

How Religious Affiliation and Religiosity Shape Attitudes Toward Medically Assisted Reproduction in Switzerland

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Abstract

Although Western societies are becoming increasingly secular, religion continues to play a significant role in shaping attitudes toward family-related issues, including medically assisted reproduction (MAR). Existing research on this topic is limited, often focuses on specific procedures or subgroups, and frequently overlooks the multifaceted nature of religion. Our study addresses these research gaps by examining how various dimensions of religiosity—affiliation, religious socialization, self-assessed religiosity, and religious practice—relate to attitudes toward a broad spectrum of MAR procedures in the general Swiss population. Using data from the representative CHARLS 2023 survey, we assessed public acceptance of nine MAR techniques through both a composite index and evaluations of individual procedures. Our findings show that higher religiosity across all dimensions is consistently associated with lower moral acceptance of MAR. While religious affiliation mattered, especially among Muslims and Evangelical Christians, its effect was significantly reduced when personal religiosity and practice were taken into account. Personal religiosity and frequent prayer emerged as the strongest predictors of lower acceptance. Religious socialization also had a modest negative impact, particularly among those raised in highly religious households. Acceptance was generally lower for procedures involving third-party contributions (e.g., donor gametes, surrogacy), though differences between procedures were not statistically significant. Overall, the results underscore the enduring influence of religion on attitudes toward reproductive technologies—even in a secularizing context.

Keywords

attitudes toward medically assisted reproduction; religion; religiosity; Switzerland

1. Introduction

Despite rapid secularization and the declining importance of religion in Western societies, religion continues to be an important factor shaping the attitudes, values, and behaviors of people who identify with a particular faith, influencing their worldview, moral compass, and social interactions (e.g., Halman & Sieben, 2023; Inglehart-Welzel Cultural Map, 2023; Storm, 2016). Christianity, Judaism, and Islam place great emphasis on the family, and attitudes toward marriage/relationships, sexuality, and family formation are therefore strongly influenced by these beliefs (e.g., Blyth & Landau, 2009; Grasmick et al., 1990; Kogan & Weißmann, 2019; Liefbroer & Rijken, 2019; Olson et al., 2006; Pickel, 2001). These religions also reflect distinct underlying ethical frameworks, so religious affiliation and religiosity can be expected to have an impact on attitudes toward medically assisted reproduction (MAR)—a topic with implications for the traditional family sphere. However, there are few studies on (public) attitudes toward MAR, and not all take religious factors into account (Fauser et al., 2019; Meissner et al., 2016; Yamamoto et al., 2018). Moreover, research that does examine religion often fails to consider its different dimensions (e.g., Aurrekoetxea-Casaus et al., 2022; Milewski & Haug, 2020; Shreffler et al., 2010; Szalma & Bitó, 2021). In the sociology of religion, the concept is treated as multifaceted, often differentiating between affiliation, personal belief, and religious practice or ritual. In our article, we will analyze how these different dimensions shape attitudes toward MAR in Switzerland—a country that, despite its long Christian tradition, has undergone a profound shift toward secularization in the last two decades. While the majority of the population is still religiously affiliated, almost a third no longer identify with any religion, and religious debates and figures are not prominent in the public arena. Given this juxtaposition between believers and non-believers, we expect attitudes to MAR to vary significantly between those who (still) feel they belong to a religious community and/or consider themselves religious and those who do not. We aim at closing the research gap regarding the impact of religion on attitudes toward MAR by analyzing the role of various dimensions of religion (religious socialization, religious affiliation, self-assessed religiosity, and religious practice) on the acceptance of MAR.

Another motivation for our study is the fact that few studies have comprehensively examined public attitudes to MAR (with some recent exceptions, e.g., Adamczyk et al., 2024; Szalma & Djundeva, 2019). Extensive research has been conducted on the experiences and attitudes of individuals directly involved in fertility treatments, particularly those who have either donated gametes or utilized donated gametes/gamete donations or those involved in surrogacy arrangements (e.g., Arvidsson et al., 2019; Freeman et al., 2014; Karandikar et al., 2014; Lafuente-Funes et al., 2022; MacCallum et al., 2003; Pande, 2009; Yu et al., 2021). Studies on the acceptance of (specific) MAR procedures often have a narrow focus on demographic subgroups, such as women, men, students, or individuals experiencing infertility (e.g., Fortin & Abele, 2016; Haug et al., 2017; Meissner et al., 2016; Milewski & Haug, 2020; Pennings & Provoost, 2019; Provoost et al., 2018; Wennberg et al., 2016). In addition, some studies rely on convenience samples (see, for example, the meta-study on surrogacy by Rodríguez-Jaume et al., 2021). However, existing research is not only limited by its narrow focus on specific subgroups but also in the breadth of procedures considered. Typically, research on attitudes toward MAR concentrates on specific procedures. Often, insemination and in vitro fertilization (IVF) are taken as representative of MAR procedures in general (Adamczyk et al., 2024; Präg & Mills, 2017; Szalma & Djundeva, 2019). Other studies focus exclusively on attitudes toward egg freezing, surrogacy, or preimplantation genetic testing (PGT; e.g., Aurrekoetxea-Casaus et al., 2022; Meissner et al., 2016; Yıldız et al., 2023).

Our study is motivated by the lack of research on public attitudes toward MAR, the often narrow focus on specific subgroups or procedures, and the lack of consideration of religion in its multidimensional expression. Given the current state of research on the covariation of religion and attitudes to MAR, we pose the following research question: How do the different dimensions of religion covary with attitudes in the Swiss population toward MAR in general and individual MAR treatments? We study this question based on CHARLS (2023, wave 1), a representative survey of the Swiss population. In the following we present the legal framework for MAR and the religious landscape in Switzerland, the state of research on religion and MAR, the data base of our empirical study and the empirical results of our analysis. Overall, the results show that the different dimensions of religion considered (affiliation, socialization, religiosity and practice) strongly influence attitudes toward MAR. Even in heavily secularized contemporary societies, religion is still important in shaping attitudes toward family-related issues.

2. Background and Swiss Context

In this section, we provide background information on Switzerland. We begin by briefly outlining the legal context of MAR, then present an overview of the religious landscape, focusing on the changing distribution and significance of religious affiliation within the population.

2.1. MAR in Switzerland

Since the first successful IVF in 1978, MAR has evolved into a major area of healthcare for treating infertility and/or childlessness. Along with developments in the medical field, MAR has also become an important economic sector (Deonandan, 2015; Spar, 2005). In Switzerland, the first live birth following IVF was in 1985. The number of IVF treatments then increased markedly, up to roughly 6,500 in 2010. In the last decade the numbers have remained relatively stable. The latest report from the European IVF Monitoring Consortium for the European Society of Human Reproduction and Embryology (EIM ESHRE) indicates that 6,041 IVF treatments were performed in Switzerland in 2019 (EIM ESHRE et al., 2023, p. 2323). For 2022, the Swiss Federal Statistical Office reported that 6,609 couples had received IVF treatment.

In Switzerland, MAR is regulated under the Federal Act on Medically Assisted Reproduction (FMedG, 2001), which outlines the legal framework and ethical boundaries for reproductive technologies. Procedures such as IVF and intracytoplasmic sperm injection are permitted but restricted to couples who are married or in a stable partnership and face medical infertility or a significant risk of transmitting a serious genetic disorder. This has also applied to female same-sex couples since “marriage for all” came into force in July 2022. PGT has been legal since 2017, but only in cases where there is a high likelihood of genetic disease. The number of embryos that can be created and stored is legally limited to a maximum of twelve, and embryos may be frozen for up to five years. Embryo donation and surrogacy, both altruistic and commercial, remain strictly prohibited under Swiss law. Sperm donation is permitted but limited to married couples, including married female same-sex couples, since 2022. While egg donation is currently prohibited, the law is set to be revised, with plans to legalize egg donation in the near future and to allow unmarried couples and single people access to MAR. These legal provisions reflect Switzerland’s cautious and ethically grounded approach to MAR, balancing medical innovation with concerns for child welfare and respect for human dignity (cf. FMedG, 2001; The Federal Assembly of the Swiss Confederation, 1998).

2.2. Religion in Switzerland

Switzerland is a nation profoundly shaped by Christianity, whose influence has extended over 1,500 years of cultural, political, and social development. Until the 19th century, Christianity in the forms of Catholicism and Reformed Protestantism dominated the country's religious landscape, with Judaism being the only other long-standing religious tradition—although historically it occupied a marginal position. Recent demographic shifts, however, have significantly altered the religious landscape. The traditional dominance of the Roman Catholic and Reformed Protestant churches has gradually diminished, accompanied by a rise in the number of citizens with no religious affiliation. In addition, migration to Switzerland has led to greater religious diversification (Becci & Dandarova-Robert, 2022; Stolz et al., 2014).

Figure 1 shows the religious affiliation of the population in Switzerland between 1970 and 2023 (BfS, 2025). Over the past five decades, the religious composition has changed, with the decline of the major Christian denominations and a continuous increase in the number of religiously unaffiliated people (cf. also Becci & Dandarova-Robert, 2022; Stolz et al., 2022; Stolz & Senn, 2022). The Roman Catholic population, which accounted for almost 47% of the total in 1970, has steadily declined to less than 31% in 2023. A similar trend is observed among Reformed Protestants, whose share dropped from 49% in 1970 to below 20% in 2023. This shift, particularly pronounced after the year 2000, was accompanied by a rise in the proportion of religiously unaffiliated people, which tripled from 11.4% in 2000 to almost 36% in 2023. Meanwhile, smaller religious groups have seen gradual growth. Other Christian communities have expanded from 2% in 1970 to 6% in 2023, indicating diversification within Christianity itself. The Muslim community has grown substantially, from 0.2% in 1970 to nearly 6% in 2023, reflecting migration patterns and demographic changes. In contrast, the Jewish population has seen a slight decline from 0.4% to 0.2% over the same period. These trends underscore a broader shift away from traditional religious affiliations, reflecting societal changes such as secularization, migration, and evolving new (religious/spiritual) identities (e.g., Wäckerlig et al., 2022). Despite the lack of comprehensive official data, empirical evidence points to a non-negligible

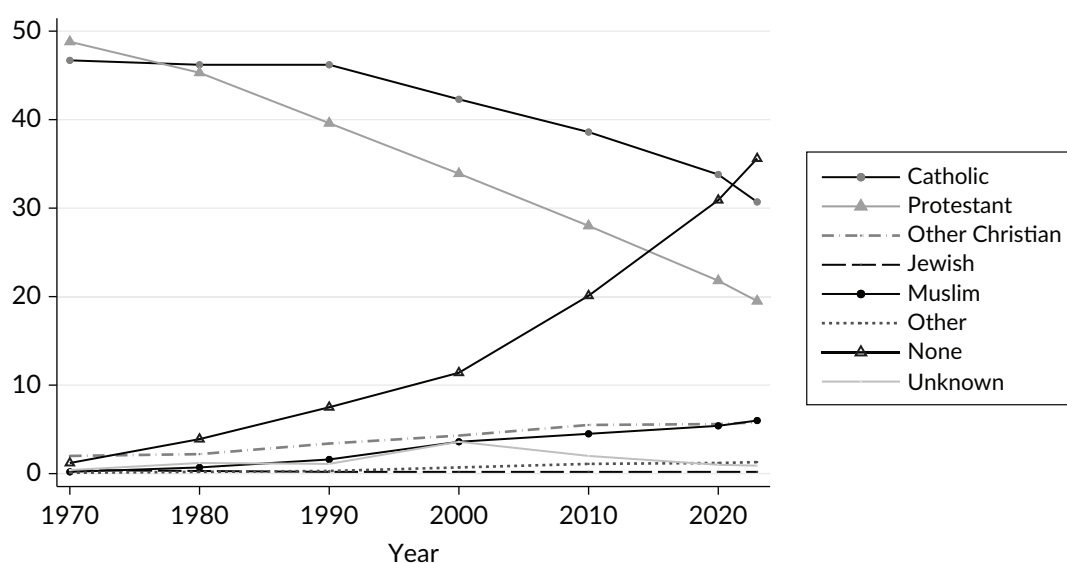


Figure 1. Religious affiliation in Switzerland from 1970 to 2023, in percent, permanent resident population aged 15 and over. Source: Own compilation based on BfS (2025).

presence of these evolving new identities (“holistic spirituals”) within the population (Becci & Dandarova-Robert, 2022; Stolz & Senn, 2022, pp. 19–21).

3. How Does Religion Shape Normative Attitudes?

The sociology of religion has focused on the function of religion in society, examining how religious beliefs, practices and institutions shape individual and collective attitudes and behaviors. It studies religion not only as a system of belief or practice, but as a powerful social institution that influences and is influenced by other areas of social life. Classical theorists such as Émile Durkheim, Max Weber, and Karl Marx laid the foundation for the sociology of religion and offered different perspectives on its function: as a source of social integration (Durkheim), a factor in economic and cultural change (Weber), or a mechanism of social control and inequality (Marx; see Durkheim, 1994, pp. 549–570; Knoblauch, 1999, pp. 20–38; Weber, 1988). In the following, we will mainly draw on social constructivist approaches to religion, which focus on how religious meanings, practices, and worldviews are created, maintained, and changed through social interaction and communication.

According to this perspective, the different religious doctrines serve as socially constructed legitimizations, which convey meaning to (religious) individuals, guide their behavior, and legitimate the social order (Berger, 1973, 1990; Knoblauch, 1999). According to Peter Berger’s theory of the social construction of reality, religious institutions provide a structured worldview that helps individuals interpret their experiences and find meaning in their lives. These doctrines are not just spiritual guidelines but also serve as legitimizing narratives, reinforcing moral norms and social cohesion. For religion to have a constant effect, there must be ongoing contact (cf. Berger & Luckmann, 1992, pp. 165–166). This means that the effect of religious doctrines should be more pronounced for those who are integrated into a meaningful context (e.g., through regular attendance of religious services). Furthermore, Berger and Luckmann (1966) argue that religious belief systems, as powerful social constructs, not only shape personal identities but also influence public morality—especially through public discourse, at least when religious authorities play a formative role in this. Similarly, Knoblauch (1999) emphasizes how religious teachings are embedded in social structures and continue to influence personal identities and collective norms. Even in increasingly secular societies, religious doctrines remain influential, providing moral justification and a sense of purpose for believers. For religious individuals, faith not only prescribes their behavior—it offers a legitimized, socially sanctioned framework, explaining the world and their place within it.

3.1. Previous Empirical Evidence

Previous studies have shown that perceptions of MAR are shaped by factors such as gender, age, educational level, and religious beliefs. For example, Aurrekoetxea-Casaus et al. (2022) highlight the role of religiosity and conservatism in shaping attitudes in Spain, noting that women generally express more supportive views toward MAR than men. This gender difference is corroborated by cross-national studies: Fauser et al. (2019), in a study covering six European countries, Szalma and Djundeva (2019), and Adamczyk et al. (2024), using data from the European Value Survey (covering 42 and 35 countries, respectively), all found that women held more positive attitudes toward assisted reproduction than men. In many studies, age has been found to negatively correlate with MAR acceptance, with older individuals typically showing lower levels of support (e.g., Adamczyk et al., 2024; Aurrekoetxea-Casaus et al., 2022; Szalma & Djundeva, 2019). In contrast, knowledge and education emerge as strong positive predictors of favorable attitudes toward

MAR. Research shows that greater awareness and understanding of reproductive technologies lead to higher levels of support (Fortin & Abele, 2016). Similarly, individuals with higher levels of education tend to exhibit more tolerant views toward MAR (e.g., Adamczyk et al., 2024; Szalma & Djundeva, 2019).

The following section highlights empirical research examining the relationship between religion and attitudes toward MAR, particularly in the European context. Recent studies suggest a complex interplay between religious factors and public acceptance of MAR, shaped by both individual and societal dimensions. At the individual level, religious affiliation often correlates with acceptance levels: Szalma and Djundeva (2019) found that Orthodox and Protestant individuals were generally more supportive of MAR (considering only insemination and IVF) than Catholics, while Muslims and members of other religious groups showed lower acceptance. Interestingly, non-religious individuals showed similar attitudes to Catholics. Additionally, frequent attendance at religious services was associated with lower acceptance of MAR. At country level, however, neither the dominant religion nor general religiosity had a significant impact.

In contrast, Milewski and Haug (2020) found that in Germany, religious women—especially Muslims—expressed more favorable attitudes toward MAR than non-religious women. However, this support did not necessarily translate into a willingness to use MAR, which the authors attributed to differences in knowledge about the procedures. Expanding on the contextual dimension, Adamczyk et al. (2024) showed that both personal religiosity and the broader national religious climate influence MAR attitudes across Europe. Their findings revealed that individuals with strong religious beliefs, particularly conservative Protestants, were more likely to disapprove of MAR, and that countries with higher proportions of religiously engaged citizens generally exhibited lower levels of acceptance. Taken together, existing research underscores the continuing influence of religion on attitudes toward MAR in contemporary societies. However, the studies presented only focused on one or a few examples of MAR and did not systematically account for the various dimensions of religion.

3.2. Religion as a Multidimensional Construct

Even when previous studies have considered the effect of religion (e.g., Aurrekoetxea-Casaus et al., 2022; Milewski & Haug, 2020), its different dimensions have rarely been taken into account. The sociology of religion does not treat it as a uniform phenomenon, but as a complex system of different aspects or dimensions. Charles Y. Glock and Rodney Stark were prominent early proponents of this thesis. Glock proposed a five-dimensional scheme of the nature of religious commitment (Glock, 1962). The ideological dimension refers to the beliefs held by a religious person or community. The ritualistic dimension covers the religious practices of adherents (e.g., participation in worship). The experiential dimension includes personal religious experiences or feelings. The intellectual dimension refers to the knowledge and understanding of religious teachings. Finally, the consequential dimension concerns the effects of religiosity on everyday behavior (e.g., donations, abstaining from contraception). Glock and Stark (1965) explicitly noted that the dimensions could overlap only partially or not at all, so someone could be considered religious in one area but not in others. Other authors extended or adjusted Glock's original dimensions (e.g., De Jong et al., 1976; Vaillancourt, 2008). Most of the research literature distinguishes (at least) three dimensions: (a) belonging to a religious community, (b) religious conviction, i.e., the depth of one's faith and adherence to its tenets, and (c) participation in traditional religious activities and rituals that reflect a sense of devotion and commitment. Empirical research on religion has shown that these dimensions tap into distinct aspects of religiousness

(e.g., Philipov & Berghammer, 2007). Furthermore, these different dimensions do not show uniform covariations with social attitudes and behavior. Therefore, it is important to include the different aspects of religiousness in a study on the covariation between religion and attitudes toward MAR (cf., e.g., Halman & Sieben, 2023). For example, Philipov and Berghammer (2007) showed that for fertility intentions and the actual number of children, participation in religious services is more salient than affiliation and self-assessed religiosity.

3.3. Hypotheses

As described above, our general prediction based on previous research is that religious affiliation and religiosity (for the religions considered) tend to coincide with a skeptical and negative attitude toward MAR. However, this might be structured by the different teachings of the world religions: According to Berger and Luckmann, religious belief systems shape their adherents' attitudes. The Abrahamic faiths share a fundamental commonality in their views on family formation and reproduction. Christianity, Judaism, and Islam all promote marriage as a sacred institution for procreation and family building (cf. Richards, 2009, p. 40; Serour, 2008). To varying degrees, these religions advocate natural conception within marriage as the divinely ordained method of bringing children into the world, emphasizing both biological and spiritual dimensions of human reproduction. While these faiths share common ground, each maintains its unique theological, philosophical, and legal perspectives and interpretations regarding specific aspects of reproduction and family building. Their shared emphasis on marriage as the proper context for procreation reflects a common understanding of family formation as an institution central to human society and divine purpose.

In Islam (as in Judaism), treatment of infertility within marriage is encouraged, as it aligns with the value placed on procreation (Al-Bar & Chamsi-Pasha, 2015; Schenker, 2005; Serour, 2008). A liberal view is generally taken on the use of MAR. For Sunni Muslims, who constitute the majority within the faith (internationally and in Switzerland), MAR is permitted as long as it is conducted within the framework of marriage, and couples use their own biological material. The involvement of third parties—such as sperm or egg donors or surrogates—is strictly prohibited (cf. Al-Bar & Chamsi-Pasha, 2015; Dutney, 2007, p. 175; Inhorn, 2006; Kooli, 2020). Shia religious authorities are more open to the usage of MAR: The donation of gametes and embryos is permitted, enabling sperm donation, egg donation, and surrogacy (Al-Bar & Chamsi-Pasha, 2015, p. 178; Dutney, 2007, p. 175). This relative openness within the (Shia) Muslim community can also be found in corresponding statements by recognized scholars (e.g., Inhorn, 2006). In contrast, the Roman Catholic Church holds a restrictive stance, viewing many reproductive practices as threats to the sanctity of the marital bond. From this theological viewpoint, MAR is seen as a potential challenge to traditional family values. The Church teaches that human procreation must be inherently tied to the sexual union between married spouses, and that an embryo holds the moral status of a human being from the moment of conception (Richards, 2009; Schenker, 2005). Accordingly, the use of most assisted reproductive technologies is rejected (Richards, 2009). For Protestants, there is no single authority and there are no clear guidelines for the use of MAR (Sallam & Sallam, 2016, p. 37). Like other religious groups, however, Protestants emphasize the importance of procreation in marriage and firmly reject the selective reduction of embryos (Best et al., 2019). Evangelical Christians (e.g., members of the Salvation Army)—organized in free churches in Switzerland—set themselves apart from other Protestants. They see it as important to base their lives on the Bible and regard life and reproduction as gifts from God. They share the

Catholics' conviction that life begins at conception and are therefore concerned about IVF, which often creates multiple embryos, from which some are selected and others frozen or discarded. Evangelical Christians are more likely to reject reproductive technologies in general because they are seen as interfering with God's sovereign control—including control over the reproductive process.

In line with the social constructivist approach, the doctrines of the various religious authorities can be expected to have an impact on the attitudes of adherents. While religious affiliation should be an indicator of an individual's religious belief, identification with religious doctrine can vary to some degree. Furthermore, affiliation is only one dimension of the multilayered construct of religion. Other dimensions may be equally meaningful for normative attitudes. Religious practice, for example, visiting the church or praying, should be more meaningful as it involves time and effort. Identifying as being religious refers to the individual dimension of religion. Being socialized in a (very) religious family might exert an influence even if an individual no longer considers themselves religious. Our first hypothesis refers to all the dimensions of religion and states that the more religious a person is (in relation to the religions under consideration, i.e., the different manifestations of Christianity and Islam), the less morally acceptable they will find MAR procedures. This assumption is in line with the finding that religious people tend to hold more traditional and conservative attitudes (e.g., Clements, 2014; Norris & Inglehart, 2012). Thus:

H1: The more religious a person considers themselves, the less morally acceptable they will find MAR procedures.

In terms of religious affiliation, based on the doctrines set out above, we expect Catholics and Evangelicals to be the most opposed to MAR technologies, followed by Muslims. We expect Protestants to be the most accepting among people who belong to a religious community, while we expect religiously unaffiliated individuals to have the most approving attitudes toward MAR. Thus:

H2a (religious affiliation): Among the religious, Muslims are more likely than Catholics or Evangelicals to see MAR technologies as morally acceptable, while Protestants are most likely to accept them.

H2b: Religiously unaffiliated individuals are likely to be more accepting of MAR procedures than religious people.

However, it should be noted that lay people's interpretation of religious restrictions on MAR may differ from official religious doctrines (cf. Blyth & Landau, 2009). This may apply more to Muslims, since—unlike the Pope in the Roman Catholic Church—there is no single authority in Islam that provides clear guidelines.

We differentiate the following hypotheses based on the different dimensions of religiosity. Research studies show that the parental home plays a decisive role in the transmission of (non-)religion. Even if the religion practiced by the parents is not the only factor, it is an essential prerequisite for the transmission of religiosity across generations (Myers, 1996). The same applies to non-religiosity (Tanner, 2022). Thus:

H3 (religious socialization): The more a person was socialized in a religious family, i.e., the greater the role religion played in their childhood, the less likely they are to accept MAR procedures.

H4 (subjective individual religiosity): The more religious a person considers themselves, the less likely they are to accept MAR procedures.

H5 (religious practice): The more committed a person is to their personal religious practice, i.e., the more often they pray, the less likely they are to approve of MAR procedures.

Regarding the various MAR procedures, we assume that these patterns are more pronounced in procedures involving third parties (e.g., sperm donation or surrogacy), since this is a belief shared by all religions and denominations covered in this study. Thus:

H6 (involvement of third parties): The more MAR procedures require contributions from third parties (e.g., sperm, the body of a surrogate), the less morally acceptable people will find it.

4. Data and Methods

In the following analyses we make use of the first wave of the Swiss (CH) Assisted Reproduction Longitudinal Study (CHARLS). CHARLS is the first Swiss panel study collecting data on attitudes, experiences, and beliefs related to assisted reproduction and family (Büchler et al., 2023). The first wave was collected from March to August 2023. The study employed a disproportionately stratified sampling approach, drawing a sample of 20,000 individuals from the Swiss population register. The population of interest comprised all individuals aged 18 and above with permanent residence in Switzerland. This includes all inhabitants registered in Switzerland, except for foreigners with a residence permit of less than 12 months. The sample was stratified according to the three language regions and, within these strata, further stratified by gender. Individuals were selected at random within each stratum. The language regions included the three main languages of Switzerland: German (including Romansh), French, and Italian. To allow representative statements for each language region, the Italian-speaking population of the canton of Ticino was overrepresented with 10% (vs. 4% in the total population). The sample was drawn with an equal distribution of males and females within each stratum. However, certain patterns of non-response were apparent. For example, the participation rate of Swiss citizens was significantly higher than that of foreign nationals, and participation rates were higher in urban than rural areas. Moreover, there appears to be an education bias, with more highly educated individuals being slightly overrepresented in the resulting sample. The target population was contacted by letter and invited to complete the survey either online or on paper. The survey was conducted in the three main languages of Switzerland (people who speak the fourth official language, Romansh, all speak German). English was also added. People who had moved to Switzerland were contacted in the language they had indicated as their preferred language of communication when registering in their municipality of residence. The response rate was 26%, yielding a total of 5,256 respondents. The questionnaire covered a wide range of topics, requiring an average of 40 minutes to complete. In our analyses, we restricted the sample to individuals aged between 18 and 85 who gave valid answers to all MAR procedures (i.e., the dependent variables). We had to exclude some respondents due to small case numbers (e.g., six who identified as neither male nor female) or missing values. Our final sample consisted of 3,599 respondents.

We ran linear regression models (with robust standard errors), with the moral acceptance of the various MAR procedures as dependent variables. Specifically, respondents were asked the following: “For each procedure listed, please indicate spontaneously...how morally acceptable you consider it to be.” The possible

answers ranged from 0 (*not at all morally acceptable*) to 4 (*perfectly morally acceptable*). A total of nine different MAR procedures were mentioned in the CHARLS questionnaire. These were insemination, in-vitro-fertilization (IVF), sperm donation, egg donation, embryo donation, surrogacy, egg freezing, embryo freezing, and PGT. The respondents were given the following brief descriptions of the various technologies:

1. Artificial insemination: Instruments that are used to insert sperm into the cervix or uterus.
2. Artificial fertilization outside the body, e.g., IVF (fertilization of the egg in a laboratory).
3. Sperm donation: A man provides sperm for use by third person(s).
4. Egg donation: A woman provides eggs to third person(s).
5. Embryo donation: Two people provide embryos to third person(s). Respondents were given the additional information that a fertilized egg is called an embryo when it has started to develop. In an embryo donation, the donated embryo is implanted selectively into the uterus. After the 10th week of pregnancy, the unborn child is no longer called an embryo, but a fetus. From then on, all internal organs are fully developed.
6. Surrogacy: A woman gives birth to a child for someone else.
7. Egg freezing, so as to be able to have children later on.
8. Embryo freezing, so as to be able to have children later on.
9. PGT: A selection of embryos is made after examination of their genetic makeup.

To determine the general moral acceptance of MAR, we used a summary index ranging from 0 to 36, where zero represents complete moral rejection of all MAR procedures and 36 represents complete moral acceptance of all procedures (only respondents who gave a valid answer to all procedures were included). Additionally, we used two summary indices (ranging between 0 to 16) to account for those procedures involving third-party contributions (i.e., sperm, egg and embryo donation and surrogacy) and those not necessarily involving third parties (i.e., insemination, IVF, and egg and embryo freezing).

Our primary explanatory variables relate to the domain of religion. To assess the influence of religion, we use four different variables, each reflecting a different facet of this construct. First, we consider membership in a religious community (*religious affiliation*). Participants were initially asked whether they belonged to a religious community. If they answered affirmatively, they were then asked to specify their religious affiliation. For Christians, an additional filter question was used to ask for further details. Our variable distinguishes between no affiliation, Catholic, Protestant, Evangelical, other Christian (e.g., Jehovah's Witnesses), and Muslim. Due to their diverse affiliations and small number, we decided to exclude individuals belonging to other religions from the analysis ($n = 24$), as well as Christians who did not indicate their denomination ($n = 26$). Second, we include the importance that religion/spirituality played in childhood (*religious socialization*). The question in the survey was: "What part did spirituality or religion play in your childhood?" This variable differentiates between (1) *none*, (2) *a small part* (e.g., only a few special occasions involved the church/religion/spirituality), (3) *a medium part*, and (4) *a big part* (part of everyday life). Third, we add a self-assessed level of religiosity (*individual religiosity*), which ranges between 1 (*not at all*) to 4 (*very much*). Representing the dimension of practice, we add the frequency of prayer within the last 12 months (*religious practice*). Respondents were asked: "How often have you prayed in the last 12 months?" We included five categories: (1) *never*, (2) *at least once*, (3) *at least every two months*, (4) *at least once per week*, and (5) *daily*. The dimensions of religion are included in the models as separate variables. As there is a risk of multicollinearity in the models, we tested for this and found that the VIF values were always well below 5.

Other explanatory variables are described below. Age is included in the model as a continuous variable. Some studies suggest that the effect of age on attitudes toward MAR may follow a quadratic pattern, where individuals nearing the end of their reproductive years show greater acceptance (compared to both younger and older individuals). We do not observe this trend in the CHARLS dataset, however. Instead, a descriptive graphical analysis reveals a clear downward trend, indicating that acceptance decreases with age. The gender variable distinguishes between male and female. Respondents who identified as another gender had to be excluded due to the low number of cases.

The previous use of MAR procedures was defined as follows: All procedures included in the moral acceptance summary index were considered, except for embryo donation, which was not covered in the questionnaire. Hormone treatments were also included, as they are essential for IVF and commonly used as a first step to induce pregnancy.

We also control for sociodemographic variables that have been shown to be important determinants of attitudes toward MAR in the research literature. The residential area variable differentiates between different types of urban and rural areas. Specifically, we included: (1) *large cities* (more than 100,000 inhabitants), (2) *suburban areas* (suburbs or outskirts of a city), (3) *small or medium-sized towns and their surroundings* (10,000–100,000 inhabitants or with historical town privileges, including surrounding agglomerations), and (4) *rural areas* (farms, mountain hamlets, and villages with fewer than 10,000 inhabitants). The education variable categorizes respondents into six groups: (1) *basic education* (no education completed or only compulsory schooling), (2) *vocational training*, (3) *upper secondary education*, (4) *professional education* (master craftsperson's diploma, federal diploma of higher education, or diploma from a professional education institution), (5) *tertiary education* (degree from a university of applied sciences or teacher training college), and (6) *higher tertiary education* (all degrees from universities or ETHs).

Table 1 contains the descriptive statistics for the sample studied. In terms of demographic characteristics, we find that women are slightly overrepresented in the data, as are people with higher education. The average age is just under 49, and most respondents (44%) live in rural areas. 9% of respondents (or their partners) have had experience with at least one of the MAR procedures (including hormonal treatment). The following picture emerges for the various dimensions of religion: More than half the respondents in our sample have no religious affiliation (54.9%), almost a quarter are Catholic (23.9%), 15.9% are Protestant, 3.1% belong to an Evangelical church, 1.3% to other Christian groups, and 0.9% are Muslim. Compared to the Swiss population (see Figure 1), the sample is significantly less religious, particularly regarding Islam. This is due to the underrepresentation of foreign nationals or people with a migration background. Despite the small number of cases for other Christian groups and Muslims, we have decided to include these groups in our analyses, as they make up a not-insignificant proportion of the Swiss population. However, we ask that the results be interpreted with caution. Regarding the part that religion/spirituality played in childhood, 18.1% of respondents state that it played no part, 36.9% say it played a small part, while for 28.8% it played a medium part and for 16.2% a big part. As far as religiosity is concerned, 37.9% describe themselves as not religious at all, 29% as not very religious, 27.3% as somewhat religious, and 5.9% as very religious. Finally, when asked how often they have prayed in the last 12 months, 47.2% respond “never,” 15.2% have prayed at least once, 13% at least every two months, 8.4% at least once a week, and 16.2% daily. Looking at the dependent variable, we can see that, on average, respondents are generally quite accepting of MAR procedures, with an average score of 20.2 (on a scale of 0 to 36). However, the large standard deviation shows that individual

answers deviate considerably from the average. A comparison of the two indices for treatments with or (potentially) without third-party involvement shows that the average acceptance of MAR procedures without third-party involvement is noticeably higher. This trend is also visible to some extent in the individual measures. The average moral acceptance is highest for artificial insemination (3.1), where medical intervention in reproduction is minimal. This is followed by IVF (2.7) and sperm donation and egg freezing (both 2.6). Embryo donation and surrogacy are well below this (1.7), and PGT is the least accepted by respondents (1.4 on average). An overview of the detailed distribution of the MAR procedures and the mean values for all dependent variables according to religious affiliation can be found in the appendix (cf. Supplementary File, Table A1).

Table 1. Sample descriptive statistics, or percentages.

Variable	Categories	Frequency	Mean (std. dev.)/ percentage	Range
<i>Index MAR procedures</i>			20.2 (9.3)	0–36
Index MAR without 3rd party involvement			10.3 (4.3)	0–16
Index MAR with 3rd party involvement			8.4 (4.7)	0–16
Artificial insemination			3.1 (1.1)	0–4
IVF			2.7 (1.3)	0–4
Sperm donation			2.6 (1.3)	0–4
Egg donation			2.4 (1.3)	0–4
Embryo donation			1.7 (1.4)	0–4
Surrogacy			1.7 (1.4)	0–4
Egg Freezing			2.6 (1.4)	0–4
Embryo Freezing			1.8 (1.5)	0–4
PGT			1.4 (1.4)	0–4
<i>Gender</i>	Woman	2,006	55.7%	
	Man	1,593	44.3%	
<i>Age</i>			48.8 (16.3)	
<i>Residency area</i>	Large cities	546	15.2%	
	Suburban areas	339	9.4%	
	Smaller towns	1,128	31.3%	
	Rural areas	1,586	44.1%	
<i>Education</i>	Basic education	132	3.7%	
	Vocational training	976	27.1%	
	Upper secondary	470	13.1%	
	Professional	662	18.4%	
	Tertiary	534	14.8%	
	Higher tertiary	825	22.9%	
<i>Use of MAR</i>	No/DNA	3,275	91.0%	
	Yes	324	9.0%	

Table 1. (Cont.) Sample descriptive statistics, or percentages.

Variable	Categories	Frequency	Mean (std. dev.)/ percentage	Range
<i>Religious affiliation</i>	None	1,975	54.9%	
	Catholic	858	23.9%	
	Protestant	571	15.9%	
	Evangelical	113	3.1%	
	Other Christian	48	1.3%	
	Muslim	34	0.9%	
<i>Role of religion in childhood</i>	None	650	18.1%	
	Small part	1,327	36.9%	
	Medium part	1,037	28.8%	
	Big part	585	16.2%	
<i>Religiosity</i>	Not at all	1,363	37.9%	
	Not very	1,044	29.0%	
	Somewhat	981	27.3%	
	Very	211	5.9%	
<i>Frequency of praying</i>	Never	1,699	47.2%	
	Once per year	546	15.2%	
	Every two months	468	13.0%	
	Once per week	301	8.4%	
	Daily	585	16.2%	
N		3,599	100.0%	

Source: CHARLS, wave 1, unweighted.

5. Empirical Results

Table 2 shows the results of the linear regression analysis of the covariates of general moral acceptance of MAR procedures. The summary index as the dependent variable includes all nine procedures. We present five models, with the first model containing only the control variables and the following four models adding the main explanatory variables for religion.

The first model shows that age is negatively correlated with general moral acceptance of MAR. The older a person is, the less accepting they are. Urban contexts seem to be associated with more positive attitudes, while living in the countryside is correlated with a less accepting attitude. There is a positive correlation with education: people with a higher level of education tend to have a more positive attitude toward MAR. For instance, university graduates score almost 4 points higher on the MAR index than people with vocational training. The previous use of MAR procedures also has a strong and significant effect on moral acceptance.

In model 2, we add religious affiliation and find partial support for our hypotheses. All respondents with a religious affiliation are significantly less likely to accept MAR than those without (H2b). Contrary to our assumption, we find that, on average, Muslims are by far the least likely to accept MAR, closely followed by

Table 2. Moral acceptance of MAR procedures (index). Results of linear regressions.

	Model 1 (Coef.)	Model 2 (Coef.)	Model 3 (Coef.)	Model 4 (Coef.)	Model 5 (Coef.)
<i>Gender</i>					
Woman (ref.)					
Man	−0.06	−0.09	−0.21	−0.37	−0.51
<i>Age (centr.)</i>	−0.14***	−0.14***	−0.13***	−0.12***	−0.11***
<i>Residency area</i>					
Large cities	1.29**	1.15**	1.14**	1.04*	0.96*
Suburban areas	1.03	1.06*	1.04*	1.13*	1.02*
Smaller towns (ref.)					
Rural areas	−0.81*	−0.65	−0.63	−0.54	−0.49
<i>Education</i>					
Basic	−0.93	−0.37	0.02	0.62	0.63
Voc. training (ref.)					
Upper sec.	0.99*	1.11*	1.17*	1.07*	1.05*
Professional	0.48	0.24	0.32	0.17	0.00
Tertiary	1.84***	1.59***	1.80***	1.51***	1.37**
Higher tert.	3.65***	3.35***	3.56***	3.33***	3.19***
<i>Use of MAR</i>					
No/DNA (ref.)					
Yes	3.70***	3.86***	3.94***	3.90***	3.94***
<i>Religious affiliation</i>					
None (ref.)					
Catholic		−2.56***	−1.96***	−0.76	−0.79*
Protestant		−1.87***	−1.88***	−0.68	−0.56
Evangelical		−8.70***	−7.64***	−4.63***	−3.91***
Other Christian		−5.00***	−3.72**	−0.48	−0.35
Muslim		−10.31***	−9.33***	−6.06***	−5.93***
<i>Role religion childhood</i>					
None			−0.01	−0.25	−0.26
Small part (ref.)					
Medium part			−0.89*	−0.24	−0.12
Big part			−2.98***	−1.60***	−1.15*
<i>Religiosity</i>					
Not at all (ref.)					
Not very				−1.20***	−0.97*
Somewhat				−3.07***	−1.74**
Very				−7.44***	−4.95***
<i>Frequency praying</i>					
Never (ref.)					
Once per year					−0.43
Every two months					0.03
Once per week					−2.55***
Daily					−3.52***
Intercept	18.64***	20.04***	20.51***	21.27***	21.55***
R ²	0.13	0.18	0.19	0.21	0.23
AIC	25775.03	25590.91	25547.18	25439.85	25392.21
BIC	25849.29	25696.11	25670.94	25582.19	25559.29
N	3,599	3,599	3,599	3,599	3,599

Notes: * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$. Source: CHARLS, wave 1, unweighted.

Evangelicals. Other Christian denominations follow, with Catholics and Protestants exhibiting the highest levels of acceptance among religiously affiliated groups. Including religious affiliation in the model alters the effects of place of residence, suggesting that religious individuals are more likely to live in rural than urban settings.

Model 3 also considers the role that religion played in childhood. Here we find that people for whom religion played a major role in childhood have a significantly more negative view of MAR in general, supporting H3. The effect for religious affiliation decreases in this model, probably indicating patterns of religious reproduction across generations. That is, individuals who grew up in families where religion played a dominant role seem to maintain this religion. Model 4 strongly supports H4 by showing that the more religious a person considers themselves, the less likely they are to accept MAR. The addition of this variable significantly reduces the effect of religion in the previous two models. Taking individual religiosity into account means that Catholics, Protestants and other Christians are virtually indistinguishable from the unaffiliated in terms of their general moral acceptance of MAR procedures (i.e., the effects become insignificant). Only Muslims and Evangelicals continue to be significantly less supportive. Finally, model 5 adds the dimension of religious practice. It shows, partially in support of H5, that only very regular practice has a significant negative correlation with attitudes to MAR. Compared to people who do not pray at all, those who pray daily score on average 3.5 points lower on the index, and those who pray weekly score 2.6 points lower.

To get a more detailed picture, we ran the same models for each MAR technique. Table 3 shows the results, indicating only the covariates for the religious dimensions (similarly to model 5 in Table 1). The full models are available in the appendix (cf. Supplementary File, Table A3). The intercept/constant is shown at the bottom, indicating the acceptance of a respondent with average characteristics (i.e., operationalized by the mean age and, in each case, the most frequent category). For example, a 49-year-old woman who lives in a smaller town, has a vocational qualification, has no religious affiliation, for whom religion or spirituality played only a minor role in childhood, who sees herself as “not religious at all” and has not prayed at all in the last 12 months has an average score of 2.58 with respect to the moral acceptance of egg donation (on a scale of 0 = *not at all acceptable* to 4 = *very acceptable*). *Ceteris paribus*, a Muslim woman would have an average score 1 point lower (i.e., 1.58).

Overall, the results for the individual techniques support the empirical results found for the summary measure. However, there are some differences. Protestants are most likely to have a positive attitude toward insemination and IVF, even compared to religiously unaffiliated respondents, while we do not find a significant effect for any of the other religious groups. For the other MAR procedures, Muslims are again significantly less likely to find the procedures morally acceptable, followed by Evangelicals. Compared to the unaffiliated, attitudes toward embryo donation, surrogacy, embryo freezing, and PGT are also significantly less likely to be positive for Catholics and Protestants. The role of religion in childhood is only slightly significant for those who grew up in families where religion played a big part (vs. a small part), and only for five of the nine procedures considered. As far as the degree of religiosity is concerned, we find that very religious people are significantly less in favor of each MAR procedure than those who are not religious at all. This is only partially the case for the two middle categories (*not very religious*; *somewhat religious*). In relation to religious practice, we find that people who pray regularly are least in favor of these procedures. Overall, our findings support H5: the more committed a person is to their personal religious practice (i.e., praying), the less approving of MAR procedures they tend to be.

Table 3. Moral acceptance of individual MAR procedures. Results of linear regressions.

	Insemination (Coef.)	IVF (Coef.)	Sperm Donation (Coef.)	Egg donation (Coef.)	Embryo Donation (Coef.)	Surrogacy (Coef.)	Egg freezing (Coef.)	Embryo Freezing (Coef.)	PGT (Coef.)
<i>Religious affiliation</i>									
None (ref.)									
Catholic	0.04	0.04	−0.05	−0.09	−0.16**	−0.19**	−0.07	−0.18**	−0.13*
Protestant	0.12*	0.14*	0.01	−0.06	−0.15*	−0.12	−0.05	−0.31***	−0.15*
Evangelical	−0.15	−0.31*	−0.55***	−0.59***	−0.52***	−0.51***	−0.43**	−0.40**	−0.46***
Other Christian	0.16	0.15	−0.21	−0.08	−0.06	−0.20	−0.01	−0.05	−0.05
Muslim	−0.27	−0.33	−0.89***	−1.00***	−0.76**	−0.86***	−0.79***	−0.53*	−0.48*
<i>Role of religion in childhood</i>									
None	−0.09	−0.13*	0.07	0.00	−0.03	0.06	−0.03	−0.12	0.01
Small part (ref.)									
Medium part	0.02	−0.03	−0.05	−0.02	−0.01	0.01	−0.03	0.01	−0.01
Big part	−0.07	−0.03	−0.17*	−0.16*	−0.13	−0.08	−0.15*	−0.18*	−0.18**
<i>Religiosity</i>									
Not at all (ref.)									
Not very	−0.14**	−0.11	−0.12*	−0.08	−0.12	−0.02	−0.05	−0.09	−0.24***
Somewhat	−0.19**	−0.22**	−0.27***	−0.21**	−0.23**	−0.13	−0.14	−0.09	−0.25**
Very	−0.56***	−0.70***	−0.73***	−0.80***	−0.56***	−0.42***	−0.52***	−0.34*	−0.34**
<i>Frequency praying</i>									
Never (ref.)									
Once per year	−0.02	−0.05	0.02	−0.02	−0.12	−0.04	−0.08	−0.13	−0.01
Every two months	−0.01	0.01	0.08	0.05	−0.04	−0.04	0.00	−0.06	0.04
Once per week	−0.20*	−0.31**	−0.23*	−0.34***	−0.39***	−0.25**	−0.35***	−0.33**	−0.15
Daily	−0.36***	−0.45***	−0.43***	−0.38***	−0.36***	−0.31***	−0.39***	−0.53***	−0.31***
Intercept	3.12***	2.77***	2.75***	2.58***	1.98***	1.95***	2.81***	2.05***	1.55***
R ²	0.14	0.16	0.17	0.19	0.15	0.11	0.15	0.14	0.13
N	3,599	3,599	3,599	3,599	3,599	3,599	3,599	3,599	3,599

Notes: * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$; all models control for age (centered), gender, residence area (urban/rural), education, and previous use of MAR. Source: CHARLS, wave 1, unweighted.

As there seems to be a much stronger rejection of MAR procedures involving third parties (sperm, egg and embryo donation, and surrogacy), we ran two different models for the relevant procedures (summary indices). We left out PGT in this comparison, as attitudes toward this technology are very negative overall. Accordingly, the two indices range from 0 to 16, each including four MAR procedures. Figure 2 shows the corresponding covariates and confidence intervals for the religion items of these indices (controlled for the same variables as in model 5 in Table 2). Full models are available upon request. The graphical representation clearly shows that MAR procedures that do not (necessarily) involve third parties' gametes, embryos, or wombs are slightly more accepted overall than those that do, but the difference is not statistically significant (H6).

Overall, the analyses presented support H1, that higher levels of religiosity will be associated with lower moral acceptance of MAR procedures. In terms of religious affiliation, the results partially support H2a. In our sample, Muslims are most likely to reject MAR technologies, followed by Evangelicals. Both groups are significantly less accepting of MAR than Catholics, who in turn differ significantly from individuals with no religious affiliation. However, religiously unaffiliated people do not differ significantly in their attitudes from other Christian groups, so H2b is also only partially supported. Similarly, H3 is partially confirmed: Only those socialized in families where religion played a big part in everyday life are less likely to have a positive attitude toward MAR. In contrast, the data clearly support H4: The more religious a person considers themselves, the less likely they are to accept MAR. There is also clear evidence that people who pray more often are less accepting of MAR procedures (H5). Finally, H6 is not supported by the data. Although there appears to be a tendency toward lower acceptance of MAR procedures involving third parties, the difference is not statistically significant. This result may reflect the fact that even measures not explicitly involving third parties can nonetheless involve them (e.g., IVF with donor sperm).

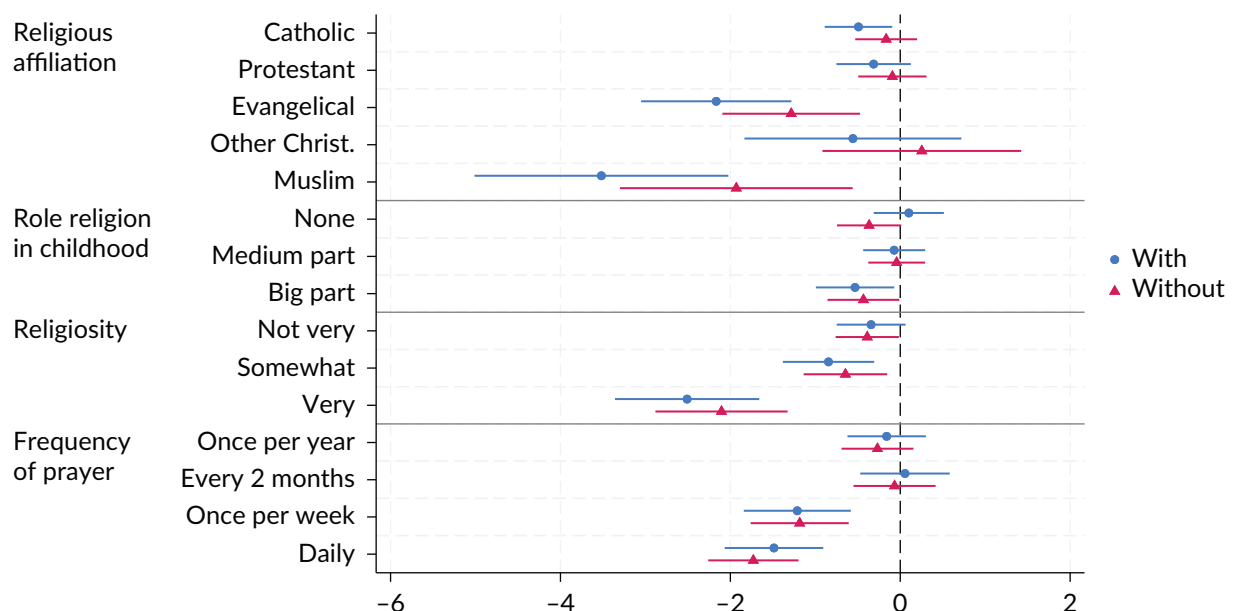


Figure 2. Moral acceptance of MAR procedures with or without third-party involvement. Source: CHARLS, wave 1, unweighted; separate linear regression models.

6. Conclusion

The current literature on the covariation of religiosity and attitudes toward MAR is still rather sparse. It usually focuses on only a few MAR procedures, does not systematically consider the different dimensions of religiosity, and is often based on samples from selected groups such as women or MAR users. In our analyses, we therefore aimed to examine how various dimensions of religiosity relate to attitudes toward a broad range of MAR procedures in the general Swiss population. We considered both a composite index covering nine MAR techniques and individual evaluations of each procedure.

Overall, our findings show a distinct pattern of acceptance across different religious groups, with religion—measured through affiliation, religious socialization, self-assessed religiosity, and frequency of praying—emerging as a key determinant. While all religiously affiliated groups tended to express lower moral acceptance of MAR than non-affiliated individuals, the extent varied considerably. Muslims and Evangelicals consistently showed the lowest levels of acceptance, followed by other Christian groups, with Catholics and Protestants displaying relatively more favorable attitudes. However, these differences diminished substantially when we controlled for subjective religiosity and frequency of prayer, indicating that religious commitment is more critical than affiliation alone.

The negative attitude of Muslims toward MAR contradicted our assumption. Although caution is advised in interpreting the results due to the small number of cases, this finding is consistent with those of Szalma and Djundeva (2019). They analyzed 42 European countries and found that Muslims were the religious group with the lowest acceptance of assisted reproduction (insemination and IVF). For Switzerland, Mertens (2025) similarly found a lower acceptance rate among Muslims. Religious socialization also influenced attitudes, albeit more modestly. Only individuals raised in households where religion played a major part were significantly less accepting of MAR, suggesting an intergenerational transmission of more conservative values. In contrast, the strength of subjective religiosity showed a clear and consistent negative association with MAR acceptance. Those identifying as “very religious” were significantly less supportive than those who described themselves as not religious at all. Frequent prayer, representing the dimension of religious practice, was also associated with lower acceptance. Individuals who reported praying daily or weekly scored significantly lower on the MAR acceptance index, supporting the idea that religious behavior is a meaningful expression of underlying values that shape moral judgments about reproductive technologies. Finally, when comparing attitudes toward different types of MAR procedures, we found that those involving third-party contributions (e.g., donor gametes, surrogacy, or embryo donation) met with greater moral resistance, especially among highly religious individuals. However, the difference in acceptance between procedures with and without third-party involvement was not statistically significant.

In summary, our findings provide strong empirical support for the hypothesis that higher levels of religiosity—across multiple dimensions—are associated with lower levels of moral acceptance of MAR. These results underscore the importance of considering different dimensions of religion in understanding public attitudes toward reproductive technologies. They also highlight the need for more nuanced and inclusive research, which goes beyond single procedures or narrowly defined populations, offering a more comprehensive view of how religion continues to shape perspectives on assisted reproduction in contemporary societies.

We would also like to highlight some limitations of our analyses. Firstly, the data was not as representative as originally intended. Religiously unaffiliated individuals, women, highly educated respondents, and Swiss citizens were notably overrepresented, while certain groups—including Muslims—were underrepresented in the sample. This should not influence the strength and significance of the covariations found, but it is possible that the results are biased due to the small number of Muslim respondents. As outlined in the theory section, attitudes toward MAR procedures are not monolithic within Muslim communities. And the Muslims in the sample who answered questions on attitudes toward MAR are very religious overall. It is possible that including additional foreign languages in the cover letter and questionnaire would have increased the response rate among Muslims, who often have a migrant background in Switzerland. Further CHARLS waves should attempt to specifically survey these underrepresented (religious) groups. Corresponding data could be used to check whether the results presented would be valid if a larger number of Muslims and other Christians were included.

Secondly, the measurement of religiosity could have been even more nuanced. While several dimensions were included, an item capturing the faith or belief dimension more explicitly would have been desirable. Thirdly, we would like to point out that the data we used for our analyses are cross-sectional and that our results reflect covariances that may suggest, but do not necessarily imply, causal relationships. Future waves of CHARLS data collection could provide further insights in this regard. Future research could examine the acceptance of different MAR techniques (in relation to religiosity) more closely in terms of access criteria: certain techniques might be considered more acceptable if they were reserved for specific groups (e.g., married couples or people with serious hereditary diseases). Further studies could also examine how the protection of life and the status of the embryo (according to religious doctrine) relate to the acceptance of MAR (see, for example, Braunschweig et al., 2025).

Despite these limitations, the CHARLS data is a very rich data source and the most representative on the topic for Switzerland to date. Our study contributes to a more comprehensive understanding of how multiple dimensions of religiosity influence attitudes toward a broad range of MAR procedures. Future research could place greater emphasis on exploring the underlying reasons for the attitudes captured, especially regarding religious beliefs, to further unpack the complex moral landscape surrounding MAR in increasingly pluralistic societies.

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Conflict of Interests

The author declares no conflict of interests.

Data Availability

At the time of publication, only the first wave of the Swiss Assisted Reproduction Longitudinal Study (CHARLS) was available. The CHARLS dataset will be provided upon reasonable request by the URPP “Human Reproduction Reloaded” (contact the data center of the URPP or the author). In the coming years, the CHARLS data will be made available to the scientific community at large.

LLMs Disclosure

DeepL Translate was used to help the author with the initial formatting of the English text.

Supplementary Material

Supplementary material for this article is available online in the format provided by the author (unedited).

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