



Artificial Insemination

Preliminary remarks

Family planning (birth control) is dependent upon the individual situation of brothers and sisters as well as upon their economic and social conditions.

Children are a gift from God and enrich family life. In this sense, the Church endorses raising children in the family. In principle, birth control is at the sole discretion of the parents.

Introduction

Artificial insemination is mainly used by those whose wish for a child remains unfulfilled. It is also an option for young men and women who, due to severe illness, are receiving aggressive chemotherapy or radiotherapy and whose fertility is thereby considerably reduced. Prior to such therapies, sperm and ova can be taken from these patients and kept in frozen storage (cryopreserved). Fertilised ova (embryos) of married couples can also be cryopreserved. Thus, should the patient recover from the severe illness, the desire for a child can be fulfilled. In some countries, artificial insemination is also used to provide early proof of a severe genetic defect. Here the goal is to avoid pregnancy with unhealthy embryos for couples with a high risk of severe hereditary diseases. Due to ethical considerations, this procedure is prohibited by law in some countries.

At present, the most commonly used method for artificial insemination around the world is extracorporeal fertilisation (fertilisation of the egg outside the mother's body). Another method is intrauterine insemination (IUI), in which the sperm taken from the man is prepared in the laboratory and transferred with a catheter into the uterine cavity.

Since the first birth of a child using extracorporeal fertilisation in 1978, up until 2008, over a million children have been born who were conceived this way. In 2006, the percentage of newborns conceived through artificial insemination was between 3% in Northern European countries, and a little over 1.0% in Central Europe.

In order to clarify our Church's position on these methods, we will first describe the procedures and problems involved.

Methods and procedures

A. In vitro fertilisation (IVF) and intracytoplasmic sperm injection (ICSI)

Extracorporeal fertilisation is currently performed in two different ways. In vitro fertilisation (IVF) is mainly used in cases of fertility disorders in women, while intracytoplasmic sperm injection (ICSI) is employed for fertility disorders in men.

Following hormonal stimulation of the ovaries, several ova are then removed and joined to the man's sperm in a reagent container (IVF). In intracytoplasmic sperm injection (ICSI), a sperm is directly inserted into an ovum.

Usually three days after fertilisation, at the 4-8 cell stage, the embryos are implanted in the uterus. Since only some of the transferred fertilised ova are viable, normally 2-3 embryos are transferred to the woman.

The majority of embryos conceived by extracorporeal fertilisation are generally not viable. Statistically, an average of only one in ten embryos transferred through IVF leads to a live birth. Therefore, the loss of fertilised ova is somewhat higher than under natural conditions, in which less than half of the fertilised ova result in a live birth.

As a rule, several transfers of embryos are required to achieve pregnancy. In order to reduce the number of hormonal stimulations – which may include considerable side effects –, it is often recommended that more ova be harvested and fertilised than can later be transferred to the uterus. The surplus embryos are cryopreserved and can be used in further treatment. This often results in surplus, cryopreserved fertilised ova that are no longer needed after a successful birth, and may then intentionally be discarded and left to die.

It is, however, also possible to fertilise only one, two, or three ova and transfer these to the woman. In this case, a milder hormonal stimulation of the ovaries is sufficient to harvest only a few ova. With respect to side effects, this milder stimulation can even be regarded as the preferable procedure. It may, however, require several stimulation treatments for pregnancy to be achieved, and therefore lead to higher costs and more treatment cycles.

B. Preimplantation diagnostics (PID)

Known, life-threatening congenital diseases can be detected in genetic material; embryos can therefore be examined prior to transfer into the uterus in order to determine whether such genetic defects are present. Here, the goal is to transfer healthy embryos. Embryos with a demonstrable disposition to (an) illness are rejected and left to die (selection by preimplantation diagnostics). This method is prohibited by law in some countries.

C. Elective single-embryo transfer (eSET)

If, in order to achieve a higher birth rate, several embryos are transferred, the occurrences of multiple pregnancies are significantly increased. These pose a greater risk for the mother and the children.

Such multiple pregnancies are avoided in the elective single-embryo transfer. Here, every embryo is examined microscopically with regard to its development capacity. Only the embryo with the highest development potential is then transferred in the uterus. This method leads to birth rates comparable to those of typical vitro fertilisation (IVF), with significantly reduced risks of multiple pregnancy. The other embryos are either discarded and die, or are cryopreserved for an additional transfer. These days, elective single-embryo transfer is increasingly endorsed. In Belgium, Finland, and Sweden it has already become routine treatment for IVF patients and is regulated by guidelines and laws.

D. Intrauterine insemination (IUI)

Intrauterine insemination is a treatment used for male fertility disorders. Fertilisation takes place in the mother's womb. The sperm obtained from the man is prepared in the laboratory and, at the optimal point of time for fertilisation, transferred with a catheter in the uterus. Prior to this, the presumed time of ovulation is estimated via hormonal and ultrasound examinations. Often ovarian maturation and ovulation are brought about by medication.

E. Reduction of the number of embryos or fetocide

If extracorporeal fertilisation is followed by pregnancy with several embryos, then in these cases of multiple pregnancy the killing of embryos (fetocide) is considered if the multiple pregnancy were to cause a significantly higher medical risk. It can, however, not be proven that reducing the number of embryos reduces the medical risks. Fetocide is also considered, if, due to the large number of children, substantial social problems can be expected.

F. Donation of sperm, ova, or embryos

In the case of serious problems with the man's sperm production, sperm from a donor can be transferred in the uterus.

In the case of anomalies in the woman's ovum development, donated ova can be fertilised extracorporeally with the husband's sperm and transferred in the woman's uterus. With donation of ovum or sperm the child is genetically related to one parent only.

If several attempts at artificial insemination with ova and sperm of a couple do not lead to a birth, embryos from another couple's treatment that are no longer needed can be transferred, as an embryo donation, in the woman's uterus. The child would then not be genetically related to the parents, but would grow up, already from the embryonic stage, as part of the new family. This method is prohibited by law in some countries.

G. Surrogate motherhood

If a woman is unable to carry a child to full term, her ova, fertilised with the man's sperm, can be carried to term by a surrogate mother. Genetically, the child is the child of its parents, but is carried to full term by a surrogate mother and after its birth returned to the parents. This method is prohibited by law in some countries.

Position of the New Apostolic Church on artificial insemination

The statements concerning artificial insemination are based on the position of our Church on the beginning of life and ensoulment. These statements are intended to clarify, from the viewpoint of our faith, that which is possible medically and desirable from a humanitarian point of view, in order to provide orientation for a well-prepared, self-responsible decision.

- The Church has no fundamental reservations concerning artificial insemination as long as it is guaranteed that no fertilised ova (embryos) are intentionally killed or selected for death.
- Intrauterine insemination (IUI) is unobjectionable, since no fertilised ova (embryos) are thereby killed.
- With extracorporeal artificial fertilisation, i.e. outside the mother's body (IVF and ICSI), embryos die after being transferred in the uterus. This is a biological selection which does not speak against performing artificial insemination.
- With artificial insemination, the Church recommends fertilising only the number of ova which will later be implanted. The Church rejects the active selection for death of fertilised ova. It is clear that with this restriction the success rate of artificial insemination could be reduced.

- The Church accepts cryopreservation of fertilised ova (embryos) if there is the clear intention to transfer, at a later stage, all fertilised and cryopreserved ova (embryos) in the uterus. The Church rejects the destruction or use for consumptive research of embryos that are not needed or have been cryopreserved.
- The Church regards marriage and the family as the best possible social environment in which children can grow up. Artificial insemination should therefore only be sought by a married couple.
- The Church has considerable reservations regarding the anonymous donation of sperm, ova, or embryos. The wish of a child to know who its parents are is just as important as the desire of a couple for a child. Donation of sperm, ova, or embryos can later lead to considerable tension in the family.
- The Church has considerable reservations regarding surrogate motherhood, particularly as the advocate of the child, whose beginning of life the parents have deliberately determined to take place in foreign surroundings. This is a psychological risk. Moreover, surrogate motherhood can be subject to legal problems. By carrying to full term and giving birth to a child, a surrogate mother develops strong inner bonds to the child. Turning over the newborn child to the parents can cause severe psychological problems for the surrogate mother, which can not be remedied with money. If surrogate motherhood is nevertheless agreed upon, qualified psychotherapeutic support is indispensable.

Adherence to our Church's position may lead to restrictions of that which is medically and legally possible.

The Church provides orientation in line with the Gospel, so that couples may be able to make the best possible decision. The Church's statements are based on the firm conviction that God, in His wisdom and omnipotence, will ensure a good outcome, in accordance with His will, if one's personal decision is made in line with these statements. The Church respects the self-responsible decision of couples, and, irrespective of the couples' decision, will non-judgmentally support the couples through soul-care.

Some couples are faced with difficult decisions, e.g. wanting to have a child, but knowing that a severe genetically linked illness has been discovered in the family. Here the Church recommends contacting the Apostle prior to any intended preimplantation diagnostics. He can, in cooperation with ministers who are also professional specialists, clarify the arguments on which the Church's advice is based and thus enable the couple to reach a well-founded and self-responsible decision. At the same time, he, as a minister, will be able to accompany and support them on this difficult path.

In the case of involuntary childlessness, adoption – together with artificial insemination – should also be taken into consideration. Through adoption, children who would otherwise grow up in difficult social environments can be provided better opportunities as they grow up.

Short statement of the New Apostolic Church concerning artificial insemination

In principle, the Church has no reservations concerning artificial insemination as long as it is guaranteed that no fertilised ova are intentionally killed.

Artificial insemination should only be performed with married couples and with their own sperm and ova.