Gender and medicine
The importance of a gender perspective in medical practice to promote the health system
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1. INTRODUCTION: THE THEORETICAL CONTEXT

In social sciences, the concept of gender has been the subject of many heated debates on its cognitive validity starting from the dichotomy between the male and female genders.

The definition itself distinguishing between sex and gender, which identifies in the former the biological difference and in the latter its social construction, was later criticized from multiple perspectives, because such an interpretation ended up putting the two genders onto a natural, non-historical level, by crystallizing identities in a rigid division of roles.

As far as biomedical laboratory research is concerned, the category of gender, already used in the ’50s to identify in bodies some features related to sex and some others to social factors, was indispensable to show to those involved in the scientific debate how pointless it was to establish rigid boundaries between nature and culture (Fox Keller 1987), by supporting such mutual influences through the more articulated definition of “sex-gender system”.

As far as health is concerned, even by keeping into account the debate and amount of studies generated in the subject matter at issue, the validity of this theoretical approach is undeniable, as it will be showed, in consideration of the plurality and often heterogeneity of the factors affecting pathologies and the severity with which they manifest themselves. Therefore, it is necessary to favor the dialogue among different areas in a hopeful integration of social-health character.

Women, in particular, experience in their everyday life and on their own body the effects of a symbolic order, of institutional practices, and of power regimes, capable of affecting their behavior and the access to resources in a broad sense, i.e. economic, cultural and welfare-related resources. From such a composite intertwining of individual experiences, life places, social contexts and relations, it derives the existence of health disparities, a differentiated exposition to complex interactions. As a result, males and females get sick in different ways.
Therefore, even if one does not intend to categorize women’s life within a condition related to a rigid social destiny, in the variety of their biographies made of an increasing number of choices, their living paths is still characterized by discriminations, starting from the widespread tendency to overlooking peculiar differences, non only organic ones, within medical and research protocols.

In other words, gender is “a crucial dimension of personal life” (Connell 2006 p.25) and thus a cross-cutting factor to read women’s health conditions and their perception, which, according to statistical data, turn out to be significantly worse than those of men.

In other words, in consideration of the apparent paradox of women having longer life expectation but at the same time experiencing a higher degree of susceptibility to diseases and disabilities, the most proper perspective from which such a phenomenon should be analyzed is the one concerned with recurrent asymmetries, or rather gender gaps. Those asymmetries or gaps characterize the different levels of social organization: from family to occupation, from scientific production to political participation.

Images from Gendered Innovations in Science, Health & Medicine, Engineering and Environment
http://genderedinnovations.stanford.edu/what-is-gendered-innovations.html
2. THE SEX-GENDER SYSTEM: THE MULTIDISCIPLINARY APPROACH

It has been underlined the importance of different social aspects for health. Therefore, one of the errors to avoid in medicine, and thus in providing medical treatments, is the adoption of a restrictive interpretation of the term gender as a synonym to sex. The former may not be considered just as a biological factor, but it has to be given a theoretical meaning, which makes it useful to detect the differences in the constructions of identities, starting from those culturally defined.

So far, indeed, reproductive, physical, hormonal aspects have been deemed to be natural determining factors, thereby ending up to overlook important information coming from persons’ biographies, life events, social relations and emotions.

The importance of such areas of knowledge, concerning a male/female patient, was traditionally underestimated in therapies and clinical practice. Therefore, body reactions and the capacity of such factors to affect health are still left to a reductive anamnesis.

This long-standing approach definitely decreases the diagnostic chances resulting from information collected through the storytelling of diseases by the individuals suffering from them.

Such a complementarity strengthens the idea that an osmosis among disciplines and sciences may increase and improve knowledge and allow the achievement of important results in the field of innovations, not just merely technological ones.

Many examples, indeed, may be provided, starting from numerous methodological links in significant domains, such as neurosciences. Those links, realized through multidisciplinary cooperation, led to important discoveries. It is modeled upon an allegedly universal system of law, which is actually built upon a male-centered tradition, as two pioneers of the feminist thought had pointed out: Olympe de Gouges e Mary Wollstonecraft.
Traditionally, an implicit prejudice reserved women the role of “second sex” for long time, by including all the differences in the term “man”. As Beauvoir argued, the patriarchal society induced women to accept the position of Other.
There exists an absolute human type, which is the male one, and accordingly French intellectuals used to wonder what women should have been expecting when they sought to escape the sphere assigned to them.
What is deemed to be natural pierced so much into our mindsets that it appears to be inevitable. Such a mental process therefore legitimizes an artificial construction that puts the sexes into a hierarchical scale. According to Pierre Bourdieu, males’ predominance may be measured by the very fact that it is not required to find a justification and, therefore, does not need a legitimation.
Such a situation has also affected scientific research, as our theoretical references are related to the more general vision of the world characterizing a given society in a given period of time. It means that implicit assumptions shape our reality even before we realize we are interpreting it (Jedlowski, 1994).
“Tacit knowledge” (Polany, 1958), an unformed type of knowledge that is originated from our experience, is a set of unknown remains but at the same time the foundation of our scientific activity.
Such a frame manifests itself when we do not see anymore what we were accustomed to seeing and begin looking in a different direction. This revelation was to ascribe in a large part to the feminist thought and to critiques brought in a variety of fields of study. As a result, what we took for granted in our daily experience, within closed scientific communities, requires a significant revision of the approaches to follow through the adoption of systemic and necessarily open vision to be able to grasp the different aspects involved in healthcare: from prevention to the treatment of diseases.
Such multiple aspects should be considered in their mutual relations, in order for the social construction of sex differences not to turn into sheer gender disparities. The purpose to achieve is also to increase the level of appropriateness of a treatment path focused on everyone’s peculiar characters.
It constitutes a significant step (up) in the approach to healthcare, to the extent that a wrong notion is replaced by a greater awareness of the complex content of healthcare. Complexity, too, is a key term, as it is closely related to the need for a multidisciplinary approach. As was recently underlined, indeed, “the paradigm of complexity, which requires the coexistence of a multidisciplinary approach and specialization, the capacity of dealing with multiple causality, in addition to linear causality, and the difficulty of foreseeing the consequences within a system influenced by initial conditions (according to which the same fact has different consequences if it manifests itself in a different context) invade science in general and medicine in particular, as a feature of modernity” (G. Barcellona, 2021).

The simplification implied in the distinction between mind and body and the use of nosology as a way of approaching diseases – by providing a formal, abstract classification of them – did not take into proper account the fact that, in human beings, the physical, psychological, and social dimensions coexist. All of these dimensions contribute to composing a multidimensional concept of health and must be inspected.

The debate between the unity of knowledge and the subdivision into specific fields of study is a common thread passing through all the history of the Western thought and marked by many scholars taking a stand in favor or against a certain method of arranging teaching courses and subject matters in general. It is something that also occurred, in the past at least, in social sciences. A similar debate developed, especially between the last decades of the 19th century and the seventies of the 20th century, on the nature of administrative science. It could be considered either as an autonomous subject matter, and thus it had to be distinguished from administrative law, or as a sort of ancillary field of study. This latter opinion deemed administrative science to be a portion of as many different subject matters as were the fields in which the public administration was involved. In other words, as Italian administrative law distinguished scholar Massimo Severo Giannini pointed out in the 1950s, the pivotal issue was whether there existed just one administrative science or many administrative sciences, related to several subject matters and disciplines, with resulting difficulties of arranging academic courses (Giannini, 2004).
The approach traditionally followed towards the varying elements, aimed at ensuring the unity of the subject matter, led to a mostly descriptive explanation. Accordingly, the interpretation of some issues concerning the gender perspective consisted merely in the comprehension of physical/reproductive differences between the genders – actually, among all the genders, not necessarily restricted to the male and female ones – while it overlooked the role played by the cultural and institutional contexts.

Today, however, such elements are usually accorded some degree of relevance in healthcare interventions, even though the notable delay in applying the gender perspective to clinical practice is limiting its effectiveness. As a result, there appears to be frequently a simplification of that composite combination between each individual’s biography and the aspects of her body that are directly visible. As Rousseau maintained in Émile, ou De l’éducation (1762), there are both many affinities and conflicts between the two sexes. Therefore, one of the wonders of nature is the existence of beings that turn out to be so similar and different at the same time. In light of what has just been said, those conflicts and differences, which appeared to be natural in the past, may be explained on the basis of their different social construction.
In a famous article written in the early ’90s, cardiologist Bernardine Patricia Healy referred to the (female) main character of a book by Isaac B. Singer: Yentl, who was forced to dress up like a man to gain access to the study of Talmud. In this article, the author expressed her concern that the U.S. healthcare system was treating women as if they were men.

Many steps forward have been taken since in the acquiring of knowledge and notions about gender medicine. In 2000, for instance, the World Health Organization included this subject matter in the Equity Act. Furthermore, while scientific associations established sections specifically devoted to gender issues, a regulation that was approved has the purpose to adapt our healthcare system and the offer of relevant services. A further step would be proper, however: the shift from gender medicine to the perspective of gender in healthcare (Biancheri 2013; 2016). It would lead to taking into adequate account in clinical practice the importance of each individual’s existence considered as a whole through the resort to narrative medicine.

Therefore, differences are twofold: on the one hand, each individual has her own peculiar characters, which are concerned with her body, her biography and her social relations; on the other hand, males and females are different and usually act differently. Women, for instance, resort to drugs and medical examinations and participate in prevention campaigns more frequently than men do. They also have a healthier lifestyle. However, women are involved in clinical trials at a much lower percentage, even when it is recognized that the level of efficiency, security, and tolerability of certain drugs is uncertain, resulting from clinical tests mostly conducted on male animals. Furthermore, delays in the diagnosis of some pathologies may derive from the same variability in the early emergence of symptoms, as is the case with heart attacks, characterized by different forms of pain suffered by the individual carrying one of such pathologies.
The social aspects mentioned above, however, are still underestimated, as a result of an epistemic limitation on multidisciplinary approaches due to the difficulty of integrating the various dimensions influencing the healthcare construction process. The awareness of the existence of so many differences, which should be taken into account in treatments, and the need for a multidisciplinary approach to pathologies require a revision of the health system considered as a whole, including such preliminary stages as education and training for doctors and all the personnel involved in healthcare. The main changes in this regard should be to review the academic courses and curricula within the medical schools and departments and to ensure a permanent medical training focusing on such an approach and thus on gender medicine. The common purpose of those changes is to improve the appropriateness of services and care provided to any individual.

The adoption of this new approach also brings about some risks. One of the main risks is that the treatment of diseases could take a longer time especially in some cases, given the need to consider all the factors that may affect an individual’s health. This observation could also lead to the establishment of some limitations to the usage of the approach at issue, which would still be compatible with the guarantee and protection of the individual right to be cured. Such limitations would derive from what Dworkin described as the metaphor of the balancing between the public interest, in this case namely the interest in not having excessive delays in medical treatments, and the demands of individuals, namely the demand to be cured in an adequate way (R. Dworkin, 2010).

The subject, that is the individual, has been seen as a “confounding event”, so the awareness of her uniqueness might seem to constitute a problem in medical care. In a deterministic and objective view, the “I”, i.e. the self, was expelled from the positivist theory and became meaningless. However, such a cultural background and approach should be reversed to embrace a concept of citizenship capable of ensuring human rights.

As Touraine (2019) argues, the issue of the role of the subject should be dealt with in light of “subjectification”, which means to put aside – or attenuate at least – a purely objective approach to knowledge to save the self “from the denial, where it was relegated".
As a result, the following question should be asked (p. 105): how can we consider ourselves democratic if we do not claim the right to be heard and understood, to the extent that we criticize the way the education and health systems are directed and organized? This view implies an advanced version of the right to be heard, which was traditionally deemed in administrative law to prevent administrations from adopting measures capable of adversely affecting the interests of individuals or groups if beforehand they were not accorded an opportunity to express their reasons and arguments in the course of an administrative proceeding (Della Cananea, 2016).

Main bibliography:

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4. ANALYSIS: OBJECT OF THE RESEARCH

Within such a theoretical context, the purpose of the Pisa working group on health (Health Union) was to ascertain how the concepts and approach explained above have been implemented in education and training by the Department of Medicine of the University of Pisa. In particular, the research was conducted by focusing on the students of Medicine and Surgery who decided to attend the course ADE – Medicina di Genere (Gender Medicine), held by Professor Rita Biancheri. The main purpose was to obtain from those participating in the course opinions on the current implementation of gender medicine and suggestions on possible ways and instruments to improve this implementation. In the long term, the purpose is to contribute to ensuring that gender medicine gain increasing recognition in that department.

THE METHODOLOGY

The methodology by which the research was conducted may be considered a mixed one. Firstly, the working unit identified the object of the research beginning with an analysis of the existing studies concerning the subject matter at issue. Secondly, it defined the investigation instruments and, namely, formulated the questionnaire that was later handed out to the students attending the ADE – Medicina di Genere course mentioned above. The questionnaire was devised as a survey. The answers given by the students to the several questions it was composed of were processed by the working unit, and the outcomes of this activity may be illustrated as follows.
QUESTIONNAIRE

• Name and surname

• Year of attendance

• Have you ever heard of gender medicine?

• If so, in what courses and/or on what occasions?

• In your opinion, how would you improve the training/teaching on these issues in your degree course?

• Are you aware of the legislative framework concerning the usage and dissemination of gender medicine? Do you believe that the existing legislation and reference centers are useful?

• In your opinion, what are the main factors hindering a widespread presence of gender medicine?

• Do you deem gender medicine to be useful for prevention, diagnosis and treatment of diseases and why?

• In your opinion, is it possible to implement this approach in hospitals and ambulatory practices?

• What methods/instruments can be used to improve clinical anamnèsis?

• Why is it better to talk about a gender perspective in healthcare?

• Observations and suggestions
THE CHALLENGES

From the questionnaire (survey) and the research conducted in general, the following challenges for the promotion and dissemination of gender medicine emerged:

I. To develop research, knowledge, and gender-related statistical data that be tailor-made for any different pathology: from the description of symptoms to the therapeutic path to formulate guidelines within evidence-made medicine

II. To promote an approach to medical education and training that be capable of ensuring that their contents take into account the innovations brought in by the sex and gender analysis;

III. To introduce the “gender budget” as an instrument of participation capable of triggering an economic-social budget cycle (participatory, anticipated, and final), in conformity with the structure of the RRF (arranged and subdivided in milestones and targets) to ensure widespread knowledge and thus allow a shared evaluation of the amount of invested resources, of their usage, and of the outcomes;

IV. To promote a gender-sensitive communication that provide the public with the outcomes of the research. The purpose of such a communication is to increase the people’s awareness about the topics dealt with in the research, as it may contribute to a widespread implementation of gender medicine in clinical practice. The ultimate goal is, therefore, to improve the offer of healthcare services and of the related budgets;

V. To promote the establishment of an international network to discuss the legislation and regulations existing in the different national or supranational legal systems and to ensure an exchange of best practices.
CRITICAL ISSUES
FROM THE QUESTIONNAIRE:
OBSERVATIONS AND SUGGESTIONS

• The proposal of adding the gender perspective transversally to all subject matters of the Medicine degree courses.
• The perception of scarce publicity of issues concerning gender medicine and of their frequent banalization, when they are addressed.
• The widespread reference to stereotypes, which do not allow the proper recognition of gender medicine. The latter is also damaged by conservative and old-fashioned views of medical methods and by a good deal of skepticism among patients, by contrast to the so-called sexe and gender innovation. It was detected a certain difficulty in the actual personalization of health care, which can be qualified as lacking a scientific and objective character.
• It is necessary to have awareness activities by the media and an improvement of communication systems to strengthen a culture that gives value to differences.
• It was put stress on a series of specific issues related to the practical application of gender medicine and to “the risks of extending the duration for diagnoses and care”, as well as the increase in costs for hospital structures.
• The need to create specific databases and have a larger number of correlation studies.
• The importance of a multidisciplinary approach, that may lead to a cooperation among disciplines and to the usage of a sociologic approach in the definition of anamnesys.
BEST PRACTICES

Suggestions and best practices were divided into 4 theme areas for the identification of possible interventions of strategic character, instruments, and implementing measures.

Gender and health

1. To follow an interdisciplinary approach among the different areas of medicine and human sciences, which take into account differences deriving from gender to guarantee the propriety of research, prevention, diagnosis and care;

2. On the basis of epidemiological data, to promote the prevention and early diagnosis of pathologies from a gender perspective;

3. To elaborate innovative solutions for the access to healthcare services to foster a more proper and personalized approach to prevention, diagnosis, treatments, and rehabilitation;

4. To promote (positive) actions aimed at applying a gender perspective in the formulation of public policies on healthcare and on safety and security in workplaces;

5. To adopt by the various entities and bodies, of public or private nature and belonging to a certain government level, depending on how each national healthcare system is organized, a three-year plan for the implementation of gender medicine, aimed at identifying priorities in the actions to carry out, actors to be involved, and indicators to apply to monitor and oversee the implementation of the plan itself. The issuance of an annual report on the implementation of the plan and its submission to the administrative body or organ at the top of the healthcare system should also be provided for to ensure the accountability of public officials, public or private managers, and other personnel charged with carrying out the actions determined by the plan;
6. To pinpoint the best practices among the States and bodies joining the network and to make them available to all the participants;

7. To analyze the data concerning health in workplaces, namely accidents, injuries, and work-related diseases, by taking into due account gender differences;

8. To validate models of digital instruments for the knowledge and integration of a patient’s clinical data with her life experience.

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### Research and training

1. To promote and support of research (biomedical, pharmacological, and psycho-social) based on gender differences;

2. To promote and support of the teaching of gender medicine, ensuring adequate levels of training and updating for medical and health personnel;

3. To prepare an annual report detailing the educational and training activities carried out and highlighting the strengths and weaknesses detected;

4. To prepare, test, and validate models for the training on gender medicine that be effective and replicable;

5. To identify gender medicine as a priority area and a cross-cutting subject matter in the calls issued at national and supranational levels for the funding of projects and, more generally, in any case a selection proceeding is carried out for the granting of resources in the medical field;

6. To conduct post-registration long-term studies and epidemiological studies concerning drug use and drug use disorders by taking into proper account gender differences;
7. To conduct investigations on gender differences with specific regard to genetic, epigenetic, transcriptional, metabolic, and hormonal aspects, as well as in physiopathology and in the study of drugs’ mechanisms of action and of medical devices.

**Organization**

1. To designate, within the administrative or teaching personnel of any university, an official (or professor) who will be in charge of ensuring the implementation of gender medicine in the academic context. This official, who may be called the responsible (or delegated) for gender medicine, will have the duty to elaborate strategic plans aimed at ensuring that gender medicine get adequate recognition in academic courses and medical training. In discharging this duty, he will act in coordination with the deans of the various courses of study in the Department of Medicine;

2. To strengthen the role of the administrative structures – which may be offices, bodies, committees and individual officials – that are assigned functions of coordination on gender issues. Indeed, they have a strategic role as a liaison, thereby making it easier to project, formalize, and give publicity to initiatives of gender medicine, in accordance with an implementation of codified activities and with the official in charge of gender medicine;

3. To establish a table, i.e. a committee, with a technical nature (and composition), tasked with a periodical evaluation of the quality levels in the educational and training offer concerning gender-related courses in the Medicine Department and of the level of satisfaction of students on such topics to keep the offer constantly updated and capable of responding to the ever-evolving challenges;

4. To adopt by the various entities and bodies, of public or private nature and belonging to a certain government level, depending on how each national healthcare system is organized, a three-year plan for the implementation of gender medicine, aimed at identifying priorities in the actions to carry out, actors to be
involved, and indicators to apply to monitor and oversee the implementation of the plan itself. The issuance of an annual report on the implementation of the plan and its submission to the administrative body or organ at the top of the healthcare system should also be provided for to ensure the accountability of public officials, public or private managers, and other personnel charged with carrying out the actions determined by the plan;

5. To define a governance strategy for the implementation of the gender medicine plan by providing for the involvement of any manager of the (university) administration, whose competence – meant as the set of duties and tasks specifically assigned to her as the head of one or more offices – is more or less directly related to gender medicine, and, accordingly, to establish working groups or internal committees devoted to this subject matter;

6. To realize a mapping of the offices and organs within the (university) administration, as well as of public bodies, whose competence is more or less directly related to gender medicine on either a theoretical or a practical level. Such a mapping should be instrumental to creating a network or at least to ensuring some sort of coordination in the activities carried out by those offices, organs, and bodies;

7. To draw up and constantly update a comprehensive account of all the administrative structures, whose competence is more or less directly related to gender medicine, and of all the types of resources – financial, material, and human – devoted to the implementation of the gender perspective. Such an account should facilitate the exchange of best practices and the proposal and application of innovative solutions for the access to services in conformity with this perspective.
Communication and dissemination of information

1. To promote and support the dissemination of information on healthcare, with an emphasis on the importance of the gender perspective, by the administrations and public and private bodies that are a part of the healthcare system in a given country;

2. To promote the acquisition of at least the fundamentals of gender medicine not only by all the healthcare personnel but also by the general public. This activity should be carried out with the involvement of journalists, media operators in a broad sense, and policy makers;

3. To identify instruments aimed at ensuring or facilitating the conveyance of the messages expressed by a given communication activity or campaign to the audience singled out for that activity or campaign;

4. To inform doctors, other hospital and healthcare personnel, and researchers in the medical field and to increase their awareness about the importance of following a gender perspective in any sector or branch of medicine;

5. To provide the general public and patients with the fundamentals of gender medicine by launching communication campaigns or organizing other initiatives with the same communication function;

6. To identify, for any communication campaign that is undertaken, the specific factors that may lead to its success. It means that the public or private authority responsible for a given campaign may consider inserting contents or approaches that are tailor-made for the audience of the campaign itself;
7. To verify the efficiency and efficacy of a given communication activity after it was carried out

8. To make information and materials on gender medicine available to anyone as open access contents posted on institutional – i.e., official – websites of the administrations and public and private bodies that are a part of the healthcare system in a given country;

9. To resort to all kinds of media, both traditional and innovative ones, namely social media, for the carrying out of communication activities on gender medicine;

10. To provide all media operators not only with the fundamentals of gender medicine but also with instructions and suggestions, though the adoption of specific guidelines, concerning how to explain and discuss about this subject matter, even by considering the organization of seminars and lectures by professors and experts in the field;

11. To make promptly and easily available to anyone the outcomes of research activities conducted on gender medicine.
WORKING GROUP

**Rita Biancheri** is Associate Professor in the Department of Political Sciences at the University of Pisa, where she teaches *Family and Education Sociology, Sociology of Health* at the Department of Medicine. Since 2012, she has been a member of the executive board of the SISS (Italian Society of Sociology of Health). From 2008 to 2016, she was a member of the executive board of AIS - Sociology of Health and Medicine. From 2005 to 2012, she was the President of the Equal Opportunities Committee of the University of Pisa. From 2006 to 2008, she was a member of the Ministerial Committee “Women and Health”, chaired by then Minister for Health Livia Turco. From 2013 to 2017, she was the scientific coordinator of the EU project called Trigger (Transforming institutions by gendering contents and gaining equality in research).

**Vanessa Manzetti** is a senior researcher in *Public Law* in the Department of Political Sciences at the University of Pisa and qualified for the position of II-level professor in the recruitment field of administrative law. She has been a part of numerous national and EU research projects. She was a local coordinator of a 2017 Research project of relevant national interest (Prin). For some years, she has had scientific responsibility for the Jean Monnet 2019 project and for the Summer school in Public auditing and accountability at the University of Pisa. Furthermore, she was a visiting researcher at the European Court of Auditors and participated in several international conferences.

**Francesca Pecori** holds a Ph.D. in *Histoire et sémiologie du texte et de l’image* at the University Sorbonne Paris Cité and in *Gender studies* at the University of Pisa. She is a post-doctorate research fellow at the Guarantee for Equal Opportunities Committee (CUG) of the University of Pisa and she is an expert in the drafting and implementation of strategic plans and documents for the promotion of equal treatment and the valorization of differences in the academic context at national and EU levels. For a long time, she has been working together with Professor Rita Biancheri in the teaching of *Gender studies and society*. She also participated in several national and international conferences.
Marco Lunardelli is a post-doctorate research fellow in Administrative law at the Bocconi University in Milan and a contract professor at the University of Pisa, where he currently teaches Civil Protection Legislation in the Department of Civilizations and Forms of Knowledge. He is also a member of the editorial staff of the Italian Journal of Public Law (IJPL) and the author of essays and articles both in English and in Italian, which are concerned with general administrative law, public procurement, urban planning law, and comparative public law. He was a visiting research fellow at the Law School of the Columbia University, New York, NY, in the academic year 2013-2014.