compared to the Sunni-Muslim authorities. In 1999, the Supreme Leader of Iran, Ayatollah al-Khamene'i, issued a *fatwa* that clearly allowed sperm, egg and embryo donation as well as surrogacy. Physicians and doctors in the Shia-dominant Lebanon, which as a country was politically influenced and financially depended on the stronger Iran, followed that *fatwa* which permitted the use of third-party donors' genetic material to married infertile couples.[11]

Considering the above, in the Sunni-dominant Turkey religious authorities represent a stricter position towards the practice of MAR techniques, since the use of third-party donors' genetic material is not allowed. On the other hand, in

11. Inhorn / Gürtin, op.cit., p. 26.

the Shia-dominant Lebanon religious authorities approach MAR techniques in a liberal way, permitting the use of genetic material of third-party donors as well as surrogacy. The common element in both cases is that MAR methods are strictly addressed to married couples.

5. What is, after all, the role of religion in the forming of the MAR legal framework?

The religious perception of the embryo can seriously influence legislation concerning MAR, as it is showed by the example of the Italian legislation, which is the most restrictive of all pieces of legislation within the European Union. The reason is that the Italian law was formed under the strict supervision of the strong Papal Church, while legal scholars, doctors and politicians in Italy failed to stop the Church from being involved in the legislative process. Thus, it does not come as a surprise that the Italian law strictly bans heterologous fertilization and surrogacy. Until recently, even the PGD technique was not in use (nowadays, PGD is practiced by many doctors, due to the decision *Costa and Pavan v. Italy* of the European Court of Human Rights).[12] Selective reduction was prohibited as well, since every single fertilized egg should return to the uterus that it came from. In 2014, another decision of the Italian Constitutional Court found that the Italian ban on the use of genetic material of third-party donors was not compatible with the Italian Constitution.[13] However, the Italian law remains intact until today.

On the other hand, in Spain, while Spanish people embrace the same religion as the Italians, the Spanish legislator appeared to be of a totally different orientation regarding MAR: Spanish law enables not only heterosexual couples, who are either married or in a steady relationship, but single women and lesbian couples as well (however not male gay couples, since surrogacy is prohibited) to use all the well known methods and techniques of MAR which involve the use of genetic material from third-party donors. The only method of MAR that is strictly prohibited by Spanish legislation is surrogacy.

From that point of view, although both Italy and Spain are considered religious countries (since their citizens tend to be baptized Catholic at a percentage which rates at about 90% of the population), the Catholic Church managed to manipulate only the 2004 Italian legislation, which is deeply influenced by the doctrine of the Papal Church about the nature of the embryo and its human status.

12. ECHR, Judgement of 28th August 2012 (Application no. 54270/10).
13. (Italian) Corte Costituzionale 162/2014.

In Spain, on the contrary, before the voting of the Spanish law, there had been a public discussion among experts (doctors, legal scholars, etc.) where the key issues were open to society for debate. As a result, the 2005 Spanish law remains until today one of the most liberal and permissive pieces of legislation concerning MAR within the European Union (with the exception of surrogacy, which is still not allowed by the Spanish legislator but it can be recognised by the Spanish authorities *ex post,* when it has taken place abroad).

When comparing Greece and Republic of Cyprus, we can also see similar diverging arguments: Although Greeks and Cypriots are both Orthodox Christians (they are also baptized Orthodox with the impressive percentage of 80-90% of the whole population), there are serious differences between the Greek legislation of 2002/2005 and the law draft which is under consideration in Republic of Cyprus.

The Greek legislation concerning MAR is, in fact, the only piece of legislation that allows surrogacy *expressis verbis* and *ex ante* within the European Union.[14] The use of genetic material (sperm, eggs, embryos) of third-party donors is also permitted and there is a provision of transferring up to three embryos, as well as the possibility of selective reduction and the PGD technique. On the other hand, the real disadvantage of the Greek legislation is that it concerns only married (heterosexual) couples or those who are in a steady relationship and single women (that is, no male gay or lesbian couples or even single men).

In Republic of Cyprus, however, which is really a small island with a population of something less than a million people, the use of genetic material of third-party donors (including surrogacy) is still under discussion. In any case, MAR methods are addressed only to *married* couples (not even those who are in a steady relationship). During the discussion of the law draft, a member of the official Church of Republic of Cyprus participated in the Bioethics Committee to help formulate an opinion on that draft. This can be explained by the fact that the Greek population of the island forms a closed and rather conservative society, in which reputation and morality still matter and where religion plays an important role. From that point of view, the regulatory framework of MAR, which is nowadays under consideration in Republic of Cyprus, is analogous to the social, religious and moral background of the country.

On the other hand, there is a similar but not identical argument regarding the Muslim's point of view: the emphasis is shifted from the embryo and its status to kinship and heritage, since religion can be seen as part of the Muslim's culture (or

14. While in the UK surrogacy is accepted *ex post*, that is after the birth of the child, according to the existing system of "parental orders".

way of living, in other words) which tries to safeguard sexual morality against the "sinful West", in an attempt to avoid the confusion of kinship relations.

In the Sunni Islam, that is the example of Turkey, MAR methods and techniques are practised under religious guidelines. These guidelines are strict, since they exclude the use of third-party donors' genetic material. In the Shia Islam, that is the example of Lebanon, the use of third-party donors' genetic material, as well as surrogacy, are permitted. This divergence is owed not only to the different religious guidance, but also to the fact that there is a religious mosaic in the country of Lebanon rather than a dominant religion. This, at the end of the day, de-strengthens the role of religion and enables the experts (that is the legal scholars, the doctors, the physicians, etc.) to act within their expertise. However, the lack of specific legislation leaves space to improvisation and does not offer a solution to the crucial issue of the *subjects* of MAR (that is who are entitled to have access to MAR methods), neither does it face the important problem of patients' compensation for the use of MAR methods and techniques.

6. Conclusion

It can be concluded, after all, that, although religious concerns are seriously taken into consideration when legislating in the area of MAR, other factors may equally influence the regulatory outcome. For Muslims, this factor is the Islamic way of living, sometimes stronger than religion, which dominates kinship relations. For Christians, the ethical values concerning the status of the embryo and the moral prejudices regarding sexual orientation set the limit to the individual's "right to reproduce through MAR methods".

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PART II

Kinship, Gender, Sexuality

ANNA CARASTATHIS

Compulsory sterilisation of transgender people as gendered violence

1. Introduction

Despite a "spatial imaginary" which constructs the continent as a location of sexual and gender freedom (Rao 2014), presently, twenty-three countries in Europe require sterilisation in order to legally recognise transgender people's gender identities (TGEU 2015).[1] Moreover, in eleven European states where there is no gender recognition, coerced sterilisation is still practised (UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, as cited in Council of Europe 2013: 13). Compulsory sterilisation is widely in force against transgender people, who constitute, according to one commentator, "the only known group in Europe subject to legally prescribed, state-enforced sterilisation" (Hammarberg 2009: 19, see Council of Europe 2013, UN General Assembly 1998: art. 7.1).[2] The compulsory medical interventions imposed by the state on trans people violates their reproductive rights, "effectively undermin[ing] their right to found a family" –at least as "family" is hegemonically defined by the heteronormative and bio/logical kinship order of these societies (Hammarberg

1. Among them are five of the seven countries in the (In)FERCIT study: Bulgaria, Greece, Italy, Turkey, and Republic of Cyprus (TGEU, 2015). Spain does not require sterilisation for gender identity recognition since 2007 (see Platero 2008). In Lebanon no gender identity recognition for trans people is provided by law (TGEU, 2015); moreover, this country lies outside the "European" region.

2. In fact, many states also continue to practice coerced sterilisation against Roma, convicted "sex offenders" and people with disabilities, under various legal and policy frameworks (Council of Europe 2013: 9-15).

2009: 21, see Butler 2002, OHCHR et al. 2014, van Anders 2014).[3] I use the adjective "compulsory" to characterise sterilisation in the context of state-mandated requirements for legal gender recognition, since in order to extend this recognition, being rendered irreversibly infertile is a legally obligatory precondition.[4] I argue that the biopolitical attempt to regulate transgender embodiments and reproduction conditions the emerging legal recognition of transgender subjects as a rights-bearing minority (Stryker 2014). These newly recognised "citizens" are coercively constructed in material and ideological ways as "non-reproductive", a precondition of the extension of state recognition. Compulsory sterilisation of trans people is not generally conceptualised by non-trans people (including state actors) as a eugenic, genocidal or even reproductively violent policy, even though trans advocates argue that it has roots in eugenics (Eisfeld 2015). In this paper, examining how trans people in Europe are ideologically constructed as non-reproductive, "infertile" citizens, I situate the compulsory sterilisation of transgender people (1) in the seemingly juridical "unlikely" context of genocide and crimes against humanity and (2) in the historicising concepts of (a) "gendercide" of third gender indigenous people in the colonisation of the Americas, as elaborated by the indigenous historian Deborah Miranda (Miranda 2010); and (b) the colonial/modern gender system, theorised by the decolonial feminist philosopher María Lugones (Lugones 2007). Then (3), I synthesise these decolonial analyses with a depathologising perspective on trans embodiment in order to trace how compulsory sterilisation is naturalised in the juridico-medical process of the determination and recognition of trans identities.

2. Genocide and cimes against humanity

Could legally mandated sterilisation of trans people constitute a crime against humanity with genocidal inflections –deliberately constructed to bring about the systematic elimination or destruction of a particular group? It is arguably not incidental that the group of human rights and legal experts who gathered in Yogyakarta, Indonesia in 2006 to clarify the states' obligations with respect to sexual

3. "The right to found a family" is listed among the Yogyakarta Principles on "the application of international human rights law in relation to sexual orientation and gender identity" and which explicitly forbid forcing individuals to "undergo medical procedures, including sex reassignment surgery, sterilisation or hormonal therapy, as a requirement for legal recognition of their gender identity. No status, such as marriage or parenthood, may be invoked as such to to prevent the legal recognition of a person's gender identity" (2007: 27, 11).

4. The terms "coerced" or "involuntary" or "forced" as modifiers are not exactly interchangeable but may also be appropriate depending on the context (see Council of Europe 2013: 3).

orientation and gender identity under the *existing* international law never invoke the concepts of "genocide" and "crimes against humanity" anywhere in the document outlining what have come to be known as the 29 "Yogyakarta Principles" (Yogyakarta Principles 2007). Not being a legal scholar, I approach the Rome statute –which stipulates the meanings of these crimes under international law– as a discursive text which informs, and is informed by "everyday" understandings of what constitutes genocide and state persecution on the basis of a hypostatised, fungible identity. To be clear: my aim in this section is to identify the obstacles of cognising compulsory sterilisation of trans people in these terms, and to state that inarguably sterilisation constitutes genocide based on these legal definitions. Indeed, my claim is that trans people are systematically written out of legal existence precisely through the normative concepts which define "the human" in cisgenderist, heteronormative and bio/logical terms.

The Rome Statute of the International Criminal Court that came into force on 1 July 2002, is a treaty to which 123 states are parties and establishes the Court's "jurisdiction over persons for serious crimes of international concern" (UN General Assembly 1998: 2).[5] The statute establishes four core international crimes of which genocide is the first and crimes against humanity is the second.[6] As many scholars have noted, the Statute and its precursor (the Convention on the Prevention and Punishment of the Crime of Genocide) limit what forms of violence are cognisable as genocide, particularly concerning issues of the perpetrators' intent, the nature of the targeted for destruction groups, and the role of the methods, apart from killing, contributing to the disappearance or disintegration of the targeted group. For instance, scholars have argued that the Convention makes it difficult to identify the so-called "slow motion genocides" of Indigenous peoples that led to the establishment of settler states in the Americas and Oceania. Moreover, as some feminist scholars have argued, the stipulation that the targets of genocide are "national, ethnical, racial, or religious group[s]" (UN General Assembly 1998: art. 6) makes it difficult to construct gendered groups as targets of genocide. Forced sterilisation, and all imposed "measures

5. A further 31 states have signed but not ratified the Rome Statute, while three signatory states have effectively withdrawn from the treaty (Israel, Sudan and the United States), and 41 other UN member states (including China, India, Turkey, and Lebanon) have not signed it at all.

6. The other two categories are "war crimes," and the "crime of aggression." Other crimes such as "ecocide" were also discussed in the proceedings but did not make it into the writ of the statute. This not the first time genocide appears as a legal concept in international or supranational law, with the Convention on the Prevention and Punishment of the Crime of Genocide (UN General Assembly Resolution n. 260, passed on 9 December 1948) being the crucial precursor.

intended to prevent births within the group," is prohibited in the Rome Statute's definition of genocide, but the imagined target is a national, ethnic, racialised or religious group, not one defined in terms of gender (art. 6d). The definition of "crimes against humanity" is even more explicit in its proscription of compulsory sterilisation, while being less restrictive in its conceptualisation of the target of this crime: it is "any civilian population" against which is directed a "widespread or systematic attack" comprised of multiple acts pursuant to a State or organisational policy to commit such attack (art. 7: para. 1-2). "Enforced sterilisation" appears among a list of other forms of "sexual violence of comparable gravity" such as "rape, sexual slavery, enforced prostitution, [and] forced pregnancy" that, along with other inhumane acts causing great suffering, injury, and death are considered "crimes against humanity" (art. 7g). Persecution of "any identifiable group or collectivity on political, racial, national, ethnic, cultural, religious, [or] gender […] grounds" in connection with such acts constitutes "a crime against humanity" (art. 7h). If gendered violence seems more readily cognisable as a crime against humanity than as a form of genocide under these definitions, a subsequent paragraph in the article defining the operative use of "gender" should give us pause:

> For the purposes of this Statute, it is understood that the term "gender" refers to the two sexes, male and female, within the context of society. The term "gender" does not indicate any meaning different from the above (art 7. para.3).

Gender, here –elided with sexual dimorphism and defined in binary terms– is contrasted implicitly with gender identity and with imagined challenges to the normative societal gender order. Persecution on the basis of gender identity (which for many transgender persons may, of course, align with the binary categories "male" and "female") seems to be excluded by definition. Reflecting heated debates around the inclusion of gender-based violence in the definition of crimes against humanity, gender is the only social identity which is qualified –in contrast to "race", ethnicity, religion, etc., the meanings of which are not explicitly defined in the text, appearing to be taken for granted (Moshan 1998: 183).

Feminist legal scholars have pointed out the limitations these concepts entail in the effective prosecution of violence against (cisgender) women.[7] But trans-

7. It should be noted that the inclusion of gender as a basis for persecution reflects the intensive efforts of feminist human rights activists in the lead-up to the Rome Conference. Drafted in the aftermath of the war in the former Yugoslavia, the Statute on the one hand represents a "recognition that gender violence is an integral and pervasive component of warfare", on the

gender people (whether they identify as women or not) are conceptually excluded from these definitions, particularly as the concepts of "genocide" and "crimes against humanity" converge with demographic nationalism which naturalises state and interpersonal violence against gender and sexual minorities as internal Others. In other words, I would suggest that conceptualising compulsory sterilisation of transgender people through the exclusionary definitions of crimes against humanity and genocide reveals the heteronormative and cisgenderist boundaries of nation-states. If the targets of forced sterilisation are normatively conceptualised in ethno-national terms, presuming the heterosexual reproduction of the social body –or what Gayatri Chakravorty Spivak has called "reproductive heteronormativity"– then members of gender-variant groups –targeted by acts and institutionalised forms of gendered violence– are viewed normatively as non-reproductive (and, indeed, as antagonistic to social reproduction).[8] The lengths to which European states have gone to control the reproduction and kinship relations of trans people –not only through gender recognition laws but also, notably, through immigration and asylum policies– reflect anxieties of reproductive heteronormativity which construct reproductive citizens as those who (in the racialised boundaries of the nation-state) reproduce heterosexually and reproduce heterosexuality.

Tied to legal gender recognition, measures regulating trans reproduction and kinship relations more broadly construed include compulsory divorce, spousal veto provisions and heterosexual remarriage; trans people may also lose custody of their children as a consequence of gender transition in many jurisdictions, or be prohibited from adopting the child of a spouse (particularly if the spouse is legally classified as "of the same gender"). There is a prevalent ideology in European societies that "trans people should not have children," which naturalises compulsory sterilisation and renders it invisible as reproductive violence.[9] The inheritability

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other hand, however, it is profoundly limited with respect to gendered violence (Chinkin 2009: 75-81; Moshan 1998: 156).

8. Spivak describes reproductive heteronormativity as "the broadest, most ancient, most amorphous institution in the world", the "agency" of which "is not confined to visible violence against women" but gender oppression and gendered subject-constitution more generally (Spivak 2008: 142; see Spivak quoted in Mookherjee 2012: 125). However, the emphasis seems to lie exclusively on the effects of this institution on cisgender heterosexualised women; for an expansion of the concept as it converges with homophobia and homonormativity in postcolonial contexts and queer criticism, see Dhawan n.d.

9. To adduce but one example, Joshua, a transgender man born in the US and residing in Denmark –where his gender identity was, at the time, not recognised because he had not undergone sterilisation– with his female spouse and three children (from a previous marriage with a

and transmissibility of sexual deviance was of prime concern to eugenicists who sought to regulate, contain, eliminate or discourage the reproduction of various sexual and gender "minorities" (McWhorter 2008). Today, some proponents of "marriage equality" emphasise the non-inheritability of trans, queer, gay and lesbian identities in order to argue that same gender marriage is socially "safe"; this strategy is problematic since offering assurance that lesbian, gay and trans parents will not produce queer or trans children stabilises the hetero- and cisnormativity internal to the very concept of reproduction. Under the dominance of the category of sex (that is, of the social relation of binary and compulsory gender assignments) writes Monique Wittig, "the rigid obligation of the reproduction of the 'species'…is the reproduction of heterosexual society" (Wittig 1980/1996: 28). If measures taken to control non-heterosexual and non-cisgender reproduction are integral to eurocentred conceptions of social reproduction, it follows that the legal instruments European nation-states have acceded to using to cognise what constitutes the purposeful elimination or demographic destruction of social groups will, by design, exclude transphobic forms of gendered and reproductive violence.

3. Gendercide

Tracing the colonial roots of these constructions might illuminate the systemically violent underpinnings of contemporary attempts to control transgender embodiments and reproduction, effectively abjecting trans people from the human. In this connection, shifting from the institutionalised legal concept of genocide to the decolonial concept of gendercide as elaborated by Chumash historian Deborah Miranda enables a glimpse into the historical context of contemporary compulsory sterilisation policies. Miranda argues that the *joyas* –third-gender people whom Spanish colonisers constructed as "homosexuals"– were targeted and exterminated for their gender identity. The *Joyas* were not only perceived as "sodomites" deviating from Spanish norms of male/masculine behaviour, but as a "'new' class of people" whose "indefinable gender" could not be assimilated to Spanish conceptions (Miranda 2010: 258-259, 262).[10] Conceptualising gendercide as a crucial

man) is quoted in a recent report by Amnesty International as saying "[s]terilization is a major surgery and seems unnecessary when no one can really see what's inside me. The idea that trans people should not have kids is an insult to my three kids because I wouldn't have them if I'd grown up here and followed the rules [about legal gender recognition]" (Joshua quoted in Amnesty International 2014: 37-38).

10. Nineteenth century Spanish mission baptismal records reveal that the *padres* categorised adult third gender people who were subjected to forced conversion as "armafrodita o *joya*" (hermaphrodite or *joya*/jewel), or "*joya* o amugereado" (*joya* or effeminate) (Miranda 2010:

component of genocide, Miranda traces the processes through which Indigenous people, in what is now known as California, who numbered one million at "first contact", were reduced by agents of the Spanish Crown to "ten thousand survivors in just over one hundred years. Part of this massive loss were third-gender people, who were not lost by 'passive' colonising collateral damage such as disease or starvation, but through active, conscious, violent extermination" (Miranda 2010: 256). In the sixteenth century Spanish soldiers trained mastiffs and greyhounds to execute *joyas*, a widespread practice immortalised in Theodor de Bry's engraving which depicts the attack of Vasco Nuñez de Balboa on "about forty indigenous men, all dressed as women" who were perceived as "sodomites" by the *conquistadores* (Miranda 2010: 258).[11] In addition to killing, *joya* gendercide was carried out through a multiplicity of methods, including renaming, regendering and replacement (Miranda 2010: 267). *Joyas'* survival depended on hiding their gender, on practicing their outlawed religious ceremonies underground, and on remaining unmarried (splitting sexual and spiritual gender) (Miranda 2010: 269). The non-biological conception of *joyas* (as opposed to "men" and "women" who were taken to be reproducible genders) –"the potential for *joya* gender to emerge" in any child of the normative population– actually functioned as a crucial resistance to the Spanish attempts to eradicate them (Miranda 2010: 268).

Indeed, *joyas* have resurged in the late twentieth and twenty-first century as "Two-Spirit people", a contemporary umbrella term for the varying distinctive, integrated gender-sexual-spiritual roles and significances of third-gender people in Indigenous societies in North America (Miranda 2010: 276-275). Two-Spirit identity interacts in complicated ways with euro-colonial gay, lesbian, bisexual and transgender identities (Driskill et al. 2011, Miranda 2010: 278). By drawing on this history of Indigenous "gendercide" to discuss European sterilisation laws,

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263). Those who were caught "dressing as a woman, doing women's work, partnering with a normative male, or actually being caught in a sexual liaison with a man" were disciplined through physical and spiritual punishment and subjected to a process of "regendering" (Miranda 2010: 263-264). "In a kind of involuntary gender-reassignment, *joyas* were made to dress as men, act as men and consort with men" while being prohibited from sexual relations with them; *joyas* were divested from their spiritual and ceremonial position within their communities: due to their gender liminality, *joyas* had traditionally led death, burial and mourning rituals surrounding "the spiritual and bodily crossing over between life and death"; their regendering as "men" resulted in a community-wide "crisis" over this aspect of social life and hastened the eventual coerced conversion to Catholicism of entire Indigenous nations (Miranda 2010: 266).

11. Theodor de Bry, "Balboa Throws the Indians Who Have Committed the Abominable Crime of Sodomy to be Torn to Bits by Dogs" (c.1598) in Bartolomé de las Casas, *Narratio regionum Indicarum per Hispanos quosdam deuestatarum verissima* (Frankfurt: De Bry and Saurii, 1598; New York Public Library, Rare Book Room, De Bry Collection).

I do not mean to elide the specificities of the colonial context, or to appropriate Indigenous histories to an analysis of European transgender oppression.[12] I do not advocate a simple application of the concept of gendercide to the latter; but it might be productive to view contemporary European state policies of compulsory sterilisation as an expression of the coloniality of power as it infuses a system of hetero- and cisnormative gender. Understanding the colonial/modern system of gender as constituted and reproduced violently through its "light and dark sides" –defining the European subject and its (post-)colonial other (whether internal or external to "Europe")– enables us, according to Argentinean philosopher María Lugones, to view "heterosexuality as consistently perverse, violent, and demeaning" (Lugones 2007: 201, 206).[13] Here, I have invoked the concept of gendercide in connection to state-mandated sterilisation of trans people in order to disrupt the self-evidence of a cisgenderist regime of state violence concealed behind a Eurocentric human rights discourse that elides Europe's historical and contemporary investment in the "coloniality of power" (Lugones 2007). European states –and western activists alike– may promulgate "a spatial imaginary in which certain places are imagined as locations of [sexual and gender] freedom and others as locations of homophobia" and transphobia (Rao 2014: 174). Yet, interrogating the coloniality of compulsory sterilisation as a form of violence perpetrated by European states on trans people's bodies enables us to reveal the continuities of this

12. In the colonial context of white settler states, compulsory sterilisation of *all* Indigenous people –regardless of gender expression– has been an official state policy into the late twentieth century, illuminating the non-normativity or "queerness" of racialised gender (Smith 2005, Smith 2010, Lugones 2007). In Puerto Rico, in 1950-1969, 1 in 3 women were involuntarily sterilised by agents of the US government through salpingectomy –a procedure which became so common it came to be known simply as "*la operación*" [the operation] (Beal 1970). According to Indigenous activists Women of All Red Nations, in the contiguous United States in the 1970s, nearly 50 % of Native women and 10% of Native men had been sterilised, as many as 80% of all women on some reservations, and most without giving informed consent (Smith 2005: 82-83). Writing about the US in 1991, Dorothy Roberts noted that "[i]n effect, sterilisation is the only publicly-funded birth control method readily available to poor women of colour" (Roberts 1991: 1443-1444), while today, long-acting hormonal contraceptives known to imperil reproductive health are used to advance the racial project of population control (Incite! 2014).

13. Lugones argues this system organises gender along racialised lines: on the "light" side of this system –to which, historically colonising groups racialised as "white" were subject– are imposed the normative axioms of biological dimorphism (and determinism), patriarchy and heterosexualism (Lugones 2007: 190). These are "hegemonically…written large over the meaning of gender" (190). Indigenous people relegated to the "dark" side of the colonial/modern gender system "were not necessarily understood dimorphically" in colonisers' imaginary and, as we have seen in Miranda's history of the gendercide of the *joyas,* were violently subjected to regendering and were specially targeted for elimination (Lugones 2007: 195).

practice with distinctively European historical processes of violent gender discipline, which "haunt" particularly its former empires notwithstanding their own Enlightenment narratives of "European racelessness" (El-Tayeb 2011: xviii). That is, juxtaposing compulsory sterilisation against an historical background of gendercide allows us to complicate the "temporal narrative" which sees northwestern European states as progressively and cumulatively granting rights to sexual and gender minorities (Rao 2014: 170). I suggest we historicise the rights European states have accorded to trans citizens in their territories –and, often, refused to non-citizens– as expressing and not breaking with a colonial/modern gender system –a system which articulates forms of "power that operates coercively on bodies that do not fit normative ideals" (Stryker 2012: 13).

4. Depathologisation perspective

If I seem to be making a leap from a context of licit eradication of gender variant people, to a context of legal recognition of people taken not to conform to a hegemonic gender system, it is worth considering how the construction of transgender as a pathology denies the historical being of trans people. The notion of gendercide complements the concept of transphobia by tracing the historical colonial/modern roots of the systemic underpinnings of the "cisgenderist social context" in which trans people are subjected to discrimination, harassment, marginalisation, erasure, stigmatisation, and violence (Bettcher 2014: 249). While the suffix "-phobia" implies irrationality, and seems to reference an individualised "psychological" state, it is clear that transphobia is invested with *rationality* by a "broader social context that disadvantages trans people and promotes and rewards antitrans sentiment" (Bettcher 2014: 249). Legal gender recognition is a precondition for substantive citizenship in liberal democratic states, yet the process of granting this recognition constitutes state violence against trans people, implicitly sanctioning interpersonal transphobic violence. Sterilisation laws are justified through a pathologising discourse on transgender lives which constructs gender reassignment interventions as medical "treatment" of gender identity disorder (Suess, Espineira & Crego Walters 2014: 73-76, Yogyakarta Principles 2007: 23).[14] Conversely, a

14. The *International Classification of Diseases 10* of the World Health Organisation defines "Transsexualism" as a "Gender Identity Disorder" characterised by "[a] desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex and a wish to have hormonal treatment and surgery to make one's body as congruent as possible with the preferred sex" (WHO 1990: 168). Based on this definition, there is a sense in which medical interventions are conceptualised as *desires*

depathologising perspective problematises the juridico-medical process of gender reassignment (Spade 2006). Specifically, it undermines the assumption that surgical and medical interventions are what bring transgender bodies into being, so that juridico-medical categories are in turn conflated with embodied transgender subjectivities. As Aren Aizura and his collaborators argue, in the hegemonic imaginary "trans experience has been subjugated under the reductive sign of surgical genital reconstruction ('the operation')" (Aizura et al. 2014: 308). On this dominant view, transgender individuals could not exist except through a medicalised technological process that, by design, precludes their "natural" reproductive capacities. Further, processes of "sex reassignment" are generally not accompanied by fertility preservation or the provision of assisted reproduction technologies (De Sutter 2001, De Sutter et al. 2002, Plemons 2014: 38).

Trans people are violated by the pathologising process that determines which compulsory interventions will constitute them *as* trans people. By this, of course, I do not mean that a given medical intervention is inherently violent or its procurement inherently pathologising. Rather, the socio-legal conditions that compel trans people to conform to these processes are what makes sterilisation coercive, even when it may be desired by some trans people, and even when it is denied to people who are deemed by experts to be inadequate candidates for medicalised transitions. As Susan Stryker has observed, the extension of human rights through which transgender people have been constructed as a "civil rights minority" in various contexts seems to be coextensive with their pathologisation (Stryker 2014).[15] As a precondition of legal gender recognition, compulsory sterilisation constitutes part of a juridico-medicalised process of sex/gender alignment which violently supplants (or more insidiously constructs) trans people's self-identities within a coercive regime of gender. In other words, it systematically violates the principle of "first person authority over gender identity" (Bettcher 2009). Talia Bettcher argues that the he-

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of the patient definitive of the "disorder" and, at the same time, as the approved means of its treatment.

15. As a result of trans activism, the depathologisation perspective is making its way into human rights discourses, which are problematising the "invidious situation" facing trans people in Europe (Amnesty International 2014: 7). In 2013, the UN Special Rapporteur on Torture and Inhuman, Cruel or Degrading Treatment or Punishment called upon the European states which require sterilisation to put an end to these practices (see Amnesty International 2014: 25). A report by Amnesty International deplores the double-binds facing trans people: "hav[ing] to choose some human rights at the expense of others […] Obtain documents reflecting their gender, which would ensure their right to private life, or refuse to divorce their partners? Being acknowledged by the state and enjoying equal recognition before the law, or preserving their reproductive rights by refusing to undergo sterilisation?" (Amnesty International 2014: 7).

gemonic western regime of gender, in which "gender presentation communicates genital status," is fundamentally "sexually abusive" (Bettcher 2009: 99).[16]

5. Conclusion

As state policy, compulsory sterilisation of trans people reveals the violence of normativity internal to a heteronormative, cisgenderist system, and is not an aberrant exception to it. In this vein, we can make two interrelated claims: first, the process of legal gender recognition as it is institutionalised in the European states in question constitutes a specific form of reproductive and gendered violence against trans people. Second, gender as such is constitutively violent. Gendered and reproductive violence against trans people are not failures of an otherwise natural and just gender order but rather symptoms of a deeply oppressive regime of gender with roots in European colonialism, which is materialised in a particularly harrowing way in the lives and bodies of those who are taken to transgress it. Existing legal instruments make it difficult (from a cisgenderist perspective) to cognise compulsory sterilisation of trans people as gendered or reproductive violence, even when they prohibit forced sterilisation as a genocidal or otherwise criminal act. As Stryker reminds us, "[t]o not be recognisably gendered as a man or woman" (whether one identifies as a man or woman or not)

> [...] is, in a very real sense, to lose one's access to and claims upon human status. This is the challenge faced by transgender activism: it involves more than merely crafting special procedures for a tiny minority to change membership from one recognised gender category to another (daunting though that project is) (Stryker 2012: 14).

Trans activism, for Stryker, involves challenging how a cisgenderist regime constitutes the border between the human and the nonhuman, the rights-bearing subject and those beings "deemed intrinsically […] incapable of bearing rights" (Stryker 2012: 14).

European states which force trans people to undergo sterilisation in order to recognise their gender identities construct trans people as "rights-bearing subjects" inasmuch as their highly regulated gender identities are concerned, yet, simultaneously, "infertile citizens." State regulation of transgender reproduction

16. In this regime, in which "gender presentation literally *signifies* physical sex," trans people are subjected to what Bettcher calls a "Basic Denial of Authenticity," whereby their gender presentation and genital status are inscribed in "an appearance or reality contrast"; trans people are normatively read as "misalign[ing] gender presentation with sexed body" and constructed as "deceivers or pretenders" (Bettcher 2009: 105).

constitutes a form of institutionalised gendered and reproductive violence inasmuch as it impedes transgender people's ability to exercise inherent first-person authority over the materiality and existential meanings of their gendered embodiments and over their reproductive desires, relations, and futures. A decolonial, depathologising trans theoretical perspective can trace the resonances of gendercide as a constitutive process of the colonial/modern gender system in contemporary European liberal democracies. Indeed, the border between the human/nonhuman etched on trans bodies is constitutive of colonial/modern gender. Thus, the decolonial task seems to involve conceptualising compulsory sterilisation of trans people not only as a form of gendered violence but as revealing the violence of gender.

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MICHAEL NEBELING PETERSEN

Between precarity and privilege. Claiming motherhood as gay fathers through transnational commercial surrogacy

1. Introduction

When I participated in a consumer conference for gay men interested in surrogacy in London in 2014, I listened to a paper given by a Spanish gay and pro-surrogacy activist. Among other things he argued that gestational surrogacy challenges the traditional concept of the mother. He argued that surrogacy fragments motherhood into at least five roles: The egg donor, the carrier, the wet nurse, the caregiver, and the guardian. The activist continued, "We need to use proper words that dignify our families", and therefore he suggested that "we" should call the woman who delivers the egg "donor", while the woman who carries the child should be called "carrier". He argued that the concept of the mother should be divided between the other three roles, roles that can be embodied by gay men.

In the narrative of the activist a fragile family takes form. A family that finds its constitutive borders through the marginalization and exclusion of specific kinship positions. "Our families" are constituted by the fragmented mother roles that separate the surrogate mother and the egg donor not only from the category of the mother but also from the family and possible kinship relations to the child. Donor and carrier are merely clinical or medical devices in the reproductive process.

The fragmented Mother is the analytical point of entry for this paper, where I will also argue that we should understand this making of the gay surrogacy family through a homosexual affective history of death. On the one hand the gay surrogacy family is now being vitalized, while on the other, this new vital position is so fragile that it can only be embodied through the active exclusion of other kinship

positions, the mother position in particular. And I will argue that this exclusion rests upon misogynous and colonial strategies.

I have examined the narratives related to these new gay surrogacy families by conducting participant observation at different conferences concerning European surrogacy and alternative families, and secondly by doing netnographic research in different social media. In addition, by elaborated qualitative interviews with Danish homosexual men who have made or are planning to make families through transnational commercial surrogacy arrangements. In this paper I focus on the interviews.

2. Theoretical stand

Firstly I present a brief theoretical context: Heterosexuality has had the patent on reproduction, and non-heterosexual reproduction has been staged as a poorer copy of the original (Nebeling Petersen 2009). In this way the cultural script of homosexuality has been maintained –through non-reproduction– as degenerated, barren, dead (Butler 1992, Nunokawa 1991, Edelman 2004, Nebeling Petersen 2014).

Surrogacy is illegal in Denmark, yet during the last ten years, homosexual choices have radically changed. From being legally and culturally excluded from reproductive technologies, homosexuals now have access to other reproductive technologies as well access to the symbolic institution of reproduction, marriage.

I draw my inspiration from queer necropolitics (Puar 2007, Haritaworn et al. 2014, Nebeling Petersen 2014), and thus I can't perceive the vitalization of the homosexual figure as a step towards more gay liberation and equality, but rather as calibrations of the demarcations between those bodies and populations that are included in the biopolitical optimization of life, and those who are left outside.

When gay men are being reconfigured as vital and reproductive it is complicit with the active as well as the indirect demarcation of other bodies from various life domains. When the Spanish activists stage the homosexual man as a subject who can embody the position of the mother, it rests upon the de-vitalization of other kinship positions, and in particular the surrogate mother and the egg donor.

3. Homophobia and suspicion

When interviewing gay men, it became clear to me, that homophobia is a constant context for gay men despite the legal and cultural changes in the configuration of homosexuality.

For instance one couple told me, that before they talked about surrogacy they had wanted to be significant adults to a child by volunteering at an organization that arranges "adult friends" to children with special needs. When applying they were suspected for being pedophiles and were questioned about their masculinity and whether they were able to be proper role models for the children. In the end they were rejected from participating in the organization. One of the men in this couple also told me that when he was younger he had been beaten up and harassed numerous times due to his "experimental clothes, hairdos and makeup". When he told me – sitting there years later without makeup, in a traditional masculine outfit – how he had learned "to keep his nose to himself", I was struck by the power of homophobia to discipline people to comply with the norm.

Other couples told me about the intense heteronormativity in their lives. How they constantly think about and negotiate their appearance as couples and families in the public. Whether or not to hold hands, to pass as friends rather as lovers, the constant feeling of exposure and betrayal of oneself.

Finally, a large number of couples told me about the experiences of heteronormativity in the state and city systems, where they are mistaken as heterosexuals, and so they didn't fit in the context of the questionnaires.

4. The haunting mother

Even though my interviewees insist that there is no mother in their families, the mother is haunting the conversations. The men tell me many stories about how the gay male couples are being reminded from their surroundings about the missing mother. And how teachers, family and friends repeatedly tell both parents and children, that despite the parents own narratives, the children must have a mother somewhere.

In this way the mother comes to stand in the way for a full parenthood that fundamentally doesn't lack anything –while notions of the mother seem to activate heteronormative assumptions of the family as being made up by a cisgendered female mother and a cisgendered male father and their genetic children.

It is no surprise then, that the mother is demarcated again and again, for instance when I asked one couple whether their children would have any contact with the surrogate mother, one man answered: "No, she isn't their mother, it isn't her they have a genetic link to," and his partner followed up: "Of course the children will ask 'why don't I have a mother?' And of course we must tell them, that they don't have a mother, but two fathers. But there is a woman who have had you in her belly." However, the mother is always present. Later on in the same inter-

view I asked the couple what the biggest disadvantage of being a gay male family was, they answer without hesitation: "It is of course, that there is no mother".

5. Reproductive vulnerability

In this way the interviews confirm Riggs and Due's argument, that gay parents must be understood as being in a position of reproductive vulnerability as "access to cultural capital arising from reproductive capacity is hierarchized to an individual's approximation to that which is still seen as emblematic of fertility, namely reproductive heterosex" (Riggs & Due 2013).

When gay men negotiate and reconfigure homosexual man, it must be understood in connection to the cultural and affective history of the gay man as non-reproductive and a threat to children and the future. This history places homosexual man in a vulnerable position, especially in relation to reproduction, measured on the ability to imitate heterosexual sex, which includes the assumption that there will always be a mother.

6. Misogynous strategies

Throughout the interviews a critique of women as dominant is a repeating pattern, where a series of misogynous strategies are launched. The men do this by underscoring that they –as men and not as homosexuals– are in an underprivileged position to women.

In these narratives women are being understood as being the ones who have the upper hand in divorces and legal fights about the children. And women are being narrated as untrustworthy, selfish, and potentially crazy.

Especially lesbian women are made suspicious and staged as deceitful. One informant tells me:

> We wanted our own child without any trouble. And there is no one who has proven, unless you have made some new research, that lesbians are particular cooperative. I simply don't understand why gay men choose dykes. Because most dykes… that is, in the project we know about, there are only two active parents in the equation, and that is the one or both dykes and one gay man. It is almost asking for trouble.

Another misogynous strategy links the heteronormative assumption, that gay men cannot be good parents, to women. Another informant tells me how women are critical towards gay male parents as they don't breastfeed and don't have the same

troubles with their children as women do, "because women make their wish for a child their life project".

In this narrative the woman is staged as someone who unrightfully suspects the man to justify her own uncontrollability, that is shown by her not being able to dose her parenthood properly.

In this way the experience of the gay man seen as a poorer parent due to his homosexuality is being moved from its homophobic context that perceives him as homosexual and thus underprivileged and framed within a misogynous context, and positions him as a man and thus privileged.

These narratives rest upon misogynous discourses about dominant women, who are deceitful and fraudulent. By activating these misogynous strategies the men can justify their choice of excluding a mother from their family, where they can articulate a critique of the heteronormative assumption that a family with a mother and a father is always the best choice. At the same time they can include themselves in a privileged masculine community, where they, as homosexuals, have been traditionally excluded from.

7. Colonial strategies

One of the interviewed couples are the parents of twins born in India by an Indian surrogate mother and an Indian egg donor. Throughout the interview ethical considerations about this choice keep popping up. On the one hand, they frame the arrangement as one of charity, as they underscore that they chose India because they wanted to find a woman who actually needed the economic help. Thus they chose a good agency that found a woman who was in special need – according to the interviewee– as she had no social status in India. This philanthropic narrative is supported by the fact that the men send money for the education of the surrogate mother's daughter every year. On the other hand, they say that the choice of India was made due to the fact that surrogacy in India is up to three times cheaper than in the US. When I asked the couple about the seemingly contradiction between charity and economic benefits, one of the men answered that they chose India because of the price and "that Indians are more emotionally distanced". In this answer it became clear to me that the charity narrative can be thus combined with the economic narrative through a colonial logic.

To analyze the global economy that surrogacy is a part of as well as the different forms of labor that surrogacy involves, Kalinda Vora understands commercial surrogacy as affective and biological labor. She argues that surrogacy is to be un-

derstood as part of a long political colonial economy that transforms vital energy from bodies in the Global South to the bodies in the Global North (Vora 2012).

The couple's narrative can be understood as part of the colonial economy where vital energy is transformed from an Indian surrogate mother to the gay surrogacy family in Denmark. A transformation that isn't staged as exploitation of the surrogate's body and reproductive functions, but rather as economic support to her body through the choice of the agency and good payment, and support to her reproductive functions by the couple paying for the daughter's education. And this narrative is further supported by the colonial assumption that Indians are particular hardworking and emotional distanced, and notably grateful for the help from the North.

Where the Indian surrogate mother is staged as a passive actor who is either being exploited or helped, the couples that have used an American surrogate mother have quite a different story. The American surrogate is framed as "a real power lady", and her motivation for being a surrogate isn't related to the money she earns, but rather to her political and personal will and commitments. And contrary to the Indian surrogate mother, the American is given voice in the interviews, when the men are quoting the surrogate mothers.

By staging the American surrogate mothers as independent power ladies the racial and economic difference between the white middle and upper class intended parents and the black and lower class surrogate mothers are underplayed: Race and class differences that could have disturbed the narrative about the free choice and will of the surrogate mothers.

I asked one of the couples who had used an American surrogate, if they had considered any other destination for surrogacy. One of the men told me:

> We opted out South America, we didn't want that. We didn't want to go to Russia, and not Asia either. It was all about what we really feel about everything that had happened, that the creation of our children has been a big magical fairytale. Yes, a lot of it happened in courtrooms and meeting rooms and legal documents, but as big fairytales there is nothing but winners. Everyone walks away happy! […] We know that, and now we don't have to think what could have happened if they hadn't done it, if it couldn't give them a bigger house or put water into the house. I'm not saying that India is about exploitation of poor people. But the possibility is there, and that was enough for us not to choose it.

By distinguishing between ethical and unethical surrogacy arrangement the informant is staging US surrogacy as a solely good and ethical solution. By contrasting it with a colonial assumption about the Indian woman as passive and exploited it becomes possible to frame the American surrogate as free and equal.

The transformation of vital energy from California to Denmark is staged as a win-win-situation by giving the surrogate mother so much agency that the economic transaction can excuse any structural forms of inequality and exploitation. I recognize that there is a vast difference between the economic and material living circumstances in India and the US. But still I find it interesting that the same transaction can be staged so differently between the US and India, with the Indian woman's lack of agency as common trope. By removing the surrogate mothers' kinship positions through misogynous and colonial strategies, the gay fathers try to conquer the position as full and valid parents.

8. Conclusion

The homosexual men, I have interviewed, are met with homophobia, and it is clear how a historical suspicion positions them as incompetent and unworthy parents and even pedophiles. This vulnerability put the men who use their new reproductive possibilities in a constant position of negotiation: They have to fit their kinship forms and practices into norms and institutions they don't fit.

Surrogacy enables gay man to enroll into the reproductive heteronormative hierarchy by making it possible for them to procreate children with a genetic link. And the men are negotiating their position in the hierarchy by actively excluding the carrying and genetic mother. When the gay man tries to rewrite the affective history from a non-reproductive pedophile to a life-making mother it demands a violent kind of work: To put another mother on the throne, the old mother needs to be excluded and marginalized.

Thus the gay man puts himself into a masculine community by activating misogynous and lesbophobic strategies, that enables the gay man to take over the role of the mother in the fragmented economy of motherhood.

The structural inequalities of the global economies of colonialism and wealth enable transnational commercial surrogacy. Yet, it is also through a colonial imagery of the Indian woman's lack of agency and it is either the dependency of economic help or exploitation by economic compensation that the Danish homosexual men are articulating a justification of both Indian and US surrogacy. And in both cases the result is that the surrogate mother cannot be a mother, but solely a carrier, so the gay man can become a worthy mother in the heteronormative economy of kinship.

Through a necropolitical lens, we could say that the vitalization of the gay man by enrolling into the heteronormative imperative of reproduction rests upon

a de-vitalization of racialized, classed, and gendered Others. A de-vitalization that runs through already given misogynous and colonial structures of privilege, that are activated in an attempt to dismantle another already given homophobic structure of privilege.

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ASPA CHALKIDOU

It's my party and I'll inseminate if I want to: Sex, sexuality, kinship

1. Introduction

Some months ago, when I was following a facebook discussion about the forthcoming pride marches in Athens and Thessaloniki and the central claims they have protested the past years –that is the right to civil partnership, marriage and shared parenthood– I came across a post by a gay friend. In this post he thrust a saying that goes like this: "Try to say the word 'dignity' with a cock in your mouth. You can't, can you?".

In my opinion, this quote sums up and at the same time stresses a principal matrix through which matters of non-heterosexual sexuality and parenthood are understood and interpreted. Although it is the discourse of the law and human rights that usually serves as a preferential lens of analysis in debates around same-sex parenthood, I have actually prepared the present paper with the intention of exploring the complexity of the issue of sexuality, as interrelated with public and state discourses on non-heterosexual reproduction and same-sex parenting in Greece, and focusing on sexual practices. Using data from interviews conducted with people who identify themselves as lesbian or gay, and who are or wish to become parents by using methods of assisted reproduction, drawing from public discourse on (homo)sexuality, same-sex parenthood, (new) kinship models and state discourse on the debate of same-sex civil partnerships, I will attempt an inquiry into: (1) The complicated ways through which concepts of sex as a practice reveal the limits of neoliberal tolerance towards conceivable and acceptable forms of family, kinship, and relatedness. (2) How sexual practices or their absence (re)

make concepts of assisted reproductive technologies. (3) How state recognition and public discourse use concepts of same-sex sexual practices in order to justify the legislative exclusion of LGBT people from legitimate forms of kinship.

2. The legal framework[1]

Let me begin with some information on the legal framework. Greece is one of the few countries in Europe which do not legally recognize same-sex relationships, either in the form of marriage or as registered partnership or registered cohabitation. There is no kind of legal recognition for same-sex individuals; neither alliance relationships (the connection between them) nor joint parenting are legally recognized. As for the law on medically assisted reproduction, non-heterosexual couples are excluded, while non-married, single women are included, but only because, as one of the exponents of the bill has stated, "a woman is born as a mother, this is a kind of information which is inscribed onto her DNA" (Kantsa 2006). As a result, access to medically assisted reproduction is only possible for lesbian women, provided that they have necessarily disclaimed their sexual preference/desire/relationship and appear as single women. In other words, the right to medically assisted reproduction does not follow a recognition of same-sex sexuality, but is founded on the recognition of a single woman's desire to have a child. At the same time, the possibility to resort to methods of assisted reproduction is chiefly available for lesbian couples or lesbian women who can afford the financial cost involved. Although the cost of assisted reproduction had been highly covered by insurance funds until some years ago, the recent changes brought about to the National Organization for the Provision of Health Services (EOPYY) coerce a lot of women to cover any expenses in their biggest part, excluding whoever cannot afford the procedures. In the Greek context, although surrogate motherhood has been established as legal by the law (3089) of 2002, gay men are excluded by relevant regulations. According to the law, inserting genetic material in the body of a surrogate mother is allowed, provided that a permit has been issued by the regional court. However, in order for the specific court decision to come into effect, *the woman* who wishes to have a child but is unable to gestate has to make a request. According to the existing legislation, the request cannot be made by a single man or by a couple of men. As a result, the state seals the exclusion of gay men from the possibility of starting a family by means of this regulation, combined with the exclusion of gays and lesbians from adoption procedures.

1. The section on Legal Framework draws from Kantsa Venetia and Chalkidou Aspa (2014).

3. Sex and necropolitics

In a previous article I have argued that the legislator's hesitation to include same-sex couples in the law on medically assisted reproduction in 2002 is closely linked to the absence of a legal framework for same-sex marriage (Kantsa and Chalkidou 2014). And this is more than true. At the same time, though, it is essential that we realize that this legal absence does not constitute the sole impediment to the recognition of same-sex parenthood, nor is it the only factor that contributes to the exclusion of same-sex couples from medically assisted reproduction and adoption. It is equally important that we draw our attention to the dominant conceptions and the commonplace ideas around the relation between sex as a practice and parenthood, and more specifically, on the ways in which queer sexual desire and sexual practice are charged with implications of death in their interpellation in the Greek context of public discourse.

To make a long story short, I will select just a few indicative examples among the countless narratives available. I would like to start with the notion of queer sexual desire and practice as charged with implications of death when interpellated in the Greek context, and go on to argue that one cannot possibly dissociate the dominant conceptions of LGBT parenthood from the conceptions of LGBT sex. For instance, in 2002, when the legislator deprived gay men of access to surrogate motherhood, Ioannis Laskaridis, head of the Greek National Council for Radio and Television (NCRTV) at the time, strongly advocated the decision of the NCRTV to censor a Greek TV series, fining the TV channel that had screened it with several thousands of Euros, because it featured a scene where two men kissed each other. His exact words on that occasion stated that "homosexuality is an eccentricity that lies outside the productive process of life." Some years later, in 2008, on the occasion of the public debate on gay marriage and the right of gay people to parenthood, metropolitan of Piraeus Seraphim published a press release, in which he stated that "the tube of excretion of the human body's waste products shall never serve as a value of life." It is more than clear that Seraphim cites anal sex among men in his statement. The problems caused by such statements are not an exclusive matter of unabashed homophobia or even a sexual hierarchy they reproduce in order to determine what is worthy of serving as "a value of life" and who is worthy of being a part of the productive process of life, of reproducing life or tending to life, or assuming responsibility for a life. The problem is that they organize strategies of necropolitics on the basis of certain sexual practices. For if it is true that from a wider perspective parenthood –that is straight parenthood, since any kind of parenthood that is defined otherwise in Greece is simply unintel-

ligible– raises issues of life management, of nurture, of custody and care of a life, then queer sexuality is only rendered visible in the public sphere and discourse as a potential carrier and disseminator of death. And this is not something that simply creates a discontinuity between these two conditions, but it also produces a constitutive opposition. Another problem has to do with the constant incrimination of queer sexuality and sexual pleasure. Therefore, I would like not to limit my analysis to the interweaving among (same-sex)sexuality-reproduction-parenthood as a matter of a legal abeyance or of queering/faggoting the nation, nor would I like to insist on an exclusively victimizing portrayal of LGBT sexuality and parenthood. For it has to do with pleasure as well. Though this pleasure comes at a price. And I do believe that within the Greek context, this has never been expressed more lucidly than in the following words of Ntinos Christianopoulos, the poet of male homosexuality, which come from a poem dating back to 1953: "I pay the steep price for my perversion with death (..) for one moment of surrender".[2]

4. The disenchantment of sex

In a similar framework, four of our interlocutors, who are friends –a couple of lesbians and a couple of gay men– decided to proceed to a d.i.y. fertilization at home. The four friends had a number of eleven fertilization sessions. Every time, Antonis went to the toilet, jerked off and poured his sperm in a glass. He gave the glass to Despina, who poured the content in a syringe and then emptied it into her vagina. "How did you come up with the procedure?" I asked her. And she said:

> I had always had this movie by Araki in my mind, *Totally Fucked up*, which I had watched when I was in Amsterdam, I was 21 back then. The movie features a group of lesbians and gay boys, the two lesbians of the group are a couple, and there's a scene where they have all gathered in a house. One of them has her birthday and one of the presents she had asked for is that they jerk off in the toilet and give her the sperm in condoms and she pours all the sperm in a bowl and then, after she has made a sperm cocktail, she fertilizes herself with a turkey baster. The scene opens with the title "it's my party and I'll inseminate if I want to", or something like that.

As far as the relation between sexuality and IVF, it is often argued that with IVF, heterosexual sex act is no longer important. And while this is partly true, it is not always the case. For at the very least, what is postulated by such a remark is the fact that fertilization is intelligible either in terms of straight sex or in terms of

2. Christianopoulos, N., 1950, «O thanatos tou Aunan» [The death of Onan] from the poetry collection *The Age of Lean*, Thessaloniki: Kohlias.

medicine. What happens, though, when fertilization is achieved by means of the self-management of a process which is considered to be the prerogative of nature or science? What about the cases in which this self-management is undertaken by faggots and dykes? Calliope, the other lesbian of the group narrates:

> I guess there was, especially on the part of straight people, when we told our friendly couples that we were trying this way etc, there was something like an aggravation…I don't know if other people have told you so, for this came from quite different directions…they were like "yes, but why don't you go to the hospital for the insemination?". Whereas whenever a straight couple say "we're attempting pregnancy", which means they've started having sex without using a condom, nobody says "yes, but why don't you try insemination?".

The kind of self-management of fertilization I am referring to partly involves medicine (on the level of medical examinations the biological parents had undergone) as well as sexual acts (as far as both the biological father would jerk off in order to produce sperm and the biological mother would sometimes masturbate in order to cause uterus convulsions, so that "the sperm could be better absorbed" as she pointed out). As pointed by Calliope one of the numerous achievements of this self-management of fertilization is that it eventually disenchants straight sex, as well as science. This is achieved within a framework which charges queer sexuality with implications of death and implications against parenthood, and in a framework where the dominant public discourse draws from the presumption that a supposed "sexual abnormality" is the symptom of a "political disorder", or the byproduct of some form of an anti-Greek sentiment, and hence vanilla sexuality is a prerequisite and a byproduct of a certain democracy. I believe that in such a framework, managing to talk back to all these assumptions is finally a process of vital importance.

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DESPINA NAZIRI

Unattainable motherhood: A psychodynamic approach

Infertility has long been of interest to psychoanalysts who have tried to help their childless patients cope with, or overcome, this condition. The prevailing psychoanalytic understanding of infertility in the 1950s and 1960s was that of psychogenic causation (Leon 2010), contributing as such to stigmatizing infertile people. When organic factors could not be identified, unconscious conflicts were believed to cause the inability to conceive. Yet, as infertility became progressively better understood medically and no evidence for these postulated psychogenic bases for infertility was found, this unfortunate emphasis on a search for psychogenic causes eventually faded (Kulish 2011).

Currently, the focus on psychoanalysis has shifted from an etiological to a therapeutic approach. Those who work with infertile women and men undergoing infertility treatments (Allison, Doria-Medina 1999, Bassin 2001, Balsam 2011) stress the patients' feelings of shame, grief, anxiety, despair, depression, rage, envy of others with babies, futility, and magical thinking, all of which follow from being deprived of parenthood while enduring painful and humiliating medical procedures, which may or may not work. According to Apfel and Keylor (2002), psychoanalysts have recently turned their attention to two salient and problematic dynamics: the failure to adequately mourn a previous loss and the absence of ambivalence and disavowal of negative feelings about pregnancy and motherhood that is frequently observed among infertile women (Filet 1993). They also underline that while adoption reduces the secondary stress of in vitro procedures, it cannot be assumed to overcome ambivalence about motherhood or to heal the sequelae of infertility.

It is also remarkable that most of the literature on childlessness has focused on women. In fact, modern diagnostic advances now show that 45% of those concerned with the issue of childlessness are men (Apfel and Keylor, ibid.). Many argue that women are more affected and pained by their childlessness than men. There are, undoubtedly, social and psychological reasons for this assumed gendered difference. Chodorow (1978) has elucidated the psychological and sociological processes by which the need to mother is instilled in women; that is to say, the reason why women reproduce caretaking and mothering, while men are not so programmed. Men are typically less likely to see a doctor for individual treatment and to come for conjoint work regarding concerns over their marriage or because they want to support their wives: "the profound shame, stigma and assault on masculinity can be so acute for men that they are too mortified to ask for help**"** (Leon 2010: 50).

In this presentation we will be looking into the impact the use of ART (Artificial Reproductive Techniques) can have on the psyche of women who use these techniques because they consider themselves infertile either for biological and psychological reasons, or for social reasons especially due to their homosexual orientation. More specifically, we will be analysing the experience of women, who try to become mothers with the use of new medical techniques and the intervention of third parties (donors and doctors), by looking both into the internal contradictions and psychological conflicts, and into the psychological readjustments associated with the processes of trying to become a mother. These psychological readjustments may facilitate the access to maternity or on the contrary promote the renunciation of becoming a mother. This renunciation is either generally expressed by a desire to remain childless, or by the decision not to be the biological mother but to still be the second parent of a child. The clinical data we use as a basis for our observations emanate both from our research work with infertile heterosexual and lesbian couples, and our therapeutical work with infertile women.

According to the studies by Alméida et al. (2002) and Goeb et al. (2006), medical treatments for infertility are very distressing, both physically and psychologically, for the woman and her partner. Recourse to ART treatments can be seen initially as protecting the couples from a psychic meltdown. It is the moment of faith in medicine. However the route of ART is often long and strewn with failures which can reactivate the couple's narcissistic wounds (Canneaux 2009) and can consequently activate acute internal conflicts.

During the treatment, the couple frequently faces all-powerful medical practitioners, whilst they are both active and passive in relation to the medical team. In other words, the aspiring parents experience contradictory feelings where on the

one hand, they feel that they engage themselves in an active process, while on the other, they realise that they can only reach their objective by remaining passive in the face of decisive interventions conducted by others. The woman can have the impression that she is having a child alone or with the help of the gynaecologist while the man finds himself constrained to adhere to a process in which he has very little to do (Alméida et al. ibid.).

When a couple resorts to ART to conceive a child, a third party is introduced into the equation –the gynaecologist– who can represent different things to different couples. According to Alméida (ibid.), the gynaecologist is generally seen as a saviour, who can, in part, heal the wound caused by the discovery of sterility. In any case, he/she becomes a central figure in the emotional life of each partner of the couple (Filet, ibid). In several interviews conducted as part of the (In)FERCIT programme, one can indeed observe that in their discourses, women define the gynaecologist in those terms, which can also be directly linked to the particularity of the way assisted reproduction is organised in Greece.

Moreover, (Dudkiewicz-Sibony 2006, Cauvin 2007) and (Naziri, Dargentas 2011, Naziri, Feld 2012) tried to explain how ART with a donor, in addition to "the third party" that the doctor already represents in an intraconjugal insemination, introduces yet another "third" party. According to these findings, a serious and careful psychic exploration is necessary to prepare for the acceptance of this third party donor. This will enable the parents to see how the failure of the biological and genetic relationship will be compensated with an increased symbolic and social relationship: what makes a parent, after all, is giving the child the family name, loving it, educating it and bringing that child up. The fact therefore of becoming a parent thanks to the intervention of a third party can bring about readjustments in the psychic economy of a woman, who is led to think of her role as a mother in a new light. The time between the acknowledgement of infertility and the suggestion of sperm or/and egg donation can be a good time to carry out this process (Carter et al. 2011). The ability of the woman and the couple to incorporate this event into their history has been shown to be important. More specifically, the idea of egg donation should only be proposed, as with adoption, when the couple has gone through the process of mourning the loss of fertility (Raphael-Leff 2002, 2007, Simoglou 2012). Dudkiewicz-Sibony (ibid.) explains that the anxieties, fears, feelings of guilt, if not explored can become an obstacle to the pregnancy.

If pregnancy does not occur, the problem of mourning the loss of fertility is even more difficult given the current social climate which extols the right to have

a child. For certain psychoanalysts, the mourning of infertility will only take place after many years (Weil 2011). According to Goeb et al. (ibid.), the rate of couples giving up ART treatment voluntarily can be as high as 60%. Psychological reasons are more often than not the reason for giving up. He notes that the women who stop ART are more likely to reflect upon the idea of existing as a woman without becoming a mother.

Taking a respite from attempts may not only provide a needed break from the cascading sense of failure and helplessness, but enable a more open examination of early and current sources of ambivalence toward parenting and result in more conscious decision making. This may include discovering that the increasingly desperate need to provide narcissistic restitution through making a baby has become more important than the wish to parent. Adaptive solutions are often found through adoption or non-parental nurturing relationships through work, extended family, or volunteering organizations (Leon, ibid.). Thus, the experience of having to go through painful medical treatments can lead an infertile woman to make decisive psychological readjustments, which enable her to give a meaning and a new direction to her life.

Nonetheless, what should we think of the psychological readjustments lesbian women may face when they decide to have a child? In exploring and analyzing the clinical material that we collected during our clinical research where we met lesbian women who wanted to become mothers through artificial insemination with an anonymous donor, we noticed that the project itself, which involved deciding who between the two women would be the biological mother and who the "social" mother, had already split the sexually identical couple by exposing it to differences and then raising the question: who is the second female parent, who is not the biological mother and who is not a father? What does this parent do, and where does she stand between the mother and the baby?

In fact, for both partners, the desire to have a child draws on the relationships with their own parents, the representations of the roles of father and mother and their conceptions of maternal and paternal functions. Hence our research shows that for these couples, bisexual identifications were particularly mobilized by this project (Feld 2010, Naziri, Feld, ibid.). All the more so, perhaps, as it is with homosexual couples that bisexual fantasies may flourish more freely and openly, since they are liberated from any anatomical reference or socially predefined sexual roles.

Through the thematic analysis of several couples' fantasy constructions, it would seem that for the woman who has chosen not to experience maternity in her own body (thus avoiding those very specific aspects of the maternal feminine re-

lated to pregnancy), the desire to have a child can nonetheless activate new possibilities of identification in terms of feminine passivity and erogenous masochism.

French-speaking psychoanalysts (David 1997, Houzel 2007) have brought some interesting contributions to the debate about psychic bisexuality which could be at the heart of the questions surrounding same-sex parenting. Thus, bisexuality has a unique status: it both reflects and glosses over the difference between the sexes. This emancipation of the psyche with regards to anatomical destiny and biological limitations has become a reality with advances in ART (Assisted Reproduction Technologies), undermining natural laws of procreation, bringing that which was previously merely imaginary into the realm of reality. Yet, in homosexual families, although these new means of conception and relationships are overturning millennium-old designs linking sexuality, procreation and lineage, nevertheless, the unconscious and psychosexuality still deal with these new realities in their own way. On a more general level we could say that both the desire to have a child and the insemination will trigger important readjustments in the psychic economy of lesbian couples asking for insemination.

Clinical vignette: Emma and Judith, or training for maternity

Even before they met, Emma and Judith both knew they wanted to have a child, and soon after they got together they decided to begin the necessary procedures. Emma was aware of her homosexuality at an early age and had never had a heterosexual relationship, whereas prior to meeting her partner, Judith had lived with a man for four years. At first, while Emma shied away from the experience of pregnancy, Judith was very enthusiastic:

> I have always wanted children since I was very young, I have always loved children and wanted to work with them! I have always wanted to have a child […] I want to go through it, to experience pregnancy, to have a child! We are made to create life and of course we should take that opportunity!

Nevertheless, despite this enthusiasm, the desire to become pregnant shifted in this couple. Emma explained that thanks to this relationship and everything Judith brought to it and to the discussions they had, she may have gradually allowed herself to realise this desire to become pregnant. Judith, who had just started to train as a plumber, gave priority to her new career, preferring to experience maternity through her partner, thus postponing the realisation of her dream:

> I am so happy that Emma is doing it, and that she's the first to do it, mostly because of her age, as it might be more difficult for her afterwards, but I'm

> happy that she's doing it because I wanted to experience it too and by being at her side, although it's not me carrying it, I'll still experience it with her; seeing her tummy grow, through all the stages of the pregnancy, being by her side whereas in a straight couple only the woman experiences it. But I'm a woman and I'll be able to experience it by her side, y'know? And…I'm really happy because I also don't think I'm ready to carry it either because at the moment my career is a little bit more important for me [...].

What happens when Judith delegates this intense desire to have a child, at the very moment she could have realised her dream, to her partner? Why did her training in plumbing become such an important step before maternity, and what meaning should be attributed to this training which has become so necessary and in which she invests herself so completely? Is the expression of an omnipotent bisexual fantasy, in which case, she will experience the pregnancy through her partner more completely than any man could, while at the same time reinforcing her masculine attributes with her training?

But beyond this omnipotent bisexual fantasy what meaning could we give to this training and its multiple meanings? Will she become formed through contact with the pregnant Emma, identifying both with the unborn child and the mother carrying the baby? Does she need to reassure the maternal feminine in herself with a woman another than her mother? Will her profession, this training that is so important to her, sufficiently reinforce her active/masculine side, her identification with the father, to take on the passive receptivity of pregnancy?

Emma, on her part, can identify with Judith's desire, then assimilate it and allow herself to become a mother. As she attributes this enthusiasm to Judith's infectious enthusiasm, might we hypothesise that Judith personifies a generous, post-Oedipal mother who accepts and even wants her daughter to become a mother in turn, symbolically depriving her of her child, and of her position of maternal monopoly.

The experience of these two women could help to shed some light on the choices made by homosexual women or even certain heterosexual women, confronted with the necessity to use ART, where the desire to be a parent can be dissociated from the desire to carry a child; and it might also help us understand the psychic factors that make it possible to reach a maternal feminine position, and those that inhibit it, without having biological links with the child.

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PART III

Embodied Experiences

LIA LOMBARDI

Reproductive technologies and "social infertility" in Italy: Gender policy and inequality

1. Introduction

This paper investigates the practices of Medically Assisted Procreation (MAP) or ART (Assisted Reproductive Technology)[1] with regard to the process of medicalisation of the body, to reproduction and everyday life, and to social and family changes. The Italian context exhibits on the one hand many contradictions in relation to advances in biomedicine and biotechnology and on the other, legislative and political conservatism.

This study will thus consider: a) not only the link between Italian policies and legislation but also the changes in the social, family and parenting structures, b) the impact of reproductive technologies on gender relationships and new forms of parenthood and c) gender inequality, which is still rooted in the Italian context and faces the challenges of MAP, as well as the resistance of procreative conventional models.

With regard to the methodology used we have carried out an "integrated study" which draws on the existing sociological and anthropological literature, on

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

international (EUROSTAT, WHO, OECD) and national (ISTAT, ISS, RNPMA)[2] databases, and finally on a qualitative study carried out in a local context (Fertility Center Hospital in Lombardy).

2. Reproductive technologies: rules and data

The analysis of ART (Assisted Reproductive Technology) involves a complex interaction of social, ethical, scientific, economic and legal factors. The first article in the Italian Act on ART (L. no.40/2004), which indirectly confers legal status to the embryo, shows the complexity of this interaction, as sociologist P. Borgna points out (2005: 66): "Each Act incorporates specific representations of women's and men's bodies and of their reproductive functions; as well as the representations of boundaries and the legitimate use of all these (bodies)". We can say the same for some other articles in the same Act: art.4 c. 3 bans gamete donation, although a recent judgment by the Constitutional Court declared this article illegal. However, despite the fact that gamete donation is now allowed, in practice it is still difficult to resort to it; art.5 states that only stable couples (adult and heterosexual) may have access to medically assisted procreation. According to this statement, it is clear that the rules indicate (or "impose") specific practices and specific representations of parenthood and family structure.

Moreover, this Act led to the creation of the National Register of Medically-Assisted Procreation, which is funded by the Ministry of Health and annually collects the anonymous data for treatment cycles, therapeutic protocols, problems encountered, results and follow-ups of pregnancies and newborns. The introduction of NRMAP is considered a success in the Italian context although there are still gaps. The spread of data will allow the circulation of information and will help create knowledge and awareness of this phenomenon (www.iss.it/rpma).

The Annual Report of the Ministry of Health (2015) confers great importance to various preventative measures, by promoting the primary prevention of infertility and providing accurate information to women and couples who access assisted reproductive technologies. It also aims to promote information campaigns directed to the entire population (especially young people), to safeguard reproductive health and to launch an action plan named "National plan for the prevention of infertility".

For the year 2013 the NRMAP collected data from 369 infertility centers, 141 (38.2%) of which are public and 228 (61.7%) of which are private, with a varied

2. Istituto Nazionale di Statistica; Istituto Superiore di Sanità; Registro Nazionale della Procreazione Medicalmente Assistita.

distribution over the national territory. During the same 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 to 13.3% live births out of 91,556 cycles of ovarian stimulation.

Regarding the age of men and women resorting to ART, the mean age for women is 36.6 (34.7 being the European mean age), while 40 is the mean age for men. The highest number of the initiated cycles occurs in the 30-39 year range, which is in line with the average age for having the first child in Italy.

Recent studies have revealed as well that age has an impact on male fertility too (which decreases for men over 35), and at the same time it also increases the risk of births with genetic or chromosomal problems (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 able to have children throughout their life.

3. The medicalisation of reproductive bodies

If "medicalisation is the transformation of human conditions into medical problems" (Maturo 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, contraception and conceivement. Infertility, within this process of progressive medicalisation of daily life, bodies, relationships and desire (including the desire for parenthood), is constructed as a problem prone to medical treatment, for which MPA techniques represent the "cure" (Lombardi 2013). In fact, the notion of "bio-medicalisation" introduced by Clarke (2003) describes the increasing invasive intervention of medicine and bio-technology, which are nowadays used to improve human conditions in the wider sense rather than to cure ill bodies.

As A. Maturo (2013) points out, we are witnessing a proliferation of syndromes and symptoms to which medicine responds through greater than ever sophisticated drug treatments and bio-technologies, although these are not always effective and do not successfully investigate the causes of these disorders or diseases. The examples in the field of sexual and reproductive health are numerous: male impotence, pre-menstrual tension, postpartum depression, whereas syndromes and diseases related to sexuality and reproduction have multiplied in the second half of the 20th century. More or less effective drugs are offered to

men and women to overcome such syndromes and disorders, while very little interest is shown to their extra-biological causes. This also applies to infertility and sterility, given that a significant percentage of cases cannot be explained by bio-medicine (Lombardi and De Zordo 2013). In actual fact, 36.2% of couples treated with simple insemination and 15.1% of those treated with fresh cycles in 2012 are "suffering" from idiopathic infertility and these rates have significantly increased (respectively + 5.1% and + 1.7%) compared to 2009 (RNPMA, 2014). Research increasingly focuses on ART through biomedical interventions aimed at the "functioning" of the reproductive organs, their efficiency, and their ability to intervene rather than remove the causes of infertility (Pitch 2006).

Gender becomes a key factor in the construction of sexual and reproductive pathologies: compared to the campaigns and treatments offered to solve male impotency (Waggoner and Stults 2010), there are no medical or pharmaceutical campaigns aimed at women's sexual problems. While male reproductive life (from puberty to old age) has not played a big role in the specialized literature, a whole series of pathologies and problems characterise women's reproductive life (from pre-menstrual syndrome, to post-natal depression and menopause). Studies on the causes of infertility and sterility tend to concentrate on the pathologies affecting the female rather than the male reproductive system. In our culture and society the male gender is mainly associated with sexuality, while the female gender is still associated with reproduction, despite the huge changes of male and female social and reproductive roles and behaviours that have happened in recent decades (Ventimiglia 1994, Culley et al. 2013, Lombardi 2013, Hinton, Miller 2013, Burnes 2014).

The impact of the absence 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 (ibid.). Female infertility does not cast any doubts on a woman's seductive and sexual abilities, while the contrary applies to men. The latter try to dissociate themselves from the stigma of impotency and seem to want to locate the causes of sterility in the female body (ibid.). The medical and technological emphasis on the female treatment confirms and reproduces this stereotype.

The following patient's narrative highlights on the one hand the acceptance ("imposed" by medical practices) of her partner's infertility on her body; on the other, it revisits the stereotype and the request for "strength" and "potency", which is addressed to the male:

> [...] I feel somehow disappointed…at times even 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 a less manly image of my husband in my imagination. If he were "stronger" I would not have to face all this. It is hugely different to have to face a conceivement in this way. It lacks the intimate relationship. (1.OS-MM)

The infertile female patient also draws on herself the other's/her partner's desire:

> My womanhood, my being a woman is not so strictly related to maternity. What has led me to consider this opportunity (MPA) 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)[3]

In institutional representations such as the one in table 1, male infertility is neither classified nor named and this is in stark contrast to female infertility. While the latter is closely "dissected" and investigated, male infertility is forgotten. And yet proper names exist in medicine for the latter, such as: azoospermia, oligozoospermia, criptorchidism, hypospadias, varicocele etc.[4]

Table 1 - Distribution of couples treated with fresh cycles, by cause of infertility - 2013 (number of couples in brackets). Total couples: 46.491

Female and Male factors	18.4% (8,538)
Tubal factor	**10,1% (4,671)**
Idiopathic infertility	14.8% (6,854)
Female multiple factor	**6.9% (3,204)**
Endometriosis	**5.4% (2,486)**
Ovulation infertility	**5.5% (2,539)**
Ovarian factors	**11.0% (5,130)**
Abortions	0,8% (376)
Other factors	0.7% (341)
Male infertility	**35.4%**

Source: Ministry of Health Report, 2015

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

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

We don't know why there is such a "forgetfulness" in the National Register Data. In any case we can read this as a linguistic, cultural and analytical "removal": that is, the fragmentation and the objectification of women's bodies (pregnant/non pregnant) are opposite to an indistinct, absent male body, removed from his fertility/infertility and his parenthood.

4. Men and women facing infertility and ART

Starting from the assumption that infertility practices are part of a wider gender structure rooted in the social construction of health and care, this paragraph focuses on the emblematic case of medically assisted procreation (MAP).[5] It analyses both the views of experts and medical practices through which it is implemented, as well as the experience of those who go through it.[6] Although MAP highlights and emphasises only the biological aspects of infertility and sterility, this analysis shows it to also be a socially and culturally constructed *experience* (Lombardi 2013). As already highlighted in the majority of recent studies (Capurso and d'Orsi 2013, Labadini 2013), in which men are often forgotten or marginalised, our study also shows that MAP techniques concentrate mainly on women's bodies, or should we say, on their reproductive organs (the ovaries and the womb). The men's role in the reproduction process is thus sidelined: sperm appears as a substance separated from the male body, which disappears from the MAP scenery (Gribaldo 2005, Labadini 2013, Capurso, D'Orsi 2013).

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 (Mutinelli 2005, Labadini 2013, Hinton and Miller 2013, Lombardi and Mambrini 2014).

A man who tells about his experience says:

> When I realized the fact that they only wanted a test-tube with my sperm, I felt ridiculous. 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)

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

6. See: Lombardi and De Zordo 2013, Becker 2000, Elia Rosalba 2006 Thesis for University Degree, Milano, Chiara Mambrini 2013 Thesis for University Degree, Milano.

"In fact, while, according to the woman: 'three people are involved in a child's conceivement' (the woman, her partner and the doctor), according to the man it is mainly the woman and her doctor who are the actors of 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). 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, it restores the "intra-gender" and "between gender" order.

On the contrary, the parenthood responsibility falls on women and their bodies, irrespective of whether they want children or not. The "desire for motherhood" emerges almost exclusively, as we can see in the medical-scientific discourse, in sociological, anthropological and psychological studies (Culley *et al*. 2013) and in media representations (Gannon et al. 2004, Maturo 2013). The maternal aspect of women's bodies and the "desperation of what it means to be infertile" are emphasised, by subjecting women's bodies to medical treatment even when sterility is medically unexplained, or it is the man who is sterile (Becker 2000, Lombardi 2009, 2013, Hinton and Miller 2013). However, the fact that the female body is involved more closely than the male body is not a privilege for women; there are numerous risks associated with the use of the most invasive MAP techniques, which are often not taken into account or not investigated (Parolari and Costantini 2013). Scientific studies on the possible effects of hormonal stimulation on women's health are still few and inconclusive. Hormonal stimulation is used both for the production of oocytes for donation and for the preparation of the womb for the embryonal implant during the cycle of artificial fecondation or in cases of surrogacy (cfr. Chavkin 2008). This emphasis on the female body has specific social and cultural repercussions on gender relationships, on parenthood and on the different perceptions and practices of motherhood 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 changes in familial and social structures. (Pinnelli and Lariccia 2013, Lombardi and De Zordo 2013).

One of the most emblematic biomedical processes is the way the so-called "unexplained infertility"[7] is defined and managed [Lombardi, Mambrini 2014]. It

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

is a particularly problematic issue because it subjects women (and men to a lesser extent) to strenuous and often risky paths of ART, given the absence of specific or detectable diseases. The fact that unexplained infertility is hardly discussed greatly affects gender relationships, the "culture of fertility/infertility" and their perception. Some of the women affected by unexplained infertility, who participated in the survey mentioned in this paper, talked about their feelings of being unluckier than infertile women, even when they had experienced abortion, because "[...] they know that they can [conceive, AG]" (Int. 10).

Infertility brings with it a profound stigma where the legacy of a 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 often was an object of ridicule, excluded from celebrations and rituals, avoided, rejected, or looked upon with suspicion and considered dangerous as being disobedient to "the law of reproduction" (Lombardi and Mambrini 2014).

These dynamics still survive today, albeit masked by other practices and prejudice. Even in cases of suspected male infertility, the woman often continues to agree to undergo medical treatments to spare her partner "the shame of infertility", which in turn drags the insinuation of impotence.

5. Social context and family structures

We should also consider the social and family context in which ART are developing. With reference to the Italian context, the country is characterized by a low fertility rate connected to important changes.

In the present historical phase, marked by a high tension between tradition and change in the Italian society, the boundaries of gender identity are being redrawn by a huge change in everyday life, the new and different family structures, the growing number of unstable families and the different types of participation in the labour market.

Some examples of such changes are shown: in the constant decrease in the number of marriages (from 4.9 per thousand in 1999 to 3.5 per thousand in 2012), which is among the lowest marriage rates in Europe (4.2 is the average rate of EU-28),[8] in the steady increase of civil marriages compared to religious ones (+ 18% between 1999 and 2012), and in the age increase at which people get married (34 for men and 31 for women) and have a baby (31.4 for both genders). Social and

8. Eurostat database, 2012.

family changes are also connected 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 2013),[9] despite the fact that there has been a slight increase (from 1.19 children per woman in 1995 to 1.39 in 2013) due, above all, to immigrant parents. Italian women and men tend to have their first baby later in life. The reasons are different and widely known: young people leave their family house later in life (in 2012 52.3% of young men and 35% of young women between the age of 25 and 34 were still living with their parents), the difficulty in gaining economic independence from their parents, and finally the precarious working conditions. The effect of these factors has been amplified in the last five years by a difficult economic situation which has affected in particular young people (youth unemployment has reached about 40%), at the same time the difficulty of combining work and family has been exacerbated, resulting in women being overloaded with family and professional work.

As far as the the female labour force is concerned, the gender gap in Italy is particularly evident when looking at the employment rate of women (11.9% vs. 3.0% for male employment), especially if compared to the EU target of 60% female employement by 2020. The economic crisis has increased gender segregation as a consequence of the decrease in qualified female employment and the increase in the number of unqualified jobs. In addition, the low employment rate for Italian women aged 20-64 (50.3% in 2014 vs. 3.4% for the EU-28 countries) is even lower for mothers who leave their jobs in order to look after their children. The employment rate decreases for all women in the 15-49 age group: it is 54.3% for mothers, while it reaches 68.8% for women in a relationship but 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 (45.7% in 2012 vs 36.3% in 2005).[10]

The unfavorable conditions of women in the labour market are often exacerbated by the unequal gender distribution of family work. In Italy, this task is very hard, especially for women: 76% of familial/domestic work falls on women (including employed women with children): for example, 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 against 8h15 for men) and even mothers without a job work longer than their partners (8h15 vs. 7h48) (ISTAT Report, 2011).

Therefore, in a social context where female employment rates are below the

9. Eurostat database, 2013.

10. ISTAT Annual Report 2014.

European average, a significant percentage of men and women in fertile age are employed on temporary and casual contracts; in a country where family care and housework division is still unequal and where the welfare system and gender policies are insufficient and inadequate, it is not so surprising that fertility rates are among the lowest in Europe and the average age people decide to marry or have their first child is higher. As it is well known, these are also among the causes of the increasing recourse to ART.

6. Final considerations

To sum up what has already been mentioned in the introduction, we have focused on the outcomes of infertility and the impact of ART on gender, and on the social context within which reproductive technologies are developed; we have also reflected on the prospects for change in gender relationships and parenthood.

As Lina Hinton and Tina Miller (2013) point out, the implications of the lack of involuntary offspring are generally very different for women and men, while the social expectations and consequences of infertility are also experienced differently by the two genders.

Although data on male infertility and sterility are well known and available, (at least in the West) and despite the fact that infertility disorders affect both men and women, the issue is neglected in common speech and in much of the medical discourse, whereas very few studies have been carried out on this topic (Culley et al. 2013). This does not mean that men do not suffer through reproduction "failure": "men can experience infertility as a threat to their masculinity and sense of Self" (Hinton, Miller 2013: 247). The diagnosis of infertility influences the daily lives of infertile men and on how their masculinity is constructed (Burton 2014) by questioning the patterns of male hegemonic power: in this way, infertility opens possible areas for the reconstruction and renegotiation of men's identity.

However Burton (2014: 49) explains that the "medical discourses function in a way that moves men towards accepting the hegemonic norm rather than an alternative male identity". On the other hand, while most of the infertility treatments are addressed to the female partner, "the requirement to produce spermatozoa in the clinic, on demand, was central in men's accounts and described as 'awkward' and 'humiliating' " (Hinton, Miller 2013: 247).

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 forthcoming).

This shows that the male involvement in the reproductive process is not yet complete and leads to questions about how and how many men are prepared to manage the reproductive process, torn between maintaining their "hegemonic masculinity" and their "fathering" role (Hobson 2002, Lombardi forthcoming). Another question that ensues this reflection and is considered to be central to this discussion is whether men's involvement in the reproductive process and in healthcare service activities can promote the inclusion of gender and/or acknowledge gender differences (Hinton and Miller 2013).

The second point concerns the social context in which ART develop. With reference to the Italian context, the country is, as already mentioned above, characterized by a low fertility rate, which reflects important changes in social and relational terms: the current historical phase is characterized by a strong tension between tradition and change, which sees the boundaries of gender identity redrawn with respect to the huge transformations of life courses, the different ways of starting a family, the instability of families and the various forms of participation in the labour market.

Directly linked to these changes is the delay in the realization of the parental project, as a consequence of several social factors rather than of clinical ones. Among these are the difficulty of young people in building their own path of empowerment, the permanence of residence in the family of origin, which affects men to a much higher extent than women, the unstable and precarious working conditions, and the difficulty of reconciling family responsibilities and work commitments (ISTAT 2014).

The factors described above point to a gender condition that is still significantly unequal and concerns both the labour market and the sharing of family responsibilities and childcare (Lombardi 2013, ISTAT 2014).

Following from the observation of these social and relational dynamics, which are not excluded from the welfare policies and support for parenting and childcare, we consider that, in addition to the clinical factors that determine the difficulty or inability to conceive, 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.

The third and last consideration leads us to a reflection on future prospects with regard to gender relationships. We have seen that the path to equal rights and responsibilities between the genders is still to be achieved in many societies; despite being over half a century since infertility and sterility were scientifically proved not to be just a female responsibility, in many societies the equality pro-

cess 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".

In agreement with several authors, we think that "it is time for 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 and more included in the reproductive process: this involves the creation of services that provide spaces in which to share fears and concerns and express emotions and vulnerability, without the fear of "punishment" because of being male. In addition, greater attention should be given to the investigation of the meanings that men themselves attribute to their involvement (Lombardi forthcoming).

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CHRISTODOULOS BELLAS
and ALBERT DICRAN MATOSSIAN

ART experience, ethical perceptions, and socioeconomic characteristics of (in)fertile citizens in Greece: A statistical analysis

1. Introduction

Infertility can be regarded as a serious capability failure[1] affecting the welfare of persons who wish but are unable to have children of their own. Assisted Reproduction Technologies (ART) offer an important means of empowering this category of citizens. Their failure may be due to medical reasons but can also be attributed to social norms excluding certain types of households (e.g. homosexual couples, single males) and prohibiting certain practices (e.g. commercial use of genetic material). In particular, Greek legislation allows the deployment of ART "only in order to face the inability of acquiring children in a natural way or to avoid the transmission of a serious disease to the child".[2]

What we investigate is, first, the extent of the empowerment of Greek infertile citizens, i.e. the enhancement of their freedom that was made possible by their actual recourse to ART. We probe, secondly, into their views on parenthood, adoption, abortion, infertility and, of course, homologous and heterologous ART. The latter is essentially an inquiry into their ethical stand on the rights to ART and

1.The capabilities approach to human development was pioneered by Amartya Sen and elaborated further by Martha Nussbaum.It has gained considerable ground over older theories of human welfare such as utilitarianism and its more general version,welfarism. See Sen (1999a, 1999b, 2000) and Nussbaum (2000) for the theoretical presentation. Comim at al. (2008) and Anand et al. (2009) provide related contributions and various applications of the capabilities approach.

2. Article 1455 of the Greek Civil Law.

parenthood and to what, according to their view, constitutes a "natural" way of acquiring children.

In what follows we present the results of a nationwide sampling survey of 235 Greek citizens with ART experience and thus provide comprehensive first-time statistical evidence on Greek (in)fertile citizens' socioeconomic characteristics, experience with ART, and ethical stand on issues of human reproduction. It is intended to supplement a growing volume of recent academic research on ART in Greece conducted by ethnographers, lawyers, and psychologists.[3] The survey was part of the research program "(In)Fertile Citizens: On the concepts, practices, politics and technologies of assisted reproduction in Greece. An interdisciplinary and comparative approach"[4]. The questionnaire was the product of deliberation by all members of the research team and comprised mostly closed-ended questions.

	Women	**Men**	**Total**
Public hospital	78	5	83
Private clinic	15	6	21
Associations	14	0	14
Interview	58	32	90
Internet	26	1	27
	191	44	235

Table 1: Respondents' place of interview

Sampling was conducted with the assistance of six ART clinics, four of which are private and two are university clinics; assistance was also provided by two Athens-based associations that engage in the support of persons using ART (Kyveli and Magna Mater). Another valuable source of information was the interviews conducted within the context of the ethnographic part of the project in Athens, Thessaloniki, Larisa, Hania and Mytilini. Finally the questionnaire was dissem-

3.See Daskalaki 2015, Kantsa 2014, 2015, Chatzouli 2015, Tountasaki 2015 for ethnographic contributions. This research follows an extensive corpus of anthropological work on assisted reproduction –see indicatively Konrad 1998, 2005, Orobitg and Salazar 2005, Inhorn 2006, Almeling 2006, Bergmann 2011. Trokanas (2011) Kaiafa-Gkmpanti, Kounougeri-Manoledaki and Symeonidou-Kastanidou (2014), Rethimniotaki (2014) examine legal issues related to ART; Papaligoura et al. (2012) and Papaligoura (2013) provide a view of assisted reproduction in Greece from the point of view of social psychology.

4. The program was implemented within the framework of the Action «ARISTEIA» of the Operational Programme "Education and Life Long Learning" and co–financed by National and Community Funds (20% from the Greek Ministry of and 80% from the European Social Fund).

inated via the electronic forum www.ivf.gr. It is perhaps worthwhile mentioning that it is the first time that such survey takes place in Greece.[5] Interviewing was conducted between November 2013 and January 2015.

As the length of the interviewing period betrays, our research encountered difficulties mostly related to the sensitive nature of the required information. We originally wanted to include in the sample representatives of groups of special interest to us such as unmarried women, Muslims etc. Unfortunately we had to abandon our endeavour after it became clear that we wouldn't have enough persons from these groups in the sample to enable us to make valid inferences about their corresponding populations. We also found difficult to have males with ART experience in the sample, yet, we eventually managed to obtain 44 such replies, a number that permits reliable statistical comparisons with the sample of 191 female respondents by means of appropriate statistical tests of significance.[6]

Another difficulty was the complete lack of knowledge about the socio-economic characteristics of the population of citizens with infertility problems in Greece. This makes impossible the drawing of inferences about the whole infertile population by means of either stratifying the sample and/or weighting the derived cases appropriately. However, taking into account that in 94% of our cases the family situation of the respondent was reported as "married to a person of different sex", we decided to correct for the consequent under-representation of males in the sample by weighting the cases in such a way as to achieve equal representation of males and females for the inferences of estimates that refer to the population of Greek couples that face or faced in the past fertility problems.

What we report here are the main findings of our survey. We begin with a selected demographic and socioeconomic profile of the interviewees by invoking variables such as age, education, profession, household structure, and religious beliefs. We subsequently highlight the frequency and variety of deployment of various types of ART and their outcomes, as well as the extent of bodily and psychological suffering of the respondents; we also examine their evaluation of medical services, and of the support provided by professionals, partner and family. We complete the picture by investigating their views on the right of access to ART and parenthood in general and end with the conclusions.

5. The only relevant statistical data available pertain to strictly medical aspects of ART and are included in the 2009 final report on the comparative analysis of medically assisted reproduction in the EU published by the European Society of Human Reproduction and Embryology (ESHRE).

6. Pearson significance test of the chi-square statistic, Fisher's exact test, Mann-Whitney test of median of independent samples. All results reported refer to a maximum probability of committing Type I error of 0.05.

2. Demographic and socio-economic characteristics

Two thirds of females fall into the 35-44 age bracket and 13% are more than 45 years old. The average age of females is 39, statistically lower than the corresponding of males, which is 43.

Almost all respondents stated that they officially belong to the Christian Orthodox church. However, there are significant segments of non-believers as well as of persons who declined to answer whether they believe or not. Moreover, there are significant gender differences with regard to religious beliefs: two thirds of females are religious believers compared to a corresponding 45% of males. In contrast, 45% of males declared that they are non-believers with only 12% of females stating so.

	Female	**Male**	**Total (weighted)**
Believers	65,45%	45,45%	55,50%
Non believers	11,52%	45,45%	28,53%
Belonging to a doctrine	21,99%	9,09%	15,45%
No reply	1,05%	0,00%	0,52%
	100,00%	100,00%	100,00%

Table 2: Interviewee's religious background

The educational qualifications of females lag behind the corresponding of males, despite the fact that females are equiproportionally represented in the cohort of persons with postgraduate qualifications.

	Female	**Male**	**Total (weighted)**
Up to Lyceum certificate	22,51%	11,36%	17,02%
Post Lyceum vocational certificate	17,28%	13,64%	15,45%
University graduate certificate	33,51%	45,45%	39,53%
Post-graduate cerificate	23,04%	27,27%	25,13%
No reply	3,66%	2,27%	2,88%
	100,00%	100,00%	100,00%

Table 3: Interviewee's level of education

The presence of public employees and of persons that are out of the labor market (unemployed, house persons, persons not seeking a job) is more pronounced among females, while employment in the private sector and self-employment in particular is more frequent among males.

	Female	Male	Total (weighted)
Primary sector	1,57%	6,82%	4,20%
Self-employed	17,28%	43,18%	30,18%
Private employee	29,84%	38,64%	34,38%
Civil servant	24,61%	6,82%	15,75%
Out of labor market	21,47%	2,27%	11,81%
No reply	5,24%	2,27%	3,67%
	100,00%	100,00%	100,00%

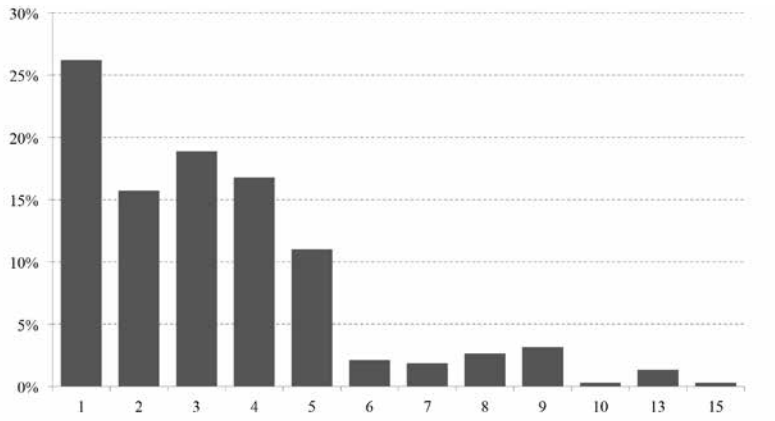
Table 4: Interviewee's profession

40% own their non-mortgaged home and one in four live in rented accommodation. The average home size is 70 m2 per equivalent adult.

As far as household structure is concerned, the dominant type is that of a couple with no children followed by the type consisting of a couple with one child. There are also small but non negligible segments of households that have more than two adults.

3. The experience with ART

Females rather than males take the initiative to seek solution to the couple's fertility problem. This is inferred by two observations: First, the average time interval between the actual realization of the problem and ART therapy commencement is longer in females than males and, secondly, males get informed about the availability of ART from their female spouses to a greater extent than females do from males.



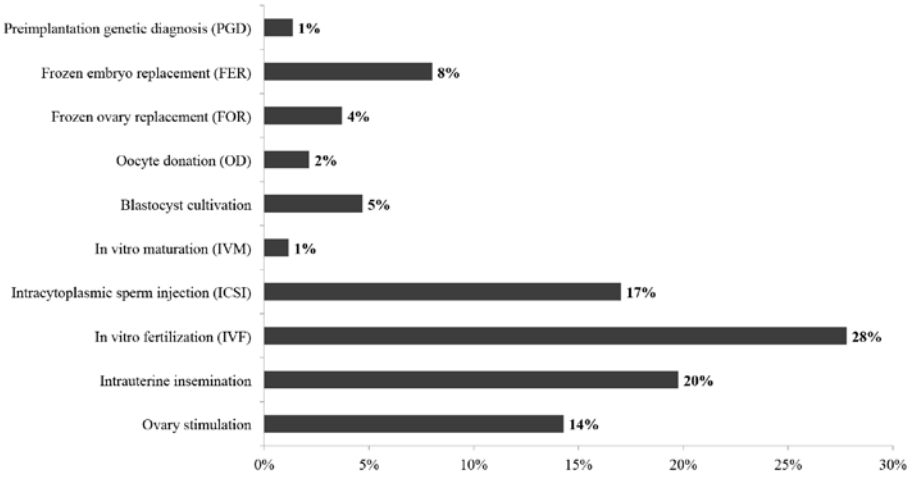
Graph 1: Respondents' number of ART trials (weighted total)

The average number of ART attempts was 3.4. Two thirds of the respondents stated that employment of ART led to pregnancy and 45% succeeded in giving birth. These findings are broadly consistent with medical facts for Greece that show a success rate of 15% in ART cycles.[7]

	Pregnancy achieved	**Birth achieved**
No	32,87%	55,12%
Yes	67,13%	44,88%
	100,00%	100,00%

Table 5: Respondents' frequencies (%) of pregnancy and births using ART (weighted total)

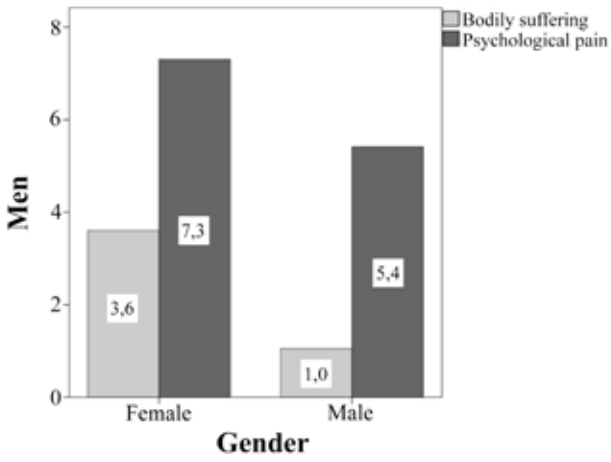
IVF was the most often quoted method used followed by sperm injection, ICSI, and ovary stimulation.



Graph 2: ART methods used by the respondents (weighted data)

The degree of reported bodily and mental suffering from ART experience was significantly higher among females than among males. Reported psychological pain was significantly higher than physical suffering for both females and males.

7. See ESHRE(2009), especially tables 12, 13 and 14 where delivery rates for IVF, ICSI and FER treatments are reported for Greece in 2006.



Graph 3: Respondents' degree of bodily and mental suffering (weighted data)

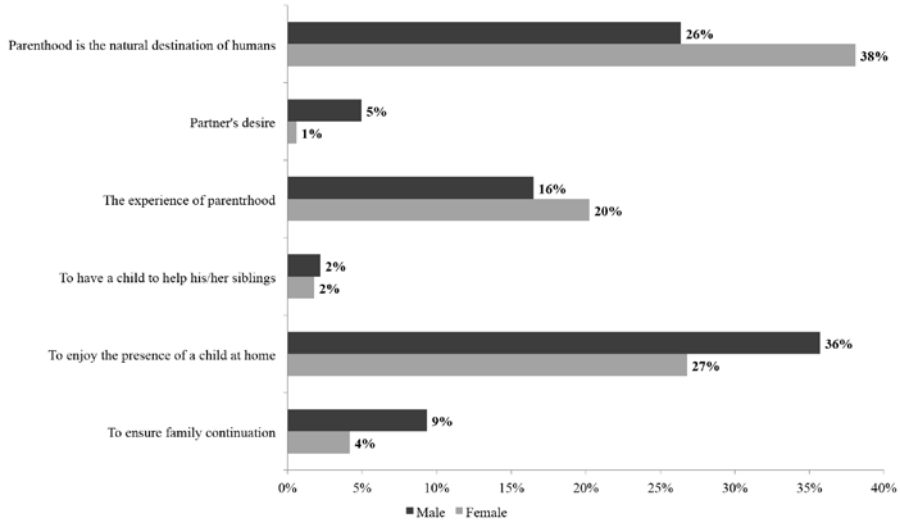
The private sector is the main provider of ART services. Both females and males rate positively the practitioners' services. Females show higher satisfaction than males from gynecologists of the public sector. High levels of satisfaction are recorded from services provided by the nursing staff of the private sector. On the other hand, males show great disapproval for the services of the public sector nursing staff. Both females and males complain about the services of public sector administrators and special counselors. The rating of the corresponding services in the private sector is better, although there are complaints about its cost.

4. Cultural perceptions about reproduction and ART

The main reason behind the desire of females to have a child is their conviction that this is their "biological aim". In contrast, males cite the joy provided by the presence of a child at home as the main reason.

The great majority think there is a problem with low fertility in Greece today and that ART offer a significant contribution to its resolution. Infertility is primarily attributed to the modern way of life and secondarily to biology, luck or God. Females attribute infertility to God to a greater extent than males.

Abortion decided by the couple for non-medical reasons is approved by a high percentage; approval by males is significantly higher. Abortion wished by a single member of the couple is less widely accepted; its disapproval becomes crushing among females in case the abortion is desired only by the male member of the couple.



Graph 4: Motivations for parenthood (weighted data)

Females, by 90%, think that the state should provide ART services completely free of charge. Males also agree, but by a lower percentage. 90% of the respondents believe that ART should at least be partially subsidized.

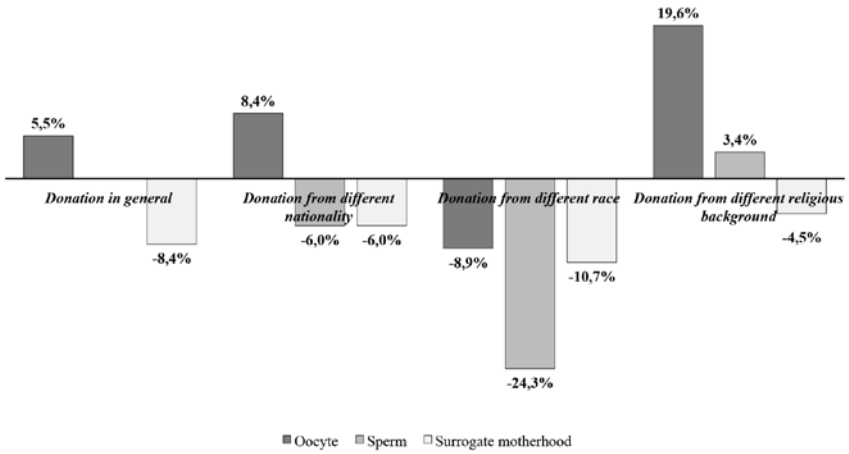
Two thirds of females and males did not want to adopt a child, although 85% do not rule out adopting in the future. The two most often quoted reasons for preferring ART to adoption are the desire of having their own biological child and that legal procedures for adoption are cumbersome in Greece.

It is estimated that roughly half consider their decision to proceed to ART as an act of duty. Males consider it as an act of duty to their spouse to a greater extent than females.

Females think to a greater extent that the decision to engage into ART is "very much" influenced by the financial situation of the couple.

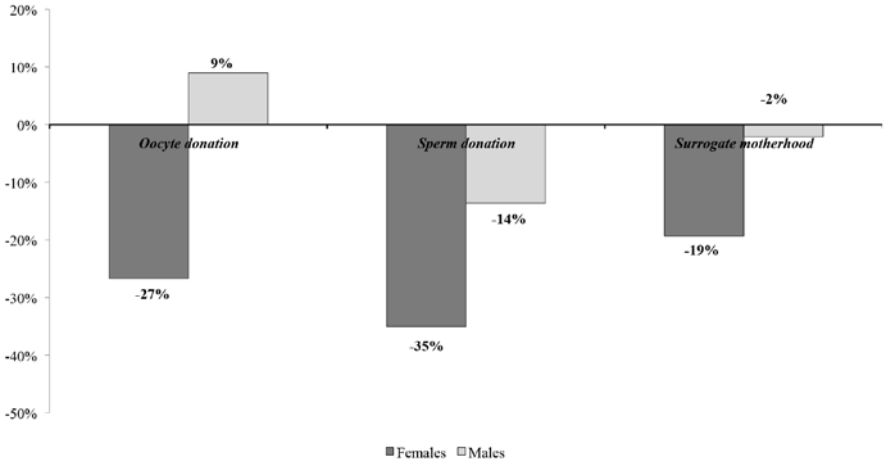
"Science" is considered the main factor that determines the successful outcome of ART. Luck, God, and the person itself follow in decreasing order of importance. Males stand out in their belief that the other half of the couple affects crucially the outcome.

Sperm donation is less acceptable than oocyte donation whilst surrogate motherhood is rejected.



Graph 5: Indices of acceptance of oocyte donation, sperm donation and surrogate motherhood **(**Difference between percentages of positive and negative answers, weighted data)

Both donations and surrogate motherhood are strongly rejected when they come from persons of different race.



Graph 6: Indices of acceptance of donation from different race **(**Difference between percentages of positive and negative answers, weighted data)

Absolute majorities of both female and male respondents think that commercialization of genetic material should be illegal. However, the absolute majority

of males and the relative majority of females believe that such transactions take place in Greece nowadays.

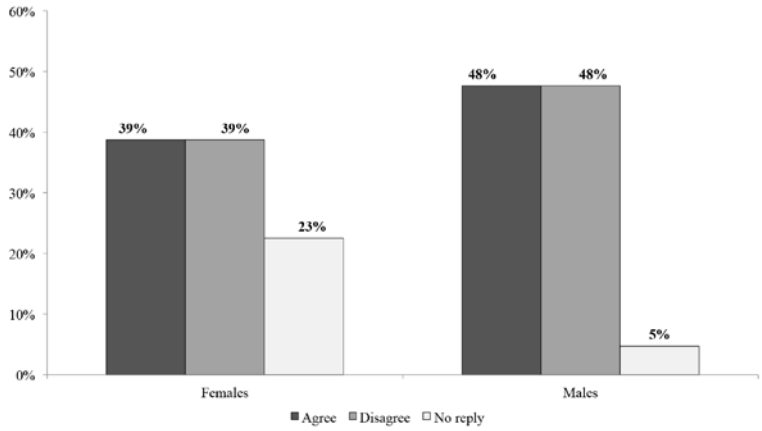
	Do you believe that the offering of genetic material can be bought and sold?		*Do you think that in Greece today, genetic material is an object of transactions?*	
	Females	**Males**	**Females**	**Males**
Agree	10,99%	22,51%	48,17%	77,49%
Disagree	73,82%	65,97%	12,57%	2,09%
No reply	15,18%	11,52%	39,27%	20,42%
	100,00%	100,00%	100,00%	100,00%

Table 6: Commercialisation of genetic material

It is estimated that the absolute majority of citizens with infertility problems, with women being less prominent, think that there should be limits to the age of women, men, and couples that wish to have a child via ART or adoption.

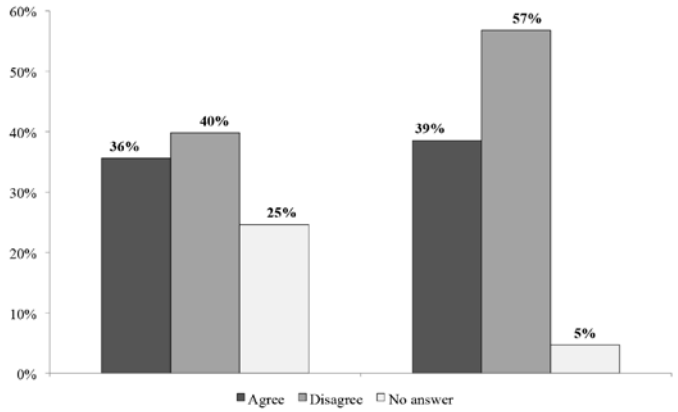
Large absolute majorities think that unmarried women and men, as well as poor and unemployed persons should have access to ART.

The number of those approving the access of same-sex females to ART balances that of those who think the opposite.



Graph 7: Perceptions on the right of access to ART of lesbian couples **(**weighted data)

Access of same-sex males to ART is rejected by a relative majority, despite the fact that the percentage of those who accept it is quite high. Rejection is more pronounced among males.



Graph 8: Perceptions on the right of access to ART of gay couples **(**weighted data)

In both cases females show a higher degree of uncertainty.

5. Conclusions

On socioeconomic and demographic characteristics:

- Average age is 39 years and 43 years for females and males respectively
- The dominant type of household is the heterosexual couple with no children
- Two thirds of interviewees hold a university degree
- Males figure more prominently in private employment while females in public services and out of the labour market.

On the "empowerment" of (in)fertile citizens:

- 45% managed to have a child. The average number of attempts was 3.4 times
- Women are more motivated in seeking a solution via ART
- Females experience a higher degree of suffering, both bodily and psychological. The degree of psychological suffering is higher than the degree of bodily suffering
- The private sector is the main provider of ART services. There is dissatisfaction from nursing and administrative services in the public sector. On the other hand, the private cost of ART is considered to be high.

On moral views of (in)fertile citizens rights to reproduction:

- Oocyte donation is more acceptable than sperm donation
- Surrogate motherhood is rejected
- Heterologous fertilization from a donor of another race is strongly rejected - especially by females
- There is a widespread view that commercialization of genetic material takes place in Greece and this is not morally accepted
- Access of unmarried women to ART is accepted
- Large percentages accept the access of same-sex couples to ART.

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IVI DASKALAKI

Religious aspects of medically assisted reproductive technologies in Greece

1. Introduction

Greece has one of the highest ratios of assisted reproduction clinics and medical centers to its population, as well as one of the most "liberal" legal profiles among European countries (Kantsa 2014, Kokota 2015c). According to the European IVF-monitoring (EIM) Consortium for the European Society of Human Reproduction and Embryology (ESHRE), in 2006 approximately 50 assisted reproduction clinics and medical centres –most of them operating in the private sector– were run in Greece (de Mouzon et al. 2010: 1853 cited in Kantsa 2011: 201). The Greek legal regulation mainly consists of three Laws (Law 3089/2002,[1] Law 3305/2005[2] and the recent Law 69 (I)/2015[3],) allowing for preimplantation genetic diagnosis, embryo freezing, anonymous sperm, egg and embryo donation, *post-humous* fertilization, surrogacy as well as research on genetic material.[4] In

1. http://nomoi.info/ΦΕΚ-A-327-2002-σελ-1.html.
2. http://nomoi.info/ΦΕΚ-A-17-2005-σελ-1.html
3. http://www.cylaw.org/nomoi/arith/2015_1_69.pdf
4. The Law 3089/2002 "Medical Assistance in Human Reproduction" introduced amendments to the Civil Code related to issues of kinship and inheritance and regulated ART, giving the right to both married and non-married couples as well as single women to use assisted reproductive technologies (Kantsa 2011: 202-203). Specifically, the 2002 Law permits: a) sperm, egg and embryo donation and protects the anonymity of the donor, b) surrogacy, c) post-humus conception and d) the use of fertilized eggs for research or therapeutic reasons. Additionally, it prohibits human cloning for reproductive reasons and sex selection. The Law 2002 was supplemented by the 2005 Law "Application of Medical Assisted Reproduction Methods". Specifically, the 2005 Law focused on the applications of medically assisted reproduction in ways that ensured the right to individual freedom, the right to personhood and satisfaction of the desire

short, the Greek legal framework allows for all medically accepted technologies and methods of assisted reproduction, including surrogacy.

Drawing on ethnographic research in Greece produced in the framework of the (In)FERCIT research program on infertility and medically assisted reproduction, this presentation examines ART in relation to religious beliefs. Indeed, the presentation focuses on official and unofficial religious discourses surrounding medically assisted reproduction by discussing the ways different religions –under the same legal system and access to technology– influence the formation of some "personal" moral codes, or "moral reasoning", in Sykes' (2009) terms, which develop on the basis of accepting or rejecting certain forms of kinship and relatedness. Specifically, based on ethnographic material that includes archival documents (such as bulletins, reports and conference presentations released by the Holy Synod of the Church of Greece) and interviews, the presentation concentrates on the official position of the Greek Orthodox Church regarding assisted reproduction technologies and juxtaposes this position with discourses concerning kin relatedness elaborated by Orthodox women and men who have sought medically assisted fertility treatment. Additionally, it compares these findings with those produced by interviews conducted with Greek women adhered to Judaism and the rabbinical authority of Athens as well as those produced by interviews (conducted by our colleagues Vily Chatzigianni and Penelope Topali) with women of Turkish origin belonging to the Muslim minority of Western Thrace.

2. The greek framework: Religion, parenthood, ART

Greece's population is approximately 11 million and an estimated 95 to 98% of its citizens identify themselves as Eastern Orthodox Christians, thus forming a nearly homogeneous –in terms of religious affiliation– population. The Greek Constitution recognizes Eastern Orthodoxy as the "prevailing" religious faith of the country, while at the same time it ensures freedom of religious affiliation for all its citizens. Although there are no official statistics on religious groups in Greece, an estimated 1% of the population belongs to the Muslim Minority of Western

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to acquire descendants in tandem with the acknowledged bioethical principles. Simultaneously, it gave primacy to "the interest of the child to be born" (Law 2005, article 1 cited in Kantsa 2011: 202-203) The recent Law 69 (I)/2015 also came to supplement the previous Laws on ART and mainly regulated the founding, organisation and operation of the so-called Committee for Medically Assisted Reproduction. It also regulated the implementation of a system of control and supervision of the operation of clinics in accordance with the existing legal framework.

Thrace (comprised of Turks, Pomaks and Roma), the only officially recognised religious minority in Greece, whose members were granted rights in the framework of the Lausanne Treaty of 1923. The population of this minority adds to a much larger number of immigrant Muslims (both legal immigrants mainly from Albania and illegal immigrants from various parts of the world) who are estimated to number between 500,000 and 700,000 people. The long-established Jewish community of Greece that until WWII used to have a large presence in Greece is estimated today to number around 5,000 people. Additionally, in Greece there are also significant numbers of Roman Catholic citizens, Protestants and Jehovah's Witnesses.

From an anthropological point of view, Greece has been largely described by ethnographers, such as Loizos and Papataxiarchis (1991), as a society where kinship and family relations play a crucial role in the definition of womanhood and manhood, while adulthood for both women and men is attained through marriage and the achievement of parenthood.[5] At the same time, parenthood, and especially motherhood, have persistently provided a metaphor for the nation's continuity and integrity appropriated by both the state and the church (Paxson 2006, Kantsa 2006, 2011, Papataxiarchis 2014). During the past years, issues of fertility and reproduction have once again attracted the interest of the ethnographers of Greek society, especially in relation to motherhood (Paxson 2004, Kantsa 2006, 2013, Georges 2008), abortion and the so-called "demographic problem" (Georges 1996, Halkias 1998, 2004, Paxson 2004, Athanasiou 2006), and lately ART (Paxson 2004, Kantsa 2011, 2014, Chatjouli 2012, Tountasaki 2013, Tsoukala 2013).

In such context, the intensive medicalization of reproduction in Greece described by Georges (2008, 2014) has provided a fertile ground for the establishment of a reproductive "industry", particularly in the private sector, within a highly "permissive" legal framework on ART. Additionally, the cultural value attributed to reproduction and parenthood, in tandem with the scientific advances that have offered a wide range of infertility diagnoses and fertility therapies have reinforced an equation of infertility with a state of ill health, "in need" of medical treatment. Yet, religious consent is not always granted.

5. Loizos and Papataxiarchis (1991) have compellingly argued that kinship and family are defining constituents of personhood in Greece and exemplified the relational dimensions of personhood anchored in kin relatedness.

3. Orthodox Christians

The Church of Greece

Anthropologists and social scientists of modern Greece have repeatedly pointed out the close ties between the state and the church, as well as the central role of Orthodox Christianity in the formation and reproduction of Greek nationalism and national identity (Dubisch 1995, Halkias 2004, Hirschon 2009, Willert 2014, Papataxiarchis, 2014). At the same time, ethnographers of Greece have long stressed the significance of Orthodox Christianity in Greek cultural representations at the level of quotidian life and practices (Dubisch 1983, 1991, 1995, Rushton 1983, du Boulay 1986, Stewart 1991, Hart 1992, Paxson 2004).

Despite the close ties between the state and the church in Greece, the church –in contrast to religious bodies and representatives of other religions and dogmas who have been more directly involved in matters concerning ART in different nation-state contexts–[6] has admittedly kept a "low" profile and has only been "discretely" involved in the relevant public discussion.[7] Nevertheless, officially the church strongly objects to ART involving embryo distraction and pregnancy termination as well as practices, such as single parenting, donation of gametes, fertilization with the sperm of a deceased husband and surrogacy that, according to her, jeopardize the stability of marriage or "the normal family order" (Metropolitan Nikolaos 2008: 32).[8]

Though it does confine the church's interference within a theological prism, and does not impose any restraints on individual rights and freedoms,[9] the Church of Greece predicates the principle that ART cannot be blessed since they are largely seen as intervening in "God's work" and "the beginning of life" (Special Synodical Committee for Bioethics 2006).[10] According to the church, infertility or involun-

6. As a proliferating body of ethnographic studies on medically assisted reproduction has demonstrated (Inhorn 2003, 2012, Kahn 2002, Clarke 2009, Gürtin 2012, Inhorn and Tremayne 2012, Zanini 2013), religious representatives of different religions and dogmas –as for example Sunni and Shia Muslims in the Middle East (Inhorn 2012, Clarke 2009), Sunnis in Turkey (Gürtin 2012), Ultra-Orthodox Rabbis in Israel (Kahn 2000, 2002) and the Roman Catholic Church in Italy (Zanini 2013)– have been directly involved in matters concerning ART in different nation-state contexts. Their involvement ranges from engaging in relevant public debates to issuing religious instructions, certifying clinics and achieving significant interventions towards constitutional reforms.

7. For a discussion of official and unofficial religious discourses among Orthodox Christians, see also Daskalaki 2015 and Daskalaki and Kantsa in press.

8. The church strongly objects to any method of procreation that takes place outside the framework of the hetero-normative nuclear family founded in marriage.

9. In line with a modernising tendency within the church see Fanaras 2002.

10. What is exemplified is the prominence of man's psychosomatic existence instilled in

tary childlessness are the outcome of "God's will" and, hence, constitute an *evlogia* "blessing" and *dokimasia* ("trial) ["a blessing in the form of a trial" (Metropolitan Nikolaos: 26)]. Additionally, although acknowledging that infertility may be a source of stigmatization for infertile couples, she neither sees infertility as "a stigma" nor as a prerequisite for a fulfilled marriage since "She acknowledges the wholeness of childless marriages" (ibid.: 31). In fact, the church's principal recommendation to couples with infertility problems is to engage themselves as spouses "in higher forms of spirituality" (Special Synodical Committee for Bioethics 2006).

Yet, if infertile couples cannot comply with the above-mentioned recommendation, and, if adoption is not feasible, the church may "on the basis of Her spiritual dispensation"[11] "tolerate" insemination and IVF through techniques which do not lead to a surplus and distraction of embryos and which do not involve gamete and embryo donation, or what Metropolitan Nikolaos (2014: 24) called the church's "red line". Whereas the church accepts adoption as an alternative to involuntary childlessness, she defines the parent-child relationship almost exclusively as a genealogical relationship legitimized through marriage founded on fertilization with the reproductive material of the genitrix/genitor and pregnancy only by the mother that owns the reproductive material.

As we explain elsewhere (Daskalaki 2015, Daskalaki and Kantsa in press), the official position of the Church of Greece for ART is not uniform among the members of the Holy Synod and the clergy, with the latter often adopting either a more rigid or a more flexible stance than the former. The unofficial discourse of the clergy often challenges the official discourse of the Holy Synod (either being more permissive as, for instance, when supporting and *encouraging* infertile couples to pursue IVF with their own gametes or even with donated ova and surrogacy or less permissive in relation to ART, when they do not approve of any assisted reproductive method). Overall, however, one may observe a significant degree of "tolerance" towards ART by the church, which conflicts both its official and unofficial discourses in many respects.

Orthodox Christian Co-discussants

The interviews with the Orthodox Christian co-discussants demonstrated that for them decision-making about reproduction and the very decision of pursuing ART

"the simultaneous birth of soul and body" (Metropolitan Nikolaos 2008: 26). What is also underscored is that "the conception of every human being should constitute an asserted expression of God's Will and not the exclusive result of man's decision" (ibid.: 27).

11. For the concept of "spiritual dispensation" or "*ekonomia"* in Orthodox Christianity, see also Paxson 2006: 500.

clearly constitutes an issue of *prosopiki epilogi* (personal choice) or, in the case of spouses and partners, of *koini epilogi* (common choice) that is disentangled from religious impositions.[12] Indeed, none of the co-discussants –neither women nor men, even those claiming to be very religious– except the cleric, was aware of or interested in the position adopted by the church on ART. For instance, forty-one-year-old, Sophia Tobazi, when asked if she was aware of the church's official position on ART, answered: "I have no idea and I don't want to know…". However, despite the co-discussants' strong claims for choices on reproduction, as well as choices associated with assisted reproduction to be separated from religious considerations, their narratives reveal that religious-based ideologies and practices interweave with their actual reproductive practices in their encountering infertility. In fact, both religious and non-religious co-discussants admitted that they have followed certain practices with religious content, seeking divine or spiritual support along with medical assistance in order to achieve parenthood.

Additionally, compliant with the law on ART and in contrast to the official position of the Holy Synod, the co-discussants acknowledged the benefits of the scientific developments associated with a wide range of medical procedures which enable (in)fertile women and men to become parents. Even "religious" co-discussants and co-discussants who maintained that too much is put at stake by the use of ART considered that methods other than insemination and IVF with the gametes and the embryos of the persons under treatment should all be (legally) available as medical solutions to those who encounter (in)fertility. For example, forty-three-year-old Stamatis Georgiou, who claimed to be a practicing Orthodox Christian, viewed both scientific developments related to ART and the individual's free choice to resort to ART as "absolutely compatible" with his "conception of religious faith". For our co-discussants, infertility is considered to be a medical condition attributed to both biological and social factors –the process of aging and the postponement of pregnancy– that equates to an "unhealthy" state that can be reversed through medical treatment leading to pregnancy.

Despite the co-discussants' broad acceptance of the wide range of ART and their emphasis on the independence of the very decision of pursuing ART from religious impositions, their views about involuntary childlessness, third-party assistant reproduction and alternative forms of parenting bear some sort of resemblance to the church's discourse on the same matters.

Though acknowledging the social significance of parenthood and, motherhood in particular, as well as an enduring stigmatization stemming from popular

12. As well as nationalist projects and concerns over the country's demographic decline.

images of infertility within the Greek society, our co-discussants –at least at a level of discourse, since they themselves have aspired to become parents, neither see procreation and having children as a necessity for everybody, nor as the sole destination of women and men and a precondition for an accomplished marriage (joining). Following the church in her view that infertility is the outcome of "God's will" and hence a "challenge" [*dokimasia*] and a "non-stigma", most of our co-discussants regard involuntary childlessness as a medical condition and voluntary childlessness as a respected "choice", rather than a "stigma" which degrades women's and men's sexuality and social status. For example, thirty-seven-year-old, Iphigenia Grammenou, explained explained: "I can't see it as a disadvantage".

As for the relationship between parent and child, both the co-discussants and the church concur that it is principally a genealogical relationship, premised on a sequence of biological processes (such as conception, childbearing and birth-giving) and the existence of shared genetic material (DNA), often depicted in idioms of "common blood".[13] However, in contrast to the church, which does not only accept adoption as an alternative to childlessness, but also considers the parent-child relationship to be almost exclusively genealogical, the co-discussants' views on constituents of the parent-child relationship clearly extend beyond genealogical bonds, entailing or in some cases even involving exclusively socio-emotional attributes, defined in terms of "responsibility" "devotion", "care" and "offer" in the child's upbringing, as well as technocratic and legal attributes, defined in terms of the "child's custody".[14]

What is more, the co-discussants' views on gamete and embryo donation and gestational surrogacy reflect a wide range of dilemmas and contradictions, related to questions of legitimacy and perplexity of family bonds that in many respects bear resemblance with the church's arguments against the use of such technologies. Particularly, when discussion revolved around a hypothetical need of spouses or couples to resort to the donors' reproductive material and surrogacy, their answers often revealed anxieties over the "dangers" inherent in *daniko* ("donated") or *xeno* ("unknown") genetic material that "may carry hereditary diseases", or the "obscure" relationships implicated in surrogacy, as well as the "risk" of incest among children who, without being aware of it, may carry the same genetic material (Chatjouli 2015, Chatjouli, Daskalaki and Kantsa 2015).

13. See also Chatjouli, Daskalaki and Kantsa 2015.

14. For an ethnographic analysis of the socio-emotional and legal attributes of parenthood, see Kantsa 2006, Tountasaki 2013, Papadaki 2013, Tsoukala 2013.

Additionally, whilst most co-discussants recognized women's and men's right to reproduction within or outside marriage and their right to free sexual orientation, many of them expressed reservations or, in a few cases, objections regarding the new possibilities that ART (and not the law) give to single women (be them heterosexual or non-heterosexual) and men, as well as non-heterosexual couples to have a child. Again, these reservations and objections are primarily grounded in a discourse similar to that of the church about the parents' "selfish motives" and "injustices" against the child who will be brought up in a society that is not yet ready to embrace unconventional parenting relationships. As for example, thirty-eight-year-old, Marios Kanarelis, puts it: "[...] in that case, *the child* would be the one who would encounter the problem." This discourse also bears resemblance with that used by the church which condemns childbearing outside marriage and sees homosexuality as an abnormality. However, our co-discussants do not express so great a concern over cases where ART are linked to a non-heterosexual orientation, especially when referring to lesbian or bi-sexual women. Clearly, the co-discussants' reservations about the access to ART are more negotiable concerning single women of any sexual orientation, than they are when referring to non hetero-normative couples.

4. Jews

The Rabbi of Athens

Within Judaism different rabbis represent different theological "branches" of Judaism (such as Orthodox, Conservative, Reform Judaism), each of these "branches" also upholds different positions on various matters, including ART (Kahn 2000, 2002). Acknowledging these internal differences within Judaism, we could say that the positions of the highest-ranking religious Jewish authority in Greece, the rabbi of Jewish community of Athens, follows the "branch" of the so-called *Reform Judaism* which is a liberal version of Judaism. In accordance with the stance of the Anglo-Saxon reform rabbis across the world and the reform rabbis of Israel, the rabbi of Athens straightforwardly admitted in an interview that he accepts ART on the basis of the following three main reasons: 1) that ART enable women and men to fulfill the principle commandement of the Bible "be fruitful and multiply", 2) and 3) that ART ensure the harmony and cohesion of the family in cases where involuntary childlessness may jeopardize marriage and result in adultery. As he put it:

> This is why the high-ranking rabbis in the United States and Israel…and in the U.K. dealt seriously with this matter, that of the assisted conception. And they permitted ART, they said "yes, they are allowed, under three…three rules". The

> first and most important is the fundamental principle of the Bible "Be fruitful and multiply". This is everything in Judaism. The second is what we call the unity and cohesion of the family. When a couple has no children, then marriage is at stake. In order to avoid this we can give them a child. They can have a child through assisted conception. They can have a child. The third and more difficult to grasp as a concept is adultery. So, we resort to ART in order to avoid adultery.

According to the rabbi of Athens, the majority of rabbinical authorities across the world accept all kinds of methods of assisted reproduction when these involve the reproductive material of a married couple. For him, "If the reproductive material belongs to the couple, if it is the egg…, if it is the sperm from the man and the egg from the woman …, any method is acceptable. *Any method!*". However, when reproductive material donation is involved, especially among non hetero-normative couples, many (conservative, orthodox or ultra-orthodox rabbinical authorities) may pose serious objections. As he explains, since sperm and egg donation may be seen as causing *halakhic* problems, there are rabbinical authorities that discourage or even reject such methods (see also Kahn 2000). Nevertheless, along with the majority of the Reform Rabbis and in spite of the *halakhic* problems that some methods of ART may create, the Rabbi of Athens accepts all kinds of methods that the Greek law approves, under some pre-conditions (such as in the case of sperm donation, the sperm should not come from a Jewish donor so that hereditary diseases are avoided). As he put it:

> If the man can't have children, there is a problem. If he decides to use donor's sperm. Many rabbis say this is adultery […] But most rabbis allow it, under the precondition that the sperm does not come from a Jew. It has to come from a non-Jew.
>
> If a woman uses a donor's egg, then we have the problem…who is thought to be the mother? The one who gestates the embryo or the one who produces it? Most rabbis would say the one who carries the embryo.

He would even accept ART for same-sex couples that the Greek legal framework does not approve of. For instance, according to the rabbi's own words:

> We don't burn them. […] This thing exists. It exists. Eh, what shall we do? Burn them? […] This is part of life. In any case, we ought to offer assistance, to find a way, to find a way…

Jewish Co-discussants

As it also happens with the Orthodox Christian co-discussants, most of the Jewish ones, including those who see themselves as religious, agree that reproduction

primarily constitutes a matter of personal "choice" or "expectation" that arises within a relationship that should not be subject to religious constrains and prohibitions. However, unlike the Orthodox Christian co-discussants who emphatically disentangle their choices in relation to ART from the relevant inducements set out by religious authorities, for the Jewish the desire for procreation and their "choice" for having a child, although not directly associated with the reproduction of the ethnic and religious community, cannot be seen as disentangled from their sense of belonging to the religious/ethnic group assigned to the term "Greek Jew". Within the context of a progressively "shrinking" Greek-Jewish community due to the economic crisis, this entanglement is of particular importance. This is evident in their association of our co-discussants' wish to become mothers with their "sense of responsibility" or a sense of "strong will" as they themselves call it, to contribute to the continuity and reproduction of the Greek-Jewish community. As also among Jews in Israel [Kahn 2000: 3-4, Carsten (citing Kahn 2004: 4)], reproduction among Jews is of the utmost importance. Additionally, similarly to the Orthodox Christians, religious-based ideologies and practices are evident in the Jewish co-discussants' discourse about ART (also Kahn 2000).

Whereas for the Orthodox Church and most of the Orthodox Christian co-discussants having a child is not considered as a precondition for the accomplishment of both womanhood and manhood and as a prerequisite for a completed marriage, for the Greek rabbinical authorities and the Jewish co-discussants the arrival of a child in an individual or couple's life is seen as equating with the achievement of women and men's "destination" and as fulfilling a couple's happiness through bringing into life what fifty-year-old, Jozephine Nahmia, calls the "fruit of an intimate relationship and the relationship of love". This is reflected both in the wide acceptance by the co-discussants of the core mandate of the Bible: "be fruitful and multiply" and the importance attached by them to the status of parenthood that is seen as related to the accomplishment of womanhood and manhood (see also Kahn 2000). According to fifty-year-old, Lousie Samson: "It is the most significant event in the life of a woman, when you hold your newborn child in your arms. It's a divine moment."

In accordance with the rabbinical authority's more "open" stance towards ART than that of the Church's, the Jewish co-discussants not only do they accept ART as methods that should be available to those who wish to have children, but they also maintain a more "open" stance than that of the Orthodox Christians *vis à vis* the (hypothetical) use of donor's reproductive material and surrogate motherhood. Indeed, the fact that some of the Jewish co-discussants had actually pursued

ART with donated reproductive material and almost all of them spontaneously answered that they would most probably use borrowed sperm, egg or embryo and, possibly surrogacy, if needed in order to have children verifies their more "open" stance towards donated reproductive material and surrogacy. As Louise Sampson who got three children through IVF explained:

> Within a certain ethical and legal framework, I would do anything. [...] We sat down the two of us [her husband and her] and said...I said first that for me it would be inconceivable to remain childless.... We would try. I said, "I'm ready" because I had been through all the diagnostic procedures, "I'm ready to try whatever the doctor suggests...."[...] We were both very straight with that.

Furthermore, in accordance with the rabbi of Athens the majority of Jewish co-discussants agree that all kinds of ART should be legally available to single parents (women and men) and to both hetero-normative and non hetero-normative couples, even male couples.

5. A comparative comment on Muslim co-discussants from western Thrace

The main findings of the ethnographic material produced by our colleagues point to the fact that the Muslim women of Turkish origin accept that access to ART may be emancipating for those wishing to consolidate a more autonomous female identity within a context of a local community with strong Sunni Islamic values in which the protection of paternity and family is seen as one of the principal goals of the Islamic law. However, the co-discussants' acceptance of biomedical treatment for infertility seems to be compliant with the Sunni Islamic view in which biomedical technologies can help the reproduction of the family in cases of involuntary childlessness among couples –who are seen as encountering medical problems– but ART are endorsed as long as they are limited within married couples using their own gametes. Indeed, the Muslim women reproduce the discourse of Sunni religious authorities in Turkey and elsewhere in the Middle East that ART with a donor's reproductive material and surrogacy endangers the sanctity of the family which is premised on the protection of inheritance, the prevention of incest, the prohibition of adultery and the preservation of lineage (Gürtin 2013, Inhorn and Tremayne 2012). In particular, the equation of the use of donated reproductive material with adultery discourages most of the Muslim co-discussants who pursued ART (even if assisted reproduction took place with their own reproductive material) from openly admitting this to members of their community,

since such a confession would easily raise suspicions about the use of donated reproductive material, jeopardizing both their personal and family dignity.

6. Conclusion

To summarise, the comparison of the ethnographic material produced among Orthodox Christians and Jews points to the more "open" stance towards ART of both the rabbinical authority and the Jewish informants compared to the more "restrained" stance of the church and the Orthodox Christian informants. Despite the claims made by the informants of both groups for the autonomy of their reproductive choices from religious inducements, religious-based ideologies and practices are implicated in reproductive practices. For the former, this autonomy seems to be in line with the church's acknowledgement of the freedom of individual choice. Additionally, their ambiguous discourse towards third-party assisted reproduction and unconventional parenting relationships often resembles the "moral code" used by the church. For the latter, it is clear that the *Bible's* emphasis on the significance of procreation has strongly influenced the broad acceptance (both by the rabbi and the informants) of its accomplishment through artificial means and even outside the framework of gestational parenthood and hetero-normative relationships.

Additionally, the ethnographic material among Muslim women indicates that what is evident in their discourse about ART is the Sunni interpretation of the *Quran* that sees medically assisted treatment sought by involuntarily childless couples as not contradicting God's will as long as it does not involve third-party assistance which is contrary to what the Orthodox Church maintains and something that rabbinical authorities encourage.

Taking into account the above-mentioned analysis, we could suggest that even within the nation-state context of Greece and under the same legal framework on ART, official religious discourses elaborated by the Church of Greece and the Jewish rabbinical authority of Athens regarding ART do influence unofficial discourses on medicalized fertility treatments expressed by Christian Orthodox and Greek Jewish citizens. The same applies to Sunni Islamic values and Muslims of Turkish origin living in Western Thrace. In other words, religious authorities' discourses about "accepted" forms of medicalized technologies of childbearing in relation to "accepted" forms of relatedness and wellbeing influence the formation of a more "personal" moral code that in some cases accepts and in other cases rejects certain forms of kinship or relatedness. In a broader sense, we see here

what Kahn (2000: 1-2) has called the "conceptual and practical overlaps between secular and religious uses of, and beliefs about, these technologies".

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AGLAIA CHATJOULI

(In)fertility and ART drugs. Making sense ofART drug consumption and the art of achieving motherhood

1. Introduction

This paper draws from 84 interviews from Greek women and men with infertile pasts, presents and possibly, futures. It aims at the problematizing of ART drug consumption in relation to the concepts and practices of (in)fertility and the art of achieving motherhood linked to dominant and emerging representations of womanhood and motherhood.[1] The specific focus is on women's experiences and fears around the process of hyperstimulation expressed by them and their partners. How does the biomedicalized aim of producing "more and better quality eggs" reveal tensions and personal dilemmas regarding reproductive choices, the embodiment of science, the gender of ART?

The way women navigate themselves in the consumption of the necessary ART drugs reveals dominant norms linked to the local context which offer us analytical insight regarding spoken and unspoken beliefs around the female body and its resilience and persisting patterns of normalcy concerning reproductive potentiality. At the same time, it discloses shifts regarding the content and dynamics of prevalent power relationships between ART women clients and ART experts, between infertile women and their partners, between infertile

1. This paper draws from research carried out in Greece during the period September 2012 - September 2015 as part of the research project: (In)FERCIT *–(In)Fertile Citizens: On the Concepts, Practices, Politics and Technologies of Assisted Reproduction in Greece. An Interdisciplinary and Comparative Approach*, a three-year research program funded by the European Social Fund and the General Secretariat of Research and Technology, Greece, and conducted by the Lab of Family and Kinship Studies (for more details visit www.in-fercit.gr/en).

women and other people witnessing and commenting upon the journey of infertility and ART use.

The women and men interviewed are in permanent heterosexual relationships mostly in the context of marriage and they embody the dominant cultural norm of family making and conjugal household (*nikokirio*) (Loizos and Papataxiarchis 1991, Papataxiarchis 1992, 2013, Papataxiarchis and Paradellis 1992). They have all experienced involuntary childlessness. Most have also experienced some form of ART while others are in the process of doing so. The majority is based in Athens but some live in a peripheral Greek town or on an island. The interviews were open-ended and covered a vast number of themes raised both by the researcher and her co-discussants.

2. Notes on the biomedicalization of reproduction in Greece

Reproduction along with the wellbeing of the female body have been extensively medicalized in Greece (Lefkarites 1992 Traka 2013, Georges 1996a, 1996b 2008, 2013, 2014, Paxson 2002, 2003, 2004, 2006, Halkias 2008, 2014, Kantsa 2011, 2013, 2014b, Chatjouli 2013, Tountasaki 2013, 2015). Ethnographic research has highlighted the transition of life course processes and events such as menstruation and menopause, pregnancy and birth into medical constructs that are not only medically conceived and understood but also medically managed and treated. Along this line, involuntary childlessness is gradually reduced to infertility, to a medical problem based on a known or unknown organic cause. Thus, successful conception also changes into a target of biomedical intervention. Even though ethnographers working on these areas have shown the comparatively fast course of this transition taking place in the Greek context, which has been explained both by cultural forces linked to the modernization and Europeanization of the Greek society and by the connections between using novel technologies and "gender proficiency", whereby for women predominately reproduction is a key area of performing their best gendered selves in order to achieve both womanhood and adulthood (Paxson 2014), technologies linked to reproduction haven't been unanimously appropriated. So, on the one hand medicalized pregnancy and birth have became the norm, with the medical monitoring of pregnancy (e.g. ultrasounds), high numbers of hospital births and cesarean sections reaffirming that (Georges 2008), while on the other, contraception (mostly regarding the use or oral contraceptives, *to hapi* [the pill] and to a lesser extent regarding the use of condoms) haven't been widely used. The high numbers of abortions are linked in Greece

with the termination of unwanted and un-programmed pregnancies along with more "traditional" and non-medical methods of contraception such as "counting the fertile days" and abstaining from sex or via withdrawal. Even so, the extensive use of abortions points to the extensive medicalization of women's bodily management and reproductive potentiality. Yet, the hesitation to use a modernized method of contraception has been attributed to the strong link between sex and procreation together with the argumentation that one has to be able to choose the right time to become a proper and good parent and therefore the arrival of children should be controlled. Many transitions have been documented regarding the making of alternative decisions in the area of family making, beyond the dominant heterosexual-conjugal biomedical regime (Papataxiarchis 2013, Kantsa 2006, 2007, 2014a, Kantsa and Chalkidou 2014a), and ART use has in many ways mediated such shifts (see current Kantsa and Chalkidou 2014b), but despite this process and also along this process the biomedicalization of reproduction is only marginally being challenged.[2]

IVF was introduced in Greece in 1984. The number of reproductive clinics and centres are around 70. Most (more than half) are located in Athens and the remaining are based in various major cities of the periphery. According to rough estimations, since there are no official national statistics,[3] 300,000 couples in Greece are infertile, 12,000 assisted reproduction cycles were performed in 2012, while the average cost is 4,000 euros for each effort (drugs included), *(Kathimerini* newspaper 9-6-2013). Only few ethnographers of reproduction in Greece have researched the way ART have been appropriated by Greek women and men. From her research during the 90s, Paxson reports an overall positive stance towards these new technologies of overcoming involuntary childlessness (Paxson 2014), while emerging voices of criticism have only recently been documented (Kantsa 2014b, Chatjouli, Daskalaki, Kantsa 2015).

The use of ART usually follow a strong and persisting desire to have children, to make a family, to achieve motherhood and parenthood and therefore it is usually conceptualized (from the beginning or gradually) as another "technical means" to realize one's desire and to resolve an equally "technical-organic-bi-

2. The most tangible forms of resisting steps towards extreme forms of biomedicalizing reproduction in Greece have been the more recent return of home-births aiming at ensuring birth in its most natural form and protecting it from unnecessary intrusive medical technologies (see the work of Chronaki 2015), as well as the emergence of women actively pursuing natural birth after having had a cesarean section in a previous birth.

3. Regarding the lack of state control and evaluation of ART use see Chatjouli, Daskalaki, Kantsa 2015.

ological problem", that of infertility. In other ethnographic accounts reflecting on the same data, we have analyzed the conceptual content these technologies acquire, along with the social technologies triggered in the process of biotechnological use (Chatjouli, Daskalaki, Kantsa 2015). Furthermore, we look into the overall wide spread and use of ART in Greece in the context of a very allowing legal environment and an absence of state control.[4] This paper argues the mixed and often contradictory feelings and meanings enacted in the more specific part of the ART process linked to the use of hormonal therapy for ovary hyperstimulation. Interestingly, it is seems that this particular aspect of the whole treatment (along with the controversial use of donated sperm and egg) is what troubles women the most as it is them who have to undertake it. The use of such *farmaka* and *ormones* (medications and hormones) raise fears regarding potential side-effects of both "organic-somatic" and "psychological" nature. Ethnographically it is intriguing to find that "hormonal treatment" is contested both regarding contraception (Georges 1996a, Paxson 2004: 109, 110) and boosting fertility.

In the context of ART, either when undergoing IVF or sperm injection, women usually follow a protocol of hormonal ovarian stimulation. Despite tendencies in other countries to aim at reduced doses and less intervening protocols, such as the "natural cycle method", in Greece, hormonal ovarian stimulation is a preferable, normalized and routinized practice amongst medical practitioners and the most widely known among non-experts. Couples might be presented with the long- or the short protocol, with explanations regarding the biological process involved and guidelines on how to correctly follow the protocol and do the injections, the timetable to be followed and the process of getting hold of the medication. Information will be also given about the potential symptoms due to side-effects of overstimulation and what to do if they appear.

IVF was initially a technique that didn't include hormonal therapy for ovary stimulation. It quickly evolved into one where hormonal treatment became an inseparable part of the process and the high number of eggs a goal. Later on though,

4. The legal context is based on the 3089/2002 Law on "Medical Assistance in Human Reproduction" and the 2005 Law on "Application of Medical Assisted Reproduction Methods". All techniques are allowed except human cloning for reproductive reasons and gender choice, while permitting the use of fertilized eggs for research or therapeutic reasons, surrogate motherhood, posthumous conception and imposing donor anonymity for both egg and sperm donors. In addition, preimplantation genetic diagnosis, embryo freezing, anonymous sperm donation, anonymous egg donation, embryo donation, surrogacy, research on genetic material (donated gametes and fertilized eggs) and the free transportation of genetic material and fertilized eggs from and to other European countries are also regulated and allowed (see Chatjouli, Daskalaki and Kantsa 2015).

the aim changed in an effort to reduce the possibilities of twin and triplet births and so avoid the risk attached, and finally the introduction of the "natural cycle method", whereby hormonal stimulation is avoided altogether but which has been developed only in a limited number of ART clinics and medical centers in Greece.

Hormonal ovarian (hyper)stimulation is a technique used in ART involving the use of medication to induce ovulation by multiple ovarian follicles which are then collected and used *in vitro* fertilization (IVF), or be given time to ovulate, resulting in superovulation which is the ovulation of a larger-than-normal number of eggs. When ovulated follicles are fertilized *in vivo*, whether by natural or artificial insemination, there is a very high risk of a multiple pregnancy.[5]

According to the Human Fertilization and Embryology Authority (a UK's independent regulator overseeing the use of gametes and embryos in fertility treatment and research),[6] in Natural Cycle IVF, "the one egg you release during your normal monthly cycle is collected and fertilized. No fertility drugs are used in this treatment and it is suitable for those unable to take fertility drugs (for example, cancer patients or those whose clinician has suggested that they are at risk of OHSS –ovarian hyper-stimulation– a dangerous over-reaction to fertility drugs) or for those that for personal or religious beliefs you do not wish to have surplus eggs or embryos destroyed or stored". […] "The treatment is the same as conventional IVF, but without the fertility drugs that are used to stop natural egg production and hormones that boost the supply of eggs". Patients are monitored in a natural cycle with ultrasounds and blood work to track the growth of the dominant follicle. An egg retrieval is then performed when the dominant follicle of the appropriate size.[7] The chances of having a baby with natural cycle (in live birth rates) are "lower per treatment cycle than with conventional (stimulated) IVF. Because this treatment does not rely on any artificial aids, much depends on your individual circumstances". So for some cases it might be the ideal option. "The risks with natural cycle IVF are lower than those with conventional IVF. Natural cycle IVF avoids the side effects of fertility drugs and you are less likely to have twins or triplets".[8] In all, the advantages include no risk of ovarian hyperstimulation syndrome (OHSS), very low or no gonadotropin injections, lack of excess embryos production, and the elimination of multiple pregnancies.

During fieldwork I was amazed by the fact that only very few users were

5. https://en.wikipedia.org/wiki/Controlled_ovarian_hyperstimulation
6. http://www.hfea.gov.uk/index.html
7. http://uscfertility.org/fertility-treatments/natural-cycle-ivf/
8. See footnote 7.

aware of this alternative especially since they disliked hormonal therapy, expressed fears about development of cancers later in life, and had experienced somatic and psychological discomfort. Natural cycle IVF was not presented as an option even when the above fears were explicitly expressed to the doctor, and even in cases of women who had a record of many failed attempts. I came to realize that at the time the research took place only few of the centers actually had invested in this protocol. In addition, the production of many eggs was often perceived as a successful first step, adding hope to the couples and providing the experts with adequate numbers of reproductive material to work with. Despite the trend in other European centers to reduce the numbers of eggs retrieved and embryos transferred and to focus on getting better quality reproductive material, the prevalent idea in Greece can often be reduced to the slogan: "the more the better", despite the users fears and their feelings that their bodies are being used as reproductive machines (Chatjouli, Daskalaki, Kantsa 2015, Chatjouli 2015). This trend is gradually changing but only slowly due to profit related factors and to an absent public voice regarding the rights of infertile citizens.

Very few women who demand more information and less medication, either made the choice to try the therapy once, maximum twice, or persuaded the doctor to give them lower dosage. I often asked women and men about the option of the natural cycle. In most cases, I had to explain the method to my co-discussants after which they clearly said that they would have liked to know during the period they were undergoing treatment. Some felt betrayed.

It is perhaps of no surprise that the unquestioned use of hormonal treatment in infertility protocols has become the norm in a highly biomedicalized setting like Greece, especially regarding reproduction as mentioned above, consumption of medicines, dominance and wide appropriation of biomedical reasoning (Chatjouli 2014). In the case of overcoming infertility the stakes are so high –socio-cultural, economic and emotional– that users will rarely not comply even if they feel uneasiness and exploitation. They might change doctors after a failed attempt but they would not disrupt the protocol and the course of therapy. Compliance to ART protocols becomes almost a ritual and often a stressful one, the epicenter of the couple's everyday life. Despite this disciplined behavior women users and their husbands continuously express their worries about hormonal therapy.

3. Worried voices – Worried bodies

Patient's narratives (women's and men's) can be roughly organized in the following three groups, while processes of biologization, psychologization and somatization seem to mediate the users' need to make sense of the whole experience: a) fearing, enduring, suffering and obeying, b) fearing, enduring, suffering but not following blindly and ultimately making a choice of differentiation, c) not fearing & overall trusting the medical protocol.

Sandra, still childless with one experience of artificial insemination and in the process of preparing herself for IVF explains:

> There is a fear…that I will definitely get cancer, a big fear […] well it is not just that I heard a talk about it but because in my mind I make a connection with my family's cancer history. […] There was a public talk from a child psychiatrist in Athens […] I have kept the following […]: We do IVF and we book a date with cancer […] She was talking about violence against children and by "violence" she meant a number of things. That we do things violently and we don't let things happen, we don't let them unfold. In other words we put pressure on women to have children via this way… and I have kept these words and when I make the connections I understand that is it stupid […] The fear comes because we do a kind of violation. I violate something that could be done another way. It could be done naturally […]

A sense of having no control over what is taking place inside the body, and a sense of an uncontrollable future, are characteristic concerns. Parallel to the determination, discipline and stoicism performed by women going through the many tests and the continuous medical monitoring and beyond personal variation of the degree of difficulty felt, of the psychological hardship experienced, there is a more or less uniform problematizing and fear linked to ART drug consumption.

Only very few women didn't express concerns about the potential risks and they did so via biologizing the process, arguing that these *farmaka* ("medication") are just like the *ormones* ("hormones") produced by the body naturally, that they are then discarded from the body and that this method had been tested for years now. Such narratives often include a trust towards the medical regime and the specific doctor. Such explanations are usually given by women that didn't hesitate to proceed with the treatment, are very determined and don't believe that the non-expert should take the expert's role.

Nana, pregnant to twins via IVF describes her unwillingness to look into the issue:

> One thing I didn't search at all and I don't know if I did well, probably not, is that I didn't inquire about the risks of all the medications I took. I know nothing and it is not very mature of me to say this, but when I came back home from the pharmacy with all these medications…I didn't go through each one of them. I trusted what the doctor told me […] That is all. Until my father in law asked me if I had looked into the matter: "They talk about risks, about breast cancer". This was not going to stop me. I would definitely go through it. The end justifies the means […] The point is to have children […]

When experts are questioned they seem to provide very cautious responses. They might refer to potential risks linked to a family history but overall they are reassuring. Some doctors have refused to offer treatment to couples with a history of many failed attempts, something valued by users since it shows that the expert looks after the wellbeing of the customer and not his personal financial gain. But most often, despite the expert's reassurances, the majority continues to express their worries

> Meropi, a mother of twins via IVF explains:
>
> In the beginning it was a shock … well I am one of those people that say: this is what you have to do and you must deal with it. Then, when I got hold of the injections Puregon, and I opened the box and started reading the instructions, that is when the shock came because you realize that this medication is given to people with prostate cancer and you ask yourself: what are you doing? Some things continue to make me feel uneasy, even now. I still think about them. What might be the future implications of all these medications. I called at the time my uncle [who is a gynecologist] and I said to him, Gianni I read this, and he replied, well look, even if you take aspirin and read the instructions…you' ll never take it. Now you have entered a path that you will either follow or you' ll stop. Ok, well I continued…This other girl had four attempts and she said I will not do more because I am afraid.

Mika while preparing for her first IVF, talks about the cost of the process which is not only financial but also somatic and psychological:

> I am optimistic and luckily this optimism comes naturally at this point […] but in the back of my mind I think about the fact that no one can promise me I'll get pregnant by doing IVF. And as I already mentioned before, it will cost me…financially…since we will have to borrow money […] and my psychology, the fact that I will re-enter the therapy process with all these injections and medications. I listened to this woman's story on TV… about her own path and, well, until she managed to have a child, and this was the first time I heard about this, that after a number of attempts, after the 4th, 5th time, because of the medications, something no one will easily say, not even the doctors…the risk

> to get cancer is highly increased. […] well I take this very seriously. Plus we have a family history. I will do some attempts, 3 or 4, I don't know how many I can endure. […] I don't like this, it bothers me as an idea, as part of IVF. Why should I stress my organism with so many medications…

Sofia, after five cycles of IVF and twin girls describes the serious problems caused to her body and her psychology:

> I was terribly swollen. I would wake up in the morning and I was like a sponge that you squeeze and then I was ok. Swollen, as if I was pumped. I had psychological ups and downs, a moody behavior which was not like me. Luckily it has gone now. The slightest would cause me…would bring tears to my eyes. Luckily I was working which helped a great deal.

Roula, still childless with four artificial inseminations in her record and currently preparing for IVF explains how all this crosses personal boundaries:

> Well, I have gone against my beliefs […] Yes the medications I fear […] I believe they can be responsible for cancers. I believe that it is not a natural process of the organism and I am not sure you should pressure things that much […] Yes, I will go through this despite my doubts. But I am turning against my own self…

Worrying about ART medications is something experienced and expressed during the various phases of the whole treatment and in relation to distinctive aspects of the process. The fact that the actual treatment has to be endured by the woman herself, after being given instructions, can be translated as a shift of responsibility from the expert to the user. The woman must stick to the protocol, to the timetable and do the injections herself. This partial and temporary passing of control to the "patient" creates a space for self-problematizing and triggers mechanisms of resistance, of an anti-discourse towards the dominant medical one, or at least a space to express and communicate somatic and psychological discomfort or confusion. There is a qualitative difference between being subjected to a treatment by the expert's hands and when you have to do it yourself. The women's difficulty and often refusal to carry out the injections on their own is not a coincidence. Some go to a pharmacy, to a nurse or they ask their husbands to do the injections, something men do willfully. All men acknowledge the fact that it is the women who have to go through most of the hardships.

Some women experience strong side effects, others minor ones, while some don't feel anything. Such symptomatology includes: feeling bloated, gaining weight, feeling dizzy or emotionally unstable, etc. It is argued that the various somatizations and psychologizations experienced and the meanings given to them

form an attempt to react against something felt as a violation of one's somatic integrity even within a context of more or less docile bodies. This duality and ambiguity is nonetheless characteristic of a biosocial resistance towards current forms of biopower where the expert retains a diffused kind of power but where the non-expert has become a consumer and client, a more or less informed patient, who has often appropriated the experts discourse and has willfully, freely, for one's own good, chosen the specific life course no-matter how contradictory or difficult that may feel.

All these fears and discomfort constitutes a sufficient reason for some women not to proceed with further attempts. The violation of certain naturalized somatic boundaries, the stress presented to the body seem to suffice for some to make an alternative choice such as adoption, or to impose their personal limits during treatment.

Stella, a mother of an adopted child explains:

> I had no trust to try another time…I didn't want to put again more hormones into my body. This had damaged my psychology for quite a while […] this didn't suit me at all. I had never before taken medication to such an extent, I don't take medication, not even contraception […] and all this hormone that I put into my body, all this chemistry didn't feel right at all.

Panagiota, with a child via IVF, who a couple of months after the interview conceived naturally her second child mentions her persistence to take less medication:

> I doubt that I will enter the whole cycle again. I am not a friend with all these medications. The truth is I was afraid of them and I tried to avoid them but I made everything clear to the doctor. […] So initially I was given five of these tubes, like a pen that you had in a way to stab yourself with, I thought…I was supposed to use them all. So after I made myself clear to the doctor I ended up using 2 and one dose. Not even…

Iakovos, a father of twins after four IVF attempts also discusses the over-production of eggs as problematic:

> No, we didn't freeze any and it was because of this precise reason […] my wife was very skeptical about the medications that led to over-production of eggs. This is not something to do over and over again. She was extra sensitive about issues of hormonal disruptions and carcinogenesis […] It was a battle for her to choose between I want to have children and […] she knew very well she was taking risks she couldn't estimate properly…

It is important to focus on these exact fears and how they formulate reproductive agency as they inform an embodied form of biosocial resistance towards the

imperative of achieving motherhood by any means and at any cost –something that some women are willing to do, echoing more traditional but dominant cultural norms about construction of womanhood via motherhood and the sacrificial content of the "good mother and woman" (Georges 1996a, Paxson 2004). Refusing hormonal treatment, putting limits on dosage and the number of attempts, form an opposition towards this medicalized and commodified handling of the reproductive body. Another kind of resistance emerges also in cases where limits and boundaries are set by the fears and anger felt, expressed and communicated, through psychologizing a sense of being at risk, and somatisizing worries in the context of all this "violation" talking place. Trying to navigate oneself within the complications of a technology that an infertile woman "ought to try", according to the rationale and morality of "scientific motherhood" (Apple 1995), present in the Greek context, the problematizing by the users of the concept of choice marks by itself a form of resistance.

In addition, all this uncertainty is compounded by the unclear messages provided by the experts. As Menia, a mother of a child after 14 attempts explains:

> The English experts say do as many as you want but no more than two per year…The Americans and the Australians: do up to 6 and then give it up […] everyone used to tell me, because the method is present since 1975 and there are many studies showing that there is no burden to the woman's body because these are natural hormones and leave the body after some time. But this other oncologist […] had told me…all the protocols are done in order to produce results so don't count on them. Do as few as you can and put an end to this thing […]

Beyond the fears, the somatic and psychological burden, many women felt their bodies were exploited and misused as reproductive machines. Such narratives are usually also linked to a concern regarding the uncontrollable use of the reproductive material once this has left the body. The "industrial feel" of the ART clinics, the anticipation of producing many eggs, the fact that others (doctors, biologists, embryologists, geneticists etc.) handle the reproductive material once out of the body, are in many cases negative reflections of the whole experience of reducing the infertile woman to her (of questionable quality and quantity) eggs, whereby women feel objectified, their bodies being fragmented into reproductively valuable parts, their embodied integrities felt as being threatened.

Rena Kalli, forty-years-old, mother of one child after one IVF attempt, describes how she felt being in a production line, in a context where many women themselves and the personnel focus primarily on the production of reproductive material:

> Yes, well at that point, it was the first time I got stressed. I said wait, what is going on here [she is laughing]. They asked me what my problem was and I replied I don't have a specific problem. I am telling you we were very relaxed. It was there that I got a bit stressed for the first time. After that it was ok. It felt weird because it is a bit like being in a production line. Still it was discrete, but yes […] with a work uniform, this green thing you have on and you are waiting on these beds, some women going in, the others coming out intoxicated, because that is how it works. Then they come out and ask, how many eggs did you have? You, how many? I mean how many can we make, because you know, these women, they were good women, they had a lot of eggs. When they woke me up I asked the doctor how many and he said, only 5 and I asked is this ok, and he said it's ok. But I am telling you, some women came out and they were in there a long time and they had more than 20, even 30.

Panagiota, who demanded a limited dosage refusing to be turned into an "egg machine", also demanded for a limited number of embryos to be transferred. She also ended going to a low-key doctor because she could not trust the big centers, with big numbers, big successes, many cycles, many eggs, many embryos etc., and where the couples often feel they lose control of their reproductive material.

> Yes, I had 15 [eggs], but after I explained to the doctor, and after I had been to 200 doctors […] but not one of the very big names, I was afraid of all these centres, in general I didn't want a centre, I wanted to be in a hospital, that is why I went to that place. I don't know, I was a bit scared to be in any clinic if something serious happened […] The man was very clear, he made me understand that I would not become a guinea pig because that is what I was afraid of in the big centres and I understood this when this one asked me: "what do you want, so that I know how much medication to give you". So, I made 15, with 115 units and the initial estimation was for 325. I mean, if I had taken 325 what would have happened? An egg machine? I told him I didn't want to become an egg machine. I wanted to have 1 or 2 babies […] My organism was virgin, because also this plays a role […] In the last time, I was lucky and because they store them in twos or every four, the last two I had, they were not a couple, they were separate. He told me I should defreeze all four and I said no, only two and if they are not good, like the other time that he had defrozen them and they were not good, I will believe you and tell you it is ok. I will be here waiting, I will wait for you to put them to me after. But first, you defreeze only the two and only if they are not good you will defreeze the other two. I don't want you to put in me four but two. He was very cooperative, really, even after I gave birth.

4. Somatizations, risky medications and losing control

ART medications almost became poisonous in this context: the *farmako* (the medication) becomes *farmaki* (poison),[9] echoing the work of a Greek ethnographer Athena Peglidou (2005, 2010).[10] Looking into psychiatric diagnoses, psychiatric medications and the ways women take them in the Greek periphery make sense in the context of their small communities. These women seem to, in various degrees and modes, use their somatic symptomatology linked to their condition and to the "side-effects" of the medications in performing acts of resistance by disobeying their doctors' orders when taking their medications, negotiating as such their positions within hierarchical power relations. The fears of hormonal treatment in the case of oral contraceptives and the resulting under-usage of such medications, as it has been documented in the Greek context (Georges 1996a, Paxson 2004: 108-110, 114, 118), also point to a deleterious effect of an often believed as "natural medication" and linked to somatizations ranging from mood shifts to weight gain.

More than two decades ago Margaret Lock and Wakewich-Dunk (1990) in their article: "Nerves and Nostalgia: Expression of Loss Among Greek Immigrants in Montreal", discussed the local moral worlds which traveled along with the Greek women migrants all the way to Canada, and were mediating the emotional turbulence of these women expressed as *nevra* ["an intense sensation, usually of boiling over, that it associated metaphorically rather than literally with the nerves" (ibid.: 257)]. The authors showed how the discomfort of these women in relation to their oppressive husbands, their oppressive workplace, the foreign and alienating social environments, the absence of traditional support networks, was somatisized to the extend they had to reach out for medical help. The researchers, looking for culturally-sensitive ways to approach the management of health and disease of migrant populations highlighted the importance of understanding "local" expressions and articulations of peoples states of being, as was the case of "having nevra" and by doing so they discussed not only the specific oppressive contexts, but also the cultural tools these women had or didn't have in order to deal with their problems. The result of "having nevra" could be seen in a strong negative physical and emotional symptomatology.

As in the case of these women, in the case of our co-discussants, the body is "habitually used symbolically as a vehicle for expressing stress and oppres-

9. Interestingly the lay word for *dilitirio* (poison) is often *farmaki* which is an altered form of the word *farmako* (medication). See the work of Peglidou (2005).

10.www.aegean.gr/genderpostgraduate/Documents/Fylo_Chrima_Antallagi/Πεγκλίδου.pdf

sion, while the form of expression is culturally constructed and can range from a dramatized performance or ritual to altered states of consciousness, from direct verbalization of the problem to more subtle forms of somatization in which the corporeal body rebels" (ibid.: 255). The underlying reasons that led those migrant Greek women to *nevra* were to be found in normativities linked to rural Greek life in combination to their lives in Canada.

In the case of the infertile women undergoing hormonal treatment, who uniformly say that they have *nevra* (being nervous and feeling tension) as well as *aghos* (stress) and *stenahoria* (feeling sad) about their infertility and ART experiences and who fear, resist, invariably endure, or don't mind ART medications, we can trace processes of "how the corporeal body rebels", as well as the different (normative) potentialities of being a woman and becoming a mother in the Greek context nowadays. Some may reproduce traditional prototypes of sacrificial, enduring behaviors and practices (Paxson 2004), others may distance themselves from such representations to variable degrees, by verbalizing and sharing discomfort, asking for information, imposing some kind of limits. Others may choose not to become mothers at any cost (echoing an "ethics of both choice and wellbeing"),[11] presenting another rightful motherhood which presupposes that the woman must feel contained in order to become a good mother, as it has been demonstrated by more recent ethnographies (Vlahoutsikou 2015, Vlachoutsikou and Teazi-Antonakopoulou 2013).

Reflecting on my personal accounts regarding this paper, when I originally thought about writing on this topic and the related narratives, I wrongly, as I later realized, used the word drugs instead of medications. In Greek I wouldn't have made such a mistake since the word *narkotika* ("drugs" as in narcotics) is never used to refer to prescribed medications as the ones used in ART treatments, referred to in Greek as *farmaka*. I then realized it must have been a subconscious choice, one that at least partly represents the feelings and symptomatology of the women expressing discomfort. In addition, being drugged, or taking drugs, refers most commonly to a sense of losing control, which is what is mostly at stake here. Having *nevra*, *aghos*, *stenahoria*, as Lock and Wakewich-Dunk argue, are "thought to be the result of a lack or loss of control over social events or of anxiety about unpredictable futures". "One way to express an ongoing state of distress" they argue is "by focusing attention on somatic symptoms, and this is particularly true of the powerless" (1990: 257).

11. According to Paxson (2004), an "ethics of choice" and an "ethics of wellbeing" have appeared along the making of modern mothers along with the enduring "ethics of service".

In the context of ART use, women feel they are losing control over their current and future health, over their emotional and physical states, over their reproductive bodies and their reproductive material as they are turned into "reproductive machines". Ultimately they feel they are losing control over a truly informed choice-making process when willfully or unwillingly, consciously or subconsciously, psychologically or somatically, they are made to take the treatment in the context of a much desired personal and conjugal dream, within the context of a rather unclear biomedical reality in terms of risks, choices and responsibilities.

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PART IV

Transnational Repromobilities

GIULIA ZANINI

Transnational medical reproductive mobilities from, to and across the Euro-Mediterranean: Reflections from the (In)FERCIT project

1. Introduction

The project *(*In)FERCIT, *Infertile Citizens: Anthropological and Legal Challenges of Assisted Reproduction Technologies*,[1] run by the Laboratory of Family and Kinship Studies, in the Department of Social Anthropology and History at the University of the Aegean, aims at exploring the understandings and practices of assisted reproduction both in anthropological and legal terms in different countries. This paper presents the possibilities of comparison that have emerged in the framework of this research project and gives some examples of how comparative work may produce a fruitful understanding of the phenomenon of ART and their multiple dimensions. This paper draws on the reports that have resulted from this comparative investigation.

The comparative work has developed within two complementary axes. Firstly, attention was given to the literature review concerning the social, cultural, moral and practical factors in the public and private domains, informing the introduction of ART in Greece and in six different neighbouring countries: Bulgaria, Cyprus (including both the Republic of Cyprus and Northern Cyprus), Italy, Lebanon, Spain and Turkey. In the meantime, efforts have been made to search and underline the transnational connections that emerged in the literature from,

1. (In)FERCIT is a three-year research program funded by the European Social Fund and the General Secretariat of Research and Technology, Greece, and conducted by the Lab of Family and Kinship Studies (see www.in-fercit.gr/en).

to, and across these localities. This second axe explores the anthropological and sociological literature regarding ART in these countries and tries to map the reproductive trajectories of patients, practitioners, gametes, embryos, machines, ideas, expertise and knowledge that travel from, to, across and between these countries at official and unofficial level.

While being aware of the multiple risks embedded into open comparative transnational endeavours and of the large debate that comparison has provoked in the history of anthropology (Gingric and Fox 2002), we should acknowledge that some extremely interesting and successful attempt to compare different contexts of ART development has been made. Furthermore we still believe that on the one hand, more work in this direction is needed to understand the ways in which biotechnologies are being exchanged, and on the other, we should look into the ways in which human reproduction and kinship formation are being differently affected and affect the development and use of biotechnologies.

The fundamental idea behind this project resulted from the existence of a growing literature on ART and from the increasing number of scholars engaged in the study of ART-related topics as to build a detailed and informed map of when and how ART emerge in different localities. A growing interest for translocal networks and connections is also present within different disciplines, including anthropology. Within the (In)FERCIT project, we have tried to put this material together and to see whether or how it is possible to make different studies interact with each other and to evaluate whether such a dialogue may result in the emergence of data and observations that were hidden in single-case works.

We call this work transnational. The reason why we do so is that the majority of case-studies available on ART are especially constructed on a country-based logic, even in those cases where investigations are eventually concentrated on specific regions of given countries. We are aware of the biases and the shortcomings that exist in adopting this logic when referring to practices that are both locally embedded and globally interconnected and have tried to make explicit geographical and geopolitical entanglements emerging in the literature.

Furthermore, we have observed that the existing literature on reproductive mobilities is also often shaped on a transnational level, taking countries or the countries of origin as units of analysis. Given the material we had in our hands, we also mainly followed this trend. But we have noticed that, when speaking about "transnational mobilities" it is not rare to encounter specific reference to trajectories which do not have countries as departure or destination points but rather particular places, such as the so-called reproductive hubs, and situations

which are not necessarily directly dependent on the country-system, including socio-economic characteristics of specific populations (see i.e. Inhorn 2011).

Altogether, we have acknowledged that the dominant perspective within the existing literature remains country-based and so in most of our study we have chosen to work within this framework. In doing so, though, we have tried not to solely follow such country-based approach, but rather to use it in order to explore within the literature ethnographic data which bring forth other focuses, both in the analysis of local realities and in the study of interconnections, exchanges and networks. We have analysed the literature with special regard towards indications of regional peculiarities, local samples, specific localised phenomena and we tried to stress when this was the case.

For the purpose of this paper, the first part of the comparative work that has been implemented within the (In)FERCIT project will be left in the background, because there were many important scholars involved in the conference and have written in the conference proceedings about the different local contexts that were involved in the project. Instead, this paper presents some of the topics that our comparative approach has made emerge from the literature in a rather multi-sided way and that have stimulated our idea about a process of mapping that allows to zoom in and out and at the same time see connections and perspectives at different levels.

In particular, this paper firstly discusses the terminology employed by different scholars to refer to different aspects of what, following Stefan Beck's suggestions (2012), we term "reproductive biomedical mobilities". Afterwards it takes egg donor conception as a paradigmatic example of how searching and comparing existing literature that analyses different perspectives of the same practice in different localities within our geographical and theoretical framework, allows an extensive multi-sided mapping of the phenomenon and sheds light to the translocal social and medical entanglements that it involves.

2. Methodology of the comparative enquiry

The present paper has especially drawn on the existing sociological, anthropological and psychological research concerning ART in countries of (In)FERCIT interest (Bulgaria, Cyprus- including the Republic of Cyprus and Northern Cyprus-, Greece, Italy, Lebanon, Spain and Turkey). Our search for different sources, including especially journal articles, edited volumes, monographs and conference papers, has been based on article databases, cross-references and direct contact

with scholars in the fields. In some cases we have referred to legal studies. In the case of The Republic of Cyprus, we had mainly access to two Cyprus National Bioethics Committee (CNBC)'s official opinion documents about ART and related matters and to the oral presentation by Thodoros Trokanas on the topic of the new Act on ART approved by the Cypriot Parliament at the end of May 2015.

The languages we could use to search and analyse the literature are English, Italian, Spanish, French and Greek.

We have made evident the kind of methodology and sample that every author has used in each study and have asked ourselves questions about how the author made the data relate to a "country" and how he or she drew on and/or created relations with other ethnographies about the same and other localities. To this aim we have acknowledged, for every document we analysed, the sample involved, the literature the author referred to, the historical data provided in the texts, the data about internal mobility within each country and inter-regional mobilities, the attention paid to different populations within each country, and the different kind of approaches to the study of ART (including laws, moralities, religions, public debates, patients' experiences of infertility, patients' experiences of medicalised conception, biopolitics of reproduction, formation and experiences of medical professionals, gametes and embryo management and circulation, biosocialities, kinship practices and gender).

The amount of material we managed to gather is not equal for all countries. In particular, research carried out in some countries (Greece, Italy, Lebanon, Spain, Turkey) is more abundant and more accessible than studies about other countries (Northern Cyprus, Republic of Cyprus, Bulgaria).

The relevant literature we referred to for this work mainly includes anthropological, sociological and psychological works. The ethnographic accounts and sociological studies available for the different countries not always overlapped in terms of focus. While in some contexts, infertile and ART patients have been directly addressed and thoroughly explored (Bulgaria, Greece, Italy, Spain, Lebanon, Turkey), in others, the patients' experiences were mainly reported by practitioners or they were only little or never addressed (Northern Cyprus, Republic of Cyprus). Religion, an important topic of research, although it emerges in the studies of some countries (Lebanon, Italy, Greece, Turkey and Bulgaria), it has almost never been addressed in the context of Spain and the Republic of Cyprus.

Necessarily, our work did not aspire to exhaustively look into the topic, but rather to grasp the multiple ways in which ART have been explored in relation

to different countries and how the existent literature has found reproductive networks crossing these countries in different ways.

3. The European and Mediterranean framework.

The project has arisen from the intention to combine theoretically and ethnographically a European and a Mediterranean focus. Much has been said about an emerging "Euro-American" approach to ART (Bonaccorso 2009, Edwards 2009, Edwards and Salazar 2009, Strathern 1992), about the epistemological value and limits of such a concept in a shared definition of understanding and practicing ART, and about how the use of such a theoretical tool makes room for local peculiarities. Drawing on such an elaborated debate, the (In)FERCIT project aims at going beyond this analytical focus by enlarging the comparative scope through the introduction of a European and Mediterranean perspective.

Some clarifications of how we intend to employ a European and Mediterranean perspective are necessary. In particular, we are aware that the use of the term Mediterranean to define the kind of approach the comparative project has embraced may sound misleading or even naive, if not inappropriate both for its epistemological value in general and for our specific case in particular.

We do not approach the Mediterranean as a cultural area, but rather as a region where diverse configurations of differences, similarities and interconnections emerge with a particular intensity and modulation. We are not interested in the evidence of presence or absence of given characteristics bur rather on the variability that emerges in different and contiguous localities and on the interconnections and tensions from, to, across and between them. We agree with Dionigi Albera that taking this approach means to consider that "differences overlap with similarities", that these similarities can be "overall similarities" or "similarities of details" (Albera 2006)

As said, we tried to avoid a strict and misleading direct superposition between place and culture and we agree to consider the Mediterranean as a "fluid space, inside which one can adopt many levels of comparison. It is a flexible space, of variable geometry, that can open onto other spaces and allow for other triangulations" (Albera 2006: 124). From this perspective, our reference to the Mediterranean is not to circumscribe a definite area nor to rehabilitate a cultural notion that has been used and then harshly and rightly criticized in the past (Albera 2006, Bromberger 2006), but rather to draw an open framework where to explore and construct a space of differences, similarities, interconnections and tensions.

The use of a Euro-Mediterranean perspective allows us to mobilise the notion of Mediterranean as an open concept and as a tool that encourages comparative research. We propose to explore how this notion may be fruitfully employed for a better development of our understanding of ART within and beyond the European context.

4. Beyond care and/or tourism: a terminology debate

The question of terminology regarding mobilities which take place in the context of ART is crucial within the examined literature.

The expression "cross-border reproductive care" (CBRC), proposed by Guido Pennings (2002) and supported by the European Society of Human Reproduction and Embryology (ESHRE) has gained momentum as it allows a more inclusive and precise definition of the kind of movement that reproductive travels entail (across borders) and especially highlights the dimension of care that characterise the travellers' expectations and demands. The use of the term "care" remains contested as it does not only risk downplaying the economic dimension of the reproductive industry, but obscures the power-relations that the medicalization of reproduction can entail and the cases of mistreatment that transnational reproduction may involve.

The literature that we analysed made reference to the value of the notion of care in the context of CBRC in different ways. The understanding that people have of "reproductive care" may involve the very fact of being informed about transnational reproductive options and referred to known and reliable clinics abroad (Gürtin 2013, Zanini 2013a). Moreover, medical assistance is not the only "care" people may look for when they come to fertility clinics abroad. Some reproductive travellers especially appreciate when clinics provide them with assistants who manage their relationship with the clinics from abroad, check the exam results they send over by fax, help them organise their trip to the clinic, welcome them when they arrive, introduce them to practitioners, translate the consultations in case they are required to do so, follow them when they are back at home and act as their first contact every time they need anything from the clinic. These assistants are so much present in the reproductive experience of transnational patients that, while some think they make their experience more comfortable and less frightening, others find that this person confuses their reproductive process by putting one more obstacle between themselves and the practitioners who follow their case (Zanini 2013).

The feeling of "unfamiliarity" is very much connected with the feeling of "care" that people experience during treatments. Despite the guidelines of good practice that are being implemented at transnational level, the patients' experiences of CBRC seem to be characterised by the strong feeling that being treated "at home" would be the best option given that the combination between mobility and "unfamiliarity" of foreign context amplifies stress (Hudson et al. 2011).

In some cases, travels are guided by the hope to find both care and familiarity. Marcia Inhorn (2011) reports how Middle-Eastern men were preoccupied with their wives undergoing assisted reproduction in a comfortable context where they would preferably be practically and emotionally supported by their closed relatives, especially the wives' mothers. According to Inhorn, many diasporic Middle-Eastern couples believe they have more chances of success if they undergo assisted reproductive treatments in their home countries, as they may experience "more 'relaxed', more 'familiar' and more 'comforting' " (Inhorn 2011: 589) treatment conditions.

Inhorn calls this phenomenon "return reproductive tourism" and observes that this is not so much related to the motives for CBRC listed in the emerging literature that includes mainly local restrictions, waiting lists and affordability of treatments, as it is connected to "a number of cultural, moral and psychological 'pull' factors" (Inhorn 2011: 587), which the author places under the following headings: "medical expatriotisme", "language of medicine", "co-religion and moral trustworthiness", "donor phenotype", "comforts of home". On top of that, Inhorn illustrates how return reproductive travellers may have experienced discrimination in their host countries, including misinformation about possible treatments *in loco.*

Before Inhorn reintroduced the term tourism to define the specific phenomenon of "return reproductive tourism", where people come back to their home countries to visit their families and friends and to undergo reproductive treatments, the expressions "reproductive tourism" –"procreative tourism" and "fertility tourism"– had been discussed and criticized as erroneously implying pleasant travels rather than focusing on the primary medical goals of these travels (Ferraretti et al. 2010). Moreover, these terms have been strongly criticised by travellers themselves as they felt they misrepresented their experiences (Inhorn and Patrizio 2009).

Although much attention has been paid to reproductive travellers, the phenomenon of CBRC does not only show the movement of patients, it also implies a more complex movement of health professionals, knowledge, technologies, phar-

maceuticals and money. The following part of the paper will give an insight into the literature that investigates reproductive biomedical mobilities, including but not limiting our interest in the movements of ART patients.

The multiplicity of connections that emerge in the literature concerning ART transnational networks calls for a more comprehensive and flexible terminology than CBRC, which is mainly used in the literature to address the patients' border crossing. The urgency to move away from a perspective that mainly considers the patients' movement as one which includes different kinds of mobilities in different directions, we would rather follow Stefan Beck's suggestion to look at "biomedical mobilities", meaning " 'civil' as well as 'scientific' practices in the medical domain that form relations beyond the boundaries of states, societies or institutions by moving people, knowledge, ideas as well as biomedical 'things' " (Beck 2012: 357). By using this term, Beck wants to focus on the "heterogeneity of elements set in motion" (ibid.: 358) and to explore how reproductive medicine and infertility industry makes room for "new types of mobilities and new transnational practices that are in conflict with established regimes of governing territory and a population demarcated by well defined national borders" (ibid.).

Following this perspective, we have tried to make room for different kind of networks and mobilities in the field of translocal reproductive practices which have been either openly addressed and analysed or only mentioned or speculated in the works we have reviewed.

5. Intersecting mobilities: Egg donor conception

One of the possible ways to develop an understanding of ART as it is found on existing research and to extend this knowledge, is to combine the emergence of very localised phenomena with a non-exhaustive but more complex and broader picture of ART diffusion and implications. In this session, we propose to explore the intersections between gamete circulation and people circulation from different perspectives, at different levels and how a thorough examination of a given locality can allow us to compose a broader picture of ART realities**.** Egg donor conception is a paradigmatic case of how different perspectives assumed in the literature may shed light on the different dimensions of a multifaceted phenomenon.

Mobile donor eggs recipients

The most investigated case of mobility within donor conception is that of CBRC, meaning intended-parents who travel across regions or borders to re-

ceive egg donation treatments in a given place. Works by Shenfield et al. (2010), Bergmann (2011a, 2011b, 2012), Gürtin (2012, 2013), Inhorn (2006a, 2006b, 2006c, 2012), Whittaker and Speier (2010) and Zanini (2011, 2013a, 2013b), have focused on such cases within and across different localities. Nowadays, we have gained quite an insight concerning the motivation behind travelling for egg donation, which is especially connected to local legal prohibitions, state or personal religious prohibitions, the existence of local waiting lists or the costs involved. Practicalities have also been explored by the same authors, who have made explicit the difficulties, challenges and distresses of translocal medical treatments.

At the same time, the same travels have been strongly criticized for the pressure international patients put on private clinics to perform successful donor conception treatments. Feminist groups in Great Britain and Germany have pointed out the risks that egg donors may run as a consequence of heavy hormonal stimulation (Bergmann 2011a: 284).

Mobile egg donors

Although the literature focuses in particular on intended parents on the move towards egg donor conception (Bergmann 2011a, 2011b, Hudson et al. 2011, Whittaker and Speier 2010, Zanini 2011, 2013a, 2013b), some scholars have reported the cases of women crossing borders to donate their eggs (Inhorn 2012), such as North American girls offering their eggs to Lebanese clinics.

The fertility clinic that Gürtin conducted her research in Northern Cyprus advertises to mainly recruit Turkish egg donors to match with Turkish couples and that this is not a difficult task to do, because there is not any lack of women offering to serve as donors. The nurse interviewed by Gürtin explains that this clinic prefers donors who clearly specify the reason for their donation to be purely economic more than those who mention "altruistic" reasons, because they fear that the second group might have problems in dealing with the feeling of the existence of donor-conceived babies born out of their acts. Turkish egg donors are said to be usually "prepared" for donation in Turkey and to only travel to Northern Cyprus for egg pick-ups.

Mobile people entering egg donor conception

Fertility centres use different means to advertise egg donation to potential donors locally and internationally (Bergmann 2011a, 2012). In Spain, these seem to attract especially students and Latin American and Eastern European migrants

(Bergmann 2011a), who meet phenotypical requests by clinics which are obliged by law to match the phenotypes of donors and recipients.

This particular case illustrates new ways in which the transnational trajectories of people may start much before their engagement into ART and still be considered crucial for the donation industry. On the other hand, the donation industry has become one of the sectors where female migrants may resort to in their effort to increase their income. A further exploration of how this occurs, what kind of expectations and understandings these donors have about their donation and how the recipients relate to donors, whose origin is different from the country where they undergo donation, should be carried out in order to inscribe donor conception and reproductive mobility into a wider analysis of global mobilities and new labour sectors.

Social inequalities and economic structures

Many people perceive the transnational travels of recipients as part of an international exploitative business, based on the transnational movements of wealthy intended parents towards poorer countries (see for instance Gupta 2006, Smith-Cavros 2009), where poor women are involved in egg retrievals in exchange for money that they couldn't make with another job (Gupta 2012, Nahman 2008, 2012a,b). Certainly, global inequalities are inscribed in the international map of gamete production and circulation, they affect the international economy of donor conception and surrogacy and the individual trajectories of transnational reproductive travellers.

Agentive role of egg donors

As Bergmann argues, referring to local egg donors as victims of such an international reproductive industry may overlook the agentive role of donors and fail to carefully represent the reality of egg donation. Bestard and Orobitg (2009) observe that money is not sufficient to make women engage in egg donation. Altruistic reasons and a process of desubstantialisation and re-substantialisation[2] facilitate egg donors' acts.

Non-transportability of eggs

Such a picture misses the fact that eggs cannot be transported so easily as sperm and that different "economic structures" support egg and sperm collection and

2. This process consists of depriving donated eggs from their original meaning as kinship-carriers (desubstatialisation) and in re-conceptualising them as substances which allow kinship to take place (resubstantialisation).

manipulation (Bergmann 2011a). Egg donor procedures require a special coordination of spatial and temporal commitments by donors, recipients and practitioners. Although some steps may be taken by actors living at a distance and coordinated through e-mail, telephone and fax, the process of egg retrieval, egg fertilization and embryo transfer require the presence of donors and recipients at the same clinical site and the availability of laboratories and practitioners. Such practicalities of egg donation make the transportability of non fertilized eggs more complicated than that of sperm. If gametes are difficult to trade, reproductive biocapitals may encounter transnational demand through the cross border movement of all involved actors.

Transportability of eggs

On the other hand**,** we know from existing literature that Israeli practitioners travel to Romania in order to collect eggs from local Jewish women and bring them back to Israel after having fertilized them with Jewish sperm (Nahman 2011).

Furthermore, the new Italian legal framework has been allowing donor conception since April 2014. Although the majority of people who want to undertake donor conception still seem to prefer centres abroad, the local request for donor eggs is increasing in the fertility centres in Italy, where egg donation programmes have not yet been put into practice. While many centres are planning to be ready in order to be able to recruit donors and treat eggs locally, they are awaiting for official guidelines from the government setting the framework within which they can organize recruitment and circulation of gametes; there are centres though already offering this service that have started to buy and import eggs from banks and centres abroad. This practice has not been investigated yet. But it shows how a special legal and socio-cultural framework leads to less explored and less expected practices such as the transnational market and transport of donor eggs.

6. Multiple actors on the move

The existing research illustrates that Italian patients were not the only Italian citizens involved in the transnational networks of CBRC. Many Italian patients, in fact, report to have been directed abroad by their local practitioners who often offered informal recommendations about foreign fertility clinics. Moreover, Italian fertility experts have started to be especially appreciated in foreign clinics and some decided to try their fortune abroad than work under very restrictive regulations in Italy (Zanini 2013a). In some cases, then, Italian practitioners decided to

organize their medical practice transnationally, either by meeting patients in Italy and treat them in private clinics abroad, or by establishing cooperations with foreign clinics in order to send their Italian patients to them after their patients had undergone their physical or psychological preparations for treatments in Italy. In other cases, Italian clinics have established special agreements and cooperations with other clinics abroad in order to ensure a more stable control and follow-up of local patients (Zanini 2013a).

Similarly, the transnational entanglements of ART within the Turkish context are not limited to the reproductive travels of patients who seek donor conception treatments outside national borders with or without the support of local practitioners.

A transnational movement of expertise and competences has been present since the beginning of the Turkish ART, when IVF practitioners trained in Germany made the birth of the first IVF baby possible in Turkey (Gürtin 2013, Beck 2012). Stephan Beck traces the experience of Erol and Ege Tavmergen, two siblings who travelled to Germany to be trained in gynaecology and returned to Izmir in the mid 1980s to start a pioneer programme of infertility treatments. To this end, they transported test animals, lab equipment and chemical substances and counted on their transnational professional relationships to access necessary materials which were not available in Turkey (Beck 2012). In doing so, they managed to develop high-quality treatments and intercepted patients who had previous experience of crossing borders from seeking treatments abroad. Their immediate success attracted the support of local patients and private sponsors, whose financial aid was determining in making the clinic an important national reference site of reproductive medicine.

The effort made by the two gynaecologists to economically secure their practice was in accord with Erol Tvemergen's strong engagement in the national association of reproductive medicine, contributing to the creation of a favourable political framework for the improvement of ART in the Turkish context.

Reproductive biomedical mobilities include the emergence of transnational "universal, naturalized bodies" (Beck 2012: 372) through the special configuration of transnational collaboration between clinics and/or the expansion of North American and European hospitals and fertility centres. Stefan Beck reports one paradigmatic case (2012) of a Turkish fertility centre which constantly cooperates with another clinic in Baltimore (USA). The existent link involves the use of the same standard protocols, substances and materials in the USA and in Turkey, allowing the collection of comparable data and making room for the telematic

exchange of experiences between transnationally-based practitioners. This approach does not take into account local understandings and practicalities, and it especially makes the North American patient the paradigmatic character on which procedures are imagined, studied and developed (Beck 2012).

Turkish ART practices, and both Turkish and other patients treated in Turkey, concur to the creation of a standard global patient, who although it is initially shaped on the basis of the USA patient, it later evolves into a virtual translocal being, whose characteristics and treatment results will affect not only patients in the two locations but also in many other countries.

The Republic of Cyprus is also involved in transnational reproductive biomedical mobilities at different levels. Stefan Beck explores the transnational trajectory of a Cypriot patient organization gathering together Thalassemia sufferers and playing as "one of the key actors in implementing the most successful prevention program against a genetically caused disease world-wide" (Beck 2012: 369). The campaign that the organization promoted, including an early diagnosis of carriers and a recommendation not to marry other carriers, spread internationally and so created the first Cypriot migrants and then other patients around the world to ask for screenings and prenatal diagnoses. The organisation has had as its goal to diffuse their campaign into developing countries where the genetic condition is of particular public interest, given the high number of people who are potentially carriers of the disease. While being engaged in "cheap, effective *social intervention*" through educational programmes which advise that carriers do not marry to avoid risk of conceiving diseased babies, the organisation lobbies for IVF-treatments and PGD to be offered in these countries. Altogether, the organisation has played as a local and global actor, "cooperating with grass-roots initiatives as well as with global agencies like WHO to create new preventive regimes in the field of reproductive practices" (Beck 2012: 370).

7. Conclusion

Being very perceptive and detailed in their methodologies and scopes, the existing works let us understand that they only cover a small portion of the biomedical mobilities which characterise the reproscape (Inhorn and Shrivastav 2010) involving the area of research covered by the (In)FERCIT project. If we consider the dimension of the phenomenon of CBRC, we can only count on an estimation of the number of people seeking assistance transnationally which has been elaborated in 2010 (Shenfield et al. 2010) and which does not include some of the countries covered by

this project. Moreover, the practicalities and challenges of CBRC for both foreign and local people in these areas have been only partially investigated. We know more about the movements of people seeking reproductive assistance translocally and transnationally than about other actors and entities, whose mobilities, as we have seen, are necessary for the very implementation of ART in any location and their development as "global form" (Knecht et al. 2012). Further investigation is certainly required to unpack the trajectories that practitioners, machines, gametes, money and knowledge follow in order to make the fertility industry active in very different localities. A European and Mediterranean framework of research allows for acquiring a wider picture/ oversight across and beyond the Mediterranean.

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POLINA VLASENKO

Desirable bodies/precarious laborers: Ukrainian egg donors in context of transnational fertility

1. Introduction

Ukraine, one of the few countries in Europe that endorses the commodification of donor egg cells, has become a popular destination for "reproductive tourism" or "reproductive exile", "defined as the search for assisted reproductive technologies (ART) and human gametes (eggs, sperm, embryos) across national and international borders" (Inhorn 2011: 87). Its inclusion in the global bioeconomy generates transnational traffic in oocytes and medical migrants. This uneven use of reproductive technologies across borders often leads to the precarization of the clinical labor of Ukrainian egg sellers along the lines of class, gender and race. Thus, in this paper I explore how the ideas about race, gender and class intersect in transnational reproductive migration and commercial ova donation to determine the labor of Ukrainian egg donors as precarious.

For this purpose I have to answer two questions: 1) How the ideal egg donors are constructed along the lines of race, gender and class in the discourses of donor recruitment agencies and infertility clinics, as well as donors' and agents' ads in the social media. 2) How, on the other hand, the persistent non-recognition of egg donors as full-fledged subjects conforming to the ideals of normative motherhood and womanhood renders their re/productive labor precarious.

My paper has the following structure. First, I give an overview of the political and economic context in which my research is situated. Secondly, I review the relevant scholarly literature on the production of donors' desirability along the lines of class, gender and race in the context of commercial ova-donation and transna-

tional reproductive migration. Thirdly, I apply discourse-analysis to the websites of Ukrainian private infertility clinics and donor recruitment agencies, as well as to the advertisements of egg donors and agents on the social media websites, to explore the construction of egg donors in donor recruitment procedures. Fourthly, I develop the theoretical framework for understanding of ova donation as labor. Lastly, I use the method of case study to present one interview conducted with an egg donor in Ukraine and so reveal how re/productive labor of ova donation is rendered precarious in Ukraine. In conclusion I assess the importance of the findings for my future research.

2. Context

International travel of infertile couples seeking ART services is determined in many ways by the differences of national state-policies on the matter (Storrow 2006: 299). In some EU countries, like Italy, Germany, Austria, Norway, egg donation is illegal. In a lot of other countries it is legal only if gratuitous, since most countries in Europe prohibit the sale of body parts. Twenty-seven out of the twenty-nine countries included in the 2nd report of the European Commission on Voluntary and Unpaid Donation of Tissues and Cells have some legislation or guidelines aimed at ensuring voluntary and unpaid donations of tissues and cells in accordance with Article 12 of Directive 2004/23/EC (European Commission 2011). Therefore, even if egg donors receive compensation, it is "strictly limited to making good the expenses and inconveniences related to the donation", rather than aiming at paying for the eggs (European Commission 2011). Fourteen countries in Europe give some form of compensation to donors for the donation of reproductive cells (both eggs and sperm), with ten countries providing reimbursement of travel costs and only 5 countries providing reimbursement of medical costs and compensation linked to loss of earnings (European Commission 2011). While there is an escalation in demand for oocytes in Europe due to the high levels of female infertility[1] and the growing number of couples postponing parenthood to later in life,[2] nine countries report regular shortage of oocytes (European Commission 2011).

Despite the fact that in Ukraine it is illegal to buy and sell organs and other human anatomical material, this law does not apply to transplantation of gonads, re-

1. The prevalence of primary female infertility in Central/Eastern Europe and Central Asia has grown from 1.8 % in 1990 to 2.3% in 2010. (Mascarenhas et al. 2012)

2. The mean age of mothers at first birth in Northern, Central and Southern Europe around 2003 was between 27 and 30 years old, in Eastern Europe - between 22 and 26 years old. (Botev 2006)

productive cells and embryos, as a result egg donation in Ukraine is legal and commercial (as well as gestational surrogacy) (Verkhovna Rada 1999). Thus, it is legal to sign a contract of sale between a female egg donor and a specialized medical facility, as well as between a specialized medical facility and an egg recipient. However, due to the requirement to ensure the anonymity of the donor, the unmediated contract between the egg donor and the egg recipient is not legal. Moreover, at the request of the patient her biological material can be transported to another healthcare facility both in Ukraine and abroad, while the donor herself can also travel**.**

Furthermore, the regulations that determine the personal characteristics of those entitled to fertility treatments in most of the EU countries include age limits, social criteria (sexual orientation or civil status) and medical diagnosis requirements. In Ukraine ART are largely unregulated with very few actual restrictions and the only criterion for a demand for ART is the diagnosed female and/or male infertility (MOH 2013). The legislation determines that "an adult woman and/or man have the right to carry out assisted reproduction treatment programs for medical reasons" (MOH 2013). Therefore, treatment seekers are not legally required to be below certain age, heterosexual, married or in a relationship. However, this doesn't apply if treatment involves surrogacy, since in this case it is permitted only to married heterosexual couples (Verkhovna Rada 2002). This situation makes Ukraine especially attractive for infertile couples to whom infertility services in their home countries may be unavailable due to different reasons.

Since in Ukraine egg donors receive payment for their eggs, many Ukrainian women are willing to donate. Thus, the supply of eggs in Ukraine is much larger than in other European countries. This is conditioned by the fact that Ukraine has large impoverished population of women, for whom ova donation becomes an option to earn "easy money". In Ukraine 18,2% of households with children have per capita equivalent money income below the subsistence level (1,113 hryvnia or 70 US dollars) and 69,6% below the average level per capita equivalent money income (1,920 hryvnia or 120 US dollars), (State Statistics Service of Ukraine 2014). A lot of these households are headed by single mothers. Their biological availability contributes to the country's transformation into a popular market for infertile couples mostly from Western Europe who seek conception.

3. Egg donors and their desirable bodies

Debora Spar (2006) argues that there is an increasing tendency to organize reproductive experience according to the rules of the market and points out that

"a global market in baby-making" emerging because of the commodification of gametes and embryos for the most part remains legally unregulated. Precarization of labor of Ukrainian egg donors can be understood only in relation to this broader framework of global bioeconomy shaped by gender, class and race inequalities. It engenders the transfer of medical technologies and the outsourcing of many reproductive tasks to Ukraine. It also transforms Ukraine into one of the emerging colonial markets and connects wealthy infertile couples mainly from Western Europe with impoverished Ukrainian egg donors.

There are a number of great ethnographies that track the local manifestations of the global dynamics of race, class and gender inequalities in other European countries, in particular Spain and Denmark. Based on the interviews with Danish women and couples who go to Spain for IVF treatment involving egg donation, Charlotte Kroløkke examines how they naturalize and idealize Spanish donors along the lines of gender, race and nationality as fertile, gift-giving and Western, in order to construct a "desirable procreation story as well as new collective bodies –loveable, northern, and white European children" (2014: 69). She does this by providing an analysis of "the ways that desire, hope, gifting, and imagination flow to form particular affective assemblages on trans-European oocyte donation", where the concept of assemblage stands for "complex, unstable, partial, and situated elements that come together to form something else" (Kroløkke 2014: 58-59).

The point of interest for me was that Kroløkke reports that Danish women often construct Spanish donors as empowered, white, civilized, having a desirable mentality, and shared culture and history in opposition to Russian and Eastern European donors, thus forming "the imaginary boundaries between East and West" (2014: 69). While at the same time Spanish clinics that have a predominantly white clientele still recruit Eastern European immigrant women as egg donors in order to secure the reproduction of whiteness. Moreover, the evidence of the demand for the Eastern European egg cells in Western Europe can also be found in the fact that couples from Western Europe are becoming an increasingly significant segment of consumer-patients in infertility clinics in Ukraine, whose competitive advantage seems to be well trained medical personnel and high quality service.

Another example that can also shed some light on the processes in Ukraine is the relations between Israel and Romania in the context of transnational ova donation. Michal Nahman has widely elaborated on the racial and nationalist frames of the medical travel of Israeli infertile couples to Romania, as well as Romanian donors to Israel, and the reverse traffic in egg cells between the

two countries. As a result, she contributed to the critique of the dominant ideas of national belonging in Israel by discussing how the borders of Israeli nation become "materialized" through discourses, images and practices involved in "exchanges and extractions" of human eggs (Nahman 2006: 200). Based on her research into two Israeli IVF clinics and one clinic in Romania, Nahman analyzed how scientific and national discourses work together to implement "technologies of racism", that produce racialized ideals of national bodies, in particular through selection of donors. Her main questions are: what is allowed to pass into and what is kept out of the imagined "Israeli body"? What kinds of mixtures are desirable?

Moreover, Nahman (2011) argues that the "reverse traffic" in egg cells increases rather than reduces the inequalities between women situated in different locations by making them invisible to one another, prioritizing the well being of recipients of tissues/embryos/eggs over the wellbeing of oocyte sellers and letting the market entirely determine their relations. By reverse traffic she means the change in the direction of travel of people and biological materials, which supposes that instead of donors and patients travelling across borders for egg donation and embryo implantation, the journeys are accomplished by doctors who bring either cryopreserved ova, spermatozoa, or zygotes (fertilized ova) from one location to another.

Nahman (2008) also asks what the feminist response to reproductive technologies should be and what kinds of feminist coalitions can exist in the field of transnational ova donation. She approaches these questions from the perspective of Romanian female egg sellers, whose subjects are formed according to race and gender expectations as desirable to Israelis. Based on their experience she argues against the reduction by some feminist organizations of egg sellers to the victims of exploitation. In her opinion, this erodes their personhood as participants of the neoliberal economy guided by their profit. Moreover, she makes an important claim that the position of ova donors in relation to the state and global economy depends on their specific social, political and cultural context. For example, in Romania, which still faces the heritage of restrictive reproductive policies during Ceausescu's rule, women's desire to participate in commercial ova donation can be seen as "an act of resistance against a repressive past" (Nahman 2008: 69). It is crucial then to take into account the experience of egg sellers in Ukraine as situated within certain economic, social and cultural context, and be sensitive to all different ways in which they exercise their agency in negotiating ova donation arrangements.

4. The construction of egg donors in donor recruitment procedures in Ukraine

The joint work of government and medical professionals in constructing the ideal citizen meant to enter the body of the nation through regulation of ova donation in Ukraine is something that can be very fascinating to study in the future. However, in this part of the paper I am going to explore how egg donors from Ukraine are constructed in the discourses of infertility clinics and recruitment agencies as bearers of whiteness (both in terms of producing white children and belonging to "white culture"), femininity and hypersexuality in relation to the predominantly European recipients. I examine how only "white (Slavic/European), beautiful, healthy and feminine" bodies are considered desirable to both fellow citizens as representative of the Ukrainian national body and to European women as being worthy of fulfilling their outsourced reproductive tasks.

In Ukraine ova donation can be performed under the condition of a written informed voluntary consent of the patients, preservation of anonymity of the donor and medical confidentiality. The required documents are a written application of the patient for the use of the donor eggs and an informed voluntary consent of the egg donor. Clinics that usually work with international recipients are "Nadiya", "BioTextCom", "Kyiv Institute for Reproductive Genetics", "Intersono", "Adonis", "Mother and Child", "ISIDA", "Institute of Reproductive Medicine", "Remedi", "ART Clinic", "Implant" "Medical Centre of Infertility Treatment" and others. There are a number of egg donor agencies that work as mediators between the infertile couples, donors and clinics; in particular: "Successful Parents Agency", "Assisted Motherhood International Agency", "Center of Donation and Surrogacy in Ukraine", and "New Life Ukraine", who mostly address their clients by referring to the "difficult and painful road" or "heartache and disappointment" that brought the infertile couple to consider the option of ova donation.[3]

Usually the egg donation program offered by the agency to the infertile couple from abroad would include assisting the recipient and donor in signing the contract with the agency and infertility clinic. Then, both intended parents and egg donors have to fill out the forms. The intended parents must fill in a statement-obligation, while the donor provides a written informed consent to participate in donation program and if applicable, a written consent of the husband for her participation. The agency also searches for the egg donor in its database or outside it according to the wishes and phenotype of the recipient, assists in

3. New Life Ukraine. Available at: http://www.newlifeukraine.com/

complex medical investigation of the donor corresponding to all demands of the Ministry of Health of Ukraine, supports stimulation protocol of the donor till the obtaining of eggs.[4]

All agencies advertise Ukraine as a place where legislation is very friendly towards foreigners, since the infertile couple who applies for ART treatment is considered to be the parents of the child born as a result of both surrogacy and ova donation (Verkhovna Rada 2002). They also emphasize that the prices on surrogacy and egg donation are less in Ukraine than in other EU countries and in the US. Another infertility clinic in Lviv advertises its services by claiming that it is situated in a "truly European city" by virtue of its "geographic and mental proximity to Europe, rich cultural traditions and historical heritage".[5] The clinic and agency websites often mention "the availability of young, healthy egg donors and surrogate mothers", who "comply with legal and medical requirements, have at least one child of their own and are in excellent health".[6]

The regulation of ova donation and use of the certain criteria of donor selection draw the boundary between women whose offsprings are desirable and those whose aren't. In Ukraine to be eligible for egg donation a woman must be between 18 and 36 years old, although most of the agencies and clinics require women to be younger than 30. The donor must have one child and satisfactory somatic health, have no negative phenotypical features, no contraindications for participation in oocyte donation, no hereditary diseases and no bad habits (drug addiction, alcoholism, substance abuse) (Ministry of Health of Ukraine 2013). Recipients can be provided with the phenotypical portrait of gamete and embryo donors if he/she demands it (Ministry of Health of Ukraine 2013). Some clinics allow infertile couple to choose a donor according to the medical and personal profiles and photos. Other clinics due to the anonymity of the donor do not allow infertile couples to see the photo of the donor, but only inform them about her height, weight, color of hair and eyes, nationality, education, family and children, blood type and Rh factor.[7]

The infertility clinics advertise their donors by emphasizing that they are physically and mentally healthy and that their eggs are efficient, due to their young age (usually between 20 and 28 years old), without chronic or genetic dis-

4. Assisted Motherhood International Agency. Available at: http://www.surrogacy.in.ua/index.php?option=com_content&view=section&layout=blog&id=3&Itemid=4&lang=en

5. Intersono. Available at: http://www.egg-donation.com.ua/en/16/about-intersono-egg-donation-centre.html

6. New Life Ukraine. Advantages. Available at: http://www.newlifeukraine.com/advantages

7. Nadiya. Available at: http://www.ivf.com.ua/ua/Oocyte_donation.html

eases, and having at least one healthy child.[8] For example, the "Intersono" clinic calls its donors "efficient" or "proven", "checked", meaning that these are women who previously donated eggs that led to the patient's pregnancy. They claim that they "regularly monitor the effectiveness of donors and remove from the base inefficient donors".[9] Contrary to the infertility clinics that focus on medical characteristics, the recruitment agencies also "pay attention to the personal characteristics" of the egg donors and claim that "all ladies possess regular features, good figure" and are "well educated".[10]

There are a number of databases with Ukrainian egg donors created by donor recruitment agencies, where the description of the egg donor usually includes the photo, first name, age, country of origin (Ukraine), height, weight, hair, eyes, face and skin description, complemented by such characteristic: "She is a teacher. She likes reading. She is married. She has 2 children, 2 and 4 years old. She doesn't smoke and drink and has no bad habits whatsoever".[11] On one of the databases you can narrow the search results by indicating not only which color of eyes or hair you want the donor to have, but also whether the donor must be ready to travel abroad from Ukraine in case it is required by the recipient.[12]

Those women who advertise themselves on the social media as potential egg donors usually indicate their age, height, weight, color of eyes and hair, family status and the number of children. They often describe themselves as Slavic or European, which usually implies being fair skinned, beautiful, young, tall, slim, having blonde or brown hair and blue or green eyes. To provide evidence of their appearance they upload photos of themselves, which are often staged to show them attractive and desirable. On these pictures they often wear the clothes that reveal their bodies, such as evening dresses or even swimsuits and pose near or with flowers to emphasize their femininity and sexuality. They also upload pictures of them with their children, or of their children alone, showing that their current children (assuming that their future children too) are beautiful, thus, perfectly fitting into the European collective body. They usually present themselves as responsible mothers who care for their children, while at the same time they are sexy and seductive.

Some of them say that they are healthy, lead a healthy lifestyle, have no bad

8. Successful Parents. Available at: http://www.successful-parents.com/main/packages/ivf/

9. Intersono. Available at: http://intersono.ua/ua/341/centr-donaciji.html

10. Successful Parents. Available at: http://www.successful-parents.com/main/packages/ivf/

11. BioTexCom: Center for human reproduction. Egg donor database. Available at: http://donors.mother-surrogate.info/?eggdonors_start=0

12. European Egg Donors. Available at: http://europeaneggdonors.com/en/database/donors/

habits, have no history of genetic diseases in their family and had no problems during pregnancy and childbirth. In the same way they mention that their children are healthy, smart and develop fast. A lot of them also mention having higher education and knowing several languages. If they previously had an experience of ova donation, they mention their success. Interestingly enough, most of them don't speak about the question of monetary remuneration that they demand for their eggs. Some justify their choice by their desire to help infertile couples.

As a result, the overall qualities that are considered by potential egg donors to be important are whiteness, youth, femininity, sexuality, beauty and health.[13] The agents who look for egg donors require almost the same characteristics. For example, one of such messages in the social media says: "I am looking for a young woman with European/Slavic appearance, healthy, good body balance, without predisposition towards gaining weight, without bad habits. Eyes: blue/grey/green, hair: fair (desirable, but not necessary)".[14]

Through this recruitment process the donors' subjects construction is based on genetic (genotype) and ocular (phenotype) dimensions of female biological bodies in accordance with the imagery of normative motherhood, femininity and belonging to the Slavic/European ethnicity. Moreover, I would suggest that in the future it can be fruitful to look at the discourse of egg recipients to explore how the process of constructing the donor's racial, class, national or even cultural identity, has also its reverse direction with Western couples re-inventing themselves as white, upper-class, civilized and belonging to distinct national culture in the process of their encounter with Ukrainian ova and its donors.

5. Ova donation as productive labor

An account of the construction of the "ideal" egg donors with the bodies desirable to international recipients in terms of race, gender and class is accompanied by the persistent erasure of the labor that these bodies perform and their non-recognition as subjects that comply with the ideals of normative motherhood and womanhood. One of the possible ways to understand how a new market around a controversial technique of ova donation comes to be established and maintained in Ukraine is to recognize ova donation as productive labor. Since it is a productive labor that consists in the mere fact of biological reproduction, it requires the reconceptualization of the productive/reproductive divide.

13. https://vk.com/club60719887
14. https://vk.com/club42128159

One of the representatives of such approach is Donna Dickenson (2007) who argues that the labor women put into ova donation is rendered invisible due to the fact that women's reproductive activities are not recognized in general as labor. This happens since they are naturalized and perceived as unproductive (occupying the domestic sphere and not counted as adding value), while priority is always given to productive labor. Productivity of labor in Marxism is defined through its ability to produce a "surplus", which lies in the fact that human power is not exhausted when it has produced the means of its own reproduction. In the same way, ova donation results in the accumulation of biocapital and production of the surplus of oocytes. In addition, since ova is created as a result of women's intentionality and subjectivity, it has as such its use and exchange value and can be seen as property. Dickenson advocates an entitlement of property rights to women for their ova as a way to empower them, because it can make visible women's efforts and their involved control in producing them, whereas it does not view ova production as just a natural process.

It can be very fruitful to see how the egg sellers in Ukraine negotiate their place in the economy through the lens of this approach. I suggest interpreting their activity as intentional labor, which is aimed at the production of "surplus" in ova, but is rendered precarious due to its non-recognition as labor. I use the definition of the concept of precarity developed by Judith Butler and apply it to the labor of egg donors. Butler argues that any life is vulnerable, since it fully depends on the power structures that are necessary to sustain it. To be supported by power it must be recognized by power. To be recognized by power it must be compliant with the norms that determine what a recognizable life is. However, some lives are treated as not worthy of support and are made precarious in their dependencies because they don't conform to these norms (Butler 2009a: 7). Thus, the precarity is allocated differentially, since while power assists lives of those subjects who do count as subjects, it disregards others, encouraging and augmenting their precariousness. As a result, precarity can be defined as "that politically induced condition in which certain populations suffer from failing social and economic networks of support and become differentially exposed to injury, violence, and death" (Butler 2009a: 25). I use this concept to show how egg sellers are shaped as precarious population. Since they don't fit the norms that govern "the intelligibility of the body in space and time", they become those subjects who are not "recognizable as subjects" and whose labor is not recognizable as labor (Butler 2009b: ixiii).

Another important scholar who discusses how reproductive labor, in the bi-

ological sense of giving birth, enters the realm of market relations and becomes commodified precisely as an economic labor, is Catherine Waldby. Using the example of the EU oocyte market, Waldby shows how contemporary models of reproduction presuppose outsourcing of many reproductive tasks and feeds into a "global reproductive labor market, supported by cheap transnational travel, involving not only multiple bodies but also multiple locations" (2012: 268). Together with Melinda Cooper she discusses surrogacy, tissue donation and clinical trials as forms of transactional service work, or "clinical labour" which exists in the continuum with the other kinds of embodied service labor that proliferate in contemporary post-Fordist economies and explores the transnational geography of the contractual economies that connect infertile couples in North America and Western Europe with surrogates or egg donors from India and Eastern Europe (Waldby and Cooper 2014).

Her research is very relevant to the study of Ukraine, since she argues that the reproductive labor of oocyte sellers in Europe can be understood together with other kinds of feminized labor performed mainly by precarious young women from Eastern Europe who provide "care, nurture, and fertility" to "create and maintain families elsewhere" (Waldby 2012: 294). She concludes that this global economy of reproduction nannies and oocyte donors from Eastern Europe provides "both well-educated care and fair-skinned biological capital" which meets the market demand for whiteness (Waldby 2012: 294).

Waldby also presents a study on the relation of potential donors to the payment for reproductive and research egg donation that was carried out in Australia and involved asking fertility patients, reproductive donors and young, non-patient women about their attitude towards "altruistic, reimbursed, subsidized, compensated and paid" donation (Waldby et al. 2011: 34). Despite the spread of transactional markets in egg donation and commercialization of human tissues, the women in the study saw reproductive donation as an act of generosity to one of their relatives or friends (Waldby et al. 2011). The question of payment for egg donation is crucial in Ukraine as well. However, when combined together, the presence of large, impoverished and precarious population in Ukraine, a scarcity of welfare services provided by the state, and the commercialization of egg donation, have a formative effect on the attitudes of potential donors towards payment for reproductive egg donation, which they mostly undergo in order to earn some means of subsistence.

6. Precarious labor of egg donors in Ukraine

I have conducted the interview with Anna, an egg donor from Kyiv, in the summer 2014. At the time of the interview Anna was 29 years old, unemployed, had two boys (6 and 8 years old) and had recently divorced their father. She donated eggs in 2013 in Moscow to a Russian infertile couple and received 1,000 US dollars for her eggs. She travelled to Moscow three times. The first time she travelled for several days to sign a contract and pass medical tests. During her second trip she spent a month in Moscow to take oral medications and injections, calibrate her menstrual cycle with the recipient's cycle, and undergo transvaginal eggs retrieval. The third time she also went to donate eggs, but the recipient rejected her candidacy, so it was unsuccessful. She also tried several times to become surrogate mother in Moscow, but without success, since every time the couples would change their mind in the last moment.

I use Anna's case to illustrate how the clinical labor of Ukrainian egg sellers becomes precarious along the lines of class and gender. In Ukraine ova donation becomes the last resort for women who have very poor standard of living and can't earn money in any other way. As a rule they are single mothers, who don't have stable employment and are rarely supported by their families. Even if married, they often don't have enough financial resources to provide for their children. They may need money to pay back some loans or rent an apartment. Their precarity as poor and often unemployed single mothers conditions the fact that they have to engage in precarious labor, like ova donation.

> Those people who are in the right place in their life and have a good job are not even going to consider this "bullshit". It's only for women, who have found themselves in some very complicated life situations. Their main reason is financial.

Anna says that she decided to undergo ova donation since it was the only solution for her to earn money, which she desperately needed. Her older son has autism. She found a good treatment program for him, but her husband was against treating the child and didn't agree to give any money to cover the medical expenses. As a result, she needed to earn some money by herself that would allow her to divorce her husband and treat her child. She sold her eggs, since she felt that it was impossible for her to find any other job due to the lack of higher education, working experience and professional skills.

> 10 years I was with my husband sitting at home, not working, and this was his act of violence. I didn't want to sit at home since my younger son was 3 years

> old. I wanted to give him to the kindergarten, like all normal people do, and run to look for a job, far away from this horror. But my husband was against it, he would all the time put a spoke in my wheel.

Ova donation can be considered precarious not only by the virtue of becoming a refuge for precarious populations, but for a number of other reasons. Anna conveys that the attitude in society towards egg donors, as well as towards surrogates, is predominantly negative both among men and women. She discovered it herself by reading articles on the Internet and asking her friends what they think about her job as egg donor and her attempts to become a surrogate mother. Most people she talked to didn't recognize egg donation or surrogacy as labor. Some were condemning the practice since it undermined the genetic connection between parents and children and intervened into the natural process of reproduction. Others thought that the fact of commercialization of eggs (or womb) made treatment immoral and shameful. Women who would sell their eggs or "rent" their womb didn't comply with society's perception of "true" women that should always prioritize the responsible motherhood and connection with children over their "self-interest". No one criticized egg donation from the position of egg donors or surrogates as a terrain of possible exploitation of the labor of their bodies. Instead my interviewee recalls receiving following response from some people: "Oh, my God! How could you? Selling your own child!" which placed all the blame on her for abnegating her female reproductive responsibilities and didn't account for her actual life situation. However, Anna herself was very skeptical about such attitude and thought that ova donation is absolutely "normal":

> I think it is bullshit, which is absolutely not objective. I call it "grandma's underwear"–something that was outlived long time ago. In the time of technocracy, when it is going to be possible soon to clone and robotize people, it is stupid to think in such an ancient way. I think donation and surrogacy are normal processes of one person helping another to give birth.

She also argued that ova donation is a form of labor, which must be adequately rewarded.

> It is normal that the relationship between recipient and donor to be commercial. I see it as labor and each labor must be rewarded. And this is not the easiest labor you can perform to earn money. It also takes away your health and calmness, because you have this storm of hormones inside your body. It is logical for all of it to be paid for, thus to be commercial. I don't think it is immoral, when it is done for money.

Despite the fact that Anna recognized ova donation as labor, she agreed with its negative connotations that suggested that it contains no intellectual or mental work fit for people with dignity and self-respect. Anna saw ova donation as a "temporary extreme measure" that she was left with due to a difficult situation in life, rather than "a permanent source of income" for herself. She associates it with devalued manual re/productive labor and thinks that she has "much more talents, besides just dully giving birth to children all the time" (Anna). She also told me that once she tried to be an agent herself and looked on the social media for women who would have liked to donate eggs or become surrogate mothers. She received a lot of negative responses from women, indicating how stigmatized egg donation is and how is considered as degrading labor.

> There are a lot of people who take care of two and more children and don't have money in our country. Everything is very complicated for them. So I suggested them egg donation as an option to earn money. They answered: "What are you talking about? Do you think I am stupid to earn money in such a way?

Anna says that the main criteria of egg donors selection in the donor recruitment agency and in the infertility clinic were based on appearance, so that the future child could bear some similarities to the parents. As a result, she felt that they saw her "as a mere body" rather than as a "person". This attitude influenced her own relationship to her body as fragmented into parts that become commodified.

> So they picked me just because of my appearance, of course. There were no psychologists talking to me, they just liked how I look. They are all concerned with the body, wondering bodies all around. I encountered all these people who look at you with cold gaze and conscience as only a mere body. Because who are you? If you are so cool as a person, why can't you even earn money in a normal way?

My interviewee partly agrees with the understanding of egg donation as disgraceful labor and starts to perceive herself as "just a mere body" whose eggs, genes and appearance have become a commodity. Her position can provide evidence of her alienation from the product of labor ("surplus" of ova that she produced), as well as from her reproductive/productive labor and from her own self in the process of ova donation. At the same time, my respondent resists the discourse of alienation by claiming that she was emotionally and intellectually invested in the process. For example, when asked what she would change in the egg donation she went through, she said the way the staff in the agency and in the clinic underappreciated her "humaneness" and heartfulness and reduced her to just "bio-robot" and "a source of profit".

> Both doctors and representatives of the agency become very callous in relation to other people's pain, because they see it all the time. They don't care anymore about your feelings and worries. You just perform your work and this is all for them. This work is not a part of your soul or something intimate you share with them. It is just a job you do to receive money. I would change this attitude.

Anna also doesn't approve of systematic ova donation, because it includes precarious medical procedures and treatments that can lead to the donor having health problems. Ova donation is risky and painful. It requires hormone treatment in order to stimulate the ovaries to release multiple eggs and involves the extraction of these eggs in a surgical procedure. Anna didn't have any major complication during and after egg donation. However, due to the hormonal oral medications and injections, one of her legs was swelling and hurting. She also was in a lot of pain after the transvaginal oocyte retrieval, feeling "as if they smashed everything inside" and "picked open" her body. She also complains that the hormones have injured her endometrium.

> I had a very good endometrium. The eggs would implant very easily. I was getting pregnant almost from the Saint Spirit. These hormones inhibit the endometrium, but stimulate the ovaries to collect more eggs. So it is like always: we cure one while crippling another. After the clinic, I felt that my menstruation became scarce. I don't even know whether I can get pregnant now.

Despite the fact that she knew about the risks against the donor's health before undergoing the procedure herself, she became much more conscious about them in the process. During her stay in Moscow she met a lot of people who had had bad health consequences that resulted from donorship.

> It became less blurry. I came to realize how difficult it is, how different situations can happen. I realized all consequences for my own organism. During donorship you can lose one of the fallopian tubes. Something can go wrong and the belly can swallow. They can bring infection inside you. And then they will have to cut everything you have inside: one or even two tubes. And imagine, just because of some 2,000$ you can end up without the possibility to give birth anymore.

Anna recalls that the donor recruitment agency told her about this possibility in the beginning, but not directly, rather superficially.

> They try not to scare the donors. In the beginning they were giving it all in a very pink light.

There were a lot of other moments in the work of the agency and clinic that made Anna feel insecure and precarious. Anna argues that the approach of the doctors and the agency representatives to donor selection was not very careful, since they

didn't follow all the necessary requirements in testing donors. She knew a lot of cases when women who were ill, in particular having sexually transmitted infections, were nevertheless donating eggs. In this case when the doctors during the egg retrieval intervene into the ovaries, they transport the infection deeper into the uterus. Therefore, it is dangerous for the donor. Moreover, not all clinics and agencies check the genes of the donors. Anna argues that her genetic tests "were just a fiction". Only rarely do clinics have a psychologist available to work with the donors. Thus, this procedure of donor recruitment both reveals which bodies are desirable to the recipients and unsettles these grounds by letting in the undesirable bodies for the sake of material benefit on the part of agencies, clinics and donors. She also mentions that if not for commercialization, it would be only people with "ideal" genes who would undergo the procedure.

> Those who want donor eggs, it doesn't really matter what donor they want. It is important what the clinic actually does. Maybe they want the ideal person, with ideal character, ideal genes, ideal everything, but clinics are not very responsible. One of the consequences of commercialization is my own case. In an ideal situation, I'm not supposed to be a donor due to the condition of my child. But the agency wasn't choosing the donors carefully, they needed money. Thus, I was able to conceal it and undergo the procedure also for the sake of money. If there would be no money paid, I wouldn't go. As well as a lot of other girls, who had a disease, or who had ill relatives in their family, cancer or something else that is considered to be related to genetic predisposition.

She also claims that she understood later "that it's all just a big fraud", since she was paid for her eggs 1,000 US dollars, while the agency received from the couple 5,000 US dollars. As a result, Anna is very reluctant to undergo ova donation one more time in the future and plans to work as a surrogate mother instead. It is interesting that one of the reasons why she doesn't consider undergoing ova donation in the future is her own assessment of her genes as "not very ideal".

> But I don't want to be a donor. Firstly, because it harms my body. Secondly, because there is some possibility that my genes, which are not very ideal, are going to result in someone's illness. Thirdly, because it is difficult, painful and not pleasant.

Another question is how the experience of ova-donation allowed Anna to reinforce or undermine the priority of genetic connection, emotional attachment and responsibility for one's genetic offspring over the cultural and social understanding of kinship as expressed by parents caring about the wellbeing of the child who is not necessary genetically related to them. This distinction is nicely illustrated by the opposition between two reproductive decisions: either to buy eggs (in case the sperm

still belongs to the husband), or employ a surrogate mother to carry a couple's genetic material, or adopt a child. This priority of blood relations plays along with the argument that proper mothers cannot give away their genetic children, as surrogates do in case of traditional surrogacy or donors do by providing their eggs and accepting the fact that other people will care for their genetically related offspring, no matter what, even in the case when the lack of material and other resources does not allow to take care of this offspring in the way that will assure its well being.

As a result, donors are rendered precarious for finding utilization of one's reproductive capacities not in the way that is recognized as appropriate for the "normal" mothers. Thus, both surrogates and donors are presented as monster mothers, since they don't care about their genetic children, and have "unnatural" maternal practices that do not comply with the "maternal instincts", which are seen as given by nature. At the other pole of this binary, there is an argument made by a donor herself that she reconsidered the norms of motherhood and that pursuing happiness of children is more important for her than satisfying her "maternal instinct". She claims that people should be able to care not only for their genetic offspring, but for the children not related to them by blood.

> I think it would be much better for infertile couples to adopt children from the orphanage. But people think on a very primitive level, those are my children, and those are not. Very small number of people are ready to love other people's children.

She is skeptical about the idea that a "normal" mother is the one that is going to be with her children despite the presence of social and material conditions in her life that can endanger them. She conveys that it is better to be apart from the children when it is impossible to support them due to a lack of material resources.

> I had a moment in life, when I left husband and my two children living with him for three months. Only recently I have taken one son to live with me for a month and a half. And I understood that I need to give him back, because he feels lonely and suffers without his brother. I can't financially support both of them at the moment. I don't want to make them beg at the railway stations. I think I should not behave as a mere "bitch": these are my children, thus they must be somewhere around me. The most important thing is for the children to be happy.

In the same way she argues that it is better to give away your genetic children in a form of eggs or after gestational or traditional surrogacy, than to make the children you are responsible for suffer from poor material conditions.

> I think it is better to give birth to the child who is half-yours and give it away, than to make your children unhappy. My husband was very strongly against

> it, while my mom supported me. She was telling me: you have to think first about your own children. One of my sons is not completely "ordinary" and it can be cured or corrected to a certain extent, but I had no money to do so. So this is what is really awful –when you bring up your own child and you can't give him what he needs. Other moral issues are not so important. So you need to overcome yourself: your principles, your fears, and go for it. Because there are aims, which are more important.

Anna reclaims the idea of motherhood as constructed socially and dependent on material conditions, rather than as related to the immature nature of "maternal instinct" and genetic connection. At the same time, she reinforces the motherhood mandate for women by claiming that the main reason why she underwent egg donation was in order to take care of her children.

This overall precarity of ova-donation largely plays into the reinforcement of already existing precarity among many poor single mothers by channeling it from the financial realm to the realm of their health, intellect/dignity, and identity as women and mothers. As such, it becomes a fertile place for reproduction of exploitation and stigma. At the same time, for many of those precarious populations it also serves as an opening of the window of opportunity. Anna for example was able to radically change her life after she returned from Moscow with the money she earned from selling her eggs.

> For me it was a lot of money. I was able to treat my child where I wanted. It was acupuncture in a very good clinic in Dnepropetrovsk. And after this the child became really like an ordinary child. Before that he was like an animal. He became cheerful, communicable, loving, having adequate reactions. One time has solved so many problems. The fact that I went and earned this money and that my child underwent treatment was a tremendous breakthrough. It gave me the strength to leave my husband.

Thus the example of Anna illustrates how important it is to take into account different ways in which egg sellers exercise their agency in making use of ova donation as a source of profit and participate in certain local and global economic, social and cultural arrangements, instead of reducing them solely to being the victims of exploitation.

7. Conclusion

In this paper I explored the construction of the "ideal" Ukrainian egg donors through the lens of the ideas about race, gender and class that intersect in transnational ova donation arrangements. I have also examined how the non-recognition

of Ukrainian egg donors as labor and their unfitness in terms of hegemonic social norms about womanhood and motherhood leads to the reinforcement of their precarity in the context of commodification of donor egg cells and uneven use of reproductive technologies across borders.

The scholarly consideration of the politics of ova-donation in Ukraine is important since it reveals gendered, classed and racialized procreative imagery that is formed in the process of the emergence of new reproductive markets in post-Soviet countries. The future examination of the experience of egg sellers in Ukraine through the prism of growing gender, class and race inequalities in health practices, promises to shed some light on the transformations that post-Soviet social and political structures have undergone in the context of the commercialization of health care. Further research in this direction can help to investigate how neoliberalization of Ukraine triggers the production of citizenship grounded in biomedical knowledge about the female reproductive body. Further elaboration on this topic can also have a big social importance, since it can help political officials, egg sellers and infertility service providers to acknowledge the role of the reproductive market in Ukraine in rendering precarious the labor of egg donors, the increasing stratification of reproduction and health inequality for the participating women.

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BURCU MUTLU

The gendered ethics of secrecy and disclosure in transnational sex selection from Turkey to northern Cyprus

1. Introduction

In Vitro Fertilization (IVF) has gone through a normalization process (Thompson 2005) in Turkey, especially since the introduction of state funding for up to 3 IVF cycles in the mid-2000s, which has increased its media popularity and social acceptance, thus expanding the IVF market. A Turkish ban on third-party gamete donation has also contributed to this normalization process, serving as "a safety valve for couples who may face suspicious inquiry" (Demircioğlu-Göknar 2015: 174). Since its very inception in the late 1980s, IVF has been accessible in Sunni Muslim-majority secular Turkey only to married heterosexual couples to create a child using their own gametes on the ideological grounds of preventing a third party from intruding into (hetero-normative) marriage/reproduction and protecting the parental lineage of offsprings; all forms of third-party reproduction are strictly banned, as in other Sunni Muslim countries (Inhorn and Tremayne 2012). One notable exception to this trend is Northern Cyprus, more similar to Shia-dominant Iran and Lebanon where third-party gamete donation is allowed. As a result, increasing numbers[1] of Turkish affluent citizens are travelling abroad-mostly in secrecy- to neighboring Northern Cyprus[2] to access assisted reproduc-

1. It is estimated that 4,000-5,000 couples annually travel from Turkey to the island for reproductive purposes (Urman & Yakin 2010: 730).

2. Cyprus, located in the Mediterranean Sea just south of Turkey, is a politically divided island since 1974 between Greek-Cypriots in the south and Turkish-Cypriots in the north. Northern Cyprus declared its independence as a separate state in 1983, but this independence is rec-

tive procedures, thereby contributing to the emerging tube baby tourism,[3], as it is popularly called in the Turkish and Turkish-Cypriot media.[4]

So as to channel smoothly and profitably the rising demand among Turkish citizens for legally and morally controversial reproductive practices, Turkish IVF clinics or even IVF practitioners themselves are developing complex professional and commercial connections with Northern Cypriot clinics. In 2010, however, the Turkish government forbade its citizens from travelling abroad (especially to Northern Cyprus) for gamete donation, although the Turkish reproductive ban seems to be largely symbolic and unenforceable (Gürtin 2011, Inhorn and Patrizio 2012), as reflected in the mushrooming of the clinics in Northern Cyprus (their number, which now stands at 11, has almost doubled since the ban).

In the last decade, Northern Cypriot clinics are increasingly offering not only gamete/embryo donation but also non-therapeutic sex selection via Preimplantation Genetic Diagnosis (PGD) to Turkish "reproductive tourists" from the mainland. I first realized this emerging phenomenon of transnational sex selection among Turkish citizens when I went to Northern Cyprus for my preliminary research in the summer of 2012. Although sex selection may appear consistent with patriarchal and pro-natalist family ideologies[5] in Turkey, non-therapeutic use of any sex selective technologies has been legally prohibited since the mid-1990s (Ministry of Health 1998, 2010). Notably, however, non-therapeutic sex selection, which Turkish people had been seeking in Northern Cyprus for a decade, was overlooked in the 2010 legislation, while gamete (especially sperm) donation has become in Turkey an increasing focus of biopolitical attention.

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ognized only by Turkey, even though Turkey maintains a military presence on the island, along with ongoing political, bureaucratic and economic influence. Since then, Northern Cyprus has gradually emerged as Turkey's ethical grey zone, an offshore site where legally and ethically problematic practices take place, including not only third party reproduction but also "gambling tourism" (which has emerged since the mid-1990s when casinos were banned in Turkey).

3. "*Tüp bebek*" –literally "tube baby"– is commonly used in *colloquial Turkish* as an umbrella term to refer to all assisted reproductive technologies (ART). IVF or ART, as more technical terms, are predominantly used in legal documents.

4. Hasan Kahvecioğlu (August 2, 2009) "Tube Baby Tourism" available at http://www.kibrispostasi.com/print.php?news=28111 (accessed September 13, 2015).

5. The demographic politics of Turkey fall into three periods (Akşit 2010): post-Independence pro-natalism from the early 1900s to 1960; developmentalist anti-natalist population planning from 1960 to 2000s (e.g. legal provisions for family planning introduced in 1965, and abortion legalized in 1983 up to ten weeks); and a contemporary return to pro-natalism under the now 12-year rule of the conservative neoliberal party embracing Sunni Islamic ethics and principles. For further discussions on the changing contours of reproductive citizenship in contemporary Turkey, See Acar and Altunok 2013, Unal and Cindoğlu 2013, Açıksöz 2015.

This paper shifts the focus towards this relatively understudied topic of emerging transnational sex selection. Drawing on ongoing fieldwork in Northern Cypriot IVF clinics and interviews with Turkish couples seeking PGD for non-medical sex selection, it explores the ethics of secrecy and disclosure that people perform, when a situation is potentially stigmatizing in order to manage to whom and under what conditions things are told. Examining how the perceived need for secrecy on the part of Turkish PGD seekers leads to moral dilemmas of disclosure, this paper sheds light on the question of how Turkish couples make moral sense of transnational sex selection in relation to gender and family ideologies. The aim is to show how people navigate the moral (gendered conflicts) that reproductive technologies can introduce for users for whom these technologies are "simultaneously promising and problematic" (Inhorn 2004: 163).

2. In vitro sex selection

As a technique of pre-pregnancy sex selection (Whittaker 2012: 144), PGD is used to determine the sex of embryos created by IVF techniques before implantation, either for identifying serious sex-related genetic disorders or for non-medical reasons. However, interest in influencing the sex of a future child did not initially start with new reproductive technologies such as PGD. As my preliminary research on moral negotiations of sex selection in a highly popular Turkish web portal, *Women's Club*[6] has revealed, discussions on such forums depict how new sex selection technologies are "inserted into a pre-existing cultural milieu in which the sex of a baby is a central concern" (Whittaker 2012: 148). One forum member (a 28-year-old woman, married for 15 months and 35 weeks and pregnant with her first child –a girl) posted a long list of things to do in order to have a boy:

> Here is my list:
>
> I am planning to get pregnant this September. In September of 2011 I am going to start a diet three months beforehand. My intent is to get to know better my period and ovulation time as well as its pattern by then.
>
> Pray and *namaz* are the first things I'll do. I'll make big vows to God. If God grants my wish, I'll willingly fulfill them.
>
> I'll lie down on my right side. I'll wash my vagina with bicarbonate water as to make my vagina fluid alkaline. [Have intercourse] on odd days for girls and even days for boys. And as it is said it is a boy if the moon is half;

6. I examined a sample of 541 messages about sex selection posted between 2007 and 2013 to *Women's Club*, with 400,000 current registered members.

> it is a girl if the moon is full. I'm not sure but that's what I know. I might use klomen and an "egg-cracking shot" [HCG trigger injection] as to make sure it is the right time to conceive.
>
> Yet, it is also said in the sayings of the Prophet Muhammad *(hadis*) [to have intercourse] 5 days after menstruation for a boy, which sounds logical to me. I might try that. I've also heard that [to have intercourse] after ovulation for a boy. I might try that, too. I believe in the benefit of sexual abstinence. My husband is not supposed to be tired as well. I make him drink coffee.
>
> I am praying every day every moment…Babies born in August are mostly boys. If I get pregnant in November, I might give birth in August or I might get pregnant in September to give birth in June.
>
> Another thing to do is to collect baby boy stuff from every house I visit.
>
> I know these are all pleas. If God grants, my baby boy will come and find me. (Derin Duygular 29 January 2010)

Therapeutic uses of PGD are allowed in many countries, including Turkey (Jones *et al* 2010), but PGD is available for non-therapeutic sex selection only in those countries that do not mention it in a law or are largely self-regulated (Bhatia 2014: 206), such as the USA, Northern Cyprus, Thailand, Mexico, the United Arab Emirates and South Africa. Due to the not "illegal" status of sex selection in the bylaw in Northern Cyprus, the clinics provide nonmedical sex selection in increasing numbers; some clinics told me that PGD for sex selection accounts for 30 % of all reproductive services they offer. Transnational sex selection involves undergoing a typical IVF cycle (using the couple's own or donated gametes) starting in Turkey with hormonal ovarian stimulation, and ending with a trip to Northern Cyprus, where egg retrieval, sperm provision, in vitro fertilization, Day 3 embryo biopsy (biopsied embryonic cells are sent to the genetic lab either on the island or in Turkey), genetic screening for sex selection and Day 5 embryo transfer occur within approximately 5 days.

Given the highly fragmented, potentially disguised and extremely mobile nature of the research subjects under study, finding people to participate in this project was a methodological challenge. To recruit PGD users, I began my fieldwork research in Turkish Cypriot IVF clinics that coordinate sex selection as "receiving" clinics. I gained full access to one such clinic in the Turkish part of the capital city of Nicosia, with the permission of the head IVF practitioner who is also the owner of the clinic. I closely tracked the arrival dates of PGD users to the clinic for interviews. I kindly requested mostly nurses to introduce me to PGD patients as a researcher and asked them on my behalf if they were available and would like to participate in my research by consenting to be interviewed, most often during

an approximately two-hour rest following embryo transfer in their private recovery room in the clinic.

As numerous anthropological and sociological studies on infertility and IVF have noted, the failure to produce a child has a profound impact on the gender identities of both men and women, as procreation serves for a particular realization of hegemonic masculinities and femininities (Inhorn 1994, 2012, Riessman 2002, Goldberg 2009). However, the globally-circulated medical definition of infertility (defined as the inability to achieve pregnancy after a year or two of regular unprotected sexual intercourse) "may diverge considerably among individual subjective definitions, which are often based on socially relevant indigenous categories and systems of identity formation" (Inhorn & van Balen 2002: 12). For example, in some societies people may consider themselves infertile when they do not achieve pregnancy within the first month or two of marriage; or "bearing no sons may be socially equivalent to having no children at all, rendering the parents infertile under the terms of a classic patriarchal social system" (Inhorn & van Balen 2002: 12-13). Similarly, some of my interviewees seeking PGD so as to have a son have expressed that they have experienced a sense of infertility, in varying forms and degrees, fueled by social judgments and prejudices toward couples who did not have a son. Therefore, as in the settings of infertility and IVF (Bharadwaj 2003, Carmeli & Birenbaum-Carmeli 2000, Paxson 2003), Turkish couples' pursuit of transnational sex selection might lead them to be engaged in moral dilemmas of disclosure in Turkey, usually characterized as classically patriarchal with strong son preference, alongside India, China and South Korea (Whittaker 2011). Adopting Paxson's formulation of "ethics" as a matter of "anticipating and circumventing 'what the others will say'" (2003: 1862), the following sections will focus on the ethics of secrecy and disclosure enacted by Turkish PGD seekers in relation to gender anxieties so as to craft not only moral selves, but also moral technologies.

3. Fragile (technologized) masculinities

On the second day of my fieldwork research in the clinic in November 2014, the head IVF practitioner introduced me to a Turkish couple seeking PGD in order to have a son after 5 girls. I had a short conversation with the couple in the patient coordinator's room, where a lady was also present. The husband (aged 44), who dominated all conversation, explained how they had used a calendar method for the last pregnancy, upon the advice of the doctor in Turkey, to have a son after four girls, but it did not work. So, they did not want to risk it this time and decided to try

PGD for sex selection in Northern Cyprus. The woman (aged 32) said, somewhere in the conversation, that she actually did not want to do sex selection (to have a son) because she adores her daughters. She was willing to try it just for her husband. The man explained how social and familial pressure on men without a son was difficult and painful. When I asked them who knew about their trip to Cyprus for sex selection, they replied "It is just between the two of us". In the man's words, "At first, we were suspicious about IVF. But, after doing some research, and due to social pressure, we finally agreed to pursue it. Our society still believes that someone else's sperm is used, while we never thought it like that. But our society still sees IVF this way, as a suspicious thing. That's why we did not want to tell anybody about it". Throughout the conversation, the man seemed nervous about talking to me. Later, I learned from the coordinator that it is because the man accidently saw the name of their neighbor, who seems to have come to the same clinic for gamete donation, on the memo book of the clinic's chauffeur; he freaked out that the story of a marriage anniversary celebration in another city of Turkey was about to fail as cover for their reproductive travel.

As in this case, sex selection sometimes becomes "a two-person cult of silence," as Inhorn (2004) describes the use of IVF in Egypt for male infertility, which shelters the couple (and the husband specifically) from social prejudices and misconceptions that threaten the masculinity of the husband. This couple's (especially the man's) endeavor to conceal their pursuit of IVF/ PGD in Cyprus is related not only to the concerns regarding the legitimacy of the future child due to social misconceptions about IVF, but also due to gender anxieties that link male fertility to sexual identity and virility in the normative constructions of masculinity. When competence is perceived as impregnating a wife, fertility becomes for men not only about making children but also reassuring their sexual and gender identity. In Turkish, there is a popular expression: *Erkek adamın erkek oğlu olur* (male men have male sons), in which "'male' precedes both words to emphasize the significance of masculine ideals (of both being a male and having a son)" (Demircioğlu-Göknar 2015: 133). Thus, the man's inability "to make a son" is associated with sexual incompetence.

When I asked another couple married for 16 years (who sold their car to pay for treatment, which is around 4,500 Euro)[7] what had brought them to the clinic, the

7. While I was taking notes during the interview, the man told me "We did not have enough money. We sold our car and came here. Take that note, too!" Some men were more reluctant to reveal the financial difficulties (if they had any) in their pursuit of sex selection, than others like this man. This might say something about differences in men's experiences and perceptions of class, purchasing power and masculinity. Reproductive services are priced in Euro in Northern

woman (a 31-year-old, primary school-educated housewife) replied "We already have four daughters; the youngest is one year old. My husband wants a male child (*erkek çocuk*).[8] One desires what one lacks. So, here we are!". When I asked for whom (men or women) not having a son was more difficult, she replied, "It is of course difficult, but it is more difficult for him" (pointing to her 38-year-old, primary school-educated, construction worker husband sitting on the single couch chair in the left corner of the room). He continued, "[I am asked] for whom you are working, To whom you will leave your property, money, Excuse me, you do not feel more "male" (*erkeksi*)… psychologically I am…as if they [men having sons] are better than me". His wife added "'We have a son, you do not!' They say such things." When I asked the couple who knew about their treatment, they replied that only some family members knew while others were told they were on holiday.

As Inhorn points out the stigma and secrecy surrounding male infertility in Egypt and Lebanon, the inability to have a son can be "not only a stigmatizing and potentially emasculating condition for" some men in Turkey, "but the very technologies designed to overcome it add additional layers of stigma and cultural complexity" (2004: 163), referring to "the "technological stigma" (ibid. 175) of IVF/PGD itself. This technological stigma may further take spatial meanings in the transnational setting. IVF in Northern Cyprus can be more stigmatizing than IVF in Turkey due to the availability of gamete donation on the island. For this reason, even a trip to the island itself can become potentially stigmatizing and therefore itself something to be disguised.

4. Womanhood in/complete[9]

> Hello all,
>
> I could not talk to anybody about my special situation so I have created this topic here. I look forward to the comments of those who have any information and experience about that topic.

Cypriot clinics, as some other services are priced in foreign currencies such as rental houses in GBP. Another couple mentioned that they paid 4,250 Euro for their (failed) first sex selection, and then only 2,000 Euro for their second try in the same clinic.

8. In Turkish, "*erkek çocuk*" (a male child) is also used to refer to a son (*oğul*) while *"kız"* is used to refer to a girl/virgin.

9. In some interviews, the theme of "incompleteness" also emerged around the issue of sisterhood, revealing how sisters may (be forced to) feel incomplete without having a brother in the family and desperately desire for a brother, like their parents desire for a son. As some couples say, girls, who are not even considered as children, are also subject to social prejudices and offending comments/ treatments in social and family gatherings. Recalling Suad Joseph's analysis of the brother/sister relationship in the reproduction of Arab patriarchy (1994), this issue begs for further inquiry, which goes beyond the limits of this paper.

> I am a 29-year-old woman, married for 6 years. I had a miscarriage in the first year of my marriage. Then, I had two girls. My problem is other than conception. I know it might sound strange to some, but I am actually living all through these: My in-laws and their relatives keep saying to me "you could not give birth to a son." Especially my mother in-law, and even my little sister in-law constantly insinuate that. I am psychologically broken down. I do not want to see the faces of any of them. That's why I started searching [online] about sex selection. It is said we can choose whether we can have a baby boy or a girl. It is said this has already been done. I am wondering if it is really possible to do so. Is there anybody here who has already done it or has any knowledge of it? I need your help… (f_ozkn February 22, 2013)

This 29-year-old woman, married for 6 years, having two daughters, searching for advice online in *Women's Club* about sex selection to have a son, later posted on May 6, 2013 about her decision to undergo PGD in Northern Cyprus by taking the daughters with them as if they were going on a vacation; they would not tell others, especially her in-laws, about it. As this online posting illustrates, women can become distressed, be treated badly and even humiliated because of their inability "to give" to others (especially to their husband and in-laws) a boy (Demircioğlu-Göknar 2015:44). Similar to infertile women, women without a son can experience a sense of "incompleteness" in their gender identities, as well as in their families and lives, sometimes because of the pressure they face from their in-laws, and sometimes because having a son is the only way for a woman to acquire certain privileges and better treatment at home.

One woman (aged 48) whom I interviewed together with her husband explained how women who do not have a son fear that their husbands might marry a second wife. She was undergoing PGD using donated eggs to have a son after having two daughters. She said she had been pressured not only by her in-laws but even by her own family to give birth to a son. She was constantly told "Go, get it done [sex selection/ IVF], and give birth!" while her husband was told "Go, get it done, otherwise go get married [to another woman]!" Her husband (aged 54) had studied philosophy at one (in Istanbul) of the most prestigious universities in Turkey while the woman had not finished primary school. She defined herself as a religious person while her husband defined himself as a deist (believing that God exists and created the world, but does not interfere with His creation). He admitted that he was just like his wife before his university education in philosophy. During the interview, he told me that having a son was not particularly significant to him; but however, because of the social and familial pressure they felt, they had to try it. When I asked him if, as a college graduate, it was so hard to resist social pressure, his reply was that

"We are only 1%, but they are 99%". When I asked him about his wife's concerns regarding the possibility of him remarrying another woman, he just said: "If you just ask me, I do not probably want to do it". "But, you do not say 'never!' ". He replied, "I do not want it, but what should we do against the 99%?". The couple told me all their family knew that they were doing sex selection and all supported it. The couple had collected some money from the man's family because they were having financial problems. However, they kept egg donation a secret from their families, except the woman's sister. According to the man, people generally think that the use of reproductive technologies is interfering in God's business because people adopt a religious perspective of it. The woman also admitted that she had thought so before, but later changed her mind, especially after consulting a professor of religion who studied in Malaysia and supports egg donation because, in her words, "It is better than adoption since you are the one who gives birth, breastfeeds the child, so there is nothing wrong with it".

While talking to another couple, the theme of co-wives emerged again, but as a real experience this time, not just as a woman's fear. During the interview, I learned that the woman (a 24 year- old, secondary school-graduate housewife) was the second wife of the man (a 42 year-old, primary school-graduate trademan). He was the only man in his family who had taken a second wife because of the infertility of his first wife (she had the womb of a 70 year-old woman, in his words). They were all living together in the same house. The man had had a civil marriage to the first wife (aged 42) 20 years ago, and a religious marriage to the second one (religious marriage is not officially recognized in Turkey) eight years ago. However, the second wife also had trouble conceiving as the husband seemed to suffer from low sperm count due to his age. They went to the doctor in the second month of their marriage. After two or three failed attempts of artificial insemination, they underwent IVF in Turkey through which they had twin girls at their first try, one of whom was disabled. The children were officially registered to the first wife, so she was the legal parent. However, because the second wife did not give birth to a son, she started developing a fear that her husband might get married to yet another woman. While she and the husband were in Northern Cyprus, the first wife was taking care of the daughters at home in Turkey. The couple had disclosed to others that their twins were test-tube babies, and now they also preferred to tell people that they were trying IVF again, but failed to mention that they went to Northern Cyprus. The man's family and the first wife knew that the couple was undergoing IVF in Istanbul, but the "Cyprus business" was kept a secret just between the husband and the second wife, because of the technological stigma of IVF in Northern Cyprus, associated

with the availability of gamete donation on the island. The couple did not even tell the first wife about it because both believed that if she knew, she would tell others when she got angry at her husband or her co-wife.

In December 2014, I interviewed a 40-year old woman (teacher) who was undergoing her second round of IVF/PGD (using her own and her husband's gametes) in an attempt to have a son after two girls. This woman was accompanied only by her mother on her trip to the island for the embryo transfer. The interview took place right before the embryo transfer while waiting for the genetic lab to send the results of the embryo biopsy to the clinic. For this reason, she was very nervous and constantly texting updates to her husband who had to go to work and take care of their daughters in Istanbul. She presented to me their quest for having a son through sex selection more as a means of "family-balancing"[10] by framing it as a natural desire to have children of both sexes in a family; she took pains to distinguish their quest from "traditional son preference", which she associated with the eastern part of Turkey, considering it as being backward and patriarchal. Her explication may be seen as an example of the modern "identity work" enacted by people "to communicate how they want to be known" (Riessman 2002:152); in other words, it is to perform a preferred (modern) identity rather than being seen as "traditional" because of their pursuit of sex selection in order to have a son. She was willing to talk about her quest for PGD only with people who, she thought, would understand her rationale, even though she believed she was doing nothing wrong. Interestingly, when I asked her if sex selection should be readily available in Turkey, she replied at first that it might be better to have it in Turkey, but then reconsidered noting that if it were available in Turkey, everybody would want to have a son –which would not be good.

10. Whereas social scientists have criticized discriminatory uses of prenatal technologies, such as ultrasound, amniocentesis and chorionic villus sampling to limit female offspring in places such as India and China, where son preference is prominent (Purewal 2010, Croll 2000), discussion of sex selective technologies in Western contexts invokes a discourse of personal desire for family balancing deemed less discriminatory. For further discussion questioning the orientalist rhetoric contrasting (western) family balancing and (eastern) son preference, See Whittaker (2011). From my preliminary findings, I can say that "family balancing" vs "son preference" and their spatial connotations get complicated in the Turkish context. For some, it is all Turkey characterized by son preference vis-à-vis European countries. For a man without a son facing social pressure, son preference might not exist only in very few "elite places" like Nişantaşı, a fashionable shopping district and an affluent, secular residential area on the European side of Istanbul. For some others like this female teacher, son preference is predominantly prevalent in the eastern part of Turkey, associated with Kurds and Kurdish culture. Yet, for a Kurdish couple, the "east" of Turkey is beyond the east of Antep, a large, industrialized and densely populated city of the Southeastern region of Turkey.

In the clinic, I met only one couple who wanted to have a girl. This Turkish couple lived in Germany and came to Turkey to do IVF after a failed attempt in Germany. Their second attempt in Turkey also failed. Upon some friends' advice, they contacted the IVF doctor in Istanbul, who works as a "partner doctor" with the clinic where I am conducting my fieldwork. The couple was told that they needed egg donation to have a child and that they had to travel to Northern Cyprus to access the procedure. When the woman (a 40 year-old, high school graduate, who moved to Germany after her marriage five years ago and runs a business together with her husband) mentioned to the doctor her desire for a girl, the doctor suggested that she should have PGD for sex selection, along with egg donation. During our interview, she admitted to me that to some extent her desire to have a girl, or even a child, was partly because her husband had two sons from his previous marriage. In response to my question, her husband replied that he would want a son if he did not have any; therefore now he probably agreed to undertake PGD using donated eggs to have a girl only for his wife. When I asked her who knew about their treatment, she replied that people knew that they were seeking IVF treatment, but not egg donation –or sex selection.

As the case of this Turkish woman from Germany has revealed, sex selection is pursued not only by couples who already have children (usually girls), but also by "fertility patients" who have no children. In this case, PGD would be offered by the doctor to the couple. If the couple agrees, PGD is included in the couple's fertility treatment (using the couple's own or donated gametes). As distinct from the couples who are pursuing PGD primarily for sex selection to have a child of the opposite sex after having children of one sex, fertility patients who have no children are primarily driven by the desire to have a child and to become parents. Fertility patients are usually asked to consider PGD to increase their chance of pregnancy and to guarantee healthy embryos of desired sex. When this is the case, the couples who do not have any children tend to want to have one "girl" and one "boy"[11] embryos transferred together only if there is a healthy one of each. Unsurprisingly, in such cases, women are the ones who want to have the female embryo transferred, along with the male one. If the couple is using donated gametes to have a child, along with sex selection, the issue of secrecy always emerges around gamete donation, rather than sex selection.

11. Most couples refer to an embryo as a "baby" and tend to call transferred embryos as "girls" or "boys" in the case of sex selection since they know their sex. Medical personnel also use the word "baby" to refer to an embryo so as to make it more comprehensible while talking to their patients.

5. Conclusion

I have discussed the (gendered) ethics of secrecy and disclosure in the context of transnational sex selection from Turkey to Northern Cyprus, through which Turkish couples try to keep their acts and even gender identities from being subject to moral evaluation and inquiry due to gender anxieties surrounding the inability to have a son (for both men and women) as well as the "technological stigma" of IVF even if gamete donation is not used. The availability of gamete donation in Northern Cyprus makes the issue of disclosure morally ambivalent, not only the pursuit of the technology, but even their trip to Northern Cyprus itself. As Gürtin (2012: 97) notes, transnational reproduction has two elements. For practitioners, nationally illegal aspects of their practice are outsourced to another country, thereby keeping it outside national jurisdiction. For patients, "the trip to Cyprus is short enough to be explained as a holiday or disguised altogether, meaning that the treatment can be effectively hidden even from intimate others". Exploring the couples' perspectives, this paper has revealed the range of motivations, desires and concerns of Turkish PGD users and their negotiations and moralizations of the risks and benefits of transnational sex selection.

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SVEN BERGMANN

Assisted authenticity: Naturalisation, regulation and the eactment of "race" through donor matching

1. Introduction

Donor-recipient matching or simply "matching" involves the comparison and classification of phenotypical traits; therefore, it is an interesting object of ethnographic research. What is more, matching can be viewed as an assignment of relations. It is a technique of doing and naturalising kinship with –and despite– IVF and gamete donation. This article follows the practice and the regulation of matching through ethnographic fieldwork in a Spanish IVF clinic that deals with patients from different international background. Therefore in the case of egg donation, a good match is required both by the customers and through the Spanish law: How is phenotypical difference in clinical practice negotiated? How are categories like ethnicity, nation and even "race" enacted in specific situations? Furthermore, how is the application of matching seen and valued by clinical staff? What is seen as a good form of regulation and governance? What kind of matching emerges and becomes standardised?

First, I give a short overview about assisted reproductive technologies in Spain, then introduce the Spanish regulation of (anonymous) donor matching. Secondly, I present two ethnographic cases that show both the limits and flexibilities in matching resembling criteria. Finally, I present a discussion about how categories of "race" interfere with the concept of physical resemblance. In addition, the last part of the article describes how this applied system of matching is valued by Spanish doctors. The analysis focuses on what kind of boundaries are drawn and what kind of moralities are evoked in the discussion.

2. Transnationalisation of Spanish IVF

In Spain, the first IVF baby was born in 1984. In 1988 the first Spanish law on reproductive Medicine was implemented and renewed in 2006, both under a social democratic government (PSOE). Spanish regulation is characterised as rather non-interventionist in family questions (Orobitg and Salazar 2005: 34). The Spanish law counts as one of the most liberal in Europe with respect to gamete donation and access to IVF treatment for lesbians and single-mothers.[1] IVF has become a biotechnological success story in Spain: over 160 public and private IVF clinics exist in the country, many of the latter established in the 1990s (Pavone and Arias 2011: 247-8) and offer the most advanced techniques in reproductive medicine. As a result, Spain is one of the most important European destinations, a *hotspot* for reproductive mobility (Arranz 2015).

According to the latest published results of the European Society for Human Reproduction and Embryology (ESHRE), Spain gained place 4 with 58,735 treatments in the European ranking of ART (Kupka et al. 2014: 2101). Taken into account that in contrast to other countries, in Spain only 103 out of 160 clinics did report, Spain might be ranked even higher in this list. Performing an outstanding number of PGD in Europe (2,743 out of 6,399 treatments) Spanish IVF is famous for its large number of treatments where oocytes of another woman are used, a procedure usually called "egg donation" in ART, irrespective of the fact that it is paid or strictly commercial: more than the half of the 25,187 counted egg donations in Europe in 2010 according to the ESHRE registry were performed in Spain (12,928) (ibid.). It can be estimated that a high number of these egg transfers were undertaken for international patients.[2] Spanish Clinics do recruit gamete donors with posters and flyers at universities, via radio announcements and adverts in free newspapers like *20 minutos*. While most campaigns are in Spanish or regional languages like Catalan, some clinics also advertise in other languages like Russian to address migrants from Eastern Europe as egg providers.[3]

1. The actual governing Partido Popular (PP) has tried to withdraw some of these options by claiming that the lack of a husband is not a medical issue (Tardón 2013). Therefore these treatments should not be carried out in public hospitals but not all communities followed that advice; this does not affect international patients going to private clinics.

2. In the first study about the dimensions of cross border IVF treatments in Europe, only six Spanish clinics participated (Shenfield et al. 2010).

3. While before 2008 most donors had been university students or migrants from Latin America and (Eastern) Europe, the impact of the financial crisis has driven more women to unemployment or in care for children into the part time job of egg donation (information from

Whereas Spain in comparison to other European countries has a quite liberal approach to reproductive medicine, there is not much public debate about the issue, and Spanish regulation is characterised by lacking efficacy and transparency (Pavone and Arias 2011: 251). Disclosure, although so much debated in other countries and international journals like *Human Reproduction* seems not to be much of an issue in the Spanish debate. The reluctance against disclosure or open donor systems is underpinned by the Spanish law's strict rule of anonymity in gamete donation. Moreover, the Spanish law obliges clinics to match several physical characteristics between the donor and the recipient. As I will show later, anonymity, resemblance and non-disclosure are related and intertwined here in a specific way. In the following section, I will show how matching is done and regulated in clinical practice.

3. Doing regulation in practice: Not too much, but not too little

One day during my fieldwork in the Institute Fontana I was sitting in the office room that was shared by most of the physicians while doing paper work and communication with patients via e-mail or telephone.[4] Alba Roca and Debora Fàbregas, [5] two doctors of the clinic in Barcelona, were discussing an alternative egg donor for a recipient because the designated donor had to cancel treatment. Later that day I asked Debora what would happen if a blue-eyed recipient expressed the wish for a donor with brown eyes. She responded that the law does not say so much in detail but that they as a clinic would always try to find a blue-eyed donor.[6] Whenever I tried to discuss hypothetical scenarios like the one mentioned before the physicians often evaded such ideas by saying that most people do not want that and relied on matching resembling traits. Most of the time doctors referred to the Spanish law that states:

> The choice of donor is the responsibility of the medical team, as specified in Art. 6.4. Under no circumstances can the donor be chosen by the patients.

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ongoing research on ART in Spain by Vincenzo Pavone and Cathy Herbrandt, presentations at "Critical Kinship Conference", Odense 8.-10/10/2014).

4. Ethnographic fieldwork in Barcelona in 2006, another visit in 2011. Furthermore, ethnographic fieldwork in an IVF clinic in Prague (2007) and several visits to Czech and Spanish clinics and two Danish sperm banks; interviews with physicians, embryologists, patients and donors complete the ethnographic data.

5. People or institutions' names are changed into pseudonyms.

6. Apart from the fact that in Spain some people have green or blue eyes, the clinic was quite active in recruiting donors among the large group of Russian and Eastern European migrants that live in Barcelona.

> Maximum phenotypical and immunological similarity must be ensured, as well as maximum compatibility with the receiving woman. Anonymity of the donor must also be ensured. (Ley 14/2006, Artículo 6.4.)

In clinical consultations I observed, patients (or donors) took part in a procedure of classifying their own phenotypic traits. Thereby, doctors filled out the columns in the clinical software containing information such as differentiating eye colour in grey, blue, green, hazel, chestnut or black.[7] During my first stay in the clinic, doctors used for the final assignment of a donor a simple folder. In my second visit at the clinic five years later in 2011, I noticed that the folder had become history and that doctors relied on proposals of the clinical software for the assignment of donors. If there is more than one possibility they decide by comparing photos of recipients and donors to find the best match.

4. Doing kinship via matching

Matching is a form of mediation: the donated gamete contains several phenotypic features of the donor that will be transferred to the recipient. To match according to resemblance(s) means to substitute one's own gametes as closely as possible to the recipient, so that the offspring could be regarded as conceived naturally: "The closer to nature families looked, the closer to realness children got" (Herman 2008: 125). Throughout my research, I often participated in consultations between IVF practitioners, patients or egg donors. During these consultations, mostly primary visits of patients or donors, classifications of physiognomic traits were negotiated. Based on two observed cases in the clinic in Barcelona with patients from abroad I will show how this kind of matching is performed in clinical practice and which categories and classifications are thereby enacted.[8]

Case I: The Lamberts

Helen Collins, a gynaecologist of English origin, who works in the Instituto Fontana, welcomed the English couple Patricia and Bruce Lambert initiating some small-talk about English and Spanish weather. 41-year old Patricia Lambert had

7. Here I address only the procedure of phenotypical matching. Before being elected as gamete donor, egg and sperm donors were screened according to different protocols using sperm samples and/or blood tests for HIV, Hepatitis B, other STMs and a karyotype.

8. In the clinic in Barcelona I participated in clinical practices like consultations with patients and donors, during egg retrieval and embryo transfer. I attended clinical meetings and observed the practices in the lab from evaluating oocyte or sperm cells, IVF and ICSI techniques, preimplantation diagnosis and last but not least I hang around the clinic's coffee machine or accompanied doctors and staff in the lunchtime.

a history of two failed IVF treatments in the UK, so her British doctor advised her to consider egg donation as an option. Helen explained to the couple how the cycles of donor and recipient are synchronised with the pill. She continued with the information that most of the clinic's egg donors are from Catalonia and Spain. Nevertheless, she stated that in the case of Patricia a matching would be quite easy because she is very suntanned and has brown eyes. After answering some of the couples' questions, Helen opened a folder in the clinical software where she noted some of the couple's phenotypic traits.

The Spanish clinic worked with eight parameters in their protocol for matching donors and recipients: 1) blood group, 2) race, 3) eye colour, 4) hair colour, 5) skin colour, 6) hair texture/form, 7) height, 8) weight. These parameters were in accordance with the Spanish law decree for matching donors, el Real Decreto 412/1996, the only document that explicates how matching should be applied in the clinics. In most cases, patients from the more northern European countries were matched in the column "race" as "Caucasian". But in this situation, Helen suggested Patricia to classify her as "Mediterranean" because as she put it, Patricia could easily pass as a Spaniard. Patricia was really flattered and immediately opted for Helen's proposal, adding that Spain is such an attractive country.

Case II: The Fergusons

Whereas the atmosphere during the Lambert's consultation was relaxed, humorous and even enthusiastic, the setting had been quite different in the case of Angus and Karen Ferguson, a Scottish couple attended by Víctor Domènech, another gynaecologist of the Instituto Fontana. Angus Ferguson was very suspicious about looking for an egg donor in Spain because, as he emphasized, resemblance with the offspring is of great importance to him and his wife. In his words: the child should not appear as non-Scottish on the streets of Glasgow. Suddenly during the consultation, Angus pointed at Víctor and remarked that Spanish people like Víctor rather look different from Scottish people like him and his wife.

With this gesture, Angus enacted his Scottishness by "othering" Víctor, the stranger with other phenotypic traits who did not resemble his red hair and pale skin colour. Víctor, the Catalan physician kept calm and reassured the couple that they will look for the most similar matching phenotype –but later, after the consultation, he told me that he found the gesture of the patient very disrespectful.

5. Passing & shopping for gametes

In contrast to Angus Ferguson who was anxious that a child resulting from an egg donation in Spain would not phenotypically "fit" in the Scottish environment at home,[9] English patient Patricia Lambert felt comfortable with incorporating Mediterranean traits in her family. She regarded the doctor's classification of her as Spanish-looking as a compliment. Both examples show that classification is an active and performative task. In the first case, IVF practitioner Helen made a specific offer that shows how performative the task of classification can be: The proposal, to pass form Caucasian to Mediterranean was welcomed by her British patients.

Passing, a term made popular through the title of Nella Larsen's novel *Passing* from 1929, denotes in cultural theory a shifting or queering through class, racial or gender categories. Whereas Angus Ferguson was still bothered with reassuring his ethnic identity in opposition to the other, Patricia Lamberts reaction was different. Helen did not ask Patricia how she would classify herself in racial or ethnic categories. Rather, her suggestion to opt for Mediterranean was about desirability: how Patricia would like to be. In the case of Patricia Lambert, passing is not about achieving a certain societal status, instead it is an individual form of shopping for attractiveness. A gamete from Spain that contains sun and other Mediterranean features becomes a desired "fashion accessory" (Sarah Franklin, cit. op Haraway 1995: 364) in transnational reproduction. Here, whiteness is not such a stable form (cf. Szkupinski-Quiroga 2007), it is rather a performative category alternating between different shades of whiteness as pale, sun-tanned, Caucasian or even Mediterranean.

In the case of Patricia Lambert, one can detect a form of passing that is possible between different nuances of European whiteness. In opposition: if a white recipient would desire a black donor, clinics as the Instituto Fontana would refuse this request with reference to the Spanish law on assisted reproduction that enforces similarity between recipient and donor as much as possible. According to the law and regimes of normalisation in reproductive medicine, IVF clinics have installed different systems of classifications and work with different sets of categories. Thereby they often use crude categories that show why matching is not only about individual physiognomic traits but also deals with cultural conceptions of phenotypic variations. Matching triggers a classifying procedure to recognise,

9. Rosemarie Garland-Thomson's concept of "misfit" (2011)) is quite helpful to theorize the connection between otherness (different abilities, bodies or looks) and the environment. In the case of the Fergusons resemblance between parents and offspring should guarantee "visual anonymity" (ibid: 596).

to distinguish and to enact physiognomic characteristics. Matching translates ideas of genetic heritance, resemblance and kinship into the realm of gamete donation. Both the navigation as the reassurance of categories in matching shows the making of nature/culture in these cases. [10]

6. Ir/relevance of race concepts in ART

In addition to designating non-white people as African, Arabian, Asiatic or Latin American, the Instituto Fontana in Barcelona has implemented a specific construction of race categories for the differentiation of their majority of white European patients: it distinguishes white Europeans in a Mediterranean and a Caucasian type. The racial term "Caucasian" was first introduced by Johann Friedrich Blumenbach (1806: 70) and was used for most inhabitants at the European continent, in Western Asia and North Africa. In the former US census, it was used to describe a wide range of people with white skin colour, from Iceland to Lebanon. For this reason I was (epistemologically) irritated by the dichotomy Caucasian – Mediterranean the Catalan clinic had implemented. I asked Víctor, the clinician who had developed the clinical software together with a friend, what does the term Caucasian mean. Víctor's answer is in several points instructive with respect to the implementation of categories in clinical work:

> Caucasian…Well, that's to differentiate from the Mediterranean. Caucasian would be more a Slavic or something like that. A person more, well, Aryan, with light skin, lighter hair and all that. Whereas Mediterranean refers to genotypes with darker skin and all that. In fact, I always say the same: the term race is not a good choice – because there is only one race, the human race. The rest is genotypes, varieties of skin and other forms. Thus, the difference between a Mediterranean and a Caucasian, that's a question of type, generally speaking when you imagine a patient from northern Europe or a patient from southern Europe. More or less.

Víctor explains here the need of a differentiation between "lighter" northern and "darker" southern Europeans. The citation is intriguing because it shows that on the one hand "race" as a concept seems outdated for the physician and rather irrelevant. On the other hand, he is in need for differentiating human diversity and therefore he still relies on racial categories, thereby reproducing uncanny

10. For my argument I draw here on cases where these categories were particularly negotiated. There had been also cases where classifying phenotypic criteria did not lead to discussions or questions during consultations; it also depended a lot on how doctors or patients emphasized these topics.

concepts like the Aryan when referring to his idea of a light white (Northern) appearance. Reproducing racialized concepts is not first and foremost a phenomenon of reproductive medicine, but for biomedicine in general (Aspinall 2014). What is interesting in donor-recipient matching is the participation of patients (and donors) in the practice and the enactment of categories in specific situation. When I visited the clinic for another time in 2011 the category Caucasian in the column race was changed into white. Nowadays the clinic differentiates between a white and a Mediterranean type.[11]

7. Performative typologies

Categories like "race" or ethnicity refer to the performativity of classification (Bowker and Star 2000). They show how in clinical practice such categories are still vivid or, more concretely, have become reanimated. Often articulated or translated under the label of phenotypic difference, they still bear the meaning of racial classification.[12] IVF practitioners cultivate a certain technique of typology which was foremost a domain of biological and physical anthropology. Typology had used morphological and phenotypic differences as a base for the classification of humans in racial groups (Reardon 2005: 33). But typology in assisted reproduction does neither share the epistemologies, nor the techniques of early 20th century anthropology like the chromatic skin colour charts used by Austrian anthropologist Felix von Luschan, or other anthropometric or biometric procedures like diagrams, charts or genetic analysis. In IVF, typology is a rather profane translation of these former practices; it is more or less regulated through a somewhat phenotypic plausibility –a common sense knowledge system where "[e]veryone thinks he's an expert" (Geertz 1983: 91).

In the Spanish case, matching is not orientated on a complex phenotypic or genotypic classification, but on few parameters –which are regarded as mere (natural) facts.[13] "Race" and different shades of skin colours are often assumed as

11. In addition, skin colour is categorised ranging from pale to white, to olive, to brown, to black. All these categories are columns in the clinical software and have to be filled in. The Spanish clinic (in concordance with Spanish law) does not liberate its patients and its doctors from categorising people.

12. Hair texture even was an important mode of racial classification in the Apartheid regime (Bowker & Star 2000: 210-212).

13. Compared with the Spanish case, the clinic Fertilmed in Prague, operated a quite similar system of classifying recipients and donors. In addition, the Czech doctors handed over to their patients a sheet of paper with a table for ranking categories (blood group, skin colour, eye colour, hair colour, weight and height).

biological categories. But, in situations like matching in IVF clinics, they do not only appear as "mere facts", instead they emerge as Amade M'charek writes as "matters of concern" (2010b: 318), as some kind of anxiety that has to be negotiated. M'charek asserts that, "there is no firm ground from which to access race", rather she concludes "racial identities are made in specific contexts" (M'charek 2010a: 146). According to STS theorists like M'charek or Annemarie Mol, difference then becomes the effect of certain interferences of entities and practices that are mobilised and enacted in specific situations like clinical matching. Practices like matching serve as a specific context for the fabrication of race. The enactment of matching shows how categories of race, ethnicity and resemblance become matters of concern in doing kinship in transnational reproduction.

The definition of resemblance taken up in the matching procedure correlates with a specific idea of "race" and ethnicity under the lens of constructing a family. This idea regulates the limits of matching. More precisely, it specifies which nuances in physical criteria are possible and imaginable within the classification and which are not and thus have to been excluded via matching. As I have shown, matching relies on two procedures or typologies. On the one hand, individual characteristics are classified, on the other, a person is sorted into collective types like "race" by mobilising categories like skin colour (e.g. "olive") and/or geographical origin ("Mediterranean").

8. The paradox of detaching relations while attaching traits

The ethnographic description and analysis of categories that are in use for classification in donor-recipient matching show how "race" and ethnicity become relevant in questions of kinship and heredity where physical resemblance matters. In other contexts, these preoccupations with "race" people would regard as irrelevant and racist.[14] The emergence and persistence of racial concepts in IVF is related to questions of reproducing with biological substance from non-known others or third persons. In anonymous donation, the subject of the donor is supposed to fade away or is detached. In contrast, his or her phenotypic traits are demanded –traits, which in contrast to her or his subjectivity, are assumed to be contained

14. However, Stefan Helmreich indicates that analysing the construction of classification practices in a Boasian way does not explain the consistence of race and racism. Race has not always been such a stable and fix concept (and therefore the same cultural construction), rather Helmreich argues with W.E. DuBois that race is a "group of contradictory forces, facts and tendencies" (Helmreich 2003: 436).

in or attached to their gametes.[15] Because gametes have no skin colour, the possible genetic expression of skin colour is negotiated via the donor's appearance (Thompson 2009).

The idea of resemblance does not only cover concepts of generative relatedness like family or kinship. As I have shown these ideas of resemblance are entangled with ideas of ethnicity, nation and even "race". In the case of traditional heterosexual, "natural", conception, these ideas of resemblance do not play such a great role –they are seen as self-evident, even in "mixed couples". However, when the nature of reproduction becomes destabilised through practices of assisted reproduction, transnational adoption and models of queer kinship, the self-evidence of resemblance becomes unstable. Resemblance becomes a matter of concern regarding images from where families originate and from a certain sense of belonging. Therefore, resemblance in kinship relates to broader social concepts of self-assurance of where people came from and what the majority of these groups shall have to look like –therefore ethnicity, nationality and "race" experience a "comeback" via the issue of resemblance and donor matching.

In the pragmatic systems, clinics in Spain or the Czech Republic fit the case, matching is a technique of assigning donors that should resemble certain phenotypic criteria. It is an approach towards resemblance –or in other words: that the donation should not be at first glance all too obvious. This should help people conceal the fact of donation later. Therefore I refer to this kind of matching in terms of *Not too little matching* –which distinguishes the method from the possibility of not-matching or "mismatching" (Konrad 2005: 150, Tyler 2007). Nevertheless clinicians defended this system of "minimal matching" (Bateman 2001: 329) as inevitable and essential: Don't leave it to chance.

9. Not too much choice: against catalogue and too much consume

I have called the system of the Instituto Fontana elsewhere "The 'Production' of Donors Just in Time" (Bergmann 2012: 343) without long waiting lists for donors and recipients. The Catalan clinic had established a technique of matching that adheres to the Spanish legislations without too much effort. More investment in matching detailed parameters would cost too much time for all participants. It might be less

15. The idea that something still remains attached to the gift or the transaction coincides with anthropological theories of the gift exchange like Annette Weiner's notion of "keeping-while-giving" (1992) or Monica Konrad's term "transilient relations" (2005: 130). See also Bergmann (2013) for a further discussion on detachment and attachment of reproductive material in the clinic and the lab in contrast to other biological substances.

attractive for donors to be put on a waiting list because here and now they can directly start with their cycles. And for patients, too: most of the British patients came to Barcelona because they wanted to circumvent the long waiting lists existing in their homeland. They very much appreciated the straight forward approach of the clinic. At the end of the consultation the usual question of doctors was: "So when will you start, this month, next month or…?". This is a consumer-oriented approach that shows how business is done with international patients in a private IVF clinic. However, when it came to certain points related to the patient's agency or choice, the practitioner's attitude changed and the question of *choice* became highly controversial –and was often related to the US model in ART:

> Looking for genes…this is so American. This is a different world, it's another world. Regarding this aspect, the European world is quite different from the North American. Here in Spain, it's impossible, the recipient couple will get not access to data about the donors. Only medical staff are allowed to. (Ferran Valdes, IUCI Barcelona)

Arguments like these were posed to defend the Spanish model as more rational and more moral than the US model that is seen as an example for a neoliberal and deregulated market that has cut loose. Central symbol for this argument was the catalogue. In this debate, the catalogue represents choice, liberalisation and commercialisation of reproductive treatments. It stands for patients who can choose donors via a catalogue and therefore will construct designer-babies à la carte.

> If a couple wants to have some determined characteristics [of the donor], then they will travel to Ukraine, to Moscow, to the United States where they can select characteristics: I want this, I want that. These people will go there. The people who really want to have a child, a pregnancy, come here [to Spain]. (Pilar Casillas, Instituto Fontana).

In an IVF clinic, where in 2011 an IVF treatment with egg donation did cost around 10,000 euros, it was paradoxically interesting to hear so many arguments against too much choice and commercialisation. Too much choice then would alienate the patient from an authentic wish for a child. Too much choice is not an adequate mode for parents, rather it stands for selfish patient-customers who want to buy a child like a commodity or like an accessory. In contrast, the Spanish law and regulation is seen as rational or logical: On the one hand it prevents too much choice and therefore the commercialisation of egg donor babies. On the other, it avoids the production of too much difference like non-intended forms of mismatching, but also intended forms of hybridisation that would immediately transgress assumptions about a certain family resemblance.

When I tried to analyse the discursive positions of practitioners, I first constructed a messy "positional map" (Clarke 2005: 125-136) that showed the distribution of different positions and arguments alongside the axis of *too little* and *too much* matching. Then I translated clusters of arguments into more selective codes and abstract terms. With the following chart I illustrate my analytic conceptual play. The categories in the columns are generated through my analysis, they were not used in that form by actors in the field. Here, they shall express the problem of governing rationality and moralities in assisted reproduction.

	Too little Matching	Moderate Matching	too much matching
Selection	By chance	Selection through medical staff	Catalogue / Selection through Recipients
Form of Matching	Mismatching	Minimal Matching: After Nature	Cloning / Enhancement / Hybridisation
Categories	No categories	Eight parameters	Special requests
Anonymisation	Anonymity	Anonymisation	Selection via patients
Regulation	No Regulation	Regulation via doctors	De-Regulation
Social Effects	Non-Resemblance/ Stigmatisation	Social Legitimacy	Commercialisation Children as commodity: "Designer-Baby"
Type of Rationality	Irrationality, Non-reflexive	Rational, Reflexive, Modest	Irrationality, Excessive

In the middle of the chart one can see the position most of the Spanish interviewees adopt. In contrast to the extreme positions on the left and on the right side I have called it the moderate, the modest, the restrained or the low-key position. The moderate position is one that has left behind the *natural state* of the early days of gamete donation without regulation and a proper matching. As well, the moderate position reflects the excesses of too much choice and desire. According to Michel Foucault, the moderate position constitutes a specific "type of rationality" (1981: 242) by contrasting others. The moderate position distances itself from the position without regulation or measurement. Indeed, the position on the left column is seen as historical or one that is still at use on the margins, in IVF at the periphery or outside Europe. Distancing from the position of excess on the right is much more a question of morality. Here, what is imagined is a patient-consumer with too much agency and too much

choice who does not fit the person that just wants desperately a child. Here reproductive treatment is not only about helping to get a child, but also about reflecting about adequate parental models.

10. Versions of assisted authenticity

Two incommensurable spheres are constructed: market vs. treatment, consumption vs. becoming parents. Too much choice here stands for the free market, for consumption. Something that still seems –even in IVF– to be incompatible with an authentic wish to become parents. The production of the modest parent starts even before and during IVF treatment:

(1) A complete neglecting of matching is irresponsible: If the child would look totally different than his/her parents, social coherence is disturbed or transgressed and might lead to stigmatisation and misfits. Matching resemblances should help parents to pass as natural or authentic parents: Authenticity assisted version 1.0: creating authentic-looking offspring.

(2) To choose traits of a potential child via choosing a donor is seen as too much consumption, as some sort of excessive commercialisation: you don't choose a child and his accessories via a catalogue. This is authenticity assisted version 2.0: creating the authentic, the modest, the "good" parent.

For Spanish doctors too much choice here symbolises *too much culture* in IVF. Again, IVF is constituted as "giving nature a helping hand" (Franklin 1997: 103). The helping hand of reproductive medicine should act modest and should govern in a wise and prudent manner.

11. Less agency and choice in matching as more moral and less problematic?

The boundaries drawn in the discussion about matching have shown that in IVF, physicians and clinical staff "emerge as 'moral entrepreneurs' who are deeply involved in cultural transformations" (Beck 2007: 24). In my case the physicians relied on their favoured regulation model which empowers the decisions of doctors and limits the choice and agency of patients. As a result, matching is a rather asymmetric procedure: patients have little agency, donors and recipients become anonymised –the decisions are done by the clinics, information about donors and recipients is kept in the clinics (Serna Meroño 2007: 209).

The patient's attitudes towards agency in matching and the selection of the donor were diverse. Spanish doctors often distinguished between patients from the

South (Spanish and Italian) and the North (e.g. the UK, Germany), identifying the latter group as more enquiring. For Spanish and Italian patients the question of phenotypical matching in Spain was not such an issue while for some patients from the North of Europe it became an important issue in choosing a treatment abroad. I have elsewhere characterised speculations about where to get a donor with blue eyes as the creation of "phenotypical landscapes" (Bergmann 2012: 338-340). In contrast, other patients I met did not even reflect about resemblance and matching before and where confronted in the clinic with that issue for the first time. While some stated that they would like to have more agency in the process, for others the delegation of selection via the clinic creates a "comfort zone" that makes it easier to conceal the practice. More agency in the choice of donors could confront patients much more with the person of the donor and would trigger ambiguity in the process. In the clinic in Barcelona, recipient and donor will never meet. After fertilisation with sperm in the IVF laboratory, the donated oocyte will transform in some kind of property of the recipient, although the clinic will keep data of the donor, her reproductive contribution will fade away and will be detached from the new kinship project that might get started with her substantial help.

Besides being so attractive for lesbian patients and single women, the cultural model of anonymization and concealment clinics have applied for gamete transactions is still mostly concerned with heterosexual couples that may want to conceal donation and want to pass like a "normal" family. Too put it more provocatively: Why is this model of biological kinship or passing like a genetic family still so important while on the contrary IVF yet can enable alternative forms of kinship? Maybe here practitioners deny their heterosexual patients more creativity in dealing with donor-conceived children. Of course, a position towards non-anonymity or even disclosure would also endanger the successful Spanish model in egg donation that attracts each year an increasing number of patients from abroad. Despite denying agency, this specific form of Spanish regulation has helped to install the largest egg donation programme in Europe and has guaranteed with its combination of paid egg donors, anonymization and minimal matching the regulatory base for a still growing business for private clinics.

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