



# A TIME TO BE BORN

A Faith-Based Guide to Assisted Reproductive Technologies

---

©2009

Religious Institute

ISBN:1-893270-58-0

978-1-893270-58-9

---

# **A Time to Be Born**

**A Faith-Based Guide to Assisted Reproductive Technologies**

---

Kate M. Ott, Ph.D.

Assisted Reproductive Technologies Project Director

---

For everything there is a season,  
And a time for every matter under heaven:  
A TIME TO BE BORN, and a time to die;  
A time to plant, and a time to pluck up what is planted;  
A time to kill, and a time to heal;  
A time to break down, and a time to build up;  
A time to weep, and a time to laugh;  
A time to mourn, and a time to dance;  
A time to throw away stones, and a time to gather stones together;  
A time to embrace, and a time to refrain from embracing;  
A time to seek, and a time to lose;  
A time to keep, and a time to throw away;  
A time to tear, and a time to sew;  
A time to keep silent, and a time to speak;  
A time to love, and a time to hate;  
A time for war, and a time for peace.

*Ecclesiastes 3:1–8*

This guidebook provides up-to-date information as of April 2009. The information provided in this guidebook should not be substituted for professional medical diagnosis or genetic counseling recommendations. For the most current medical information on assisted reproductive technologies, see Centers for Disease Control, Assisted Reproductive Technology (<http://www.cdc.gov/ART>) or consult a medical practitioner.

---

## Table of Contents

ACKNOWLEDGEMENTS .....	5
INTRODUCTION .....	7
THE SCIENCE AND LANGUAGE OF ASSISTED REPRODUCTIVE TECHNOLOGIES .....	9
ETHICAL CONCERNS RELATED TO ACCESS, SAFETY, AND REGULATION.....	14
RELIGIOUS TRADITIONS .....	17
PASTORAL CARE AND COUNSELING .....	21
THE ROLE OF CONGREGATIONS AND DENOMINATIONS .....	25
OPEN LETTER TO RELIGIOUS LEADERS ON ASSISTED REPRODUCTIVE TECHNOLOGIES .....	27
CONGREGATIONAL MATERIALS.....	30
DENOMINATION STATEMENTS ABOUT ASSISTED REPRODUCTIVE TECHNOLOGIES .....	32
RESOURCES .....	40
ORGANIZATIONS .....	44



---

## ACKNOWLEDGEMENTS

Many people contributed to the development and writing of this guidebook.

Major sections of the guide were informed by previous writings. The Science and Language of Technology and the Ethical Concerns sections are adapted with permission from *Assisted Reproductive Technologies: Overview and Perspective Using a Reproductive Justice Framework*.<sup>1</sup> I am grateful to the Center for Genetics and Society and Generations Ahead for the use of this material. I am also thankful to its author, Emily Galpern, for her generous review of the adapted and updated sections.

Rev. Debra Haffner's work on pastoral counseling related to sexuality issues was an invaluable resource for the Pastoral Care and Counseling section. In addition, I thank her for her overall direction and close review of the guide as it developed.

Dustin Frazier completed the research for the denominational statements and resource section begun by our summer intern Delfin Bautista. This collection of materials is a signature of Religious Institute publications and an integral piece of any educational resource. They provided time, effort, and meticulous attention to detail to bring these to the hands of the reader.

My colleague, Tim Palmer, crafted the text to a clergy and religious professional audience with skill and careful attention. He deserves my gratitude for his many reviews, edits, and overall contributions to this guide.

Prior to drafting the guide, a colloquium of clergy, theologians, ethicists, religious leaders, and health professionals assisted the Religious Institute in developing the *Open Letter to Religious Leaders on Assisted Reproductive Technologies* (page 27). They include Jessica Arons, Center for American Progress; Dr. Wendy Chavkin, Columbia University; Emily Galpern, Generations Ahead; Rev. Dr. Larry Greenfield, American Baptist Church of Metro Chicago; Rev. Debra Haffner, Religious Institute; Kierra Johnson, Choice USA; Laura Jimenez, SisterSong; Rev. Maria LaSala, First Presbyterian Church of New Haven; Dr. Barbara Lukert, UMC Board of Church and Society; Dr. David Kraemer, The Jewish Theological Seminary; Michal Raucher, Religion Department, Northwestern University; Shira Saperstein, The Moriah Fund; Dr. Aana Marie Vigen, Department of Theology, Loyola University Chicago; Miriam Yeung, National Asian Pacific American Women's Forum. The *Open Letter* drafting, including prior and subsequent conversations with participants was indispensable in writing and organizing the guide.

In addition to the Open Letter participants, many clergy served as reviewers of original drafts. Their questions, comments, and reflections helped hone the final version and brought depth to

---

<sup>1</sup> Emily Galpern, *Assisted Reproductive Technologies: Overview and Perspective Using a Reproductive Justice Framework*, Generations Ahead, Center for Genetics and Society, December 2007, <http://geneticsandsociety.org/downloads/ART.pdf>

---

the guide. They are: Rev. Kimberly Koczan-Flory, Rev. Kent Lundy, Rev. Susan Murtha, Rev. David Pettee, Rev. Tracey Reynolds, Rev. Michelle Thomas, and Rev. Kurt Washington. Also, Dr. Charles C. Coddington of the Obstetrics and Gynecology Department of the Mayo Clinic reviewed the Science and Language of Assisted Reproductive Technologies section providing the guide with greater accuracy and nuance.

No project of the Religious Institute would be complete without thanking our colleagues at Christian Community. Holly Sprunger lent her keen eye for copy editing. Stacey Sellers reviewed the guidebook and collated reflections from other reviewers. Rev. Steve Clapp also donated his time to review the guidebook and reached out to other colleagues to serve as reviewers.

The *Open Letter*, guidebook, and ongoing outreach would not be possible without the generous support of the Moriah Fund to whom we are deeply grateful. Our sincere thanks goes to Shira Saperstein for her foresight of pressing reproductive justice issues and for her continued support of the work of the Religious Institute.

Kate M. Ott, PhD  
Assisted Reproductive Technologies Project Director



---

## INTRODUCTION

*F*or millennia, religious traditions have provided direction, discernment and doctrine on issues of fertility and childbirth, family and kinship. These themes resound in the sacred texts and historical traditions of every major faith. New reproductive issues have become increasingly more complicated. Today, biotechnology has created opportunities for millions of families to have genetically related children through the use of assisted reproductive technologies, or ARTs. The use of ARTs has begun to shift the way we think about reproduction, family structure, and children.

These technologies raise ethical issues and moral questions for religious leaders and the families they serve. Many couples seek counseling and support from their faith communities. Unfortunately, these topics are usually not addressed in seminaries, and if they are, it is likely in the context of a medical ethics course that does not engage the pastoral issues that religious leaders will face.

Consider the following scenarios:

- Malcolm and Anne are diagnosed with infertility and they come to discuss the faith community's teachings on in vitro fertilization.
- Emma recently received genetic screening during her pregnancy and the results show a severe chromosomal abnormality or severe disability; she and Robert come to discuss their options.
- Sarah and Denise seek advice on using sperm donation to have a child.
- Diana, a woman in her late forties, wants to carry her own child, and is in the process of choosing an egg donor.
- Sean, a 24-year-old single man, finds out he has non-Hodgkin's lymphoma, and he is deciding whether or not he should freeze his sperm so that he can have genetically related children later in life.
- Janelle and Marcus are carriers of sickle cell genes; they are considering genetic selection of their fertilized embryos to avoid passing on the disease to their child.
- Craig and Laura have contracted with a surrogate and want to educate the congregation about their child's birth before she is baptized.
- Sue and Bill have five children. They come to discuss using in vitro fertilization to have one more child.

*A Time to Be Born* is intended to help clergy and other religious professionals address the complex pastoral, moral, and ethical issues raised by assisted reproductive technologies. This manual provides an overview of the technologies and how they are used; examines traditional religious perspectives on reproduction and fertility; and outlines a model of pastoral care and counseling that will enable religious leaders to effectively minister to the individuals and communities seeking their help. This manual also suggests ways that congregations and denominations can support, educate, and engage the ethical issues surrounding ARTs.

---

These technologies are sophisticated and ever changing. By no means can any clergy member or religious professional be expected to know how all reproductive technologies work or what makes someone a candidate for various technologies. However, clergy and religious professionals *do* need to know how their faith tradition views ARTs. They must prepare appropriate pastoral responses to individuals and couples seeking their counsel, and explore their own capacity and limitations when it comes to dealing with these issues. At the end of the manual, there are references and resources for further investigation and up-to-date information.

Assisted reproductive technologies raise hope for individuals and couples longing for biologically related children. A pastoral response to ARTs is at its best when it affirms the moral agency of women to make their own reproductive choices, provides a supportive and educated environment for decision-making, and extends a call for communal responsibility. As a society and as faith communities, we must commit to an ongoing conversation that respects individuals' and couples' desires, holds medical professionals accountable to nondiscriminatory and medically effective practices, and supports reproductive justice. *A Time to be Born* is intended to prepare religious leaders to join in a dialogue about ARTs.

---

## THE SCIENCE AND LANGUAGE OF ASSISTED REPRODUCTIVE TECHNOLOGIES<sup>2</sup>

Over the last three decades, more than three million babies have been born through assisted reproductive technologies. The circumstances of the parents involved vary widely: heterosexual couples in which one or both persons is infertile; lesbian couples; gay male couples; a couple in which one or both partners are transgender; single parents (female, male, or transgender; heterosexual, lesbian, or gay); women and men undergoing chemotherapy; women who want to delay childbearing; and couples and individuals who want to screen against disability or for other genetic characteristics.

Most often, ARTs are used by individuals or couples diagnosed with infertility. Infertility is a disease of the reproductive system that impairs the body's ability to perform basic reproductive functions. Infertility is often defined as the failure to conceive after one year, or six months if the woman is over 35 years of age, of unprotected, heterosexual intercourse. Infertility can also include women who have had multiple miscarriages. Infertility can be caused by genetics; by environmental factors; by endocrine or immune system disorders, or by untreated sexually transmitted infections. Infertility also tends to increase with age. A third of infertility cases can be attributed to male factors, another third to female factors, and a third to a combination of problems or unexplained factors. More than eight in 10 cases are treated successfully with conventional therapies, such as drug treatment or surgical repair of reproductive organs.

### Assisted Reproductive Technologies<sup>3</sup>

This section defines the basic technologies and terminology of assisted reproduction, circumstances of donation or surrogacy, along with key factors of which prospective parents and those who counsel them should be aware.

#### Basic Terms

A human *Gamete* is a mature reproductive cell, an egg or a sperm. Gametes are capable of fusing with a cell of similar origin but of opposite sex to form a zygote.

A *Zygote* is two fused gametes. In human fertility, it is the fused egg and sperm before the cells begin to divide.

An *Embryo* is an organism arising from the fertilized egg following cleavage (cell division). The term embryo is often used to describe the pre-fetal cells from implantation through the eighth week of gestational (in utero) development.

---

<sup>2</sup> Materials in this section are adapted with permission from Emily Galpern, *Assisted Reproductive Technologies: Overview and Perspective Using a Reproductive Justice Framework*, Generations Ahead, Center for Genetics and Society (December 2007) at <http://geneticsandsociety.org/downloads/ART.pdf>. Additional facts provided by *Bioethics Guide, Spiritual Discernment: A Guide for Genetic and Reproductive Technologies*, produced by the General Board of Church and Society Bioethics Task force of the United Methodist Church (2008) at <http://www.umc-gbcs.org/atf/cf/%7B689fea4c-8849-4c05-a89e-c9bc7ffff64c%7D/BIOETHICSGUIDEWEB.PDF>.

<sup>3</sup> There is no standard definition for ART. The World Medical Association does not include alternative insemination in its definition. The U.S. Centers for Disease Control only includes technologies that involve the handling of both sperm and eggs in a laboratory, such as IVF. In this document, ART refers to all of the technologies listed in this section. For a more extensive list, see Emily Galpern, *Assisted Reproductive*

---

*Intrauterine or Artificial Insemination (AI).* AI refers to several different procedures, all of which involve inserting sperm into a woman's body; the difference is whether the sperm is placed in the vagina, uterus, cervix, or fallopian tubes. AI can also be combined with hormonal drugs to stimulate production of multiple eggs to increase likelihood that one of them will be fertilized. AI can be done at home or in a medical setting. Sperm used for AI is usually "washed," which separates the sperm from the semen and eliminates dead or slow sperm and other chemicals that may impair fertilization.

*In Vitro Fertilization (IVF).* IVF and related treatments are the most medically invasive ART treatments. Unlike AI, fertilization takes place outside the woman's body. Current egg retrieval practice involves giving women hormonal drugs to stimulate multiple eggs in one cycle. For this process, women inject three different hormones over the course of four to six weeks to shut down their ovaries, hyperstimulate them, and control when mature eggs will be released. This is followed by a surgical procedure in which an ultrasound-guided needle is inserted through the vaginal wall into the ovary and the eggs are suctioned out. Eggs (retrieved from the woman trying to get pregnant or from an egg donor<sup>4</sup>) are then fertilized with sperm (from a partner or donor) in a petri dish. Because several attempts are frequently required to produce a successful pregnancy, multiple eggs are usually fertilized (excess embryos can be frozen). One or more embryos are placed in the woman's uterus through her vagina in a process called embryo transfer. The success of IVF depends on the woman's age, the quality of the embryos and, with infertile women, the specific causes of infertility.

*Gamete Intrafallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT).* GIFT and ZIFT are similar to IVF, but used much more infrequently. In GIFT, the eggs and sperm are both placed directly into the woman's fallopian tube, allowing fertilization to happen in the woman's body, rather than in a petri dish. With ZIFT, eggs are fertilized in a petri dish and the resulting zygote(s) is placed directly into the woman's fallopian tube through laparoscopic surgery. GIFT and ZIFT were thought to have had a 5-10% higher success rate than other forms of IVF, but as embryo transfer has improved there is little difference.

*Intracytoplasmic Sperm Injection (ICSI).* ICSI involves manually injecting a single sperm into the cytoplasm (the material outside of the nucleus) of an egg. It is used when a man has a low sperm count, no sperm present in the ejaculate, low sperm motility, abnormally shaped sperm, or when IVF has been unsuccessful.

*Preimplantation Genetic Diagnosis.* PGD can accompany IVF and tests the embryo for particular genetic traits, such as medical conditions or biological sex. PGD is done in 4–6% of all IVF procedures. Individuals may or may not be infertile who use PGD and IVF to avoid implantation of embryos with known serious hereditary diseases. The use of PGD to determine sex, physical traits, or abilities is controversial.

---

*Technologies: Overview and Perspective Using a Reproductive Justice Framework*, Generations Ahead, Center for Genetics and Society (December 2007) at <http://geneticsandsociety.org/downloads/ART.pdf>.

<sup>4</sup> A female partner may also freeze eggs at a younger age due to cancer-related treatments such as chemotherapy, though this has a very low success rate. For American Association of Reproductive Medicine guidelines, ethics committee report, and patient factsheet see <http://www.asrm.org/Patients/topics/cancer.html>.

---

### **Factors to consider in IVF-related treatments**

*Age.* The rate of live births achieved by in vitro fertilization decreases with the woman's age, beginning at about 35 years. The live-birth rate per embryo transfer in women under age 35 years is 40–49%. In those older than 35, the live-birth rate drops by 2–6% for each one-year increase in age. By age 43, the live-birth rate is just 5%.

*Multiple Births.* More than one embryo is usually transferred into the uterus. As a result, multiple births occur more frequently with IVF. Generally, 66% of women using IVF have one baby, 31% bear twins and 3% have three or more. Multiple births increase the risk of miscarriage, premature births, and very-low-birth-weight infants (less than 1,500 grams). Premature birth is often associated with long-term lung and nervous system abnormalities. Though IVF accounts for 1% of all live births, it counts for about 18% of all multiple births in the U.S.

*Cost.* One cycle of IVF costs an average of \$12,400, plus the cost of medications, which can be in excess of \$5,000. Added costs are incurred when using donor gametes (sperm, egg, embryo), a surrogate, and preimplantation genetic diagnosis (PGD).

*Adverse Outcomes.* Studies suggest that the majority of IVF-conceived infants do not have disability or medical conditions significantly different from children conceived through intercourse and matched for maternal age and other factors. In the case of multiple births, there is an increased risk for low-birth-weight babies with increased health risks (see health risks on page 14).

*Maternal Health Risks.* The most common side effect from IVF is ovarian hyperstimulation syndrome (OHSS). OHSS is the over-stimulation of ovaries through use of hormonal treatment associated with egg retrieval and embryo implantation procedures. Twenty to 30% of women get mild to moderate OHSS, while around 5% have severe OHSS. It is potentially, though rarely, life-threatening, and long-term consequences of excess hormone use are unknown.

*Success Rates.* In 2006, 138,198 ART cycles were reported to the Centers for Disease Control. Less than one-third (41,343) resulted in live births with 54,656 infants born. Of ART cycles that used fresh non-donor eggs or embryos, the most successful IVF option, 64% of cycles did not produce a pregnancy.

*For the up-to-date information on IVF, see the Centers for Disease Control, Assisted Reproductive Technology, <http://www.cdc.gov/ART>.*

### **Donation**

People often turn to donors when they cannot use their own eggs or sperm to become pregnant, or when they don't have both eggs and sperm available to them (e.g., single persons, same-sex couples). Potential sources include fertility clinics, egg brokerage agencies, and sperm banks. Individuals and couples might also recruit a known donor (such as a friend or family member) or an unknown donor (from an online or newspaper ad). Sperm donation can be used for AI, IVF, GIFT and ZIFT; egg donation for all but AI.

---

*Egg Donation.* Eggs from another woman can be used if the recipient has impaired ovaries or is a carrier of a genetic disease. Women may also harvest their eggs if they are preparing to undergo chemotherapy. The egg donor may be anonymous or known. Ideally, the donor should be aged 21–30 years because her eggs are in prime condition. The donor’s eggs are removed the same way they are for IVF. The woman who carries the pregnancy takes increasing doses of estrogen to synchronize her hormone levels in preparation for the embryo transfer. Those involved sign a consent form to cover the legal issues of such a donation. Women may also harvest their eggs if they are undergoing chemotherapy, though this has a low rate of success.

*Sperm Donation.* A male partner may “bank” sperm if he anticipates situations, such as chemotherapy, or other medical conditions that may affect his sperm. If a man has a low sperm count, or if his sperm has abnormal shape/structure, sperm donation can be by an anonymous donor from a sperm bank or by someone known to the couple.

*Embryo Donation.* Excess frozen embryos, created for others and left unused, may also be donated. The donor couple must sign an advance directive regarding embryo ownership and disposition. These directives should include statements regarding: (1) embryo donation to another couple, (2) donation of the embryos for research, or (3) disposition of the embryos after thawing.

The term “donation” can be misleading, as “donors” are often paid. Sperm donors typically receive about \$75 per sample and egg donors anywhere from \$3,000 to \$10,000, and in some cases up to \$100,000 per cycle.<sup>5</sup> The American Society for Reproductive Medicine (ASRM) and Society for Assisted Reproductive Technology (SART) suggest that payments to donors in excess of \$5,000 should require justification and sums above \$10,000 are not appropriate. The process of collecting sperm and eggs is radically different, as the former simply involves masturbation while the latter requires the use of multiple drugs and surgery entailing some degree of risk. Medical professionals do not yet know the level of long-term risk for egg retrieval. The ASRM recommends that egg donors go through no more than six cycles, but there are no limits set by law and no tracking of egg donors who go from one clinic or broker to another.

## **Surrogacy**

There are several paths to surrogacy. Most surrogacy is gestational because of legal issues that arise based on relationship (genetic versus gestational) of surrogate mother to child. For a woman who can conceive an embryo but not carry a fetus, the embryo of the genetic parents is implanted into a surrogate (gestational) mother using IVF. The child is then the genetic offspring of both partners and is not genetically related to the surrogate in any way. For a woman who cannot ovulate, a fertile surrogate is alternatively inseminated with the male partner’s sperm, thus producing an embryo who has the male partner’s and the surrogate mother’s genes. Again, this is less frequent. Surrogacy can also be an option for gay male

---

<sup>5</sup> For more on issues raised by egg donorship, see *Becoming an Egg Donor: Get the Facts before you Decide* at [http://www.health.state.ny.us/community/reproductive\\_health/infertility/1127.htm](http://www.health.state.ny.us/community/reproductive_health/infertility/1127.htm) and specific to college students see *College-age Women, Donor Eggs, and Assisted Reproduction* at <http://geneticsandsociety.org/downloads/CollegeWomenAndEggs.pdf>.

---

couples. Finding a woman to be a surrogate can be more complicated than finding a suitable male sperm donor. Surrogate mothers are often more involved with the prospective parent(s) through pregnancy and birth, and in some cases beyond.

When the surrogate's own eggs are used through alternative insemination or IVF, she is known as the "genetic surrogate." When embryos are created using another woman's eggs and implanted in the surrogate, she is known as the "gestational surrogate." According to the Centers for Disease Control, a majority of reporting fertility clinics offer gestational surrogacy. Multiple birth rates are high among surrogates, because the current practice is to implant multiple embryos to increase success rates in this very expensive treatment. Yet, implanting an excess of embryos does not increase the probability of a live birth; but does increase health risks for the surrogate/mother and children if multiple births occur.<sup>6</sup>

Surrogacy can be paid or unpaid, and often involves a legal contract in which the surrogate gives up parental rights to the child. Surrogacy in the U.S. can cost \$40,000 to \$100,000, including the surrogate's fee, insemination or IVF, and costs related to medical care, transportation, and legal services. Hired surrogates receive an average of \$25,000. Some couples hire women in developing countries to be surrogates for a much lower cost. Hiring a surrogate in India, for example, ranges from \$5,000–12,000, and the surrogate gets paid \$3,000–6,000. The term "reproductive tourism" has been coined to describe men and women who seek out surrogates and egg donors in economically impoverished countries where there are fewer restrictions on reproductive and genetic technologies.<sup>7</sup> Reproductive tourism raises ethical concerns related to the coercion, economic exploitation, quality of medical care and reproductive capacity of poor women.

---

<sup>6</sup> L. Muriel Ríos, et al. "Single Embryo Transfer does not Compromise the Pregnancy Rate in Oocyte Recipient Patients," *Fertility and Sterility*, Volume 90, Supplement 1 (September 2008).

<sup>7</sup> *Reproductive Tourism: Ethical and Health Concerns*, Session 4115.0, at the Public Health Without Borders, 136<sup>th</sup> Annual Meeting and Expo (October 2008) at <http://apha.confex.com/apha/136am/webprogram/Session23361.html>.

---

## ETHICAL CONCERNS RELATED TO ACCESS, SAFETY, AND REGULATION<sup>8</sup>

The development and use of reproductive technologies are never value-neutral. We know from history how forced sterilization, eugenics, and medical experimentation have harmed marginalized persons and communities. Ethicists and reproductive health advocates have raised a number of ethical questions about assisted reproductive technologies that must concern religious leaders as well. Ethical questions include issues of medical safety, personal control of decision-making, the right to have/not have children (or choose their characteristics), economic inequalities and issues of access, and potential commodification of women's reproductive capacity and reproductive tissues. There is a need for increased regulation to safeguard health, additional research to determine risks, and increased caution on the use of high-risk, low-success technologies.

### Unequal Access

Current access to ARTs is limited by cost, insurance coverage, and discriminatory policies. High financial cost creates a system in which only the well-to-do have access. Insurance coverage is variable; currently no state includes IVF procedures in its public benefits program. Although some states require private insurers to cover ARTs, this typically applies only to individuals with a medical diagnosis of infertility. State laws and fertility clinic practices often discriminate on the basis of partner status, sexual orientation, and gender identity. For example, some fertility clinics only offer services to married couples, and some insurance companies require use of a husband's sperm for IVF coverage.<sup>9</sup> The American Society for Reproductive Medicine reports that fertility clinics vary in their willingness to treat single women, single men, and same-sex couples.<sup>10</sup>

### Safety Concerns

Not all ARTs are the same; they vary in their cost and medical risk. Some procedures have unknown long-term health implications and limited success. There is a need for research to determine the risks and caution on the use of high-risk, low-success technologies.

The degree of risk for women using ARTs depends on the technology used. Women using alternative insemination with donor sperm that has been screened for sexually transmitted infections (STIs) face virtually no health risks beyond those that any pregnant woman would face. Women undergoing egg retrieval for IVF, on the other hand, face short-term risks

---

<sup>8</sup> Materials in this section draw upon Emily Galpern, *Assisted Reproductive Technologies: Overview and Perspective Using a Reproductive Justice Framework*, Generations Ahead, Center for Genetics and Society, (December 2007) at <http://geneticsandsociety.org/downloads/ART.pdf>.

<sup>9</sup> For more specific state laws see Jessica Arons, *Future Choices: Assisted Reproductive Technologies and the Law* (2007) at [http://americanprogress.org/issues/2007/12/pdf/arons\\_art.pdf](http://americanprogress.org/issues/2007/12/pdf/arons_art.pdf).

<sup>10</sup> The Ethics Committee of the American Society for Reproductive Medicine "Access to Fertility Treatments by Gays, Lesbians, and Unmarried Persons," *Fertility and Sterility*, 86 (2006): 1333–5. Retrieved from [http://www.asrm.org/Media/Ethics/fertility\\_gaylesunmarried.pdf](http://www.asrm.org/Media/Ethics/fertility_gaylesunmarried.pdf).



---

associated with taking hormones to stimulate multiple egg production, such as ovarian hyperstimulation syndrome.<sup>11</sup> The long-term health risks are still unknown.

The majority of studies on children born using assisted reproduction have focused on IVF, which can contribute to low birth weight, a higher likelihood of premature births, and higher rates of Caesarean deliveries, infant death, and congenital disabilities. Many of these problems result from the high incidence of multiple gestations that are common when using IVF and can affect maternal health as well.<sup>12</sup> Additionally, there have been conflicting studies on the increased risks of developmental delay and cerebral palsy among children born from ARTs. New research suggests some abnormal patterns of gene expression may be associated with IVF and with a possible increase in rare genetic disorders.<sup>13</sup>

### **Lack of Regulation**

The United States Fertility Clinic Success Rate and Certification Act of 1992 requires fertility clinics to report their success rates annually to the Society for Assisted Reproductive Technology (SART) for publication on the website of the Centers for Disease Control and Prevention (CDC). There is no penalty for failing to comply, aside from being listed as a “non-reporter” by the CDC. Professional organizations such as the Society for Assisted Reproductive Technology and the American Society of Reproductive Medicine have requirements for membership, but for the most part regulation of fertility clinics and the use of ARTs comes from a patchwork of state laws.<sup>14</sup> The lack of regulation of the industry and the accompanying gap in reporting on adverse health reactions is a major reason there has not been more research and data on the health effects of ARTs.

Also, without adequate regulation, technologies can be used for purposes beyond their originally intended application. For example, prenatal and pre-implantation genetic diagnosis (PGD) raise new ethical issues. PGD allows doctors to screen for genes that show the presence of disease or medical conditions (e.g., Tay-Sachs, sickle cell anemia, spina bifida). Embryos without these genes can be chosen for implantation. PGD in the future may be used to screen for social traits as well (e.g., eye color, sex, skin tone, or intelligence). The use of this technology can contribute

---

<sup>11</sup> Ovarian hyperstimulation syndrome (OHSS) usually occurs as a result of taking gonadotropins—hormonal medications that stimulate the production of eggs in a woman’s ovaries. These injectable fertility drugs may be prescribed to treat irregular ovulation or infertility. In OHSS, the ovaries become swollen and painful. About one-fourth of women who use gonadotropins get a mild form of OHSS, which goes away after about a week. If pregnancy occurs after taking one of these fertility drugs, symptoms of OHSS may last several weeks. Research varies on the percentage of women who develop a more severe form of OHSS. From Mayo Clinic, Women’s Health Resource, <http://www.mayoclinic.com/health/ovarian-hyperstimulation-syndrome-ohss/DS01097>.

<sup>12</sup> In 2004, 50% of all IVF pregnancies in the U.S. resulted in multiple births. That same year, 1% of all U.S. births were from IVF, yet they accounted for 18% of all multiple births in the country. See Wright, V.C., Chang, J., Jeng, G., Chen, M., Macaluso, M., Assisted reproductive technology surveillance—United States, 2004. [2007, June 8 MMWR 56(SS06), 1–22]. Available from the Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion at <http://www.cdc.gov/MMWR/preview/mmwrhtml/ss5606a1.htm>.

<sup>13</sup> “National Birth Defects Prevention Study Shows Assisted Reproductive Technology is Associated with an Increased Risk of Certain Birth Defects,” Centers for Disease Control and Prevention (December 2008) at <http://www.cdc.gov/media/pressrel/2008/r081117.htm>. Yet, no absolute conclusions have been drawn from the available data on the impact of ART on children because of methodology problems with most of the studies.

<sup>14</sup> For a detailed description of ART regulation, including court cases, see Jessica Arons, “Future Choices: Assisted Reproductive Technologies and the Law,” (2007) at [http://americanprogress.org/issues/2007/12/pdf/arons\\_art.pdf](http://americanprogress.org/issues/2007/12/pdf/arons_art.pdf).

---

to the prevention of disease or can be used in morally questionable attempts for the perfect baby. Disability advocates raise critical issues about how such technologies affect the culture's understanding and contributions of people with disabilities. For example, in which category does Down syndrome fall—disease prevention or social engineering? As genetic screening becomes more popular, affordable, and able to test for a greater number of characteristics, it is possible that more people who are *not* infertile will use in vitro fertilization and pre-implantation genetic diagnosis (PGD) in order to select characteristics of their children.

### **Conclusion**

Now, more than ever, a commitment to human dignity and diversity situated in the common good is necessary. Faith traditions have a shared tradition of advocating for justice issues by balancing individual and community limits as they discern their place in the world and ethical relationships to one another. For example, several denominations, such as the Episcopal Church, Evangelical Lutheran Church in America (ELCA), Presbyterian Church, USA, and the United Methodist Church (UMC) affirm the use of genetic testing to avoid hereditary disease or severe medical abnormalities, but deride the use of technologies for cloning or trait selection such as biological sex. (See the Denomination Statements section on page 32.) Ethical discernment includes examination of the technologies themselves, regulation of their use, and adverse outcomes. Clergy may wish to become more involved in national deliberations of these types of ethical issues through denominational dialogues.

---

## RELIGIOUS TRADITIONS

Assisted reproductive technologies raise fundamental theological questions about fertility, the connection of sexual intercourse to childbearing, definitions of parenthood and family, and the desire for biological children. Yet the rapid development and widespread use of these technologies have outpaced the ability of many religious communities to render a moral and ethical response. While some traditions have developed discernment guides for clergy and congregations regarding ARTs (see page 40), many have simply fallen back on conventional theologies of marriage and family rather than address how these new technologies challenge traditional understandings.

This section explores traditional religious perspectives on infertility and marriage and how these perspectives can inform religious views on ARTs. It concludes by offering religious leaders an alternative approach to assisted reproductive technologies.

### **Traditional Teachings on Infertility and Marriage**

Many faith traditions affirm human dignity and uniqueness, respect women's and men's moral agency, and promote community responsibility for the common good. At the same time, traditional religious teachings about women, childbearing, and parenting can be hurtful and exclusionary. Some present infertility as a punishment and suggest that people without children are somehow less faithful. Such teachings can intensify the yearning for biological children, in some cases encouraging individuals and couples to experiment with reproductive technologies that are unsafe and lack testing.

Religious messages may link fertility and procreation to God's will. For example, Jewish and Christian scriptures present procreation as a mark of religious duty: Adam and Eve are told to be fruitful and multiply (Gen 1:28), and individual identity is tied to genealogy (e.g., Gen 5:1–29, 1 Chronicles 1–8; Luke 3:23–38). Reproduction is not just a duty, but a sign of God's blessing (e.g., Gen 17:16, Psalms 139, 1 Samuel 1:17–20; Luke 1:13–14). Similarly, in the Qur'an, Allah is described as the one who bestows children or chooses to leave women barren (Qur'an 42:49–50).

Procreation was so important to ancient Israelite society that Biblical texts promote alternative methods of reproduction. In the book of Genesis, for example, Rachel and Leah bargain over the use of mandrakes, an aphrodisiac thought to promote fertility (Gen 30:14–16). Sarah and Rachel engage the female slaves Hagar and Bilhah as surrogates for childbearing (Gen 16:1–12, Gen. 30:1–13). The book of Deuteronomy promotes levirate marriage (Deut 25:5–10), marriage between a man and his deceased brother's wife, as a way to produce children and continue the family name.<sup>15</sup>

---

<sup>15</sup> For further interpretation of the Christian and Jewish scriptural references to infertility, see Allen Verhey, *Reading the Bible in the Strange World of Medicine* (Grand Rapids: Eerdmans, 2003).

---

Traditions within Islam, Judaism, Hinduism, and Christianity understand childbearing and rearing as a way to fulfill a religious life and as a primary purpose of marriage.<sup>16</sup> In these traditions, marriage is defined as a relationship between one man and one woman. Historically, infertility could be grounds for divorce in Jewish, Muslim, and Hindu communities and was accepted as grounds by Christian writers such as Martin Luther and John Calvin.

Traditional religious teachings on fertility and childbearing often reinforced the view that a woman's value lies primarily in her reproductive capacity. (Rarely in sacred texts is infertility attributed to the man, although low sperm count is a major factor in infertility.) In Hebrew and Christian scripture, when a woman was "barren," she often used another woman to fulfill her duty to birth the next generation (e.g. Gen. 16:2–3). Typically, the surrogacy relationships described in scripture reinforce the oppressive and exploitative social norms of the culture.

### **Current Teachings and Doctrine on ARTs**

Among the world's religions, moral guidance on the use of assisted reproductive technologies has tended to reflect traditional positions on marriage, sexuality and fertility.

In Hinduism, for example, biological progeny are necessary for carrying out important religious rites. This tradition encourages the use of reproductive technologies, with the notable exception of surrogacy, which can raise questions about the social caste of the surrogate mother and the inherited religious standing of the child. Surrogacy may also be considered a kind of adultery, a perspective shared by Sunni Muslim teachings.

In Sunni Muslim countries such as Egypt, surrogacy and other forms of assisted reproduction are strictly controlled to avoid adultery and potential confusion about the lineage of the child. In Iran, a predominantly Shi'a Muslim country, gamete donation is permitted so long as the gametes come from the married couple. IVF is permitted in both countries.

The influence of religious tradition on public health practices is also evident in Israel. Given the significance of progeny to lineage and religious identity, and the traditional instruction that to bear children is a religious duty, it not surprising that Israel has the highest number of ART clinics per capita in the world, or that ART infants account for nearly five percent of all births.

Recent Jewish teachings have sought to temper the understanding of childbearing as a religious duty for infertile couples. In 2007, the Central Conference of American Rabbis (Reconstructionist) stated that Jewish tradition does not compel a couple to pursue assisted reproduction, although both ARTs and adoption are encouraged. Similarly, the Committee on Jewish Law and Standards (Conservative) stated in 1994 and reaffirmed in 1997 that ARTs are

---

<sup>16</sup> For a fuller description of each religious tradition and the development of their teachings on ARTs, see Wendy Chavkin, "The Old Meets the New: Religion and Assisted Reproductive Technologies," *Development* 49.4 (2006): 78–83 and Cynthia B. Cohen, "Protestant Perspectives on the Uses of the New Reproductive Technologies," *Fordham Urban Law Journal* 30 (2002): 135–146. The contents of this section regarding non-Western traditions is informed by Chavkin's article. Also, see page 32 for direct references to Christian and Jewish denominational statements on ARTs and related issues.

---

permissible but not obligatory, and that “the commandment to procreate ceases to apply to those who cannot do so through sexual intercourse.”

Among Christian traditions, opposition to ARTs has been strongest in the Roman Catholic Church and more conservative Protestant traditions. Roman Catholicism has denounced any use of IVF, because the procedure separates the creation of embryos from the physical act of heterosexual married intercourse—a disruption of the natural law. The Church also regards human embryos obtained in vitro as human beings with a right to life, a position shared by the Southern Baptist Convention and other conservative Protestant denominations. Because IVF typically produces more embryos than can be used at one time, religious leaders in these traditions object to excess embryos being discarded, frozen, or used for research purposes.

Mainline Protestant traditions generally assume a more liberal view, taking into account not only tradition, Scripture, and reason, but also the experience and moral agency of the individuals contemplating ARTs. The Episcopal Church, the Presbyterian Church, USA, the United Methodist Church (UMC), and the United Church of Christ (UCC) have all adopted resolutions in favor of IVF, while encouraging individuals to seek both professional counsel and pastoral guidance. The UCC resolution explicitly states that the Church “supports the rights of families to make decisions regarding their use of the reproductive technologies.” The UMC resolution argues for caution in the production of embryos, however, urging that “we [not] produce more embryos than we can expect to introduce into the womb. . . .”

Other Protestant leaders and denominational statements have expressed similar concerns with respect to the human embryo, as well as to ART practices that involve the use of paid “donors.” Payment of donors not only suggests a commodification of reproduction but also creates a system that privileges those of economic means. Mainline Protestants have joined other religious traditions in opposing reproductive cloning and genetic manipulation to determine the sex or other attributes of the child.

### **Alternative Religious Approaches to ARTs**

Besides traditional theologies of marriage and historical understandings of infertility, religious traditions promote other values that can guide moral and ethical discernment on assisted reproductive technologies. Increasingly, many faith communities have come to value diverse family structures, uphold the dignity and diversity of human persons, articulate a principle of communal responsibility, and witness against social injustices that perpetuate inequality based on race, gender, economic class, sexual orientation, age, and ability.

*Diverse Family Structures.* Throughout history, religious traditions have embraced many forms of family beyond the male-headed, heterosexual marriage model. Early Christian communities—where women, men, children, and servants were part of inclusive households—and ashrams that support families of monks and nuns are just two examples. By lifting up alternative forms of family, faith communities demonstrate that values of diversity, mutual support, and intentional care-giving are the basis of family, rather than simply having the “right” kind of parents or number of children. Indeed, faith communities themselves model a form of family built on the many talents and gifts that individuals willingly share to fulfill each other’s needs and those of the community and society at large.

---

*Dignity and Diversity of Human Persons.* Historically, couples (and women in particular) were taught that childbearing is the means to religious fulfillment and family duty. Yet there are many more ways to fulfill one's religious and spiritual calling. In Hinduism, Saraswati, one of three principal goddesses, embodies power and fruitfulness but does not have "biological" children. Saraswati's children constitute the Vedas; she is both childless and the embodiment of mother/creative principle.<sup>17</sup> Similarly, both Jewish and Christian scriptures extol the faithfulness of individuals and couples who are not known in the text as having biological children—such as Deborah, described as a mother to Israel (Judges 5:7), Esther, Miriam, Huldah, Mary Magdalene, Martha and Mary, Lydia, and Priscilla and Aquila. Buddhist and Christian nuns, brothers, and monks have witnessed faithfully to their religious callings. Couples and single people without children respond to their religious calling in various ways that enrich and diversify our faith communities.

*Communal Responsibility.* Faith communities are communities of responsibility that form relationships based on mutual need, care, love of neighbor, and common commitment—not solely on biological or genetic relationships. All individuals bear a responsibility not only to their families, but to the broader community as well. Regarding ARTs, individuals, couples and the larger society all bear ethical responsibility. For individuals considering assisted reproductive technologies, the moral questions involve health risk to self and potential child(ren), ability to care for child(ren), religious belief/teaching, partner's desires, and personal motives. In addition to guiding individuals to make their own moral and ethical choices regarding ARTs, religious leaders can help them consider how these choices influence the broader community, such as use of resources. For faith communities and religious leaders, social justice issues include diversity as a community value (discouraging trait selection), medical effectiveness, disability rights, distributions of resources, and equal access.

It is time to mind our religious traditions' rich sources of spiritual and moral support for an expanded understanding of creativity, generativity, and family formation. These aspects of our traditions can best guide ethical discernment, inform compassionate counseling, and lead to justice-based advocacy.

---

<sup>17</sup> André Van Lysebeth, *Tantra: The Cult of the Feminine*. Translation of *Tantra: le Culte de la Féminité*. (Boston: Weiser Books, 1992).

---

## PASTORAL CARE AND COUNSELING

There are a number of ways clergy can let their congregations know they are open to talking about infertility, family formation, and reproductive technologies. The first might be during pastoral counseling, when related issues are raised. For example, discussing the couples' plans for children during pre-marital counseling provides an obvious opportunity. Clergy might also raise or acknowledge issues related to ARTs and infertility from the pulpit, thus giving congregants permission to bring up these issues privately. Some pastoral counseling may become crisis care when congregants face pregnancy loss, infertility, decisions about abortion, or repeated disappointments in ART treatments.

### Counseling with the PLISSIT Model

The PLISSIT counseling model may prove useful for pastoral care providers as they address pregnancy, infertility, and ARTs.<sup>18</sup> It was developed almost 35 years ago for health care providers who are not psychiatrists, psychologists, or sex therapists, but who address sexual needs and concerns in their work. PLISSIT is an acronym for *Permission, Limited Information, Specific Suggestions, and Intensive Therapy*.

PERMISSION GIVING on infertility and ARTs means letting congregants know that many others have experienced what they are going through. Infertility affects about 7.3 million women and their partners in the U.S.; infertility affects men and women equally.<sup>19</sup> They should also know that the majority of people using any variation of IVF will fail. It may be useful for clergy to share pages from this manual that provide baseline information (see page 9) and refer congregants to additional resources (see page 40).

Permission giving is not the same as telling someone what to do; it means giving congregants an opportunity to talk about their feelings and decisions in a safe and caring place. In some cases, this may be best handled in individual counseling or in couples counseling. Clergy recognize the stress that comes with infertility and use of certain ARTs. For many couples, intercourse becomes an obligation timed to ovulatory cycles; medical procedures and doctor visits can be exhausting. Individuals and couples may struggle with questions about which technologies to use, how often or how long to keep trying, as well as individual or shared conflicts about their decisions. ARTs can be costly; many couples and individuals may also be considering how to prioritize financial resources.

Permission giving is also a way to help individuals and couples articulate their personal limits about using ARTs. This includes exploring where personal decisions come from and fit within shared moral values. Many individuals and couples may find it difficult to break the silence about creating families in new ways. They may also have conflicting feelings between yearning for children and becoming parents, or confusion between seeking biological children versus

---

<sup>18</sup> Rev. Debra Haffner applies the PLISSIT model to pastoral counseling on sexuality-related issues in *A Time to Build: Creating Sexually Healthy Faith Communities*. (Norwalk, CT: Religious Institute on Sexual Morality, Justice, and Healing, 2001). J.S. Annon, "The PLISSIT Model: A Proposed Conceptual Scheme for the Behavioral Treatment of Sexual Problems," *Journal of Sex Education and Therapy* 2 (1976): 1–15.

<sup>19</sup> National Survey of Family Growth, Centers for Disease Control (2002).

---

adoption, or if they could have a “full” life without children against society/familial pressure that children “complete” a family. These questions are complex and difficult, carry life-long implications, and can raise feelings of guilt, shame, anxiety, failure, and confusion. Encouraging individuals and couples to engage spiritual discernment as they walk through decisions about family formation locates their decision-making within their spiritual journey.

The experience of infertility can trigger religious and cultural assumptions regarding masculinity and femininity that may affect a couple’s or individual’s feelings and motivations regarding ARTs. Infertility and failed attempts to have a child using ARTs are usually experienced as loss—there is often emotional pain, and clergy can offer needed ministerial support. A sense of loss can also occur when an individual or couple receives a prenatal or genetic diagnosis (e.g., when one parent is a carrier of sickle cell anemia). In these cases, similar needs arise with regard to exploring personal moral limits and offering a safe space for such discussions. Permission giving affords congregants the opportunity to explore and balance their options in a non-judgmental way.

LIMITED INFORMATION involves providing information to congregants. Clergy are not expected to be medical experts. Rather, the information they provide should be placed in a religious context and be intended to facilitate decision-making. Limited information is not meant to remove options, but to explore all options available with as accurate information as possible. This may be the time for clergy to share their faith tradition’s position and teachings regarding reproductive technologies (see page 32). In some cases, the messages of traditional religion and particular interpretation of sacred texts can increase congregants’ distress. Clergy might look for alternate texts or interpretations regarding fertility, childbearing, and family that are supportive and comforting, and provide an opportunity for guided reflection.

Limited information may also include sharing information about alternative options. For example, clergy might share information about the number of children in the community in foster care or awaiting adoption, or provide an updated reference list to offer more information about adoption options. In other cases, clergy might share resources on raising a child with a disability or genetic disorder, or link congregants to others in the community who are disabled or raising a disabled child.

In addition, clergy can help congregants determine how much information they will share about their experience. For example, a couple who implanted an embryo into a surrogate needs to decide how much information they will share not only with their child, but also with their fellow congregants, friends, and colleagues—information about how the child was conceived, the donor’s identity, and the identity of the surrogate. The experience of multiple pregnancy losses through failed implantation, late-term abortion or miscarriage also raises questions about disclosure and a need for pastoral and faith community support to which clergy must respond.

SPECIFIC SUGGESTIONS refers to ways to address reproductive issues within the faith community and within the limits of what a clergy member knows about a particular issue. For example, a couple with little knowledge about how conception occurs may need basic



---

---

### **Informational Books on Infertility and ART**

Glahn, Sandra and William Cutrer. *The Infertility Companion: Hope and Help for Couples Facing Infertility*. Grand Rapids: Zondervan, 2004.

Kittel, Mary and Deborah Metzger M.D. Ph.D. *Stay Fertile Longer: Everything You Need to Know to Get Pregnant Now—Or Whenever You're Ready*. New York: Rodale Press, 2004. Chapter 15–19 include issues of spirituality.

Inhorn, Marcia C. and Frank van Balen, eds. *Infertility around the Globe: New Thinking on Childlessness, Gender, and Reproductive Technologies*. Berkeley: University of California Press, 2002.

Mohler, Marie and Lacy Frazer. *A Donor Insemination Guide: Written By and For Lesbian Women*. New York: Harrington Park Press, 2002.

Orenstein, Peggy. *Waiting for Daisy: A Tale of Two Continents, Three Religions, Five Infertility Doctors, an Oscar, an Atomic Bomb, a Romantic Night, and One Woman's Quest to Become a Mother*. New York: Bloomsbury, 2007.

Pence Frantz, Nadine and Mary T. Stimming eds. *Hope Deferred: Heart-Healing Reflections On Reproductive Loss*. Cleveland: Pilgrim Press, 2005.

Sember, Brette McWhorter. *Gay and Lesbian Parenting Choices: From Adopting or Using a Surrogate to Choosing the Perfect Father*. Franklin Lakes: Career Press, 2006.

Additional resources can be found on pages 40-43.

information about fertility and sexuality. In these situations, clergy might refer congregants to an urologist or obstetrician/gynecologist, and suggest books on infertility and sexuality. Some religious traditions, such as the Roman Catholic Church, offer couples training (natural family planning) on basic reproductive health and conception, including how to recognize fertility. (See box for resource books on infertility, pregnancy and ART.)

A faith community with several members using ARTs may, with consent, connect people within the congregation. These individuals might be encouraged to form a support group within the congregation or within a region of multiple congregations. Clergy should have a referral list of organizations, websites and literature in various areas related to ARTs (see pages 44-46). These can include information on organizations that specialize in adoption, pregnancy loss, infertility, disabilities, ART methods, and genetic counseling.

INTENSIVE THERAPY is beyond the scope of pastoral care and counseling. For some individuals, coping with these issues can cause a mental health crisis—depression, anxiety disorders, or inability to cope. Pastoral care providers know that they need a well-developed referral network of mental health professionals and services in the community. Clergy can work with families, friends, or local mental health professionals to recommend or even bring a congregant to a professional counselor to provide services while maintaining a pastoral involvement. For individuals or couples with potential genetic disorders, or a fetus or newborn diagnosed with a genetic disorder or disability, clergy can play a supportive ministerial role, but trained genetic counselors and disability support groups will be needed.

---

It is important that a referral network includes sexuality, marriage, and family counselors. A list of national organizations that deal with sexuality issues can be found in the Resource section on page 40. Additionally, RESOLVE: The National Infertility Association provides a list of local chapters that include peer support groups and referral networks for local counselors. The American Society for Reproductive Medicine (ASRM) provides a list of certified counselors and medical practitioners by state.

---

## THE ROLE OF CONGREGATIONS AND DENOMINATIONS

*F*rom family support groups to adult education, public advocacy to denominational discernment, faith communities have many opportunities to educate themselves and raise awareness of the ethical, pastoral, and medical realities of assisted reproductive technologies. Denominational commitment is also important to address the needs of congregations and communities with regard to ARTs.

Clergy are often sought out for counseling and seen as resources on marital issues, family planning, and moral decision-making. In order to become more aware and educated, clergy and religious leaders need to:

- Become knowledgeable about the teachings of their faith tradition, sacred texts, and current science and technology related to reproduction, families, and ARTs.
- Have a highly developed referral network of professionals who provide sexuality, pregnancy, abortion, adoption, and genetic counseling that is comprehensive, medically accurate, nondirective, and unbiased. (See resource list on page 40).
- Reach out to professionals in the faith community to offer support for their work.
- Preach about pregnancy-related issues, infertility, and ARTs.
- Provide rites of passage for adoptions, foster care placements, IVF births, surrogate births, and pregnancy loss.
- Offer counseling to families on how to address the circumstances of conception and family history with their children, who are adopted or conceived through ARTs, as well as with their extended families and faith community.
- Work with other clergy to develop community-wide forums on technology issues.

Congregations can support individuals and couples who may experience feelings of isolation, guilt, or fear of not being accepted. Congregations can help in the following ways:

- Assess their current programming to determine if single people and couples without children have opportunities to participate. Often congregational programs focus on children's and parents' needs, leaving single adults and child-free couples to feel excluded.
- Offer support groups or prayer circles for individuals or couples experiencing infertility and other pregnancy-related issues.
- Conduct healing services for infertility and reproductive loss.
- Promote awareness about sexuality, pregnancy, infertility, and ARTs through resources in the congregation's library.
- Use the newsletter and bulletin to post information on pregnancy, infertility, ARTs, and related services available in the community.
- Share stories in the newsletter that deal with ARTs or pregnancy issues.
- Be aware of the special needs of congregants who are child-free on occasions such as Mother's Day and Father's Day.
- Host adult education forums to raise awareness. Many congregations have healthcare professionals, physicians, or representatives from community agencies who would be willing to discuss the medical issues related to ARTs and infertility.

---

Family ministries and religious education committees can educate volunteers and the children in their care to be compassionate and informed as they respond to issues related to ARTs and family formation. These ministries can contribute to awareness through:

- Training family ministry coordinators and religious education teachers about specific issues related to welcoming unconventionally conceived children. For example, a second-grade student might ask, “Jennifer has two mommies, how could she be born without a dad?” How would a teacher respond?
- Providing age-appropriate resources that address ARTs in addition to other books on reproduction and family formation in the context of a comprehensive sexuality education program.
- Discuss the complexities of surrogacy and egg and sperm donation with young adults, especially college age youth.
- Invite single people and child-free couples to serve as teachers and mentors to children in the faith community as a way of extending the “faith family.”

Denominations have a unique responsibility to educate religious leaders, provide policy statements and initiate development of current resources. In the case of ARTs, many denominations are only beginning to realize the pastoral needs and social impact at the congregational level. Denominations can begin to:

- Identify health care professionals in their denominations who work with ARTs and families who have experience with use of ARTs to be resources for development of denominational study guides and statements.
- Develop worship materials that respond to the growing needs of ART-related issues such as alternative family formations and loss or grief related to infertility diagnosis and pregnancy loss.
- Use their communication networks to promote educational materials about ARTs, pastoral concerns, and existing resources and networks.
- Provide education related to ARTs and other sexuality-related issues to those preparing for religious vocations, and expand continuing education opportunities for current clergy to address the changing technologies and pastoral response.
- Distribute this guide to the congregation.

A public dialogue that involves denomination leadership, theologians, ethicists, clergy, health advocates, and the scientific community is necessary for a responsible and sustained evaluation of ARTs. Individual clergy and congregational social action programs can:

- Raise issues from the pulpit and in the public square about the ethics of ARTs, such as access, safety, and regulation, based on medically accurate information, current practices, and public policy options.
- Publicly advocate for state and federal regulations to safeguard health and prevent negative outcomes, and for increased research regarding risk and efficacy of ARTs.
- Stay up to date on new technologies and ethical issues (see Organizations on page 44).
- Speak out against reproductive practices that violate human rights and dignity.

---

## OPEN LETTER TO RELIGIOUS LEADERS ON ASSISTED REPRODUCTIVE TECHNOLOGIES

As religious leaders, we are committed to promoting the spiritual, emotional, and physical health of all people, including their reproductive health. We assist women, men, and couples seeking to be parents, and counsel many who are considering assisted reproductive technologies (ARTs). During the past thirty years, millions of women and men have used ARTs to try to have children.

Yet many technologies have been developed without intentional ethical deliberation regarding their complex and varied implications for individuals, families, and society. Most religious leaders have not been prepared to educate and counsel their congregants about ARTs. Moreover, there is growing concern about the promotion of high-cost technologies that have low rates of success. We further recognize the intense yearning that many people feel for biological children, yet we are acutely aware that many children need adoptive and foster care parents.

In this *Open Letter*, and its accompanying Guidebook, *A Time to Be Born*, the Religious Institute on Sexual Morality, Justice, and Healing invites you into a discussion about the moral and religious implications of these technologies.



### RESPECT FOR LIFE

Religious traditions affirm that life is sacred. Our faiths celebrate the divinely bestowed blessings of generating life and call for all children to be nurtured and valued. Religious traditions have differing beliefs on when life begins and the moral status of the embryo and the fetus. These differing religious understandings profoundly affect individual decisions about the use of ARTs, but no one religious viewpoint should determine public policy or medical practice. We urge that the creation and handling of embryos always be regarded with respect and humility.



### MORAL AGENCY

The use of ARTs is always a serious moral and medical decision. We affirm women and men as moral agents who have the capacity, right, and responsibility to make their own decisions about reproduction, including pregnancy, contraception, abortion, adoption, ARTs, gamete donation, and surrogacy. This right should be accorded equally to all persons regardless of marital status, sexual orientation, gender identity, disability, class, and race. These decisions must be based on informed consent about medical and health risks. They are best made when they include a fully informed conscience, and insights from one's faith, community, and family.



## **SACRED TEXTS AND RELIGIOUS TRADITIONS**

Over time, people of faith approach sacred texts and traditions with fresh questions, changing circumstances, and new understandings. In light of the discrimination that has resulted from religious traditions' over-identification of women with fertility and biological reproduction, there is a need for broader interpretations of texts such as "be fruitful and multiply" and those that present infertility as a penalty for sin or unfaithfulness. Yet, religious traditions can be a rich source of spiritual and moral support for various kinds of creativity, generativity, and family formation. Children are a blessing, not a requirement or entitlement. We honor those sacred texts and traditions that welcome diverse families, individuals with disabilities, persons without children, and alternative family formations as part of a commitment to foster just and loving social relationships and communities.



## **RELIGION, SCIENCE, AND TECHNOLOGY**

Fundamental questions of values and ethics are raised by expanding understandings of science and the development of technologies unimagined by earlier generations. Technological advances must be developed responsibly, cognizant of how marginalized persons and communities have been harmed by forced sterilization, eugenics, and medical experimentation in the name of progress. Theologians, ethicists, clergy, health advocates, and the scientific community need to be in dialogue to understand the cultural context within which science operates and to respond to the societal issues raised by scientific discovery and technological development.



## **ACCESS, SAFETY, AND PUBLIC POLICY**

There are biological and social conditions that cause individual infertility, such as harmful environmental conditions; the failure to adequately prevent, screen, and treat sexually transmitted infections; and postponement of childbearing for career, economic, or personal reasons. Faith communities must support public funding for prevention, screening, and diagnosis of infertility in addition to access to information, health care, and unbiased counseling about ARTs. As long-term health implications of some procedures are still unknown, there is a need for increased regulation to safeguard health, research to determine the risk of ARTs, and caution on the use of resources for ARTs that are high risk and low success. The availability of effective and safe ARTs should respect the diversity of family structure and not exclude on the basis of partner status, economic circumstances, or sexual orientation.

---

❧

## A CALL TO RELIGIOUS LEADERS

We call on leaders of all faiths to prepare themselves to offer counsel compassionately, competently, and justly to individuals and families making decisions about the use of ARTs.

We urge religious leaders to:

- Become knowledgeable about the teachings of their faith tradition, sacred texts, and current science and technology related to reproduction, families, and ARTs.
- Have a highly developed referral network of professionals who provide pregnancy, abortion, adoption, and genetic counseling that is comprehensive, medically accurate, nondirective, and unbiased.
- Educate their faith community about ARTs through preaching, study groups, healing services for infertility and reproductive loss, as well as education for young adults about the complexities of surrogacy and egg and sperm donation.
- Assist families in developing strategies to share with their children, who are adopted or conceived through ARTs, the circumstances of their conception and family history.
- Promote denominational study of pastoral and ethical responses to ARTs such as access, use, and counseling.
- Publicly advocate for counseling, accurate medical information, regulations to safeguard health and prevent negative outcomes, and increased research regarding risk and efficacy of ARTs.
- Engage in public discourse about the social and ethical issues involved in ARTs and speak out against ART practices that violate human rights and dignity.

❧

## IN CLOSING

The broad spectrum of assisted reproductive technologies calls for deeply personal and complex moral decisions that are unprecedented in human history. As religious leaders, we seek to promote what is best for individuals, couples, families, children, and society and to support those who face these decisions. Religious leaders and theologians have an integral role to play with families, medical providers, and scientists as these technologies unfold.

---

The *Open Letter* was developed at a colloquium of clergy, theologians, ethicists, religious leaders, and health professionals in 2008, sponsored by the Religious Institute and funded by The Moriah Fund. Participants included Jessica Arons, Center for American Progress; Dr. Wendy Chavkin, Columbia University; Emily Galpern, Generations Ahead; Rev. Dr. Larry Greenfield, American Baptist Church of Metro Chicago; Rev. Debra Haffner, Religious Institute; Kierra Johnson, Choice USA; Laura Jimenez, SisterSong; Rev. Maria LaSala, First Presbyterian Church of New Haven; Dr. Barbara Lukert, UMC Board of Church and Society; Dr. David Kraemer, The Jewish Theological Seminary; Dr. Kate M. Ott, Religious Institute; Michal Raucher, Religion Department, Northwestern University; Shira Saperstein, The Moriah Fund; Dr. Aana Marie Vigen, Department of Theology, Loyola University Chicago; Miriam Yeung, National Asian Pacific American Women's Forum.

---

## CONGREGATIONAL MATERIALS

Congregations may choose to use this guide for an adult education study. The responsive reading can be used in worship or at the beginning of a group meeting. Scriptural references in the Religious Traditions section are available for closer study. Perhaps, media resources listed in this section would be helpful discussion starters. The questions for reflection may assist in guiding discussion based on various issues including religious tradition, ethics, pastoral care and counseling, and congregational response. Lastly, there are resources for teachers and parents to use with children when discussing ARTs.

### RESPONSIVE READING

#### **Responsive Reading based on the *Open Letter to Religious Leaders on Assisted Reproductive Technologies***

We celebrate that life is a blessing.

**We recognize that the decision to become a parent is personal and complex.**

May all children be nurtured and valued.

**May all children be wanted and cared for.**

We recognize the intense yearning that many people have for children.

**Together we break the silence surrounding infertility, pregnancy loss, still births, and difficulties in adoption.**

We support individuals and couples who struggle with these issues.

**We celebrate the many ways that people create families and are involved in children's lives.**

We welcome all types of families.

**We pledge together to help the children of this congregation grow and mature into responsible and healthy adults.**

**Together: We affirm and commit to just and loving relationships for all.**



---

## Adult Study Questions for Reflection

1. How do new technologies for helping couples become pregnant conform to or challenge our tradition's understanding of fertility and reproduction? Are there limits to how far science should go in helping people reproduce?
2. What might it mean to counsel or support individuals and couples struggling with infertility, or who are considering or currently using ARTs? When do you think adoption should be raised as an option?
3. How does a faith community signal openness to discussing issues of reproductive loss, infertility, still births, and difficulties in adoption? What additional training and information do the minister, pastoral care team, and lay leadership need? What resources in our area could help?
4. How do we support further education on the moral and ethical issues raised by the use of assisted reproductive technologies?

### Teaching Aids

#### Adult Study Group

*All in One Basket*. Directed by Lauren Berliner. 2005. This documentary follows three US women through the egg donation process. The film explores the physical and emotional experience of the donation process while also discussing some of its ethical implications. Available from Fanlight Productions: <http://fanlight.com>

*The Child the Stork Brought Home*. Directed by Gillian Goslinga-Roy. 2000. This film explores the ethical complexity of the controversial process of gestational surrogacy. Available from Documentary: Educational Resources: <http://www.der.org>

*Offspring*. Directed by Barry Stevens. 2001. Barry Stevens, the film's director, was conceived through donor insemination. The documentary follows his search for his donor father.

#### Talking to Children

Appleton, Tim. *My Beginnings: A Very Special Story & I'm a Little Frostie*. Cambridge: The IFC Resource Centre, 2008.

Ehrensaft, Diane. *Mommies, Daddies, Donors, Surrogates: Answering Tough Questions and Building Strong Families*. New York: Guilford Press, 2005.

Howey, Noelle and E. Samuels, eds. *Out of the Ordinary: Essays on Growing up with Gay, Lesbian and Transgender Parents*. New York: Stonewall Inn Editions, 2000.

Schaffer, Patricia. *How Babies and Families are Made: There is More than One Way*. Berkeley: Sarah Tabor Books, 1988.

For more resources, visit:

CNY Fertility Center. *ASRM's Annotated Bibliography for Children*. <http://cnyfertility.com/resources/asrms-annotated-bibliography-for-children/>

---

## DENOMINATION STATEMENTS ABOUT ASSISTED REPRODUCTIVE TECHNOLOGIES

The length and specificity of denominational statements regarding assisted reproductive technologies varies significantly. For the purposes of this guidebook, only statements referring directly to assisted reproductive technology or (pre)natal genetic diagnosis and engineering have been included. Statements regarding cloning and stem cell research have not been listed.



### Central Conference of American Rabbis

---

#### **In Vitro Fertilization and the *Mitzvah* of Childbearing**

*Responsa 5758.3, 2007 (not yet published)*

“From all of this, it follows that the various technologies which enable the infertile to conceive ought to be understood as medicine. Our Committee has indeed taken this position with respect to artificial reproductive techniques in general and IVF in particular. Human infertility is a disease, not because it threatens the life and health of the infertile but because it frustrates our attainment of the goal—the *mitzvah*—of bringing children into the world. The scientific tools developed to cure this disease are therefore advances in *medicine* and should be welcomed, as we welcome other medical advances, as a positive good. The question we must answer at this juncture is the extent to which this particular kind of medicine ought to be regarded as obligatory. Medical treatment, after all, is a *mitzvah*, understood in our tradition as a religious duty... Does IVF, which we clearly regard as medical treatment for disease, fall into this category of ‘tested remedy’? If it does, then we would have strong grounds on which to urge the couple who bring this *she’elah* to undertake the procedure despite its discomfort and its cost.”

“Jewish tradition regards the bringing of children into the world as a *mitzvah*, a religious duty. At the same time, it does not require or oblige this couple to undertake in vitro fertilization. How can an act be both a *mitzvah* and yet not obligatory? One way of thinking about this question is to remind ourselves that the word ‘*mitzvah*’ can indicate a general religious requirement, one that applies to most of us, even the preponderant majority of us, most of the time, but which exempts particular individuals depending upon the circumstances of their lives. ... Thus, it neither compels individuals to marry nor infertile couples to divorce. And, significantly, it does not demand that a woman sacrifice her health for the sake of this *mitzvah*; as one eminent authority has put it, ‘one is not required to lay waste to one’s life in order to “settle the world.”’

We might also keep in mind that our tradition draws a distinction between *mitzvot* which are defined as *chovah* and those which are not. A *chovah*, or “obligation,” is a religious duty that one is required to perform, regardless of the expense or inconvenience involved. At the same time, there are a number of *mitzvot* which do not impose absolute requirements; “one who performs this act receives a heavenly reward for doing so, but the one who does not perform it is not punished thereby.” We might say that the decision to undertake IVF falls into this latter category. Reform Jewish teaching would endorse this distinction. It is certainly a *mitzvah* to have children, and couples considering IVF or similar procedures deserve our full

---

encouragement and support. Still, if this couple decides against IVF, we must pay the highest deference to their freedom, human dignity, and unique experience. ...”

---

❧

**Church of the Brethren**

---

**Annual Conference Statement on Genetic Engineering**  
*1987*

- “We recommend the continuing use of scientific research for the alleviation of human suffering...
- We recommend that members of the church become knowledgeable about genetic engineering through readings, classes, college courses, church seminars, special lectures, and articles from professional journals.
- We recommend that members of the church become involved in discussions about genetic engineering and especially encourage members of the scientific community to be in dialogue with nonscientists.
- We recommend that select persons with appropriate credentials, skills, or potential be encouraged to become knowledgeable for the purpose of being genetic counselors to persons who are trapped in a conflict of values.
- We recommend that congregations as a part of their ministry encourage persons contemplating parenthood to research their genetic histories and to especially seek counseling if there is a history of genetic diseases.
- We recommend that institutions of the church, especially our colleges and seminary consider including professional courses or discussions within appropriate courses to disseminate information about genetic engineering.
- We recommend a continuing emphasis on the rights of all persons to dignity, freedom, justice, love, and respect.”

---

❧

**Committee on Jewish Law and Standards**  
**The Rabbinical Assembly, International Association of Conservative Rabbis**

---

**Mitzvah Children**  
*Even HaEzer 1:5.2007*

“Judaism sees children as a blessing and an obligation. The duty to procreate does not apply to couples who cannot have them through their conjugal relations, but infertile couples are encouraged to explore alternatives such as adoption and the assisted reproductive techniques that medicine has now made available...our views require that the husband and wife together should decide the number of children they would like to have, as long as they fulfill the command to have at least two.”

**Artificial Insemination, Egg Donation, and Adoption: The Blessing of Children, the Pain and Prevalence of Infertility**  
*Approved by the CJLS on March 16, 1994*

---

“When couples cannot conceive, they often feel anger, dismay, and even guilt and shame. Contemporary fertility techniques provide new hope to such couples, and we certainly rejoice with them when they succeed in having the children they want. Whenever we *can* do something new, though, we must ask the moral and legal question of whether we *should* do so. The new methods of achieving conception come with some clear moral, financial, communal, and personal costs which must be acknowledged and balanced against the great good of having children.”

“Infertile couples may take advantage of fertility drugs and other techniques which may help them have children. When such interventions do not work, artificial insemination is permissible, but it is not required. The commandment to procreate ceases to apply to those who cannot do so through sexual intercourse.”

“...infertile couples thinking about using these procedures need to get appropriate counseling and to think very hard about whether they want to try these methods. Again, the CJLS has ruled that according to Jewish law, they are permissible *but not obligatory*.”

“For those who need help in having children, we hope, along with them, that artificial insemination, egg donation, or adoption can afford them the blessings of children.”



## Episcopal Church

---

### **Reaffirm the Recommendation Considering External Fertilization**

*General Convention Resolution Number: 1991-A101*

“Resolved, the House of Deputies concurring, That the 70th General Convention reaffirm the recommendation that married couples who are members of this Church and who are considering the use of external fertilization and embryo transfer, seek the advice and assistance of a qualified professional counselor and the pastoral counsel and care of this church and consider adoption as one of the options open to them.”

### **Adopt Guidelines for Genetic Testing and Reproductive Technology**

*General Convention Resolution Number: 2003-A012*

“Resolved, That the 74th General Convention reaffirm that children are entrusted to us as gifts from God to be nurtured toward maturity. Therefore: Genetic testing of children can be an important part of parental responsibility, and may be carried out if it is clearly in the child’s best interests to be tested; Treatment for genetic diseases and the use of somatic gene transfer therapies may be used if they are proven safe and effective; New genetic techniques may be used in conjunction with in vitro fertilization to avoid procreation of human beings with clearly serious disorders of their DNA or chromosomes; It is not morally acceptable to use reproductive cloning, and it is therefore morally irresponsible for physicians, scientists, and prospective parents to engage in it.”

---

## **Approve Use of “In Vitro” Fertilization**

*General Convention Resolution Number: 1982-A067*

“Resolved, the House of Bishops concurring, That this 67th General Convention of the Episcopal Church gives approval to usage of so-called “in vitro” fertilization for the purpose of providing children in a marriage.”



## **Evangelical Lutheran Church in America**

---

### **Sexuality: Some Common Convictions, Church Council of the Evangelical Lutheran Church in America**

*November 9, 1996*

“Conceiving, bearing, adopting, and rearing children can be wondrous and challenging ways through which a couple participates in God’s creation and new creation... New reproductive technologies have opened further possibilities for conceiving and bearing children. Yet, such technologies also pose complex ethical questions. This church seeks to be a community that provides spiritual support and assists persons in their deliberations on these matters.”

### **Human Sexuality and Sexual Behavior, A Social Statement of the American Lutheran Church, a predecessor church body of the ELCA**

*1980*

“We would wish that every conception would be mutually desired, sought by both partners in its specific time and circumstance. Both partners should desire the child; both should be prepared to provide emotionally, spiritually, physically, and socially for the child... Should either partner bear hereditary traits that might impose serious genetic difficulties upon their child, we encourage them to seek competent genetic counseling.”

“Artificial insemination, conception in which only one of a couple (the woman in present circumstances) provides genetic material and the other genetic material comes from an anonymous donor, becomes a consideration for some married couples. There are, however, such moral, emotional, and legal ambiguities that must be taken into account as to render the procedure suspect for a Christian. Questions of artificial insemination, sperm banks, in vitro fertilization, surrogate gestation, and genetic engineering are in need of critical study. These questions which a technological world raises provide an opportunity for the church to clarify its own attitudes and to resolve the many ambiguities in each issue.”



## **Orthodox Church of America**

---

### **Statement on Marriage, Family, Sexuality, and the Sanctity of Life the Procreation of Children**

*July 1992*

*From <http://www.oca.org/DOCmarriage.asp?SID=12&ID=19>*

---

“Convinced of these God-revealed truths, we offer the following affirmations and admonitions for the guidance of the faithful: The procreation of children is to take place in the context of marital union where the father and mother accept the care of the children whom they conceive.”

“Married couples may use medical means to enhance conception of their common children, but the use of semen or ova other than that of the married couple who both take responsibility for their offspring is forbidden.”



## Presbyterian Church, USA

---

### **Covenant and Creation: Theological Reflections on Contraception and Abortion Report of Study from the Advisory Council on Church and Society.**

*1983, The 195th General Assembly received the reports and adopted the policy statements and recommendations.*

*From <http://www.pcusa.org/oga/publications/covenant-of-life-and-covenant-and-creation.pdf>.*

“5. Advances in the enhancement and control of fertility have created many new options for families. The 195th General Assembly (1983), while recognizing that all human undertaking is open to abuse, affirms these advancements. To parent or not to parent is a decision of utmost concern, with clear implications beyond individuals and families to the community, society, and even the species.

While the option of bearing children should be available as universally as possible, to bear a child should not be undertaken without clear intentionality. The choice should not be determined for voiceless minorities or disenfranchised groups, including the physically disabled and the mentally retarded. Within this area of concern, the 195th General Assembly (1983):

- a. Urges compassion and sensitivity for those who face fertility or conceptive problems; and
  - (1) Affirms the use of drug and surgical therapies to overcome anovulation, hormonal disorders, and other problems that lead to infertility;
  - (2) Affirms the use of artificial insemination by husband as a responsible means of overcoming certain fertility problems;
  - (3) Affirms in vitro fertilization as a responsible alternative for couples for whom there is no other way to bear children.
- b. Urges couples who cannot conceive to consider adoption as an alternative to childlessness, even if available children are beyond infancy or handicapped; and condemns efforts to procure infants for adoption through illegal means.
- c. Urges that the high standards of the initial in vitro fertilization programs be maintained as the procedure becomes more widely available; and
  - (1) Opposes state or local legislation that would prohibit in vitro fertilization and urges church advocacy against such legislation where it exists (Illinois) or maybe proposed;
  - (2) Discourages development of human embryos and their use for experimentation except in those cases of clearly demonstrable benefit where no other substitute could accomplish the same end;
  - (3) Opposes legislation that, while attempting to curtail abuse, would serve to prohibit amniocentesis and beneficial fetal therapy.

---

d. Urges that informed consent be [sic] required from all participants in contraceptive and fertility drug experimentation and states emphatically that racial-ethnic, poor, and Third World women should not be used as guinea pigs for drugs deemed too risky for testing in affluent United States communities.

e. Urges further study on the psychological, ethical, and legal ramifications of surrogate motherhood and anonymous artificial insemination donors for all parties, including the child.



### Roman Catholic

---

#### **Congregation for the Doctrine of the Faith, Instruction on Respect for Human Life in its Origin and on the Dignity of Procreation Replies to Certain Questions of the Day (Donum Vitae)**

*How is One to Evaluate Morally the Use for Research Purposes of Embryos Obtained By Fertilization 'In Vitro'?, 1987*

“Homologous artificial insemination within marriage cannot be admitted except for those cases in which the technical means is not a substitute for the conjugal act but serves to facilitate and to help so that the act attains its natural purpose.

... This teaching is... based on the Church's doctrine concerning the connection between the conjugal union and procreation and on a consideration of the personal nature of the conjugal act and of human procreation. “In its natural structure, the conjugal act is a personal action, a simultaneous and immediate cooperation on the part of the husband and wife, which by the very nature of the agents and the proper nature of the act is the expression of the mutual gift which, according to the words of Scripture, brings about union ‘in one flesh’” . . . . Thus moral conscience ‘does not necessarily proscribe the use of certain artificial means destined solely either to the facilitating of the natural act or to ensuring that the natural act normally performed achieves its proper end’ . . . . If the technical means facilitates the conjugal act or helps it to reach its natural objectives, it can be morally acceptable. If, on the other hand, the procedure were to replace the conjugal act, it is morally illicit...”



### United Church of Christ

---

#### **16<sup>th</sup> General Synod**

*Resolution “The Church and Genetic Engineering” (87-GS-90), 1987*

“4. We support genetic screening of pregnancies at risk, although we believe that the religious communities bear a great responsibility to supplement genetic counseling with religious understandings of genetic health and moral choices.

. . . we reject screening as a basis for determining civil, economic, or reproductive rights.”

#### **17<sup>th</sup> General Synod**

*Resolution “The Church and Reproductive Technologies” (89-GS-48), 1989*

---

“This resolution recognizes that reproductive technologies enable many infertile couples the opportunity to have children, and that these technologies are to be commended for their contribution to reproduction. We affirm the contribution of science to be a gift of God. We see these contributions extending the gift of parenthood, the context for human nurture, the opportunities for joy and love and thereby helping humanity’s celebration of the Divine Image...”

“Therefore be it resolved the 17th General Synod of the United Church of Christ supports the rights of families to make decisions regarding their use of the reproductive technologies. We strongly recommend that our churches and the medical community provide honest and compassionate counseling in a supportive environment.”



## United Methodist Church

---

### **General Conference Statements on Genetic and Reproductive Technology** *2004 Book of Resolutions of The United Methodist Church*

#### *162 (M) Genetic Technology*

“The responsibility of humankind to God’s creation challenges us to deal carefully with the possibilities of genetic research and technology. We welcome the use of genetic technology for meeting fundamental human needs for health, a safe environment, and an adequate food supply. We oppose the cloning of humans and the genetic manipulation of the gender of an unborn child.

#### *Resolution #366*

“A human embryo, even at its earliest stages, commands our reverence and makes a serious moral claim on us, although not a claim identical to that of a more developed human life. For this reason we should not create embryos with the intention of destroying them, as in the creation of embryos for research purposes. Neither should we, even for reproductive purposes, produce more embryos than we can expect to introduce into the womb in the hope of implantation.

We recommend the following guidelines to minimize the overproduction of embryos:

We urge clinicians and couples to make the determination of how many eggs to fertilize and implant on a case-by-case basis.

Only enough embryos should be produced to achieve one pregnancy at a time.

We insist that rigorous standards of informed consent regarding the procedures, the physical and emotional risks, and the associated ethical issues be applied to all reproductive technologies. This is especially important regarding the disposition of “excess” embryos and should be the norm of practice around the world.”

#### *On Therapeutic Cloning*

...Be it further resolved, that the United Methodist 2004 General Conference go on record in support of those persons who wish to enhance medical research by donating their early embryos remaining after in vitro fertilization (IVF) procedures have ended, and



---

Be it further resolved, that the 2004 General Conference urge that the United States Congress pass legislation that would authorize federal funding for derivation of and medical research on human embryonic stem cells that were generated for IVF and remain after fertilization procedures have been concluded, provided that:

- These early embryos are no longer required for procreation by those donating them and would simply be discarded;
- Those donating early embryos have given their prior informed consent to their use in stem cell research;
- The embryos were not deliberately created for research purposes;
- The embryos were not obtained by sale or purchase...”



**Union of Orthodox Jewish Congregations of America and the Rabbinical Council of America**

---

**Support for Couples Facing Infertility**

*2002*

“Access to medical treatment for infertility, which exacts both a financial and emotional price, is an important concern to the Orthodox Jewish community. We believe that the family unit plays an extremely important part in the success and stability of American society, our communities, and in our religious and educational institutions.

Families should indeed be able to have access to coverage for infertility treatments.”



**World Council of Churches**

---

**Biotechnology: Its Challenges to the Churches and the World—REPORT BY WCC  
SUBUNIT ON CHURCH & SOCIETY**

*1989*

“Recommendations:

- In light of the real and growing threats posed by reproductive technologies to the integrity and dignity of women and men, and in view of the ethical and pastoral issues which these technologies raise, the following recommendations have been approved:
- The World Council of Churches calls for the banning of commercialized child bearing (i.e. partial and full surrogacy) as well as the, commercial sale of ova. [sic] embryos or foetal parts and sperm.
- The World Council of Churches advises governments to prohibit embryo research, with any experiments; if agreed, only, under well defined conditions.
- The World Council of Churches encourages its member churches and other groups to keep themselves informed on how new developments in reproductive technology affect families, and especially women, and develop a pastoral ministry to counsel people facing these issues,. [sic] including those who choose, or are pressurized into, utilizing such reproductive techniques.”

---

## RESOURCES

### RELIGION, ART, AND INFERTILITY PUBLICATIONS

#### Study Guides

Lutheran Church Missouri Synod. *LCMS World Relief and Human Care: Reproductive Issues*. <http://www.lcms.org/pages/internal.asp?NavID=8140.45>

National Council of Churches USA. *Fearfully and wonderfully made: A Study Document on Human Biotechnologies*. 2005. <http://www.nccusa.org/news/051111BioTech.html>

National Council of Churches USA. *Study Guide for "Enough": Human Genetics and Progress*. 2005. <http://www.nccusa.org/news/051111BioTech.html>

Nishmat: The Jerusalem Center for Advanced Jewish Study for Women. "Halachic Issues in Infertility Treatment." *Jewish Women's Health: Hilchot Niddah Guide for Medical Professionals*. <http://www.jewishwomenshealth.org/article.php?article=28&search=1>

Religious Institute on Sexual Morality, Justice, and Healing. *A Time to be Born: A Guidebook on Assisted Reproductive Technologies*. 2009. <http://www.religioustheology.org>

Union of Reform Judaism. "Bio-Ethics Study Guide XI: Infertility and Assisted Reproduction." Department of Jewish Family Concerns. Fall 1999.  
E-mail Rabbi Richard Address for more information at: [raddress@urj.org](mailto:raddress@urj.org).

United Methodist Church. *Spiritual Discernment: A Guide for Genetic and Reproductive Technologies*. 2008.  
Available from the General Board of Church and Society: <http://www.umc-gbcs.org/site/c.frLJK2PKLqF/b.2794211/k.BCDB/Home.htm>

#### Books

Bhattacharyya, Swasti. *Magical Progeny, Modern Technology: A Hindu Bioethics of Assisted Reproductive Technology*. Albany: SUNY Press, 2006.

Harwood, Karey A. *The Infertility Treadmill: Feminist Ethics, Personal Choice, and the Use of Reproductive Technologies*. Chapel Hill: The University of North Carolina Press, 2007.

Kilner, John F., W. David Hager, and Paige C. Cunningham, eds. *The Reproduction Revolution: A Christian Appraisal of Sexuality, Reproductive Technologies, and the Family*. Grand Rapids: Eerdmans, 2000.

---

Ryan, Maura. *Ethics and Economics of Assisted Reproduction: The Cost of Longing*. Washington, DC: Georgetown University Press, 2003.

Verhey, Allen. *Reading the Bible in the Strange World of Medicine*. Grand Rapids: Eerdmans, 2003.

## Articles

Ahmad, Norhayati Haji. "Assisted Reproduction—Islamic views on the Science of Procreation." *Journal of Asian and International Bioethics* 13 (2003): 59–60.

Chavkin, Wendy. "The Old Meets the New: Religion and Assisted Reproductive Technologies." *Development* 49.4 (2006): 78–83.

Eyer, Richard C. "A Review of Reproductive Technologies." *Lutheran Church Missouri Synod: World Relief and Human Care* (April 2001).  
<http://www.lcms.org/pages/internal.asp?NavID=814>

Fadel, Hossam E. "Islamic Viewpoint on New Assisted Reproductive Technologies." *Fordham Urban Law Journal* (November 2002).

Greil, Arthur L. "Religious Response to Reproductive Technology." *Christian Century* 106.1 (January 1989): 11–14.

Harakas, Stanley S. "For the Health of Body and Soul: An Eastern Orthodox Introduction to Bioethics." *Greek Orthodox Archdiocese of America: Our Faith* (1980).  
<http://www.goarch.org/en/ourfaith/articles/article8076.asp>

Hass, John M. "Begotten Not Made: A Catholic View of Reproductive Technology." *United States Conference of Catholic Bishops*.  
<http://www.usccb.org/prolife/programs/rlp/98rlphaa.shtml>

Lasker, Judith N and Harriet C. Parmet. "Rabbinic and Feminist Responses to Reproductive Technology." *Journal of Feminist Studies in Religion* 6.1 (1990): 117–130.

Mercadante, Linda. "From Infertility to Spiritual Abundance." *Religious Coalition for Reproductive Choice Educational Series* 11. [http://www.rcrc.org/issues/ed\\_series.cfm](http://www.rcrc.org/issues/ed_series.cfm)

Serour, Gamal I. and Bernard M. Dickens. "Assisted Reproductive Developments in the Islamic World." *International Journal of Gynecology and Obstetrics* 74.2 (August 2001): 187–193.

Thompson, Charis. "God in the Details: Comparative Perspectives on the Intertwining of Religion and Assisted Reproductive Technologies." *Culture, Medicine, & Psychiatry* 30.4 (2006): 557–561.

---

## MEDICAL, LEGAL, AND PUBLIC HEALTH PUBLICATIONS

### Organizational Publications

American Fertility Association. *Embrace the Possibilities: 2007 National Fertility and Adoption Directory—The Family Building Resource*. 2007.

Fertile HOPE. *Cancer & Fertility: A Guide for Young Women*. 2004.

RESOLVE. *Resolving Infertility: Understanding the Options and Choosing Solutions when You Want to Have a Baby*. New York: HarperCollins Publishers, 1999.

Vayena, Effy, Patrick J. Rowe, and P. David Griffin, eds. *Current Practices and Controversies in Assisted Reproduction: Report of a Meeting on “Medical, Ethical and Social Aspects of Assisted Reproduction”*. Geneva: World Health Organization, 2002.

### Books

Agigian, Amy. *Baby Steps: How Lesbian Alternative Insemination is Changing the World*. Middletown: Wesleyan University Press, 2004.

Bleiklie, Ivar, Malcolm L. Goggin, and Christine Rothmayr, eds. *Comparative Biomedical Policy: Governing Assisted Reproductive Technologies*. New York: Routledge, 2004.

Potter, Daniel A. and Jennifer S. Hanin. *What to do When You Can't Get Pregnant: The Complete Guide to all the Technologies for Couples Facing Fertility Problems*. Cambridge: Da Capo Press, 2005.

Spar, Deborah L. *The Baby Business*. Boston: Harvard Business School, 2006.

### Articles

Arons, Jessica. “Future Choices: Assisted Reproductive Technologies and the Law.” *Center for American Progress*. December 2007.  
[http://www.americanprogress.org/issues/2007/12/future\\_choices.html](http://www.americanprogress.org/issues/2007/12/future_choices.html).

Becker, Gaylene, Carrie Friese, and Robert D. Nachtigall. “Older Motherhood and the Changing Life Course in the Era of Assisted Reproductive Technologies.” *Journal of Aging Studies* 22.1 (January 2008): 65–73.

Burnett, Judith A. “Use of Assisted Reproductive Technology and Gay and Lesbian Couples: What Counselors Need to Know.” *Journal of LGBT Issues in Counseling* 2005 1.1 (2005): 115–125.

---

Coleman, Carl H. "Conceiving Harm: Disability Discrimination in Assisted Reproductive Technologies." *UCLA Law Review* 50 (November 2002): 101–156.

Dickens, Bernard M. "Ethical Issues Arising from the Use of Assisted Reproductive Technologies." *World Health Organization*. <http://www.who.int/reproductive-health/infertility/31.pdf>.

Galpern, Emily. "Assisted Reproductive Technology: Overview and Perspective Using a Reproductive Justice Framework." *Gender and Justice* (December 2007). <http://geneticsandsociety.org/downloads/ART.pdf>

Roberts, Dorothy. "Privatization and Punishment in the New Age of Reprogenetics." *Emory Law Journal* (Summer 2005).

---

## ORGANIZATIONS

### *Faith-Based / Religious*

#### **Catholics for Choice**

1436 U Street NW, Suite 301  
Washington, DC 20009-3997  
202-986-6093  
<http://www.catholicsforchoice.org>

#### **Hannah's Prayer Ministries**

P.O. Box 15053  
Long Beach, CA 90815  
336-848-1552  
<http://www.hannah.org>

#### **Presbyterians Affirming Reproductive Options**

100 Witherspoon Street, Room 4617  
Louisville, KY 40202  
888-728-7228, ext. 5800  
<http://www.pcusa.org/phewa/paro>

#### **Religious Coalition for Reproductive Choice**

1025 Vermont Avenue, NW, Suite 1130  
Washington, DC 20005  
202-628-7700  
<http://www.rcrc.org>

#### **Religious Institute on Sexual Morality, Justice, and Healing**

21 Charles Street, #104  
Westport, CT 06880  
203-222-0055  
<http://www.religiousinstitute.org>

### *Medical / Bioethics*

#### **American Fertility Association**

305 Madison Avenue, Suite 449  
New York, New York 10165  
888-917-3777  
<http://www.theafa.org>

---

**American Society for Reproductive Medicine**

1209 Montgomery Highway  
Birmingham, Alabama 35216  
205-978-5000  
<http://www.asrm.org>

**Centers for Disease Control—Division of Reproductive Health**

4770 Buford Highway, NE  
MS K-20  
Atlanta, GA 30341  
770-488-5200  
<http://www.cdc.gov/ART>

**Center for Genetics and Society**

436 14<sup>th</sup> Street, Suite 700  
Oakland, CA 94612  
510-625-0819  
<http://www.geneticsandsociety.org>

**Choice USA**

Egg Donation and Women's Health Campaign with the Center for Genetics and Society  
1317 F Street, NW, Suite 501  
Washington, DC 20004  
888-784-4494 / 202-965-7700  
<http://www.choiceusa.org>

**Generations Ahead**

1404 Franklin Street, Suite 240  
Oakland, CA 94612  
510-832-0852  
<http://www.generations-ahead.org/issues/reproductive-rights-and-justice/>

**The Hastings Center**

21 Malcolm Gordon Road  
Garrison NY 10524  
845-424-4040  
<http://www.thehastingscenter.org>

**Reproductive Health Technologies Project**

1020 19<sup>th</sup> Street, NW, Suite 875  
Washington, DC 20036  
202-530-4401  
<http://www.rhttp.org/fertility/assisted/default.asp>

---

**RESOLVE: National Infertility Association**

8405 Greensboro Drive, Suite 800  
McLean, VA 22102  
703-556-7172  
<http://www.resolve.org>

**Women's Bioethics Project**

4616 25<sup>th</sup> Avenue, NE, Suite 556  
Seattle, WA 98105  
206-200-1101  
<http://www.womensbioethics.org>

**World Health Organization**

**Department of Reproductive Health and Research**

Avenue Appia 20  
CH-1211 Geneva 27  
Switzerland  
(41) 22 791 21 11  
[http://www.who.int/topics/reproductive\\_health/en/](http://www.who.int/topics/reproductive_health/en/)

*Hotlines/Referral Sources*

**Fertility LifeLines**

Hours: Monday-Friday, 8 am–midnight ET; Saturday-Sunday, 8 am–6 pm ET  
Phone: 1-866-LETS-TRY (1-866-538-7879)  
<http://www.fertilitylifelines.com/>

**RESOLVE: National Infertility Association**

For Support Groups by region, visit <http://www.resolve.org>  
Listing under “Coping with Infertility”, then “Support Groups”  
Search by region or contact RESOLVE 24 hour HelpLines.



---

## ABOUT THE RELIGIOUS INSTITUTE

Founded in 2001, the Religious Institute is a national, multifaith organization dedicated to promoting sexual health, education and justice in faith communities and society. The Religious Institute partners with clergy and congregations, denominations, seminaries, national advocacy organizations, and sexual and reproductive health communities to promote:

- Sexually healthy faith communities
- Full equality of women and of lesbian, gay, bisexual, and transgender persons in congregations and communities
- Marriage equality for same-sex couples
- Comprehensive sexuality education
- Reproductive justice
- A responsible approach to adolescent sexuality
- Sexual abuse prevention
- HIV/AIDS education and prevention

The mission of the Religious Institute is to develop a new understanding of the relationship between religion and sexuality. This mission involves:

- Developing and supporting a network of clergy, religious educators, theologians, ethicists, and other religious leaders committed to sexual justice.
- Building the capacity of religious institutions and clergy to provide sexuality education within the context of their faith traditions.
- Helping congregations, seminaries, and denominations to become sexually healthy faith communities.
- Educating the public and policy makers about a progressive religious vision of sexual morality, justice, and healing.

More than 4,800 clergy, professional religious educators and counselors, denominational and interfaith leaders, seminary presidents, deans and faculty members, representing more than 50 faith traditions, are members of the Religious Institute's national network.

The Religious Institute is an affiliate of the Christian Community, a nonprofit, tax-exempt organization.

Religious Institute  
21 Charles Street, Suite 140  
Westport, CT 06880  
203-222-0055  
<http://www.religiousinstitute.org>

---

## NOTES



Religious Institute  
21 Charles Street, Suite 140  
Westport, CT 06880  
Phone 203-222-0055

Email: [info@religiousinstitute.org](mailto:info@religiousinstitute.org)  
Website: [www.religiousinstitute.org](http://www.religiousinstitute.org)

ISBN:1-893270-58-0  
ISBN:978-893270-58-9