

Chapter 6

Self-insemination

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Assisted insemination is a procedure that involves the transfer of sperm into a woman's vagina, cervical canal or uterus. It may be used to assist a woman with a male partner to conceive where the woman has failed to become pregnant because her partner is infertile or for some other reason. It may also be used to enable a woman who does not have a male partner to become pregnant, using sperm provided by a donor. Self-insemination is assisted insemination done by a woman to herself.

In this chapter, we consider whether clinics should be able to provide services to assist women who wish to self-inseminate. We also consider whether self-insemination which is done without such clinical support should continue to attract criminal penalties.

CURRENT LAW

In Victoria, women who do not have male partners are not eligible for treatment under the *Infertility Treatment Act 1995*, unless they are clinically infertile.¹ For this reason, many women who want to conceive make private arrangements with male friends or acquaintances to donate sperm so they can self-inseminate. Even if a woman is eligible for treatment in a clinic, she may prefer to self-inseminate at home. Self-insemination often takes place without counselling of the woman or the donor and without medical or legal advice. There is a risk that serious health and other issues may emerge for the woman and any child who is conceived, including:

- the possibility that the mother and/or child may contract a communicable disease as the result of self-insemination with sperm from a donor who has not been screened for such diseases
- failure to record information about the identity of the donor resulting in difficulties for the child in obtaining access to this information in the future
- potential for conflict between the donor, the birth mother and her partner (if she has one) about the donor's involvement in the child's life, which might have been avoided through counselling
- the fear that the woman and her partner (if she has one) may be committing a criminal offence by self-inseminating, which may make them less willing to seek advice.

Some fertility clinics have attempted to address these concerns, within the restrictions imposed by the law, by facilitating storage of sperm from a known donor, which is screened by the clinic and then used by women to self-inseminate outside the clinic.² Licensed clinics do this under interim licensing conditions issued by the Infertility Treatment Authority (ITA) which require clinics to satisfy similar requirements to those which apply when a woman is inseminated within a clinic.³

The requirements include:

- screening and testing of donors for communicable diseases and quarantining of sperm prior to its use
- provision of counselling and information to:
 - the man who provides the sperm and his spouse or domestic partner (if any)
 - the woman wishing to utilise the sperm and her spouse or domestic partner (if any) pursuant to the requirements of the Infertility Treatment Act⁴
- consent of the donor and his spouse (if any) to the storage of sperm and recording of any conditions the donor wishes to place on the length of storage
- obtaining the donor's consent to lodge his details with the clinic so that the ITA can record them if a child is born.

In addition, the release of the sperm is conditional on the woman signing an agreement that she will use the sperm in accordance with the donor's consent and that she will notify any birth to the ITA so that the details can be entered on the central register.⁵

Melbourne IVF established a sperm storage service at the Royal Women's Hospital in December 2004 in accordance with these conditions. The service is available to all women who wish to use the sperm of a known donor, although it is expected that primarily single and lesbian women will use the service. Heterosexual couples generally have insemination performed in clinics.⁶ In 2005, 13 known donors stored sperm for release from the Royal Women's Hospital clinic, and 16 women completed agreements for sperm to be released.⁷ In 2006, six known donors stored sperm, and seven women completed agreements. At December 2006, the ITA had received no reports of children born, although one failed pregnancy was reported.⁸

Preliminary feedback about the sperm storage service has generally been positive. In its submission, the ITA reported that clinics had received positive responses to the program from

people seeking treatment.⁹ However, concerns have also been expressed about the limited availability of information about the service, which could be affecting the number of people using it.¹⁰

Conditions imposed on clinics with storage facilities provide some protection for women and for children conceived through self-insemination by sperm from a known donor, and for donors and their spouses. Sperm stored at clinics for self-insemination must be screened, tested and quarantined (in the same way as for other sperm donations) to prevent transmission of communicable diseases.¹¹ Medical expertise and insemination techniques at clinics may also optimise the chance of pregnancy.¹²

The process of sperm storage offers additional protection for all parties. The sperm donor, the woman wishing to inseminate, and both of their partners (if any) must undergo counselling in accordance with the Infertility Treatment Act. The donor (and his partner) must consent to the storage of sperm and state the name of the person who is to receive it. As discussed in Chapter 5, counselling during this process assists in informing the parties and can help to address issues that may arise through assisted conception.

The process also ensures that a donor's contact details are registered with the ITA, and creates an obligation on women to notify the ITA when a child is born.¹³ In Chapter 15, we discuss the importance of ensuring that children conceived using donated gametes have access to information about their genetic origins. The reporting requirements contained in the ITA's conditions for storage of sperm create important long-term benefits for children conceived through self-insemination.

Overall, the sperm storage service minimises potential harms that can arise from self-insemination, with benefits for women, donors and children. The service facilitates 'people who choose to self-inseminate being supported to be able to have a safe service in a healthy environment'.¹⁴

- 1 For further discussion, see Chapter 4.
- 2 See *Infertility Treatment Act 1995* ss 106, 110. The ITA obtained legal advice that allowing storage subject to conditions was not contrary to the Act. Storage for this purpose is subject to conditions imposed by the ITA.
- 3 Infertility Treatment Authority, *Storage of sperm by women using known donors for the purposes of self-insemination, Interim Conditions imposed under s 106, Infertility Treatment Act 1995* (2006a).
- 4 *Infertility Treatment Act 1995* ss 18, 19, 103, Part 7.
- 5 Infertility Treatment Authority (2006a), above n 3, condition 6.
- 6 Access roundtable, 9 February 2006.
- 7 Infertility Treatment Authority, *Annual Report* (2006b), 13.
- 8 Information provided by the Infertility Treatment Authority, 22 January 2007.
- 9 Submission PP1 337 (Infertility Treatment Authority).
- 10 Access roundtable, 9 February 2006.
- 11 Infertility Treatment Authority (2006a), above n 3, condition 1. The Reproductive Technology Accreditation Committee code of practice requires that sperm is tested for HIV virus (Types 1 and 2), hepatitis C virus, hepatitis B virus, human t-cell lymphotropic virus type 1, syphilis and microbiological contamination testing: Reproductive Technology Accreditation Committee, *Code of Practice for Assisted Reproductive Technology Units* (rev ed, February 2005), 9.9.
- 12 Submissions PP1 270 (Dr Ruth McNair), PP1 226 (Professor HWG Baker and Dr JC McBain).
- 13 Infertility Treatment Authority (2006a), above n 3, conditions 4 and 6.
- 14 Submission PP1 345 (Health Services Commissioner).

RECOMMENDATIONS

42. Clinics should continue to be permitted to screen and store sperm for use by women who wish to self-inseminate with sperm from known donors.

CHOOSING TO SELF-INSEMINATE

The current law in Victoria leaves many women with no choice but to self-inseminate if they wish to become pregnant. However, some women also have a preference for self-insemination over treatment in a clinic.

Research has identified a number of reasons why women choose to self-inseminate. As part of the Lesbian and Gay Families Project, 136 women living in Victoria were surveyed about their methods of family formation. Twenty-eight per cent of women with children had used self-insemination to conceive. Of 43 women attempting to conceive, 33% intended to use clinic insemination and 44% intended to self-inseminate.¹⁵ Women who had self-inseminated cited a desire for the child to know the identity of all biological parents as the primary reason for their decision (96% of respondents). Half of the women also said that ineligibility for clinic treatment in Victoria was a factor in their decision. Other reasons why women prefer self-insemination identified in the study include:

- the relative affordability of self-insemination
- beliefs regarding women's rights to control their fertility
- a desire to involve their partners in the insemination process
- opposition to medical intervention.

By contrast, women who used clinic insemination cited the safety of the procedure and the desire for anonymous sperm donors as key reasons for their decision.¹⁶

Studies have also shown that self-insemination remains a preferred choice for many women even when clinic services are available. A survey of 84 lesbian women conducted in Sydney in 2000 found that self-insemination was still a preferred method of conception, even though the women were eligible for treatment in a clinic. Sixty-eight per cent of respondents self-inseminated using sperm from a known donor, and 8% used sperm from an unknown donor to self-inseminate.¹⁷

Submissions received by the commission also discussed the reasons some women elect to self-inseminate.

One submission said that:

constituting donor insemination as a treatment procedure (and failing to distinguish it from more sophisticated and physically interventionist techniques such as IVF) unnecessarily medicalises the process.¹⁸

The Fertility Access Rights group reported that 'many lesbian couples would prefer that their attempts to create a family stay within the intimate, private realm, and not be unnecessarily medicalised'.¹⁹ This statement was confirmed in submissions written by individuals wishing to conceive. One woman wrote:

My partner and I are still on our long journey to becoming parents. The process thus far has been both clinical and medical. When my time comes, we would greatly appreciate the opportunity to inseminate in our own home.²⁰

Women were also concerned not to undergo invasive ART procedures. After a number of unsuccessful inseminations, a clinic might suggest that a woman commence IVF treatment. However, some women may want to continue to attempt to self-inseminate. The commission also heard that some clinics are perceived as unfriendly by lesbian and single women.²¹ Women may also wish to self-inseminate at home because it is less expensive than accessing a clinic.²²

A submission from a man who was a known donor to a lesbian couple expressed support for the sperm storage service offered by clinics. He said:

when it became known to us that clinics would provide a sperm storage service that would be made available to lesbian couples, we embarked on this method as it would give greater comfort to the couple on the safety of the sperm used.

I agree that the women concerned should be strongly encouraged to attend the clinic and be artificially inseminated with my sperm, however, if in the end they decide they wish to self-inseminate away from the clinic then that right should not be denied to them.²³

CLINICAL SELF-INSEMINATION SERVICES

In *Position Paper One: Access*, the commission made an interim recommendation that the practice of clinics providing sperm to women so that they can self-inseminate be discontinued if our recommendations about expanding access to treatment were implemented. The commission assumed that most single and lesbian women would access clinics if they became eligible for treatment. The commission was also concerned about the uncertainties that arise when sperm is removed from a clinic, and was seeking to ensure as many women and children as possible would be protected by the full range of safeguards offered through clinic treatment. This recommendation was supported by the South Australian Council on Reproductive Technology, which stated that:

*all assisted reproduction procedures are best conducted in specialist reproductive medicine units licensed by RTAC to ensure that clients have access to the highest standard of appropriate clinical practice and counselling services.*²⁴

The safeguards provided in a clinic setting are not always present when women self-inseminate because once the sperm is removed from the premises, no controls exist on its use. Although the women must agree to provide birth details to the ITA, there is no guarantee this will occur. If the ITA is not advised of the birth, a child may be denied access to information about paternity. In some submissions, concern was expressed that self-insemination might be used to circumvent legislation requiring the donor's identity to be registered.²⁵ Other submissions argued that self-insemination should not be legitimated because it is exploitative of men's reproductive capacity.²⁶

The commission did, however, receive a significant number of submissions arguing for retention of the current arrangements for sperm screening and storage for women who intend to self-inseminate.

The benefits of a clinic sperm-screening service were highlighted in a submission from a woman who had unsuccessfully attempted to conceive at home using (unscreened) sperm from a known donor. She wrote:

I was so pleased when I heard through a friend that the Royal Women's Hospital is now running an outpatient program where women can have known-donor sperm vetted and stored, and be taught how to use it at home.

*A program like that would have been perfect for someone like me—someone who can find their own donor, would like the process to be as natural and non-intrusive as possible, yet is keen to avoid the possibility of dealing with dud sperm (like we had) or worse, the chance of disease.*²⁷

Others appreciated the increased clarity surrounding the relationship with the sperm provider that is created by using clinic services such as screening and counselling.²⁸ The Lesbian Parents' Project Group said:

*The benefits of the services that clinics can offer—sperm testing, storage, counselling, being clearly positioned as the recipient of a donation and having the donor clearly positioned as the donor—should not be underestimated (and currently extend even to such things as making it very much easier to deal with the Registry of Births, Deaths and Marriages and the Passports Office).*²⁹

The commission has reconsidered its interim recommendation about self-insemination services in light of the research findings mentioned above, and the submissions we received in response to Position Paper One. The research indicates that even if eligibility for clinic treatment is expanded, many women will continue to choose to self-inseminate. The commission is convinced that services which support self-insemination should continue to be offered because the key aim is to diminish the health and other risks associated with insemination, both for women and children. It also provides women with additional choices to control their fertility and conception and is consistent with the guiding principle contained in our Recommendation 1 that 'the health and wellbeing of people undergoing assisted reproductive treatment procedures must be protected at all times'.

The commission acknowledges that allowing sperm to be removed from a clinic environment means there is no guarantee that it will be used in accordance with the conditions set down by the ITA. However, the commission was encouraged by submissions which said that it was highly unlikely sperm would be used by anyone other than the woman intending to use it, or that women would not comply with the ITA's conditions for donor and birth registration.³⁰ The commission believes that the harm minimisation benefits of the sperm storage service outweigh the unlikely potential for the program to be misused. As the purpose of the program is to protect those who self-inseminate from a range of risks associated with the practice, we do not believe people who use the service should be subject to our proposed eligibility criteria for ART treatments detailed in Chapter 5.

- 15 Ruth McNair et al, 'Lesbian Parenting: Issues, Strengths and Challenges' (2002) 63 *Family Matters* 40, 43.
- 16 *Ibid* 44.
- 17 *Report of the Sydney Lesbian Parenting Conference* (2000), 10, cited in Jenni Millbank, *Meet the Parents: A Review of the Research on Lesbian and Gay Families* (2001) 31.
- 18 Submission CP 88 (Deb Dempsey).
- 19 Submission PP1 251 (Fertility Access Rights).
- 20 Submission PP1 254 (Anonymous).
- 21 Access roundtable, 9 February 2006; submissions PP1 341 (Dr Elizabeth Short), PP1 255 (Lesbian Parents' Project Group).
- 22 Submissions PP1 341 (Dr Elizabeth Short), PP1 226 (Professor HWG Baker and Dr JC McBain), PP1 254 (Anonymous).
- 23 Submission PP1 146 (Brenton Thomas).
- 24 Submission PP1 347 (South Australian Council on Reproductive Technology).
- 25 Submission PP1 231 (Michael Linden and Lia Vandersant).
- 26 Submission PP1 138 (The Australian Family Association).
- 27 Submission PP1 236 (Anonymous).
- 28 Submission PP1 341 (Dr Elizabeth Short). See Chapter 8 for a discussion of the legal status of donors.
- 29 Submission PP1 255 (Lesbian Parents' Project Group).
- 30 Submissions PP1 323 (Rhonda Brown), PP1 319 (Women's Health West), PP1 254 (Anonymous), PP1 341 (Dr Elizabeth Short).

RECOMMENDATIONS

43. The Infertility Treatment Authority should develop information resources for people who use self-insemination to conceive. Such resources should:
- include information about the implications of donor conception for parents and children
 - refer people to available support services including counsellors, doctors and lawyers
 - be made available for distribution by the Registry of Births, Deaths and Marriages, obstetricians and gynaecologists, and gay and lesbian health services and resource centres.
44. The Infertility Treatment Authority should be empowered to accredit non-clinic-based counsellors who have received specialist training in relation to donor conception and same-sex parented families. Training should cover same-sex parenting, family arrangements, health issues, legal implications, disclosure of donor information, and children's outcomes.
45. Counselling should:
- be available to all women who are contemplating, or engaged in, conception through assisted reproduction, irrespective of whether they are undergoing treatment in a clinic or not
 - be available before conception and throughout the process as required
 - discuss options, clarify rights and responsibilities of all parties and ensure informed consent
 - be affordable
 - be provided by trained and accredited counsellors working both inside and outside the clinic system.

SUPPORT SERVICES

It is important to encourage women to have counselling and receive legal information about the implications and consequences of becoming a parent through donor conception. For women who use the services of a clinic to assist in conception, counselling and provision of information are already elements of the process. The commission believes that it is also important to make such support services available for women who choose not to use the services of a clinic.

The need for prospective parents, donors and partners to receive accurate information was acknowledged in submissions by health services such as Women's Health West, which stated that:

There is an urgent need for people in the community to receive such health information and support—a need that for a long time has been primarily met by volunteer community groups.³¹

There was particular support in submissions for the provision of counselling to all parties involved in the conception process. Fertility Access Rights said fertility clinics, as well as other health service providers, should be encouraged to support women who are self-inseminating and to ensure all parties explore the issues involved. Others said that counselling, donor screening services and advice would help to 'maximise the safety of those making this choice [self-insemination]'.³² However, submissions also drew attention to the need for counsellors to be 'trained in and sensitive to all the issues relevant to ... diverse families'.³³

The commission recommends that specialist counselling should:

- be available to all women who are contemplating, or engaged in, conception through assisted reproduction, irrespective of whether they are undergoing treatment in a clinic or not
- be available before conception and throughout the process, as required
- discuss options, clarify rights and responsibilities of all parties and ensure informed consent
- be affordable
- be provided by trained and accredited counsellors working both inside and outside the clinic system.

The ITA should be empowered to accredit non-clinic-based counsellors who have received training in relation to donor conception and same-sex parented families to provide specialist counselling to women who choose to self-inseminate. The training should cover a broad range of topics relevant to donor conception, such as same-sex parenting, family arrangements, health issues, legal implications, disclosure of donor information and outcomes for children.

The commission believes the ITA should also play a role in promoting the importance of counselling and legal advice, and making resources readily available to those seeking assisted insemination. The ITA should develop resources for distribution through services beyond fertility clinics that are accessed by women who conceive through self-insemination. Places where information resources should be available include medical centres, obstetricians' and gynaecologists' practices, gay and lesbian health services, and the Registry of Births, Deaths and Marriages.

CRIMINAL LIABILITY

Section 7 of the Infertility Treatment Act states:

- (1) A person may only carry out artificial insemination of a woman using sperm from a man who is not the husband of the woman at a place other than a hospital or centre licensed ... for the carrying out of donor insemination if he or she—
- (a) is a doctor who is approved ... to carry out donor insemination; and
 - (b) is satisfied that the requirements [concerning consent, information and counselling] have been met.

Breach of section 7 attracts a criminal penalty of up to four years imprisonment and/or a fine of 480 penalty units (currently equal to \$51,566.40).³⁴

The reference in this section to ‘another person’ indicates it was not intended to apply criminal penalties to those who self-inseminate, but this qualification is not beyond doubt. The ITA has advised clinics and approved doctors that self-insemination is not regulated by the Infertility Treatment Act.³⁵ However, it appears that many people believe it is an offence. Further, it is likely that on a strict interpretation of section 7 the partner of a woman who assists her to inseminate is guilty of a criminal offence.

Self-insemination is only regulated in states that have legislation governing access to ART. In South Australia, artificial fertilisation is not illegal if carried out gratuitously,³⁶ or by a registered medical practitioner granted an exemption from licensing requirements,³⁷ or by a licensed practitioner.³⁸ The penalty for contravening these conditions is \$10,000.³⁹ Similar provisions apply in Western Australia, where artificial fertilisation procedures must be carried out by a licence holder,⁴⁰ or a medical practitioner granted an exemption.⁴¹ No licence or exemption is required if a person carries out the insemination under the direction of a licensee and agrees to provide details of the outcome of the procedure to the licensee.⁴²

Concerns about the effects of potential criminal liability were expressed in submissions.⁴³ One submission posed the following questions:

Would my partner or I be guilty of an offence by virtue of s.7 of the Infertility Treatment Act 1995 if we [use self-

insemination]? We both have jobs where police checks and evidence of good character are required. Could the simple act of attempting to fall pregnant compromise our future employment? Are we willing to take a risk, trust in the fact that such a prosecution has not been initiated before? We are in the position of having to commit an offence to become pregnant. This places us in an extraordinary conflict, as a woman who wants to parent[,] self-insemination is a possible avenue to achieve this.⁴⁴

In addition, other submissions revealed that some women:

- have been told by doctors, lawyers and government officials that what they have done or are planning to do is a crime⁴⁵
- fear seeking appropriate health or legal advice because they believe that self-insemination is illegal and subject to penalties
- are unable to obtain information from doctors who believe it is illegal to provide information that will assist women to self-inseminate.⁴⁶

Section 7 ensures that the safeguards about all aspects of clinical practice provided by the Infertility Treatment Act apply, by specifying that only licensed clinics and approved doctors can carry out assisted insemination. This is achieved by penalising health professionals or others who do not satisfy the requirements in the Act. Should criminal penalties also apply to those who self-inseminate or their partners?

We have discussed the benefits to women and their children of clinic-based insemination procedures or insemination by an approved doctor. The commission believes that while women should be encouraged to use a clinic or a doctor because of the associated safeguards, it is not desirable to criminalise women who self-inseminate, nor partners who may help them. Expansion of eligibility requirements for access to assisted reproductive services should provide an incentive to seek clinic-based treatment and may well result in fewer single women and women in same-sex relationships engaging in self-insemination. The continuation of sperm screening and storage services will also minimise the risks involved for women who still wish to self-inseminate.

- 31 Submission PP1 319 (Women’s Health West).
- 32 Submission PP1 232 (Ministerial Advisory Committee on Gay and Lesbian Health).
- 33 Submission PP1 251 (Fertility Access Rights), see also PP1 321 (Anonymous).
- 34 *Victoria Government Gazette*, No G 14, Thursday 6 April 2006 (effective 1 July 2006) available from <www.gazette.vic.gov.au>.
- 35 Infertility Treatment Authority (2006), above n 3.
- 36 *Reproductive Technology (Clinical Practices) Act 1988* (SA) s 13(7)(b).
- 37 *Reproductive Technology (Clinical Practices) Act 1988* (SA) s 13(7)(a).
- 38 *Reproductive Technology (Clinical Practices) Act 1988* (SA) s 13(1).
- 39 *Reproductive Technology (Clinical Practices) Act 1988* (SA) s 13(1).
- 40 *Human Reproductive Technology Act 1991* (WA) s 6.
- 41 Human Reproductive Technology (Licences and Registers) Regulations 1993 (WA) r 2.
- 42 Human Reproductive Technology (Licences and Registers) Regulations 1993 (WA) r 2(3).
- 43 Submissions CP 82 (Anonymous), CP 89 (Ministerial Advisory Committee on Gay and Lesbian Health), CP 112 (A&H), CP 143 (The Bouverie Centre), CP 149 (Prospective Lesbian Parents), CP 171 (Fertility Access Rights), CP 179 (Lesbian Parents Group), CP 198 (Dr Elizabeth Short). These arguments were repeated in submissions in response to Position Paper One.
- 44 Submission CP 82 (Anonymous).
- 45 Submission PP1 255 (Lesbian Parents’ Project Group).
- 46 Submissions CP 88 (Deborah Dempsey), CP 89 (Ministerial Advisory Committee on Gay and Lesbian Health), CP 133 (Women’s Health West), CP 143 (The Bouverie Centre), CP 149 (Prospective Lesbian Parents), CP 171 (Fertility Access Rights).

RECOMMENDATIONS

46. It should not be an offence for a woman to carry out self-insemination, nor an offence for her spouse, domestic partner (if any) or friend to assist her to carry out self-insemination.
47. No person should be permitted to carry out assisted insemination as a service unless he or she is licensed to do so.

Criminal sanctions may themselves have adverse effects on the health of women and children. The Australian Infertility Support Group commented that:

We believe that criminal implications of self-insemination only serve to place a woman accessing unscreened sperm for the purpose of self-insemination at significant health risk. If there were fewer impediments to women accessing AI [assisted insemination] in a normal clinic environment, regardless of the woman's sexual orientation, greater scope to protect her & any prospective child/ren would exist ... Because not all locations are ideal, implements are not always sterile; self-insemination introduces a number of variables, which could endanger the woman ... Whilst we believe that self-insemination should be discouraged we do not believe that there needs to be legislation or criminal consequences applied to the act.⁴⁷

Similarly, Victoria Legal Aid opposed imposition of penalties involving a custodial sentence for self-insemination.⁴⁸

The commission believes that if a woman (and her partner if she has one) wish to carry out assisted insemination outside a clinic environment, criminal penalties are unlikely to deter them. Detection of the offence would be difficult and prosecution is extremely unlikely. Imposing penalties would also be at odds with the provision of sperm screening and storage services at clinics for the purpose of self-insemination.

For these reasons, the commission recommends that criminal penalties should not apply to women who self-inseminate or partners who assist them. The commission believes that women should be encouraged to seek treatment in a licensed clinic or by an approved doctor, but acknowledges that some women will not do so and their actions should not be criminalised. Section 7 of the Infertility Treatment Act should be amended to remove any ambiguity on this matter.

The language of the legislation should also be modified to state that no one should carry out assisted insemination as a service unless they have a licence to do so. This provision is intended to restrain people from setting up businesses that are not subject to the safeguards and compliance requirements of a licence granted by the ITA. It would not penalise someone who assists a woman to self-inseminate on a particular occasion. The woman herself, her partner and any other friend assisting would not be committing an offence.