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► **To cite this version:**

Corinne Fortier. The gendered gift of gamets : Sexuality, Incest and Procreation. Roisin Ryan Flood; Jenny Gunnarsson Payne. Transnationalising Reproduction: Third Party Conception in a Globalized World, Routledge, pp.45-58, 2018. hal-03913374

HAL Id: hal-03913374

<https://hal.science/hal-03913374>

Submitted on 26 Dec 2022

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3 The gendered gift of gametes

Sexuality, incest and procreation

Corinne Fortier

In France, medically assisted gamete donation is carried out by CECOS (Centres d'études et de conservation des oeufs et du sperme), centres involved in the study and conservation of human ova and sperm. CECOS is organised in a French national network (Fédération Française des CECOS) within the framework of the public healthcare system. In the French system, fertility patients are entitled to up to four attempts of medically assisted reproduction (MAP) covered by the social security system. While as such, it is accessible to people with different levels of income, this opportunity is only available for heterosexual couples who have been married or cohabiting for a minimum of two years, and not to homosexual couples or single people. There is strict limit of age for the recipients, especially for women. Women must not be older than 42 years of age, while men can be over 60 years old.

In France, since the bioethics law of 1994 was instigated, medically assisted gamete donation is anonymous, and considered equivalent to donation of other parts of the body, such as blood or organs. The French law opposes commodification of the body and its parts, and as a consequence donations of sperm and oocyte in France are unpaid and considered an altruistic¹ act (see Scheper-Hughes and Wacquant 2003). Until 2011, any donor at CECOS-centres had to be a parent and if he or she is in a couple relationship, his or her partner had to have agreed to the donation. The age limit for sperm donors is 45 and egg donors must not be older than 37. Egg donation is rarer than sperm donation, which is related to the medical risks involved in ova stimulation treatments and oocyte retrieval, while sperm donation does not request any medical procedure but masturbation. The number of children born from a sperm donor is limited to ten. Donors are not informed how many children are born from their donation.

As an anthropologist, I interviewed geneticists, gynaecologists, endocrinologists and psychologists from the CECOS-centre based in Cochin Hospital in Paris where I conducted my anthropological fieldwork over two years. This study is based on one hundred interviews of couples at varying stages during medically assisted procreation and on ninety persons who have donated their gametes, sixty in the form of sperm and thirty in the form of donating oocytes

either anonymously to a CECOS centre or directly in the neighbouring country of France, Belgium.²

The new technology utilised for medically assisted procreation has resulted in a situation where the gametes, either as sperm or oocytes, are detached from the person, allowing for reproduction *in vitro* in a laboratory, as opposed to *in vivo*, as part of a sexual act. During my research, I quickly gained the impression that it was not considered acceptable to comment in generic, or gender neutral, terms on procreation via gamete donation, but rather, I found the circulation of these gametes to be highly “sexed”. In my analysis, therefore, I make use of the term “sexed” in its generic dimension, to the extent that, although there is general discussion of gamete donation, the circulation of masculine and feminine gametes certainly does not have the same connotations depending on whether it involves the donation of sperm or oocytes. On the other hand, I make use of the term “sexed” in the sense that refers to the “sexual”, because the way in which MAP attempts to distinguish procreation from sexuality is an entirely erroneous concept, given that sexuality in all its multiple dimensions including the physical dimension is far from having disappeared from this method of procreation.

In this chapter, I use the concept of sexuality in its psychoanalytic meaning with its implications of adultery and incest, that I have found significant in order to understand the social – and even more so the personal – stakes involved in processes of MAP (see Freud 1987, 1997). In my research, issues concerning sexuality, adultery and incest have been shown to be significant for couples who involve a third-party (a donor) in the reproductive process, because it raises the question of what this third person represents for the couple (Fortier 2013).³

A foreign fertilising sperm

Firstly, the actual term “insemination”, utilised in the medical expression “donor insemination” – equal to the term utilised in veterinary medicine – has strong sexual connotations; it raises associations of “the inseminator” as some kind of “stallion”. As a result, certain women who unconsciously desexualise the act of insemination prefer to describe it as injection (Fortier 2005). Similarly, in an attempt to neutralise the implications of certain terminology, the term “sperm” is seldom used by either doctors or couples; instead the word “sperm” is substituted by the term “straw” to designate the thin, plastic straw that contains the sperm preserved in liquid nitrogen. The use of a synecdoche (a rhetorical trope where part is substituted for the whole, or the other way around), in which a description of the whole package is utilised to designate its contents, here speaks of a genuine discomfort among the medical profession with regard to the substance of sperm, which is both considered sacred in so far as it is procreative, while at the same time disturbing in so far as it is sexual.⁴

The desire to desexualise perceptions linked to procreation by donor is equally evident when it comes to talking about the act by which a man donates his sperm. In this instance, the medical profession prefer to use the term “sampling” rather than masturbation. Despite the procreative goal of donor insemination, it remains difficult for the medical profession to use the term “masturbation” due to its connotations, that essentially refer to an auto-erotic, solitary sexual act rather than sexuality among a couple for procreative means.

Among the couples I have met during this study, the female appeared as the “prime mover” towards the goal of the couple having a child, while the choice of how to achieve this goal via donor insemination instead of adoption was most often centred on the male. When questioning men about this choice, one reply was prevalent: the ability to offer their female partners the opportunity to be pregnant. Consequently, their choice appears to be based on an altruistic manoeuvre in relation to their spouses; the men do not want to deprive their wives of going through the specifically female stages of pregnancy, childbirth and caring for their new-born baby. Some of the men interviewed added that these stages were also important for the development of a sense of paternity.

Despite the fact that their wives could be impregnated by the sperm of another man, donor insemination allows these men to get a sense that, and to have others believe, that their wives are pregnant because of them – thereby allowing them to use the wording: “I want to allow my wife to be pregnant”. A man’s virility and sexual potency also rely on the ability to make a woman pregnant. Although pregnancy affects the female body, it is the man who is supposedly the origin, the female body comprising the corporeal expression of the man’s phallic potency.

Moreover, and as opposed to their husbands, a certain number of women expressed a preference for adoption. These women mainly justify this choice with the argument that adoption (as opposed to procreation by donor) does not present any dissymmetry with regards to genetic relations with the child. Consequently, just as men express a preference for donor insemination in the interest of their wives, women express a preference for adoption in the interest of their husbands. Now, in the same way as the husband’s statement may conceal something unsaid, the reason stated that led their wives to prefer adoption may also mask an incentive that is less comfortable to concede and that makes donor insemination difficult for them to envisage: that of carrying the child conceived by a man who is not their husband.

Women who have the physical experience of becoming pregnant by way of donor insemination can at times find certain difficulties in accepting this third person’s presence in the relationship. Despite the lack of a sexual act and penetration, these difficulties arise from the fact that the sperm of an unknown person has penetrated their bodies, leading some women to experience “the intrusion of a foreign body inside of them”. Some women claim they feel “soiled” by this sperm that they have to accept inside themselves

instead of, and in the place “reserved” for, their husband’s sperm. As a result, they experience donor insemination more or less unconsciously as a transgression of the concept of fidelity. Despite the fact that the choice of this technique is principally that of their partner, they might be afraid of being rejected by their husband during pregnancy.

Although the CECOS-centres attempt to diminish the significance of the anonymous donor by referring to him as a mere provider of substitutable genetic material, the donor is in general the object of fantasy on the part of woman being inseminated. Because her ability to get pregnant depends on the donation of the donor, he possesses something that her partner does not, namely fertility – which in turn is associated with virility. Some women struggle to cope with the sudden emergence of this type of fantasy, which tends to generate a certain remoteness from their partners. It can in fact be verified that it is not uncommon for couples to separate during medically assisted procreation and after the birth of a donor-conceived child. On the other hand, certain women who associate donor insemination with adultery equally fear that their husbands will not recognise the child as emotionally theirs (although legally, the male partner will have already signed a paper confirming their paternity). Despite the fact that the husband or male partner was supporting the decision to have a child by donor insemination, the woman may be afraid that he will not consider the child his own and will not provide it with all the affection it deserves, or indeed even reject it.

The shame felt by these women is at times so substantial that they feel too embarrassed to embrace the openness that they would like to have concerning the donation in relation their donor-conceived child – and that is recommended by the CECOS-centres. The ideal of openness concerns all phases of the process towards donor conception, including willingness to adopt. The shame that they feel about donor insemination, however, in these cases, has the consequence that they instead become the keepers of a secret – the secret of the existence of a third person involved in the reproductive process – fearing that the child may develop a “bad impression” of their mother. In these cases the initial fear of being rejected by their partner is substituted by a fear of being rejected by their child, but for the same reason – namely the feeling of guilt over having procreated using the sperm of a man who is not their husband or partner. Some women, who live by their decision to keep their method of conception secret, nonetheless experience the fear of rejection by their child; one woman, for example, discloses her intention to show the medical folder containing the information about the donor insemination to her child as soon as the child is old enough to understand, in order to prove to the child that his/her mother is not “at fault”.

This secret also affects the family and friends of the couple. Most often, even if those close to the couple are aware of the difficulties the couple are having to conceive and their use of medical assistance to have a child, they are not aware of the type of technique used for procreation. There are very few couples who admit to their family and friends that they have used a

donor to conceive, preferring for them to remain in the dark or alluding to intra-marital IVF. As a result, family and friends are led to believe that it is the woman who is responsible for the fertility problems, a belief that is further strengthened by the fact that she is the one undergoing the medical treatment (Fortier 2013). In these cases, the husband or male partner may be content with this collective illusion which upholds the image of him as a man, effectively transferring the illusion on to his wife or female partner who, in addition to withstanding the difficulties of medical treatment and the guilt of having a child with a man who is not her husband or partner, now also bears the responsibility for the couple's infertility. Women who allow this "unsaid" truth to materialise undoubtedly do so in order to protect their partner's virility, but also – more unconsciously – to protect themselves against the suspicion of adultery linked to procreation by donor insemination.

The female body as recipient

From the very moment when the process of medical procreation starts, it is no longer the man but the woman who bears the heavy burden of creating a child, to the extent that the child develops inside her body. Despite the belief in the absolute power of technology, numerous attempts at insemination are often required before a woman becomes pregnant. This often represents the start of a long course of obstacles with its fair share of disappointed hopes and, at times, miscarriages. As some reversal of fate, the fertility problem that originally was caused by the husband hereinafter becomes that of the wife.

Donor insemination is more or less well accepted by different women, and certain psychological factors are without a doubt not to be underestimated in explaining the failures linked to this technique. Such a hypothesis can be confirmed by certain situations where women, who have lost faith in science after repeatedly experiencing failed insemination attempts, paradoxically fall pregnant when their husbands finally accept to go ahead with a request for adoption, at the same time as the medical treatment.

It appears that resorting to adoption as a possible alternative to the relentless restraint of medical treatment on their bodies and, at times, also their professional lives, frees them from the anxieties of medical treatments and liberates them from the heavy burden of having a child practically single-handedly. The new perspective offered by the alternative of adoption may psychologically liberate the women from this burden, allowing them the opportunity to welcome the longed for child, sometimes even without medical assistance. A biological child may then arrive at the moment when least expected or no longer expected, with the release affected by the idea of becoming a mother by means of adoption and not her own body paradoxically appearing extremely fertile both psychologically and physically.

If, for the male partner, the announcement of his infertility remains traumatic, there still remains the advantage of having a medical diagnosis for the infertility. On the other hand, an objectively fertile woman who is not able to

fall pregnant after several attempts at insemination is confronted with the nonsensical. On the one hand, it may be difficult to believe that technology can succeed where nature fails, the success rate for donor insemination being approximately equal to the rate of natural pregnancies.⁵ On the other hand, this scientific fact does not provide a response to the questions of a woman diagnosed as fertile who anxiously questions herself as to why her repeated attempts at insemination fail.

Women often feel at fault for the unexplained failures, given that the sperm used for insemination cannot be at fault as it has been selected according to strict criteria on properties that normally represent a fertile sperm. The medical term occasionally used to designate women who have undergone hormonal treatment without success – “poor responder” – appears to echo the age-old and slightly teleological concept by which the female body could insidiously oppose the task for which it was created, childbirth: an opposition that emerges in this medical context as all the more powerful as it has the potential to impair the hormonal treatments that are intended to stimulate female fertility. The procreative female body appears to have contradictory attributes: the womb, a place designed for the development of a foetus, is also perceived as an inhospitable belly where, according to the expression frequently used by women who have to resort to medically assisted procreation: “I’m not able to keep it”. This indicates that the reproductive role of the female has been reduced to that of a repository, a female function *par excellence* that undermines the female’s reproductive function to the advantage of the male. The opposition between the invisible egg that by nature remains internal and the greater visibility of the sperm could explain why the existence of the oocyte cannot be perceived, even by women themselves.

Nevertheless, this concealment of the role of a female substance in conception is accordingly all the more paradoxical given that donor insemination attaches importance to using hormonal treatment to produce several oocytes, and not just one as in a natural cycle. This hormonal treatment is practised prior to insemination in order to multiply the chances of conception and pregnancy. The importance awarded to the oocyte is also emphasised by the progress of visualisation technology, and in particular the ultrasound, which by displaying the ovarian follicles assigns a much higher value of reality to that which remains apparently invisible and, as such, practically non-existent.

Nonetheless, it appears that this “ovist” representation brought about by the medical techniques for procreation (IVF, donor insemination) coexists with a “spermatist” representation that is more current and more significant in terms of conception. We know as a fact that scientific knowledge can without excessive contradiction coexist with other collective beliefs and cultural narratives. It is possible, for example, to understand that the normal explanation for how we “make babies” that we tell our children – “daddy’s seed was placed in mummy’s tummy” – which conveys the concept of a mother as a repository and the father as the fertiliser, has permeated the minds of numerous individuals. Moreover, the permanence and invariability of this

theory of conception has as its evidence the perspective that it is based on the most direct representation of sexual relations, which every adult knows is for female pregnancy, the representation where the man visibly plays an active role in conception via the ejaculation of sperm.

An adulterine sperm

Furthermore, the specifically female phases of pregnancy and childbirth conceal the role played by the female in conception. In addition, maternal filiation is linguistically referred to in numerous societies as the mother's belly or womb. This is also true in France where we talk of "uterine filiation". This concept can also be found in French legislation where legal maternity is primarily defined by childbirth. Consequently, in the case of oocyte donation, it is the woman who wanted the child, who has carried and given birth to the child, who becomes the mother and not the woman who donated the oocyte. The fact that biological maternity, as opposed to biological paternity, is not merely based on conception and that this phase may have less value from a female point of view – partly due to the fact that it has links with sexuality, in which female participation in terms of producing a fertile substance that is not actually visible, and where at that moment the role of the man is the most evident – explains why women benefiting from oocyte donation may not view themselves as completely removed from their capacity to create a child, as opposed to the man who has to resort to sperm donation. There is in fact a major difference between masculine infertility, signifying the incapacity of the man to reproduce, and feminine infertility that does not prevent the woman from having a child when she can benefit from oocyte donation. On the other hand and as opposed to men for whom infertility has an impact on their virility, infertile women may not feel less feminine to the extent that, thanks to oocyte donation, they are able to experience the act of carrying a child, giving birth and possibly breastfeeding, phases of life that are specifically feminine and have a certain social value.

In other respects, oocyte donation appears to cause less fantasies involving adultery than sperm donation. There are without doubt several reasons for this. On the one hand, sperm is a substance with obvious sexual connotations, whereas oocytes do not have such connotations; in this respect, the reported method of "sampling", being a sexual act, masturbation, is required to gather sperm whereas surgical intervention is required to collect oocytes in the same way as any other internal organ (see also Fortier 2010).

The non-sexual nature of the egg is equally apparent in the attitude of women who decide to donate their oocytes, as they mainly reach the decision to do so without feeling the need to discuss it with their husbands, in the same way as they might decide to donate one of their organs, only informing their husbands of their decision. Moreover, the conviction of women who decide to go ahead with donation is so strong that their husbands are only able to accept their choice, even if they do not entirely approve. (Note,

however, that if the person who has decided to donate gametes is part of a couple, the CECOS will require that that person's partner has been informed and consented to the donation.) The situation is different when it comes to sperm donation, where men most frequently feel the need to talk about this with their wives, aware of the fact that their actions may have implications on their relationship. For that matter, some women will not allow their partners to donate sperm, as if they equate adultery with the fact that their partner's sperm will be used to fertilise other women.

In other respects, oocyte donation – a transaction between two women and not from a man to a woman – has less obvious (hetero)sexual connotations than in the case of sperm donation; the denial of sexuality between women being partly explained by the masculine perception according to which such sexuality is not “veritable”. The medical terminology used makes a notable contribution towards isolating such a feminine couple, describing their subjects as the “donor” and “receiver”. As a result, the medical profession and the interested parties themselves perceive the donation of oocytes as a procedure that takes place exclusively between two females and thus tend to forget the third-party to the transaction, the husband or male partner. In cases where the sperm of another man is inserted into a woman's body, it appears more straightforward to associate adultery with donor insemination than with oocyte donation, where the husband's spermatozooids come into contact *in vitro* with the donor's oocytes, before the fertilised oocytes are transferred to the wife's womb and the wife carries and gives birth to the child. On the other hand, in French society as with numerous other societies, adultery is seen as more severe when it is the woman who is adulterous rather than the man, as this has an impact on masculine honour.

The interviews I carried out with women who donated their oocytes non-anonymously to another woman who they know in Belgium indicate that the question of sexuality is very much present. It is in fact possible that the husband or male partner may be slightly troubled by the fact of knowing the woman who, having donated her oocytes to his infertile wife or female partner, is thus the biological origin of his offspring.

It is possible that a symmetrical emotion may develop in the case of donor insemination if the donor was not anonymous. Consequently, propensities, often subconscious propensities, exist in relation to the person who makes an anonymous donation because of the feeling of acknowledgement for the union achieved thanks to the donor's substances and of the role he/she has played in the conception of the child. Due to the fact that these new methods of procreation are not neutral but involve sexuality, they place individuals in new situations that may involve a certain level of confusion with regard to emotions and positions. These complex situations occur – both on the part of the couple who receive the donation and on the part of the person(s) who donates and his/her partner – adulterous or incestuous desires that are more likely to become the reality when these persons know each other and are emotionally linked. In order to allow these emotions to remain in their

correct place, that is, in the imagination and not in reality, anonymity appears from this perspective to be a necessary safeguard. Anonymity does not prevent the emergence of fantasies with regard to the donor, be it male or female, as the imaginary figure of a lover, but does prevent this fantasy becoming a reality.

The current trend of exclusively linking the question of anonymity to the child tends to ignore the fact that this question, currently the subject of major debate, equally concerns the parents and the persons who have made a donation. Anonymity provides improved psychological and social conditions for those involved in their efforts to complete their projects – be it becoming parents or making a donation. Anonymity allows each of the individuals concerned by the donation to occupy their position: on the one hand that of the person who has made a donation in order to assist an infertile couple and not to become a parent, and on the other hand, that of the infertile couple themselves who have to fully assume the role of parents for the child.

Incest and social regulation

Before the approval of the first French bioethics law in 1994 by which it was stated that all gamete donations had to be anonymous, the aforementioned desexualisation of oocyte donation made it possible for women to receive the oocyte from her male partner's sister; today, this situation where the woman carries a child conceived by her partner's sperm with his sister's oocyte, is not culturally recognised as incestuous. In comparison, if this situation were to be symmetrically and genetically reversed, involving a man donating his sperm to his sister and brother-in-law, it would be more immediately perceived as incest, that is why it has not been practised in France. Certain types of direct donations between relatives do comprise incest, notably the secondary form of incest, so named by Françoise Héritier (1994) in order to distinguish this from the primary form of incest. Secondary form of incest is one in which two sisters or a daughter and mother have substantial contact via the intermediary of sperm from the same man; this is the case when one sister donates oocytes to the other, a transaction now possible in Belgium or could have existed in France.

Donation between relatives is practised insofar as the advantages provided appear more immediate and more tangible than the perception of incest implied by such a donation. In addition to the claimed desexualisation of donations between relatives, there is the argument that it is preferable to have donations between close relatives in order to ensure transfer of a genetic capital. In such a case, there would be a greater chance of the child resembling his/her parents than if he/she were conceived by a person outside the family.⁶ Such donations are based on the idealised mode of solidarity, as if the fact that the donation took place between relatives completely eliminates any sexual characteristics. This is a case of denial as the relationships between the relatives are not devoid of sexuality, even if this is refused.

Sexuality is not actually confined to a physical level involving the meeting of bodies and their substances (Godelier 1995). It also comprises a level of psychological identification mechanisms, as illustrated by the analysis of a current practice at the CECOS implemented to remedy the lack of donations. Couples who have to resort to sperm or oocyte donations are invited to inform a man or a woman from their family or friends who is already a parent of their problems in having a child, so that in agreement with his or her partner, he or she voluntarily donates sperm or oocytes, a donation that will benefit other couples than those who have requested the donation; with this donation – made with the intention of benefiting the couple who requested it but who will not benefit directly from it – the requesting couple will actually benefit by reducing the time they have to wait to receive a donation from a person they do not know.

Now, certain choices relating to this type of so-called “indirect” donation appear to bear witness to a subconscious desire for adultery that symbolically facilitates artificial insemination donation, for example when a woman chooses one of her friends, her ex-husband, brother-in-law or even the husband of her best friend. Moreover, such an act may generate confusion for the couple – and equally for the person who makes the donation and his/her partner – given that, although the person requested by the couple will not be the biological origin of their child, as the sperm or oocyte will be donated to other couples, the couple who made the initial request still display a propensity to subconsciously look upon the donor as the father or the mother of the child. On this subject, the question could be raised of the possibility that the realisation of incestuous fantasies facilitates indirect donations of sperm or oocytes. In fact, the person chosen by the couple is rarely a stranger from the point of view of the relationship, as it is often a close relative – for example and with the case of a sperm donation, one of the brothers of either the wife or husband, or one of their uncles.

Although the CECOS has no rules regarding the position of related persons who may be presented as indirect donors, if a couple were to suggest the father of either the husband or the wife, the medical personnel would refuse such a choice, more or less due to its incestuous character. Even the implicit acknowledgement of the possibility of such incest also requires the acknowledgement that this apparently non-sexual action conceals a certain form of sexuality.

In conclusion, once one has admitted that sexuality is not limited to the sexual act of procreation, but can also be found in the circulation of substances such as sperm, which has both sexual and procreative value, and that sexuality is equally encompassed in a less “physical” but no less “authentic” sense in our most subconscious thoughts, it becomes clear that sexuality has not disappeared entirely from the medical techniques for procreation, this despite the commonly accepted idea that these techniques operate with a distinction between procreation and sexuality. This study in fact displays that, far from having evacuated sexuality, it has been reactivated in a complex manner by

the methods of procreation via donation insofar as they no longer involve one couple alone but comprise three persons – who may also be related – two of the same sex and one person of the opposite sex, who reactivate the act of identification and of incestuous desires of the Oedipal triangle.

Notes

- 1 On the notion of semen as “gift” or “goods” see Tober (2001) Becker (2000), and also Edwards et al. (1999).
- 2 According to Pennings et al. (2009), most of the foreign patients in Belgium are coming from France (38%).
- 3 My study will concentrate on the adults involved in these methods of procreation, rather than any child that may be born.
- 4 On the subject of sperm and its social meaning, see Almeling (2007, 2011) and Moore (2007).
- 5 There is approximately a 25% probability of pregnancy for each cycle. The success rates differ depending on women’s age.
- 6 For more detailed information on the importance of resemblance in MAP, see Fortier (2009, 2011, 2012).

Bibliography

- Almeling, R. (2007). Selling Genes, Selling Gender: Egg Agencies, Sperm Banks, and the Medical Market in Genetic Material. *American Sociological Review* 72: 319–340.
- Almeling, R. (2011). *Sex Cells. The Medical Market for Eggs and Sperm*. New York and London: New York University Press.
- Becker, G. (2000). *The Elusive Embryo. How Women and Men Approach New Reproductive Technologies*. Berkeley, Los Angeles and London: University of California Press.
- Edwards, J., Franklin, S., Hirsch, E., Price, F. and Strathern, M. (1999). *Technologies of Procreation: Kinship in the Age of Assisted Conception*. New York: Routledge.
- Fortier, C. (2005). Le don de sperme et le don d’ovocyte ou “trois font un”. *Sexualité, inceste et procréation*. In P. Bidou, J. Galinier and Bernard Juillerat (eds), *Anthropologie et psychanalyse: regards croisés*. Paris: EHESS, 59–80.
- Fortier, C. (2009). Quand la ressemblance fait la parenté. *Défis contemporains de la parenté*, 251–276.
- Fortier, C. (2010). Se masturber pour les hommes, montrer son sexe pour les femmes: recueil de sperme et pratiques gynécologiques dans le cadre des Procréations Médicalement Assistées (Islam sunnite-Égypte-France). *Sociologie et Santé* 31, *Islams et santé*, L. Kotobi et A.M. Moulin (eds), 221–232.
- Fortier, C. (2011). “Des gamètes de couleur”: phéno-type, race ou ethnique? *L’Autre. Cliniques, cultures et sociétés, Revue transculturelle. Parentalités* 12(3): 289–303.
- Fortier, C. (2012). De troublantes ressemblances: un sentiment de parenté. *Corps*, 10, *Corps des affects, corps en migrations*, N. Dasio and V. Vinel (eds), 105–113.
- Fortier, C. (2013). Genre, sexualité et techniques reproductives en islam. In F. Rochefort et M. E. Sanna (eds), *Normes religieuses et genre. Mutations, Résistances et Reconfiguration XIXè–XXIè siècle*. Paris: Armand Colin (Recherches), 173–187.
- Franklin, S. (2013). *Biological Relatives: IVF, Stem Cell, and the Future of Kinship*. Durham, NC and London: Duke University Press.

- Freud, S. (1987). (or. 1905) *Trois Essais sur la théorie sexuelle*. Paris: Gallimard (Folio Essais).
- Freud, S. (1997) [1908] *La vie sexuelle*. Paris: PUF.
- Godelier, M. (1995). Qu'est-ce qu'un acte sexuel. *Revue internationale de Psychopathologie* 19, 351–382.
- Héritier, F. (1994). *Les Deux sœurs et leur mère*. Paris: Odile Jacob.
- Moore, L. J. (2007). *Sperm Counts: Overcome by Man's Most Precious Fluid*. New York: New York University Press.
- Pennings, G., Autin C., Decler W. *et al.* (2009). Cross-Border Reproductive Care in Belgium. *Human Reproduction* 24. 3108–3118.
- Scheper-Hughes, N. and Wacquant, L. (2003). *Commodifying Bodies. Theory, Culture and Society*. London: Sage Publications.
- Tober, D. (2001). Semen as Gifts, Semen as Goods: Reproductive Workers and the Market in Altruism. *Body and Society*, 137–160.

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