The Best Interests of the Child Conceived by ART – Law in Book and Law in Action

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The Best Interests of the Child Conceived by ART – Law in Book and Law in Action

Edited by

Aleksandra Korać Graovac



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Foreword: The Best Interests of the Child Conceived by ART – Law in Book and Law in Action

Aleksandra Korać Graovac

Modern medicine has enabled assisted reproduction technologies that help couples and individuals to fulfill an inherent desire to become a parent despite infertility. As medical and biomedical sciences are developing extremely fast, philosophers, ethicists, moral theologians, psychologists and legislators have offered rules and drafted public policies and legal rules on sensitive issues concerning human reproduction. Jurisprudence tries to fulfill *lacunae* in law and plays an important role.

At the beginning of medical success in the field of human reproduction, public discussion started from the rights of infertile couples, but than focus shifted to the child conceived by medical help as well. It soon became clear that the central figure in these debates should be the child whose dignity, identity, security, and well-being must guide our legal and ethical frameworks. Still, legal solutions might be (and they are) quite different in particular national legislation, as it is shaped by culture, values, international obligations arising from international agreements, and the interpretation of human rights.

With the above in mind, the Central European Academy, University of Miskolc. appointed at the beginning of 2024 the research team 'ART and the best interests of the child': prof. Tímea Heinerné Barzó (University of Miskolc, Hungary); prof. Gordana Kovaček Stanić (University of Novi Sad, Serbia); prof. Marek Andrzejewski (Polish Academy of Sciences, Poland); prof. Marek Bielecki (Faculty of Law and Administration, War Studies University in Warsaw), prof. Emese Florian and prof. Marius Floare (Faculty of Law, 'Babeș-Bolyai' University, Cluj-Napoca, Romania); prof. Lilla Garayová (Pan-European University, Bratislava, Slovakia); dr. Dominik

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Goluch (Cardinal Stefan Wyszynski University in Warsaw); prof. Aleksandra Korać Graovac (University of Zagreb, Croatia); prof. Zdeňka Králíčková (University of Brno, Czech Republic); prof. Suzana Kraljić (University of Maribor, Slovenia) and prof. Paweł Sobczyk (University of Opole, Poland). During our exciting research, we realized that international aspects are of great importance, especially cross-border surrogacy, so prof. Sibilla Buletsa (Uzhhorod National University, Ukraine) joined the authors with valuable insight in legislation of surrogacy in Ukraine. As co-authors of two chapters participated prof. Edit Sápi and dr. Zsófia Nagy (University of Miskolc, Hungary).

The collective work of the research team – encompassing two conferences and numerous formal and informal scholarly debates and discussions culminated in this monograph, whose purpose is to offer a comparative analysis of law in the books and law in action concerning assisted reproductive technologies and the best interests of the child.

The concept of the book was agreed as somewhat interdisciplinary, so we decided to include psychological and ethical aspects of human reproduction, and to offer an international perspective on this issue. National reports were agreed to encompass policies regarding ART, constitutional provisions, medical regulation of ART, and family law regulation of ART from the perspective, when applicable, through the best interests of the ART – conceived child. Medical terminology is not unified, as we agreed to try to follow the content and terminology used by national legal provisions as much as possible.

The Ukrainian chapter is a little bit different, as the main focus was on surrogacy, which is extremely interesting because many children conceived by surrogate technique arrive in countries where surrogacy is not regulated or is banned. This phenomenon illustrates how deeply interconnected our legal systems have become.

The law addresses challenges arising from new possibilities and new social realities, so after finishing particular chapters till publishing, there were some changes in national legislation and jurisprudence. For example. Slovakia introduced a constitutional ban on surrogacy in September 2025; the Constitutional Court of Croatia ordered in December 2025 that a child born out of a surrogacy agreement has to be entered into the birth certificates and Slovenia amended legislation. We tried to reflect the reported changes in Conclusions and Synthesis.

The outcome shows that in Central and Eastern European countries presented in this monography, different approaches may be recognized in the field of medically assisted reproduction; the interpretation of the best interests of the child shapes legal solutions with the significant influence of the rights of adults. Predominant is the tendency that will ensure that the child will be raised in traditional families, but this is not a general rule. While the best interests of the child increasingly guide legal solutions, the rights and expectations of adults continue to play a significant role. Balancing these interests remains one of the most challenging tasks for contemporary family law, trying to resist the attempt that the law becomes *ancilla medicinae*.

As the editor, I would like to express my deep gratitude to all members of the project (Central European Professors' Network) and the authors who devoted their scientific effort to the project and, of course, to the Central European Academy for bringing us together and supporting our collective effort to better understand and promote the best interests of the child in the environment of assisted reproduction.

Chapter 1

In Search of an International Standard for the Use of Assisted Reproductive Technologies



Paweł Sobczyk

Abstract

The use of assisted reproduction techniques (ART) concerns one of the most intimate spheres of human life, which is procreation. It is therefore not surprising that ART is of interest not only to medicine, ethics and religion, but also to law. Lawyers are trying to answer the question, among others, whether it is possible to create an international complete and consistent standard (system) regulating the use of assisted reproductive technologies. Such a standard (at least in principle) should take into account both universal human rights based on the respect for and the protection of human dignity and freedom, as well as the specificity of regional and national ethical, cultural, religious and social and, of course, legal contexts. The aim of this study, which is the eponymous search for an international standard for the application of ART, will be achieved by means of a legal and comparative analysis taking into account acts of international law of a universal and regional nature, selected case law and literature on the subject.

Keywords: assisted reproductive technologies (ART), best interest of the child, dignity, human reproduction, human rights, international law

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1. Introduction

The World Health Organization (WHO)[1] defines infertility as a disease in which a woman does not get pregnant after 12 months of regular intercourse (2–4 times a week) without using any contraceptive methods.[2] *A contario* definition of reproductive health – developed at the International Conference on Population and Development in Cairo[3] – 'reproductive disease' is the inability of partners to have a satisfactory sexual life and the inability to fulfil their reproductive goals. What is more, the WHO also recognises infertility as a social disease, which means that it is a widespread, chronic, difficult to treat disease, requiring long-term and regular medical care. Infertility limits the ability to perform basic life tasks and poses a significant problem not only for the individual, but also for the entire society.[4] Such a position is criticised primarily due to the fact that the disease affects a single person, in its course there are several periods and the disease can be acute, subacute and chronic. As noted in the literature on the subject,

> Infertility is a completely different and quite specific disease, because its basic feature is the lack of a child in a partnership. It does not cause pain (in the physical sense), does not lead to disability and is not life-threatening. It concerns a married couple, and it often happens that each partner may, in a different relationship, have a child separately. The way to overcome it (cure) is to get pregnant and give birth to a healthy child.[5]

Regardless of the dispute outlined above on the classification of infertility as a disease, it has been recognised by the World Health Organization (WHO) as a significant health problem requiring action in the field of medical care, as well as the creation of an appropriate legal basis for the regulatory framework. Progress in the field of solving the problem of infertility (disease) has made it possible for many people who did not have such a chance to realise their dreams of parenthood.[6] However, the dynamic development of medical technologies in the area of assisted reproductive techniques (hereinafter: ART), such as *in vitro* fertilisation (hereinafter: IVF), embryo

1 The Constitution of the World Health Organization (WHO) was signed on July 22, 1946, in New York during the International Health Conference. As part of this conference, the Agreement establishing the Interim Commission and the Protocol concerning the International Office of Public Hygiene were also concluded.

2 Rowe et al., 2000; See pacjent.gov.pl, 2024; this position has been formulated in WHO documents such as the 'International Classification of Diseases' (ICD-10), where infertility is classified under codes N46 (male infertility) and N97 (female infertility).

3 Reproductive health is a state of physical, mental, and social well-being in all matters related to the reproductive system. Health population and development, See Cook and Fathalla, 1996, pp. 115–121.

4 Łepecka-Klusek et al., 2012, pp. 163–166.

5 Ibid.

6 Ibid.

cryopreservation or gamete donation, raises numerous legal, ethical and social challenges. The problem of infertility is solved on several levels.[7] The first is the national level, which is characterised by a variety of medical practices and legal standards. In some countries, assisted reproductive techniques are widely available and well regulated, while in others, the lack of legislation leads to the abuse or restrictions on access for individuals and couples wishing to use these methods.[8] The second level of solving the problem of infertility is the international level, both regional and universal.[9] Regional – supranational organisations, such as the European Union, and universal ones, such as the World Health Organization, in the absence of initiative on the part of some countries or the lack of a uniform approach to assisted reproductive techniques, are trying to create a certain standard for the use of assisted reproductive techniques. In this sense, among other things, it can be said that the application of ART is an international problem.[10]

An important aspect of international deliberations on ART is to ensure a balance between scientific progress and the protection of fundamental human rights, such as the right to start a family, privacy or individual dignity.[11] In addition, there are questions about the limits of permissible interventions in reproductive processes, such as genetic modification or cloning, which raise both hopes and ethical controversies.[12]

The aim of this Study is to answer the question whether it is possible to create a complete and coherent international standard (system) regulating the use of assisted reproductive techniques, which would take into account both the specificity of local ethical, cultural, legal, religious and social contexts, as well as universal human rights based on respect for and protection of human dignity and freedom.[13] The legal analysis will be carried out on the basis of acts of international law of universal and regional character, selected case law and literature on the subject. The Study will also attempt to identify the challenges and opportunities for the harmonisation of regulations in the face of the so-called globalisation of medical services and the dynamic development of reproductive technologies.

7 Cook and Fathalla, 1996, pp. 115–121.
8 Van Voorhis, 2007, pp. 379–386.
9 Lampman and Dowling-Guyer, 1995, pp. 213–222; Wischmann et al., 2001.
10 Griessler et al., 2022.
11 Klusek et al., 2012, pp. 163–166.
12 Szamatowicz, 2004, pp. 21–24.
13 Page, 2024.

2. The Concept and Classification of Assisted Reproductive Technologies

Analyses of the title issue should begin with the definition of assisted reproduction technologies. The key definition was formulated in 'The International Glossary on Infertility and Fertility Care, 2017' developed by an international team of scientists composed of: Fernando Zegers-Hochschild, G. David Adamson, Silke Dyer, Catherine Racowsky, Jacques de Mouzon, Rebecca Sokol, Laura Rienzi, Arne Sunde, Lone Schmidt, Ian D. Cooke, Joe Leigh Simpson and Sheryl van der Poel.[14] The glossary contains a set of 283 consensus-based and evidence-driven terminologies used in infertility, and fertility care has been generated through an inclusive consensus-based process with multiple stakeholders. It should be emphasised that the definitions contained in 'The International Glossary on Infertility and Fertility Care' were developed by a team of twenty-five experts who worked in five working groups examining: clinical definitions, outcome measurements, embryology laboratory, clinical and laboratory andrology and epidemiology and public health. The experts included in their research the first glossary of 53 terms, which was published by the International Committee for Monitoring Assisted Reproductive Technologies (ICMART) in 2006, and an extended version of this glossary, containing 87 terms, which was published by ICMART together with the WHO in 2009. However, it was recognised that there was a need for a new improved glossary that would address, among others, the male factor, demography, epidemiology and public health issues.

Assisted reproduction technology is defined as follows:

> All interventions that include the *in vitro* handling of both human oocytes and sperm or of embryos for the purpose of reproduction. This includes, but is not limited to, IVF and embryo transfer ET, intracytoplasmic sperm injection ICSI, embryo biopsy, preimplantation genetic testing PGT, assisted hatching, gamete intrafallopian transfer GIFT, zygote intrafallopian transfer, gamete and embryo cryopreservation, semen, oocyte and embryo donation, and gestational carrier cycles. Thus, ART does not, and ART-only registries do not, include assisted insemination using sperm from either a woman's partner or a sperm donor.

A broader term in relation to 'assisted reproduction technology, ART' is 'medically assisted reproduction, MAR'. This concept, in 'The International Glossary on Infertility and Fertility Care, 2017', is defined as follows:

> Reproduction brought about through various interventions, procedures, surgeries and technologies to treat different forms of fertility impairment and infertility. These include ovulation induction, ovarian stimulation, ovulation triggering, all ART

14 Zegers-Hochschild et al., 2017.

procedures, uterine transplantation and intrauterine, intracervical and intravaginal insemination with the semen of husband/partner or donor.

The definitions of ART and MAR referred to above are recommended by the European Society of Human Reproduction and Embryology (ESHRE) and the American Society for Reproductive Medicine,[15] therefore it is difficult to overestimate their importance for the further considerations contained in this study.

Assisted reproductive technology (ART) is a broad category of medical procedures and technologies that aim to support reproductive processes in individuals and couples experiencing difficulties in conceiving naturally.[16] ART includes a variety of methods that interfere with the natural biological processes of fertilisation, both through stimulation of ovulation, manipulation of reproductive cells, and fertilisation outside the mother's body.[17] Modern ART technologies are evolving dynamically, leading to an increasing number of available methods, but also to ethical and legal challenges.[18]

At the beginning it should be noted that 'assisted reproductive technologies' are not the same as 'assisted reproductive techniques' and 'medically assisted procreation'.[19] The concept of 'assisted reproductive techniques' includes specific medical procedures that help treat infertility by manipulating eggs, sperm, and embryos. These are methods used as part of assisted reproductive technologies.[20] 'Assisted reproductive technology', on the other hand, is a term that encompasses all tools, devices, equipment and procedures used in the treatment of infertility.[21] Technology is a broader concept that includes assisted reproduction techniques, but also other aspects, such as diagnostics, ovulation cycle monitoring, laboratory methods or new biotechnological solutions. Examples of assisted reproductive technologies include: embryoscope systems, i.e. devices that facilitate the continuous monitoring of embryos without removing them from the incubator; preimplantation genetic testing (hereinafter: PGT), i.e. the examination of embryos for genetic defects before transfer into the uterus; artificial intelligence technologies in embryology, i.e. algorithms that analyse the quality of embryos and predict their implantation potential, as well as automated systems for freezing and storing gametes and embryos.[22] Thus, 'assisted reproductive technologies' encompass the entire set of tools, procedures and devices that support fertility treatment, including both techniques and innovative technological solutions.[23]

15 ASRM, 2017.
16 Wołczyński, 2006.
17 Alon et al., 2019, pp. 1665–1681.
18 Czajkowska et al., 2015, pp. 57–69; Wołczyński and Radwan, 2011.
19 Trolice, 2011, pp. 12–19.
20 Łukaszuk et al., 2018, pp. 112–140.
21 Ibid.
22 Cybulska, 2019.
23 Łukaszuk et al., 2018, pp. 112–140.

Medically assisted procreation (hereinafter: MAR) is a technique and procedure used to treat infertility and assist in human reproduction. MAR covers both assisted reproductive techniques (ART) and other medical procedures to support conception. MAR is therefore a broader concept, covering not only laboratory technologies (part of the ART), but also procedures supporting natural conception.[24] Non-invasive methods of assisted reproduction include ovulation stimulation (pharmacological induction of ovulation in women with ovulation disorders), ovulation cycle monitoring (tracking natural fertility to increase the chances of conception) and intrauterine insemination (IUI – placing sperm in the uterine cavity at the time of ovulation).[25] On the other hand, advanced MAR techniques, which are part of ART, include: *in vitro* fertilisation (IVF – *In vitro* Fertilisation – combining an egg and sperm outside the woman's body), ICSI (Intracytoplasmic Sperm Injection – microinjection of sperm into an egg), cryopreservation of gametes and embryos (freezing of eggs, sperm and embryos for later use) and preimplantation diagnostics (PGT – genetic analysis of embryos before their implantation).[26] Thus, MAR is a comprehensive set of infertility treatment methods, including both natural and advanced assisted reproductive techniques (ART).[27]

Returning to the title 'assisted reproduction techniques', their classification is based on distinguishing basic and advanced assisted reproduction techniques.[28]

One of the basic and simplest methods of ART is intrauterine insemination (IUI), which involves introducing previously prepared semen into the uterine cavity during ovulation. It is used in the case of problems with sperm quality, cervical abnormalities or unexplained infertility.[29] *In vitro* fertilisation (IVF), on the other hand, involves the collection of eggs and their fertilisation in laboratory environment outside the woman's body. The embryos created by fertilisation are then transferred to the uterus. IVF is used in cases of obstruction of the fallopian tubes, endometriosis, problems with sperm quality, as well as other causes of infertility. Part of the *in vitro* (IVF) procedure is embryo transfer (ET), which involves inserting embryos into the uterus. The selection of embryos for transfer is often based on a prior assessment of their quality.[30]

The group of advanced assisted reproduction techniques includes, in the first place, Intracytoplasmic Sperm Injection (ICSI), which involves injecting a single sperm directly into the cytoplasm of the egg cell.[31] This technique is used in cases of severe male infertility when sperm counts are very low or have limited motility. Preimplantation genetic diagnosis (PGD), on the other hand, is a method that allows

24 Bączyk-Rozwadowska 2018.
25 Bagińska, 2020, pp. 321–331.
26 Kapelańska-Pręgowska, 2014.
27 Nadon et al., 2021, pp. 3021–3024.
28 Cohen, 2015, pp. 452–465.
29 Łukaszuk et al., 2018, pp. 112–140.
30 Safjan, 1990.
31 Kuczyński, 2005, pp. 109–113.

embryos to be tested for genetic defects before they are transferred to the uterus.[32] PGD is especially important for people with inherited genetic diseases. Embryo and egg freezing (Cryopreservation) is the process of freezing eggs, sperm or embryos for storage and use at a later time. This method increases time flexibility in family planning and is particularly important for people undergoing cancer treatment.[33]

The so-called advanced assisted reproduction techniques also include egg and embryo donation (oocyte donation and embryo donation), which is an alternative for couples who cannot use their own gametes. Like surrogacy,[34] however, it is an issue that raises numerous ethical and legal controversies, especially in the context of the anonymity of donors and the rights of children born from such procedures.

In creating a conceptual network related to assisted reproduction techniques and technologies, modern technologies and innovations used in infertility treatment are also worth mentioning.

Advances in molecular biology have made it possible to use technologies such as CRISPR-Cas9 to modify the genome of embryos. The introduction of genetic changes in embryos is aimed at eliminating genetic diseases, but it raises ethical controversies related to the possibility of abuse in the form of the so-called 'designer babies'.[35] Technologies related to the artificial uterus are currently in the experimental phase, but their potential in the future could completely change the way pregnancies are managed.[36] This solution could be used in cases when a natural pregnancy or surrogate pregnancy is not possible. In the absence of appropriate legal regulations, further development of gamete and embryo biobanks should also be expected. Biobanks provide the storage of reproductive cells and embryos for medical, scientific or social purposes. This solution is especially popular among women who want to delay motherhood, but maintain the possibility of getting pregnant at a later age.[37]

To conclude this part of the analysis, it should be noted that there is no uniform definition and classification of these methods, despite the fact that ART are used globally.[38] Each of these techniques is followed with specific legal, ethical and social challenges that require careful consideration at national and international levels. Differences in terminology, as well as in legal regulations between individual countries, make it difficult to harmonise international standards.[39]

32 Jain and Singh, 2021, pp. 1–10.
33 Mikuła and Rybczyński, 2006, pp. 145–163.
34 A procedure in which a woman (surrogate) agrees to carry a pregnancy to term for another person or couple. It can include both traditional surrogacy (where the surrogate also provides her egg) and gestational (where the embryo is entirely of the genetic origin of the future parents).
35 Nowacka and Kopania, 2016, pp. 107–130.
36 De Jonge and Barratt, 2002.
37 Stoczyńska-Fidelus and Rieske, 2021, pp. 175–182.
38 Łepecka-Klusek et al., 2012, pp. 163–166.
39 Safjan, 1990.

3. International Universal Legal Bases for The Application of ART

International and national laws that relate to assisted reproductive techniques (ART) are intrinsically linked to human rights issues.[40] Regulations at the international level, despite their diversity, provide an important framework for legislative activities and practical implementation in individual countries.[41] In this section, acts of international law of a universal nature, regional regulations and initiatives of international organisations that affect the standards of application of ART will be discussed in detail.

3.1. Acts of International Law of an Universal Nature Indirectly Affecting ART

3.1.1. Universal Declaration of Human Rights

The Universal Declaration of Human Rights was adopted by the UN General Assembly in 1948,[42] which means that it does not refer directly to assisted reproductive techniques for objective reasons. Although these technologies did not yet exist at the time of its adoption, several of its provisions may be applicable in the context of the right to use ART. Art. 16 should be considered elementary in this respect – the right to found a family, which reads 'Men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family'. This provision can be interpreted as the right to access assisted reproduction methods for people who have difficulty conceiving a child naturally.[43] Art. 3 – The right to life, liberty and security of person 'Everyone has the right to life, liberty and security of person' can be interpreted in the context of the right to reproductive health, which includes access to fertility treatments.[44] Art. 12 of the Convention – Protection of Privacy and Family may serve to protect the right to make decisions concerning one's own reproductive health, including the use of assisted reproductive methods without interference from the state or society. It follows from its content that 'No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation'.[45] Art. 25 of the Convention – The right to a standard of living ensuring health and well-being – also indirectly refers to the discussed issue: 'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing

40 Safjan, 1990.
41 Griessler et al., 2022.
42 Universal Declaration of Human Rights. (adopted and proclaimed resolution of the United Nations General Assembly. 217 A (III) on 10 December 1948).
43 Kulczyk and Puppinck, 2018, pp. 18–30.
44 Gugla, 2018, pp. 107–126.
45 Babula, 2019, pp. 121–136

and medical care and necessary social services [...]'. It can be considered that the right to health also includes access to infertility treatment and assisted reproductive techniques.[46] The prohibition of discrimination is being increasingly noticed in the context of access to assisted reproductive techniques. In this context, Art. 7 of the Convention – Equality before the Law and Non-Discrimination 'All are equal before the law and are entitled without any discrimination to equal protection of the law'. Access to assisted reproductive techniques should not be restricted on the basis of gender, social status, sexual orientation or other factors.[47]

3.1.2. International Covenants on Rights of 1966

The standard of human rights protection created by convention guarantees relating to the most important spheres of human life has been developed under the UN system, among others, in the international Covenants on Human Rights of 1966.[48]

Thus, Art. 17 – Protection of Private and Family Life of the International Covenant on Civil and Political Rights contains the guarantee 'No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, (...)'. It means that the state should not restrict access to assisted reproductive techniques and interfere in decisions regarding procreation.[49] On the other hand, Art. 23 – the right to marry and the right to found a family, which reads as follows: 'The family is the natural and fundamental group unit of society and is entitled to protection by society and the State' includes, among others, the right to have children, which could indicate the need to ensure access to infertility treatments.[50]

Furthermore, in the International Covenant on Economic, Social and Cultural Rights of 1966 it is possible to indicate two Arts indirectly referring to assisted reproductive techniques. The first of them is Art. 10 – Protection of the family and motherhood 'The States Parties to the Covenant recognise that the widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society, (...)'. It is argued that supporting access to assisted reproduction methods is part of the protection of marriage and family.[51] Similarly, Art. 12 – Guarantee of the right to the highest attainable level of physical and mental health – refers only indirectly to the title issue. Access to ART can be seen as part of the implementation of this right, particularly in the context of reproductive health.[52]

46 Bucińska, 2003, pp. 121–136.
47 Florczak-Wątor and Kowalski, 2019.
48 International Covenant on Civil and Political Rights, opened for signature in New York on 19 December 1966, United Nations Treaty Series, vol. 999, p. 171.; International Covenant on Economic, Social and Cultural Rights, opened for signature in New York on 19 December 1966, United Nations Treaty Series, vol. 993, p. 3.
49 Kubicki, 1999.
50 Sękowska-Kozłowska, 2012.
51 Schulz, 2018, pp. 448–512.
52 B. Pawelczyk, 2018, pp. 595–624.

It is worth noting that in its General Comments the UN Committee on Economic, Social and Cultural Rights emphasises the need for equal access to health services, including reproductive health.[53] Of particular importance is General Comment No. 14 of 2000 – The Right to the Highest Attainable Standard of Health. The Committee defines the right to health as the right to enjoy a range of services, goods and conditions necessary to achieve the highest possible standard of physical and mental health.[54] It is pointed out that health services should be accessible to all, without any kind of discrimination, and they should take into account the principles of cultural acceptability and quality. In addition, the importance of reproductive health is highlighted, including access to sexual health education and information, as well as to family planning services. In General Comment No. 22 of 2016 – The Right to Sexual and Reproductive Health, the Committee points out that the right to sexual and reproductive health is an integral part of the right to health. It also stresses the obligation of states to ensure universal access to sexual and reproductive health services, including contraception, prenatal care and safe abortion where legal.[55] The Committee calls for the elimination of all forms of discrimination in access to these services, especially against women, young people, LGBTQ+ people and other marginalised groups. In the General Comments referred to above, the Committee stresses that states have a duty to ensure equal and non-discriminatory access to health services, including reproductive health, as a fundamental element of the implementation of the right to health.

3.1.3. Convention on the Rights of the Child

The Convention on the Rights of the Child, adopted by the United Nations in 1989, does not directly refer to assisted reproductive techniques, like the above-mentioned documents of international law, but it contains several provisions that can be interpreted in the context of children born through these methods and the rights related to their legal status and protection.[56] In this context, reference is primarily made to Art. 3 of the Convention – Best Interests of the Child: 'In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration'.[57] The guarantee resulting from this provision is that regulations concerning assisted reproductive techniques should, first of all, take into account the good of children conceived as a result of these procedures. This

53 Unic Warsaw, 2018.
54 Committee on Economic, Social and Cultural Rights, General Comment 14, 2000.
55 Committee on Economic, Social and Cultural Rights, General Comment 22, 2016.
56 Convention on the Rights of the Child, adopted by the General Assembly of the United Nations on 20 November 1989, United Nations Treaty Series, vol. 1577, p. 3.
57 Cała-Wacinkiewicz and Szwed, 2022, pp. 111–124.

includes the creation of appropriate rules on parenthood, parentage rights, and legal protection for children born as a result of ART.[58]

Important guarantees regarding ART arise from Art. 7 of the Convention – Right to identity and to know one's parents

> The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and as far as possible, the right to know and be cared for by his or her parents.

This article addresses the issue of anonymous gamete donation and the child's right to know his/her genetic origins.[59] In many countries, there are debates about whether children born through gamete donation should have the right to know their donor.[60] An extension of these guarantees is Art. 8 – Preservation of Identity, in which 'States Parties undertake to respect the right of the child to preserve his or her identity, including nationality, name and family relations as recognised by law without unlawful interference'.[61] In the context of ART, this provision should refer to the protection of the identity of children born through assisted reproductive techniques, especially in cases of surrogacy and gamete donation.[62] In turn, in Art. 9 – Right to Parenting

> States Parties shall ensure that a child shall not be separated from his or her parents against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child.[63]

This provision should be addressed to surrogacy and the issue of the legal recognition of parenthood in the case of children born abroad as a result of ART.[64] The last provision of the Convention on the Rights of the Child that should be mentioned in the context of assisted reproductive technologies is Art. 24 – Right to Health 'States Parties recognise the right of the child to the enjoyment of the highest attainable standard of health (...)'.[65] Children, regardless of the method of conception, should have access to health care and monitoring of the long-term effects of these procedures.[66]

58 Kondratiewa-Bryzik, 2009.
59 Bosek, 2008, pp. 947–984.
60 Burtowy and Zajączkowska-Burtowy, 2020, pp. 101–115.
61 Schulz, 2012, pp. 79–118.
62 Łukasiewicz, 2023, pp. 58–101.
63 Holewińska-Łapińska, 2008, pp. 119–179.
64 Mostowik, 2019.
65 Kosińska, 2014, pp. 79–100.
66 Haberko 2010.

3.1.4. Universal Declaration on the Human Genome and Human Rights – UNESCO

International – universal guarantees concerning human rights are created as part of the activities of specialised United Nations organisations, which deal with diverse areas such as health care, agriculture and meteorology. These institutions coordinate their work with the UN through special agreements, but remain separate, autonomous organisations. These include: the International Labour Organization (ILO),[67] the Food and Agriculture Organization of the United Nations (FAO),[68] the Educational, Scientific and Cultural Organization of the United Nations (UNESCO),[69] and the World Health Organization (WHO).

It was the United Nations Educational, Scientific and Cultural Organization (UNESCO) that adopted the Universal Declaration on the Human Genome and Human Rights on November 11, 1997.[70] Although the declaration does not contain direct provisions on assisted reproductive technologies in general, *in vitro* fertilisation (IVF) or gamete donation in its actual form, it does introduce general principles for the protection of the human genome, which have an impact on the ethical and legal aspects of assisted reproductive techniques (ART).

As follows from Art. 1 of the Declaration, 'The human genome is the common heritage of humanity', and Art. 2 reaffirms that 'Human dignity requires recognition and respect for the human genome'. It is difficult to overestimate the significance of these formulations, since they clearly indicate the need to respect human genetic material, including embryos created as a result of *in vitro* fertilisation.[71]

According to Art. 5 of the document, 'Any intervention concerning the human genome may be carried out only after obtaining the free and informed consent of the person concerned'. Therefore, each person participating in ART procedures (e.g. gamete donors, recipients, parents) must consciously consent to their involvement. This also applies to the examination of embryos before implantation and the storage of gametes and embryos. These guarantees may affect, for example, regulations on embryo storage, preimplantation testing (PGT) and gamete donation.[72] The declaration reiterates the provisions of the Universal Declaration of Human Rights and the International Covenant on Civil and Economic Rights regarding the right to privacy.

The above guarantees are to a certain degree complemented by Art. 12 of the Universal Declaration, which states that 'Research on the human genome should be

67 Constitution of the International Labour Organization, adopted in 1919, League of Nations Treaty Series (LNTS), vol. 1, p. 22.

68 Constitution of the Food and Agriculture Organization of the United Nations, signed in Quebec on 16 October 1945, United Nations Treaty Series (UNTS), vol. 1, p. 3.

69 Convention concerning the Establishment of the United Nations Educational, Scientific and Cultural Organization (UNESCO), signed in London on 16 November 1945, United Nations Treaty Series (UNTS), vol. 4, p. 275.

70 Universal Declaration on the Human Genome and Human Rights – UNESCO.

71 Tabaszewski, 2016.

72 Gradocka and Kowalski, no date.

conducted with respect for human rights and ethical and legal principles'. This way, UNESCO not only supports embryo genome research, which is conducted in accordance with ethical and legal principles, but also indirectly influences the permitted genetic research in the ART, e.g. the selection of embryos for health.[73]

Extremely important provisions from the aspect of the application of ART are contained in Art. 10 of the Declaration, which prohibits reproductive cloning: 'Practices contrary to human dignity, such as cloning human beings for reproductive purposes, must not be carried out'. This means, first of all, that cloning as a method of assisted reproduction is not permissible. Unfortunately, the document does not refer to therapeutic cloning, which can be used in medical research. This raises the question of the axiological coherence of the Declaration and its provisions contained in Arts 1 and 2 concerning respect for dignity.

The Universal Declaration on the Human Genome and Human Rights supports ensuring equal access to ART for all, regardless of economic status, as well as it can influence the regulation of ART's funding by health care systems. This primarily ensues from Art. 14, which reads as follows: 'Progress in genetics should be used to improve public health' and Art. 19 'States should cooperate to guarantee equal access to genetic therapies'.

In Art. 11 of the Universal Declaration on the Genome, UNESCO also formulated a prohibition of genetic discrimination in access to ART: 'It is not allowed to discriminate against individuals on the basis of their genetic characteristics'. This provision may be the basis for counteracting discrimination in access to ART, e.g. for people with genetic defects. It also applies to access to preimplantation diagnostics (PGT), which allows the detection of genetic diseases before embryo implantation.[74]

Thus, as the analysis of selected provisions demonstrate, the Declaration on the Human Genome and Human Rights does not refer directly to ART, but its provisions on the protection of human dignity, genetic privacy, the prohibition of cloning and equality in access to genetic therapies have a key impact on the ethical and legal aspects of assisted reproductive techniques.[75]

3.2. Examples of International Expert Documents on Assisted Reproductive Techniques

3.2.1. Declaration of Sexual and Reproductive Rights

The Declaration of Sexual and Reproductive Rights was adopted by the World Association for Sexual Health (WAS) in 1999 and updated in 2014. The purpose of this document is to define fundamental human rights in the area of sexual and reproductive health. It can therefore serve as a basis for national and international health

73 Kaźmierczak, 2022.
74 Krekora-Zając, 2014.
75 Birenbaum-Carmeli and Inhorn, 2009.

policies and actions for equality and human rights, which is why it is referred to as a reference document.[76]

The Declaration distinguishes 16 basic sexual rights, such as: the right to equality and non-discrimination (Everyone is entitled to enjoy all sexual rights free from discrimination on the basis of sex, sexual orientation, age, race, religion or social status), the right to autonomy and bodily integrity (Everyone has the right to make decisions about their own body and sexual health, including access to contraception, abortion and health care), the right to sexual and reproductive health (States should ensure access to sex education, medical care and treatment for sexually transmitted diseases), the right to sexual information and education (Everyone has the right to reliable, scientific and age-appropriate sexual education), the right to sexual freedom (Freedom from sexual coercion, exploitation, violence and intolerance), the right to a life free from sexual violence (Everyone has the right to protection from sexual violence, including rape, forced marriage, child exploitation and trafficking), the right to sexual privacy (Includes protection of gender identity, sexual orientation and intimate relationships), the right to decide about one's own fertility (Everyone should be able to freely decide whether to have children, use family planning methods and access ART (assisted reproductive techniques) services, the right to live in a society free from discrimination and sexual prejudice (Governments should prevent homophobia, transphobia and all forms of intolerance) and the right to equality in marriage and relationships (Everyone has the right to choose a partner and equality in the rights to marry and adopt children).[77]

The rights referred to above included in the Declaration of Sexual and Reproductive Rights may result in the impact of the document on at least three areas related to assisted reproductive techniques. Since the Declaration provides for the right to decide about one's own fertility, thus, support for the legality of *in vitro* fertilisation (IVF), gamete donation or even surrogacy can be concluded from the document. Indicating the right to privacy and bodily autonomy consequently leads to the fact that every person has the right to decide about his/her body, including the use of assisted reproductive techniques without unnecessary restrictions. The declaration guarantees equality in access to ART, so states should not discriminate, for example, against single women or same-sex couples in access to reproductive methods.

The content of the document clearly shows support for the rights of women, LGBTQ+ people and sexual minorities fighting discrimination and coercion in the field of sexual health, as well as the promotion of sex education, which should be based on science and devoid of ideology, knowledge about sexual health, which unfortunately is not lacking in the document.[78] In the Declaration of Sexual and Reproductive Rights there is too little content concerning respect for human dignity

76 Dobrowolska, 2016, pp. 163–181.
77 Bassa, 2012, pp. 363–377.
78 Birenbaum-Carmeli and Inhorn, 2009.

and the rights of conceived children, also with the use of assisted reproductive techniques.[79]

3.2.2. Casablanca Declaration

The Casablanca Declaration was announced on March 3, 2023 in Casablanca (Morocco) by an international group of experts, including lawyers, doctors and psychologists, from more than 75 countries.[80] The purpose of the declaration is to strive for the universal abolition of the practice of surrogacy (surrogacy). The parties of the Declaration emphasise that surrogacy violates the dignity of women and children, leading to their objectification and commercialisation,[81] and therefore call on states to take action to prohibit surrogacy at the national level, declare surrogacy agreements invalid, punish individuals and entities supporting such practices, and promote an international convention to prohibit surrogacy globally.

The Casablanca Declaration does not only refer to surrogacy related to the use of assisted reproductive techniques. It is an important step towards international cooperation to protect human rights and counteract the commercialisation of human reproduction. The parties of the Declaration call for a total prohibition of surrogacy, which directly affects ART practices that include surrogacy.[82]

The signatories of the Casablanca Declaration, by emphasising the need to protect the dignity and rights of women and children, can indirectly contribute to the tightening of regulations on ART procedures to prevent their potential abuse.

The postulate of adopting an international convention prohibiting surrogacy should be considered extremely valuable. The declaration may thus affect the harmonization of ART regulations at a global level. It can also lead to the revision of existing practices and regulations, especially in the area of surrogacy, and convince states to introduce stricter laws to protect human rights.[83]

79 Glińska, 2016, pp. 35–52.
80 Declaration-surrogacy-casablanca.org, 2023.
81 Ibid.
82 Horsey, 2024.
83 Ordoiuris, 2024.

4. European Guarantees

4.1. The European Convention for the Protection of Human Rights and Fundamental Freedoms and the Jurisprudence of the European Court of Human Rights

The unquestionable contemporary European foundation of the system of human rights protection is the European Convention on Human Rights, adopted by the Council of Europe in 1950.[84] It does not directly regulate assisted reproductive techniques, which is obvious due to the time of its creation, but at least five Arts. of the Convention have been repeatedly interpreted by the European Court of Human Rights in cases concerning, above all, *in vitro* fertilisation (IVF), surrogacy and rights to parenthood.

In the first place, it is necessary to point to Art. 8 of the Convention – Right to respect for private and family life:

> Everyone has the right to respect for his private and family life, his home and his correspondence. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society (...).[85]

The right to decide on starting a family also includes the right to use assisted reproductive techniques. States can regulate access to ART, but they cannot arbitrarily restrict these techniques if it would violate the right to private life.[86]

In the context of assisted reproductive techniques, reference should first be made to the judgement of the ECtHR Evans v. the United Kingdom of 10 April 2007.[87] The judgement was issued on the basis of the following factual and legal situation. Natallie Evans and her partner Howard Johnston submitted themselves to the *in vitro* fertilisation (IVF) procedure in 2001 because Evans was diagnosed with a tumour that required removal of her ovaries, which made her unable to conceive naturally. The couple mutually agreed to create and freeze embryos to use for implantation in the future.[88] After the breakup, Johnston withdrew his consent to the use of embryos. British law required the consent of both parties for each phase of the process,

84 Convention for the Protection of Human Rights and Fundamental Freedoms, signed in Rome on 4 November 1950, subsequently amended by Protocols No. 3, 5, and 8 and supplemented by Protocol No. 2, European Treaty Series (ETS) No. 5.

85 Kwiatkowski, 2019, pp. 179–192.

86 Łącki and Wróblewski, 2016, No. 3, pp. 21–37; Łącki and Wróblewski, 2013, pp. 51–74; Wiśniewski, 2011, pp. 433–450; Mirocha, 2018, pp. 164–188; Łukasiewicz 2023, pp. 58–101.

87 Nowicki, 2008.

88 Łącki and Wróblewski, 2016, pp. 21–37.

so the clinic had to destroy the embryos.[89] Natallie Evans claimed that the withdrawal of consent by her ex-partner violated her right to have a biological child, because after cancer treatment she had no other option to get pregnant. In her view, the destruction of the embryos violated the right to respect for private and family life[90] and that her interest in having a child outweighed her ex-partner's interest in refusing paternity.[91] The Court found that there was no violation of Art. 8 of the ECHR. It decided that the right to respect for private life includes both the right to have children and the right not to have them. Since the partner consented to the creation of embryos, but had the right to withdraw it later, the national law did not violate the ECHR. The Court found that the State had a wide 'margin of assessment' in regulating assisted reproductive techniques, and that British law was consistent with the principle of voluntary reproduction.[92] From the point of view of the relation between Art. 8 of the Convention and assisted reproductive technologies, the judgement confirmed that the consent of both partners is necessary at every stage of the ART. The Court in Strasbourg found that both the right to have children and the right not to have them are of equal importance, in other words, the decision of one partner not to use embryos cannot be imposed by the other.[93] From the point of view of ART, the ruling on the margin of assessment of states within the scope of ART is also extremely important, as the Court admitted that ART regulations differ between countries and there is no uniform international norm. Unfortunately, the judgement did not decide whether embryos have the right to legal protection as 'persons', but only indicated that their fate is subject to national law.[94]

The second extremely important case setting standards for the use of assisted reproductive techniques based on the provisions of the European Convention for the Protection of Human Rights and Fundamental Freedoms is S.H. and Others v. Austria.[95] The judgement in the first instance was issued on 1 April 2020, and the Grand Chamber decided on 3 November 2011. The Court found that Austria has the right to prohibit the donation of reproductive cells, leaving the decision on ART to the discretion of the Member States.[96] The judgement was issued on the basis of the following factual and legal situation. The case was about two couples from Austria who could not have children naturally and wanted to use assisted reproduction methods.[97] However, Austrian law prohibited the use of egg donation (oocytes) and sperm donation in combination with *in vitro* fertilisation (IVF). The couples argued that the

89 Human Fertilisation and Embryology Act 1990.
90 Art. 8 of the ECHR.
91 Mirocha, 2018, pp. 164–188.
92 Falski, 2016, pp. 9–24.
93 Kurosz, 2017, pp. 105–118.
94 Wiśniewski, 2011, pp. 433–450.
95 Nowicki, 2012.
96 Piaskowska and Piesiewicz, 2018, pp. 13–22.
97 Mirocha, 2018, pp. 164–188.

prohibition of Austrian law violates their right to private and family life[98] and the prohibition of discrimination[99] because the prohibition deprives them of the possibility of having a biological child, even though ART technology is sufficient enough to solve their health problem.[100] The couples also pointed out the disproportionality of the restriction, as other ART techniques (e.g. donor insemination) were legal, so the ban was not consistent.[101] With regard to the prohibition of discrimination,[102] the applicants argued that other European countries allow oocyte and sperm donation, so Austria should not restrict access to these methods.

At first instance, the Court found that the prohibition was disproportionate and violated Art. 8 of the ECHR and that Austria was inappropriately restricting access to ART, and that the technology should be accessible to those who needed it. The Court also noted that the State had not demonstrated sufficient reasons justifying the prohibition. With the judgement of the Grand Chamber, the Court radically changed its position and found that Austria had not violated the Convention. The Grand Chamber found that States have a wide 'margin of assessment' in regulating ART, because there are no uniform standards in Europe.[103] The lack of general consensus on the admissibility of gamete donation in ART justified that Austria could determine the rules of access to these technologies independently. The Court found that the prohibition in Austrian national law was intended to protect the child, family relationships and to avoid ethical problems related to the separation of genetic and biological parenthood.[104] Importantly, in the opinion of the Grand Chamber, a country cannot be forced to legalise a particular ART technique if the legal system considers it undesirable. The most important findings of the judgement, from the aspect of shaping the European standard for the use of assisted reproductive technologies, include the lack of a uniform standard in Europe,[105] and therefore States have the right to regulate access to ART according to their own value system and legal regulations,[106] consequently the right to family life[107] does not mean an automatic right to ART.[108] The Court also noted that the use of assisted reproductive techniques raises a number of problems, not only of a legal nature concerning, for example, the identity of the child and the risk of 'genetic selection'. Thus, the *judgement* of the Grand Chamber *of*

98 Art. 8 of the ECHR.
99 Art. 14 of the ECHR.
100 Wiśniewski, 2011, pp. 433–450.
101 Łącki and Wróblewski, 2013, pp. 51–74.
102 Art. 14 of the Convention.
103 Kwiatkowski, 2019, pp. 179–192.
104 Piaskowska; Piesiewicz, 2018, pp. 13–22.
105 In the opinion of the Court, legal differences within the scope of ART are admissible, which means that, for example, in France, Italy or Germany different regulations may apply than in Austria.
106 Not every restriction of ART is a violation of human rights, and as a result, States may prohibit gamete (sperm and oocyte) donation in IVF if they consider it in the public interest.
107 Art. 8 ECHR.
108 There is no 'right to the child' under the ECHR. The Court held that the right to family life includes the possibility of using the ART, but does not oblige the State to make it available.

S.H. and Others v. Austria confirmed that States have the right to regulate access to ART, including prohibiting certain methods (e.g. gamete donation) if they consider it in the public interest, and that the ECHR does not guarantee an automatic right to ART.[109]

The third case, which should be indicated as an important stage and element in the development by the European Court of Human Rights of the European standard for the use of assisted reproductive techniques, is Costa and Pavan versus Italy.[110] The Court decided on August 28, 2021, that the prohibition of preimplantation genetic diagnosis (PGT) in the case of the risk of transmitting genetic diseases violates the right to family life. The judgement was issued on the basis of the following factual and legal situation. Mrs. Costa and Mr. Pavan were carriers of cystic fibrosis, a genetic disease that they could pass on to their offspring.[111] However, Italian law prohibited preimplantation diagnosis (PGT) as part of *in vitro* fertilisation (IVF). Instead, the applicants could only conceive naturally and have prenatal diagnosis performed, and then – if the child had cystic fibrosis – they could decide to have a therapeutic abortion (which was legal).[112] As in the case referred to above, the applicants argued that the prohibition of PGT violated their right to private and family life, a right guaranteed by Art. 8 of the ECHR, because it prevented them from making a conscious decision about the health of their child. In Costa and Pavan's view, the prohibition of PGT, while at the same time legalising therapeutic abortion, is illogical and mutually contradictory, since it allows the late removal of the affected foetus, but not the early prevention of the disease. Moreover, the limitations in the ART in the Italian legal system – in their opinion – constitute discrimination,[113] because people who can become pregnant naturally have better opportunities to make decisions about the health of the child than couples who require ART.[114]

The Strasburg Court found that Italy had violated Art. 8 of the ECHR because the ban on PGT is disproportionate and does not give parents the opportunity to make conscious decisions about their child's health. The Court also pointed out the lack of legal coherence, since Italy allowed therapeutic abortion; therefore, the prohibition of preventing the disease before pregnancy was illogical. In the Court's view, excessive restrictions on ART violate the autonomy of parents and force them to make more difficult decisions in the later stages of pregnancy.[115]

Therefore, the two extremely important decisions of the Court in this case should be considered the link between preimplantation diagnosis (PGT), which is one of the key ART techniques, enabling the examination of embryos for genetic defects before implantation, with the right to privacy guaranteed by the Convention, since the

109 Łącki and Wróblewski, 2013, pp. 51–74.
110 Nowicki, 2013.
111 Łącki and Wróblewski, 2016, pp. 21–37.
112 Łącki and Wróblewski, 2013, pp. 51–74.
113 Art. 14 of the ECHR.
114 Kwiatkowski, 2019, pp. 179–192.
115 Łącki and Wróblewski, 2013, pp. 51–74.

prohibition of PGT violates the right to privacy and autonomy of parents in making reproductive decisions.[116] Second, in the context of the prohibition of discrimination, States cannot discriminate against couples using ART, since therapeutic abortion is legal, PGT should also be available as an alternative. ART should therefore be available on an equal basis for all couples. In *Costa and Pavan v. Italy*, the Court set a precedent for PGTs, indicating that the prohibitions on ART must be justified and proportionate.[117] In other words, the judgement in *Costa and Pavan v. Italy* confirmed that ART techniques, such as preimplantation diagnosis (PGT), are part of the right to private and family life, and that their prohibition, especially when the state allows therapeutic abortion, may violate the ECHR.

The Department for the Execution of Judgements of the European Court of Human Rights in its study on reproductive rights draws attention to another issue, important from the point of view of ART.[118] It is about the legal recognition of the parent-child relationship between biological fathers and their children born abroad thanks to surrogacy. Surrogacy is a separate and important legal problem occurring in the jurisprudence of the European Court of Human Rights, related to the title issue of ART. Although the issue of surrogacy goes beyond the scope of this study, it is worth pointing out the issues raised in the document prepared by the Department for the Execution of Judgements of the European Court of Human Rights.

Several cases decided by the ECtHR concerned the violation of the applicants' right to the private life of children born abroad as a result of surrogacy, due to the refusal by the authorities to recognise and thus establish a legal parental-animal bond with their biological fathers under national law.[119] The Strasbourg Court ruled that the consequences of the non-recognition of this legal family tie in French law are not limited only to the parents, but also affect the children themselves, whose right to respect for their private life – which means that everyone must be able to establish the essence of his/her identity, including the legal bond of kinship – is significantly violated.

The jurisprudence of the European Court of Human Rights in this area is important because the Court strongly stands on the side of the good interests of the child. It is to be hoped that this is the direction in which the next rulings related to the issues of ART and surrogacy will go.

116 Kwiatkowski, 2019, pp. 179–192.

117 As a consequence of the judgement, Italy had to change its law and allow PGT in certain cases.

118 Department for the Execution of Judgments of the European Court of Human Rights, Reproductive rights.

119 See ECtHR's ruling of 26 September 2014 in the case of *Mennesson v. France*, Application No. 65192/11; ECtHR's ruling of 26 September 2014 in the case of *Labasse v. France*, Application No. 65941/11; ECtHR's ruling of 19 January 2017 in the case of *Laboire v. France*, Application No. 44024/13; ECtHR's ruling of 21 September 2016 in the case of *Foulon and Bouvet v. France*, Application No. 9063/14.

In conclusion, it should be stated that the ECtHR had a great influence on shaping legal standards for ART in Europe through its jurisprudence.[120]

4.2. The Oviedo Convention

The Convention for the Protection of Human Rights and Dignity of the Human Being in the Context of Applications of Biology and Medicine regulates the applications of biology and medicine.[121] The purpose of the Convention is to protect human dignity and the resulting freedoms and rights of the individual in the context of new medical technologies and biomedical research. Art. 1 is of key importance in this respect, in which the principle of the primacy of human dignity and rights has been formulated, and science and medicine must serve the human being.[122] It is also worth noting the provisions of Art. 11 on the prohibition of genetic discrimination and Arts. 15 and 16, which state that scientific research on humans must be conducted in an ethical manner with respect for the rights of participants.[123]

120 See ECtHR's ruling of 15 September 2009 in the case of *Amato Gauci v. Malta*, Application No. 47045; ECtHR's ruling of 21 February 1975 in *Golder v. the United Kingdom*; Application No. 4451/70; ECtHR's ruling of 6 September 1978 in the case of *Klass and Others v. Germany*, Application No. 5029/71; ECtHR's ruling of 13 June 1979 in the case of *Marckx v. Belgium*, Application No. 6833/74; ECtHR, 22 October 1981, *Dudgeon v. the United Kingdom*, Application No. 7525; ECtHR, Judgement of 25 March 1983, *Silver and Others v. the United Kingdom*, Application No. 5947/72 and others; ECtHR's ruling of 26 March 1985 in *X and Y v. the Netherlands*, Application No. 8978/80; ECtHR, 28 May 1985, *Abdulaziz, Cabales and Balkandali v. the United Kingdom*, Applications Nos. 9214/80, 9473/81 and 9474/81, see also: ECtHR's ruling of 04 May 2021 in the case of *Jurčić v. Croatia*, Application No. 54711/15; ECtHR's ruling of 24 March 2014 in the case of *Topcic-Rosenberg v. Croatia*, Application No. 19391/11; ECtHR's ruling of 04 December 2007 in the case of *Dickson v. United Kingdom*, Application No. 44362/04; ECtHR's ruling of 11 February 2013 in the case of *Costa and Pavan v. Italy*, Application No. 54270/10; ECtHR's ruling of 14 March 2011 in the case of *Ternowszky v. Hungary*, Application No. 67545/09; ECtHR's ruling of 26 September 2014 in the case of *Mennesson v. France*, Application No. 65192/11 ECtHR's ruling of 26 September 2014 in the case of *Labassee v. France*, Application No. 65941/11; ECtHR's ruling of 19 January 2017 in the case of *Laborie v. France*, Application No. 44024/13; ECtHR's ruling of 21 October 2016 in the case of *Foulon and Bouvet v. France*, Application No. 9063/14; ECtHR's ruling of 16 December 2010 in the case of *A. B. and C. v. Ireland*, Application No. 25579/05; ECtHR's ruling of 29 October 1992 in the case of *Open Door and Dublin Well Women v. Ireland*, Application No. 14234/88; CtHR's ruling of 03 May 2009 in the case of *Women on Waves and Others v. Portugal*, Application No. 31276/05; ECtHR's ruling of 18 March 2013 in the case of *G.B. and R.B. v. Moldova*, Application No. 16761/09; ECtHR's ruling of 08 February 2012 in the case of V.*C. v. Slovakia*, Application No. 18968/07; ECtHR's ruling of 12 June 2012 in the case of *N.B. v. Slovakia*, Application No. 29518/10; ECtHR's ruling of 15 July 2014 in the case of *Radu v. Moldova*, Application No. 50073/07; ECtHR's ruling of 06 November 2009 in the case of *K.H. and Others v. Slovakia*, Application No. 32881/04; ECtHR's ruling of 10 June 2015 in the case of *Y.Y. v. Turkey*, Application No. 14793/08.

121 Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Applications of Biology and Medicine (Convention on Human Rights and Biomedicine), adopted by the Committee of Ministers on 19 November 1996).

122 Biesaga, 2006, pp. 24–28.

123 Winter, 1997, pp. 73–77.

Although the Convention does not refer directly to assisted reproductive techniques, its provisions may have an impact on their regulation, especially in the context of the protection of embryos. It follows from Art. 18 of the Convention that research on human embryos may be carried out only within the limits of national law, which has an impact on the issues of cryopreservation of embryos and their use.[124] The Convention also prohibits cloning in human reproduction. In addition, the prohibition of genetic discrimination refers, among others, to preimplantation genetic testing (PGT). The Oviedo Convention is relatively commonly considered to be a key document in the field of bioethics and human rights in medicine, although it does not comprehensively regulate issues related to assisted reproductive techniques.[125]

4.3. European Union Law

The European Union does not have a uniform legal act regulating assisted reproductive techniques, but certain standards result from the Charter of Fundamental Rights of the European Union,[126] the Treaty on European Union,[127] the Treaty on the Functioning of the European Union[128] and the directives on health and safety, in particular Directive 2004/23/EC[129] and Implementing Directives 2006/17/EC[130] and 2006/86/EC.[131]

The key provisions indirectly relating to assisted reproductive techniques are found primarily in the Charter of Fundamental Rights and in the Treaty on the Functioning of the European Union. In the first of these documents, modelled on the European Convention for the Protection of Rights and Fundamental Freedoms, the system of protection of individual freedoms and rights was based on the principle

124 Roscam Abbing, 1998, pp. 377–387.

125 Safjan, 2000, pp. 5–18.

126 Charter of Fundamental Rights of the European Union, Official Journal of the European Union, C 303/1, 14 December 2007.

127 Treaty on European Union, Official Journal of the European Union, C 325, 24 December 2002.

128 Treaty on the Functioning of the European Union, Official Journal of the European Union, C 325, 24 December 2002.

129 It sets out quality and safety requirements for the collection, storage and use of human cells, including gametes and embryos. Directive 2004/23/EC of the European Parliament and of the Council of 31 March 2004 on setting standards of quality and safety for the donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells, Official Journal of the European Union, L 102, 7 April 2004.

130 Commission Directive 2006/17/EC of 8 February 2006 implementing Directive 2004/23/EC of the European Parliament and of the Council as regards certain technical requirements for the donation, procurement and testing of human tissues and cells, Official Journal of the European Union, L 327, 24 November 2006.

131 Commission Directive 2006/86/EC of 24 October 2006 implementing Directive 2004/23/EC of the European Parliament and of the Council as regards traceability, notification and notification requirements for serious and adverse reactions and occurrences and certain technical requirements for the coding, processing, preservation, storage and distribution of human tissues and cells, Official Journal of the European Union, L 294, 25 October 2006.

of respect and protection of human dignity formulated in Art. 1 – Human dignity: 'Human dignity is inviolable. It must be respected and protected'.[132] This principle affects the regulations on embryo protection and ethical aspects of assisted reproduction methods.[133] Consequently, the obligation to respect human dignity prohibits inhumane treatment of persons using ART, including forced donation of gametes or the use of ART in a manner contrary to ethics. Human dignity sets a specific standard for the implementation of individual freedoms and rights guaranteed by the Charter.[134]

A right that is undoubtedly associated with the use of assisted reproductive techniques is the right to the integrity of the person. According to Art. 3 of the Charter,

> In the fields of medicine and biology, the following must be respected, in particular: (a) the free and informed consent of the person concerned, according to the procedures laid down by law; b) the prohibition of eugenic practices, in particular those aiming at the selection of persons; c) the prohibition on making the human body and its parts as such a source of financial gain; d) the prohibition of the reproductive cloning of human beings.[135]

These guarantees indicate the right to conscious consent for medical procedures, including those related to the use of ART, the prohibition of genetic selection and reproductive cloning, which affects the genetic testing of embryos, and limits the commercialisation of ART, e.g. the sale of eggs and commercial surrogacy.[136]

As in the case of the European Convention on Human Rights and Fundamental Freedoms, Art. 7 of the Charter of Fundamental Rights of the EU implies respect for private and family life, which includes the possibility of using ART methods, if Member States deem it compatible with health policy.[137] The right related to the use of assisted reproductive techniques is the right to marry and found a family,[138] included in Art. 9 of the Charter of Fundamental Rights. The last of the rights that should be indicated as forming the basis of the ART standard in the European Union is formulated in Art. 35 – Right to health care: 'Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices'.[139] The meaning of these regu-

132 Stefanicki, 2009, pp. 6–22.
133 Kondratiewa-Bryzik, 2009.
134 Koncewicz, 2012, pp. 171–181.
135 Pyziak-Szafnicka, 2016, pp. 21–26.
136 Wnukiewicz-Kozłowska, 2012, pp. 55–76.
137 Schulz, 2012, pp. 79–118.
138 This law is at times interpreted to mean that States can regulate access to ART, but cannot arbitrarily restrict this right, e.g. by prohibiting ART from same-sex couples or single people. See Osiejewicz, 2015, pp. 24–30.
139 Wróbel, 2014, pp. 104–108.

lations leads to the statement that EU Member States can regulate the availability of ART independently, but equality in access to healthcare should be ensured.[140]

In addition to the above-mentioned provisions of the Charter of Fundamental Rights of the EU, which obligate to respect and protect human dignity and guarantee the right to the integrity of the person, respect for private and family life, the right to marry and establish a family, and the right to health care, the prohibition of discrimination is of key importance from the EU perspective. According to Art. 21 of the Charter of Fundamental Rights,

> Any discrimination based on any ground such as sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion, membership of a national minority, property, birth, disability, age or sexual orientation shall be prohibited.[141]

Therefore, EU Member States must not discriminate against unmarried women, same-sex couples or people with disabilities in access to ART. The prohibition of discrimination may also be grounds for challenging restrictions on access to ART in individual countries.[142]

Legal analyses concerning the standard of assisted reproductive techniques in the European Union law cannot omit several provisions of the Treaty on European Union and the Treaty on the Functioning of the European Union. In the first of them, Art. 5, the principle of subsidiarity (subsidiarity) was formulated.[143] The European Union has no competence to impose uniform regulations in the field of ART. The Union can only coordinate health policies and ensure that national regulations do not violate the fundamental rights of citizens.[144] This means that it is up to the Member States to decide whether to allow surrogacy, IVF, gamete donation or PGT.

In the TFEU, on the other hand, the issue of ART is indirectly addressed by a provision concerning public health.[145] It follows from Art.icle168 TFEU ('The Union's actions shall be aimed at improving public health, preventing diseases and eliminating sources of threat to physical and mental health'.) that the EU may coordinate health policies concerning ART, but may not impose uniform regulations on the Member States. Provision on the harmonisation of rules[146] ('The Union may adopt measures for the harmonisation of national law if this is necessary for the proper functioning of the internal market'[147]) may be the basis for the introduction of common regulations

140 Kuciński, 2011, pp. 19–46.
141 Maliszewska-Nienartowicz, 2021, pp. 35–48.
142 Szpunar, 2015, pp. 4–10.
143 Tomaszewski, 2020, pp. 171–184.
144 Gagatek, 2013, pp. 31–39.
145 Jończyk, 2007, pp. 4–9.
146 Art. 114.
147 Czapliński, 2004.

on ART in the field of cross-border procedures, e.g. the donation of reproductive cells or the recognition of parenthood in the case of surrogacy.[148]

In addition to the above-mentioned provisions of the Treaty of Lisbon, the European Union has introduced directives aimed at establishing quality and safety standards for the collection, testing, processing, storage and distribution of human tissues and cells, which also include gametes and embryos. An example is Directive 2004/23/EC of the European Parliament and of the Council of 31 March 2004.[149] It lays down quality and safety standards for the donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells intended for human use. Although the Directive does not directly address assisted reproductive techniques, some of its provisions address this issue.[150] Firstly, the Directive sets out the eligibility criteria for donors of tissues and cells, including germ cells, to ensure that the risk of transmission of infectious diseases to recipients is minimised. Second, it sets standards for methods of tissue and cell collection and mandatory testing to ensure their quality and safety. Third, the Directive imposes the obligation to apply appropriate procedures and conditions for the processing, preservation, storage and distribution of tissues and cells in order to maintain their integrity and functionality. Fourth, it requires the establishment of a system for monitoring and reporting serious adverse events and responses related to the collection, testing, processing, storage and distribution of tissues and cells. Finally, the Directive requires that all tissues and cells be traceable from donor to recipient and vice versa, in order to ensure safety and responsiveness when hazards are detected.[151]

As it can be observed from these decisions, the Directive in the context of ART aims to ensure that all procedures related to the use of reproductive cells meet high standards of quality and safety, thus protecting the health of both donors and recipients.

The analysis of European Union law on assisted reproductive techniques should be complemented by the European Parliament resolution of 24 June 2021 on the situation of sexual and reproductive health and rights in the EU, in the light of women's health.[152] The European Parliament treats reproductive health (along with sexual health) as an essential element of good health.[153] In this regard, the Member States

148 Malczewska, 2020, pp. 4–19.

149 By way of example, it should be pointed out that, for example, Poland, implementing these directives, introduced appropriate legal regulations, such as the Act on Infertility Treatment and the regulations of the Minister of Health on training in the collection, processing, storage, testing and distribution of reproductive cells and embryos intended for use in the procedure of medically assisted procreation.

150 Grabowska, 2015, pp. 245–252.

151 Ibid.

152 The resolution was adopted on the basis of the Report of the Committee on Women's Rights and Gender Equality on the situation of sexual and reproductive health and rights in the EU in the context of women's health, A9-0169/2021.

153 European Parliament Resolution of 24 June 2021 on the situation of sexual and reproductive health and rights in the EU, in the frame of women's health.

are called to establish effective monitoring strategies and programmes to ensure universal access to the full range of quality and affordable sexual and reproductive health and rights services, in line with international health standards, regardless of the financial, practical and social obstacles and in a non-discriminatory manner, with a particular focus on marginalised groups, including women belonging to ethnic, racial and religious minorities, migrant women, women from rural areas and outermost areas where geographical restrictions prevent direct and immediate access to such services, women with disabilities, women without health insurance, LGBTI people and victims of sexual and gender-based violence. However, the part entitled 'Access to infertility treatment' is crucial from the aspect of ART. In issue 39 according to the Resolution, the European Parliament calls on the Member States to ensure that all persons of childbearing age have access to fertility treatment, regardless of their socio-economic situation, marital status, gender identity or sexual orientation; stresses the importance of comprehensive research into fertility in the EU as a public health issue and the prevalence of infertility and reduced fertility, which are difficult and painful for many families and individuals; calls on the Member States to adopt a holistic, rights-based, inclusive and non-discriminatory approach to fertility, including measures to prevent infertility and ensure equal access to services for all people of childbearing age, and to make artificial insemination available in Europe.[154]

It should be called to mind that European Parliament resolutions are official positions or appeals of the European Parliament adopted on specific political, social, economic, international or legal issues. However, they are legally non-binding in nature, although they can have a political influence on decisions taken in the European Union. Hence, the Resolution of 24 June 2021 'calls' on Member States to eliminate barriers to access to ART and to counteract all forms of discrimination in this regard, and 'highlights' the need to take into account the gender perspective and ensure equal access to health services for all, regardless of gender identity, sexual orientation or socio-economic status.[155]

To conclude the part of the discussion concerning the Treaty of Lisbon, it should be stated that it does not contain provisions directly referring to ART, but it introduces principles affecting the reproductive policy of EU countries. The provisions of the Charter of Fundamental Rights of the European Union protecting human dignity, the right to integrity, privacy and health protection, and prohibiting discrimination should be considered as the most important decisions concerning the title issue.[156] Moreover, it follows from the TEU and TFE that the EU cannot impose uniform regulations on ART, but it can influence the protection of human rights and the

154 European Parliament Resolution of 24 June 2021 on the situation of sexual and reproductive health and rights in the EU, in the frame of women's health (2020/2215(INI)), Official Journal of the European Union, C 81/4, 24 February 2022.

155 Staszczyk, 2013, pp. 251–263.

156 Stefanicki, 2009, pp. 6–22.

elimination of discrimination, which means – in accordance with the principle of subsidiarity – maintaining a certain autonomy of the Member States in the field of ART.[157]

5. Conclusions

The conducted legal analyses allow us to formulate ten conclusions regarding the eponymous search for an international standard for the use of assisted reproductive technologies.[158]

Firstly, international law instruments of a universal nature concerning the protection of human rights, such as the Universal Declaration of Human Rights of 1948, the International Covenant on Civil and Political Rights of 1966 and the International Covenant on Economic, Social and Cultural Rights of 1966, do not contain provisions directly relating to assisted reproductive technologies. This is mainly due to the time of their adoption by the United Nations and the fact that at the time these types of reproduction methods were unknown. In legal analyses based on these documents, assisted reproductive technologies are usually indirectly referred to by provisions concerning the right to privacy, the right to establish a family or the right to health protection.[159]

Secondly, the same is true for The Convention on the Rights of the Child. Although this document was adopted by the United Nations in 1989, the Arts. on the best interests of the child,[160] the right to identity and knowledge of one's parents,[161] the right to parenting[162] refer to ART only indirectly.

Thirdly, the general principles of human genome protection that affect the ethical and legal aspects of assisted reproductive technologies are contained in the Universal Declaration on the Human Genome and Human Rights of 11 November 1997 adopted by the United Nations Educational, Scientific and Cultural Organization (UNESCO). The provisions of this Declaration referring to human dignity should be considered extremely important: 'The human genome is the common heritage of humanity'[163] and 'Human dignity requires recognition and respect for the human genome'.[164]

Fourthly, it should be noted that the issue of the use of assisted reproductive technologies is addressed by so-called expert documents, such as: the Declaration

157 Kruk, 2016, pp. 28–51.
158 Cahn, 2015, pp. 751–765
159 López et al., 2021, pp. 1–12.
160 Art. 3 of the Convention.
161 Arts 7 and 8 of the Convention.
162 Arts 9 and 24 of the Convention.
163 Art. 1 of the Declaration.
164 Art. 2 of the Declaration.

of Sexual and Reproductive Rights was adopted by the World Association for Sexual Health in 1999, updated in 2014, and the Casablanca Declaration announced on March 3, 2023. In the first document, the rights of women, LGBTQ+ people and sexual minorities were reaffirmed. Unfortunately, it lacks guarantees concerning respect for human dignity and the rights of conceived children, also with the help of assisted reproduction techniques. The goal of the signatories of the Casablanca Declaration is to strive for the universal abolition of the practice of surrogacy (surrogacy).

Fifthly, in addition to universal documents, regional regulations are important for the development of international standards for the use of assisted reproductive technologies. Due to the perspective of the Central European countries, European regulations are of key importance in this respect, created both at the level of the Council of Europe (European Convention for the Protection of Human Rights and Fundamental Freedoms) and the European Union (the Treaty of Lisbon and other documents).

Sixthly, the 1950 European Convention on Human Rights and Fundamental Freedoms – because of its similarity to the Universal Declaration of Human Rights of 1948 and the International Acts of Rights of 1966 – does not contain provisions relating directly to ART.

Seventhly, in the case of the 'living instrument', which is the European Convention for the Protection of Human Rights and Fundamental Freedoms, the European Court of Human Rights plays an increasingly important role in the application of its Art. 8 (on the right to privacy) to ART. Examples of such a broad interpretation of the right to privacy are the judgements indicated in this study: Evans versus the United Kingdom, S.H. and Others versus Austria and Costa and Pavan versus Italy. The analyses allowed us to conclude that 'ECtHR had a great influence on shaping legal standards for ART in Europe through its jurisprudence'.

Eighthly, the key document in the field of bioethics and human rights in medicine in Europe is The Convention for the Protection of Human Rights and Dignity of the Human Being in the Context of Applications of Biology and Medicine, adopted by the Committee of Ministers on 19 November 1996. Although it does not refer directly to assisted reproductive techniques, its provisions may nevertheless have an impact on their regulation. It follows from Art. 18 of the Convention that research on human embryos may be carried out only within the limits of national law, which has an impact on the issues of cryopreservation of embryos and their use. The Convention also prohibits cloning in human reproduction.

Ninthly, the European Union has some references in its law to the issue of assisted reproductive technologies. The Charter of Fundamental Rights of the European Union contains provisions protecting human dignity, the right to integrity, privacy and health protection, and prohibiting discrimination. On the other hand, the TEU and TFE show that the EU cannot impose uniform regulations on ART, but it can influence the protection of human rights and the elimination of discrimination, which means – in accordance with the principle of subsidiarity – maintaining a certain autonomy of the Member States in the field of ART testing, processing, storage and

distribution of human tissues and cells, which also include gametes and embryos.[165] In addition, in the European Parliament Resolution of 24 June 2021 on the situation of sexual and reproductive health and rights in the EU in the frame of women's health, the European Parliament considers reproductive health (alongside sexual health) as an essential element of good health.

Tenthly, it should be expected that the Court of Human Rights in Strasbourg, which has a creative approach to its activities and is constantly striving to expand its competences, will attempt to influence the sphere of human life, which is reproduction, creating (or at least strive to create) specific standards in the field of assisted reproduction techniques.

In conclusion, the title research leads to the conclusion that the process of shaping the international standard for the use of assisted reproductive technologies, which has been ongoing since at least 1948 (the adoption of the Universal Declaration of Human Rights), has not ended. Moreover, the cultural, religious, social, and consequently legal pluralism of the contemporary world (including the European region) is unlikely to contribute in the coming years to the adoption of a single universal model for the application of ART.[166] Nevertheless, it remains imperative to persistently and unwaveringly advocate – contrary to the prevailing narrative – for the protection of the dignity and rights of not only parents but also, and perhaps most importantly, children, in the name of respecting their inherent dignity and best interest…

165 Directive 2004/23/EC, Implementing Directives 2006/17/EC and 2006/86/EC.
166 McDermott et al., 2022, pp. 1–12.

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Chapter 2

Legal and Ethical Aspects of Assisted Reproductive Technologies in the Teaching of Christian Churches and Religious Associations

Marek Bielecki

Abstract

The subject matter of the present study concerns the legal and ethical aspects of assisted reproductive technology in the teaching of Christian churches and religious associations. The author analyses the teaching of selected religious entities functioning in the Republic of Poland. The largest Christian community in Poland, as well as worldwide, is the Catholic Church of the Latin Rite. Notably, most references to bioethical problems appear in the teaching of this confession, including those concerning assisted reproductive technology. The author reviews the doctrine of the Catholic Church both from the perspective of both documents adopted by the Holy See and the position of the Polish Bishops' Conference. The Catholic Church consistently opposes methods of assisted procreation, asserting that conception outside the conjugal act is morally unacceptable. Alongside the doctrine of the Catholic Church, the teaching of the Orthodox Church and Protestant religious communities is also investigated. In Poland, the largest denomination representing the Orthodox Church is the Polish Autocephalous Orthodox Church, which has not developed an official position on issues of assisted reproductive technology but follows the universal Orthodox doctrine. The Orthodox Church does not support *in vitro* fertilisation, yet it does not categorically prohibit it, leaving the decision to the conscience of spouses. Protestant churches do not hold a unified position on assisted reproductive technology. An exception is the Evangelical Church of the Augsburg Confession in the

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Republic of Poland, which has officially expressed support for the use of *in vitro* fertilisation.

Keywords: assisted reproductive technology, Catholic Church, orthodox churches, Protestant churches, churches and other religious associations

1. Introductory Remarks

Infertility is a phenomenon which, according to the World Health Organisation (WHO), permanently or periodically affects approximately 60-80 million couples. In Poland, the corresponding figure ranges between 1 and 1.5 million, a substantial percentage of the population.[1] Research on artificial insemination has been carried out since as early as the seventeenth century, initially on fish and insects, and by the late eighteenth century, successful artificial insemination of dogs' bitches had been achieved. In 1799, the first artificial insemination of a woman was carried out using her husband's semen. By the end of the 19th century, further successful attempts were made using semen from outside the marriage.[2] The twentieth century brought the development of techniques enabling insemination outside the woman's body. In the 1960s, research on *in vitro* fertilisation commenced at the University of Cambridge, initially on mice, later on rabbits, and finally on human embryos. On 25 July 1978, the first child conceived through IVF was born, a girl named Lesley Brown.[3]

Methods of assisted reproduction provoke strong emotions among various groups, and some churches and religious associations take an active role in the debate. These entities evaluate such practices in light of their doctrine and the legal norms functioning within their respective communities. It must be emphasized that no unified position exists even within Christian confessions. The present study aims to present the teaching of several Christian churches and denominations concerning their stance on assisted reproductive methods. The Catholic Church has the most extensive doctrine and has expressed its views on these issues since the nineteenth century; thus, the greatest attention will be devoted to this entity. Additionally, the position of Christian communities outside the Catholic Church that address assisted reproductive techniques in their doctrine will also be presented. The study predominantly offers a national perspective, focusing on those confessions active in Poland.

1 Koperwas and Głowacka, 2017, p. 33.
2 Olczyk, 2017, p. 96.
3 Kubicki, 2012, p. 21.

2. The Catholic Church

The attitude of the Catholic Church towards assisted reproductive methods (artificial insemination) was officially articulated on 17 March 1897 when the Holy Office responded to the question of whether artificial insemination could be permitted. It stated unequivocally that it could not. The position was subsequently accepted by Pope Leo XIII.[4] Pope Pius XII also presented negative responses in his speeches to Catholic doctors and midwives.[5] Pope John XXIII addressed assisted reproductive techniques in his encyclical *Mater et Magistra*,[6] emphasising that human life should be transmitted within marriage through a natural and conscious personal act. Furthermore, means acceptable in the propagation of plant and animal life are not permitted in human procreation (n. 193). John Paul II in his address 'Experimentation in Biology' to the members of the Week of Studies at the Pontifical Academy of Sciences,[7] condemned all forms of experimental interference with the human embryo.[8] In the Charter of the Rights of the Family issued in 1983, the Holy See states that respect for human dignity excludes all experimental manipulation or exploitation of the human embryo. Any intervention on the human genetic heritage not aimed at correcting anomalies violates the right to bodily integrity and contradicts the good of the family.[9]

A comprehensive exposition of Catholic doctrine, whose basic principles remain valid today, is included in the Instruction of the Congregation for the Doctrine of the Faith *Donum vitae* of 22 February 1987.[10] As Edmund Kowalski notes, scientific activity, like any rational and free human activity, is subject to moral evaluation. Thus, the Catholic Church' official position must be comprehended within this framework.[11] The terms 'artificial insemination' or 'artificial transmission of life' are interpreted as the use of technical methods intended to achieve conception without sexual intercourse. In the chapter on biomedical research, it is emphasised that the gift of life, which God the Creator and Father has entrusted to humanity, calls for recognition of its inestimable value and for responsible stewardship. The Congregation for the Doctrine of the Faith recognises the progress of biological and medical sciences and the increasing availability of effective therapeutic interventions, but it also notes the emergence of methods allowing interference with human life from its earlier stages of development. This may lead individuals to attempt to determine their own destiny and exceed the limits of rational control over nature.

4 Wróbel, 2009, p. 184.
5 Ibid.
6 John XXIII, 1961.
7 A selection of doctrinal statements of the Catholic Church from the list on the official website of the Polish Bishops' Conference, see Konferencja Episkopatu Polski, 2024.
8 Ibid.
9 Art. 4 b. and c.
10 Kongregacja Nauki Wiary, 1987.
11 Kowalski, 1989, p. 45.

This document further states that the Church does not claim competence to judge the nature of scientific progress but only to offer moral evaluation of research, especially that concerning the origins of human existence. Criteria include respect for, development and protection of, and care for the human person, the right to life, and human dignity. According to this position, knowledge and technology should serve man, his well-being, and his inalienable rights, and must remain compatible with moral principles. The document notes that technological development has made it possible for reproductive cells to be integrated outside sexual intercourse. However, not everything that is technically possible is morally acceptable. According to Church teaching, the gift of life should be transmitted within marriage by acts that are proper and exclusive to the spouses. According to the Congregation, the conception outside the mother's body violates personal dignity, as from the point of view of the Catholic Church, the human embryo is already endowed with this attribute. Cryopreservation is evaluated negatively, since frozen human embryos are exposed to risks of death or damage to their physical integrity. Genetic manipulation that allows interference at the conception stage with features determining human identity, such as gender or eye colour, cannot be justified by concern for the good of future generations.[12]

The Church opposes artificial homologous insemination within marriage, except in situations where the technical means employed do not substitute the conjugal act, but merely support and help in achieving its natural aim. Political authorities were also urged to ensure that, for the good of the family, they would not guarantee the use of artificial insemination techniques in which human gametes are transferred between unmarried persons. Furthermore, the Congregation believes that the creation of 'embryo banks', *post mortem* insemination and surrogate motherhood should be prohibited.

Assisted reproductive techniques and other bioethical issues were also addressed in the Charter for Health Care Workers (CFHCW 94), issued in 1994 by the Pontifical Council for Pastoral Assistance for Health Care Workers.[13] As emphasised in the literature, this document analyses and recalls the ethical dimension of medicine.[14] It is not a typical set of principles articulated in legislative-style format; rather, it is dominated by an anthropological-ethical reflection justifying the ethical positions invoked.[15]

The Charter recognises that scientific developments in the field of genetics provide astonishing prospects for medicine, yet they simultaneously generate new and ethical questions (n. 12). It distinguishes between strictly therapeutic genetic interventions and non-medical manipulations altering the human genetic patrimony. The first category, genetic surgery is aimed at improving the individual's health.

12 Ibid.
13 The Pontifical Council for Pastoral Assistance for Health Care Workers, 1995.
14 Garbarz, 1997, pp. 179–184.
15 Biesaga, 2006, p. 20.

The second includes practices aimed at producing human beings with specific characteristics, such as gender or eye colour (n. 13). The Charter further notes that techniques of artificial reproduction, even when used with the intention of serving human life, may create new possibilities for illicit interference with its essence (n. 22). It stresses that every medical intervention concerning human procreation must not substitute the conjugal act but may only have an assistive function (n. 22). The Council states that methods aimed only at facilitating the natural act should not be immediately rejected; this includes, for example, homologous artificial insemination (within marriage, using the spouse's sperm obtained through the normal conjugal act) (n. 23). However, homologous inseminations in a test tube (spousal cells), as well as all heterologous techniques using cells from outside the marriage are condemned. The dangers associated with these fertilisation methods include the destruction of frozen embryos and the serving of the connection between conception and the natural conjugal act. The freezing of embryos and surrogate motherhood are also negatively evaluated (n. 24–28).

The Pontifical Council for Pastoral Assistance for Health Care Workers clarified its position in the New Charter for Health Care Workers (2016).[16] The new document aimed to present updated scientific and doctrinal issues in the field of medical science, in an accessible manner.[17] It addresses the cryopreservation of the oocytes, which was introduced to avoid ethical concerns surrounding the freezing of fertilised embryos. The Charter states that if oocytes are frozen for the purpose of *in vitro* fertilisation, the practice is unacceptable even when the aim is to protect the cells from anticancer therapy (n. 38). A different assessment applies to the preservation of ovarian tissue intended for orthopaedic transplantation to restore fertility (n. 37). It is considered morally unacceptable to undertake fertilisation between human and animal gametes, the development of a human embryo in an artificial or animal embryo, reproduction through twinning, cloning, parthenogenesis and similar procedures (n. 39).

The Council calls for the establishment of ethics committees and clinical ethics consultation services within healthcare institutions. In addition to administrative control of the procedures, ethics committees should evaluate biomedical practices, while consultation services ought to assist staff, patients and families in evaluating proposed diagnostic and therapeutic procedures (n. 140). In different countries, these bodies may take different forms, for example, committees for scientific ethics, advisory bodies, national bioethics councils or ethics committees for animal research. In Poland, bioethics committees operate at medical universities, universities with medical faculties, and medical research and development units.[18]

16 The Pontifical Council for Pastoral Assistance for Health Care Workers, 2016.
17 Ibid., p. 10.
18 Smykowski, 2021, pp. 177–186.

Their functioning is regulated by the regulation of the Minister of Health and Social Welfare of 11 May 1999.[19]

Papal teaching forms the principal reference point for documents issued by the Holy See and its institutions. Pope John Paul II's 1995 encyclical '*Evangelium vitae*' contains a comprehensive exposition of the Catholic Church's doctrinal principles on respect for human life at all stages. The Pope states that 'artificial reproductive techniques' are unacceptable because they separate procreation from its proper human context of the conjugal act. He also condemns the fact that many embryos are exposed to the risk of death. Moreover, embryo research undertaken to develop science and medicine, diminishes human life to the role of 'biological material' (n. 14).[20]

Twenty-one years after the publication of the Instruction *Donum vitae*, the Congregation for the Doctrine of the Faith issued the Instruction *Dignitas personae* (2008) to update Catholic teaching on bioethical issues.[21] As noted in the literature, the motivation for recalling and clarifying the Church's teaching was that, after the release of *Donum vitae*, the situation in many countries had changed. Many highly industrialised countries adopted legal solutions that were more or less contrary to the indications contained therein. The number of people accepting the new reality also increased, while understanding of the moral indications included in Catholic doctrine diminished.[22] Furthermore, as emphasised in the Instruction itself, the teachings contained in *Donum vitae* remain valid, both in terms of the principles presented and the moral evaluations formulated. However, because new biomedical technologies have raised questions, particularly regarding research on human embryos, it was decided to issue a new document (n. 1).

In defining the criteria used to assess the ethical value of biomedicine, it was emphasised that unconditional respect is due to every human being in all phases of his or her existence (n. 10). With regard to the development of new techniques, it was specified that they should meet the following requirements: first, respect for the right to life and physical integrity of every human being from conception to natural death; second, acceptance that the unity of marriage entails reciprocal respect for the right within marriage to become a father or mother only together with one's spouse; third, recognition that the specifically human values of sexuality require that the procreation of a human person be the fruit of the conjugal act expressing spousal love (n. 12). It is therefore necessary to exclude all techniques of heterologous artificial fertilisation that substitute the conjugal act. On the other hand, techniques that aid the conjugal act and its fertility are permitted (n. 12). Acceptable methods include, for example, hormonal treatments for infertility, surgery for endometriosis, and the unblocking of fallopian tubes or their surgical repair (n. 13).

19 Regulation of the Minister of Health and Social Welfare of May 11, 1999 on detailed rules for the appointment and financing and mode of operation of bioethics committees (Dz. U. – Journal of Laws of 1999, No. 47, item 480)

20 Wróbel, 2021, pp. 69–89.

21 Kongregacja Nauki Wiary, 2008.

22 Kraj, 2009, pp. 283–294.

The Congregation also addresses several specific techniques. *In vitro* fertilisation is considered unacceptable because of the deliberate destruction of human embryos (n. 14). Intracytoplasmic sperm injection (ICSI), a technique that can address certain forms of male infertility, is likewise considered unacceptable. As with IVF, it is deemed intrinsically illicit due to its complete separation of procreation from the conjugal act (n. 17).

Cryopreservation of embryos is also unacceptable, since many embryos do not survive freezing and thawing. Moreover, embryos are temporarily deprived of the possibility of developing in the womb (n. 18). The freezing of oocytes for *in vitro* fertilisation has also been criticised (n. 20). It is morally unacceptable to reduce embryos or foetuses present in the womb; such practices are described as intentional selective abortion (n. 21). Pre-implantation diagnosis, aimed at discarding embryos identified as having genetic defects before their transfer to the woman's body, is likewise considered morally acceptable (n. 22).

Papal teaching on the dignity of human life and its protection from the moment of conception remains central to the doctrine of the Catholic Church. Pope John Paul II often addressed these issues,[23] as did his predecessors and successors.

Pope Benedict XVI, in his encyclical *Caritatas in Veritate*,[24] noted that bioethics is a battleground in the cultural struggle between the absolutism of technology and the moral responsibility of the human person. According to Benedict XVI, the fundamental question is whether the human being is the product of his own making or depends on God (n. 74). Referring to assisted reproductive technology, the Pope observed that biotechnology places the manipulation of life under human control (n. 75).

During one of his audiences, Benedict XVI referred to the ruling of the Inter-American Court of Human Rights on *in vitro* fertilisation.[25] In November 2012, the Court stated that embryos are not persons and therefore do not possess human rights, including the right to life. Consequently, the Court held that a ban on IVF to protect embryos violates the human rights of infertile persons.[26] The Pope interpreted this position as undermining the protection of life from the moment of conception. He consistently rejected IVF in his other statements, drawing upon the Catholic Church's established teaching.[27]

Statements of Pope Francis also include references to assisted reproductive methods. In a 2014 address, he spoke firmly on bioethical issues, including abortion, euthanasia, and IVF. He emphasised that Catholics have a duty to express conscientious objection to these practices. Assisted procreation, he argued, results in the child being treated as something owed, rather than as a gift. He described such

23 More extensively on this topic: Struzik, 2009, pp. 149–162.
24 Benedict XVI, 2009.
25 The Holy See, 2013.
26 Pogodzińska, no date.
27 Radio Watykańskie, 2012.

practices as a scientific assault, since children are produced in the laboratories., and noted that lives are theoretically sacrificed to preserve others. According to Pope Francis, there is no room for leniency or misplaced compassion towards those who participate in killing or producing children.

Particular references to bioethical issues also appear in the intentions Pope Francis recommends to the followers. In the indications for March 2022, he emphasised the need to use biotechnological achievements on the basis of respect for human dignity. The Pope noted that, with the development of science, Christians face numerous bioethical problems. Human embryos cannot be treated as disposable material. Rejected embryos form part of what he termed as 'culture of exclusion'. According to Pope Francis, this culture must not be spread, as it causes great harm and rests upon profit-driven biomedical research. Human dignity cannot be sacrificed for progress, thus, the two must remain inseparable.[28]

Pope Francis' encyclical *Laudato si*[29] raises issues concerning respect for the human embryo, including in the context of biotechnological research.[30] The Pope accuses some environmental movements of failing to apply the same principles to human life when defending the integrity of the environment. He claims that, when experiments are carried out on human embryos, it is forgotten that the inalienable worth of a human being transcends his or her degree of development. When technology disregards fundamental ethical principles, it ends up considering any practice whatsoever as licit (n. 136).

The Church's magisterium consistently teaches the unacceptability of methods that remove the conception process from the conjugal act. The essence of this approach is the recognise that human life begins at the moment of the union of a female cell with a male cell. According to official teaching, every human being is endowed with inherent and inalienable dignity.

Particular Churches in individual states also address bioethical issues in their official statements.[31] The Polish Bishops' Conference (PBC) has frequently spoken on this issue. It is not possible to discuss and quote the whole teaching; nevertheless, selected parts are presented here to illustrate its standpoints.[32]

The Polish Bishops' Conference, established by the Holy See, consists of bishops canonically tied with the territory of the Republic of Poland.[33] In the Letter of the Council of Bishops for the Family of 8 December 2007, addressed to Members of Parliament and Senators, the position of the Church's Magisterium on the method of *in vitro* fertilisation was reiterated.[34] It was emphasised that numerous embryos die during every attempt, and this was described as 'a kind of sophisticated abortion'.

28 Ołdakowski, 2022.
29 Vatican.va, 2015.
30 Muszala, 2016, pp. 39–65.
31 More extensively on this topic: Konferencji Episkopatu Polski, 2008.
32 Konferencji Episkopatu Polski, 2003.
33 Konferencji Episkopatu Polski, no date.
34 Wiara.pl, 2007.

Furthermore, it was acknowledged that every child has the right to be born of the loving conjugal act of its parents. It was also stressed that the child cannot be treated as a thing, and that future parents cannot justify their decision regarding *in vitro* as a 'right to the child'. As the PBC stresses, the birth of a child conceived through this procedure 'is always accompanied by the death of its brothers and sisters'.

In a firm Communiqué from the 352nd Plenary Assembly of the Polish Bishops' Conference of 20 June, it was acknowledged that those using the *in vitro* method commit a 'grave sin' (n. 5). Pastors, catechists and all people of goodwill were urged to learn and communicate the truth about objectively immoral medical procedures (n. 6).[35]

A comprehensive position of the PBC concerning assisted procreation was expressed in the 'Bioethics Document' adopted at the 361st Plenary Assembly of the Polish Bishops' Conference on 5 March 2013.[36] The *in vitro* method was described as another experiment on human beings. It was argued that this technique constitutes a form of control over the human person. The freezing of 'surplus embryos' was criticised because many of them die, a process deemed to violate human dignity. According to the PBC, *in vitro* excludes harmony and unity of the spouses. Sperm is obtained from the father through an act of self-abuse, the mother's body is repeatedly subjected to medical manipulation, and the child itself becomes a product.[37]

The document provoked considerable comments both in favour and against the Church. Supporters emphasised that the Church consistently proclaims its teaching, while opponents, including persons conceived through IVF, alleged that they were discriminated against and stigmatised.[38] The dispute particularly concerned passages which the PBC pointed to an increased risk of genetic defects in children conceived through IVF. Referring to these claims, members of the PBC's Team of Experts on Bioethics maintained that their position was based on 'reliable and credible scientific studies'. At the same time, they emphasised that the position expressed should not be interpreted as discrimination against either the children born through this method or their parents.[39]

The activity of the PBC on bioethical issues increased significantly during the work on the draft law on medically assisted procreation. The PBC formulated its doubts about the bill in an appeal addressed, inter alia, to Catholic MPs and senators debating its final version.[40] It stressed that a Catholic participating in the legislative process has a duty to show loyalty to Christ and the Church's teachings, and should engage prudently and with integrity in public life. A Catholic cannot be involved in the adoption of a law that is morally imperfect. The government was urged to develop solutions to infertility by supporting, among other things, research into

35 Konferencji Episkopatu Polski, 2010.
36 Opoka.org.pl, 2013.
37 Ibid.
38 Kmieciak, no date.
39 Konferencji Episkopatu Polski, 2013.
40 Konferencji Episkopatu Polski, 2015a.

naprotechnology (identification and treatment of infertility). In the PBC's view, the *in vitro* procedure cannot be qualified as a method of treating infertility. Moreover, the previous position of the PBC, expressed in the document of 5 March 2013, regarding the dangers of the technique, were recalled.

On 25 June 2015, the Act on Infertility Treatment[41] was adopted. The matters regulated include: principles of embryo and germ-cell protection; methods of infertility treatment, including medically assisted procreation; tasks of public authorities; the conditions for the donation, collection, processing, testing, storage and distribution of germ cells, and embryos intended for medically assisted procreation; the principles governing the operation of medically assisted procreation centres and germ-cell and embryo banks.[42]

The explanatory memorandum to the Act emphasises that it

> aims to protect reproductive health and to create conditions for the use of methods of treating infertility in a way that protects the rights of persons affected by infertility and children born as a result of medically assisted procreation procedures.[43]

The Polish Bishops' Conference evaluated the adopted solutions several times through its various bodies. In a statement by the Expert Team for Bioethics, it was acknowledged that the Act has numerous negative ethical, medical, social, and legal nature. According to the Team, in the light of the Church's teaching and that of Pope Francis, the *in vitro* method should be considered unecological and contrary to the principle of intergenerational justice. The behaviour of Catholic MPs who voted in favour of the bill was also condemned.[44] Speeches addressed to the President of the Republic of Poland[45] and to the Senate[46] after the adoption and signing of the Act were similar in tone.

The teaching of the PBC aligns with the Magisterium of the Church on bioethical issues. The Catholic Church in Poland articulates a negative position toward *in vitro* fertilisation and other assisted reproductive techniques, claiming the moral wickedness of these methods.

When analysing the doctrinal statements of the Catholic Church, it is also essential to mention the position expressed in the Catechism of the Catholic Church (CCC)[47] on bioethical issues. In the section entitled 'The Child as a Gift', it is emphasised that techniques that separate parenthood through the intervention of a third party, such as sperm donation, egg donation, or surrogacy, are profoundly illicit.

41 The Act on Infertility Treatment of 25 June 2015 (Dz.U. – Journal of Laws of 2020, item 442, consolidated text).
42 Art. 1.
43 Sejm.gov.pl, 2015.
44 Konferencji Episkopatu Polski, 2015b.
45 Konferencji Episkopatu Polski, 2015c.
46 Konferencji Episkopatu Polski, 2015d.
47 Pallotinum, 1994.

Both artificial insemination and *in vitro* fertilisation, using the genetic material of a third party violate the child's right to be born of natural parents united in marriage (n. 2376). Homologous insemination (artificial insemination or IVF) within marriage is also considered morally unacceptable, since it separates the sexual act from the procreative act (n. 2377).

A degree of ambiguity remains regarding homologous insemination. Indeed, in the already examined Instruction *Dignitas Personae,* it is stated that all heterologous assisted reproductive techniques must be excluded, as well as those methods of homologous insemination that substitute for the conjugal act. Conversely, practices that support the conjugal act and its fertility may be accepted (n. 12). However, the document does not specify which methods are intended. The New Charter for Health Care Workers, issued by the Pontifical Council for the Pastoral Care of Health Care Workers, states that:

> interventions that aim to remove obstacles to natural fertility, or that are intended solely to facilitate the natural act or to bring about the attainment of the proper end as normally performed, are certainly licit. This may be the case with homologous artificial insemination within marriage, using the husband's semen, when it is obtained through the normal conjugal act and the temporal continuity between the conjugal act and conception is respected (n. 25).

The Catholic Church is the largest religious community in Poland, with approximately 90% of the population belonging to it. However, it faces significant problems in its functioning. Its conservative teaching is questioned even by those who identify as Catholics. This is particularly evident in matters of bioethics, such as abortion, euthanasia, and assisted reproductive methods. In his publication, Janusz Mariański presented the attitude of Poles toward *in vitro* fertilisation, observing that approximately two-thirds of self-declared Catholics approve of IVF, while the remainder accept the Church's teaching on the matter.[48] There is an obvious inconsistency between doctrine and attitudes. Nevertheless, it should be emphasised that the Church's attitude on the issue has not changed since its first statements in 1897. The doctrine developed over centuries continues to be transmitted to contemporary Catholics.

3. Position of Other Churches and Religious Associations

Since its beginnings, Christianity has been characterised by division. From the first centuries, a distinction existed between Chalcedonian and Monophysite

48 Mariański, 2022, p. 59.

Christians.[49] The Council of Chalcedon (in 451) led to religious conflicts. The doctrine of Pope Leo the Great, asserting that Christ has two natures, divine and human, was accepted at the time.[50] Christians who rejected this doctrine were referred to as followers of Monophysitism, which itself had differing interpretations. According to the first conception, divinity and humanity fused into a third 'nature' through the Incarnation; according to the second view, Christ's divine nature absorbed his human nature, in the same way that the ocean absorbs drops of water.[51]

The division of Christianity into Roman Catholic and Orthodox traditions appeared in 1054. The Great Schism, as this separation is known, deepened existing divisions between the churches. Disagreements related to numerous issues, including the formula of the profession of faith, the primacy of the Pope, and disciplinary differences. The Patriarch of Constantinople, Michael I Ceruralius, and Pope Leo IX imposed excommunications. Doctrinal issues gradually transformed into political problems, and despite several attempts at reunification, the schism continues to this day.[52]

Another major split appeared in the sixteenth century with Martin Luther, who in 1517 started the movement known as the Reformation. However, its foundations however, were laid by Jan Hus and the Hussite movement in the early fifteenth century. Luther's aim was the renewal of Christianity, but the outcome was the establishment of religious organisations independent of the papacy and the formation of national churches, in which secular rulers became the heads of local communities. As a result of divisions, currents such as Lutheranism, Anglicanism, and Calvinism appeared.[53] Within Protestantism, numerous denominations developed that function throughout the world.

Polish Radio, referring to the Catholic News Agency and the 'Study of Global Christianity' conducted by Boston-based researchers, reported that in 2023 the total number of Christians worldwide had increased significantly to 2.6 billion. Every year, the number of Christians increases by 30 million, or about 82,000 per month. Growth in the Catholic Church is mainly observed in Africa and Americas, with an annual increase of 0.93%. For Protestant communities, the figure is 1.87%.[54] As far as Orthodox believers worldwide, according to various estimates, their number ranges from 250–300 million.[55]

In addition to the three main streams of Christianity, there are also independent or evangelical movements, which independently determine their doctrine.[56]

49 Chadwick, 2009, p. 12.
50 Grzywaczewski, 2012, pp. 137–179.
51 O'Collins and Farrugia, 2002.
52 Stanios-Korycka, 2016, pp. 273–274.
53 Medwid, 2013, pp. 267–292.
54 Polskieradio.pl, 2023.
55 Kompasje.pl, 2024.
56 Zbawiciel, 2023.

Referring the data to the Polish background, it should be noted that the dominant church, in terms of numbers, is the Latin Rite Catholic Church, with 31.587.211 believers. Other Catholic rites include: Ukrainian Greek (Byzantine) Church with approximately 60,000 members; Armenian Catholic Church with 630; and the Byzantine-Slavic with 117. The Orthodox Churches include: Polish Autocephalous Orthodox Church (503,966), Eastern Old Believers Church in the Republic of Poland (1.452), and the Old-Orthodox Church of Old Believers (502).

The largest number of confessions is found within Protestantism. These include: the Evangelical Church of the Augsburg Confession in Poland (60,244), Pentecostal Church in Poland (27,309), Seventh-day Adventist Church (9.949); Church of Christ in Poland (6,650), Baptist Christian Church of the Republic of Poland (5,760), Church of God in Christ (5,058), Evangelical Methodist Church in Poland (4,216), New Apostolic Church in Poland (3,476), Free Christian Church in Poland (3,212), Evangelical Reformed Church in Poland (3,200), Church of God in Poland (3,018), Evangelical Christians' Church in Poland (2,391), Church of Christians of the Evangelical Faith (1,646), Community Evangelical Pentecostal Church (622), Evangelical Community for Christ (formerly Evangelical Brotherhood) in Poland (560), The Saturday Day Christian Church (329).

Taking all the data into consideration, the Catholic Church in all its rites is estimated to have 31,647,958 believers, the Orthodox Churches 505,950 believers, and the Protestant Churches 137.640, with a total population of 36.754.000.[57] Several points need to be clarified. First, these are not all religious communities, but only those included in available statistics. In Poland, 100 persons are sufficient number to establish a church or religious association. The current list includes about 190 entities and can be found on the website of the Ministry of the Interior and Administration.[58] Second, the number of believers is estimated by the communities themselves based on internal criteria. For example, in the Catholic Church, the count is based on the number of persons baptised. The data do not include official censuses, as the Constitution of the Republic of Poland specifies that no person may be compelled by public authorities to disclose their philosophy of life, religious convictions, or beliefs.[59] Consequently, the probability of presented data may be unreliable. However, this does not change the fact that the Catholic Church in Poland is the largest religious community, with rich historical and cultural traditions. Given the huge number of confessions within Christianity, it is only possible to examine the teachings of selected denominations. Therefore, the doctrines of selected religious communities on the territory of the Republic of Poland will be presented.

57 Statistics Poland, 2024, pp. 107–109.

58 Ministerstwo Spraw Wewnętrznych i Administracji, no date.

59 The Constitution of the Republic of Poland of 2 April 1997 (Dz.U. – Journal of Laws, No. 78, item 483, as amended), Art. 53(7).

3.1. Orthodox Church

As noted in the literature, Orthodox theologians hold diverse views on *in vitro* fertilisation. Some argue that it dehumanises human life and is incompatible with the aims of the sacrament of marriage; others view the procedure as a form of support for spouses who cannot have children.[60] Official statements appear in documents from the Greek, Russian, and American Orthodox Churches. In addition, bioethics committees and advisory bodies attached to the Synods of local Orthodox Churches have expressed their positions.[61]

The Orthodox Church's attitude towards the human embryo largely corresponds to the teaching of the Catholic Church. It is accepted that, from the moment of conception, the embryo has its own genetic and personal identity. From the moment of combination of male and female cells, a human being is present. Every life is sacred and inviolable, including that created through *in vitro* fertilisation.

As Artur Aleksiejuk points out, from an Orthodox perspective, the decisive role in fertilisation lies in divine intention rather than human will or technical possibilities. Therefore, the question of whether parents who choose IVF, and the doctors and technicians involved, act against God's will is therefore complex. According to Aleksiejuk, there is no harmony on the issue, and an absolutist approach would be incompatible with the spirit of Orthodoxy. Nevertheless, the Church does not recommend the use of artificial fertilisation as a method of fertility treatment.[62]

Orthodox ethics holds that human life is unique and exceptional. It is a gift from God and is therefore sacred and inviolable from its very beginning. Consequently, the creation of new life must not reflect pride or selfish motives, but must respect the dignity of the being brought into existence.[63]

Orthodox doctrine explicitly condemns the destruction of unused embryos, as life is believed to begin at the moment of conception. Heterologous fertilisation, involving sperm from an extramarital donor, is also unacceptable. Surrogate motherhood is excluded due to the involvement of a third party in the fertilisation process. Nonetheless, the decision to implement assisted reproductive techniques is left to the conscience of the spouses, who must mutually consent. The Church's role is to advise them against such solutions rather than impose prohibitions.[64]

As Aleksiejuk, a lecturer at the Christian Academy of Theology, stressed in an interview with the Polish Press Agency, the Polish Autocephalous Orthodox Church has no official position on IVF and relies on doctrinal documents developed by the Greek and Russian Orthodox Churches.[65] In 2000, the Russian Orthodox Church

60 Leśniewski, 2019, p. 190.
61 Aleksiejuk, 2010.
62 Ibid.
63 Pawłowicz, 2011, p. 320.
64 Leśniewski, 2019, pp. 189–190.
65 Non-Catholic churches allow the *in vitro* method in exceptional situations. See Gazeta Prawna, 2008; Kuźma, 2022.

adopted the document *Fundamentals of Social Conception*, which stated that all types of *in vitro* fertilisation involving cryopreservation and the deliberate destruction of surplus embryos are morally unacceptable. However, following suggestions from Orthodox dioceses outside Russia, particularly in the European Union and the United States, discussions began on revising this position. A draft document *Ethical Problems Associated with In-Vitro Fertilization* was presented for consultation. It considered the possibility of allowing the method for spouses of childbearing age and examined the issue of cryopreserving oocytes (ova) for potential use in subsequent fertilisation attempts. According to the draft, the final decision regarding IVF would be left to the priest who spiritually cares for the couple concerned.[66]

Summarising the Orthodox Church's teaching on assisted reproductive technology, it should be stressed that although such methods are not recommended, there is no clear objection in situations when spouses, after exhausting other options, choose to use *in vitro* fertilisation.

3.2. Protestant Churches

The Reformation appeared in Poland a few years after Martin Luther's intervention. Between 1520 and 1525, King Sigismund issued edicts forbidding the dissemination and reading of Luther's works under penalty of death. Lutheranism became popular among the bourgeoisie of Royal Prussia and Greater Poland, while Calvinism found support among the nobility. Poland became a country in which followers of various confessions, persecuted in their own countries, found protection.[67] In 1573, the Act of the General Confederation of Warsaw was signed, guaranteeing peace and religious freedom to those of different faith. This document was groundbreaking in the development of the idea of human rights and, in 2003, was added to UNESCO's *Memory of the World* list, which includes the most important documents in the history of humanity.[68]

When Poland regained independence in 1918, there were more than one million Protestant believers within its borders. That denomination differed from other religions in that it was not centred around a single entity, but consisted of numerous churches and denominational associations. Membership in Protestant communities was mainly linked to nationality, as in the case of the Greek Catholic Church.[69]

After the Second World War, the number of Protestants significantly decreased, and by the end of the 1960s, the Protestants population was estimated at around 150,000 followers,[70] a figure that remains similar today.

66 Human Life International – Polska, 2021.
67 Jagiełło, 2015, p. 103.
68 Popławski and Kąkolewski, 2023, p. 198.
69 Alabrudzińska, 2004, p. 9.
70 Szlak Dziedzictwa Protestanckiego w Krakowie, no date.

Bioethical issues appear in the teaching of some Protestant communities functioning in Poland. However, there is no identical position among those confessions that have expressed views on *in vitro* fertilisation. As Paweł Przyłęcki emphasises, divergences sometimes exist even within the same confession.[71]

In Poland, only some Protestant communities have articulated clear positions on assisted reproductive methods. One such entity is the Evangelical Church of the Augsburg Confession, which in 2009 issued a statement on the admissibility of IVF.[72] The introduction emphasises that the Evangelical Church worldwide has not developed a uniform position; nevertheless, Polish Lutherans accept IVF as a method of treating infertility. The statement expresses clear opposition to creating and storing surplus embryos, when there is no intention of implanting them in the mother's body. The IVF method is recognised as a form of family support. Homologous fertilisation, where the sperm is obtained from the legal father, is approved. However, heterologous fertilisation and the use of surrogate mothers are not accepted. The statement also calls on the state to provide financial support for couples who are unable to have children, and it affirms the Church's duty of pastoral care for such couples.

The claim that IVF treats the child as a consumer good is explicitly rejected. IVF should be a last resort, not an impulse or whim. The statement stresses the need to protect the human embryo from being used for research purposes. In agreeing to the admissibility of IVF, the Evangelical Church of the Augsburg Confession refers to the biblical imperative of fertility, where God is the source of life who grants the blessing of children. The statement also encourages adoption for couples who cannot have biological children.[73] The literature notes that this approach reflects personalism, which emphasises the inherent and autonomous value of personality,[74] and the unique perfection of human person among other entities.[75]

3.3. Pentecostal Church in the Republic of Poland

The second largest Protestant denomination in Poland is the Pentecostal Church in the Republic of Poland. It is the largest Pentecostal denomination in the country, belonging to the Pentecostal European Fellowship, the World Assemblies of God Fellowship, the Evangelical Alliance in Poland, and the Bible Society in Poland.[76]

The literature states that the Pentecostal Church in Poland has not developed a clear position on assisted reproductive techniques. A statement of the Church Council affirms that holy married life is oriented towards procreation. Mariusz Kocoł draws attention to the fact that the Church's official periodical, '*Chrześcijanin*'

71 Przyłęcki, 2013 pp. 65–66.
72 luteranie.pl, 2009.
73 Ibid.
74 Zapart, 2011.
75 Encyclopaedia of the Polish Scientific Publishers, no date.
76 HISTORIA kościoła, no date.

(the Christian) contains publications discussing these issues. The author refers to the opinion of Tomasz Józefowicz, who emphasises that many Protestant Churches tend to accept IVF under certain conditions. Only married couples may use IVF; there must be no selection of embryos; and the number of embryos created should correspond to the spouses' ability and willingness to accept and raise them.[77]

The World Assemblies of God Fellowship, to which the Pentecostal Church in Poland belongs, issued an official statement in 2010 addressing IVF.[78] It states that, based on the Holy Scriptures, conception should take place through the sexual act of a man and a woman performed within marriage. However, when a couple cannot have children, they may face the decision whether to use IVF. The statement stresses that there are a number of ethical concerns, including: the manner of obtaining sperm and ovum; the protection of human embryos, especially those not intended for implantation; and considerations regarding the health and life of the mother if several implanted embryos survive, which may lead to selective abortion. Therefore, couples choosing IVF are therefore encouraged to cooperate with medical personnel on an ethical basis.[79]

Among the Christian denominations functioning on the territory of the Republic of Poland, only some of them officially express their views on assisted reproduction techniques: specifically, the Catholic Church, the Orthodox Church, and certain Protestant Churches. In non-Christian communities, such as Judaism and Islam, reference to this issue also appear, though divergences arise depending on the faction within each confession.

4. Summary

Summarising the findings of the present study, the following conclusions can be drawn:

(1) Since as early as the 17th century, research on artificial insemination has been carried out, initially on fish and insects, and, by the end of the 18th century, also on animals.
(2) By the end of the 19th century, successful attempts were already being made using semen from outside the marriage.
(3) The 20th century brought the development of techniques and methods that made insemination outside the woman's body possible.
(4) On 25 July 1978, the first child conceived through the *in vitro* method was born.

77 Kocoł, 2018, p. 78.
78 Ag.org, 2010.
79 Ibid.

(5) Methods of assisted reproduction provoke extreme emotions among various groups; some churches and religious associations take an active part in the debate, evaluating the implemented practices in the light of their doctrine and the legal norms functioning within their particular community.

(6) The attitude of the Catholic Church towards assisted reproductive methods (artificial insemination) was officially articulated on 17 March 1897, when the Holy Office referred to the posted question whether artificial insemination could be implemented. As a response, it firmly stated that it could not.

(7) A comprehensive exposition of Catholic doctrine, which in its basic principles remains valid, is included in the Instruction of the Congregation for the Doctrine of the Faith *Donum vitae* of 22 February 1987.

(8) According to the Catholic Church, knowledge and technology should serve the human, his well-being and his inalienable rights, while remaining in harmony with respect for morality. (D.v.).

(9) The Church is opposed to artificial homologous insemination within marriage, except in situations where the technical means used do not substitute the conjugal act, but merely assist in achieving its natural aim (D.v.).

(10) According to the Catholic Church, techniques of artificial reproduction (assisted reproductive technology), although often intended to serve human life, may in fact create possibilities for illicit interference with its essence (D.v.).

(11) The Catholic Church does not accept the freezing of oocytes for the purpose of *in vitro* fertilisation. This fact is unacceptable even if the reason is to protect the cells from anticancer therapy.

(12) The Catholic Church considers morally unacceptable attempts involving fertilisation between human and animal gametes, the development of a human embryo in an artificial or animal embryo, and reproduction by twinning, cloning, parthenogenesis, and other analogous practices.

(13) Twenty-one years after the publication of the Instruction *Donum vitae*, the Congregation for the Doctrine of the Faith updated its teaching on bioethical issues by issuing on 8 December 2008 the Instruction Dignitas personae (D.p.).

(14) In the Constitution *Dignitas personae*, it was specified that assisted reproductive techniques should meet the following criteria: firstly, respect for the right to life and physical integrity of every human being from conception to natural death; secondly, acceptance that the unity of marriage requires reciprocal respect for the right within marriage to become a father or mother only together with the other spouse; thirdly, recognition that the specifically human values of sexuality require that the procreation of a human person be brought about as the fruit of the conjugal act specific to the love between spouses.

(15) Intracytoplasmic sperm injection (ICSI) is also unacceptable; although it allows some male infertility problems to be addressed, it remains intrinsically illicit method due to the complete separation of procreation from the conjugal act (D.p.).
(16) It is unacceptable to freeze oocytes for the purpose of *in vitro* fertilisation (D.p.).
(17) It is morally unacceptable to reduce embryos or foetuses present in the womb, as these practices constitute intentional selective abortion.
(18) In addition to documents issued by institutions within the Holy See, the position of the Catholic Church is also shaped by papal teaching.
(19) Particular Churches within individual states also refer to bioethical issues in their official statements. The Polish Bishops' Conference (PBC) has frequently spoken on this issue.
(20) The teaching of the PBC aligns with the teaching of the Magisterium of the Church on bioethical issues. Consistently, the Catholic Church in Poland articulates a negative position towards *in vitro* and other assisted reproductive techniques, claiming their moral wickedness.
(21) According to the Catechism of the Catholic Church (CCC), techniques that separate parenthood through the intervention of a third party (e.g., sperm or egg donation, surrogacy), are profoundly illicit. Both artificial insemination and *in vitro* fertilisation using the genetic material of a third party violate a child's right to be born of natural parents united by marriage (n. 2376).
(22) Homologous insemination (artificial insemination, *in vitro*) within marriage is also considered morally unacceptable, as it separates the sexual act from the procreative act (n. 2377).
(23) Orthodox theologians hold varied opinions on *in vitro* fertilisation. Some believe that it causes dehumanisation of human life and is incompatible with the aims of the sacrament of marriage; others view the procedure as a support for spouses who cannot have children.
(24) The Orthodox Church's attitude towards the human embryo largely accords with that of the Catholic Church: from the moment of conception it has its own genetic and personal identity. From the moment of combination of male and female cells, we are dealing with a human being. Every life is sacred and inviolable, including that created through *in vitro* methods.
(25) Orthodox doctrine explicitly condemns the destruction of unused embryos due to the belief that life begins at the moment of conception. Heterologous fertilisation, in which the sperm of an extramarital donor would be used, is also unacceptable. Surrogate motherhood is also excluded due to the involvement of a third party in the fertilisation procedure.

(26) In the Orthodox Church, the decision to implement assisted reproductive techniques is left to the spouses' conscience, provided they mutually consent. The Church's role is to ask them not to implement such solutions.
(27) Bioethical issues are present in the teaching of some Protestant communities in Poland. However, it should be emphasised that there is no identical position among the confessions that officially speak on *in vitro* fertilisation.
(28) In Poland, only some Protestant communities have clearly articulated their positions on assisted procreation methods. One such entity is the Evangelical Church of the Augsburg Confession, which in 2009 issued a statement on the admissibility of the *in vitro* method.
(29) Polish Lutherans accept this method as a way of treating infertility.
(30) The Evangelical Church of the Augsburg Confession expresses clear opposition to the creation and storage of surplus embryos, when no clear purpose exists for their later implantation in the mother's body.
(31) Lutherans approve homologous fertilisation; heterologous fertilisation and surrogate motherhood are not accepted.
(32) The Pentecostal Church in Poland does not have a clear position on the issue of assisted procreation techniques.
(33) The World Assemblies of God Fellowship, to which the Pentecostal Church in Poland belongs, issued an official statement in 2010. It stated that, according to God's plan, conception of a child should take place through the sexual act of a man and a woman within marriage. However, when a couple cannot have children, they may face with the decision whether to use *in vitro* fertilisation.

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Chapter 3

Psychology of Families Founded by Assisted Reproductive Technologies and Surrogacy

Dominik Gołuch

Abstract

Assisted reproductive technologies (ART) and surrogacy have changed the way family, parenthood, and kinship have been considered over the past decades. Owing to ART, couples struggling with infertility, single people, and same-sex couples have acquired new opportunities to realise their dreams of parenthood. Although these changes bring enormous benefits, they also create new psychological challenges for both parents and children born through these methods. This chapter aims to present the psychological and emotional challenges faced by families founded through assisted reproductive technologies and surrogacy. The study outlines whether and how these methods affect family relationships, the development of children's identity, and the psychological support useful at each stage of this process. Unique aspects related to parenthood for singles and same-sex couples are also addressed. The importance of transparency in conversations with children about their origins and the role of informed consent as a basis for ethical decisions in ART and surrogacy are presented.

Keywords: ART, surrogacy, family psychology, parenthood, informed consent

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1. Introduction

Assisted reproductive technology (ART) and surrogacy have significantly transformed contemporary conceptions of family, parenthood, and kinship over recent decades. These reproductive innovations have expanded the possibilities of parenthood for individuals and couples facing infertility, as well as for single individuals and same-sex couples, enabling them to pursue the formation of families. While these developments offer profound benefits, they also introduce a range of psychological challenges for both parents and children conceived through these methods.

The psychological dynamics within families formed via ART or surrogacy encompass a multitude of complex factors. These include the emotional impact of infertility, the decision-making processes involved in pursuing reproductive assistance, and the long-term psychological outcomes, particularly regarding the identity formation of the child. A comprehensive understanding of the psychosocial and legal dimensions of ART and surrogacy is essential to ensure that decisions and practices remain aligned with the best interests of the child.

This chapter examines the psychological and emotional challenges encountered by families created through assisted reproductive technologies and surrogacy. It explores the potential effects of these reproductive pathways on family relationships, children's identity development, and the forms of psychological support beneficial at various stages of the reproductive and parenting process. The chapter also addresses issues unique to parenthood among single individuals and same-sex couples. Emphasis is placed on the importance of openness in discussing children's origins and on the foundational role of informed consent in guiding ethically responsible decisions in the context of ART and surrogacy.

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2. Family Psychology – Primary Challenges

Family is the first and most important environment in which a person develops. This is where we learn love, support, conflict management and communication. Family psychology is a field that focuses on the study of relationships and dynamics in the family and their impact on individuals. Family psychology is not only an analysis of problems, but also an attempt to understand how family relationships shape the overall life of an individual.[1] It deals with the study of family structure, family roles, communication and emotional processes occurring in the family. Family psychologists attempt to understand how family interactions affect the mental and emotional development of individual family members. Studies indicate that family relationships

1 Fine and Fincham, 2013, pp. 2–7.

are crucial for the mental and emotional health of both children and adults.[2] The family performs many functions: from providing safety and emotional support, through socialisation and education, to material support. Family psychology pays special attention to the way families cope with challenges such as divorce, death of loved ones, financial crises, or illness. Each of these factors can affect the mental and emotional health of family members. For example, studies indicate that children from high-conflict families may experience emotional difficulties such as anxiety and depression.[3] Families that can effectively resolve conflict, support the development of coping skills in their children.

Moreover, family psychology addresses topics related to family therapy, which aims to improve the functioning of the family as a whole. A popular approach is the structural model, developed by Salvador Minuchin.[4] It focuses on understanding the hierarchy and boundaries in the family, which can be a source of conflict. Family therapy helps families communicate better, resolve conflicts, and support each other in difficult situations. Family therapies are effective in treating a wide range of problems, from behavioural disorders in children, through communication problems in marriage, to support in the treatment of mental illnesses such as depression or addiction.[5] Contemporary research in family psychology often focuses on the diversity of family structures, such as reconstructed families, same-sex families, or multicultural families. This study helps to better understand how different family models affect the development of individuals. Additionally, there is an increasing emphasis on understanding the role of technology and social media in family life. Studies indicate that new technologies can have both positive and negative effects on family relationships.[6]

The psychology of families formed through ART or surrogacy is a relatively young discipline that evolves alongside advancements in biotechnological methods. Additionally, it deals with the study of emotions, relationships, and functioning of families, as well as understanding how various intra- and peri-family processes affect the development of the child, identity of children and parents, and dynamics of family relationships. In this case, it is crucial to understand the impact of ART and surrogacy on family bonds. For example, children conceived using *in vitro* fertilisation (IVF) do not differ emotionally and cognitively from children conceived naturally, however, unique challenges may result from the transparency of parents about the methods by which the child was born.[7]

A primary area of research is the impact of ART on parents, including their emotional experiences related to infertility, the treatment process, and decision to opt for assisted reproductive technologies. Parents may experience stress, anxiety, and

2 Minuchin, 1974, pp. 241–256.
3 Cummings and Davies, 2010, pp. 101–120.
4 Minuchin, 1974, pp. 46–64.
5 Nichols and Schwartz, 2007, pp. 7–24.
6 Hertlein, 2012, p. 386.
7 Golombok et al., 2013, p. 658.

tensions related to societal expectations and decisions about revealing how the child was born. Additionally, children born through assisted reproductive technology may struggle with questions about their identity, particularly in cases of surrogacy, where the roles of the biological mother and the carrier may be separate. Studies suggest that it is crucial for families to talk transparently and appropriately about the child's conception.[8]

Families created through assisted reproduction often face social challenges, such as stigma and discrimination. Studies suggest that social perceptions of surrogacy and assisted reproductive technologies can affect family relationships and family members' self-esteem. These families may experience misunderstandings or negative perceptions, which can increase stress and affect their daily functioning.[9] Family psychologists provide support and interventions to help families cope with the unique challenges of assisted reproductive technologies. Therapy can include helping to manage emotions related to infertility treatment, supporting communication about the conception of a child, and helping to establish parental bonds. Therapeutic work can be particularly important in surrogacy, where building a bond between the child and the parents and managing the relationship with the surrogate mother are important. Family therapies focus on supporting the transition through these processes in a healthy and positive way for all parties involved.[10]

Continuous technological, cultural, and social developments imply that family psychology must consider new forms and possibilities of family formation.

3. Genetic Community and Psychology

Surrogacy, although associated with advanced medical techniques in modern times, is not a new phenomenon and has been known throughout history. There are numerous examples from different cultures and eras that indicate that the practice of surrogacy has its roots in ancient times. Examples can be found in ancient religious and legal texts. One of the oldest recorded examples of surrogacy comes from the Bible, from the Book of Genesis. The story of Abraham and Sarah describes a situation in which Sarah, unable to have children, asked her slave Hagar to become a surrogate and bear a child for Abraham. Hagar gave birth to a son, Ishmael, who was planned to be recognised as a descendant of Abraham.[11] In ancient Babylon, surrogacy was regulated by law. The Code of Hammurabi allowed a man who had no children with his wife to have offspring with another woman, usually a slave, and

8 Jadva et al., 2012, p. 3013.
9 Zadeh et al., 2018, p. 1104.
10 Riddle, 2022, pp. 126–127.
11 Bible, 2003, Gen. 16:1–4.

these children were considered legitimate.[12] Surrogacy was also employed in ancient Egypt, Greece, and Rome. If a woman could not have offspring, husbands could become closer to their concubines or slaves. In such a situation, the child had rights analogous to the rights of the wife's biological children, and sometimes was directly considered the child of the legal wife.[13]

'Traditionally', in families, there has always been genetic closeness between parents and children. This has its consequences not only at the biological level (e.g. owing to shared genes, there are more possibilities for effective medical interventions between members of a given family; however, having offspring by people who are extremely closely related genetically, significantly increases the risk of various genetic diseases in the offspring), but also at the psychological level. For example, the paradigm of evolutionary psychology assumes that one of the basic motivations of every human action is the survival of one's own genes. Therefore, people will take actions that will increase the chance of passing on their own genetic pool and will protect this pool; however, they will fight against competing genes.[14] For example, the effect of this motivation will be stronger bonds with biological – children and slightly weaker bonds established with adopted children – depending on the parental investment levels.[15]

Moreover, the aspect of genetic proximity is relevant in the practice of ART and in surrogacy. Although technological development has enabled to separate genetic motherhood from biological motherhood, children remain genetically related to both or at least one of the 'intended' parents. Even in surrogacy, the surrogate mother most often carries the child of the genetic mother, who for medical reasons is unable to carry the pregnancy to term.[16] Only in the case where it is not possible to use the genetic material of both the father and the mother, embryo donation is used.[17] Children born from such procedure are not genetically related to their parents and in this regard, they can be compared with adopted children. The difference is that in the case of embryo donation, the parents (particularly the mother) have an opportunity to establish a bond with the unborn child through pregnancy – despite the lack of a genetic bond.[18] Further, it is difficult to discuss ART or surrogacy where the surrogate mother carries a pregnancy that is not genetically related to either the 'intended' mother or father. In such a situation, we are dealing with the adoption of an unborn child, which is regulated in some countries,[19] and in others it is only possible after the child is born.

12 Stępień, 2000, pp. 49–51.
13 Hostiuc et al., 2016, p. 99.
14 Buss, 2019, pp. 198–208.
15 Hamilton, Cheng and Powell, 2007, pp. 109–110; Grotevant and McDermott, 2014, pp. 263–264.
16 Imrie and Jadva, 2014, pp. 432–434.
17 Sauer and Genovese, 2023, p. 472.
18 Navarro-Aresti et al., 2024, pp. 26841–26842.
19 California Courts, 2024.

Thus, genetic community of children with one or both parents, after the use of ART or surrogacy provides the family a beginning point for building a bond and identity. Despite the circumstances, which did not allow for natural pregnancy, there is a genetic relationship between the parents (parent) and children, and in the case of embryo donation, a sense of community that is created during pregnancy. This is an important beginning point for possible couples and family therapy, however, not the only one.

4. The Psychological Situation of Heterosexual Couples Who Cannot Have Children

The decision to have or not to have children is one of the most fundamental choices that people face in their lives. This decision has not only a personal and familial dimension, but also a social, biological, and psychological dimension. When deciding to have children, parents – whether consciously or not – must consider various factors, including biological, psychological, social, cultural, and economic aspects.

Having children is deeply rooted in biology. Evolutionary pressure to reproduce is associated with the instincts of passing on genes and ensuring the continuity of the species. Despite this, modern societies provide individuals several other alternatives to select from, as well as tools to control their fertility. Studies on the influence of biology on the decision to have children display that factors such as age, health, and general physical conditions affect the desire and possibility of having children. An example is the phenomenon of the biological clock, which puts pressure particularly on women, because female fertility decreases after the age of 36.[20]

The decision to have children is also deeply psychological and emotional. It includes complex issues related to identity, a sense of fulfilment, and readiness to assume responsibility for a new family member. Psychological research suggests that motivations for having children may include the need to be loved, to share love, the desire to provide care in old age, or the desire to continue one's name or genetic line.[21] Simultaneously, psychologists highlight the importance of emotions related to the decision to have children, such as fear of losing freedom, concerns about the ability to play the role of a parent, or social pressure. Many people decide to postpone having children because of the desire for self-fulfilment, building a career, or acquiring financial stability.[22] Further, the decision to have children is socio-culturally conditioned. Cultural norms, family traditions, and social expectations can have a

20 The ESHRE Guideline Group on Female Fertility Preservation et al., 2020, p. 8.
21 Miller, 1994, p. 250.
22 Berrington, 2004, pp. 17–18.

strong influence on individuals. In many cultures, having children is considered as a social and moral obligation, which is particularly true for women. In traditional societies, the lack of offspring can be considered as a failure in life and can lead to social exclusion in extreme cases.[23] However, in more liberal and individualistic societies, acceptance of the decision to be childless is growing. In such environments, people have more freedom of choice and less social pressure to start families. There is an increasing discussion on 'voluntary childlessness', that is, a conscious decision to not have children, which is becoming more and more accepted, particularly in developed countries.[24]

Furthermore, economic factors have a significant impact on the decision to have children. The costs of raising a child, including the costs of education, health care, as well as reduced ability to work in the early years of a child's life, may delay the decision to have children. More people are deciding to have children at a later age, attempting to first achieve professional and financial stability. Economists indicate that rising living costs, lack of available housing, and employment instability may be the cause of low fertility in many developed countries.[25]

Therefore, the procreative decision process is complex and multi-threaded. People who decide to have children, most often attempt to become pregnant naturally. This decision is usually associated with hopes and plans. For many couples, it is a moment full of joy, excitement, and ideas about family life. Unfortunately, when attempting to have children takes longer, this initial euphoria can transform into increasing stress, frustration, and anxiety. Couples who struggle to conceive often feel disoriented, and their relationship may deteriorate. The time that passes without success can introduce a sense of uncertainty and tension that affects mental and emotional health. We can even discuss the cycle of hope and disappointment. Each new menstrual cycle is a hope for success, and each subsequent failure brings disappointment. This endless waiting can cause feelings of helplessness and frustration.[26] People struggling with difficulties in conceiving experience significant emotional stress, which can be compared with the stress caused by serious diseases such as cancer.[27] Couples often experience this in different ways: while women may experience more emotional suffering, men may avoid discussing it, which leads to a deepening of differences in the relationship. Long-term difficulties with conceiving a child can negatively affect the couple's relationship. Attempting to have a child often becomes the focus of the relationship, which can lead to neglecting other aspects of the life together. Tensions, guilt, mutual recriminations, and communication problems arise. Some couples experience a decline in the quality of their sexual life when attempting to have a child becomes a duty rather than an expression of closeness. This can lead

23 Inhorn, 2012, pp. 63–90.
24 Garncarek, 2014, pp. 114–115.
25 Blomberg Jensen et al., 2015, pp. 8–9; OECD, 2019.
26 Hoyle, Davisson and Novice, 2022, pp. 405–406; Jiang et al., 2024, pp. 3643–3644.
27 Domar et al., 2000, pp. 568–569.

to emotional isolation and a lack of support in the relationship, which in turn can further increase stress.[28] Failure to have a child can lead to serious health problems, such as depression and anxiety. Infertile people are more likely to suffer from depressive symptoms and anxiety than the rest of the population.[29]

A challenging moment for a couple is deciding when to stop attempting to conceive and whether to pursue alternatives such as adoption, surrogacy, or a child-free life. What happens when a couple decides to have children but discovers after analysis that they are infertile? The most common emotional reactions to a diagnosis of infertility are sadness, depression, stress, disappointment, fear, frustration, disorientation, and loss of self-confidence. Scholars indicate a significant variation in the intensity of emotions experienced; however, a diagnosis of infertility is a significant emotional burden for both patients and their partners.[30] They experience not only the loss of the biological possibility of parenthood, but also the need to revise their life plans and dreams. Infertile people may experience similar stages of mourning to people who have lost loved ones – they go through phases of denial, anger, bargaining, depression, and acceptance.[31]

Losing the ability to have a child is not only a biological problem, but also a challenge to the identity of the individual. In societies where parenthood is strongly associated with social roles, particularly for women, infertility can lead to feelings of personal failure and low self-esteem. Women may feel pressured to meet the expectations of their family and society, which intensifies their suffering. Societal norms regarding parenthood and family have a significant impact on the psychological situation of infertile people. In many cultures, infertility is perceived as a stigma, leading to social exclusion and isolation. In traditional societies where having children is considered the norm, not having children can cause tensions in family relationships and even the breakdown of marriages.[32] Men and women experience this stigma differently. Women often feel greater social pressure, while men may have difficulty expressing their emotions owing to cultural expectations of masculinity. In both cases, infertility can lead to problems in partner relationships, causing emotional tensions, conflicts, and decreased quality of sexual life.[33]

Some people, after a long struggle with infertility, decide to pursue other forms of parenting, such as adoption or using assisted reproductive technologies. These alternative paths are often the subject of intense emotional and social considerations. Others, after exhausting the available alternatives, learn to accept a life without children. This process can be long and painful, however, for many it is the key to regaining inner peace and building a happy life without children. Ultimate acceptance can lead to a sense of fulfilment, particularly if one manages to transform one's life

28 Moura-Ramos et al., 2012, pp. 503–504.
29 Greil, Slauson-Blevins and McQuillan, 2010, p. 147.
30 Boivin et al., 2023, pp. 407–408.
31 Greil, Slauson-Blevins and McQuillan, 2010, p. 141.
32 Inhorn, 2012, pp. 63–90.
33 Moura-Ramos et al., 2012, pp. 503–504.

in a way that brings joy and satisfaction despite the lack of children.[34] If infertile people decide to use ART or surrogacy, they must cope with the entire psychological burden that affects them. Experiencing the stress of infertility will also affect the experience of parenting stress after the birth of the child, which may indirectly affect the functioning of the entire family.[35]

5. Infertility Diagnosis – What Follows? Psychological Support Before, During, and After ART or Surrogacy

Psychological support is a crucial element at every stage of the treatment process – before, during, and after the use of ART and surrogacy. At the initial stage, when people learn about the inability to have children, psychological support plays an important role. The couple must cope with all the negative emotions, shock, and identity crisis and decide how to proceed.[36] Professional support, in the form of individual or couples therapy, can help process emotions and understand how infertility affects the psyche. Couples can discuss their fears and challenges and begin the process of adapting to the new reality.

After advancing to the acceptance stage, couples must decide whether to have children. If they decide to do so, the next major decision is to select from the available alternatives: adoption, ART, or surrogacy. These decisions depend on many factors, listed in the previous subsection. However, in the case of ART and surrogacy, there is an important religious-cultural or more generally ethical aspect. Some religious systems do not accept ART. Depending on how deeply rooted such views are in society, people considering ART methods will experience stress related to being exposed to exclusion and stigmatisation.[37] Therefore, in many cases, people may quit infertility treatment in favour of adoption or quit having children at all. However, social acceptance of ART will be associated with a lower sense of stress in the infertile couple, which will also translate into greater opportunities for institutional and professional support for couples treating infertility.

Couples who decide to undergo treatment with assisted reproductive methods face a choice of one of the methods. This choice is only partly dependent on the couple's preferences, however, is guided to a greater extent by the medical possibilities in a specific case. In extreme situations, the lack of sense of greater decision-making power may negatively affect couples, who may lose their sense of agency; increasingly because different ART methods may be associated with specific challenges,

34 Daniluk, 2011, pp. 444–449.
35 Burgio et al., 2022, p. 48.
36 Greil, Slauson-Blevins and McQuillan, 2010, p. 151.
37 Skrobić and Pucarević, 2021, pp. 151–152.

including emotional ones. Popular alternatives include IVF, intrauterine insemination, the use of donor gametes or embryos, and surrogacy. The IVF process can be lengthy and stressful, as it involves many steps, such as hormonal stimulation of the ovaries, egg retrieval, and embryo implantation. Couples often experience hope and disappointment during the cycles of attempts. Depending on the number of embryos that are successfully retrieved, couples may feel more stressed (few embryos) or less stressed (several embryos) as they can perceive better possibilities with more embryos; and the possibilities decrease after each unsuccessful attempt, which can be a source of stress. Psychological support during IVF treatment can reduce stress and improve treatment outcomes.[38] An additional psychological burden can be the issue of excess embryos if IVF ends successfully. There is no way to predict the number of attempts before implantation ends with birth. For example, if a couple has obtained five healthy embryos and the first implantation was successful, the parents are faced with a dilemma of the remaining four. Potentially, these are four more children, however, are the parents ready for that number? Often, infertility clinics specify in their regulations or contracts with parents that under certain circumstances or when certain conditions are fulfilled, frozen embryos can be donated. When deciding to opt for ART, parents must be aware of this, which is also a challenge.

The choice of surrogacy can bring additional emotions related to control over the pregnancy process and the relationship with the surrogate mother. These relationships are often regulated by agreements between the surrogate mother and the couple, however, various negative emotions or tensions can arise. Couples may feel anxious about not being fully present during the child's development during pregnancy. Psychological support during surrogacy helps not only in the relationship between the couple and the surrogate, but also in coping with feelings of helplessness and uncertainty.[39]

The decision to use donor gametes or embryos brings additional emotional challenges, particularly related to the child's identity and openness about its origins. Couples often face dilemmas related to whether and when to tell the child that they were conceived with the assistance of donor. Studies suggest that transparency and psychological support in this matter contribute to better family functioning and the emotional health of the child. Children who learn about their origins in a timely and open atmosphere develop emotionally better than those to whom this information is revealed late or in an unthoughtful way.[40]

Psychological support before commencing ART is essential, as it prepares the couple for the emotional challenges associated with treatment. Therapy helps not only to cope with anxiety and stress, but also to better understand the process itself. Studies reveal that women who used psychological support before and during ART were more likely to feel less stressed and have a greater sense of control over the

38 Boivin et al., 2023, pp. 407–408.
39 Zadeh et al., 2018, p. 1104.
40 Harper et al., 2021, p. 2.

treatment process.[41] During ART, particularly during IVF cycles, patients often experience many emotions – from hope for success to disappointment and a sense of failure. Each unsuccessful cycle can affect mood, self-esteem, and relationships with the partner. Therefore, psychological support should include strategies for coping with emotions and help in building psychological resilience. Additionally, support groups or group therapy can be a valuable tool, as they allow one to share experiences with other couples who are undergoing similar challenges.

Regardless of the outcome of treatment, psychological support is equally important after the completion of the treatment. In the case of success, that is, the birth of a child, parents often experience post-IVF anxiety, related to concerns about the health of the child and a sense of relief after long-term stress.[42] Psychological support helps to adapt to the new role of being a parent and build a bond with the child. However, not all ART attempts are successful, and failures can lead to intense sadness and even depression. Studies indicate that couples who are not successful after ART treatment often experience a deep emotional crisis, comparable with the loss of a child.[43] Psychological support at this point is crucial to working through this loss and deciding whether to continue treatment or consider other options, such as adoption or living without children.

6. ART and Surrogacy in Same-Sex Couples and Singles

ART and surrogacy methods are also used by same-sex couples and singles, for whom – apart from adoption – they are often the only available means to have children. This also applies to situations when both partners in the couple are healthy. Such couples are in a better position than heterosexual couples because they skip the stage of attempting to become pregnant using natural methods and when deciding to have children, they turn to ART or adoption. Similar to heterosexual couples, ART can be used to maintain genetic kinship with one or both parents. Men usually use gestational surrogacy, in which an embryo created from the donor's eggs and the sperm of one of the partners is placed in the surrogate's body. Alternatively, women use intrauterine insemination or *in vitro*, using donor sperm. Studies indicate that parenthood in same-sex couples is as valuable and has a positive impact on the development of children as in the case of heterosexual couples. However, both parents and their children may encounter challenges resulting from heteronormative social norms that continue to dominate many cultures.[44]

41 Domar et al., 2000, pp. 568–569.
42 Pasch et al., 2012, p. 463.
43 Greil, Slauson-Blevins and McQuillan, 2010, p. 141.
44 Golombok, 2015, pp. 32–69.

Although ART and surrogacy enable same-sex couples to have children, this process is often associated with emotional and psychological challenges that may be different from those of heterosexual couples. The issue of social stigma that same-sex parents may face is at the forefront. In some countries and environments, LGBT+ people may face discrimination owing to their sexual orientation and decision to start a family. This situation can lead to low self-esteem, anxiety about the child's future, and difficulties in social relationships.[45] Same-sex couples may feel pressured to prove that they are 'perfect' parents, particularly in the face of social prejudices. They may feel obliged to be 'better' parents, which can lead to stress, emotional burnout, and excessive self-esteem issues in the context of parenting. Thus, psychological support can help reduce unhealthy expectations towards oneself and learn to cope with external pressures. One of the most difficult aspects is the issue of the child's identity and biological origin. In the case of sperm or egg donors, one of the biological parents is a third party, which may raise questions about whether and how to inform the child about their origins. As aforementioned, in this case too, children who learn about their origins at a young age cope better psychologically than those who learn this later or from whom this information is hidden.

The issue of development of children raised by same-sex couples has been the subject of numerous studies. The results indicate that children raised by same-sex couples develop just as well emotionally, cognitively, and socially as children raised in traditional families. The quality of the relationship with the parents and parental involvement is most important for a child's development, not the structure of the family.[46]

In the case of gestational surrogacy, same-sex couples, particularly men, must cope with the relationship with the surrogate. This unique challenge involves balancing trust in the surrogate with the need to protect one's privacy and parenting role. Psychological support helps manage the relationship with the surrogate, as well as bond with the child in a way that is consistent with the parents' values.

Single people can realise their dreams of parenthood using ART. Changing social norms, greater acceptance of diverse family models, and technological advances imply that more single people are using these methods. The decision to parent alone, using ART or surrogacy is associated with many emotional challenges that are often different from those faced by couples. First, a single person takes this step alone, which is not only associated with a sense of responsibility, but also with the lack of a partner to share the daily responsibilities and challenges of raising a child. For many single people, such challenges can be a source of stress and anxiety, particularly if they lack support from family or friends.[47] Studies suggest that single people, who decide to parent using ART, often have to deal with social pressure and even criticism, which can affect their emotional health. In addition, single mothers and fathers often

45 Ibid., pp. 192–217.
46 Hamilton, Cheng and Powell, 2007, pp. 109–110.
47 Golombok et al., 2016, pp. 415–416; Golombok et al., 2021, pp. 198–200.

experience difficulties related to the division of roles – they simultaneously act as a caregiver, parent, and financial provider, which can lead to burnout.[48]

In families where children are conceived through ART or surrogacy, the family dynamics are specific to the context of single parenthood. A single parent builds a bond with a child without the support of a partner, which indicates that the full responsibility for the emotional relationship with the child falls on one person. Studies on single parents who have used ART demonstrate that family bonds are usually as strong as in the case of two-person families, and children develop well as long as the parent provides them with emotional support and a stable home environment.[49] It is important for a single parent to have a support network in the form of family, friends, or therapists, which can help in coping with emotional and logistical challenges. Children who learn they were conceived through gamete donation or surrogacy may have questions about their biological origins. This is particularly true for children who have no contact with their biological father or mother, if the gamete donor is unknown.

Limited research suggests that children raised by single parents who have used ART do not differ in emotional and social development from children raised in traditional families, as long as they have access to transparent and honest communication about their origins.[50] Single parenting through ART or surrogacy brings social challenges, particularly in more conservative environments. Single people may experience stigma, both for choosing single parenting and for using assisted reproductive technology. Such social reactions can affect their emotional well-being and self-esteem. Therefore, psychological support, as well as social support, is important for single parents. Individual therapy, support groups and therapeutic support can help to cope with social pressures and build self-confidence as a parent. A support network can also include other single parents who have been through a similar journey, which can help to share experiences and strategies for coping with everyday challenges.

Surrogacy is becoming an increasingly accessible option for single people, particularly for single men who want to become biological fathers, however, are unable to conceive. Gestational surrogacy, in which a surrogate mother carries a child created from the gametes of a parent and a donor, allows men to become biological parents without having to have a partner. The family dynamics in such cases often involve questions about the relationship with the surrogate and the biological origins of the child. According to Sophie Zadeh and her team,[51] children raised by single fathers using surrogacy develop well, provided they have emotional support and a stable home environment.

48 Golombok et al., 2021, pp. 198–200.
49 Ibid.
50 Landau, Weissenberg and Madgar, 2008, pp. 581–582; Weissenberg and Landau, 2012, p. 526.
51 Zadeh et al., 2018, p. 1104.

7. Development of Family Ties and the Child's Identity

When a child is born after successful ART, less often in the case of surrogacy, parents must consider whether to inform the child about how it was conceived. Unless this has been specified earlier, for example, in the contract with the surrogate or during embryo donation, it is primarily the parents' decision. Parents may want the child to remain unaware of its genetic origin and want to raise it as if everything was 'normal'. While in the case of heterosexual couples it is relatively easy to hide, in the case of same-sex couples or singles, eventually the child will be aware that it has a different biological parent than the one raising it. In addition, parents who want to hide it from the child risk conflict and a loss of trust of the child in the future if it finds out. Medical considerations are also important, particularly in the case when one of the parents is not the child's genetic parent. In the future, when the child itself is an adult, it may turn out that the genetic parent may have been burdened with certain diseases that do not occur in the target family. Moreover, some medical procedures are more likely to be successful or even possible only with the participation of people who are genetically close. Therefore, knowledge of a child's genetic origins can be a matter of life or death for the child.

Several studies have been published on children born using ART. However, as some have emphasised, the ART population itself is characterised by significant diversity (intracytoplasmic sperm injection – ICSI; *in vitro* fertilization – IVF; pre-implantation genetic diagnosis – PGD; gamete donation; pre-implantation genetic testing). This complicates the possibilities of intergroup comparisons. Simultaneously, as studies indicate, the process of psychosocial maturation of children conceived as a result of the use of ART is comparable with the development of children conceived naturally.[52] The available literature on the socio-emotional development of PGD/ preimplantation genetic screening (PGS) children suggests a normal maturation process.[53] However, the complex reality (e.g. safety of the technique and the psychological burden of genetic histories) requires larger and more similar groups with matched control groups and a multi-informant approach.[54] Thus, any differences, particularly in the teenage period, between children conceived using ART or surrogacy and children conceived naturally will result not so much from the method itself (biological and medical reasons), but from psychosocial and social issues. Particularly from how the environment (including the closest one) in which children grow up approaches the issue of their origin.

An important question in families created using ART is whether the way in which the child was conceived affects the development of family bonds. Studies indicate that the emotional bonds between parents and children in such families are as strong as in families where children were conceived naturally. Moreover, some

52 Winter et al., 2015, pp. 1132–1135.
53 Ilioi and Golombok, 2015, pp. 84–92.
54 Winter et al., 2015, pp. 1132–1135.

studies suggest that parents who had to experience the difficult process of infertility treatment often demonstrate a higher level of parental involvement and care for their children.[55] This appears evident considering the psychological problems that couples with a diagnosis of infertility struggle with. Parenting in ART families involves unique challenges related to parental identity. In cases where gamete donation (sperm or egg) is used, one of the biological parents is a third party. This can raise questions about how to build a parental identity in the context of the lack of a full biological bond with the child. Studies indicate that an essential element in building a healthy parent-child relationship is transparent and honest communication about the child's origins.[56] Children who are conceived through ART or surrogacy may at some point in their lives wonder about their origins. Questions about biological identity may arise particularly in families where gamete donation or surrogacy has been used. These children often ask themselves questions about their genetic identity and how this has affected their identity. They may reflect on and re-evaluate not only their relationship with their parents, but also their relationship with the surrogate. In the case of sperm or egg donors, these questions may concern the biological parent who does not directly participate in the child's upbringing. Children who grow up in families where their origins are openly discussed tend to have healthy coping mechanisms for dealing with challenges related to biological issues.[57] Parent-child bonds develop in a way similar to other families when parents are actively involved in the child's life from the beginning. It is important for the surrogate mother to have clear emotional boundaries and a role in the process, which facilitates easier bonding between biological parents and their child.[58]

Are there differences in the development of children conceived using different types of ART? Scholars report minor differences, however, simultaneously they highlight the limitations of their own studies, which have examined insufficiently large samples or are too diverse to be justified in drawing conclusions about differences.[59] Scholars highlight in particular that the quality of the parent-child/teenager relationship depends primarily on the gender of the parent and the child, as well as on the age and the process of disclosing the method of conception.[60]

55 Golombok, 2015, pp. 192–217.
56 Jadva et al., 2012, p. 3013.
57 Ilioi and Golombok, 2015, pp. 84–92.
58 Zadeh et al., 2018, p. 1104.
59 Ilioi and Golombok, 2015, pp. 84–92; Winter et al., 2015, pp. 1132–1135.
60 Ibid., pp. 84–92.

8. Openness Towards Children in the Context of Their Conception and the Role of Informed Consent

Finally, two issues must be emphasised. The first is the previously mentioned importance of transparency towards children in the context of their conception using ART or donor gametes or surrogacy. Children who learn about their origins in an appropriate manner and in a favourable atmosphere usually develop emotionally in a healthy way. Transparency in family relationships strengthens trust and builds a sense of security. It is important for a child to believe that their parents are honest and ready to answer questions about their conception. Children conceived using ART who are informed about their origins at the right time and in a manner appropriate to their age have better outcomes in terms of mental health and family relationships than those who learn about their origins late.[61]

A significant concern for parents is whether they should inform, and when and how to inform their child about their origins. Studies indicate that the best time to initiate a conversation is early childhood. Preschool children are open to information and treat it as a natural part of their history. Early and gradual discussion about this topic allows the child to integrate this information in a way that does not cause an emotional shock. Children who learn about their origins at a young age cope better emotionally because they have more time to assimilate this information and understand their place in the family. Knowing one's origins from an early age increases a sense of stability and belonging and reduces the tendency to experience identity conflicts. Additionally, it helps to cope better with emotional problems during adolescence. However, a lack of openness can lead to increasing emotional problems. Children who discover the truth about their origins later in life, particularly during adolescence or adulthood, may experience feelings of betrayal, loneliness, and distrust of their parents. The literature describes cases in which late disclosure of information about the child's origin led to emotionally difficult situations and even to the breakdown of family relationships.[62]

The second noteworthy issue is the role of informed consent in assisted reproduction and surrogacy. This is a complex issue, however, extremely important for patients, donors, surrogates, and children who will be born as a result of these procedures. Informed consent is a process in which the patient, gamete donor, surrogate or other persons involved in the ART process express their voluntary and informed consent to participate in each medical process. This includes a full understanding of the procedures, risks, alternatives, and effects, both medical and psychological. Informed consent is not limited to signing a formal document once. It should be interpreted as a process in which reliable and clear communication, as well as ensuring understanding of all aspects that may affect the individual's decision are extremely

61 Ilioi and Golombok, 2015, pp. 84–92.
62 Ibid., pp. 84–92.

important. Legal regulations and contracts should be secondary to psychological and ethical aspects, so that they not only cover the rights, obligations and responsibilities of all parties involved in the processes, but also define clear boundaries that can be referred to in the event of conflict or difficult situations.[63]

The psychological aspects of the entire process are complex and multidimensional, and they involve many people or institutions. Hence, mere knowledge of procedures, consequences, and alternatives is insufficient, and understanding is necessary, otherwise, it is doubtful whether we can discuss informed consent. Understanding legal issues, such as the rights of donors and parents, donor anonymity, and the child's right to information about their biological origins, is also crucial. Studies indicate that the lack of adequate information in the consent process can lead to difficult moral decisions and psychological problems in the future, such as what happens to frozen embryos in the event of a successful IVF procedure.[64]

Informed consent in the surrogacy process concerns primarily the surrogate mother, and subsequently the parents being the commissioners and potentially the gamete donors. Surrogacy involves unique challenges because it concerns the physical and emotional issues related to the pregnancy and the relationship between the surrogate mother and the parents of the child. It is crucial that the surrogate mother is fully aware not only of the physical consequences of carrying the pregnancy, but also of the emotional difficulties that may arise during and after childbirth. This includes understanding issues related to parental rights. For the surrogate mother's consent to be conscious and voluntary, it should be free from any financial or social pressure. It is necessary to ensure that the process does not become a form of exploitation, particularly in countries where legal regulations are weaker and women with a difficult financial situation may be more susceptible to accepting surrogacy offers for financial reasons. Studies suggest that the lack of appropriate protection for surrogates can lead to serious negative emotional and psychological consequences for themselves.[65] Informed consent is not only an ethical requirement, but also a legal one. In several countries, the regulations for ART and surrogacy are clearly defined to protect all participants in the process. In the case of surrogacy, there are different legal approaches. In some countries (e.g. the UK), commercial surrogacy is prohibited, while altruistic surrogacy is strictly regulated. In other countries, such as India or Ukraine, commercial surrogacy is legal, however, this leads to serious problems related to the protection of surrogates' rights, which increases the risk of their exploitation. Ethicists emphasise that the protection of surrogates' and gamete donors' rights must include not only appropriate legal provisions, but also psychological, medical, and legal support before, during, and after the procedures. Therefore, informed consent in ART and surrogacy should be a process that ensures

63 Oakley, 1992, pp. 269–270; Perrotta and Hamper, 2023, p. 238.
64 Gürtin, Ahuja and Golombok, 2012, pp. 700–706; Takahashi et al., 2012, p. 10.
65 Teman, 2010, pp. 184–204.

that all parties are fully informed about the possible consequences and have the possibility to withdraw at any stage of the process.[66]

It is important to remember that the children who will be born also participate in the entire process. For evident reasons, they cannot give their informed consent, which raises ethical issues regarding the child's right to know about their biological origins, particularly in the context of gamete donation and surrogacy.[67] In some countries, upon reaching the age of majority a child has the right to find out who their biological parents are. Parents and surrogates must be aware of possible questions that may arise in the future regarding the child's identity. Understanding that current decisions may have long-term consequences for the child is important regarding informed consent and the ethical conduct of the entire process.[68]

9. Summary

The psychological condition of children, parents, and surrogates is complex, and as presented, encompasses several aspects. The diagnosis of infertility and the requirement for treatment often leads to stress, a sense of loss, and various emotional challenges that can profoundly impact relationships within a couple and the family. However, the process of ART or surrogacy provides possibilities to fulfil the dream of parenthood, although not without challenges, such as genetic or biological community, or the relationship with the surrogate. This chapter presents various areas that require psychological support, which should accompany couples and single people at every stage of the process – before, during, and after the use of ART or surrogacy. It also indicates the specific difficulties faced by same-sex couples and single people who decide to parent using these technologies. In this context, it must be emphasised that family relationships and emotional bonds in such families are as strong, and children develop as well as in traditional families, as long as appropriate psychological and social support is provided. Children born through ART or surrogacy may struggle with questions about their origins, particularly in the case of gamete donation. An important aspect here is transparent communication with children about their conception. Studies indicate that transparency towards children in the context of their origins strengthens family bonds, rendering it easier for children to integrate information about their biological origins with a sense of their own identity.

In summary, assisted reproductive technologies and surrogacy have changed the contemporary understanding of parenting, enabling new forms of families. However,

66 Ethics Committee of American Society for Reproductive Medicine, 2014, p. 333.
67 Rocha et al., 2023, p. 199.
68 Golombok, 2015, pp. 192–217.

with these changes, complex psychological challenges have emerged that require special attention. Understanding the emotional needs of families, supporting open communication, and ensuring informed consent at every stage of the process are crucial for the proper functioning of these families. With appropriate psychological support and education, families created through ART and surrogacy can experience harmonious development and a fulfilled life. Knowing the psychological complexity of the entire situation will allow for better organisational, institutional, and legal actions in the future, which will be focused on the understood well-being of the child.

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Chapter 4

Croatia: Struggling for the Best Interests of the Child and Assisted Reproduction Technologies

Aleksandra Korać Graovac

Abstract

The article deals with the legal regulation of medically assisted reproduction (MAR) and the origin of the child conceived by MAR in Croatia.

The first legal provisions regulating medical aspects date back to 1978, and the first legal act dedicated entirely to MAR was enacted in 2009 and amended in 2012 bringing a more liberal approach, concentrating on the best interests of the child as one of the underlining principles of the legal regulation. Among others, legislation protects the right to health, the right of a donor-conceived child or person to know his/her origins, the right to privacy, and the right to be cared for by both parents. The embryo enjoys some kind of protection (ban on experiments, creation chimeras, restriction of creating too many embryos, creation of embryos solely for donation…), but not entirely.

Intended parents, as patients, also enjoy the protection of their rights, but with some restrictions owing to the possibility of being beneficiaries of Assisted Reproductive Technology (ART), such as personal status, age, capability to exercise parental responsibility, etc.

In practice, even though heterologous assisted reproduction technologies are permitted, no donor programmes exist, so couples seek medical help abroad, supported financially by the State Health Insurance.

Aleksandra Korać Graovac (2026) 'Croatia: Struggling for the Best Interests of the Child and Assisted Reproduction Technologies'. In: Aleksandra Korać Graovac (ed.) *The Best Interests of the Child Conceived by ART – Law in Book and Law in Action*, pp. 113–147. Miskolc–Budapest, Central European Academic Publishing.

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Keywords: medically assisted reproduction, assisted reproduction technologies, the rights of the child, the best interests of the child, donor-conceived children, reproductive rights

1. Introduction

The history of assisted reproduction in Croatia is rich and effective. The success story began at the Clinic for Women's Diseases and Childbirth in Petrova at Peter's Hospital in Zagreb, in 1953, where the anti-sterility programme was introduced. According to the observation of respected Croatian medical doctor, Professor Velimir Šimunić, initially the chances for anti-sterility procedures were very modest, and they dominantly dealt with the consequences of inflammation. Subsequently, the global progress in gynaecological endocrinology and reproductive medicine brought an immense change in making *in vitro* fertilisation (IVF) possible.[1] Edwards and Steptoe gained an international fame developing the technique leading to the birth of the first test tube baby in 1978. The birth of the famous first *in vitro* conceived child Louisa Brown, was followed by *in vitro* conceived births in Australia in 1980, in the USA in 1981, in Germany, Austria and France in 1982, and in 1Belgium, Canada and Croatia in 1983. Thanks to the avid efforts of Croatian embryologists and gynaecologists, Robert, the first *in vitro* conceived child in Croatia was born in 1983, causing sensational success.[2]

Legislation in Croatia followed medical science with a delay, so in 1978 the first provisions on medically assisted reproduction were introduced in a more general act that regulated issues related to reproduction.[3] Three decades later medically assisted

1 Obstacles for successful modern infertility healing were numerous, as 'without material help, expensive equipment, and with numerous obscurities and unknowns in the process, there was scepticism about the final success. At that time, each laboratory created a recipe for the embryo feeder, and the details of the procedure were kept secret. The success rate of treatment was only 5–7% and there were few centers with proven success. Knowledge was reluctantly transferred, education was often expensive and waiting lists for training in the area were long'. Šimunić, 2023, p. 379.

2 Ibid., p. 381.

3 Act on Medical Measures for Exercising the Right to the Free Decision on Giving Birth to Children (*Zakon o zdravstvenim mjerama za ostvarivanje prava na slobodno odlučivanje o rađanju djece*) Official Gazette, No. 18/78.

reproduction (hence after MAR)[4] was regulated by an act dedicated solely to the regulation of MAR,[5] and was replaced by a new act in 2012 that modernised assisted reproductive technologies and enabled extra-marital couples to seek medical help.[6]

MAR procedures are not without controversies, due to the diverse interests of the participants. Intended parents desire to establish a family, children have their rights as human beings and the rights they enjoy as children, third parties (donors and surrogate mothers) have their specific interests (mostly to remain anonymous and receive some reimbursement for their services), and medical clinics that perform MAR to achieve the highest possible success and to get paid for their services.

Public interest in how MAR is regulated is also significant, as specific technologies have to be accepted in order to be regulated or silently sanctioned in national legislation, as some MAR technologies are ethically controversial (such as surrogacy, donor issues, *post-mortem* insemination, choice of beneficiaries, genetic embryo screening, etc.).

The ultimate objective of MAR technologies is the birth of a healthy child. Several individuals and couples seek medical help for various reasons, so when the state denies intended parents access to MAR, their human rights might be infringed and be considered by constitutional and international courts.[7] The court's task is, among others, to balance the different rights at stake.

Legal regulation of assisted reproduction technologies is closely linked to social values, which makes policies and legislative choices even more difficult, as we live

4 Medically assisted reproduction is 'reproduction brought about through various interventions, procedures, surgeries and technologies to treat the various forms of fertility impairment and infertility. These include ovulation induction, ovarian stimulation, ovulation triggering, all ART procedures, uterine transplantation and intra-uterine, intracervical and intravaginal insemination with the semen of husband/partner or donor'. Assisted reproduction technology (ART) are 'all interventions that include the *in vitro* handling of both human oocytes and sperm or of embryos for the purpose of reproduction. This includes, but is not limited to, IVF and embryo transfer ET, intracytoplasmic sperm injection ICSI, embryo biopsy, preimplantation genetic testing PGT, assisted hatching, gamete intrafallopian transfer GIFT, zygote intrafallopian transfer, gamete and embryo cryopreservation, semen, oocyte and embryo donation, and gestational carrier cycles. Thus, ART does not, and ART-only registries do not, include assisted insemination using sperm from either a woman's partner or a sperm donor. (See broader term, medically assisted reproduction, MAR)'. Zegers-Hochschild et al., 2017, p. 1796.

5 Act on Medical Assisted Procreation (Zakon o medicinski potpomognutoj oplodnji), Official Gazette No. 88/2009. This act was drafted for a period of more than ten years, as it included the regulation on in vitro fertilisation.

6 Medically Assisted Reproduction Act, Official Gazette No. 86/2012. (cited as the MAR Act).

7 The European Court for Human Rights considers that some aspects of MAR falls within scope of Art. 8. The right to (assisted) procreation is not an absolute right, as the European Court refers to the moral and ethical sensitivity of the subject of assisted procreation and the little consensus between the Contracting States. It acknowledges a wide margin of appreciation to the Contracting States to shape their laws, balancing the interests at stake. Spaander, 2022, p. 469.

in a pluralistic, postmodern society: not all values are shared by every member of society. Certain things acceptable for some individuals is a moral hell for others. Legislators need to find common core values and design appropriate legal solutions. This demand is hard to achieve, and the situation makes the demand for considering the best interests of the child principle even more complicated.

The best interests of the child can be interpreted in several ways, depending on the system of values of the construing person, using legal argumentation. Although it is almost impossible to find the final answer, particularly in bioethics[8] (which also includes MAR), it is necessary for developing the appropriate legal regulation that is applicable to a particular society.

This article will reassess the national legal regulation of medically assisted reproduction, the social environment and the best interests of the child conceived through MAR.

2. Social Environment and MAR in Croatia

Croatia is a traditional, Mediterranean country.[9] Family plays a vital role in the private lives of individuals.[10] The influence of the Catholic Church is still quite strong in both politics and society.[11] Theologians strongly oppose medically assisted reproduction, considering it as a departure from the natural way of the procreation of the child (as a form of a natural union of spouses),[12] but the interests of infertile couples to receive medical help still predominate in public attitudes.

There is no surprise that legislation from the late seventies was restrained and concentrated on 'artificial insemination'. The Act on Medical Measures for Exercising

8 'Bioethics, a branch of applied ethics that studies the philosophical, social, and legal issues arising in medicine and life sciences. It is chiefly focused on human life and well-being, although occasionally it also treats deals with ethical issues relating to the nonhuman biological environment'. Chadwick, 2024.

9 Korać Graovac, 2021.

10 In the project titled 'European Study Values' in 2017, 98.47% of individuals surveyed found the family to be important or very important in their personal life. In the same project, 75.5% of the surveyed persons in Croatia stated that to grow up happily required that the child have a mother and a father. Aračić, Baloban and Nikodem, 2019, p. 336; 337. The original study was carried out in 4 waves in a certain number of European countries.

11 Bremer, 2010.

12 'Additionally, these interventions could make possible, for example, for a child to be born without the father's knowledge, or after both parents are deceased, by a surrogate mother who can at the same time be the child's genetic sister or grandmother'. 'Along with the encyclical Evangelium Vitae, we remind you that human life starts at the moment of conception and as such, it needs to be protected instead of being created in a way unfitting to its dignity, used for objectionable purposes, and later destroyed as excess material'. Statement by the Justice and Peace Commission of the Croatian Bishops, in For the Sake of Justice and Peace, 2009, pp. 325–326.

the Right to Free Decision on Giving Birth to Children[13] regulated just the medical aspects of assisted reproduction by five articles.[14] As at the time only artificial insemination was known, artificial insemination by husband (AIH) and artificial insemination by donor (AID) were regulated. Only a married couple could request medically assisted reproduction, if the intended parents were not able to have children otherwise. This restrained regulation was not able to follow the progress in medical science, so it needed to be replaced by the act dedicated solely to assisted reproduction.

Although the legislation was not comprehensive, medical institutions in that time applied AIH, AID and *in vitro* fertilisation with the gametes of the couple, gamete intrafallopian transfer (GIFT) with the gametes of a couple, the storage of semen and of embryos (according to a questionnaire from 1994). Medical institutions strived to replace the existing legal regulation by introducing their own rules; some of them were formulated by hospitals' ethic committees. This situation provoked the need for more legal certainty for patients.[15]

National legal literature at the beginning of the nineties (after the birth of the first child conceived *in vitro*), pointed out that the first medical infertility procedures raised numerous ethical and moral doubts, and the general public reactions ranged from sharp disapproval to uncritical acceptance and enthusiasm.[16]

A couple of years later, in the beginning of the twenty-first century, it was evident that there was an increasing interest in the legal regulation, meaning that intended parents wanted to have as many medical procedures as possible to assist them in becoming parents. Additionally, there was a pressing need to secure the protection of the welfare of children conceived with medical help (in respect of their origin and emotional stability), and to prevent the possible abuse of medical proceedings (including the trade of gametes or already-born children).[17]

In 2009 the first comprehensive legislation was introduced – the Act on Medically Assisted Procreation.[18] Some gynaecologists strongly opposed the new legislation, advocating for a much more liberal approach, characterising the period following

13 Act on the Medical Measures for Exercising the Right to Free Decision on Giving Birth to Children, Official Gazette Nos. 18/78, 31/86, 47/89, 88/09). That act regulated some important aspects of human reproduction: voluntary abortion, sterilisation and artificial insemination. It is still in force, except for human reproduction. The name of this act reflected the right according to which each and every person had the right to free decision about giving birth to children. That right was laid down in Art. 272 of the Constitution of the former Socialist Republic of Croatia of 1974 (Constitution of the Socialist Republic of Croatia, Official Gazette 8/1974).

14 Arts. 29–34.

15 In the year 1993/1994 318 children were born through medically assisted procreation: 98 children by artificial insemination by the husband, 26 children by artificial insemination by the donor, 190 children through in vitro fertilisation with the couples' gametes and 4 children by gamete intrafallopian transfer. Korać, 1999, p. 231.

16 Alinčić, 1994, p. 203.

17 Hrabar, 2001, pp. 219–220.

18 Act on Medically Assisted Procreation, Official Gazette Nos. 88/09, 137/09, 124/11, 125/11, 86/12.

the introduction of this act as 'dark age of ART',[19] but the Act on Medically Assisted Procreation (2009) was nevertheless drafted and initiated by medical professionals as well.

Public opinion was divided, especially regarding the creation of potentially surplus embryos.[20]

On the occasion of a bitter public debate on the draft proposal of the Act on Medically Assisted Reproduction (2012), Children's Ombudswoman reacted, calling for tolerance in the debate: 'Inappropriate statements were expressed during the public debate on the proposal of the Act on Medically Assisted Reproduction, so Ombudswoman for Children Mila Jelavić reacted: All children are equal, regardless of the way they had been conceived and came into the world'.[21]

A decade later, during the European Study Values research in 2017, when asked about the extent they approved of 'artificial insemination', 42.2% answered 'always' and 27,2% answered 'almost always', i.e. a total of 69.4% of respondents, and 8.3% answered 'never' and 6.8% 'almost never', i.e. a total of 15.1% of respondents, while 15.4% of respondents were neutral. There was no significant difference between the sexes in approving or disapproving 'artificial insemination' in this research.

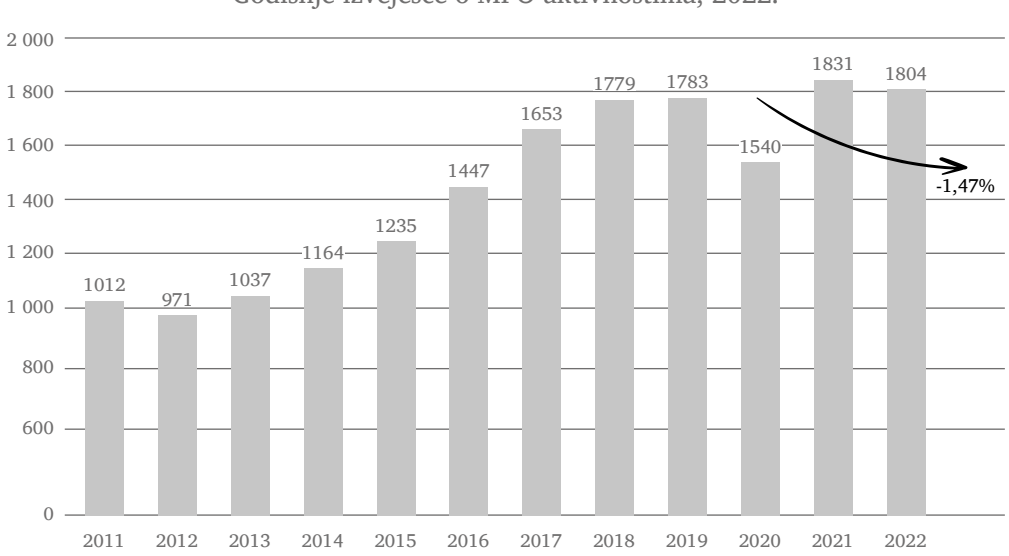
Irrelevant of public attitudes, medicine has been making constant progress. Medical experts emphasise that 'according to the Global Clinic Rating, Croatia is among the first 20 or so countries in terms of success'. Today, in 16 IVF centres in Croatia, 6000–7000 procedures of medically assisted fertilisation are performed annually, and 1600–1800 children are born. This is a significant 5% contribution to the decreased birth rate in Croatia. From the initial 5%, the overall success rate in recent years has reached 30%. During the 40 years of treatment with ART, 40 000 children

19 They complained because of 'unnecessary difficulties for patients and being denied the gold standard of treatment, as well as forcing medical professionals to adopt an unprofessional, unethical, and uneconomic approach to ART'. Further complaints were exposed, such as the restriction of fertilisation to maximum three oocytes, the prohibition of embryo freezing, the anonymity withdrawal for gamete donation, the discrimination against specific subgroups of patients based on sexual orientation and the mandatory psychological and legal counselling required prior to ART infertility treatment. Radončić, 2023, pp. 75–76.

20 Following a more liberal legislation in 2012 that permitted the cryopreservation of embryos, some Croatian citizens joined the initiative 'I was an embryo too', attempting to prevent legislation that would create surplus embryos. Čartolovni, Casini and Spagnolo, 2014.

21 The trigger was the regulation of new possibilities – the cryopreservation of embryos, and as a consequence, the creation of surplus embryos. 'First of all, we point at a statement that speaks of the need to sacrifice ten brothers and sisters to have one child'. A child born using the method of medically assisted reproduction is directly incriminated with the rhetoric of 'responsibility' for the destruction of innocent sisters and brothers and creates a negative image about his/her parents, which we consider absolutely unacceptable. Also, the development of a negative attitude towards children born this way may be encouraged in the general population and among other children. We condemn any inappropriate speech about children and appeal to the members of political parties, associations, and individuals to bear this in mind during their reactions and discussions that are heard and observed by children, who are important members of our society, and who, due to their developmental characteristics, deserve special protection and the considerate attitude of adults. See dijete.hr, 2012.

have been born in Croatia, and about 18 000 at the Petrova Clinic in Zagreb (till 2023). Only from 2015–2022, during the span of seven years, 12 000 children were born in Croatia thanks to the medically assisted fertilisation treatment.[22]



Graph No. 1
Number of children born through MAR 2011–2022 in Croatia[23]

The European Atlas of Fertility Treatment Policies (2024 Edition),[24] published by the Fertility Europe in collaboration with the European Parliamentary Forum for Sexual and Reproductive Rights[25] scores 49 countries and territories on access to equal, safe and efficient fertility medical treatments. It evaluates three criteria: legal regulations on access, public funding/reimbursement and patients' perspective,[26]

22 Šimunić, 2023, p. 381.
23 Ministarstvo zdravstva Republike Hrvatske, 2022. Graph redesigned by the author.
24 European Atlas of Fertility Treatment Policies, 2024.
25 The European Parliamentary Forum for Sexual and Reproductive Rights is a network of Members of Parliament throughout Europe committed to protecting the sexual and reproductive rights (SRHR) of all people, both at home and overseas. The Secretariat is based in Brussels.
26 Perfect country criteria are: legislation (dedicated ART laws for stable access), data management (National registers for MAR treatments and for donors), inclusive access (treatments and donor services are available to all who need them), genetic testing (access to genetic testing for embryos), transparency (non-anonymous donation with donor identity revealed to children), funding (full treatment funding for 4 IUIs and 6 IVF/ICSI cycles nationwide), support services (funded psychological support as part of the fertility treatments), consultation (policymakers consult patient associations on policies and legal changes), education (state-organised and funded fertility education programmes). Fertility Europe, European Atlas of Fertility Treatment Policies, 2024.

with a remark that the success of MAR is not the criteria of this evaluation. Croatia holds a high, eleventh position on this Atlas, accompanied closely by Hungary, Iceland, Germany and Spain.[27]

Various ethical problems came to light in public debates in connection with MAR technologies: *in vitro* technologies as such, heterologous technology (particularly the donation of *ova* and embryos), the choice of embryos, the cryopreservation of embryos, the destroying of cryopreserved embryos and surrogacy. Social policy discourse commenced as to who the beneficiary of MAR (*vide infra*) could be. Possible future issues in Croatia can also be foreseen regarding the 'three-parent technique',[28] the usage of artificial human sex cells,[29] and several others.

3. The Constitutional Framework

Human rights are strongly connected to reproductive rights, which may be overlapping and at times inseparable. Positive aspects of reproductive rights, such as the right to procreate, are often in the second row compared to the issue of abortion or access to contraception. The possibility of using ART and benefiting from ART come closest to the right to health, although there are debates about the issue.

Provisions of the Constitution of the Republic of Croatia[30] that are applicable to human rights issues related to ART are: (a) the right to healthcare,[31] (b) non-discrimination,[32] (c) the right to dignity and the right to privacy,[33] (d) the right to consciousness,[34] (e) the right of ownership,[35] (f) the right to life,[36] (g) the protection of children.[37]

27 European Atlas of Fertility Treatment Policies, 2024.
28 Schafer and Labude, 2017.
29 Hanzelou, 2022.
30 The Constitution of the Republic of Croatia (*Ustav Republike Hrvatske*), *Narodne novine* Nos. 56/90., 135/97., 8/98. – officially consolidated text, Nos. 113/00., 124/00. – officially consolidated text, Nos. 28/01., 41/01. – officially consolidated text, Nos. 76/10., 55/01. – officially consolidated text, 5/14., 85/10. – officially consolidated text. Translations of provisions in further footnotes: official translation of the Croatian Parliament. See sabor.hr, 2010.
31 Art. 58: 'Everyone shall be guaranteed the right to healthcare in accordance with law'.
32 Art. 14: 'All persons in the Republic of Croatia shall enjoy rights and freedoms, regardless of race, colour, gender, language, religion, political or other conviction, national or social origin, property, birth, education, social status or other characteristics. All persons shall be equal before the law'.
33 Art. 35: 'Respect for and legal protection of each person's private and family life, dignity, reputation shall be guaranteed'.
34 Art. 40: 'Freedom of conscience and religion and the freedom to demonstrate religious or other convictions shall be guaranteed'.
35 Art. 48 (1): 'The right of ownership shall be guaranteed'.
36 Art. 21: 'Each human being has the right to life'.
37 Art. 65: 'Everyone shall have the duty to protect children and infirm persons'.

The right to healthcare is the pillar stone of reproductive rights, especially when a couple suffers from infertility. The right to healthcare is anchored in the determination of the Republic of Croatia as a social state.[38] Some experts argue that only medical infertility should entitle a couple or an individual to seek medical treatment. The World Health Organization defines infertility as

> a disease of the male or female reproductive system defined by the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse. Infertility may occur due to male, female or unexplained factors. Some causes of infertility are preventable. Treatment of infertility often involves in-vitro fertilisation (IVF) and other types of medically assisted reproduction.[39]

Thus, 'social infertility' or infertility due to the lack of a partner of the opposite sex would not lead to a medical cure facilitating assisted technologies.

This viewpoint leads to the issue of who is entitled to MAR procedures (a married or non-married heterosexual couple, registered homosexual partners, non-registered homosexual couples, a single woman with or without health issues, transgender persons etc.). These questions could raise the problem of discrimination concerning the status of a beneficiary. Croatian legislators opted for heterosexual married or non-married couples or a single woman who is not capable of conceiving a child due to her medical condition. Some complaints were raised about this decision, but the Constitutional Court of Croatia evidently decided to wait for the decision of legislators and instead of making the decision itself.[40]

38 Art. 1 of the Constitution; Smerdel and Sokol, 2005, p. 152.

39 World Health Organisation, 2024.

40 There were several requests to examine the constitutionality of acts that regulate medically assisted reproduction, but the Constitutional Court has never decided on merit. Some requests are staying in a drawer of the Constitutional Court, and the ex-president of the Constitutional Court of Croatia, Prof Jasna Omejec, (after the first comprehensive act on MAR was enacted in 2009) referred to the extremely negative attitude of the public, and many media reports that this practice must be overturned. Omejec, 2009.

Although an unborn child is not a person, it does have certain rights; for example in medicine, an unborn child is treated as a patient or in case of inheritance rights the *nasciturus* rule applies.[41]

The dignity of a human being is associated with the potential misuse of embryos[42] (and the interpretation of what misuse is). It is reflected in the preference of permitted assisted reproduction techniques (*vide infra*).

The right to privacy may be at risk when it comes to the non-anonymity of donors and, consequently, when the question of the right of the child to know his/her identity comes to the forefront. Besides the non-anonymity of the donor, 'all persons involved in the MAR procedure are obliged to keep all personal and health data of women, men, and children conceived in the procedure of medically assisted reproduction (professional secrecy)'.[43]

The right to conscientiousness is granted to medical staff by virtue of Art. 44 of the MAR Act, as healthcare and non-health professionals who should carry out or participate in medically assisted reproduction procedures have the right to invoke conscientious objection arising from their ethical, religious or moral views or beliefs and to refuse to perform or participate in medically assisted reproduction procedures.

The right to property is questionable as gametes might be considered as being in the ownership of gamete providers (intended parents or donors). Contrary, the European Court for Human Rights pointed out in *Parillo v. Italy*[44] case: 'Concerning Art. 1 of Protocol No. 1 (protection of property), the Court considered that it did not

41 Some medical doctors in Croatia consider foetus as a patient, for example Kurjak, 1991, and some adopted the dual-patient theory: 'From the discussion on the ethical status in general and on the ethical status of the pregnant woman and the foetus, as well as from the discussion on asymmetric ethics and the multidisciplinary-multiperspective approach to the problem of attitude towards life, it is concluded that the pregnant woman/woman and the foetusfoetus should be treated as two patients. However, it is important to point out that we are dealing with two patients of unequal status, that is, one moral subject and one moral object, whereby the first patient (who is the moral subject and object of the medical procedure) has priority over the second patient (who is the moral object and the object of a medical procedure). Since the status of the first patient is higher, regardless of the principle of respect for the status, interests and rights of the second patient, in conflict situations priority should always be given to the first patient, including the right of the first patient to decide on the fate of the second, considering the specific situation of these two entities'. Jurić, 2016.

42 Hrabar, 2007, pp. 40–41; Turković and Roksandić Vidlička, 2011.

43 Art. 45, para. 1 The MAR Act.

44 *Parillo v. Italy (GC)*, Application No. 46470/11, judgement 27 August 2015.

apply to the present case, since human embryos could not be reduced to 'possessions' within the meaning of that provision'.[45]

The right to life belongs to every human being. In the context of MAR may it be questionable if this right is possessed by an embryo. It is quite clear that human life begins with the fusion of female and male gametes – i.e. with fertilisation.[46]

The Constitutional Court of Croatia so far has not decided *in meritum* on the constitutionality of the provisions of the Act on Medically Assisted Reproduction[47] (although some media reported on the requests to assess its constitutionality).

The Constitution of the Socialist Republic of Croatia had a provision in place on the right to decide freely on the giving birth to a child,[48] along with Art. 191 of the Constitution of the Socialist Federative Republic of Yugoslavia.

The proclamation of the right to the free decision on giving birth to children could create a strong argument for the 'pro-choice' movement that this right should be unconditionally formulated in other legal acts. Since in 1990, it was not clear which political forces would develop the new legislation, the authors of the Croatian Constitution did not intend to predict the content of future laws, especially liberties or restrictions concerning abortion.

Although there is no constitutional provision that protects reproductive rights directly, Croatia is bound by the Convention on the elimination of all forms

45 German legal theory expressed another view: 'Although the body of a living human being is not a hing, its component parts themselves become things after they have been separated or removed. …. So sperm cells and eggs are things that are owned by a man and woman. With the fertilisation of the egg cell by a sperm cell both are joint owners according to the legal concept of Sec. 947 para. 1 *Bürgerliche Gesetzbuch* own 2-PN cell. Anyone who intentionally damages or destroys the 2-PN cell can be sued, on the grounds that the person damaged the property and committed a criminal offense in accordance with Sec. 303 of the Criminal Code' (translation from Germany by the Author) 2-PN cell is early, the 2nd day stage of the development of an embryo. Börger and Frister, 2010, p. 2. But, in case of the death of one of the genetic parents, the right to demand the return of the fertilised egg is not a property right that can be inherited, but rather a sui generis, a highly personal right. The partner cannot therefore inherit such a claim and therefore cannot assert such a claim alone. Who the owner of the embryo after the death of a patient is still not quite clear.

46 In 'the abortion-decision' of the Constitutional Court of the Republic of Croatia (Official Gazette No. 25/2017) the Constitutional Court asked for the opinion of a leading gynaecological clinic in Croatia (Petrova Clinic). 'In the opinion of the internal management of the Clinic for Women's Diseases and Obstetrics (...) it is stated that they unanimously concluded that life begins with the fusion of male and female gametes'. (para. 5.7.) In legal theory, the question was raised: 'Can advanced medical methods, with the use of high technology, support the birth of children and under what conditions? This question is being asked in many countries today and dominates the debate in Croatia'. Smerdel, 2020, p. 334.

47 There is only one decision on the inadmissibility of the complaint instigating proceedings for the assessment of constitutionality of the MAR Act 2012 (U-I-5640/2016, decision of the 9th of October 2018). Praksa Ustavnog Suda Republike Hrvatske, 2024.

48 Art. 272: 'It is a human right to decide freely on giving birth to child. This right may be restricted only for the protection of health'. (translation of the author). Constitution of the Socialist Republic of Croatia (*Ustav Socijalističke Republike Hrvatske*), Official Gazette No. 8-86/74. There is a possibility that the Constitution of the Republic of Croatia deliberately bypassed such a difficult issue as abortion. Hrabar and Peročević, 2023, p. 907.

of discrimination against women.[49] This Convention is a ratified international agreement, and as such by virtue of Art. 134 of the Constitution, the source of law at the domestic level. The Convention guarantees women: 'The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights'.[50] That means that women in Croatia still have the right to decide on the number and spacing of their children, and that future Croatian law will have to be in accordance with this right (although it is not a constitutional right and is not an absolute one).

4. Current Legal Regulation on the Medical Aspects of MAR

Generally, the rights and duties of individuals as patients are regulated by the Healthcare Act,[51] the Act on Mandatory Health Insurance,[52] and the Patients' Rights Protection Act.[53] The more specific regulation on the medical aspects of MAR is the content of the Act on Medically Assisted Reproduction (the MAR Act).[54]

According to Art. 1 of the Healthcare Act, 'healthcare shall include a system of social, group and individual measures, services and activities for health maintenance and improvement, disease prevention, early disease detection, timely treatment and medical care and rehabilitation'. According to Art. 2: 'Everyone shall be entitled to healthcare and to the possibility of the attainment of an optimal health level under the provisions of this Act and the Mandatory Health Insurance Act'.

It is the duty of every person who acquired legal capacity to take actions to maintain and improve his/her health and to avoid any risk factors that might jeopardise his/her life and health.[55]

The State Health Insurance Fund covers MAR treatments. Treatment of infertility through the MAR procedure funded by the Croatian Health Insurance Fund includes four attempts at intrauterine insemination (IUI) and six attempts at *in vitro*

49 UN General Assembly, Convention on the Elimination of All Forms of Discrimination Against Women, 18 December 1979, United Nations, Treaty Series, vol. 1249, p. 13.

50 Art. 16, para. 1e.

51 The Healthcare Act (*Zakon o zdravstvenoj zaštiti*), Official Gazette Nos. 100/18, 125/19, 133/20, 147/20, 136/21, 119/22, 156/22, 33/23, 145/23, 36/24).

52 The Act on Mandatory Health Insurance (*Zakon o obveznom zdravstveno osiguranju*), Official Gazette No. 33/23.

53 The Patient Rights Protection Act (*Zakon o zaštiti prava pacijenata*), Official Gazette Nos. 169/04 and 37/08)

54 The Medically Assisted Reproduction Act (*Zakon o medicinski potpomognutoj oplodnji*), Official Gazette, No. 86/12. In text: the MAR Act.

55 Art. 27, para. 2 of the Healthcare Act.

fertilisation (IVF), with the obligation that two attempts be performed in a natural cycle.[56] A number of covered attempts are in line with the warning that overstimulation may trigger the risk of developing cancer at a later stage.[57]

The Patients' Rights Protection Act regulates who the patient is, and evidently, the beneficiary of the MAR procedure enjoys a patient status. A patient is considered to be any sick or healthy person who requests or is provided with a certain type of caretaking for the purpose of preserving and improving his/her health, preventing diseases, treatment, care and rehabilitation.[58] The status of a patient as the beneficiary of MAR treatments, as a couple or a woman who is not able to conceive naturally, and who had previously been unsuccessfully treated for infertility, for which he/she decided to undergo a medically assisted reproduction procedure.[59]

The principles of accessibility and humanity are basic principles of the Patients' Rights Protection Act. The first principle should ensure that all citizens, under equal conditions, undergo the MAR treatment.[60] This provision requires a standard that should be achieved, and even though all authorised medical clinics should ensure the same standard, it is not always the case, especially in demanding bio-medical reproductive technologies. In 2024 seventeen authorised medical institutions in Croatia offered MAR treatments: nine of them are public and eight of them are private.[61]

The MAR Act regulates the medical aspects of procedures, the beneficiaries of MAR, the rights and obligations of donors and the cryopreservation of gametes and embryos, the procedures of the MAR technologies, the prerequisites for the use of gametes, the method by which the medical technologies are operated, including different bans, authorised medical clinics, the National Commission for the Medically Assisted Reproduction, the functioning of the state registry for MAR, state supervision, and the provisions on misdemeanors during the performance of the MAR technologies. The act includes 64 comprehensive and coherent provisions.

Family law regulates the establishment of the origin of a child in the Family Act[62] (*vide infra*).

56 Art. 10 of the MAR Act. Some municipalities co-finance further medically assisted reproduction attempts in the amount of 40 to 80% of the entire cost; these financial supports are provided with the aim of increasing the birth rate. For Osijek see Decision on co-financing the costs of medically assisted reproduction in 2024, Official Gazette of City of Osijek, No. 3, 26. February 2024. See osijek.hr, 2024. Korać Graovac, 2024, p. 110.

57 'Due to the large number of studies, high doses of the ovulation-stimulating drugs and their repeated use with this method can increase the risk of the ovarian hyper stimulation syndrome (OHSS), and ovarian cysts, which can lead to ovarian cancer'. Fahrud et al., 2019.

58 Art. 1, para. 2.

59 Art. 4, para. 1 of the MAR Act.

60 Art. 5.

61 Register of authorised medical clinics – medically assisted reproduction (*Registar ovlaštenih medicinskih ustanova – medicinski pomognuta oplodnja)*. See zdravlje.gov.hr, 2024.

62 The Family Act (*Obiteljski zakon*), Official Gazette Nos. 103/15, 98/19, 47/20, 49/23 and 153/23.

The Criminal Code[63] also has certain provisions concerning MAR issues. It penalises the illicit trading of parts of the human body, including human tissues, gametes, embryos, or foetuses; cloning and altering the human genome;[64] mixing human sex cells with animal cells;[65] malpractice;[66] and the unauthorised taking and transplanting of parts of the human body, including tissues, gametes, embryos, and foetuses.[67] Listing human tissues, gametes, embryos or foetuses explicitly as the possible object of illicit trading was an important step forward.[68] Human trafficking for the exploitation for surrogacy is punishable by law.[69]

4.1. The MAR Act

After the first comprehensive legislation in 2009, which provoked much criticism (*vide supra*) the MAR Act 2012 was amended to reflect a more liberal approach. A more liberal approach was particularly represented in the beneficiaries of MAR, the possibility to cryopreserve surplus embryos created by IVF, and the possibility to donate eggs.

Provisions concerning the protection of the best interests of the child born through MAR were further substantiated through the permissible technologies, the beneficiaries of MAR, the provisions on donors, the provision of ART, including different bans, the cryopreservation of gametes and embryos and measures ensuring the quality of MAR services.

4.1.1. MAR Technologies

The primary objective MAR is

> to attain conception, pregnancy and the birth of a healthy child, complying with the requirements of modern medical science and experience, with special regard to the

63 The Criminal Code (*Kazneni zakon*), Official Gazette Nos. 125/11, 144/12, 56/15, 61/15, 101/17, 118/18, 126/19, 84/21, 114/22, and 114/23.

64 Art. 108 of the Criminal Code.

65 Art. 109 of the Criminal Code.

66 Art. 181 of the Criminal Code.

67 Art. 182 of the Criminal Code.

68 Medical and legal experts greeted this legislative change as an improvement of legal certainty ad further protection of human tissues, gametes and embryos. Zečević and Škavić, 2012, p. 41; Turković and Roksandić Vidlička, 2011. Conversely, some distinguished legal theoreticians considered gametes and embryos to be parts of the human body as well. Bačić and Pavlović, 2004, p. 860. The discussion evolved about the nature of ova when an eminent gynaecologist allegedly stole ova and used them to attain the pregnancy of another women, without getting the consent of all the patients. The charge were dismissed as women who gave birth to children conceived by possibly stolen ova declined to take DNA examination.

69 Art. 106 of the Criminal Code.

> protection of women's health, reducing the risk of the treatment and ensuring the welfare of the offspring.[70]

The welfare and health of the forthcoming child should be the primary focus, representing the commonly accepted highest values. The World Health Organization emphasises: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. It is clear that it includes all aspects of a person, not just physical health, but also mental and social health.

As family is of crucial importance for the development of a healthy person,[71] legislators must set up legal provisions in order to secure a good family environment for a child as far as possible. According to Art. 10, paras. 1 and 2 of the MAR Act, a beneficiary of MAR needs to be capable of taking care of a child, although medical clinics don't examine if an intended parent is capable of exercising parental responsibilities.[72] A clear parallel may be drawn with adoption, as, similarly, the state allows adults to become parents. But, as there is no recognised right to become a parent, there are also differences, as intended parents enjoy the right to health, and providing a possibility to achieve pregnancy is also a part of a medical treatment (and healing) procedure. In the case of adoption the state has a duty to find the best possible adopting parents in order to protect the best interests of the (already born) child.

The Croatian legislation opted for the *ultima ratio* principle as one of the principles[73] governing MAR. A patient may get medical assistance 'only when the previous treatment of infertility has been unsuccessful or unpromising and when it is necessary to avoid, in the cases of natural conception, the transmission of a serious disease onto the child'.[74] Heterologous techniques (the use of donor gametes) can only be used

> when it is not possible to use one of the spouse's or extra-marital partner's own gametes in the procedure of medically assisted reproduction, or when medically assisted reproduction is carried out to prevent the transmission of a serious hereditary disease to the child.[75]

70 Art. 2 of the MAR Act.

71 For example, see attachment theory – Bowlby, 1969; theory of psychosocial development – Erikson, 1980; ecological systems theory – Bronfenbrenner, 1992. Several other psychologists emphasise the importance of family for the mental health of an individual.

72 Medical clinics are mostly satisfied with the fulfilment of formal requirements, such as marital or personal status, age or medical conditions.

73 Korać Graovac, 2024, pp. 107–108.

74 Art. 4, para. 1 of the MAR Act.

75 Art. 8, para. 1.

Intrauterine insemination should always be used before IVF treatment when donated gametes are used.[76]

That means that homologous techniques have a priority over heterologous ones if conception can be achieved through the homologous technique (using gametes of the couple).

The various medically assisted techniques are named precisely named in the MAR Act: intrauterine insemination (IUI), *in vitro* fertilisation (IVF), intracytoplasmic sperm microinjection (ICSI), cryopreservation of gametes and embryos and their defrosting, transfer of gametes or embryos into the fallopian tube, and preimplantation genetic diagnostics. Some of these procedures may be homologous or heterologous.[77] Of the total number of MPO procedures performed in 2022, most procedures were performed using intracytoplasmic sperm injection (35%), followed by the transfer of cryopreserved embryos (26%), IVF techniques (23%), intrauterine insemination with a frequency of 15%, and secondary intracytoplasmic sperm injection (1%). A total of 1804 children were born from these procedures in 2022.[78]

Selecting the sex of the future child is ethically unacceptable, so it is prohibited; the only exception is selecting the sex of a child in order to avoid a serious hereditary disease related to sex,[79] that is inherited by either the (female) X or the (male) Y gene.[80] The National Commission for Medically Assisted Reproduction is responsible for the approval of the selection of the sex of the child.[81]

The prohibition of cloning protects the dignity of a future child – the creation of a human being or part of a human being genetically identical to another human being, whether alive or dead is not permissible.[82] This prohibition is even more extensive than the prohibition of the cloning of human beings as part of the Additional Protocol to the Convention for the Protection of Human Rights and Dignity of the

76 Art. 8, para. 3 of the MAR Act.
77 Art. 9 of the MAR Act.
78 Medicinski pomognuta oplodnja, 2022.
79 Art. 27, paras. 1 and 2 of the MAR Act.
80 See Medline Plus, 2024.
81 Art. 27, para. 3 of the MAR Act.
82 Art. 32 of the MAR Act.

Human Being with regard to the Application of Biology and Medicine, on the Prohibition of Cloning Human Beings.[83]

'Contracts, agreements and other legal transactions of bearing children for another (surrogate gestational motherhood) and handing over a child after a fertility treatment, with or without a pecuniary remuneration, are null and void'.[84] Any form of surrogacy in Croatia is prohibited, regardless of the fact whether it is commercial or altruistic, traditional or gestational.

83 The Additional Protocol to the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, on the Prohibition of Cloning Human Beings ETS No. 168 '4. This Protocol does not take a specific stand on the admissibility of cloning cells and tissue for research purposes resulting in medical applications. However, it can be said that cloning as a biomedical technique is an important tool for the development of medicine, especially for the development of new therapies. The provisions in this Protocol shall not be understood as prohibiting cloning techniques in cell biology. 5. However, the Protocol does enshrine clear barriers against any attempt to artificially produce genetically identical human beings. The Protocol is not concerned with hormone stimulation to treat infertility in women and which might result in the birth of twins. It explicitly restricts genetic identity to sharing the same nuclear gene set, meaning that any intervention by embryo splitting or nuclear transfer techniques seeking to create a human being genetically identical to another human being, whether living or dead, is prohibited'. Explanatory Report to the Additional Protocol to the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, on the Prohibition of Cloning Human Beings, Paris, 12 January 1998 (European Treaty Series No. 168). The Republic of Croatia ratified this Protocol in 2003. Also of utmost importance for ART is the Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (European Treaty Series No. 164).

84 Art. 31, para. 3 of the MAR Act. The EU Parliament 'condemns the practice of surrogacy, which undermines the human dignity of the woman since her body and its reproductive functions are treated as commodity; considers that the practice of gestational surrogacy which involves reproductive exploitation and use of the human body for financial or other gain, in particular in the case of vulnerable women in developing countries, shall be prohibited and treated as a matter of urgency in human rights instruments'. Para. 114 of the Annual Report on Human Rights and Democracy in the World 2014 and the EU Policy on the Matter. (European Parliament Resolution of 17 December 2015 on the Annual Report on Human Rights and Democracy in the World 2014 and the European Union's Policy on the Matter (2015/2229(INI)). In the year 2021, the European Parliament stated that it 'acknowledged that sexual exploitation for surrogacy and reproductive purposes… is unacceptable and a violation of human dignity and human rights'. Para. 32 The EU Strategy for Gender Equality, European Parliament Resolution of 21 January 2021 on the EU Strategy for Gender Equality (2019/2169(INI)). Directive (EU) 2024/1712 of the European Parliament and of the Council of 13 June 2024 amending Directive 2011/36/EU on preventing and combating trafficking in human beings and protecting its victims directly refers to surrogacy. Art. 1 Amendments to Directive 2011/36/EU. The Directive is amended as follows: (1) Art. 2 is amended as follows: '(a) para. 3 is replaced by the following: (b) 3. Exploitation shall include, as a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, including begging, slavery or practices similar to slavery, servitude, or the exploitation of criminal activities, or the removal of organs, or the exploitation of surrogacy, of forced marriage, or of illegal adoption; (c) para. 5 is replaced by the following: '5. When the conduct referred to in paragraph 1 involves a child, it shall be a punishable offence of trafficking in human beings even if none of the means set forth in paragraph 1 has been used. This paragraph shall not apply to the exploitation of surrogacy as referred to in para. 3, unless the surrogate mother is a child'.

Similar to other states, intended parents attempt to circumvent this prohibition and seek surrogacy arrangements abroad, but most of these cases remain hidden.[85] Most media are benevolent toward such practice (for example welcoming news on the birth of a child by a surrogate mother in the USA, whose father is a popular Croatian actor).[86] It is not known if this child has also been registered in the Croatian birth recording system.

The way of evading the legal system is by having the child come to Croatia with a temporary birth certificate, generally issued by a Croatian consulate abroad (Ukraine was a popular in this sense), thus the child's origin is not revealed. Birth certificates carry the data specified in the certificate issued by the hospital where intended parents are entered as biological parents.[87]

The ban on human embryo experiments ensued from adhering to the principle of the protection of human dignity. It is also prohibited to facilitate the extracorporeal development of an embryo that is older than six days, fertilise a female egg with a seminal cell of any species other than the seminal cell of a human or an animal egg by the seminal cell of a human, change the embryo by transplanting other human or animal embryos, introduce human sex cells or human embryos into the animal, introduce animal sex cells or animal embryos into a woman, create human embryos for scientific or research purposes, or perform scientific or research work on an embryo.[88]

The rights of participants are obviously balanced: infertility treatment is allowed to a single woman in certain cases (see below: Beneficiaries of ART), but if a couple seeks medical help 'marriage or a non-marital union must exist at the time of placing sexual cells or embryos into a woman's body'.[89] Posthumous fertilisation is also banned, due to the provision referred to earlier. Furthermore, if the person who has provided and stored sex cells or tissues passes away, the medical institution must destroy the person's sex cells or tissues within 30 days of having learnt about the person's death.[90]

The explanation for such a legislative solution lies in the fact that a child has the right to be cared for by both parents. In a situation where one of the providers of gametes dies, the child would be deprived of the parental care of the deceased parent.

When prospective parents decide to use ART techniques, it is up to them to decide if two or more *ova* will be fertilised: the MAR Act offers the possibility for

85 One of the stories is exposed in the media: telegram.hr, 2024. Čulo Margaletić, Preložnjak and Šimović, 2019.

86 *Goranu i Ivani Višnjić zamjenska majka rodila sina. Večernji list*. See Pacek, 2011.

87 Like in ECtH case, *Paradiso and Campanelli v. Italy*, Grand Chamber Judgement of 24 January 2017, Korać Graovac, 2022, pp. 48–49; Hrabar, 2020; Preložnjak, 2020; Čulo Margaletić, Preložnjak and Šimović, 2019.

88 Art. 36 of the MAR Act.

89 Art. 11, para. 1 of the MAR Act.

90 Art. 33, para. 3 of the MAR Act.

patients to give their cognisant consent if they want embryos to be created for just one cycle, or they want more embryos to be created and subsequently cryopreserved. The ethical dilemma of protecting a woman from overstimulation due to hormonal therapy or to risk surplus embryos is the patients' decision.

However, the problem of stored embryos is complex and a paradox in some way: it is not possible for a woman to use an embryo that is fertilised by her egg as well (and by the sperm of her late husband), but it is possible to donate such embryo to another couple or woman. At the same time, as providers of the embryo (genetic parents) have not undergone screening procedures for genetic and other serious diseases, this embryo, according to ESHRE standards, should not be used.[91] Moreover, Croatian legislators ruled that such surplus embryos should preferably be used, not destroyed, but the use of them, due to the new medical standards of good practice, is impossible. It is also confusing that such an embryo may be donated to another single woman, while a woman who is a widow is not allowed to use it (or let it be destroyed).

Moreover, a high number of allegedly 10,000 cryopreserved embryos in Croatia's medical clinics (cryopreserved during a short period after the MAR Act 2012) somehow posed not just an individual, but a social and a political problem. Medical clinics hesitate to destroy cryopreserved embryos when the time limit of five years – the period the clinics are required to keep them at the state's expense – has passed, and the couple does not want to pay for the extension of cryopreservation. Medical clinics are reluctant to destroy embryos that are not wanted any more even at the request of the couple from whom they originate.

In the first case, the reason behind this is the fear of the potential court interpretation of the status of an embryo if prospective parents subsequently take legal action against the medical clinic. This fear is not without reason, as the Alabama Supreme Court in February 2024 ruled that frozen embryos are 'unborn children located outside of a biological uterus'.[92] The politically influential Catholic Church, and some medical professionals hold a similar position to that of Alabama's Supreme Court, stating that life is born at the moment of fertilisation and, consequently, should also be protected from this moment on.

4.1.2. Beneficiaries of MAR and the Best Interests of the Child

Naturally, the right to found a family is a human right, and the state should not interfere with this right. On the other hand, there is no such right as to become a parent, so the state is not obliged to allow everyone to fulfil his/her desire to have a child.

The legislator has to balance the interests of the intended parents and the interests of the (forthcoming) child. The best interests of the child is not represented by anyone yet, as the child to be born through ART has not yet been conceived.

91 ESHRE Working Group on Reproductive Donation, 2022.
92 See cases.justia.com, 2024. More: Ginod and Dahan, 2024.

However, it seems that the legislator is compelled to ensure that the child desired by the intended parents will receive adequate parental care.

Should the child welfare principle be interpreted so that the intended parents should be screened similarly to how they are screened in the case of adoption and fostering? On the other hand, the implication of screening patients to determine whether they have parental capacities, and thus making decisions about access to or the denial of medical treatment is contentious.[93]

The Croatian MAR Act provides guidance about eligibility – which is partly formal, partly more general.

The more formal precondition is that the beneficiaries of MAR are a man and a woman of legal age who have the legal capacity to make personal statements,[94] and who are married or live in a non-marital union. Non-marital spouses must provide a statement certified by a notary that they live in a non-marital union.[95]

These facts are quite simple to establish (through birth certificates or a statement). For a medical doctor, a specialist in reproductive medicine should play a role in providing medical help to establish that he previous infertility treatment remained unsuccessful or unfeasible' according to Art. 10, para. 2 of the MAR Act, through their patients' medical record.

It is not quite clear who is entitled to establish that patients, intended parents, are capable of exercising parental care (parental responsibilities), taking into account their age and overall health conditions (the condition stated in Art. 10, para. 1). It may be possible that there could be some individuals who are, for example, drug addicts and would like to use medical help in order to become parents, or some individuals with inferior mental capacity who are not deprived of their legal capacity in making personal decisions, or some individuals where there is a great age difference, e.g. a woman is in her forties, and her husband is in his seventies or even older. If a doctor of reproductive medicine is doubtful about their parental capacity, he/she would have a legally based reason to deny medical help.

It is clear from the legal provisions that Croatian legislators did not give priority to a couple's desire to become parents but also introduced the assessment of their capability to take care of the child.

A single woman who has reached the age of majority, has legal capacity and does not live in a marital, non-marital, or same-sex union; whose previous treatment of infertility has ended unsuccessfully or was futile; and who, due to her age and overall health condition, is capable of exercising parental care (parental responsibilities),

93 De Lacey, Peterson and McMillan, 2015, p. 617.

94 The MAR Act in Art. 10 para. 3. implemented Art. 23 of the Convention on the Rights of Persons with Disabilities, whereas a person with disabilities has the right to freely and responsibly decide on the number and spacing of their children. According to this requirement, a person who is not deprived of his/her legal capacity in making statements regarding his/her personal condition has the right to receive medically assisted reproduction.

95 Art. 11, para. 3 of the MAR Act.

may also seek MAR treatment.[96] The main reason for providing medical help to a single woman is medical.[97] The fact that she does not have a partner, or her sexual orientation, is not relevant.

There is another requirement against a woman: if she wants to use an assisted reproduction procedure covered by the Croatian Health Insurance, she must not over the age of 42 years. Exceptionally, the medical doctor overseeing the treatment is entitled to examine whether a patient is, due to her age and overall health condition, capable of caring for the child.[98] There are no measures to prevent this woman from seeking help in another licensed medical clinic if one of the clinics previously refused her the treatment.

So, single women are excluded, unless there is a medical reason; a man and a woman who do not live as a marital or non-marital couple but would like to conceive the child with medical help are also excluded, and same-sex couples are excluded from ART as well. These legal choices reflect political attitudes and reflect societal values as well. So far there were no constitutional decisions concerning this legislative position of the legislator.

The principle that a future child should, if possible, enjoy parental care by both parents, is encompassed in the stipulation that either marriage or non-marital union must exist at the time of the introduction of gametes or embryos into the woman's body.[99] Consequently, insemination or transfer of embryo *post-mortem* is not permitted. As there is no paternity presumption applicable in the case of a non-marital couple,

> in the procedure of medically assisted reproduction, the man shall be obliged to give a notary certified statement of acknowledgment of paternity of the child to be conceived before the procedure of medically assisted reproduction, and the woman shall be obliged to provide a notary certified statement of consent to the acknowledgment of the paternity of that child.[100]

A medical clinic is not permitted to perform an assisted reproduction procedure if these statements are not provided.

As stated above, there are some differences and some similarities in the regulation of MAR, compared to the regulation of adoption. Adoption is a family-law institute that is aimed at protecting a child without parental care and enabling the

96 Art. 10, para. 2 of the MAR Act.

97 Art. 10, para. 7 of the MAR Act provides clear instructions: 'A woman's reproductive capabilities are determined by a doctor specialising in gynaecology and obstetrics with a specialisation in human reproduction on the basis of ovarian reserve tests. In case of women over 42 years of age or women whose ovarian reserve tests are unfavorable, the doctor is obliged to warn them about the poor treatment results, the risks of treatment and pregnancy, and the risks to the child'.

98 Art. 10, paras. 4 and 5 of the MAR Act.

99 Art. 11, para. 1 of the MAR Act.

100 Art. 16, para. 2. of the MAR Act.

child to enjoy the right to family life. Simultaneously, adoption enables, and to enable prospective adopters to become legal parents (to found a family),

The most significant difference is that adoption is the best way to protect children who are already born and were left without parental care. In drafting the provisions of MAR, the rights and interests of a possible future child, a child who has not even been conceived and subsequently has not been born yet should be taken into account.

Another difference is that it is not possible to fulfil every request of the potential adopters, as there is an imbalance between the number of adoptable children and the number of potential adopters. So, it is obvious that not all of potential adopters will be permitted to adopt a child (in 2022 there were 833 potential adopters and 196 adopted children).[101]

Couples and individuals who are struggling with infertility are seeking medical help to exercise their right to health. Furthermore, some of them argue that even though they do not have medical problems, should have the right to seek medical help to become parents (in case of social infertility, sexual orientation etc.).

Similarities are that legislators set up a system of values to ensure that the child left without parental care or a future child will be cared for by a heterosexual couple (or an individual) where the child's best interests will be protected in advance. For adopters requirements are more formal, and they need have an opinion stating that they fulfil the requirements of adoption. Patients who seek medical help do not need such verification – they are left to the assessment of medical doctors. Hence, when patients seek help by using heterologous techniques, which may lead to some issues concerning upbringing of a donor-conceived child (who is not genetically related to one or both of them), the psychological consultation is requested.

ART procedures are, to a certain extent, regulated similarly to adoption when formal prerequisites (age, personal status, parental capacity, legal capacity, and others) are met. In Croatia, traditional families and in some cases single women are considered as the best choice to raise children, and this attitude is taken into account in the regulation of adoption and ART.

4.1.3. Heterologous Techniques and the Best Interests of the Child

According to Art. 7 para. 1 of the MAR Act 'in medically assisted reproduction procedures, preference shall be given to homologous fertilisation using the own gametes of the spouses or extramarital partners'. Heterologous techniques are a subsidiary choice due to more complex issues, as they involve a third person, a donor of gametes or a donor of embryos.

101 *Godišnje statističko o primijenjenim pravima socijalne skrbi* 2022, Ministry of Labour, Pension System, Family and Social Policy (*Ministarstvo rada, mirovinskoga sustava, obitelji i socijalne politike*), see Republika Hrvatska, 2023.

When donors' gametes or embryos are used, several values need to be protected: the health of the future child, the right to know the origin of the child, and the right to family life after the birth of a child. There are no unique answers to these issues in Europe, but Croatian legislators have offered legal provisions that comply with the values of Croatian society.

Donors may donate gametes or embryos (but not embryos created solely for donation).[102]

The main goal of assisted reproduction should be the birth of a healthy child, so medical clinics must perform, before proceeding with heterologous technologies, all necessary examinations and laboratory tests of donors and gametes prior to the selection and storage of semen and oocytes. The Minister of Health prescribes by ordinance procedures and criteria for the assessment of gamete donors, the procedures for the collection of gametes, the procedures for their receipt and their storage in the gamete bank, as well as the mandatory laboratory screening.

Gametes may be donated by a person who has reached the age of majority and has the legal capacity to consent to donation. To prevent the excessive donation of gametes, they can be donated only to one of the medical clinics (licensed for performing heterologous techniques). A medical clinic needs to report the existence of donated gametes to the gametes' bank and the State Register of MAR.[103] All these provisions have not been applied yet as a donor programme has not been introduced due to the lack of interest of potential donors.

According to the most recent census in 2021, Croatia is a small country with only 3.9 million inhabitants; therefore, there could be a significant danger that individuals get into contact with their half-siblings without being aware of their kinship. To prevent the birth of half-siblings who do not know about each other and to rule out incest, it is prohibited to use gametes or embryos of the same donors, after it has been established that three children have been born.

Donated gametes may be used for fertilisation after it has been assessed, following the medical requirements that they are suitable for fertilisation and that their use cannot cause harmful consequences in the health of the woman or the expected child.[104] As already pointed out, this is the reason why cryopreserved embryos cannot be used for donation,[105] although this is permitted by law. An embryo may be, as stated above, created only if it will be used by the couple. In that case,

102 Embryo donors are spouses or non-marital spouses who have given up using an embryo that was created for their procreation. Both of the donors are required to give their consent certified by a notary to the donation of their embryo to another couple or to a woman who is a beneficiary of ART.

103 Art. 20, paras. 1. and 3. of the MAR Act.

104 Art. 24 of the MAR Act.

105 A maximum of 12 embryos may be produced in one IVF procedure, and in principle, a maximum of two embryos can be transferred to the woman's womb (three if a woman is over 38 years old, and has some medical issues). Spouses (marital and non-marital) are obliged to declare in writing before initiating MAR proceedings whether they want the fertilisation of up to two or more eggs, as surplus embryos are cryopreserved (Art. 7 of the MAR Act). Korać Graovac, 2024, p. 112.

genetic parents do not go through health screening, so the donation of their embryos is not compliant with medical standards and is not permissible.

Although embryos do not have the legal status of (non-born) children, it is possible to envisage different attitudes toward this issue. Hence, an embryo cannot gain the status of a person in the current Croatian legal system.

Heterologous techniques can sometimes be challenging for parents and the child. Earlier, the social community adjudicated individuals who suffered from infertility, so couples concealed the fact of adoption or the use of medical help to attain pregnancy. This has changed since, but some subsequent psychological issues may still surface during the upbringing of the child, particularly regarding identity issues. Additionally, in the event of the breaking up of the family, one of the legal (but not genetic) parents may be more likely tempted to stop taking care of the child who is not genetically linked to him/her.

Therefore, the MAR Act requires prospective parents to complete compulsory psychological or psychotherapeutic counselling if they intend to use heterologous procedures.[106]

The real battlefield in Europe regards the right of the child (or donor-conceived person) to learn about his/her origin. Art. 7 para. 1 of the United Nations Convention on the Rights of the Child[107] and Art. 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms applies to donor-conceived children.[108]

Only Art. 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms applies to a donor-conceived adult person, and it encompasses, as interpreted by the European Court of Human Rights, 'the right to an identity and to personal development', which includes the right to access information that would make it possible to trace 'some of [one's] roots', the right of a person to know their origins and the circumstances of their birth. None of the Court's decisions have specifically involved the right of a person conceived by a donor's gamete to have the right to know the identity of the donor yet.

The Act on Medically Assisted Procreation (2009) enabled a donor-conceived person to find out the identity of the donor only if a donor agreed thereto.[109] Since

106 Art. 13 of the MAR Act.

107 Art. 7: '1. The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents…' Convention on the Rights of the Child, of 20 November 1989, United Nations Treaty Series, Vol. 1577, p. 3.

108 Art. 8, para. 1: 'Everyone has the right to respect for his private and family life, his home and his correspondence'. European Convention for the Protection of Human Rights and Fundamental Freedoms, Rome, 1950, European Treaty Series, No. 5.

109 Art. 10, para. 2 of the MAR Act

2012, Croatia has been applying Art. 7, para. 1 of the Convention on the Rights of the Child in and completely veiled the anonymity of donors.[110]

If parents choose so, the usage of ART may remain a secret inside the family, contrary to their obligation to inform their donor-conceived child at least by the age of majority on how he or she was conceived.[111] No one has control over the parents, so if they do not fulfil this obligation, a child may only accidentally find out the truth about his/her conception.[112] That means that legal provisions on donors' non-anonymity may easily retain a declaratory meaning. The right to identity of a donor-conceived will easily not be achieved, even though

> a person conceived and born with the help of medically assisted reproduction with a donated sperm cell or a donated egg or a donated embryo, if he/she has reached the

110 Reasoning is expressed in Draft of the Proposal of the MAR Act in 2012: 'The non-anonymity of amete or embryo donors is prescribed in order to protect the child's right to know his or her own origin, as protected in Art. 7 by the Convention on the Rights of the Child, ratified by the Republic of Croatia ('Official Gazette of the SFRY', No. 11/81, 'Official Gazette – International Treaties' No. 12/93). In Art. 7, para. 1 of the Convention on the Rights of the Child states that a child has: 'as far as possible, the right to know who his parents are'. The Committee on the Rights of the Child, to which states submit regular reports on the application of the Convention, criticises the non-application and endangerment of this right. In the case of medically assisted reproduction with a donated gamete, i.e. an embryo, it cannot be claimed that it is not possible to determine the origin of the child. In addition, the right of the child stipulated this way is a reflection of modern understandings in developmental psychology and child psychiatry that clear knowledge of one's own origin forms a healthy mental identity of an individual and the possibility of building quality personal relationships with other people'. See Republika Hrvatska Ministarstvo zdrastva, 2012. (The author's translation). Argumentation for this choice was expressed in legal literature: 'What is the meaning of 'im/possible'? Objectively or subjectively is impossible? It is objectively impossible when we cannot find the mother (and consequently the father) or when the mother does not know which of the many men conceived her child. Let us ask ourselves, is it not possible to know who donated the gamete? Isn't there a donor registration and a preliminary procedure that confirms or eliminates them? Should insisting on not recognising the truth and the turmoil about the origin of the child from medical insemination simply be attributed to the protection of the personality of the donor? The exculpation about the impossibility ('as far as possible') is an illusion of the truth that we do not want, not that we cannot, find out about the child's origins, that is, we want to deprive him of knowledge about his ancestors'. Hrabar, 2010, p. 430. At that time such an approach was quite uncommon in the comparative legal system, although in contemporary European policies, more and more states accept this approach concerning the anonymity of donors.

111 Art. 15, para. 2 of the MAR Act.

112 Greater usage of consumer DNA testing may break the secret. By the year of 2019, more than 26 million consumers had added their DNA to four leading commercial ancestry databases, which may increase to 100 million within a few years according to estimates by the MIT Technology Review. Family secrets are being revealed if donors and other donor-conceived persons provide commercial DNA database with their data. Regaldo, 2019.

> age of eighteen, has the right to access the Register of Conception Data and all data on his/her biological origin, including the information on the identity of the sperm cell donor or egg donor, i.e. the embryo donor … which is kept at the State Register of Medically Assisted Reproduction of the Ministry of Health.

If it is necessary to reveal the identity of a donor, for medically justified reasons, and the person's well-being, access to the data on the donor of gametes or embryos shall be provided to the legal representative of a donor-conceived child or the doctor. The National Commission for Medically Assisted Reproduction should approve this request.[113] The donor and the child do not have any family-law obligations or other mutual obligations or rights.[114]

The consequence of the non-anonymity concept[115] was that donors ceased to participate in a donor programme, so currently there are no donor and no gamete bank in Croatia.

113 Art. 15, paras. 1 and 3.

114 Art. 19, para. 5.

115 Recommendation 2156 (2019) on 'Anonymous donation of sperm and oocytes: balancing the rights of parents, donors and children', Points 2 and 3: 'In recent decades, there has been movement towards the recognition of a right to know one's origins, connected to the right to an identity and to personal development: in international human rights law, through its inclusion in the United Nations Convention on the Rights of the Child as a 'stand-alone' right for children, and in European human rights law through the case law of the European Court of Human Rights, which has recognised this right as an integral part of the right to respect for private life. This right includes the right to access information that would make it possible to trace one's roots, to know the circumstances of one's birth, and to have access to certainty of parental filiation….However, this right is not absolute and must thus be balanced with the interests of the other parties involved in sperm and oocyte donation: principally those of the donor(s) and the legal parent(s), but also those of clinics and service providers, as well as the interests of society and the obligations of the State. The Parliamentary Assembly invited the Committee of Ministers to propose a legally binding instrument based on the following principles: 7.1. anonymity should be waived for all future gamete donations in Council of Europe member States, and the use of anonymously donated sperm and oocytes should be prohibited. This would mean that (except in exceptional cases, when the donation is from a close relative or friend) the donor's identity would not be revealed to the family at the time of the donation, but to the donor-conceived child upon their 16th or 18th birthday. The donor-conceived child would be informed at that time (ideally by the State) of the existence of supplementary information on the circumstances of their birth.…; 7.2. the waiving of anonymity should have no legal consequences for filiation: the donor should be protected from any request to determine parentage or from an inheritance or parenting claim… The donor should have no right to contact a child born from donation, but the donor-conceived child should be given the option to contact the donor, as well as possible half-siblings, after their 16th or 18th birthday – subject to certain conditions being met; 7.3. Council of Europe member States that permit sperm and oocyte donation should set up and run a national donor and donor-conceived person register with a view to facilitating the sharing of information, as stipulated in paras. 7.1 and 7.2, but also with a view to enforcing an upper limit on the number of possible donations by the same donor, ensuring that close relations cannot marry and tracing donors if the medical need should arise. Clinics and service providers should be required to keep and share adequate records with the register, and a mechanism should be established to provide for cross-border exchanges of information between national registers; 7.4. the anonymity of gamete donors should not be lifted retrospectively where anonymity was

Donors are obviously reluctant to reveal their identity to their biological children. Couples therefore travel abroad, where a donor programme is offered. The state provides financial support, but before gametes or embryos are transferred to a medical clinic abroad the consent of the National Commission for Medical Assisted Reproduction is required. The National Commission started the practice of requesting a statement from the couple that no surrogacy service would be used and that the child should be conceived in a medical clinic where the child would be able to find out the identity of the donor (if these heterologous techniques will be used). This approach is currently maintained, as it is held that the entire ART procedure is a unique one, so the State is responsible for securing the right of the child who may have been donor-conceived abroad.[116] New SoHO regulation[117] will also help the traceability of gametes and embryos.

4.1.4. Family Law Regulation

When a child is conceived by assisted reproduction, it can be by homologous or heterologous. If a child is conceived by homologous technique, it is obvious that the parents may only be a woman and a man who had undergone an assisted reproduction procedure.

The Family Act dedicated special provisions regulating the origin of the child conceived by heterologous assisted reproduction technique.[118]

The mother of the child conceived by a donated egg or a donated embryo in the procedure of medically assisted reproduction is the woman who gave birth to the child (*presumptio iuris et de iure*). This family law provision is in harmony with the MAR Act that prohibits surrogate motherhood.

Family law protects the will of the intended parents (reflected in the consent for the specific procedure of assisted reproduction), and certainty of the legal affiliation of the child as well, so

promised at the time of the donation, except for medical reasons or where the donor has consented to the lifting of the anonymity and thus inclusion on the donor and donor-conceived person register…; 7.5. these principles should be applied without prejudice to the overriding consideration that gamete donation must remain a voluntary and altruistic gesture with the sole aim of helping others, and thus without any financial gain or comparable advantage for the donor'. See European Committee on Legal Co-operation, 2023.

116 The Croatian Health Insurance financially supports couples or women if they use the donor program in states where the identity of the donor is accessible to the child. There are intensive efforts to enable at least the import of gametes from trusted gamete banks.

117 Regulation (EU) 2024/1938 of the European Parliament and of the Council of 13 June 2024 on the standards of quality and safety for substances of human origin intended for human application and repealing Directives 2002/98/EC and 2004/23/EC (Text with EEA relevance), PE/8/2024/REV/1

118 Maternity in Art. 82 and paternity in Art. 83. Hrabar, 2012; Jurin and Miškić, 2020; Korać Graovac, 2021, pp. 66–68.

> it is not permitted to contest the maternity of a child conceived in the procedure of medically assisted reproduction if the consent has been given for a specific type of reproduction under the provisions of the regulations governing medically assisted reproduction.[119]

If a child is conceived by assisted reproduction without the consent required under medically assisted reproduction provisions, a woman who is registered in the birth register as the mother of the child or a woman who considers herself the mother of the child may contest maternity.[120] A woman who has been entered into the register of births as the child's mother may dispute this maternity lodging a lawsuit within six months from the discovery of the fact that rules out her maternity, and at the latest by the time the child has reached his/her seventh birthday. This provision is intended for a woman who gave her consent to the homologous procedure, but another woman's eggs were used.

A woman who considers herself the mother of the child (whose egg cell was used in an assisted reproduction procedure without her consent) can dispute the maternity of the woman who was entered into the register of births as the mother, and at the same time should lodge the lawsuit to establish her own maternity. The suit may also be lodged in a time period of six months from having found out that she is the mother of the child and at the latest by the child's seventh birthday.[121]

Setting time limits preserves legal certainty and ensures that a child who has a family life with his/her parents will continue to be part of that life.

Pater est quem nuptiae demonstrant rule also applies to the mother's husband, when a child is conceived with donated semen or a donated embryo in the procedure of medically assisted reproduction if the child was born at the time of the marriage or within a period of up to three hundred days from the termination of the marriage and if the husband has given his notary certified consent to the specific procedure of medically assisted reproduction. The father of the child will be a non-marital spouse (common-law spouse)[122] if he gives his paternity acknowledgment certified by a notary, and the mother of the child gives her consent to her non-marital spouse's acknowledgment of the child.[123] The woman must consent to the acknowledgment

119 Art. 82, para. 1 of the Family Act. According to Art. 14, paras. 2–6 of the MAR Act the notary certified consent shall be given in advance for each specified assisted reproduction procedure, and the origin of the gametes or embryos. Patient(s) may withdraw their consent and retreat from the procedure of assisted reproduction as long as the sperm cells, oocytes or embryos have not been transferred into the woman's body. The medically assisted procedure shall be terminated when one or both spouses withdraw their consent. The medical clinic shall record the statement on the withdrawal of consent and, at the request of the woman or man, issue a written confirmation thereof.

120 Art. 82, para. 2 of the Family Act.

121 Similar to the general period of time for the contestation of motherhood in Arts. 401–403 of the Family Act.

122 Regulation of non-marital union that is informal in Croatia: Korać Graovac, 2021.

123 Art. 16, para. 2 of the MAR Act.

of paternity in advance to ensure that she will not change her mind and restrict her spouse from becoming a legal parent.

Similarly to adoption, it is not permitted to contest the paternity of a donor-conceived child if the consents were acquired prior to the birth of the child.

The same rules for the contestation of fatherhood apply as for the contestation of motherhood: if a child is conceived through the procedure of assisted reproduction without the required consents, paternity may be disputed by the man who is registered as the father, or by those whose semen was used in the assisted reproduction procedure.

The time limit for contest of a mother's husband is six months from having found out that he is not the father of the child and at the latest by the child's seventh birthday. A man who has acknowledged the child (non-marital father) may contest his fatherhood six months after having found out that is not the father, but the latest by the child's seventh birthday.[124]

Another man (whose sperm had been used without his consent) may dispute the paternity of the man who is registered as the father of the child, but the lawsuit should be filed within six months from the date of having found out that the fertilisation took place without his consent, and no later than the child reaching his/her seventh birthday.

All these rules protect the parenthood established with the help of assisted reproduction and adequate consent. Interestingly, the donor-conceived child never has the right to contest his or her origin, although he/she is the one whose consent was not required. A child only has the essential right to know his/her origin (if he/she was informed about the circumstances of conception).

5. The Rights of the Child and ART in Croatia – Final Remarks

In general, Croatia has a good assisted reproduction legislation in place, which balances the rights of the child, the rights of intended parents (patients) and the rights of donors prudently, according to social and cultural values.

Interest in MAR is increasing, as there are more and more couples who cannot conceive naturally, although there are many legal, ethical, and other issues.

The rights belong to the born child, an adult person conceived by assisted reproduction, or, rarely and with suspensive effect, to the non-born child. The most important rights are the right to be cared for by both parents (through the ban on *post-mortem* fertilisation and conception, surrogacy, and through the choice of beneficiaries of ART), the right to health (through donor screening, limitation of the

124 Arts. 401 and 402 of the Family Act.

excessive transferring of embryos to a woman's womb), and the right to know the child's origin (although there is no mechanism to compel parents to inform children about their donor-conceived status).

Croatian legislation takes into account ethical considerations (for example prohibition of cloning, creating chimeras, ban on surrogacy) and attempts to preserve family stability through the provisions of family law (legal certainty of the child's origin by prohibiting the contestation of maternity or paternity if the required consents have been provided).

The legal system protects traditional values, but there is also some room for compromise between traditional societal values and the modern approach to reproductive rights. The fact that no donor programme exists due to the lack of interest of potential donors causes a problem. The state endeavours to overcome this situation by financing medical help abroad.

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Chapter 5

Czechia: The Regulation and Legal Practice of Assisted Reproductive Technologies and the Best Interests of the Child

Zdeňka Králíčková

Abstract

In addition to increasing reproductive tourism, human infertility and rapidly developing assisted reproductive technologies are 'burning' issues not only for lawmakers, but also for the judges deciding on the recognition of a foreign public document when the registry office declines to register the birth of a child delivered by a surrogate mother for intended parents abroad. However, this topic must be seen in its broader context. It is about a new way of looking at family life, family law, parenthood and human rights, including the rights of the child in the case of the anonymity of germ cell donation and the best interests of the child born through surrogacy, in the context of family policy and public order.

Keywords: assisted reproduction technologies, health service providers, germ cell donation, anonymity, surrogate motherhood, 'gender neutral' parenthood, child, status, problems, case law, public order, family policy, designed law

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1. Introduction

In 1982, the first 'test-tube' baby was born in Czechoslovakia. It was also the first child conceived through assisted reproduction in the former Eastern Bloc. Although this new method of assisted reproduction was not regulated by law, it was widely welcomed. Medical science was ahead of the law in the 1980s.[1] It was only subsequently that the Czech or Czechoslovak legislators began to comprehensively regulate assisted reproduction methods, which was also reflected in the legal regulation of family status law in the former Act on the Family of 1963 and the civil registry regulations. The maternity of a child conceived through assisted reproduction was conferred by birth, although this was not explicitly done until an amendment to the Act on the Family in 1998. As assisted reproduction was possible only for a married couple. The husband of the child's mother, whether he was also the biological father, was considered to be the father of the child born through assisted reproduction, if he had given his consent to assisted reproduction. Subsequently, assisted reproduction was also made available to unmarried couples, which had to be supplemented by a new regulation on the determination of the paternity of the man from an infertile couple in the Act on the Family in 2006. The consent of a man from an infertile couple to assisted reproduction was again a key prerequisite of its performance and for establishing the legal paternity of the child. Germ cell donation was permitted on the principle of anonymity.

The development of assisted reproduction methods has continued, so have the ideas and needs of people struggling with infertility. Everyone has the right to respect for his private and family life according to the Convention for the Protection of Human Rights and Fundamental Freedoms (published under No. 209/1992 Sb. in the Czech Republic). However, people often have very different ideas about the forms family life takes. It is therefore very difficult to create a family policy and legal framework for the protection of the family and family life that suits everyone. The most important question is whether and how the legislature should respond to the new phenomena and proposals by intended parents and how to balance them with the rights of the child and the best interests of the child.

Should the law open up assisted reproduction to single or widowed women and create *de facto* 'social' orphans? The case law of the Constitutional Court of the Czech Republic speaks against it. Shall the legal order regulate surrogacy as a healing method of infertility? A proposal was made by the Ministry of Justice of the Czech Republic. Indeed, *de facto* surrogacy is as old as humanity itself, as human infertility and the desire to have a child at any cost are connected vessels. However, it must be stressed that the right to a child has not been established *expressis verbis* either within the legal order of the Czech Republic, nor by human right conventions, namely the Convention for the Protection of Human Rights and Fundamental Freedoms. And, apart from

1 Králíčková, 1990, pp. 12–17.

the human or human rights dimension of surrogate motherhood,[2] one must see its cultural, social, ethical, medical, religious, economic and sometimes even criminal aspects.[3] At the outset, it should be stated that no child may be the object of a contract, whether it is entered into altruistically, to help an infertile woman or intended parents, or even for payment, whatever form it may take. No child should be at the risk of having his/her status, or legal parenthood questioned.[4] The rights of the child must not be seen only as abstract rights arising in particular from the Convention on the Rights of the Child,[5] but as concrete rights to be protected.

And there are more key questions. Should the lawmaker abolish the anonymity of germ cell donation and thus allow the child to know and contact his/her 'genetic' mother or 'genetic' father? Is there a need for a radical change in family law concepts in the light of the possible 'plurality' of a child's parents? Should the rights of the child and the best interests of the child be respected more in the legislation on assisted reproduction and practice? The legislation on assisted reproduction may be seen as being parent-centred. However, if it were not for the intended parents, the child would never have been conceived. The principle of the best interests of the child is particularly manifested by the fact that a child born through assisted reproduction always has 'only' two 'legal' parents, the mother and the father, since assisted reproduction is *de lege lata* available to infertile couples of the opposite sex.

However, in reality, the traditional idea of 'one child, one mother and one father', which balances legal, social and especially biological and genetic parenting, is often undermined. Sometimes unconsciously, accidentally. It might be surprising that, following the case law of the Constitutional Court of the Czech Republic and the relevant practice of the Supreme Court of the Czech Republic, the traditional concept of status rights is gradually being eroded. That is why nowadays more and more new conceptual questions arise. Should the concept of the status rights regulated by the Civil Code be fundamentally changed? Is it constitutionally consistent or desirable to endorse a child having two 'legal' mothers or two 'legal' fathers, or just 'gender-neutral' parenthood?

The following segment is mainly devoted to the rather liberal regulation and the practice of assisted reproductive technologies, besides the general aspects of the concept of a family and family life in Czechia.[6] Although the status law regulating affinity and kindship is traditionally conservative, the 'burning' reality is a case law and a designed law.

2 Králíčková, 2010, p. 49.
3 Garayová, 2022, pp. 65–85.
4 Králíčková, 2022, pp. 83–100.
5 Published under No. 104/1991 Sb. in the Czech Republic.
6 Králíčková, 2014, pp. 71–95.

2. Family Policy and Practice Regarding Assisted Reproduction and Relevant Statistical Data

2.1. Family Policy Concept

In 2017, the Family Policy Concept was developed by the Ministry of Labour and Social Affairs in cooperation with the Expert Commission for Family Policy in order to ensure a long-term and systemic solution to family policy in the Czech Republic.[7] The Family Policy Concept was developed in parallel with the Report on the Family, which provides a detailed analysis of the situation of families in contemporary Czech society. According to the website of the Ministry of Labour and Social Affairs, the Czech Republic – like other EU countries – is at the end of the second demographic transition, which is characterised by low marriage and high divorce rates, higher age of mothers having their first-born child, low fertility, the loosening of forms of partnership and increasing life expectancy.[8]

The section entitled 'What do families need?' was supplemented by data on preparing for a demographic change.[9] Among other things, the need for access to assisted reproduction was emphasised in this context. Following the observation that the natural threshold for starting a family has shifted in recent decades to the age of 30, it was pointed out that the proportion of infertile couples is increasing with this age shift. It was stated that the cost of modern assisted reproductive techniques is a barrier to their use and that it is 'basically inaccessible' for low-income families. The cost of an *In vitro* Fertilisation (IVF) cycle, including medication, is about CZK 30 000 – CZK 50 000 and the woman involved generally pays one third of the cost even if reimbursed by public health insurance. Although assisted reproduction is now available to women up to the age of 49, the Czech Republic is one of the countries with the lowest proportion of older women undergoing IVF. Women's health status can vary greatly. It was also stated that under the current legislation, which allows assisted reproduction only to infertile couples, there is a negative practice: 'Some women who do not have a partner also tend to opt for an undignified and risky route to pregnancy'.[10] It is a common knowledge that sometimes they present a 'fake' partner to the decision-maker.

7 See Ministerstvo práce a sociálních věcí, 2017.
8 Ibid., p. 11.
9 Ibid., p. 47.
10 Ibid., p. 53.

2.2. Family Policy Strategy

Following the above-mentioned Family Policy Concept, the Family Policy Strategy for 2024-2030 was developed.[11] After the introductory part, a summary of the background and an evaluation of previous conceptual materials in the field of family policy and the current challenges facing families were formulated. Regarding the issue of assisted reproduction, it was noted that a fertility forecast table was devised.

years	**2019**	**2022**	**2023**	**2026**	**2027**	**2028**	**2030**
number of children annual growth	112 944	107 293	105 341	99 637	97 993	96 589	94 685
in the number of births	- 1 269	- 1 929	- 1 952	- 1 828	- 1 644	- 1 404	- 794
annual growth in %	- 1.1	- 1.8	- 1.8	- 1.8	- 1.6	- 1.4	- 0.8

Table No. 1
Fertility forecast for the Czech Republic[12]

According to the Family Policy Strategy the task of family policy is, on the one hand, to minimise barriers to parenthood for those who intend to have children and are mainly prevented by structural and institutional influences, and, on the other hand, to create conditions that motivate those who do not hold parenthood as a preferred value or are concerned about its costs, impacts, relational life, etc.[13]

2.3. Institute of Health Information and Statistics and National Reproductive Health Registry

In addition to the Ministry of Health of the Czech Republic responsible for public health and assisted reproduction, there is the Institute of Health Information and Statistics of the Czech Republic as an organisational unit of the state.[14] Furthermore, there is the National Reproductive Health Registry which includes five modules.[15] According to the web page of the National Registry of Assisted Reproduction ('NRAR') the main goal of an assisted reproduction cycle is – in accordance with the definition of assisted reproductive treatment – to use embryos to attain pregnancy, to give birth

11 For details see Ministerstvo práce a sociálních věcí, 2024.
12 Ibid., p. 56.
13 Ibid., p. 56.
14 See Ústav zdravotnických informací a statistiky ČR, 2024a.
15 See Ústav zdravotnických informací a statistiky ČR, 2024b.

to a healthy, living child, but the cycle does not always have to lead to pregnancy immediately.[16] That is why NRAR also records cycles where the use of retrieved oocytes or embryos to attain pregnancy, is planned for future use, for example in women undergoing ovarian cancer treatment. Similarly, NRAR records cycles of women who choose to store their oocytes in cryobanks for use when their ovaries are no longer able to provide quality oocytes due to their age. Finally, NRAR records the cycles of female donors separately from those of female recipients. Since NRAR records those cycles that do not have the immediate goal of attaining pregnancy at the time of their treatment, it is necessary to separate such cycles before starting the efficiency (pregnancy) calculations. It was stressed that, as a measure of the effectiveness of assisted reproductive cycles, birth is too distant in time from the assisted reproductive treatment of infertility, and the pregnancy itself is subject to many risks unrelated to the assisted reproductive treatment itself. Therefore, the basic outcome parameter of cycles leading to pregnancy is 'clinical pregnancy', i.e. pregnancy visible on ultrasound examination or proven laparoscopically or histologically.[17]

Regarding data, it was stated that the number of all assisted reproduction cycles is increasing year on year. However, in 2020, the number of assisted reproduction cycles performed decreased, probably due to the Covid-19 epidemic and related anti-epidemic measures (travel and centre restrictions).[18]

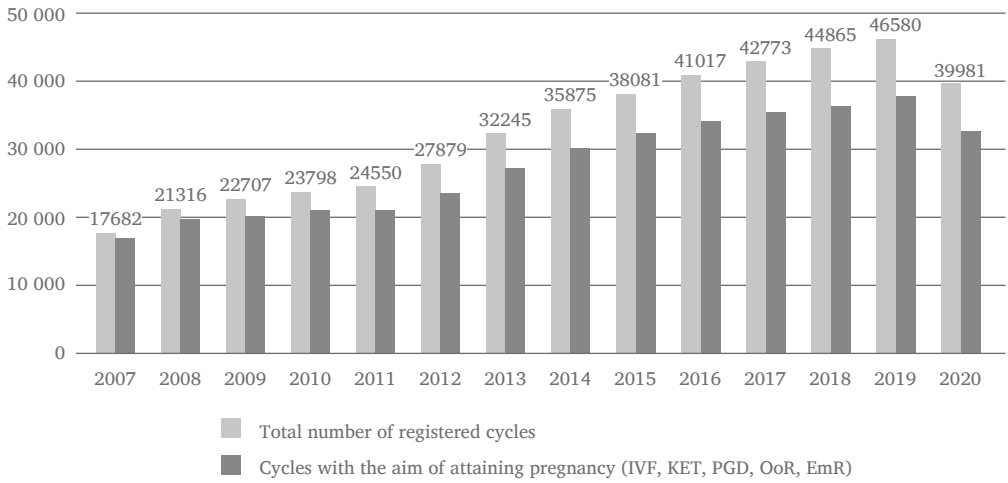


Table No. 2
Numbers of all assisted reproduction cycles[19]

16 See Ústav zdravotnických informací a statistiky ČR, 2022.
17 Ibid., p. 13.
18 Ibid., p. 18.
19 Ibid., p. 18.

As regards the details available from the webpage, it is evident that the number of 'classic IVF cycles' that are cycles aimed at treating infertility, is approximately stable (with the inclusion of cycles previously conducted under PGD). The IVF cycles in foreign women are slightly increasing.[20] It was published that while the donors are almost always women with their place of residence being the Czech Republic (99%), in contrast, the recipients of the eggs are foreign women in most cycles (85%). The trend corresponds to the well-known fact that the Czech Republic is sought by foreign women as a source of donated eggs, which is related to the availability of donors in the anonymous donation system, the quality of treatment in the Czech Republic, the intensive marketing of assisted reproduction centres and the fact that this treatment is legally permitted in the Czech Republic.[21] Finally, the 'Freeze All cycles' among women with their place of residence in the Czech Republic have increased sharply. The number of 'Freeze All cycles' is also increasing among foreign women, where the demand to maximise the chances of success and the birth of a healthy child seems to play a role, even though the reimbursement is mostly self-funded (without health insurance).[22]

It is surprising that the above-mentioned statistical data and the final summary do not provide any information about the implementation of surrogacy. This confirms the thesis that surrogate motherhood takes place behind so-called closed doors, without any official records. It is therefore not possible to say whether assisted reproduction for the purpose of surrogate motherhood concerns only Czech women, or whether it also applies to foreign women or whether it is altruistic or not.

2.4. Section of Assisted Reproduction of the Czech Gynaecological and Obstetric Society and Website 'Female Infertility'

In 1991, the Section of Assisted Reproduction of the Czech Gynaecological and Obstetric Society was founded in Brno. The reason why the city of Brno was chosen was because on the 4th of November 1982 the first 'test-tube' baby was born there at the first gynaecological and obstetric clinic in Czechoslovakia and former Eastern Europe. At the meeting, data from the new assisted reproduction registry were presented, including the results of five centres performing assisted reproduction methods in 1991.[23]

Based on the 'partner' website 'Female Infertility', currently approximately 20% of couples in the Czech Republic are struggling with infertility, so it affects every fourth to fifth couple. It was published that while infertility used to be considered a female problem, current knowledge has changed.[24]

20 Ibid., p. 28, Graf 10a.
21 Ibid., p. 29, Graf 10d.
22 Ibid., p. 30, Graf 10e.
23 See Sekce asistované reprodukce, 2024.
24 For more see Zenska neplodnost, 2024.

3. Constitutional Provisions and Other Laws on the Human Rights Aspects of Assisted Reproduction

According to the Preamble, the Charter of Fundamental Rights and Freedoms as part of the constitutional order of the Czech Republic is based on recognising the inviolability of the natural rights of man, of the rights of citizens, and of the sovereign character of law, proceeding from the universally shared values of humanity and from the democratic and self-governing traditions of the nation, remembering the bitter experience gained at times when human rights and fundamental freedoms were suppressed in the country, hoping that these rights will be safeguarded through the common effort of all free nations and recalling – among – others its share of responsibility towards future generations for the fate of life on this Earth.[25] In addition to these values and goals stated in the Preamble, the Charter enshrines other rights in its individual articles: from general to more specific ones.

First, within 'General Provisions' it is stated that 'All people are free and equal in their dignity and in their rights. Their fundamental rights and freedoms are inherent, inalienable, illimitable, and irrepealable'.[26] This introductory provision is followed by guaranteeing the other general rights and freedoms, especially through the statement that

> Fundamental human rights and freedoms are guaranteed to everyone irrespective of sex, race, colour of skin, language, faith, religion, political or other conviction, ethic or social origin, membership in a national or ethnic minority, property, birth, or other status,
> No one may be caused detriment to his or her rights because he or she asserts his or her fundamental rights and freedoms

and that

> Duties may be imposed only by law and within its limit and only if the fundamental rights and freedoms of the individual are respected. Any limits placed on fundamental rights and freedoms may be governed only by law under the conditions set by this Charter…

and

> Any statutory limitation of the fundamental rights and freedoms must apply equally to all cases meeting the set conditions.

25 Act No. 2/1993 Sb., as amended, further 'Charter'.
26 Art. 1 Charter.

And finally, there is a provision stating that

> When applying the provisions on the limits of the fundamental rights and freedoms, their essence and meaning shall be respected. Such limits may not be abused for other purposes than those for which they were instituted.[27]

The part devoted to 'Fundamental Human Rights and Freedoms' contains a key provision for the purpose of this book which is 'Everyone has the right to live. Human life deserves to be protected even before birth' and 'No one may be deprived of his or her life'.[28] It must be stressed that the wording of the provision 'human life is worthy of protection even before birth' was very ardently debated during the legislative process and is the result of a compromise between opponents and supporters of abortion. However, the provision was never recognised as a ban on abortions or as limitation to the legality of abortions.[29] For the rights of the *nasciturus* see Point 6.1.

Within the chapter devoted to 'Economic, Social and Cultural Rights' the Charter provides for the constitutional protection of pregnant women and all children as follows 'During pregnancy women are guaranteed special care, protection in labour relations, and appropriate working conditions'. Furthermore, 'Children born both in and out of wedlock have equal rights'. Finally, it must be emphasised that the Charter protects on a constitutional level family as such as it includes general rules by wording 'Parenthood and the family are under the protection of the law'.[30] There are no established definitions either for parenthood, or for the family. It is in full harmony with the wide concept of the protection of family life guaranteed by international instruments. It is particularly the Convention for the Protection of Human Rights and Fundamental Freedoms that guarantees that 'Everyone has the right to respect for his private and family life'.[31]

Regarding medical care, and its accessibility for everyone, it is necessary to add the constitutional provision that 'Everyone has the right to the protection of his/her health. Citizens are eligible under public insurance for free medical care and medical aids under the conditions set by law'.[32] It must be underlined, that this constitutionally enshrined principle applies to assisted reproduction in practice as well. As will be discussed in more detail below, it is the specific law that places certain limits on people's desire to have children.

Let us add that the human rights dimension of assisted reproduction is emphasised by the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: in short the

27 Arts. 3, 4 of the Charter.
28 Art. 6 of the Charter.
29 Holčapek et al., 2023, p. 131.
30 Art. 32 of the Charter.
31 Published under No. 209/1992 Sb. in the Czech Republic.
32 Art. 31 of the Charter.

Convention on Human Rights and Biomedicine, or the Convention on Biomedicine.[33] As the Convention's starting point is that 'the interests of human beings must come before the interests of science or society', which also includes the best interests of the child, the use of assisted reproduction methods and procedures shall not be permitted for the purpose of selecting the sex of a future child, except where the use of assisted reproduction methods and procedures can prevent serious genetically determined sex-linked diseases. See Points 4.3. and 4.8.

When it comes to the provisions of sub-constitutional law regulating medical care and health services, the Act on Public Health Insurance,[34] the Decree on the Transmission of Data to the National Health Information System,[35] the Act on Health Services[36] and the Act on Specific Health Services[37] should be mentioned in particular, being the basic sources regulating assisted reproduction, but not surrogacy, which is not regulated as a healing method of infertility in Czechia.

Furthermore, other acts related to this area should also be mentioned, primarily the Act on Quality Assurance and Safety of Human Tissues and Cells for Human Use and the amendments of related acts, in short Human Tissues and Cells Act[38] and the Act on Research on Human Embryonic Cells and related activities and on the amendment of certain related acts, in short Human Embryonic Stem Cells Research Act.[39] Additionally, there is the Act on the Artificial interruption of pregnancy, the so-called Abortion Act[40] and its implementing degree (Degree No. 75/1986 Sb.) which are relevant regarding the issue of human life before birth. See Point 6.1.

In this context the Civil Code must also be mentioned No. 89/2012 Sb., as amended, referred to as the 'Civil Code' or 'CC'. This Code regulates the civil status of the natural person and particularly the determination of motherhood and fatherhood, including adoption.[41] Besides, the Civil Code includes basic provisions regarding the autonomy of a person's will and his/her contractual freedom, and its significant limits: good manners, public order, status law and specifically the rule, that the 'Human body and its parts, even if separated from the body, are not a thing'.[42] Finally, the Civil Code regulates the 'Contract for Health Care', which is the basis

33 Published under No. 96/2001 Sb. m. s. in the Czech Republic.
34 Act No. 48/1997 Sb., as amended.
35 Decree No. 373/2016 Sb.
36 Act No. 372/2011 Sb., as amended, referred to as 'AHS'.
37 Act No. 373/2011 Sb., as amended, referred to as 'ASHS'.
38 Act No. 296/2008 Sb., as amended.
39 Act No. 227/2006 Sb., as amended.
40 Act No. 66/1986 Sb., as amended.
41 For general information on Czech Family Law, Králíčková, 2021, pp. 77–109.
42 Section 493, Civil Code.

for the provision of health services regulated by special acts referred to above[43] and the section 'Obligations Arising from Torts' expressly deals with 'Compensation for pecuniary and non-pecuniary harm'.[44]

Finally, there are public law instruments sanctioning malpractice both at the level of misdemeanours and crimes, namely the Act on Liability for Offenses and Proceedings,[45] the Criminal Code[46] and the Act on Criminal Liability of Juristic Persons and proceedings against them, in short, the Juristic Persons' Criminal Liability Act.[47] Regarding advertisements and the rules thereof in the field of (but not limited to) assisted reproduction, there is the Act on the Regulation of Advertising.[48] Finally, there are several other significant acts, among them the one regulating procedure law etc.

43 Section 2636, Civil Code – A Contract for Health Care
(1) With the contract for health care, the provider undertakes, in regard to the mandator and within the provider's scope of occupation or objects of activities, to take care of the patient's health, whether the patient is the mandator or a third person.
(2) The provider shall receive remuneration from the mandator, if so stipulated; this does not apply if another legal regulation provides that the health care is exclusively paid from other sources.
Section 2637, Civil Code.
Health care includes intervention, examination and advice, and all other services which directly relate to the patient and the purpose of which is to improve or maintain the patient's health condition. However, health care is not an activity merely consisting of the sale or other transfer of medicinal products.

44 Section 2913, Civil Code – Breach of a Contractual Duty
(1) If a party breaches a contractual obligation, this party shall provide compensation for the resulting damage to the other party or the person who was evidently intended to benefit from the fulfilment of the stipulated obligation.
(2) A tortfeasor is released from the duty to provide compensation if he/she proves that he/she was temporarily or permanently prevented from fulfilling his/her contractual obligations due to an extraordinary, unforeseeable and insurmountable obstacle arising through no fault of his/her. However, an obstacle arising from the tortfeasor's personal circumstances or arising when the tortfeasor was in default of performing his/her contractual obligations, or an obstacle which the tortfeasor was contractually required to overcome shall not release him/her from the obligation to provide compensation.

45 Act No. 250/2016 Sb., as amended.

46 Act No. 40/2009 Sb., as amended.

47 Act No. 418/2011 Sb., as amended.

48 Act No. 40/1995 Sb., as amended.

4. Medical Regulation of Assisted Reproduction

4.1. The Concept of Assisted Reproduction

In addition to the constitutional level analysed above, the medical regulation of assisted reproduction is primarily included in the Act on Specific Health Services.[49] This act defines the basic concepts such as assisted reproduction, infertile opposite-sex couple as beneficiary (married or *de facto*) and their informed consent, anonymous donor, mutual anonymity of the donor and the infertile couple, and especially the conditions and limits for its implementation, as follows.

According to law, the assisted reproduction means methods and procedures involving the collection and manipulation of germ cells, the creation of a human embryo by fertilisation of an egg with sperm outside the woman's body, the manipulation and storage of human embryos for assisted reproduction of the woman, namely (a) for medical reasons in the treatment of her infertility or the infertility of a man, if it is unlikely or unattainable for the woman to become pregnant naturally or to bear a viable foetus and if other treatments for her or the male's infertility have not led or are highly unlikely to lead to her becoming pregnant or (b) as regards the need for the early genetic testing of the human embryo, if the health of the future child is endangered because of a demonstrable risk of transmission of genetic diseases or defects carried by the woman or the man.

It is important that assisted reproduction may be performed on a woman of child-bearing age, provided that she is under 49 years of age.[50] However, financing by the public health insurance is available only till the age of 40. For details see Point 4.7. It must be added that there is no age limit for the man of an infertile couple.

Regarding details on assisted reproduction, there is a definition of germ cells by the lawmaker: germ cells mean eggs and sperm for the purpose of the act. The act provides what germ cells can be used for the assisted reproduction of a woman. These are either (a) eggs obtained from the woman; or (b) sperm obtained from a man who is undergoing fertility treatment together with the woman; or (c) germ cells donated by another person, i.e. a donor who must be anonymous. Finally, it is stated that germ cells may be collected and used for assisted reproductive techniques and procedures if the medical suitability has been assessed for (a) the persons from

49 Act No. 373/2011 Sb., as amended, referred to as 'ASHS', Section 3. See English version of the ASHS: Parliament of Czech Republic, 2011.

50 Pursuant to the Act, the beneficiary – the woman – shall not be a person whose legal capacity is limited in such a way that she is incapable of assessing the provision of health services, or the consequences of their provision, or deprived of parental responsibility, even partially (note: a woman can be limited in her legal capacity in relation to parental responsibility only for a child who is already alive). A person in police custody, detention, imprisonment or pre-trial detention may not be a beneficiary, either. Unlike the donor, there are no special conditions or requirements against a man of the infertile couple. See Point 4.2.

whom the germ cells are to be taken, and for (b) the woman to be inseminated (a. i. 'the recipient'). This means that health suitability among both infertile couples and possible donors must be assessed by the provider of assisted reproduction before it is carried out.

There are additional methods of assisted reproduction according to the law. It is stressed that the assisted reproduction method for treating woman's infertility is (a) the introduction of sperm into the reproductive organs of a woman; (b) the transfer of a human embryo resulting from the fertilisation of an egg by sperm outside the woman's body into the woman's reproductive organs (that is '*in vitro* fertilisation' and 'embryo transfer', in short 'IVF' and 'ET').

A written request from a woman and a man who intend to undergo this medical service together is the key prerequisite of assisted reproduction: a so-called informed infertile couple of the opposite sex, married or *de facto*.[51] The request from the infertile couple asking for assisted reproduction must not be more than 6 months old; it shall form part of the medical records kept on the woman.[52] The request and then the written consent shall be repeated before each assisted reproduction is performed.[53] If assisted reproduction is defined very broadly, i.e. the methods and procedures for harvesting germ cells, manipulating them, creating a human embryo, it must be concluded that a written consent is required for all these individual services.

In case the request or consent is not given, or is withdrawn, assisted reproduction shall not be performed. As referred to above, the consent must be given by both parties: the woman and especially the man of the infertile couple. This provision is in line with the well-known case law of the European Court of Human Rights in Evans v. the United Kingdom.[54] It is very important especially in the case of a *de facto* infertile couple, and sometimes even a 'fake' infertile couple. It should be added in this respect that assisted reproduction comes into consideration by the nature of the matter only between the 'living' infertile couple, although it is not expressly prohibited in the event of the death of the husband or the partner of a woman of the infertile couple. In this respect, such a case law at the European Court of Human Rights has appeared in the *Pejřilová v. the Czech Republic* case.[55] For details see Point 4.9.

The Act on Specific Health Service regulates that prior to the commencement of assisted reproduction methods and procedures, the provider shall provide the

51 According to the Act, the assisted reproduction may not be performed on a woman who has a relationship with the man with whom she has submitted an application that precludes marriage under the provisions settled by the Civil Code: they are relatives in a direct line and siblings.

52 The infertile couple may request that a witness of their choice be present when the information is given. The record of the submission of the information shall be signed by the infertile couple, the attending physician and, where appropriate, the witness; it shall form part of the medical records kept on the recipient.

53 The consent given shall be recorded in the medical records kept on the recipient by the attending physician, who shall sign the record; the record shall also be signed by the recipient.

54 *Evans v. the United Kingdom*, Application No. 6339/05, Judgement of 10th April 2007.

55 *Pejřilová v. the Czech Republic*, Application No. 14889/19, Judgement of 8th December 2022.

infertile couple information on the nature of the proposed methods and procedures, their lasting consequences and possible risks, and the manner in which surplus human embryos may be disposed of, including the estimated financial cost and duration of their storage. The infertile couple shall also be provided with information on the determination of parenthood of the child under the Civil Code, if the child has been conceived by assisted reproduction. See below, Point 5.1.

4.2. About Donors and the Mutual Anonymity Between Them and the Infertile Couple

Regarding general conditions set for germ cell donors, the Act on Specific Health Services states that an anonymous donor may be (a) only a woman who has reached the age of 18 and has not surpassed the age of 35 and (b) a man who has reached the age of 18 and has not surpassed the age of 40.[56] There are no legal limits regarding the number of donated cells. There is no central registry of donors which is sometimes noted as being a 'risky' situation due to the possibility of one donor 'visiting' several health service providers.[57] However, according to the literature, all the eggs obtained from one female-donor are used in practice by one health service provider only for one recipient.[58]

As for the so-called quality of donors, or germ cells, it was published that donors are selected on the basis of age, health, medical and laboratory examination, medical and behavioural history as stated in the questionnaire, and based on a personal interview with the health service provider. The evaluation and selection also includes factors relevant to assessing the potential risk to the future child (e.g. risk of sexually transmitted diseases, genetic defects and diseases, etc.) and to the donor (e. g. risks associated with egg retrieval, etc.). It was added that donor screening includes testing for HIV 1 and 2, HBV and HCV and syphilis and, for male-donors, chlamydia trachomatis.[59]

Finally, the Act on Specific Health Services states that the person from whom the germ cells were taken is not entitled to financial or other compensation for the removal of the germ cells. However, the provider who carried out the donation shall reimburse the anonymous donor, on the basis of his/her request, for the expenses incurred in connection with the donation of germ cells in an efficient, economical and demonstrable manner. It was published that a male-donor may receive between

56 The Act on Specific Health Services provides further details stating that a person may not be an anonymous donor, (a) whose legal capacity is limited so that he/she is incapable of assessing the provision of health services or the consequences of their provision, (b) who is incarcerated in a police cell, in custody, imprisonment or pre-trial detention or in a detention facility for foreigners or in an asylum facility, (c) ordered to be isolated, quarantined or placed under inpatient protective treatment or (d) who is hospitalised without consent.

57 Mach et al., 2023, p. 471.

58 Kohoutová, 2023, p. 8.

59 Mach et al., 2023, p. 483.

CZK 2 000 and CZK 3 000 for sperm donation and a female-donor may receive a much higher reimbursement between from CZK 25 000 and CZK 28 000, for eggs donation, which is justified by the hormonal stimulation, the longer duration of the full procedure and general anaesthesia.[60] Reimbursement may be claimed from the recipient of the assisted reproduction or from the provider to whom the germ cells or human embryos were transferred for the purpose of assisted reproduction. The provider who received the germ cells or human embryos for assisted reproduction and who reimbursed the expenses may claim reimbursement of those expenses from the recipient of the assisted reproduction, i.e. the infertile couple.

The strict approach to donor anonymity by the Czech lawmaker is not only about the rights of donors for their identity to be kept anonymous, but it is also a necessity, or condition of assisted reproduction.[61] The provider who is authorised to perform assisted reproduction methods and procedures shall ensure that the mutual anonymity of the anonymous donor and the infertile couple and the anonymity of the anonymous donor and the child born from assisted reproduction is preserved. And finally, it is emphasised that a provider who has carried out a medical suitability assessment of an anonymous donor and a woman or man of an infertile couple shall be obliged to transmit the information on their health status necessary for assisted reproduction to the provider who carries out the assisted reproduction; this provider shall keep the information on the health status of the anonymous donor for a period of 30 years following the assisted reproduction and shall, on written request, provide the information on the health status of the anonymous donor to the infertile couple or the adult born from assisted reproduction.

As referred to in the introduction, the anonymity of donors is a rather controversial, topical issue in Czechia. There are a large number of supporters of the present concept, although the right of the child to know the origin, his or her roots is, pursuant to the law, limited to medical information, or health data. On the other side, some critics of the *de lege lata* regulation call for child open identity, sometimes with idealistic views. However, there are no European standards in this domain.[62] The European Court of Human Rights stated in many cases that the states have a relatively wide range of appreciation regarding the anonymity of donors.[63]

4.3. On the Other Limits of Assisted Reproduction

Regarding the limits of assisted reproduction, in addition to those settled by the international conventions referred to above, particularly by the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: the Convention on Human Rights and

60 Kohoutová, 2023, p. 9.
61 Sections 10 and 11, ASHS.
62 Ignovska, 2015.
63 Holčapek et al., 2023, p. 127, see case-law referred to.

Biomedicine, the Act on Specific Health Services provides that assisted reproduction methods and procedures may be performed if the requirements set out in the Human Tissues and Cells Act have been met.[64] The use of assisted reproduction methods and procedures shall not be permitted for the purpose of selecting the sex of a future child, except where the use of assisted reproduction methods and procedures can prevent serious genetically determined sex-linked diseases. And finally, germ cells and human embryos may be used only for assisted reproduction. This shall not apply in the case of human embryos not used for assisted reproduction which may be used for research on human embryonic stem cells under the conditions and for the purposes laid down in the law governing research on human embryonic stem cells by the Human Embryonic Stem Research Act.[65]

4.4. Surrogacy as a Healing Method of Infertility?

It must be stressed again that surrogate motherhood has never been regulated by medical law.[66] As referred to above, it is neither permitted nor prohibited in the current legal system. What are the limits or restrictions on surrogacy? Although it is not explicitly prohibited in the Act on Specific Health Services, it must be concluded that the prohibition on surrogacy for health service providers follows from the purpose of the Act.

First, assisted reproduction can only be performed on an infertile woman, or an infertile couple. However, the surrogate mother is not and must not be infertile by the nature of the case. Second, in the case of the donation of germ cells, the law strictly imposes the duty of anonymity. See above. Thus, it must be inferred that if the intended parents of the child and the surrogate mother know each other and have entered into a contract with each other, the law based on anonymity would be circumvented.

However, the interpretation of the Act on Specific Health Services is complicated by the fact that the Civil Code contains the words ‘surrogacy’, although only in the context of regulating the conditions of adoption, where it is expressly mentioned.[67] See below, Point 5.2.

As highlighted above, the statistical data and final summary by the Institute of Health Information and Statistics and the National Reproductive Health Registry do not provide any information about the implementation of surrogacy in Czechia. This confirms the thesis that surrogate motherhood takes place behind so-called closed doors, without any official records. See Point 2.3.

64 Act No. 296/2008 Sb.
65 Act No. 227/2006 Sb.
66 Haderka, 1986, pp. 917–934.
67 Section 804, Civil Code.

4.5. About Surplus Embryos

It is no secret that, in practice, an excess of human embryos is created due to hormonal stimulation, which raises a number of not only ethical questions. There are no limits regulated by the law. Some authors speak euphemistically about the 'reduction' of embryos,[68] others critically and directly about 'consumable' or even 'waste' material.[69]

The Act on Specific Health Services pays serious attention to the issue of unused human embryos.[70] The Act provides that if the assisted reproduction of the recipient has not used all the human embryos created for the benefit of the infertile couple, they may be preserved and used for their further assisted reproduction. This does not apply if the infertile couple declares in writing that they do not intend to use those embryos for their next assisted reproduction and consent to their use for another anonymous infertile couple or consent to the use of surplus embryos for research under the Human Embryonic Stem Cells Research Act or to their disposal. The declaration may be revoked by the infertile couple at any time; this does not apply if the human embryos have already been used by another infertile couple or disposed of in accordance with the declaration.

If the human embryos have not been used or the infertile couple has not made a written declaration about their disposal in accordance with above rules, the provider may, after 10 years of storing those embryos, repeatedly request the infertile couple in writing[71] to provide a statement on the continued storage of those embryos, including consent to their disposal. If the infertile couple does not respond to the repeated written request from the provider, the human embryos may be disposed of without the infertile couple's statement.[72] Finally, the Act states that on the basis of a written declaration or written consent given following a request, the provider shall arrange for the destruction of the stored frozen human embryos in the presence of at least 2 healthcare professionals.[73]

68 Šnédar, 2023, p. 25.

69 Valc, 2017, p. 21.

70 Section 9, ASHC.

71 Repeated written notice shall mean its verifiable mailing through a postal service provider to the address of the infertile couple known to the provider, on at least two occasions, at least 60 days apart. The time limit for the infertile couple to make a statement based on the second invitation shall be 30 days from the date of its receipt.

72 The summons is delivered on the day when the addressee receives it, otherwise it is deemed to have been delivered upon the expiry of the period of 10 days from the date of notification of its deposit with the postal service operator. If the summons is undeliverable due to a change in address of the infertile couple or if its receipt has been refused, the summons shall be deemed to have been served on the date of its return to the provider. The same procedure shall apply if the notice is undeliverable to only one person of the infertile couple.

73 The medical records kept on the recipient shall include a written declaration or written consent, or, where applicable, a delivery note or other document certifying that the written invitation was sent to the infertile couple and a record of the disposal of the human embryos; the record shall be signed by the health professionals who were present at the disposal of the human embryos.

4.6. On the Providers of Assisted Reproduction

As regards providers of assisted reproduction, the Act on Specific Health Services states, that treatment by assisted reproduction methods may only be carried out by a provider who has been granted an authorisation to provide health services in the field of reproductive medicine or, in the case of assisted reproduction in the field of gynaecology and obstetrics.[74] In accord with the freedom of enterprise, there are several providers of the treatment of assisted reproduction, both natural and legal entities in line with the private or public law without any legal distinctions. Some of these entities are divisions of university (teaching) hospitals as their contributory organisations.[75]

It was released that in 2020 there were 48 providers of assisted reproduction, or registered centres in Czechia. The increase in the number of centres serves the significant request of foreign women coming to the country for treatment.[76]

4.7. Financing of Assisted Reproduction

In addition to the constitutional level presented above, there is a sub-constitutional law regulating medical care, in particular the Act on Public Health Insurance.[77] This act stipulates that health insurance covers health services on assisted reproduction provided on the basis of a recommendation from a registered provider in the field of gynaecology and obstetrics in connection with assisted reproduction in the form of *in vitro* fertilisation (a) women with bilateral fallopian tube incompetence aged 18 years and over until the date of their 40th birthday, (b) other women aged from 22 years to the date of reaching the age of 40 years, but not more than three times in a lifetime, or, if in the first two cases not more than one human embryo resulting from the fertilisation of an ovum by sperm outside the woman's body has been transferred into the woman's reproductive organs, four times in a lifetime.[78]

This means in practice that health insurance covers the hormonal stimulation and *in vitro* fertilisation (IVF) cycles referred to earlier, but no additional and above-standard services such as cryopreservation of gametes and embryos, their prolonged cultivation, preimplantation genetic testing and other cycles.[79] As referred to above, the cost of an *in vitro* fertilisation (IVF) cycle, including medication, costs CZK 30 000 to CZK 50 000 and the woman generally pays one third of the cost even if reimbursed by public health insurance. It was stressed that the cost of modern assisted reproductive techniques is a barrier to their use and that it is 'basically inaccessible'

74 Section 4, ASHS. For details see Decree No. 99/2012 Sb., on the minimum requirements of the technical and material equipment of medical facilities and home care contact workplaces.
75 Golčapek et al., p. 20.
76 See Ústav zdravotnických informací a statistiky ČR, 2022, p. 15.
77 Act No. 48/1997 Sb., as amended, 'APHI'.
78 Section 15, para. 3, APHI.
79 Mach et al., p. 495.

for low-income families. See Point 2.1. It must be added that assisted reproduction is available for woman till the age of 49. This means that if the woman is over 40 years old, the infertile couple must pay for all the services according to the conditions set by the provider. The same rules apply to the infertile couple if surrogacy is involved.

4.8. Malpractice and Sanctions

The Act on Specific Health Services provides for an appropriate sanction for virtually every breach of the administrative obligation set out in the Act. This act is *lex specialis* in relation to the Civil Code and its regulation of a 'Contract for Health Care', 'Obligations Arising from Torts' and especially rules for 'Compensation for pecuniary and non-pecuniary harm'. See Point 3.

Regarding the topic of assisted reproduction, it is regulated that the provider carrying out assisted reproduction methods commits an offence by (a) disposing of human embryos violating the rules referred to above, (b) failing to ensure the common anonymity of the anonymous donor and the infertile couple and the anonymity of the anonymous donor and the child born from assisted reproduction, and (c) failing to keep data on the health status of the anonymous donor for a period of 30 years after the assisted reproduction has been carried out.[80]

The offence is punishable by a fine of up to CZK 100 000 – CZK 500 000, depending on the type of offence. The Act on Specific Health Services sets out the criteria to be taken into account in determining the amount of the fine. According to the commentary to the Act on Specific Health Services, a legal or natural person whose administrative offence is the subject of administrative proceedings before the competent authority must be proven in those proceedings to have breached the relevant administrative obligation under the Act on Specific Health Services. However, it is not necessary to prove its fault or harmful consequence. A legal or natural person, as a party to administrative proceedings for the imposition of a penalty for an administrative offence, may be exempted from liability if it proves that it has made every effort that could be required to prevent the breach of the administrative obligation. The burden of proof of this fact shall be on the legal or natural person concerned – the party to the administrative proceedings. The Ministry of Health is authorised to take administrative proceedings in the event of a breach of law, that is in the case of verification of non-established methods of providing health services and breach of the rules laid down by law for this activity. Furthermore, the Ministry of Health is competent to impose a sanction for an administrative offence in connection with the performance of external clinical audits. In the case of all other administrative offences, the competent administrative authority that issued the authorisation to

80 Section 90, sub-section 2, ASHS.

provide health services to the relevant provider, which is the regional authority or the Prague City Hall, is competent to deal with them.[81]

Administrative offences and penalties imposed are decided in administrative proceedings under the special Act.[82] Appeals against the decision of the administrative authority may be lodged with the Ministry of Health. Appeals against decisions of the Ministry of Health may be lodged with the Minister of Health or the Chairman of the Office. Decisions are reviewable by a court under the special Act.[83]

Criminal penalties are also regulated by a special law.[84] In relation to the topic of assisted reproduction, particularly relevant are offences related to the unauthorised handling of human tissues and organs, human embryo and human genome regulated in the section on offences against life and health; namely (a) the unauthorised removal of tissues and organs, (b) the unlawful disposal of tissues and organs, (c) the removal of tissue or organs and the performance of transplantation for consideration, and (d) the unlawful disposal of the human embryo and the human genome. It may also be an offence under the offences against liberty: namely (a) trafficking in human beings and (b) entrusting a child to the authority of another. The criminal procedural regulation is laid down in a special law.[85]

4.9. About the Case-Law on the Limits of Assisted Reproduction: Solely Inter Vivos

Recently there was a case dealt with all court instances of the Czech Republic and by the European Court of Human Rights. The result can be comprehended as 'sad' from a human point or view, but it was made in accordance with the law. The case law speaks for the 'good' practise in Czechia. However, in literature the issue was noted as 'controversial'.[86]

The facts were as follows.[87] The applicant and her husband got married in 2012. They were unable to conceive a child naturally. The applicant's husband had a serious disease, so the couple sought the help of a centre for medically assisted reproduction ('the Centre'). In June 2014 the applicant's husband had his sperm cryopreserved, signing a consent form agreeing to such preservation for the purpose of having infertility treatment. The consent form included, *inter alia*, information indicating that further written consent would be required before each occasion when sperm would be thawed for the assisted reproduction procedure, and that unless clearly determined otherwise, storage of the sperm would be discontinued in the

81 Mach et al., 2023, pp. 770–771.
82 Act No. 500/2004 Sb., Administrative Procedure Act, as amended.
83 Act No. 150/2002 Sb., Administrative Court Procedure Act, as amended.
84 Act No. 40/2009 Sb., the Criminal Code, as amended.
85 Act No. 141/1961 Sb., Criminal Procedure Code, as amended.
86 Holčapek et al., 2023, p. 125.
87 Information processed on the basis of the European Court of Human Right's case of *Pejřilová v. the Czech Republic*, Application No. 14889/19, Judgement of 8th December 2022.

event of the donor's death. In December 2014 the applicant and her husband signed informed consent forms agreeing to infertility treatment using *in vitro* fertilisation (IVF), and to the thawing of the applicant's husband's sperm and its use in intracytoplasmic sperm injection. In signing the forms, they agreed to notify the Centre of any changes in their relationship which could cause the treatment to be terminated. Subsequently, the applicant's husband's health deteriorated and he died in June 2015, before any further steps had been taken (namely, the file did not indicate that the applicant had started the necessary hormone treatment or had her ova collected). In September 2015 the applicant asked to have her eggs fertilised with her late husband's cryopreserved sperm. The Centre refused, stating that such a procedure would be contrary to the law, and suggested that the applicant instigate court proceedings in which they could reach a settlement.

Regarding court proceedings, the applicant lodged an action with a District Court in October 2015, seeking to compel the Centre to perform the treatment and, in accordance with her late husband's wishes as demonstrated by the above consent forms, fertilise her eggs with his sperm. At a hearing both parties expressed their readiness to reach a settlement. On the same day the District Court did not approve such a settlement, since it would have been contrary to the law which required that consent to the treatment be less than six months old. See Point 4.1.

There followed a series of legal vicissitudes, including an extraordinary appeal to the Supreme Court of the Czech Republic.[88] Then, in November 2018, the Constitutional Court of the Czech Republic dismissed a constitutional appeal by the applicant. It considered that the lower courts had adequately examined the applicant's arguments and provided detailed reasoning for their findings, and that the Supreme Court had duly taken into account the constitutional dimension to the case as well as the Court's case-law.[89]

Finally, in March 2019 the applicant submitted an application to the European Court of Human Rights arguing that the Czech Republic should respect her choice of the father of her child, as well as her late husband's wish to have a child with her and should allow her to continue with the assisted reproduction procedure using her late husband's frozen sperm. She relied on Art. 8 of the Convention for the Protection of Human Rights and Fundamental Freedoms. In her view, the national courts' decisions had been formalistic.

The European Court of Human Rights ('Court') admitted that in the field of medically assisted procreation in general, legal provisions are developing quickly, as demonstrated by a comparison between the Council of Europe study of 1998 and the Survey conducted by the International Federation of Fertility Societies in 2007. However, it was stated that the present case raises specific ethical questions linked to the issues of public interest, allowing for the States' wide margin of appreciation.

88 The Ruling of the Supreme Court of the Czech Republic of 21st February 2018, No. 21 Cdo 4020/2017.

89 The Ruling of the Constitutional Court of the Czech Republic of 8th November 2018, No. I. ÚS 1099/18.

It was stressed that in the Court's view, the Czech legislature's decision to enact such provisions, and their interpretation by the domestic courts, reveal the intention to respect human dignity and free will, as well as a desire to ensure a fair balance between the parties involved in assisted reproduction, so that every person donating gametes for the purpose of such treatment would know in advance that no use could be made of his or her genetic material without his or her continuing consent. The Court has already held that such general interests are legitimate and consistent with Art. 8 of the Convention. This is all the more so, that the Czech Republic has to be afforded a wide margin of appreciation in this respect, which it did not overstep. In view of the foregoing considerations, the Court is of the view that there has been no violation of Art. 8 of the Convention for the Protection of Human Rights and Fundamental Freedoms.[90]

5. Family Law Regulation on Affiliation

5.1. Law in Books: 'One Child, One Mother and One Father' as a Principle

Statutory law is regulated by mandatory rules in the Civil Code. It is stated that 'Kinship is a relationship based on a blood tie or originated by adoption'.[91] According to the Czech legal order, the child, as a rule, can have only two 'legal' parents of the opposite sex: the mother and the father. For exceptions, see below.

As referred to above, assisted reproduction is available for both married and unmarried infertile couples. Informed consent of a man and a woman – 'intended parents' – is a key prerequisite which is a base for assisted reproduction, both homologous and heterologous. See Point 4.

The Civil Code provides that 'The child's mother is a woman who gives birth to the child',[92] regardless of who the donor of the egg, or the embryos was. Legal motherhood is thus identical with biological motherhood and in the case of egg or embryo donation the genetic motherhood is irrelevant. As referred to above, the regulation of assisted reproduction is included in the Act on Specific Health Services. This Act provides the rules for implementation of assisted reproduction, but also sets various limits, or restrictions. For the sake of completeness, assisted reproduction is available only for infertile couples of the opposite sex. That is why the child cannot have two 'legal' mothers according to the Czech law on assisted reproduction, or filiation.[93]

90 Pejřilová v. the Czech Republic, Application No. 14889/19, Judgement of 8th December 2022.
91 Section 771, Civil Code.
92 Section 775, Civil Code.
93 If a woman in a partnership with another woman concluded according to the Civil Code gives birth to a child conceived by means of assisted reproduction, the man who consented to the assisted reproduction is deemed to be the father of the child.

Regarding surrogate motherhood, it is not regulated in the Czech legal order, either in the Act on Specific Health Services, or in the Civil Code, except for 'one note' in connection with adoption among close relatives. The Civil Code provides that adoption is excluded between persons who are relatives in the direct line and the siblings 'except for kinship based on surrogate motherhood'.[94] This 'supplement' to the traditional concept of motherhood, or adoption was included into the draft Civil Code by a 'the last-minute' proposal.[95] It should be added that an adoption is the only 'legal' way for a woman to become a 'legal' mother of the 'ordered' child.

Denial of maternity is not explicitly regulated in the Civil Code. However, in the practice of the Czech courts there have been cases where this issue has arisen, for example, in the case of switching babies in the maternity ward or the birth of a surrogate mother who proved her identity in the maternity hospital by the ID of her sister, a woman of the 'intended' couple.

Regarding the legal rules on fatherhood, it is provided by the Civil Code that the child's father is a man whose fatherhood is based on one of the three legal rebuttable presumptions of paternity.[96]

The first presumption is in favour of the mother's husband, if the child is born in wedlock or within 300 days since its end.[97] Generally, a husband may deny his paternity in court within six months from becoming aware of the facts constituting reasonable doubt that he is the father of a child born to his wife, but no later than six years after the birth of the child.[98] A child's mother may, within six months of the child's birth, refute that the child's father is her husband.[99] The child has no right of denial.

There are special rules regarding assisted reproduction. It must be stressed that any sperm donation is irrelevant if the husband has given his consent to assisted reproduction in accordance with the law. However, paternity may not be denied with respect to a child born during a period between the one hundred and sixtieth day and the three hundredth day after the assisted reproduction was carried out with the consent of the mother's husband, regardless of the genetic substance used. This does not apply if the child's mother got pregnant in a different way.[100] This means that a husband may deny his paternity even in the case of assisted reproduction by donation, if he has given his consent to it, but only if he proves that his wife has become pregnant in a different way: i.e. if he proves in particular that she had sex with another man and that the child is genetically linked to that man by a DNA test.

The second presumption respects the autonomy of will of the child's non married parents and provides that the man who has stated so, together with the child's

94 Section 804, Civil Code.
95 Králíčková et al., 2020, p. 491.
96 Section 776, Civil Code.
97 Section 776, Civil Code.
98 Section 785, Civil Code.
99 Section 789, Civil Code.
100 Section 787, Civil Code.

mother, is the father of her child.[101] The law provides that a man whose paternity has been determined by an affirmative statement of both parents may only deny the paternity of a child if it is impossible that he could have been the father of the child. He may do so within six months from the date on which the paternity was so determined; where the paternity is determined before the birth of the child, the time limit shall end no earlier than six months after birth.[102] The child's mother may deny that the man whose paternity has been determined by an affirmative statement of both parents is the child's father within the same time limit as the man.[103] Again, the child has no right of denial of the fatherhood.

Let us add that any sperm donation is irrelevant if the man of the infertile unmarried couple has given his consent to assisted reproduction in accordance with the law. The Civil Code provides that if a child conceived through assisted reproduction is born to an unmarried woman (or the woman is registered in a civil partnership with another woman), the man who gave consent to the assisted reproduction is presumed to be the child's father.[104] Similarly, as in the case of a married man, denial of paternity is also possible if the unmarried mother of the child becomes pregnant in a way other than as a result of assisted reproduction. This means that a man from an unmarried couple may deny his paternity even in the case of assisted reproduction by donation, if he has given his consent, but only if he proves that the child's mother has become pregnant in a different way: i.e. if he proves in particular that she had intercourse with another man and that the child is genetically linked to that man by a DNA test.

It must be emphasised that it is the second presumption, i.e. the consenting declaration of the man and the surrogate mother, that is often used in practice as a 'legal' way for a man from an infertile couple to become the 'legal' father of an 'ordered' child. The other option is a adoption, which, however, is only permitted by law for married couples (or recently for the same-sex partners who entered into civil partnership according to the Civil Code).

As referred to above, the child is not allowed to deny paternity of his or her 'legal' father *de lege lata*. However, there are special legal rules protecting the rights of the child and the best interests of the child. In this respect, the Civil Code provides that

> if an application for the denial of paternity is filed after the time limit for denial has elapsed, a court may decide that the elapsed time limit is waived if required by the child's interest and public order.[105]

101 Section 779, Civil Code.
102 Section 790, Civil Code.
103 Section 791, Civil Code.
104 Section 778, Civil Code.
105 Section 792, Civil Code.

and that

> if required by the evident interest of the child and in order to fulfil the provisions guaranteeing fundamental human rights, a court may, even of its own motion, initiate proceedings on a denial of paternity if paternity has been determined by an affirmative statement of both parents, but the child's father determined in this manner cannot be his/her father. At the same time, the court shall also typically suspend the exercise of parental responsibility.[106]

To conclude the issue, the third presumption is based on the sexual intercourse in the so-called critical period: the father of an unmarried woman's child is considered to be the man who had intercourse with her within the period of 160 days up till the birth and within the period not exceeding 300 days before the birth unless his fatherhood is excluded by fundamental reasons.[107] The court will decide on the 'legal' parenthood of a man, in practice through DNA testing.

Let us add that there are some exceptions to the above-mentioned rule of 'one child, one mother, one father'. As of 1st January 2025 an amendment to the Civil Code comes into force,[108] which verifies same-sex partnerships besides marriage designed only for opposite-sex couples and besides same-sex registered partnership regulated by a special Act.[109] According to the novelty of the Civil Code, the provisions governing marriage and the rights and obligations of spouses apply in principle to the rights and obligations of partners of the same sex entering into partnership according to the Civil Code.[110] However, it will not concern the establishment of parenthood, except for so-called stepparent adoptions. This means that it is possible for a child to be adopted even by the same-sex partner of his/her parent, male or female, living in a marriage or a partnership. That is why the only way for the child to have two 'legal' same-sex parents would be adoption or the recognition of the same-sex parenthood established abroad. For details, see below, Point 5.4.

5.2. Surrogacy as 'Burning' Issue

It is no doubt that surrogacy raises several issues, particularly legal ones.[111] Since the current legal regulation of assisted reproduction is rather liberal and the Civil Code does not prohibit surrogacy explicitly, a Pandora's Box is gradually opening. It is common knowledge that surrogacy occurs in the Czech Republic with the silence of the legislator, both factually, i.e. naturally, but also with the help of assisted

106 Section 793, Civil Code.
107 Section 783, Civil Code. Králíčková, 2008, pp. 275–282.
108 Act No. 123/2024 Sb.
109 Act No. 115/2006 Sb., on Registered Partnership, as amended.
110 Recently, the same-sex persons entering into a partnership according to the Civil Code will have, for example, community property, family dwelling protection etc.
111 Scherpe et al., 2019.

reproduction technologies at the clinics of health service providers.[112] We emphasise that the Act on Specific Health Services does not include surrogacy among the methods of treatment for infertility and makes it possible to carry out assisted reproduction only with an infertile couple. For details, see above, Point 4.

It should be noted that in the course of drafting the Civil Code the necessity of regulating surrogate motherhood was not originally discussed at all. It should be reminded again, that the primary authors of the draft Civil Code, as well as the professional public, have favoured the preservation of the traditional concept of the status of the child in the Czech Republic.[113] The aim of the drafters of the Civil Code was to follow the above principle of the origin of the child from the mother who gave birth to him/her and to expressly state that 'an action of the genetic mother against the mother who gave birth to the child cannot be successful'.[114] Nevertheless, this 'addendum' was deleted and the provision 'against' surrogacy was not included in the final version of the Civil Code. It is disappointing that the ministerial team turned away from the original aim of the drafters and several co-operators and did not deal with this issue in more detail as it was done, for instance, in the Slovak Republic.[115] However, the 'prohibition' of private law surrogacy agreements derives from the general part of the Civil Code, which states that 'stipulations contrary to good morals, public order or the law concerning the status of persons, including the right to protection of personality, are prohibited'.[116] Finally, another 'ban' against surrogacy agreements is provided by the wording that 'the Human body and its parts, even if separated from the body, are not a thing'.[117]

In general, there could be practical 'problems' associated with the enforceability of surrogacy contracts, or arrangements.[118] It may be the case that the 'intended' parents, or even an individual, change their minds about the whole 'transaction' and do not take custody of the 'ordered' child or do not seek to 'reconcile' the genetic, biological, social and legal parenthood. Although infrequently, but it nevertheless happens that the 'ordered' child is born disabled or lifeless. This raises a few more questions. Additionally, it is now a well-known fact that surrogacy is a 'global' business which can often result in difficulties concerning the establishment or recognition of the 'legal' parenthood of the 'ordered' child born as a result of the arrangement, sometimes rendering the child parentless.[119]

However, it must be repeated that surrogacy is recognised in the Civil Code. Almost near the end of the legislative work the term surrogacy was entered into the government bill in spite of the express disagreement of many experts and the

112 Nováková et al., 2018, p. 32.
113 Eliáš and Zuklínová, 2001 and 2005.
114 Eliáš and Zuklínová, 2001, p. 167.
115 Section 83, Act No. 36/2005 Z. z., the Slovak Act on the Family. For more Pavelková, 2001, p. 504.
116 Section 1, Sub-Section 2, Civil Code.
117 Section 493, Civil Code.
118 Valc, 2023, p. 12.
119 Towards inter-country issues, Wells-Greco, 2016.

main drafters and is used in the context of the regulation of adoption. The Civil Code states that 'adoption is excluded between persons related to each other in the direct line and between siblings. This does not apply in the case of surrogacy'.[120] The aim of this provision is to 'break' the ban on adoption between close relatives, i.e. all relatives in the direct line and between siblings. The reason given was that 'in practice it happens' and therefore needs to be 'legally' treated. As referred to above, after passing the Civil Code in 2012, surrogacy was not introduced as a method of treatment of infertility into the Act on Specific Health Services of 2011.

It is relevant to raise the question of how 'intended' parents can acquire an 'ordered' child? If we exclude an exchange of the identity cards of the 'legal' mother and the 'intended' mother in the maternity hospital, adoption is the only option, but not only among relatives. As referred to above, the 'legal' mother of the child is the woman who – even if upon an order – gave birth to him/her.[121] After giving birth, she may consent to the adoption of her child. We should emphasise that due to international conventions the consent is only valid after the expiry of puerperium and may be withdrawn! For details, see Point 6.4. below. If the promises on both sides are kept, a direct adoption may be implemented. But, if the mother who gave birth to the child fails to keep her promise to consent to the adoption and hand the child over to the 'intended' parents, the adoption does not take place. And if the 'intended' parents change their minds refusing to adopt the child, their decision must be fully respected. During the fairly long process of adoption, there can be a number of twists and turns and unexpected problems. The court practice shows that if there are informal private law surrogacy agreements among the relatives, the conception usually takes place in a natural manner which may sometimes disrupt a fragile family situation. There are no known cases of child 'litigation' from current court practices and no official statistics are available. If there was a 'dispute' over the child, the 'legal' mother of the child would be the woman who gave birth to the child, regardless of any egg or embryo donation, which is based in a standard situation on the anonymity of donors.

To sum it up, we hold the view that uncertainty for the 'surrogate' mother as well as the 'intended' mother constitutes uncertainty for the 'ordered' child from the very beginning. There is a trivialisation of the fact that a 'legal' mother, or a 'surrogate' mother – is instrumentalised, that her womb is factually leased for considerable financial amounts and that the human embryo is being degraded to a mere subject-matter of a contract. Numerous problems are also caused by the fact that the Czech Republic is becoming a so-called promised land in this area, even for many women from countries where surrogacy is explicitly prohibited and criminalised. That is why drafts were lodged to 'solve' the situation as described hereunder.

120 Section 804, Civil Code.
121 Section 775, Civil Code.

5.3. Proposals on the Designed Law on Surrogacy[122]

It is a common knowledge that mostly private clinics provide surrogacy without any legal regulation. It should be recalled that surrogacy has never been regulated or prohibited in the territory of the present-day Czech Republic. Nor has it ever been anchored as a method of treatment for infertility by the Act on Specific Health Services. However, it must be said that historically, the courts in the Czech Republic dealt with the problems associated with surrogacy, which has been reported with criticism in the literature.[123] Today, in the context of the European reality,[124] i.e. legal regulations mostly prohibiting surrogacy, the Czech legislator is making an effort to regulate this 'burning' issue.[125]

In 2023, a proposal by a group of MPs of the Czech Republic to amend the Civil Code and the Criminal Code was submitted.[126] According to the authors, the aim of the bill is to prevent surrogacy as a specific form of human trafficking, both of women who are used as surrogate mothers and of the children they give birth to. As far as the Civil Code is concerned, it was proposed to repeal the provision allowing adoption between relatives if surrogacy was used.[127] The Government of the Czech Republic discussed and considered the draft law and finally took a disagreeing position. It was published that a ban on surrogacy may not lead to the desired goal, i.e., that surrogacy will not be implemented, as 'intended' parents will be able to undergo surrogacy abroad, often in countries that have very benevolent or no regulation of surrogacy. Such 'reproductive' tourism then entails additional difficulties and legal uncertainty not only for the 'intended' parents and the 'surrogate' mother, but above all for the child born through surrogacy. One cannot but agree with this general statement.

Later on, in 2024, in contrast, it was reported on the web page of the Ministry of Justice of the Czech Republic that the Minister of Justice submitted to the Government of the Czech Republic a plan for a comprehensive legal regulation of surrogacy titled 'Analysis of the Institute of Surrogacy'. According to press information 'The aim of this initiative is to create a clear and legally secure framework for surrogacy, which still lacks explicit legal regulation in the Czech Republic'.[128]

Regarding details, the proposed legislation on surrogate motherhood is based on the following principles: (a) altruism, which means that surrogacy will only be possible on a non-commercial basis, with no financial remuneration for the surrogate

122 Previously in short Králíčková, 2024.
123 For details Haderka, 1986, pp. 917–934.
124 Garayová, 2022, p. 65.
125 For more, see Valc, 2024, pp. 24–40.
126 Parliament of the Czech Republic, Chamber of Deputies, Parliamentary term no. IX., Draft No. 424. For the original text see ODok Portál, 2024.
127 Section 804, Civil Code.
128 The Government of the Czech Republic discussed the material on 21st August 2024. For more see Ministerstvo spravedlnosti České republiky, 2024.

mother, except for the reimbursement of costs associated with pregnancy and childbirth; (b) infertility, or adverse health conditions or health indications or health obstacles on the part of the 'intended' mother; (c) strict medical and other conditions for the surrogate mother, including age, and the rule that the surrogate mother's own eggs must not be used to fertilise the surrogate mother; (d) genetic link to the 'intended' parents which means that the germ cells of at least one of the 'intended' parents must be used; (e) the prior court approval of surrogacy which means that the 'intended' parents will be legally recognised as the child's parents from the moment of birth and the surrogate mother will not have a 'legal' parental relationship with the child. Unfortunately, it was not possible to find more official details or specific provisions that regulate the issue and those should be incorporated into the Civil Code and the Act on Specific Health Services, or into procedural regulations.

We must add that this 'new' approach of establishing motherhood, or parenthood, will totally change the concept of status law in the Czech Republic as regulated traditionally in the Civil Code. In particular, the fact that the 'intended' mother of the child will become the 'legal' mother of the child directly on the basis of a court decision will contradict the concept of legal regulation of status rights not only under the Czech legal system, but also the concepts of the legal regulations of neighbouring states, European standards, and finally the Advisory opinion of the European Court of Human rights calling for adoption as the only 'legal' way of becoming 'legal' parents.[129]

5.4. Law In Action: One Child and Two 'Gender-Neutral' Parents in Special Cases[130]

As referred to above, the so-called gender-neutral marriage was not discussed during the drafting of the Civil Code at all, despite recent developments in many European countries.[131] Nevertheless, there was a pending draft lodged by a group of deputies in the Parliament of the Czech Republic in the last parliamentary term, which was in favour of marriage for all.[132] The draft was seen by some as being progressive and modern, while others viewed it as a step undermining traditional family values, or as referred to above, 'traditionally marriage-centric family laws with fixed perceptions of gender roles'. As this legislative proposal was not approved in the latest legislature, a new legislative proposal submitted to the Parliament of the Czech Republic in the current legislature has built on its theses.[133] The question is whether

129 Advisory opinion of 10 April 2019 in Request No. P16-2018-001. See European Court of Human Rights, 2019.

130 Previously Králíčková, 2024, in print.

131 Scherpe, 2016, p. 40; Sörgjerd, 2012, p. 167.

132 Parliament of the Czech Republic, Chamber of Deputies, Parliamentary term No. VIII., Draft No. 201/0.

133 Parliament of the Czech Republic, Chamber of Deputies, Parliamentary term No. IX., Draft No. 241/0.

it will be passed into law. As referred to above, as of 1st January 2025 an amendment to the Civil Code comes into force, which establishes same-sex partnerships and opens space for so-called stepparent adoption even for same-sex partners.[134]

As announced in the abstract, it is now a reality that Czechia is faced with requests from its citizens to register a foreign-born child, particularly through surrogacy. These often involve married homosexual couples as assisted reproduction and its 'new' forms are a challenge for all. It is not just the academic controversial issue of surrogacy, but much more about solving the predicaments of specific people. No doubt that the following decision of the Constitutional Court of the Czech Republic was quite crucial for the development of Czech family law and especially for the interpretation of the rights of a child conceived through assisted reproduction and born by a surrogate mother abroad. It influenced the practice or decision-making of the Supreme Court of the Czech Republic in relation to the best interests of the child and the practise of vital registrars in Czechia. The facts of the decision are as follows.[135]

In 2013, a child was born through a surrogate mother under a contract with two married men as 'intended' parents in the USA. The embryo was created through assisted reproduction with the egg being from an anonymous donor and the sperm of 'intended' parents. Since the child was conceived through assisted reproduction, neither of the men were unable to find out how things were going. However, by the nature of things, only one of the men was also the 'biological' or 'genetic' father of the child. If 'legal' parenthood is involved, prior to the birth of the child, the Superior Court of the State of California for Los Angeles County has declared that pursuant to the surrogacy agreement between 'intended parents' and the surrogate mother, the surrogate mother is not the 'legal' parent of the then unborn child, and that these two men are 'legal' parents. It further ruled that these men would be listed as 'legal' parents on the child's birth certificate when the child is born. Thus, after the birth of the child one man was listed in the 'father/parent box' and the other man was listed in the 'mother/parent box' on the child's birth certificate issued by the State of California. Because one of the men was a Czech citizen, who visited the Czech Republic regularly with his Danish husband and the child and was interested in maintaining contacts with 'his country', he sought to register the child in the Czech Republic as well. It was not only a matter of registering both 'legal' parents of the child in the Czech registry office and issuing a birth certificate to the child in accordance with the American birth certificate, but also that the child should have a Czech citizenship. However, the registry office in Prague refused to register the child and urged the parents to appeal to the Supreme Court of the Czech Republic to uphold the California court's decision in harmony with the rules settled by a special Act.[136]

134 Act No. 123/2024 Sb.

135 The Ruling of the Constitutional Court of the Czech Republic of the 29th June 2017, No. I. ÚS 3226/16.

136 Act No. 91/2012 Sb., the Private International Law Act, as amended, referred to as 'PILA'.

In 2015, the Supreme Court of the Czech Republic partially recognised the judgement of the California court on parenthood, but only in relation to 'one' father. According to the Supreme Court, it was not conflicting with public policy if the child was conceived through surrogacy (Sic!). However, from the court's reasoning, it was stated that the parenthood of the 'second' father was not recognised being manifestly contrary to public order and thus in breach of law.[137] The child was subsequently issued a birth certificate with only one 'legal' father listed and the 'mother's box' was left blank.

In 2017, based on a constitutional complaint, the Constitutional Court of the Czech Republic overruled the judgement of the Supreme Court of the Czech Republic. The Constitutional Court of the Czech Republic declared a violation of the right of the child to take his/her best interests as a primary consideration in decision-making. Status rights of the child to continuity of the civil status established abroad were emphasised, as well as the best interest of the child in his/her right to family life established on the 'legal basis'. According to the Constitutional Court's ruling, a foreign judgement establishing the parenthood of a child of two persons of the same sex should be recognised in a situation where the family relation and bounds have already been established between them both *de facto* and *de iure* on the basis of surrogacy. It was held that

> the non-recognition of a foreign decision which was to determine the parenthood of a child of two persons of the same sex in a situation where the family life had been effectively and legally constituted between them in the form of surrogacy, on the grounds that Czech law does not permit parenthood between two persons of the same sex, is contrary to the best interests of the child protected by the Article 3(1) of the Convention on the Rights of the Child.

It was concluded that

> If family life between persons, established on a legal basis, already exists, all public authorities must act so that this relationship can develop, and the legal safeguards that protect the relationship between the child and his or her parent must be respected.[138]

It should be added that the Supreme Court of the Czech Republic currently recognises foreign decisions on the 'legal' parenthood of two men or two women, following the just analysed decision of the Constitutional Court of the Czech Republic.[139] In connection with this case law of the Constitutional Court of the Czech Republic on the recognition of 'same-sex' parenthood towards a child born through a surrogate

137 Section 15, para. 1, e, PILA.

138 Ibid. Paragraph No. 55, Conclusion.

139 The relevant decision of the Constitutional Court provoked a great deal of emotions and was met with a negative evaluation. For instance, see Telec, 2017, p. 670.

mother established abroad, the public law regulations have been amended. The new decree established the possibility of registering same-sex parents in the birth register where the child is registered: It is now possible for a child to have 'gender-neutral' parents in the birth register and birth certificate: 'father/parent' and 'mother/parent' instead of the 'mother' and 'father'.[140]

6. On the Rights of the Child

6.1. The Human Life Before Birth

As referred to above in the section focusing on the human right dimension of assisted reproduction, the Charter of Fundamental Rights and Freedoms in its part devoted to 'Fundamental Human Rights and Freedoms' contains a key provision for the purpose of this book, which is 'Everyone has the right to live. Human life deserves to be protected even before birth'. 'No one may be deprived of his or her life'.[141] It was stressed that the wording of these provisions was very vehemently debated during the legislative process and is the result of a compromise between opponents and supporters of abortion.[142] The wording of the provision 'human life is worthy of protection even before birth' was never interpreted as a ban of abortions or as a limitation to the legality of abortions[143] or challenging the legal rules on handling surplus embryos within the process of assisted reproduction. See Point 3 and Point 4.5. However, there is still the question of when human life begins and how it is and should be protected before birth.[144] No doubt, this is a controversial issue, which is difficult to deal with, because the rights of the mother to protect her privacy and her

140 Decree of the Ministry of the Interior No. 174/2023 Sb., which amended the Decree implementing Act No. 301/2000 Sb., on Civil Registers, Names and Surnames and on amendments to certain related acts, as amended.

141 Art. 6, Act No. 2/1993 Sb., Charter of Fundamental Rights and Freedoms, referred to as 'Charter'.

142 Abortion law is very liberal in Czechia. See Act No. 66/1986 Sb., on the Artificial Termination of Pregnancy. It is provided that 'A woman's pregnancy will be artificially terminated if she requests it in writing, the pregnancy does not exceed twelve weeks, and there are no health reasons preventing it' and that 'A woman can have an artificial abortion for health reasons with her consent or at her request if her life or health is at risk, or if the healthy development of the foetus is at risk, or if there is a genetically defective development of the foetus'. Regarding minor women it is stated that 'A woman who has not reached the age of sixteen can have an abortion with the consent of her legal representative or the person to whom she has been entrusted for upbringing. If a pregnancy is artificially terminated for a woman aged between sixteen and eighteen, the healthcare facility shall inform her legal representative'. It must be added that the parents are legal representatives if they are holders of parental responsibility and allowed to exercise all the rights and duties within the scope thereof, particularly decide on medical issues. For details Holčapek et al., p. 130.

143 Ibid., p. 131.

144 Valc, 2017, p. 23.

bodily integrity and the child's right to life stand against each other. Once natural conception or *in vitro* fertilisation and embryo transfer occurs, human embryo is considered a part of the mothers' body.[145]

In contrast with the Convention on the Rights of the Child, which has been a part of the legal order of the Czech Republic since 1991,[146] the Civil Code does not define who child is. However, it can be inferred from the rules on the establishment of the kinship. For details, see Point 5.1. above. Nevertheless, there are special rules regarding the passive legal capacity of *nasciturus* as follows. The Civil Code provides that

> A conceived child is considered to be already born if it suits the child's interests. A child is presumed to have been born alive. However, if the child is not born alive, he or she is considered never to have existed.[147]

6.2. The Right of the Child to be Registered and to Know the Mother, and Possibly the Father

Pursuant to the Convention on the Rights of the Child, every child has the right to be registered immediately after birth. This means that the book of births and the birth certificate must, as a matter of principle, indicate who the child's mother and father are (in addition to the date of birth, name, surname, sex etc.). The child has the right to know his or her parents and be in their care, as much as possible.[148] The State must not create or blindly tolerate any obstacles that would enable the separation of the child from his/her parents or relatives.[149] The care by relatives in the family environment should take place before adoption by strangers or even abroad.[150] The principle of the best interests of the child should be applied when taking all the measures and it shall be a primary consideration.[151]

In this relation, it is necessary to recap the status conception of motherhood in the Czech Republic. The ancient Roman law principle of *mater semper certa est* respecting the fact of birth has been traditionally considered as the basis for creating the status relationship of mother – child, although it was expressly introduced into

145 According to the European Centre for Law and Justice, unlike embryos, to which both persons who had provided their genetic material had a certain right, gametes were only linked to the person who had provided them; the applicant had no rights over her late husband's gametes, and the absence of such rights was intended to protect his rights. For details see case law of the ECHR, *Pejřilová v. the Czech Republic*, Application No. 14889/19, Judgement of 8th December 2022, Point 40.

146 Published under No. 104/1991 Sb., referred to as 'CRC'.

147 Section 25, Civil Code; Šnédar, 2023, p. 9; Valc, 2017, pp. 18–38.

148 Art. 7, Sub-Section 1, CRC.

149 Art. 9, CRC.

150 Arts. 20, 21, CRC.

151 Preamble, Art. 3, Sub-Section 1, CRC; Public law aspects are regulated by Act No. 301/2000 Sb., on Civil Registers, Names and Surnames, as amended, and the implementing Decree of the Ministry of the Interior No. 207/2001 Sb., as amended, particularly by the Decree No. 174/2023 Sb.

the Czech legal order only in 1998. The Civil Code of 2012 builds on this concept and explicitly states that 'the mother of the child is the woman who gave birth to the child'.[152] As referred to above, during the preparation of the Civil Code the necessity of regulating surrogate motherhood was not originally discussed at all. The aim of the drafters of the Civil Code was to follow the above-mentioned principle of the origin of the child from the mother who gave birth to him/her and to expressly state that 'an action of the genetic mother against the mother who gave birth to the child cannot be successful'.[153] Nevertheless, this 'addendum' was deleted and the provision 'against' surrogacy was not included in the final version of the Civil Code. It must be stressed that without a 'legal' mother, the 'legal' father of the child cannot be established and registered. See Point 5.1., above.

6.3. On the Special Rights of the Child Conceived Through Assisted Reproduction

In the section devoted to the medical aspect of assisted reproduction it was mentioned that assisted reproduction can be provided in both a homologous and a heterologous form when germ cells are donated by a third person, i.e. an anonymous donor. It was stressed that germ cells and human embryos may be used only for assisted reproduction according to the informed consent of infertile couple and given legal exceptions. The above-mentioned legal prerequisites and limits of assisted reproduction provide for the protection of unborn life in accordance with the Charter of Fundamental Rights and Freedoms. If the infertile couple, or one of them decides to decline assisted reproduction, the whole process will end. There are special rules regarding unused, surplus embryos. See above, Point 4.5.

However, once *in vitro* fertilisation and embryo transfer takes place, the human embryo is considered a part of the mothers' body. As already referred to, the legal regulation of abortion is very liberal in Czechia. This means that abortion can be provided both in the case of assisted reproduction, as well as in the case of natural conception. The conflict between the rights of the pregnant woman and the unborn child is resolved by a law in favour of the pregnant women.

If a child is born from assisted reproduction, he/she is registered like any other child. See above. The fact that the child was conceived using assisted reproduction technologies, or even possible gamete donation, is irrelevant. However, there is only one controversial issue in the game, namely the anonymity of donation. The Act on Specific Health Services states that a provider who is authorised to perform assisted reproduction methods and procedures shall ensure that the mutual anonymity of the anonymous donor and the infertile couple and the anonymity of the anonymous donor and the child born from assisted reproduction is preserved. Finally, the Act on Specific Health Services stresses that a provider who has carried out a medical

152 Section 775, Civil Code.
153 See Eliáš and Zuklínová, 2001, p. 167.

suitability assessment of an anonymous donor and a woman or man from an infertile couple shall be obliged to transmit the information on their health status necessary for assisted reproduction to the provider who carries out the assisted reproduction; that provider shall keep the information on the health status of the anonymous donor for a period of 30 years after the assisted reproduction has been carried out and shall, on written request, provide the information on the health status of the anonymous donor to the infertile couple or the adult born from assisted reproduction.[154]

To conclude the issue, the child born from assisted reproduction only has the right to know the fact of assisted reproduction and the health data of the donor. This precludes any 'plurality' of the child's parents, contacting the donors etc. As there are no European standards in place in this field, we can assume that this rather controversial issue is very reasonably resolved in favour of the 'intended' parents.[155] Should the proposal on the drafted law on surrogacy be passed, the child's rights conceived through assisted reproduction technologies and especially by using donation of eggs, would lead to the child having 'three' mothers: in addition to a 'legal' mother established by 'prior court approval', a 'birth' mother (the surrogate mother) and a 'genetic' mother (the egg donor). See above, Point 5.3. This 'multiple' motherhood cannot be regarded as being in favour of the child.

6.4. About the 'Myth of Anonymity' of Adoption

To complete the picture, let us add some more information about the adoption of minor children. According to the Civil Code, adoption of minors is understood as taking a person of another person to be one's own. That is why adoption is the only 'legal' way not only for the children left in so-called baby-boxes[156] or for children from 'hidden' births,[157] but also for children from surrogate motherhood to have 'legal' parents. Adoption must be always taken as a benefit for children.

However, on the other hand, the Civil Code protects the mothers against impetuous or immature actions while also protecting their underage children or their right to live in their family of origin in harmony with the above-mentioned principles of the Convention on the rights of the child. We emphasise that the previous legal regulation along with the current Civil Code also guarantee full protection for underage parents, especially for underage mothers older 16 years.[158]

The law distinguishes two types of consent, namely: (a) the so-called direct consent which is given by a 'legal' mother in the court proceedings on adoption after

154 Section 10, ASHS.

155 Radvanová, 2015, pp. 55–57.

156 There are 88 baby-boxes in Czechia at the end of March 2025. They 'saved' 272 new-born children. For more, see Babybox, 2025. Regarding critics, see United Nations, 2011. In detail Zuklínová, 2005, p. 250.

157 As for data, see Kuchařová, 2024. For critics, see Hrušáková and Králíčková, 2005, p. 53.

158 Section 811, Civil Code; Králíčková, 2003, pp. 125–142.

the expiry of at least 6 weeks from the birth of the child[159] and by a 'legal' father after the delivery of the child (only if the fathership is legally established);[160] however, there is a possibility to withdraw the consent within 3 months; so-called direct consent is used in case of surrogacy or adoption by the step-parent for instance; let's add that there are no special rules for the 'surrogate' mother regarding the conditions, the protection of the puerperium period etc.; (b) the so-called blank or indirect consent given by a 'legal' mother after the expiry of at least 6 weeks from the birth of the child and by a 'legal' father after the childbirth (if he is legally established) with the same possibility of withdrawal as above; subsequently, the administrative proceedings on obtaining the adoption by the state may commence; the so-called blank consent is used in case of adoption by strangers.[161] As referred to above, if the 'legal' parents do not give their consent or are indifferent about the child's future, the court may decide in a special procedure, a so-called proceeding on adoptability.[162] If the court establishes their so-called unconcern,[163] the child does not become 'legally' free, but be adoptable.

In general, the legislation on minor children is regulated only in the form of full adoption in accordance with the principle of *adoptio natura imitatur*. The adopted child will become a member of the new adoptive family when the court decision becomes final. All ties to the family of origin cease, including maintenance obligations and any inheritance rights.[164] Registration in the book of births and the issue of the new birth certificate is necessary. The adoptive parents have a duty to inform the child about the adoption when it is appropriate, but at least before the child begins his/her compulsory school education. However, the 'myth of the anonymity' of adoption is still common knowledge. Nonetheless, the adoptive parents and, after the age of 12, the adoptee may discuss the collection of documents, unless the court has decided to keep the adoption file confidential; if the court has decided to keep the adoption confidential, the adoptee may consider the collection of documents only after he/she has acquired full legal capacity.

There are no special rules regarding surrogacy in this respect. The adopted child is allowed to consult the civil registry records to find out who the mother who gave birth to him/her is. However, as referred to above, the identity of the possible donor of the germ cells will be kept secret from the child due to the need to respect the anonymity of the donor. And finally, should the proposal on the drafted law on surrogacy be passed, the child should have the right to see the 'prior court approval' and learn who his/her 'birth' mother (the surrogate mother) was. See Point 5.3., above.

159 Section 813, Civil Code.
160 Ibid.
161 Králíčková, Hrušáková, Westphalová et al., 2022, pp. 195–197.
162 Section 821, Civil Code.
163 According to Sections 819 and 820, Civil Code.
164 Section 794, Civil Code.

7. Conclusion

It is a paradox that some women undergo artificial termination of pregnancy, i.e. abortion, ask for 'hidden' motherhood or give away a child and occasionally even murder their new-born. Other women go along a rather lengthy, emotionally demanding and burdensome treatment to conceive and give birth to their desired child through assisted reproduction. It may be the case that these women agree to conceive and give birth to a child to another woman. These 'risky' practices question the status rights of the child from the very beginning. This is also the case in Czechia, where the legal regulation of both the artificial termination of pregnancy and assisted reproduction have been traditionally relatively liberal.

There are also assisted 'openings' for subjects other than an infertile heterosexual couples, those calling for surrogacy as a method of infertility treatment for 'all'. It would be naïve to think that if the above-mentioned proposition by the Ministry of Justice of the Czech Republic to regulate altruistic surrogacy was passed, it would not be circumvented, especially by single persons, partners of the same sex and by foreigners, in whose countries surrogacy is strictly forbidden. For them, the Czech Republic has been the so-called promise land. As generally known, surrogacy is an acceptable option for many infertile people under 'any' condition. No doubt that surrogacy is as old as humanity itself and it will remain a 'burning' issue.

Many questions are raised in this matter, especially in connection with the child's right to live and to know his/her roots, origin, identity. However, these rights of the child may be seen 'suppressed' not only in the case of the anonymity of the donation of germ cells, but also due to the possibility of 'hidden' births and the reality of so-called baby-boxes, silently tolerated by the State. When it comes to germ cell donation, it is traditionally based on anonymity. The best interests of the child can be seen in the fact that the legal regulation of parenthood is predictable: 'one child, one mother, one father' as a rule. It prevents 'multiple' parentage. We fully agree with the view that some limits are necessary in the field of assisted reproduction. However, the restrictions must be well balanced. We believe that the Czech regulation on assisted reproduction *de lege lata* meets reasonable standards and protect both infertile couples and the child even though the law can be interpreted as being 'intended' parent-centred.

The European Centre for Law and Justice asserted that in most countries, assisted reproduction was only available to heterosexual couples where both persons were alive and of fertile age. Fertilisation post-mortem distorted the therapeutic aim of the procedure and became a tool in the right to have an orphaned child, interfering with the rights and interests of children conceived that way. Therefore, it is harmonising with the Convention for the Protection of Human Rights and Fundamental Freedoms to prohibit certain forms of assisted reproduction.[165]

165 Cited according to the case law of the ECHR, *Pejřilová v. the Czech Republic*, Application No. 14889/19, Judgement of 8th December 2022, Point 40.

A similar argument can be made in the case of individuals, single persons. The state should not support the birth of children into single-parent families, to create *de facto* 'social' orphans. This primarily relates to the child's rights to a complete family and a happy childhood.

A special chapter deals with the issue of the parenting of same-sex couples, or 'gender-neutral' parenthood. We are of the opinion that if these couples became 'legal' parents of the child abroad pursuant to the law, the continuity of the status of these children should be maintained as set by the Constitutional Court of the Czech Republic.[166] The same attitude should apply in the case of adoption, particularly step-parents' adoption. It is true that these 'new' phenomena are redefining the forms of family and family life, or family law as such. However, all the traditional abstract rules must give priority to the best interests of the child in individually assessed cases.

166 Králíčková and Nový, 2017, pp. 524–530.

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Chapter 6

Hungary: The Regulation of Assisted Reproductive Technologies and the Principle of the Best Interests of the Child



Tímea Barzó and Zsófia Nagy

Abstract

Assisted reproductive technologies (ART) have fundamentally reshaped the understanding of family and reproduction. As certain ART continue to challenge region-specific bioethical norms, they have given rise to distinctive legislative approaches globally. Hungary has faced emerging infertility treatments since the 1970s. Through ongoing professional and public debate, the country continues to refine legal responses to the most ethically controversial forms of ART. A careful analysis of Hungary's constitutional framework, statutory provisions governing healthcare, reproductive medicine, family law, legal parenthood and child protection reveals a more pronatalist state approach to ART utilisation, which remains embedded in traditional family values. Fundamental bioethical questions, particularly concerning the constitutional and legal status of embryo protection, remain in the background of Hungarian law. These tensions highlight the complexity of balancing reproductive innovation with deeply rooted cultural and moral commitments.

Keywords: assisted reproductive techniques, surrogacy, status of embryo, family law, presumptions of parenthood, children's rights, Hungary, right to health, medical law, bioethics

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1. Introduction

ART[1] have become one of the most dynamic intersections of medicine, ethics, law and social policy. Addressing medical infertility was the initial motivator for developing ART. However, these technologies trigger several ethical and moral questions about how we, as a society, define and conceptualise the foundations of family, biological relationships, parenthood and childrearing. The gradual reconceptualisation touches on several areas of jurisprudence as the connected foundational values reflected in the legal system are deeply rooted in cultural, moral and constitutional traditions. Hungary too faced the discoveries in reproductive medicine. ART has been available in the country since the 1980s. The regulatory framework has developed gradually; however, it has not developed proactively. Hence, the ethical dilemmas arising from the utilisation of ART have been the topic of professional and public discourse, as certain discrepancies and grey areas persist.[2]

This is understandable as ART highlighted the inherent tension between the fundamental rights of the subjects involved, that is, the intended parents and the child, before and after birth. Constitutional provisions regarding the protection of human dignity, right to life, right to health and rights of family and children have to be balanced with other individual rights linked to reproductive health. The Hungarian legislation grants special protection to foetal life from the moment of conception. However, this does not apply to IVF embryos, as the legislation distinguishes between embryonic and foetal life protection. Additionally, several provisions relate to family, marriage and child protection, which decisively influence the regulation of ART. Consequently, access to ART and its primary purpose can be understood within the Hungarian legal framework as the treatment of medical infertility in married heterosexual couples. The group of beneficiaries is defined by Hungary's value-based approach to family protection, rooted in traditional values and reflecting a pronatalist orientation.

Access to ART in Hungary is further shaped by the state's response to pressing demographic challenges, where ART is positioned as a strategic solution. Infertility affects approximately 15 percent of the global reproductive-age population at some point in their lives. Hungarian medical literature places domestic prevalence within a similar range of 10 to 15 percent.[3] Partial data on IVF cycles and live births emerged from a parliamentary report, revealing a pattern of increasing domestic utilisation of ART, though the government has acknowledged a notable gap in its knowledge of procedures performed abroad.[4]

1 For the essential elements of ART technology, see Kovaček Stanić, 2024, pp. 123–138.
2 For an analysis of ethical and legal issues related to ART, see Nagy, 2023, pp. 173–201.
3 Lengyel and Danis, 2025, p. 36.
4 In 2017, 1,470 children were born alive from 7,473 embryo transfers. In 2018, 1,726 children were born from 9,005 embryo transfers. In 2019, 1,948 children were born from 10,170 embryo transfers. In 2020, 1,719 children were born from 9,573 embryo transfers. In 2021, 2,035 children were born from 12,237 embryo transfers. See Rétvári, 2023.

Since 2020, Hungary's policies have expanded the support for infertility treatment and assisted reproduction, notably through free access to infertility diagnostics, treatment evaluations and necessary medications for couples seeking to conceive. Hence, although Hungary presents a deep commitment to advance pronatalist objectives in reproductive healthcare, the legislation of medical, constitutional and family law presents some contradictions, particularly regarding embryo status, the legal consequences of third-party reproductive involvement, the rights of children born through ART and surrogacy.[5]

2. Policies Regarding Medical Help Through ART

The emergence of new ART has reshaped the way we view reproduction, family and childrearing. Previously, the creation of a family was exclusively linked to marriage and natural reproduction. However, the new technologies have revolutionised this concept. ART represents a breakthrough in infertility treatment and has redefined our understanding of traditional reproduction and the notion of family. In contemporary times, scientific and technological advancements enable transformative outcomes that shift 'fundamental aspects of human existence from the nature-controlled 'realm of chance' to a part of human design and the 'realm of human freedom'.[6] These developments have given rise to numerous ethical, bioethical and moral questions. Although these technologies have existed since the 1970s, society's reactions to them have been mixed. Bioethics helps us navigate these complex and often sensitive issues, even though there are no clear or universally accepted answers. Instead of providing definitive solutions to ethical dilemmas, bioethics clarifies the essence of these dilemmas, identifies the conflicting interests at stake, explores alternative approaches to resolving them and rules out options that are widely regarded as morally or socially unacceptable. Hence, it serves as a critical and reflective framework that promotes informed and balanced discussion in the ethically complex realms of science and medicine.[7]

Bioethical and moral value systems are influenced by specific cultural and regional contexts. The ongoing tension between paternalistic and patient-centred approaches to medicine has shifted modern medical decision-making towards emphasising personal autonomy. In reproductive decisions involving assisted medical procedures, the patient's autonomy remains a key principle. However, to balance this with the other core bioethical principles, such as beneficence, non-maleficence

5 For a comprehensive analysis of the above issues and domestic conditions, see Sápi, 2024a, pp. 181–195.

6 Habermas, 2010, p. 53.

7 Hidvéginé Adorján and Sáriné Simkó, 2018, p. 60.

and justice, bioethical, social and legal sciences have established clear and decisive boundaries for the use of these technologies. Although there is a stronger emphasis on patient autonomy, the focus remains fairly pluralistic, as it is closely linked to the patient's individual value system, education level, socioeconomic and cultural background and the extent to which they take an active role in medical decision-making.[8] Nevertheless, the prevalence of ART and its acceptance by society mutually influence each other. Thus, if the prevalence of ART is higher in a given society, the society is likely more accepting of these technologies.[9] Hence, public debate, along with bioethical, medical and legal discussions surrounding assisted reproduction, continues to evolve regionally.[10]

The development of ART in Hungarian circumstances made its scientific breakthrough at the Obstetrics Clinic of the University of Pécs Medical University, with a research group led by Dr. Imre Csaba, in 1988, when the first Hungarian baby, Zsuzsanna, was born through *in vitro* fertilisation (IVF) technology.[11] Since then, the medical practice has gradually utilised several types of ART. However, the legal background at the beginning was minimal and incomplete.[12] The 1997 Act on Healthcare dealt with assisted reproduction in detail. Ever since, the 'test-tube baby' program has revolutionised infertility treatment in Hungary, offering hope for childless couples.[13]

In Hungary, the bioethical discourse on new biotechnological advancements can be traced back to the contemplation of the Hungarian Scientific and Research Ethics Committee of the Scientific Council for Health (hereafter, the Committee) since the birth of the first IVF baby, Louise Joy Brown, in the UK. However, some key questions regarding ART ought to be answered unambiguously, preferably accompanied by ethical guidelines.[14] A great source of professional bioethical assessment of the time is presented in the Committee's publication, Statements of the Scientific and Research Ethics Committee (1990–1999).[15] The findings of the Committee could be summarised as the challenge faced by ART regarding long-standing moral and legal principles and the necessity to re-establish clear national ethical guidelines, while duly regarding international examples.[16] Moreover, the report underscores the personal responsibility of physicians and researchers, particularly due to the absence of

8 Sass, 1990.
9 Szalma, 2016, p. 154.
10 For more about the ethical and legal development on ART see Navratyil, 2011, pp. 109–121.
11 Pécsi Orvostudományi Egyetem Általános Orvostudományi Kar, 2021.
12 Decree No. 12/1981 (29 September) of the Ministry of Health.
13 Szíjártó, 2023, p. 112.
14 Temesi and Mandl, 1999, p. 17.
15 Ibid.
16 For example, the findings and guidelines of the Warnock Committee in the UK, one of which was the suggestion that the 'the embryo of the human species ought to have a special status', accompanied by strict boundaries for embryo research, including the establishment of a 14-day limit for research on embryonic development. This '14-day rule' became internationally influential. See more in: Warnock, 1984.

well-defined moral and legal frameworks in Hungary at the time this document was drafted. The Committee warned about upcoming re-evaluations of traditional moral values and suggested particular ethical sensitivity based on the respect for life, while utilising these techniques.[17]

The ethical dilemmas raised by ART have long been debated, particularly within the context of the Hungarian Catholic Church. The Church's stance aligns with the general opposition of the global Catholic Church, frequently referring to the *Donum vitae,* the doctrinal basis of its position. The Church's scepticism towards the use of IVF stems from concerns about potential abuses and the objectification of embryos, as it maintains that, from the moment of conception, the embryo is entitled to the respect for human dignity.[18] The Catholic Church's more conservative representatives go further, arguing that IVF procedures and the resulting unused, surplus embryos, destined to be destroyed, are morally equivalent to abortion.[19]

Although they constitute a minority compared to the total population and the number of people struggling with infertility, an increasing number of individuals are confronted with the fact that their infertility stems from their body's inability to receive, carry or deliver an embryo. Thus, surrogacy seems to be the only path for intended parents to have a genetic child.[20] However, the public discussion has been more heated regarding surrogacy, with an intriguing legal development. Referencing the above-mentioned standpoint of the Committee for nanny pregnancy (altruistic form of surrogacy), although surrogacy was never formally incorporated into the Healthcare Act as an available form of ART, such arrangements have been known to the Hungarian public. With the neighbouring country, Ukraine, which traditionally allows even the most controversial form of surrogacy, commercial surrogacy, Hungarian couples could potentially access such services abroad.

17 'The ethical use of ART is acceptable only in officially designated institutions that meet the necessary professional, technical, and infrastructural requirements. Existing and newly established laboratories must be regularly inspected by an authorized committee to ensure compliance. When a new, previously untested method is introduced, the laboratory or research group leader holds full responsibility for meeting all professional and material standards and obtaining the required authorizations'. Additionally, the Committee partially supports the most controversial ART types. For instance, the IVF is ethically acceptable for medical reasons only with the possibility of the child to familiarise with the circumstances of birth; cryopreservation of ova is for later implantation, under the current circumstances, yet not ethically acceptable; cryopreservation of pre-embryos is not permissible until the legal clearance of the status of the embryo; the donation of pre-embryos is supported; gestational and partial-nanny pregnancy (altruistic surrogacy) is acceptable on strictly medical grounds; experiments on pre-embryos are acceptable if they serve the prevention or treatment of diseases, thus directly or indirectly promote human health; sex selection is ethically acceptable only for the prevention of the transmission of sex-linked hereditary diseases. However, these ethical statements should not be regarded as final because they shall be further developed and revised based on new scientific findings. See more in: Temesi and Mandl, 1999, p. 17.

18 Szíjártó, 2023, pp. 124–125.

19 In this view, the embryos are regarded as victims and those participating in IVF are seen as complicit in their destruction. See Hámori, 2016, pp. 91–151.

20 Szabó-Tasi, 2012, p. 7.

Til date, neither Hungarian law nor medical practice supports arrangements where an IVF embryo could be implanted into a woman other than the one whose eggs were used for fertilisation, or into an intended mother who was otherwise capable of carrying a pregnancy, yet relied on a donor egg for IVF. With the evolution of reproductive medicine, some countries opted for utilising surrogacy as an infertility treatment even before the enactment of the Hungarian Act on Healthcare of 1997. This likely motivated the near-regulation of surrogacy arrangements.[21] However, in Hungary, neither type of surrogacy has been introduced legally. The ethical concerns and the legally grey area[22] invokes ambiguity in the public opinion of the Hungarian society.[23]

Social attitudes are strongly shaped by concerns about exploitation and inequality, as expert commentary compares surrogacy to prostitution. The potential exploitation of economically disadvantaged women is inherently present in surrogacy arrangements, as economically well-off couples could afford financially demanding, time-consuming procedures. The arising social inequality likely leads to unfair dependence and exploitation.[24] Surrogacy and surrogacy tourism[25] are latent activities in Hungary, thus one could only rely on investigative journalism and unofficial reports on its practice. Additionally, women who decide to become a surrogate

21 Szász, 2024, p. 87.

22 We refer to the legally grey area in the sense that both public and private legal instruments discourage the practice of surrogacy, both altruistic and commercial. The Civil Code in Art. 4:115 stipulates the legal presumptions on motherhood according to the Roman law principle. Thus, the birth mother is the legal mother of the child. Additionally, the criminal law environment is significant, where some practices associated with surrogacy arrangements could fit the statutory elements of criminal offences, such as violation of family status (Art. 213), violation of the right to medical self-determination (Art. 218) and human trafficking and forced labour (Art. 192). Additionally, the recently revised Directive 2011/36/EU on preventing and combating trafficking in human beings and protecting its victims qualified 'exploitation of surrogacy' under the umbrella term of 'trafficking of human beings'. Thus, Hungary, as a member state, is obliged to criminalise conduct including new types of reproductive exploitation, which coerce or deceive women into acting as surrogate mothers, and ensure effective, proportionate and dissuasive penalties.

23 Unofficial data and reports suggest that such interventions have occurred domestically. Potentially, Hungarian infertile couples could pursue surrogacy abroad, most commonly in the Czech Republic, where these medical services are readily accessible and where Hungarian language information is available, designed to attract clientele from Hungary. See in Patakfalvi, 2025.

24 Nagy, 2023, pp. 187–188.

25 Foreign surrogacy-related cases occasionally surface in Hungary, though the practice remains largely latent. The Immigration and Nationality Office rejected a Ukrainian birth certificate-based application for civil registry entry, arguing that such certificates do not establish biological descent under Hungarian law. The Office suspected surrogacy involvement, noting that the applicant failed to demonstrate the mother's pregnancy, contrary to Hungarian public policy, and surrogacy was unrecognised domestically. However, both first and second instance courts overturned this decision, invoking the best interests of the child principle. The courts ruled that it was in the child's 'undisputed best interest' to have their citizenship settled if the father was of Hungarian citizenship. The appellate court held that mere suspicion of surrogacy was insufficient grounds for denying registration and the burden of proof lies on the Immigration Office. See Budapest Court of Appeal Case No. 2.Kf.27.291/2012/8.

frequently do it as a measure of last resort to escape their vulnerable financial position, which reinforces the argument of structural vulnerability. However, the inherent desire for parenthood experienced by infertile couples and the hardships experienced during futile infertility treatments awaken a degree of societal empathy. Nevertheless, surrogacy remains morally unclear within Hungarian society.[26]

Some interesting insights on ART in Hungary are available at the Ombudsman's office, a domestic human rights institution. A notable report from 2018 comprehensively examined several complaints from citizens regarding the access and execution of ART. The report, focusing on the institutional practice and ethical concerns about ART in Hungary, evaluated whether institutions complied with applicable laws and constitutional requirements. Among the key findings, the Ombudsman pointed out inconsistent practice on how patients were informed about embryo-related decisions, terminological conflict between the foetus and embryo, and contradicting rules regarding the storage, duration and destruction of gametes and embryos.

These overall recommendations encompassed the review and revision of all legislation and regulations about embryo storage, use, destruction and donation. Furthermore, it argued for an extension of and clarity in defining the maximum legal storage time for frozen embryos and the creation of detailed, unambiguous rules for embryo donation, including consent, procedure, documentation and institutional obligations.[27] The main concerns surrounding the uncertain legal status of the embryo, the fate of stored embryos and legal certainty regarding the persons entitled to decide upon their storage have been minimally resolved and implemented through a revision of Art. 178, para. (5) of the Act on Healthcare. It extended the storage time of embryos created for reproductive purposes to 15 years, with the possibility of an additional extension of 15 years, setting the maximum storage time at 30 years. Within this period, the person entitled to make decisions determines the storage duration. Furthermore, a partially relevant amendment clarified the continuation of the reproductive procedure for a woman who becomes single. Hence, in the absence of the required declaration of exclusion, the reproductive procedure shall continue until the completion of the course-based intervention.[28]

3. Constitutional Provisions

The constitution or civil code of most countries contains general human rights principles that must be respected in healthcare provision. Constitutionally enshrined values represent legally binding norms with the authority of fundamental

26 Balázs, 2024.
27 Ombudsman Report AJB-1232/2018
28 Art. 38, para. 1 of Act LXXVII of 2024 amending Art. 168 (1) of Act CLIV of 1997 on Healthcare.

law; therefore, there are value categories whose constitutional status stems from the constitution-making power.[29] The realisation of the right to health is a fundamental pillar of a democratic state governed by the rule of law. Thus, the right holds, irrespective of whether a country includes every essential element of the right in its constitution or it is partially constitutionalised and implemented through lower-level legislation.[30]

The Fundamental Law of Hungary is no exception, as several provisions are linked to the basic principles of medical law, precisely, for executing ART following fundamental legal and ethical values. Among the values enshrined in the Fundamental Law that guide the lawful performance of ART are those connected to medical law. These include Art. II on human dignity and the right to life, Art. III on prohibition of torture, inhuman or degrading treatment, Art. VI on privacy and protection of personal data, Art. XV on equality and non-discrimination, Art. XVI on the protection of children and Art. L on marriage as a union between a man and a woman, and family based on marriage or parent-child relationships. These provisions serve a dual purpose as they facilitate standard physician-patient relationships while articulating the key principles governing reproductive rights and family creation. Furthermore, they define the place of ART within this constitutional framework through the interpretation of these fundamental values and rights.

The protection of human dignity is embedded in the Fundamental Law. Thus, every human being has the right to life and human dignity, along with the protection of the life of the foetus. Embryo protection is a decisive matter if we research ART, as it involves the handling of embryos, even those created through IVF. The Fundamental Law protects prenatal life, although the specific provisions do not suggest whether this protection is without contradiction. Distinguishing the line between embryo and foetus protection and reproductive decision making regarding abortion and IVF is essential, which would determine the region's bioethical indicators.[31] The article on non-discrimination might apply to access to ART. Hungary 'ensures fundamental rights to everyone without any discrimination, in particular without distinction based on race, colour, sex, disability, language, religion, political or other opinion, national or social origin, property, birth or any other status'. Primarily, in the Hungarian legal environment, infertility treatment is designed to address the challenges of childbearing between married couples, *de facto* partners of different sexes and, in exceptional cases, for single women. Although the non-discrimination provision does not explicitly mention 'sexual orientation', it can be widely interpreted under the phrasing 'any other status'.

The provisions on family, marriage and child protection are relevant, as they provide specific protection for the

29 Ádám, 2010, p. 115.
30 Julesz, 2018, pp. 137–138.
31 More about the disparities of the Hungarian law on embryo protection: See Chapter 5.

> [I]nstitute of marriage, as a union between one man and one woman, established through their voluntary decision, as well as the family as the foundation for the survival of the nation. Family ties shall be based on marriage or the relationship between parents and children. Human beings shall be male or female. The mother shall be a woman; the father shall be a man.[32]

Thus, the wording of the Fundamental Law places greater emphasis on families with children, acknowledging their reproductive role and function, while falling short of presenting the family as an inherent value in itself.[33] The commitment to creating a comprehensive support system, where all wanted children are born, has economic and social aspects, which the Fundamental Law recognises.[34] This could potentially be extended to the commitment to facilitate wide access to ART.[35] This support is specifically stipulated in Art. L, para. (3), whereby families are entitled to protection and support, which are regulated by a cardinal Act.[36] The Fundamental Law expresses that the child and the family comprise the resource that, although private, is the most important public matter. Subsequently, Hungary, in several initiatives, introduced 'family-friendly measures' to create a supportive legal framework for those who decide to establish a family with children.[37] Thus, the demographic challenges are guided by the pronatalist approach of the government policies, that is, confronting population decline and insufficient birth rates through comprehensive family policies, focusing on substantiating and aiding infertility treatment and reinforcing conventional family models. Within this framework, ART becomes a fundamental demographic approach.[38]

Child protection in the Fundamental Law is expressed in Art. XVI. Its main focus is granting children the right to the protection and care necessary for their physical, mental and moral development. Child protection in the Hungarian legal system has been in focus in recent years. Thus, the cardinal legislation[39] has been revised, along with some provisions of the Fundamental Law. The protection of family, marriage and children's healthy development is placed at the forefront of constitutional protection. Therefore, it demonstrates the commitment to safeguard the traditional

32 Fundamental Law, Art. L.
33 Schanda, 2014, p. 511.
34 Kiss, 2023, Art. L.
35 See more in Chapter 5.
36 More specifically the Act CCXI of 2011 on the Protection of Families.
37 Sápi, 2024, p. 429.
38 Sipos and Szalma, 2023, p. 50.
39 For example, Act XXXI of 1997 on the protection of children and on guardianship administration.

value system, which forms an integral element of Hungary's constitutional identity and public morals.[40]

Furthermore, the medical law-related provisions enshrined in Art. VI protect the right to privacy, family life and protection of personal data. Reproductive rights are inherently connected to personal autonomy and fall within the broader framework of protections designated to private and family life.[41] Regarding reproductive rights, the Constitutional Court of Hungary issued a key decision, elaborating on the constitutionality of the annulment of the provisions on altruistic surrogacy (nanny pregnancy) in the Act on Healthcare.[42] To interpret the access to reproductive rights, the Court delivered that 'the right to freedom of self-determination does not extend to an obligation for the state to provide the possibility for any arbitrary medical intervention'. The freedom of self-determination is linked to surrogacy arrangements, although this right affects the rights of others as well. Hence, the state has the discretion to decide upon its legalisation and is not obliged to automatically introduce it as a reproductive option derived from a constitutional right. This applies to all other types of ART, as they can raise complex medical, ethical and legal questions. This attitude towards ART aligns with the guidance and the case law of the European Court of Human Rights (ECtHR), as a certain procedural approach is associated with Art. 8 – the right to respect for private and family life and the reproductive rights stemming from it. The ECtHR protects these rights by analysing whether the legal safeguards were effective, rather than evaluating the substantively conceptualised reproductive rights in the national legislation.[43] Subsequently, the types of ART to be legalised to facilitate reproductive health depend on the discretion of the Hungarian legislator.

A particularly relevant provision of the Fundamental Law addresses the prohibition of torture and inhuman or degrading treatment, which must be respected in

40 Nevertheless, this approach to family and child protection does not mean that non-traditional family forms are excluded from such protection. Family protection is a fundamental principle and is expressed in the Family Law provisions of the Civil Code. The family is protected as a social unit, focusing on several different relationships and recognised family ties, such as marriage, parentage, adoption and guardianship, and other forms of cohabitation regulated by law. See Barzó, 2017, pp. 34–38.

41 Reproductive rights encompass the values informing decisions by individuals or couples about whether, when and how to reproduce. The right not to procreate addresses contraception and abortion access, while the right to procreate involves assisted reproductive technologies, surrogacy, uterus transplantation and sterilisation procedures. Beyond these, the conditions surrounding reproduction and childbirth include matters such as prenatal diagnostic testing and the approval of home births. See Hervey and McHale, 2015, pp. 156–183.

42 The petitioners argued that the amendment to the Act on Healthcare was formally unconstitutional on several grounds. The timing of the removal of the provisions on altruistic surrogacy was problematic, as it was done merely three days before the amendment to the Healthcare Act was published. They claimed that this last-minute removal violated legal certainty and undermined the constitutionally protected legislative process by modifying multiple unrelated laws simultaneously. Moreover, the drafters did not respect the procedural requirement of consulting relevant professional and social organisations, as required under Art. 20 of the 1987 Act XI on Legislation. See Decision 108/B/2000 of the Constitutional Court of Hungary.

43 Spano, 2014.

the course of healthcare. The phrasing of the Fundamental Law indicates a bioethical connotation, stipulating that

> No one shall be subjected to torture, inhuman or degrading treatment or punishment, nor shall anyone be held in servitude. Human trafficking is prohibited. It is forbidden to carry out medical or scientific experimentation on a person without their informed and voluntary consent. Practices aimed at human eugenics, the use of the human body or its parts for profit, and human cloning are prohibited.[44]

It addresses current issues in biomedicine and establishes constitutional limits and prohibitions regarding organ trafficking and certain genetic interventions.[45] Within reproductive healthcare, the relevant provisions describe the boundaries of preimplantation genetic diagnosis, foetal reduction, forced sterilisation and the creation of gene-edited or so-called 'designer' babies associated with the 'new eugenics' movement.[46]

4. Medical Regulation and Practice of ART

In the legal landscape, the initial regulatory background of the Act on Healthcare of 1972 did not mention ART, nor did the medical ethical guidelines discuss the associated issue. IVF treatment has been performed since the 1980s, despite the absence of moral and ethical scientific considerations. The legal framework, as established by Decree No. 12/1981 (IX.29) of the Ministry of Health, was minimal to regulate certain types of ART, duly and comprehensively. The enactment of Decree No. 30/1998 (VI.24.) of the Ministry of Health enhanced the detail and accuracy of the regulations concerning ART. Nevertheless, Act CLIV of 1997 on Healthcare, Chapter IX (Special Procedures Aimed at Human Reproduction, Research Involving Embryos and Gametes, and Artificial Sterilisation) purposefully regulates ART, although not comprehensively.[47]

44 Fundamental Law Art. III.
45 Kiss, 2023; Fundamental Law Art. III.
46 Kovács, 2025, p. 510.
47 For example, the Decree does not thoroughly address the ethical questions linked to embryo and stem cell research. Another delicate question is the forms of consent of 'eligible parties' who can decide upon offering the embryo for medical research purposes. See more in: Zeller, 2009.

In connection with certain procedures aimed at human reproduction, the examination of Act CLIV of 1997 on Healthcare and the decree(s)[48] issued for its implementation is indispensable for studying the topic. Chapter IX of the Act contains the detailed regulations of certain procedures aimed at human reproduction, defining the interventions that may be lawfully carried out in Hungarian institutions authorised for that purpose. These reproductive procedures include fertilisation outside the body and embryo implantation, artificial insemination (AI) performed with the germ cells of the spouse or partner or with donated germ cells, fertilisation outside the body and embryo implantation carried out with donated germ cells, embryo implantation performed with embryo donation or any other method facilitating the fertilisation of the female germ cell, along with the implantation and development of the fertilised germ cell.[49]

The Act on Healthcare prohibits the use of non-human (that is, animal) germ cells or embryos for fertilisation or embryo implantation. Although this prohibition may seem far-fetched, the prohibition on fertilising a human egg cell with the sperm cell of a mammal or implanting an animal embryo into a human uterus appears in the regulations of other European states as well. The unification of human and animal cells (and partly, due to the hereditary material located in the mitochondria, the genetic stock) and the creation of hybrids cannot fall within the framework of assisted reproductive procedures, as combining the germ cells of primates and humans cannot create an embryo.

There is a procedure that tests the fertilisation ability of sperm cells on the egg cell of a laboratory small mammal, for example, a hamster, which is excluded by the Act on Healthcare. However, the unification of animal and human cells may arise in connection with research where the human genetic material would be inserted into an animal egg cell deprived of its nucleus, creating human embryonic stem cells. This procedure is called therapeutic cloning, which is carried out in the hope that the created cell lines would provide promising raw material for basic research. However, the prohibition in Art. 166, para. (2) of the Act on Healthcare does not apply to this case, since there is neither fertilisation nor embryo implantation.

A criminal sanction is attached to the abovementioned prohibition. According to Art. 172, para. (2) of the Criminal Code, anyone who transplants a human embryo into the body of an animal, fertilises a human and an animal germ cell or uses a non-human germ cell or embryo for human fertilisation or embryo implantation, shall be punished with imprisonment from two to eight years. Furthermore, the Act on Healthcare prohibits the use of germ cells originating from a corpse for reproductive

48 Decree No. 30/1998 (VI.24.) of the Ministry of Health on the detailed regulations concerning the performance of special procedures for human reproduction, and the handling and cryogenic storage of gametes and embryos. The decree lists in detail, and with exact medical terminology, the available types of ART and the requirements for their performance.

49 Act on Healthcare Art. 166, para. (1). Regarding point e) being left blank, nanny pregnancy (altruistic form of surrogacy) was repealed by Art. 32, para. (1) of Act CXIX of 1999.

procedures. Such a case may be, for example, when a widow would like to obtain and store sperm from a man who died suddenly in an accident (brain death) for later reproductive procedures.

The moral background and the arguments behind the prohibition are complex. Although it can be argued that the widow does not have disposal rights over the deceased's body (and over his germ cells), assisted human reproductive procedures are meant to treat infertility, which in this case is not realised.[50] Moreover, Section 169 of the Criminal Code threatens that the use of a germ cell from a dead person or a dead foetus for a special procedure aimed at human reproduction can lead to imprisonment for one to five years, along with punishment for the preparation for such an act.[51] An important argument may be that, in such a case, the child would be half-orphaned before conception, which would be considered undesirable. Hence, the legal status of a child born in this manner would be unresolved according to family and inheritance law regulations.

Among the possibly utilised types of ART, Hungary allows AI, both heterologous and homologous.[52] The essence of both of these procedures is that during the woman's ovulation period, the man's sperm cells are placed directly into the fallopian tube, facilitating conception. The most groundbreaking technique, IVF, is known to laypeople as the 'test-tube baby program'. Perhaps, it is not an exaggeration that if we ask anyone what the procedure aimed at human reproduction is called, we will receive the answer 'test-tube baby program'. However, evidently, this is merely one branch of the procedures. Notably, this procedure is more burdensome for the mother's health because during each ovulation cycle, only one or two egg cells reach the phase where they can receive the sperm cell.[53] For the procedure to be successful, the mother must take hormonal medications of various strengths and, before the implantation, she must undergo other hormone therapies. The so-called GIFT method (gamete intrafallopian transfer) appeared roughly at the same time as the IVF procedure, and can be performed in Hungary.[54]

Another similar intervention procedure is the ZIFT method (zygote intrafallopian transfer). Here the egg cell is extracted; however, the *in vitro* fertilised egg cell (the single-celled zygote) is introduced into the fallopian tube, as opposed to the traditional procedure where the fertilised egg cell is implanted into the uterine cavity. If the parties are not able to provide germ cells for the successful execution of the

50 More about post-mortem fertilisation, see De Negri, 2022, pp. 5–20.

51 Dósa, 2015, p. 50.

52 AI by Donor; by Husband; by cohabitation partner.

53 The essence of the procedure is that, within the framework of a laparoscopic operation, under anaesthesia or without anaesthesia, the woman's egg cell is removed, the follicular fluid is aspirated by an ultrasound method, it is fertilised outside the body – *in vitro*, in glass, in a Petri dish – with the previously prepared male sperm cells and the fertilised egg cell is implanted back into the woman's uterus at about 6–8 weeks of development (embryo transfer).

54 The procedure is similar and, in some cases, may represent an alternative to *in vitro*. Here, the extracted egg cell is introduced simultaneously with the sperm cell into the ampullary part of the fallopian tube through a laparoscope. See Kanyó, 2003, p. 6.

procedure, donor germ cells may be utilised. However, if both germ cells originate from a donor, there is no genetic match between the child and the parents.

Regarding *in vitro* procedures, it is important to briefly discuss embryo donation. There is a possibility that during an external fertilisation, several ova become fertilised, which can be implanted in case of procedure failure, without the mother going through the entire procedure again. For later 'usability', such ova are frozen and stored. If the first implantation is successful, the parties in the procedure may decide to donate the frozen embryo(s) to couples who cannot provide their gametes. Thus, couples who underwent a successful implantation may help other infertile couples.[55]

In addition to sperm donation, it is possible to carry out egg donation, although this is a more complex and complicated procedure. In contrast to sperm donation, egg donation has a much shorter history, as the first successful intervention of this kind was carried out in 1983.[56] The cell extraction, as in the case of sperm donation, is preceded by a comprehensive medical examination. However, in contrast to the procedure for men, this intervention involves more discomfort and higher risks, with a different assessment. Before the egg cell extraction, hormone stimulation takes place, where the synchronisation of the donor's and the recipient's menstrual cycles is essential. The extraction is a relatively quick process that requires a surgical intervention. However, in contrast to sperm cells, the success rate of freezing egg cells is lower.[57]

Notably, there have been some developments in the legal circumstances of egg donation in Hungary.[58] The Proposed Amendment to the Healthcare Act (Bill T/12787) modernises the regulations on both female and male gamete donation to further facilitate and support infertile couples, aligning with the Hungarian government's policy to support the birth of desired children. The Proposed Amendment stresses that the compensation possibility for egg donation would be introduced, as a ministerial regulation to standardise compensation for both anonymous and directed donations. This would encourage eligible egg donors to undergo a demanding medical procedure. Additionally, directed donation, previously only available for egg donation, shall be extended to sperm donation, expanding the donation channels. The Proposed Amendment establishes unambiguously that cryopreservation for personal reproductive use is available for female gametes. Hence, the Proposed Amendment expands domestic ART services to prevent or reduce reproductive tourism.

55 Embryo protection will be discussed in later chapters.

56 Frankó, 2014, p. 50.

57 Kovács, 2025, pp. 511–513.

58 The legal requirements for the donation of eggs are different from those of the sperm. Eggs may be donated by a designated recipient, provided that there must be a familial or close personal relationship between the donor and the recipient. Additionally, the donor must offer eggs exclusively for use by the recipient specified in the donor's declaration, ensuring that the donation is targeted and intentional. See Act on Healthcare Art. 171, para. (1).

The Proposed Amendment, after undergoing the necessary legislative stages, was supposed[59] to take effect on January 1, 2026.

The law regulates the types of procedures and defines who may participate in them. The procedure may be performed for a married or cohabiting couple of opposite sexes, if, due to a health reason (infertility)[60] in either party, no healthy child could be conceived naturally. In case of cohabitants, a reproductive procedure may only be carried out if neither of the partners is in a marital relationship.[61] Furthermore, if, as a result of the procedure, fertilisation has taken place, but the marital/cohabiting relationship has ended, the procedure may be continued with the single woman. The legislator allows, in exceptional cases, for a single woman to participate exclusively in the procedure if, due to her age or health condition (infertility), she is unlikely to have a child naturally. However, this rule grants an exemption regarding marital status and concerning the indication.[62] Hence, access to ART for single women must be justified by age or health condition. Nonetheless, this wording is rather uncertain, especially because the age limit for natural conception is difficult to determine objectively. Moreover, the use of assisted human reproduction procedures has an age-related condition: it can only be used if the woman has not reached the upper limit of reproductive age.[63]

We briefly discuss how the procedure of ART is carried out. Either partner in a relationship can initiate the process by seeking medical consultation at a reproductive healthcare facility. Medical evidence of infertility must be documented and the initiators must undergo comprehensive medical assessments to ensure that they are suitable for the procedure. Additionally, the infertile individuals must provide written informed consent after receiving detailed information about the procedure, its success rates, potential risks and alternative options.[64] Decisions regarding the specific type of ART to be employed are made by the treating physician or medical team specialising in reproductive medicine.[65] Healthcare providers must obtain an

59 The proposed Amendment has not yet been part of the parliamentary debate agenda.

60 Infertility, in the overwhelming majority of cases, is a diagnosis related to a partnership. The current professional regulation defines infertility as the failure to achieve a successful pregnancy after one year of regular sexual intercourse timed with ovulation. In the case of a single woman, this condition cannot always be examined; therefore, only cases with organic reasons for infertility may be considered (for example, the absence of both ovaries).

61 Act on Healthcare Art. 167, para. (1).

62 Ibid., Art. 168, para. (1).

63 Single women can be beneficiaries of embryo preservation. A single woman exercises the right of disposal over the embryo created outside the body and not implanted. She may renounce her right of disposal; the formal requirement of such renunciation is that it must be included in at least a private document providing full probative force. See Art. 1/A; Art. 4, para. (5) of Decree No. 30/1998 (VI.24.) of the Ministry of Health on the performance of special procedures aimed at human reproduction and on the detailed rules for the disposal and frozen storage of germ cells and embryos.

64 Act on Healthcare Art. 168.

65 This decision is based on several factors, including the medical diagnosis of infertility, the couple's medical history, the woman's age, previous treatment attempts and current professional protocols. See Ibid., Art. 168, para. (2).

operating license from the relevant healthcare authority to perform ART procedures.[66] It is important to understand which institutions are currently authorised to perform human reproduction procedures. The legislator stipulates that a reproductive procedure may only be carried out upon the recommendation of an appropriately qualified specialist doctor and by a healthcare provider possessing an operating license and defined by law.[67]

4.1. Regulatory and Institutional Framework of ART Providers

The Act on Healthcare narrowed the scope of providers who, regardless of financing, are entitled to perform reproductive procedures. While previously every healthcare provider possessing an operating license for such activity was authorised to carry out these procedures, under the new regulation, reproductive procedures may be performed exclusively by healthcare providers authorised by the state and by clinical centres of universities operating as public foundations.[68] The conditions under which an operating license may be granted to a healthcare provider are defined by Decree No. 60/2003 (X.20.) of the Ministry of Health, Social and Family Affairs on the professional minimum requirements necessary for the provision of healthcare services.

This decree defines minimum requirements and professional codes only regarding IVF (in the Health Act, fertilisation outside the body and embryo implantation) and the frozen storage of germ cells and pre-embryos. However, it excludes insemination (AI), although that too is a reproductive procedure under Art. 166, para. (1) of the Health Act. A healthcare provider entitled to perform reproductive procedures may not use, even as a cooperating partner, another healthcare provider who does not meet the above conditions. Furthermore, a reproductive procedure may not be carried out at a privately owned healthcare facility, even if it takes place within the framework of private financing. The previously operating private providers were bought out by the state and designated to effectively stop population decline and make infertility treatments widely accessible.[69] From the point of view of competition law, the acquisition of control over private providers was classified by

66 Ibid., Art. 169, para. (2).

67 The interventions may be used in a publicly financed form at providers contracted with the National Health Insurance Fund (NEAK): Dunamenti REK Ltd., Clinical Centre of the University of Pécs, Clinical Centre of Semmelweis University, Albert Szent-Györgyi Clinical Centre of the University of Szeged and Clinical Centre of the University of Debrecen.

68 Act on Healthcare Art. 168 (This novelty was introduced by Act CI of 2021 on certain asset-management matters and on the amendment of certain laws for the purpose of strengthening the coherence of the legal system).

69 Act CI of 2021 on certain asset-management matters and on the amendment of certain laws for the purpose of strengthening the coherence of the legal system. Amending Act LXXXIII of 1997 on the Benefits of Mandatory Health Insurance.

legislation as a synthesis of national strategic importance carried out in the public interest.[70]

It is worth understanding the changes linked to demographic policies that emerged after 2010, corresponding with Hungary's pronatalist government policy under the current administration. As the government reconceptualised infertility beyond a medical matter, infertility treatments were no longer regarded as individual health services but as mechanisms to elevate the national birth rate. This ideological transformation resulted in expanded public subsidisation, broader free access and state takeover of the infertility treatments.[71] A particular development was the government's determination to solely oversee and facilitate the ART sector. Starting in late 2019, the government declared its plan to nationalise private fertility facilities.[72] By 2021, this strategy was duly achieved, as from September 30, 2021, only centres providing care under state ownership and financed from the central budget were authorised to perform interventions for infertility treatment; the operating licenses of private institutions for this activity expired on June 30, 2022 (the ongoing treatments and frozen samples were transferred to the state provider designated by the Ministry of Human Capacities). Since 2020, the medicines used in infertility treatment have been 100 per cent state-funded. Hence, the output guaranteed universal treatment access through the removal of financial obstacles and the synchronisation of reproductive healthcare with national population objectives.[73]

On January 1, 2024, significant regulatory modifications were implemented to modernise and simplify the system. The amendments transformed the number of accessible ART treatments and the related financial support, from counting implantations to counting stimulations or commenced cycles.[74] The revised regulations permit up to six procedures of ovulation induction and AI and up to five procedures of medication-assisted stimulation for egg cell retrieval. This modification clarifies

70 See Government Decree No. 317/2019 (XII.19.) on the classification of the acquisition of control by the Hungarian State over FORGÁCS INSTITUTE Health and Service Limited Liability Company, and the acquisition of the properties necessary for the activities of FORGÁCS INSTITUTE Health and Service Limited Liability Company, as a merger of national strategic importance carried out in the public interest. Government Decree No. 318/2019 (XII.19.) on the classification of the acquisition of control by the Hungarian State over 'KAÁLI' Outpatient Gynecological Institute Limited Liability Company, KAÁLI REK Reproduction Center Limited Liability Company, Pannon Reproduction Institute Health and Service Limited Liability Company, and the acquisition of the properties necessary for their activities, as a merger of national strategic importance carried out in the public interest.

71 Government Decision No. 1011/2020. (I.31) on the implementation of the National Human Reproduction Program.

72 Government Decree No. 317/2019 (XII.19), Government Decree No. 318/2019 (XII.19), Government Decree No. 319/2019 (XII.19) and Decree No, 21/2019 (XII.19) of the NVTNM.

73 Currently, 13 state-run fertility centres operate nationwide – seven in Budapest and six in other cities (Debrecen, Győr, Kaposvár, Pécs, Szeged and Tapolca) – raising important questions about equitable geographic access. See more in Lengyel and Danis, 2025, pp. 25–61.

74 On the specifically available infertility treatments, see Decree No. 49/1997 (XII.17) of the Minister of Welfare on infertility treatment procedures available under the compulsory health insurance scheme.

the qualification criteria and ensures financial tracking of the actual commencement of medical cycles rather than implantation results.[75] Additionally, when at least one living child results from publicly funded ART treatments, couples gain eligibility for four supplementary publicly financed cycles.[76]

The recent changes enacted in the government Decree No. 43/1999 on the detailed rules for financing healthcare services from the Health Insurance Fund further motivate the healthcare institution providing ART services with performance-based remuneration. Hence, in case of every resulting live birth under the Reconstructive Reproductive Medicine service within publicly funded care, the healthcare service provider shall receive performance-based remuneration.[77] This further underscores the state's commitment to achieving successful births, especially for patients struggling with infertility.

5. Family Law Regulations

Alongside health regulations governing assisted reproduction, the new Civil Code elaborates the legal framework concerning the family status of children born through these procedures. The Family Law Book of the Code codifies longstanding judicial practices and aligns with the principles of the rule of law and the protection of family life. Over the past decade, these provisions have proven effective and stable. The regulation of parental status ensures an orderly family structure, where the child's legal family corresponds to biological descent and is duly recognised in the birth register. This legal regularity provides the foundation for a child to grow up in a secure and recognised family environment. A clear and stable determination of the family status of a child born via ART serves the child's right to identity, along with additional social rights. Birth registration serves the child's long-term well-being. It is a prerequisite for the realisation of children's rights to access education, adequate living standards, healthcare, social support and other forms of protection to which they are entitled.[78] The Hungarian Civil Code lists the legal facts that establish paternity as the matrimonial bond of the mother. In case of life partners undergoing the special procedure for human reproduction (which qualifies as ART), paternity acknowledgement and the determination of paternity are made by court decision. Additionally, it defines the legal facts establishing maternity at birth and by court decision.[79]

75 Art. 2, para. (1), points ca) and cb) of the Decree.
76 Government Decree No. 43/1999 on the detailed rules for financing healthcare services from the Health Insurance Fund.
77 Ibid., Art. 44/B. 2)-2c).
78 de Groot, 2014, p. 144.
79 Civil Code Art. 4:115.

5.1. The Matrimonial Bond of the Mother

As long as paternity can be established based on the presumption of paternity that comes first in the order, the presumption that comes later in the order cannot be applied. The only exception is when a presumption of paternity arises from a reproductive process (discussed later). The presumptions of paternity are uniform, which means that they have the same legal consequences, regardless of whether the child is born in or out of wedlock. The presumption is automatically created based on marriage. The father is the man with whom the mother has been in a marital relationship for all or part of the period from the beginning of the child's conception until the child's birth, that is, within 300 days before the child's birth.[80]

5.2. Special Procedure for Human Reproduction Between Spouses

A special procedure for human reproduction may be carried out for persons who are married or are in a *de facto* partnership. The basis of this paternity is infertility. However, in *de facto* partners, reproductive procedures are allowed if neither of the partners is in a marriage. This is because if a child is born from a reproductive procedure between spouses, the paternity is based on the presumption of marriage. Consequently, the reproductive procedure only creates paternity in the case of *de facto* partners.[81]

In Hungary, if a mother gives birth to a child during her marriage, the authorities register the husband as the child's father, even if the mother has been living with another man for a long time.[82] The same applies if the mother gives birth to a child during her marriage through a reproductive procedure with her partner. This is because the child would be fathered *De jure* by the mother's spouse, instead of the male partner involved in the procedure. Hence, the Act on Healthcare emphasises that no *de facto* partner in a reproductive procedure can be in a spousal relationship. Thus, anyone wishing to have a child through artificial means must settle their personal relationship.[83]

However, there may be cases where the marriage is terminated during the reproductive process, for example, the death of the husband or partner following the fertilisation of the female gamete. An embryo created outside the body acquires the status of a foetus from the day of implantation. Hence, paternity determination in such cases is not always straightforward. If the fertilisation was not extrauterine (e.g. AI) and was followed by the termination of the marriage, the legal paternity of the child is established by the mother's marriage. This is because the date of conception falls within the marriage. If the insemination took place outside the body and the

80 Civil Code Art. 4:99, paras. (2)–(3).
81 Sápi, 2021, pp. 135–137.
82 Civil Code Art. 4:99, para. (3).
83 Act on Healthcare Art. 167, para. (1).

embryo was implanted at the time of the dissolution of the marriage, the situation remains the same, as the date of conception (implantation) falls within the marriage. However, if fertilisation took place outside the body and the embryo had not been implanted, the reproductive process may continue after the 'termination of the marriage' at the written request of the woman.[84]

5.3. Presumption of Paternity Based on the Reproductive Process

A presumption of paternity arising from the reproductive process requires that the applicants constitute an opposite-sex partnership, neither applicant has a subsisting marriage, the male partner engaged in the reproductive process and the child's conception resulted from the said process. A *de facto* partnership refers to a relationship where two individuals live together outside of marriage, sharing an emotional and financial life in the same household (cohabitation). Such a partnership requires that neither person be married or in any form of partnership with someone else, that they not be related in the direct line and that they not be siblings.[85] The partners need not be of different sexes; hence, a *de facto* partnership may be formed between same-sex partners.[86]

Although the legislator acknowledges this type of legal relationship, access to ART is allowed for heterosexual *de facto* partners only.[87] Additionally, the Fundamental Law defines a woman as a mother and a man as a father.[88] It highlights the protection of families, which, first of all, is based on heterosexual marriage and subsequently includes the protection of the parent-child relationship. Thus, the utilisation of ART and infertility treatment is designed to help heterosexual couples and individuals. Therefore, for *de facto* partners, a reproductive procedure can only be carried out if neither partner is in a spousal relationship. A contrary situation would hinder the wishes and legitimate interests of the applicants and the child, as the man involved in the reproductive procedure, in many cases, the biological father, should be the legal father of the child.

84 Ibid., Art. 168, para. (1).

85 Civil Code Art. 6:514.

86 Registered partnership is a family relationship between persons of the same sex that establishes personal status and has the same characteristics as marriage between persons of different sexes. The regulations of the Civil Code about registered partnership refer to both heterosexual and homosexual partners. Nevertheless, a specific regulation allows officiated homosexual relationships, namely Act XXIX of 2009 on Registered Partnership, on Related Matters, and on the Amendment of Certain Acts Necessary to Facilitate the Certification of Cohabitation. Arts. 1–2 stipulates that a registered partnership could be concluded between two persons of the same sex who have reached the age of 18 years. Such individuals may enter a registered partnership before the registrar if they mutually state their intention to do so. Other formal requirements include publicity, which means a public place in general, and the presence of two witnesses. See Csűri, 2010, p. 13.

87 Act on Healthcare Art. 167, para. (1).

88 Fundamental Law Art. L.

The law lays down a further condition that the parentage must be the result of a reproductive procedure. The medical reason for the infertility may arise in the male partner, and during the reproductive process, the mother becomes pregnant as a result of sexual intercourse with another man. In such a case, the reproductive procedure does not give rise to a presumption of paternity, since the procreation was not the result of the reproductive procedure. This applies to both married and *de facto* couples.

5.4. Conflict Between Presumptions of Paternity Based on Marriage and Presumptions of Paternity Based on the Reproductive Process

In certain situations, there may be a conflict between the applicability of the presumption of paternity based on marriage and based on the reproductive process. These cases have been provided for in the legislation. One such circumstance is when a woman, who was a de facto partner, marries a man after a successful reproductive procedure, that is, after becoming pregnant but before the child is born. However, the marriage is not to the partner who was involved in the reproductive procedure. According to the rules, the partner, instead of the spouse, shall be considered the father of the child.[89] This is similar to when the presumed period of conception, 300 days, has not elapsed between the termination of the mother's marriage and the birth of the child resulting from the reproductive procedure with the ex-partner.

In both cases, the law, following the principles of reasonableness and fairness, prioritises the reproductive procedure, instead of the marriage. Hence, it excludes the husband's paternity. This is partly because both the mother and her partner had undergone the special procedure to have children together. On the other hand, it is likely that the partner is also the biological father of the child, thus it is appropriate and justified, that the presumption of paternity based on marriage is overridden.

5.5. Determination of Paternity by Court Decision

Judicial establishment of paternity is not permitted in cases involving ART. This is because, although ART is permitted under certain circumstances, it cannot result in the donor's paternal or maternal status being established or enforceable based on private law relationships. Furthermore, the family status of a child born by gamete donation is governed by the Civil Code. If the parentage is the result of a reproductive procedure, there is no judicial determination of paternity or maternity against the person who donated gametes or embryos for the procedure. This applies to anonymous gamete donors and to cases where the female gamete is offered to a recipient related to the donor.

89 Civil Code Art. 4:100, para. (2).

5.6. Related Rules for Rebutting the Presumption of Paternity

If a child is born through a reproductive procedure, the presumption of paternity can only be challenged on formal grounds if the husband or partner did not consent to the procedure. This is because, in a certain category of reproductive procedures, the presumed father is not the biological father of the child, whose tracing is unauthorised by the legislation. Therefore, the legislator should not give the presumed father the legal possibility to challenge the presumption of paternity on the basis that the child is not his. He can only do so if he subsequently proves that the human reproductive procedure was carried out without his consent or his consent did not include the use of gametes from the donor.

The consent form must indicate the specific intervention to be used. For instance, in a case, the court highlighted that consent is not of a general nature. In this case, there was a 'statement of consent' by the man, the content of which was later disputed. It did not expressly exclude the use of donor sperm; however, the man claimed that he had originally intended to use his own gametes, yet the woman used donor sperm. Hence, he sought to have the paternity annulled for the child who was born of this procedure. He claimed that the use of a donor was not discussed in the assisted reproductive procedure, and he could not have consented to it. The court decided that it was established beyond doubt that the use of sperm from a foreign donor was not involved in the case, as the parties had been informed that the procedure could be successfully carried out using their own sperm. The medical documentation for the procedure listed the male partner as the sperm donor. Hence, if there is a declaration of consent from the man, it must be explicitly related to the specific procedure. Or else, the presumption of paternity can be challenged.[90]

5.7. The Question of Motherhood

For a long time, the status of motherhood was not a matter of dispute: the law, going back to Roman law (*mater semper certa est*), treated motherhood as a fact and not as a presumption. However, as medical science evolved, the identity of the genetic mother and the birth mother does not necessarily coincide. Genetics and surrogacy (parenthood) are often separated in reproductive procedures, such as the use of donor gametes or embryo donation. Following international practice, the Family Law Book decides the choice between the birth mother and genetic mother by considering the woman who gave birth to the child as the mother. This new rule is important for the reproductive procedures permitted under existing law, and is decisive for so-called surrogacy (surrogacy – nanny pregnancy). This provision means that a woman who has asked another woman to carry an embryo from her egg, and give birth to the child, cannot be considered a mother. The identity of the mother

90 Curia Pfv.21526/2014. (EH 2015.08.P8). See Supreme Court of Hungary, 2015.

can be established with much greater certainty than that of the father because the maternity status can be recorded at birth.

5.8. Parentage Arising from Surrogacy Arrangements

Surrogacy has not been legally introduced as a type of ART in the Hungarian legal system. However, in the 1990s, based on the ethical guidelines of the Committee, domestic policymakers explored ways to regulate altruistic surrogacy, referred to as *dajkaterhesség*, and prepared detailed statutory provisions. Although these rules never entered into force,[91] the preparatory work demonstrates that Hungary once aimed to integrate surrogacy into its healthcare system in a carefully regulated, non-commercial form. The Draft of Act CLIV of 1997 Act on Healthcare proposed altruistic surrogacy, permitting the implantation of an embryo created from the gametes of a married or cohabiting couple into another woman's uterus, provided that the intended mother was physically unable to carry a pregnancy, faced serious health risks or was unlikely to give birth to a healthy child.[92] The requirements to become a surrogate mother were fairly strict. Only a woman who was a close relative of the intended parents, legally competent, medically capable of carrying a pregnancy, between 25 and 40 years old and had already given birth to a live child could become a surrogate mother. The regulation specified legal safeguards for the presumptions of parenthood, stating that the intended parents would have to make a joint request, while the surrogate mother and her spouse or partner would consent to prevent the activation of the presumption of paternity in favour of the surrogate's partner.[93] The legislator planned to refine procedural rules in a ministerial decree and postponed the entry into force to allow time for harmonisation with family and inheritance law.[94]

91 The constitutionality of this last-minute annulment came before the Constitutional Court in Decision 108/B/2000. In its ruling, the Court emphasised that the right to self-determination does not oblige the state to provide access to any chosen medical intervention and access to ART is not a fundamental right. The Court underscored that surrogacy raises complex medical, ethical and legal issues that require a well-established professional consensus, which did not exist at the time. Although the dissenting opinion sharply criticised the lack of proper consultation and the failure to establish expert bodies intended to oversee reproductive technologies, these views did not alter the outcome.

92 This model expressly excluded the use of third-party donor gametes, reflecting the legislator's intention to preserve a direct genetic link between the child and intended parents, avoid misuse of reproductive materials and reduce uncertainties around parentage and identity.

93 Draft of the Act CLIV of 1997 on Healthcare Art. 183.

94 The parliament eventually removed all provisions on surrogacy from the Act before it came into effect. The official explanation stressed that related branches of law were unprepared for such a complex institution and medical, ethical and legal dilemmas were not yet sufficiently understood. See About Art. 16, Justification for Section 16 of Bill No. T/1517 on the amendment of certain laws related to state organisation, as well as the laws on real estate registration, healthcare, and fisheries and angling.

Hence, surrogacy in Hungary is not explicitly regulated, meaning it is neither expressly permitted nor prohibited. Thus, the legal environment remains largely silent on the matter, while implicitly restricting it through various provisions of private and public law. Nevertheless, Hungarian couples who wish to pursue surrogacy may do so abroad under jurisdictions where it is legal, and return home with the intended child. However, legal ambiguities arise upon their return, particularly when having the foreign birth certificate recognised by Hungarian authorities. Given Hungary's restrictive stance towards surrogacy, the authorities may, based on legal interpretation or suspicion, refuse recognition of the parent-child relationship and, in certain cases, initiate criminal proceedings if deemed applicable.

Nevertheless, there are a few possible pathways for the intended parents to establish their parental status. The intended parents must register the foreign birth certificate in the Hungarian civil registry, managed by the competent government office under Decree No. 32/2014 (V.19.) of the Ministry of Justice, which is necessary for the child to receive Hungarian citizenship. Although in Hungary, the birth mother is recognised as the mother, a feasible way for the intended mother to get recognised is open adoption.[95] Furthermore, the intended father may acknowledge paternity and make a full declaration of acknowledgement of the surrogate mother's child. This is possible only if the surrogate mother was not married or the surrogate mother's husband rebutted the presumption of paternity. In this case, the wife of the 'intended father', who has legally become the father of the child, can adopt her spouse's child, if the surrogate mother agrees. Hence, the age requirement mentioned above can be waived.

Another way of establishing parenthood between the intended parents and the child is when only the implantation of the embryo takes place abroad in the surrogate mother's womb; however, the actual birth occurs on Hungarian territory. This allows a specific legal solution, namely, the intended father makes a full declaration of acknowledgement of the child, while the birth mother, that is, the surrogate mother, consents to the open adoption of her child by the intended mother. A significant advantage of this procedure is that there is no need for the recognition of foreign official or court documents in Hungary, making the sorting out of the legal relationship simpler and prompt, despite public policy concerns. However, in this situation, a certain method for challenging the presumption of paternity could be activated. The Civil Code stipulates that if the presumption of paternity is based on a full declaration of paternal acknowledgement, it may be challenged because the declaration of paternal acknowledgement was made to circumvent legislation.[96]

95 In this case, the surrogate mother who gives birth, if married, then the husband together with the father, consents to the adoption of the child by the 'intended parents'. It is important to respect the adoption rules, which state that the child may only be adopted by a person who is not more than 45 years older than the child.

96 Civil Code Art. 4:107, para. (2), point c).

Notably, the legal loopholes do not mean that Hungarian citizens can always have children abroad through surrogacy with impunity. In such a case, serious criminal offences, such as 'change of family status' or 'trafficking in human beings', could be established if the real background is revealed. Hence, the aim should be to ensure that similar situations are treated in the same way by law enforcement, and the rights of children born through surrogacy are not affected. However, the reality is that often the foreign birth certificate does not indicate that a surrogacy arrangement had taken place, listing the intended parents as legal parents. The non-disclosure of surrogacy creates significant challenges for national authorities, who often lack sufficient information about the circumstances of the child's birth. For instance, in some cases, lower courts ordered the registration of Hungarian intended parents based on foreign documentation.[97] However, the Appellate Court later overturned such decisions, instructing the lower courts to re-examine the cases and seek additional verification from relevant foreign authorities.[98]

6. Rights of the Child and ART

The Hungarian legal system grants the protection of families and children in both public and private legal settings. This protection applies to children born via ART as well, regardless of the circumstances of birth, although these children might have some specificities regarding protection and additional challenges in exercising their rights. The Fundamental Law recognises the protection of children, guaranteeing their right to the care and protection necessary for proper physical, mental and moral development.[99] The 15th Amendment strengthened this right by stipulating that 'This right shall prevail over any other fundamental right other than the right to life'.[100] The constitutional protection of children and family is primarily supported as a moral commitment to traditional family structures and children's developmental welfare.[101]

Notably, the rights and protection of children born via ART have different ethical and legal considerations according to their developmental stage and the nature of human rights concerns at stake. Distinctions should be made between

97 Bereczki, 2018, p. 35.

98 Budapest Court of Appeal Case No. 2.Kf.27.291/2012/8.

99 Fundamental Law Art. XVI.

100 The priority of the child's right to healthy development might have significant implications in the reproductive decision-making of the intended parents to turn to controversial types of ART, which eventuate in non-traditional family forms.

101 This commitment is further reflected in the requirements to access ART, as the Hungarian legal system supports the utilisation of ART as a solution for the rising problem of infertility in heterosexual marriage.

three categories: children born through surrogacy arrangements, children currently conceived and children yet to be conceived.[102] General human rights concerns are invoked concerning the embryo created via IVF. These rights become more concrete and individualised once the child is born through some form of ART.[103] However, the developmental stages of the embryo and the circumstances of its conception can reframe the due legal protection. These circumstances could challenge the state's fundamental duty to protect the right to life and raise critical questions regarding whether, under what conditions and within what scope of discretion embryos should be granted moral status.[104]

Constitutionally, the Fundamental Law of Hungary protects human dignity, stipulating that 'Human dignity is inviolable. Every human being has the right to life and to human dignity; the life of the foetus shall be protected from the moment of conception'.[105] The embryo's human dignity is defined as the value worthy of protection through the phrasing of the Fundamental Law. Hence, it is an objective institutional duty of the state.[106] The special nature of this protection lies in the fact that it always concerns a biologically and ethically unique individual life. The protection is not limited to life provided by a legal entity. However, in contrast to the subjective right to life, this protection is not absolute. Thus, it can be balanced with other rights, such as the right to health or self-determination, giving the legislator space for discretion.[107]

In Hungary, the embryo is granted relative legal protection to its right to life and dignity, allowing the state to balance these rights with others.[108] Additionally, the decisions of the Constitutional Court underscored that the legislator has the margin

102 More about the children's rights in ART concerning the developmental stage, see Sándor, 2021.

103 The legal status and protection of embryos present two distinct scenarios, as IVF embryos and in vivo embryos invoke different ethical and legal considerations. The in vivo embryo features in abortion cases, where ethical deliberation requires balancing individual autonomy against public interests, especially the pregnant woman's bodily autonomy and self-determination against the embryo's right to life. Here, the core tension lies between the woman, who is an established subject of rights, and the embryo, which is treated as a moral object worthy of protection but not yet a bearer of rights. The legal protection of the IVF embryo is framed through the potential risks of manipulation, abuse and misuse, and the issues surrounding medical research on embryos. See Navratyil, 2005.

104 Sándor, 2021, p. 35.

105 Fundamental Law, Art. II.

106 Explanatory Memorandum to Bill No. T/2627 on the Fundamental Law of Hungary.

107 Tersztyánszkyné Vasadi, 2009, pp. 97–98.

108 Jobbágyi, 1997, pp. 75–91.

to determine the non-existence of the legal capacity of the embryo.[109] However, the status of the IVF embryo can be examined independently, since, unlike an in vivo embryo, the only distinction between the two lies in their location – while the in vivo embryo develops within the womb, the IVF embryo exists in a petri dish. Nevertheless, giving legal status to either one of these embryos would logically give it to the other one too, undermining the right to abortion.

However, if the IVF embryo is granted legal subjectivity, it would cause legal concerns about the fate of the surplus embryos. Thus, the 'objectification' of the IVF embryos is a likely solution for the practically grounded approaches of medicine and law.[110] The Hungarian legal system distinguishes between the legal definition of the foetus and the embryo. The Act on Healthcare, in Art. 165, stipulates that the living human 'embryo' exists from the completion of fertilisation until the 12th week of pregnancy, while the foetus is the human being developing within the womb from the 12th week of pregnancy. This distinction is deliberate and points to the abovementioned 'objectification' for free utilisation in science.[111] Additionally, Art. 179 para. (3) of the Act on Healthcare grants legal status to the embryo, as the IVF embryo attains the legal status of a foetus from the day of implantation.

However, Act LXXIX of 1992 on the Protection of Foetal Life does not base the legal protection on the differentiation of the developmental stage, stating in its introductory note that 'Foetal life, which begins at conception, deserves respect and protection'. The law chooses the wording 'foetal life' rather than human life and defines the protection starting from conception, excluding abortion, as attainable through instruments outside the scope of criminal law.[112] Notably, the Act on the Protection of Foetal Life was enacted following a series of abortion cases brought before the Constitutional Court in the 1990s. The Act focuses on the protection of the in vivo embryo and does not address the status or protection of the *in vitro* embryo. Its primary purpose is to safeguard the embryo and the family, and regulate the legal framework governing abortion.[113]

109 For example, Decision 64/1991, 48/1998 and Decision (XI.23.) of the Constitutional Court. Moreover, the findings of the previous decisions are important and can be applied to the IVF embryo. The Constitutional Court has underscored that the state's duty to protect life cannot be determined by the developmental stage of embryos. It concluded that distinctions between the stages of foetal development or between born and unborn life are merely practical compromises. As expressed in the Decision, 'Why, for example, is the state 'more strongly' interested in preserving a more developed foetus than one younger than three months, even though – if protected – the latter too would have matured? Since the foetus, throughout its entire existence, represents potential human life, on what basis can the intensity of its protection be divided into stages? If, on the one hand, it is declared that the right to life also extends to the *nasciturus* (the unborn), then on what theoretical grounds can a distinction nonetheless be made between the protection of the lives of those already born and those not yet born'?

110 See Jobbágyi, 1997, pp. 198–201.

111 More about the 'objectification' of embryos, see Gyöngyösi, 2002, pp. 286–375.

112 Kovács, 2024, p. 23.

113 Filó, 2016, pp. 254–257.

Overall, the Act on Healthcare grants minimal protection to the IVF embryo. However, this has some morally questionable repercussions, as some other paragraphs facilitate 'objectification',[114] while the in vivo embryo enjoys legal safeguards supported by the Act on the Protection of Foetal Life.[115] Hence, the regulation on embryo protection is inconsistent in the Hungarian legal framework.[116] The Constitutional Court delivered two cornerstone decisions on the legal and ethical considerations of abortion, highlighting key theoretical and legal foundations relevant to the status of the embryo. First, Decision No. 64/1991. (XII.17.) of the Constitutional Court elaborated that addressing the question of whether the foetus is legally a human being and possesses individual rights to life and dignity cannot be avoided. This attains full constitutional significance because one must take a position on the foetus's fundamental rights status.[117] Furthermore, it found that 'the question of the foetus's legal personality cannot be resolved through interpretation of the current Constitution'.[118] It elaborated that the Constitutional Court can issue a substantive opinion on the constitutionality of any statutory regulation concerning foetal legal personality only after the legislature has decided on the matter.[119]

The second decision of the Constitutional Court revealed some particularities in the ethical and legal elaboration, while strengthening the findings that the state grants protection of foetal life, without it being a legal entity. Nevertheless, according to the Constitutional Court, if the legislature does not recognise the foetus as a legal person, then in determining the conditions for terminating a pregnancy, it must consider the competing rights at stake, including the mother's right to self-determination. Consequently, an absolute prohibition on abortion would be unconstitutional.[120]

The right to health is stipulated in Art. XX of the Fundamental Law, highlighting that health encompasses both physical and psychological dimensions. The subsidiary

114 The Act on Healthcare does not stipulate a specific number of embryos for individuals engaging in ART. However, Decree No. 30/1998 (VI.24.) of the Minister of Welfare on the detailed rules governing the performance of special procedures for human reproduction, and the regulation of the use and frozen storage of gametes and embryos sets numeric limits for embryo transfer during IVF, and details the framework for cryopreservation. Nevertheless, the Act on Healthcare enables foetal reduction even when the embryos are healthy to protect the mother's life or health and ensure the safe birth of healthy children, as stipulated in Art. 185.

115 Notably, the protection of the foetus is stipulated in the legislation enabling abortion. The concrete protection of the foetal life is not pointed out; however, it is exhibited as an abstract principle. Furthermore, foetal protection is mainly achievable through the elevated protection of pregnant women. See in Kovács, 2015.

116 Pivotal Decisions of the Constitutional Court highlight this conclusion, Decision No. 64/1991. (XII.17.); Decision No. 48/1998. (XI.23.). The Constitutional Court did not make a value judgment regarding the legal subjectivity of the embryo; it left this question to the discretion of the legislator. See more in: Navratyil, 2005; Gyöngyösi, 2002, pp. 365–368; Jobbágyi, 2004; Tersztyánszkyné Vasadi, 2009, pp. 93–102.

117 C) b. of the Reasoning of the Constitutional Court of Decision No. 64/1991. (XII.17.)

118 Ibid., D) 1.

119 Ibid.

120 III. a) of the reasoning of the Constitutional Court of Decision No. 48/1998. (XI.23.).

rights to the right to health are encompassed in the Fundamental Law, referring to the right to decent housing, access to public services, health during work, organisation of healthcare, and to practice sports.[121] Overall, the constitutional legal provisions facilitate the level of health protection that can realistically be achieved through available regulatory and financial means.[122] Regarding the right to health of children born via ART, the method of preimplantation genetic diagnosis can be carried out.[123] However, the Act on Healthcare prohibits procedures to select the sex of progeny purely for reasons other than heritable disease linked to sex. The alteration of the other genetic characteristics of an unborn child, may only be carried out for the prevention or treatment of expected diseases of the unborn child, to the extent and in the manner strictly necessary for that purpose.[124] Nonetheless, the extent and necessary purpose are not clearly determined in the legislation.[125]

The non-discrimination of children born via ART is expressed in the non-discrimination article of the Fundamental Law, which guarantees fundamental rights to everyone without discrimination based on birth or any other status.[126] Moreover, the Family Law Book of Civil Code contains the best interests of the child among its core principles,[127] which encompasses the equality of children, regardless of whether they were born in or out of wedlock.[128] Hence, a child cannot face negative consequences because of the conditions or manner in which they were born, allowing children conceived through ART to be treated equally as those conceived naturally. Act XXXI of 1997 on the Protection of Children and Guardianship Administration highlights the equal protection of children.[129]

The most controversial forms of ART, such as surrogacy and 'reproductive tourism' for accessing types of ART unavailable or available under stricter circumstances in the home country, carry inherent risks for children. Crossing national borders can increase the potential risks of commodification and trafficking. This means that the right not to be sold and trafficked may be at risk if a commercial

121 Julesz, 2021, p. 107.

122 See Zakariás, 2023.

123 Preimplantation genetic diagnosis in ART is not without ethical challenges, as the preimplantation genetic diagnosis is not intended to eliminate diseases in embryos before implantation, rather to avoid transferring an embryo that carries a disease. In practice, this can lead to the destruction of embryos identified as having a medical condition. Moreover, if utilised without safeguards, it might open up a pathway for selective reduction based on sex, genetic disease or disability initiated by the intended parents because of the undesirable characteristics of the future child. Furthermore, it can promote the potential manipulation of the redundant embryos, which were not implanted. These circumstances challenge the objective duty of the state to safeguard the right to life, and whether, under what circumstances, and within what margin of appreciation is the embryo given moral status. See Sándor, 2021; Kovács, 2025, p. 536.

124 Act on Healthcare Art. 182, para. (2).

125 Navratyil, 2005, p. 10.

126 Fundamental Law Art. XV.

127 Civil Code, Art. 4:2.

128 Barzó, 2017, p. 44.

129 Act XXXI of 1997 on the Protection of Children and Guardianship Administration Art. 3 para. (2).

surrogacy arrangement arises.[130] Another key issue for ART children is how their identity is framed once they are born. The right to know one's origins has a key impact on the child's healthy development, thus its construction goes beyond the guarantees of nationality, legal status and birth certificate.[131] The circumstances of birth are not necessarily disclosed to the child, especially if the intended parents choose to utilise more controversial types of ART, as their parental legal status and the unity of the family environment could be undermined with the disclosure.

The Civil Code incorporates the principle that a child's right to be raised in their family or family environment and maintain their existing family relationships may be restricted only in exceptional cases defined by law and solely in the child's best interests. Often, children born via ART divide biological and legal parenthood. The Hungarian legal system follows that the mother of the child is conclusively established based on the birth. However, as neither anonymous egg donation nor surrogacy arrangements are permitted, a scenario in which the birth mother is not recognised as the child's legal mother cannot legally arise.[132]

Focusing on the child's right to know their origin and circumstances of birth, the Act on Healthcare regulates the right to respect personal data and data control[133] of the biological parent or the donor. Although international trends favour increasingly open and transparent gamete donation practices,[134] Hungary adopts a semi-anonymous model. Under this approach, while the child cannot access the donor's identity or personal information, upon reaching adulthood, they are entitled to learn about the circumstances of their conception and birth to the extent that available data permits.[135] Whether information is shared with the child upon reaching adulthood depends on the biological parents, while whether it is shared immediately before the child reaches adulthood depends on the person serving as their legal representative.[136]

130 The Hungarian Criminal Code lists crimes against the order of medical interventions and research in Part XVI., where criminal offences, which violate constitutional fundamental values, such as life, physical integrity, health and individual rights, are associated with bioethics.

131 Somfai, 2006, p. 26.

132 This is especially evident if the IVF utilises donor gametes or if the intended parents engage in surrogacy, where the gestational mother, the genetic mother and the intended mother differ. The complexity of the surrogacy arrangements blur the line between traditional determination of legal parenthood and the actual underlying biological and gestational facts. If the possibility of using both donor sperm and ova in the IVF is added to the surrogacy arrangements, the potential parental claims may extend to as many as five individuals. See more in: Navratyil, 2012, pp. 140–141.

133 Before the donated gametes are released, the facility storing them must verify the safe usage and biological compatibility. Additionally, the identifying data of the persons undergoing the procedure must be provided. The storing facility of the gametes may not disclose, transmit or make public any information about the circumstances of the release or about the individuals involved. See Act on Healthcare Art. 173.

134 See more in Kovács, 2025.

135 Act on Healthcare Art. 179, para. (1).

136 Ibid., Art. 179, para. (3).

The extent of data which can be disclosed to the child is broad and aims to strengthen the possibility of the donor to maintain anonymity, as the family name, given name, maiden name and address cannot be disclosed.[137] This parallels the adoption and identity disclosure of the biological parents to the child. However, adoption serves the right of an existing child to grow up in a family environment, while ART, with the involvement of donor gametes, promotes family creation, serving the intended parents' reproductive rights.[138]

Nevertheless, Art. 4:135 of the Civil Code establishes the adopted child's right to information about their biological origins through the Guardianship authority. Children may request basic facts if their biological parents are living without any age restrictions. Furthermore, access to personal identifying data about biological parents and siblings is subject to strict conditions, balancing the child's right to know their origins against the biological relatives' privacy rights. Such information can only be released with the explicit consent of the biological parent or sibling. The regulation further addresses the child's access to health-related information about their biological parents.[139] Although the regulation is not extended to children born via ART; they have limited access to trace their origins.

The best interest of the child[140] is a core principle in international children's rights, encompassing that all decisions made about the child should be made primarily focusing on their best interests. This principle is incorporated into the Hungarian legal system as well. Additionally, it is encompassed in the basic principles of family law in the Civil Code.[141] Here, the best interests of the child are interpreted amid family relationships.[142]

The definition of the child in the Hungarian legal framework aligns with the definition of the child expressed in the United Nations Convention on the Rights of the Child (UN CRC). The Civil Code stipulates that any person under 18 years of age is a minor.[143] However, an exception exists whereby an individual may attain legal adulthood from the age of 16 years through marriage. Upon marriage, such individuals acquire the same rights and obligations as adults.[144] Furthermore, the UN CRC expresses that special safeguards and care shall be granted to children before

137 Weiss, 2002, p. 12.
138 Navratyil, 2022, p. 117.
139 Barzó, 2017, p. 364.
140 The UN CRC has been fully incorporated in the Hungarian legal system, although there have been some criticisms highlighted regarding the child's best interests principle. In the Hungarian translation of the UN CRC, the expression mindenek felett álló érdeke is used, meaning 'paramount interest'. However, this interpretation is not in line with what the original text intended to express. Hence, Hungarian legislation consistently follows the terminology of the child's 'paramount interest'. This may lead to misinterpretation because the child's best interests may not be the same as the child's paramount interests.
141 Civil Code Art. 4:2.
142 Szeibert, 2024, pp. 10–11.
143 Civil Code, Art. 2:10.
144 Ibid., Art. 4:9, para. (2).

and after birth. The Hungarian legal system reflects this approach through constitutional protection of human dignity, right to life and special protection through Act LXXIX of 1992 on the Protection of Foetal Life. However, as mentioned, there is a distinction in the legal definition of the embryo and the foetus. Thus, embryos, before the transfer, have the potential for 'objectification', highlighted in the phrasing of the Act on Healthcare,[145] and the possibilities of carrying out embryo research.[146] Nonetheless, despite limited academic interest in this area, the comprehensive emphasis on children's right to healthy development, grounded in the Fundamental Law and reinforced through specific legislation, extends to children born via ART, ensuring that they benefit from Hungary's broader child protection framework.

7. Conclusion

Hungary's regulation of ART highlights the complex task of blending scientific advancement with deeply embedded constitutional values, social norms and ethical principles. Over recent decades, Hungary has significantly expanded ART availability while aligning the legislative framework with traditional family values. However, this has left some unresolved ambiguities in the regulatory framework. The determination to support ART as a tool for addressing demographic decline is most visible in the sweeping institutional restructuring between 2021 and 2022. Hungary fully subsidises infertility medications and has expanded the number of publicly funded IVF cycles, signalling a policy commitment to ensuring that all desired children can be born.

The support is expansive, although the eligibility criteria are restricted to heterosexual married or cohabiting couples. Furthermore, surrogacy is legally prohibited and gamete-donor transparency remains limited. The family law provisions on legal parenthood provide that children born through ART are integrated into a stable family structure. However, surrogacy remains a grey area, forcing Hungarian intended parents to pursue cross-border surrogacy arrangements. This gives rise to legal uncertainties regarding the child's legal status, the establishment of intended parents' legal parenthood and the preservation of the child's right to knowledge about their identity and circumstances of birth, as this information often remain undisclosed or inaccessible.

145 Gyöngyösi, 2002, pp. 386–387.

146 Nevertheless, the Act on Healthcare does not allow creating embryos specifically for research purposes. Thus, only already created embryos for reproductive purposes, with proper authorisation, or damaged embryos can be utilised for research. The donated embryos can be cryopreserved up to 10 years and if offered for research, can be kept viable for an additional 14 years.

The protection of children's rights is well-developed in Hungary, enshrined both in constitutional provisions and specific statutory legislation governing child welfare and guardianship. It centres on safeguarding children's welfare and ensuring their healthy development. While children born through ART enjoy equal legal protection as those conceived naturally, additional challenges and regulatory gaps emerge in areas such as parenthood recognition and identity rights, which reflect the unique circumstances and ethical complexities inherently embedded in assisted reproduction. Moreover, the contradictory legal status of in vivo and *in vitro* embryos, although constitutionally protected as foetal life, subjects them to different regulatory treatment.

The complexities stemming from ART require a nuanced approach in the legislation. Hungary's approach to ART reflects a complex and evolving framework shaped by pronatalist ambitions, constitutional traditions and medical regulation. As demographic challenges arise, infertility rates might intensify. With cross-border practices becoming accessible, the future legislative development shall seek to balance the expectations of the beneficiaries and stakeholders with individual rights, legal guarantees and legal policy objectives, while upholding the principles of reproductive autonomy, equality and the best interests of the child.

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Chapter 7

Poland: Legal Perspective of Human Assisted Reproductive Technologies

Marek Andrzejewski

Abstract

The study aims to present Polish legislation concerning assisted reproductive technologies (ART). The author discusses several legal documents, including relevant provisions of the Constitution of the Republic of Poland, the Infertility Treatment Act, and the Family and Guardianship Code. All essential issues addressed in these documents are thoroughly analysed, such as the financing and organisation of ART, potential penalisation, and their impact on family law. The author examines these issues within the context of philosophical and legal debates, focusing on delicate topics such as the legal status of embryos, the rights of individuals seeking ART, and the status of donors of reproductive cells and embryos. The author believes there is no inherent right to reproduce as a human right, contrary to neo-Marxist claims. Therefore, the state is not obligated to fulfil the reproductive expectations of various social groups. Unfortunately, Polish legislators appear influenced by this perspective, as reflected in current Polish laws, notably through the insufficient legal protection of children in the prenatal state. Polish legal literature emphasises this concern, and the author aligns with this perspective.

Keywords: bioethics, zygote/embryos, eugenics, ART (assisted reproductive technologies), infertility, human rights

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1. Human-Assisted Reproductive Technology – Policy Documents

The phenomenon of artificially assisted reproduction stems from the naturally unsatisfied desire to have a child, as well as from medical developments and technological advances that create the possibility of satisfying this desire. The issue generates both fundamental ethical disputes over the permissibility of such activities, and several specific problems, such as the permissibility of particular ART. The technical possibilities of artificially assisted reproduction developed in the second half of the 20th century, and continue to be further advanced. The law enforced in a given country constitutes proof of which side of the argument over the permissibility of artificially assisted reproduction has prevailed in these ethical and moral disputes. The adoption of one or another legal solution indirectly reflects the views of the majority of the population, which gave a mandate for power in elections. In a study devoted to the law, there is no room for a detailed presentation of the ethical debate – on this issue; interested readers are first referred to philosophical literature.[1]

The Constitution of the Republic of Poland[2] (hereinafter, the Constitution of the RP) does not contain provisions directly addressing the issues discussed in the study. However, it undoubtedly pertains to the matter of artificial reproduction through the fundamental category related to the protection of human rights, that is, dignity (of the child, the donor of reproductive cells, and the recipient). According to Art. 30 of the Constitution of the RP, dignity is inherent, inalienable, and inviolable, and constitutes the source of freedom and human and civil rights. Public authorities are obligated to respect and protect this value. From the perspective of protecting the life of embryos created through the use of assisted reproductive technologies (ART), Art. 38 of the Constitution of the RP is significant, as it imposes on the state the duty to ensure legal protection of life for every human being. According to the jurisdiction of the Constitutional Tribunal of the Republic of Poland (hereinafter, the Constitutional Tribunal), this duty applies to every phase of human life, including the prenatal phase.[3]

The primary acts of Polish law that will be the main subject of analysis in this study were introduced by the Act of 25 June 2015, on the Treatment of Infertility[4] (hereinafter, the ITA), along with concurrent amendments to the provisions of the

1 Galewicz, 2010; Różyńska and Chańska, 2013; Cebrat, 2008, pp. 43–53; Giertych, 2010, pp. 42–53; Varlaut, 1996; Laun, 2002, pp. 91–140; Domagalska, 2015.

2 The Constitution of the Republic of Poland of 2 April 1997, Journal of Laws of 1997, No. 78, item 483 as amended.

3 Judgement of the Constitutional Tribunal of 22 Oct. 2000, ref. No. sig. K1/20, Journal of Laws of 2021, item 175; Judgement of the Constitutional Tribunal of 28 May 1997, ref. No. sig. K26/96; Jurisprudence of the Constitutional Tribunal of 1997, No. 2., item 19.

4 Consolidated text: Journal of Laws of 2020, item 442.

Family and Guardianship Code[5] (hereinafter, FGC) concerning filial relationships arising from the use of ART. Doctrine[6] correctly highlights that the constitutional protection of human embryos is implemented through provisions of other legal acts, such as the Act of December 5, 1996, on the Professions of Doctor and Dentist,[7] the Act of June 30, 2000, on Industrial Property Law,[8] the Act of June 6, 1997, on the Criminal Code[9] and the Act of January 7, 1993, on Family Planning, Protection of the Human Foetus, and Conditions for the Permissibility of Termination of Pregnancy.[10]

At least two international documents significantly affected both the direction of the debate held in Poland in the scientific and political circles and the society's perspective regarding ART: Instruction *Dignitas Personae* of the Vatican's Congregation for the Doctrine of the Faith,[11] which is the basis for the teaching of the Catholic Church, and the Council of Europe Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (adopted in Oviedo on April 4, 1997).[12] The Convention also referred to as bioethical, for some unknown reason not ratified by Poland, is a legal act of international law while the Instruction is an inside document of the Catholic Church, which – from a formal perspective – is not a high-profile document in the hierarchy of documents issued by the Church. This placement is one of the reasons for questioning the Instruction's theses within the Catholic Church discourse.[13] Moreover, the Polish public opinion on ART was swayed by the jurisprudence of the European Tribunal of Human Rights.[14]

2. Polish Public Opinion on ART

In addition to the scientific disputes rooted in philosophical, religious, legal, or political considerations, vibrant debates on artificial reproduction are widespread within Polish society. Public opinion on this controversial issue is regularly studied, and the results influence whether this topic is included in electoral programmes or avoided if the ideological stance of a political group differs from the prevailing views

5 Consolidated text: Journal of Laws of 2023, item 2089.
6 Rylski, 2020, pp. 136–137.
7 Consolidated text: Journal of Laws of 2024, item 1287.
8 Consolidated text: Journal of Laws of 2023, item 1170.
9 Journal of Laws of 2024, item 17 and 1228.
10 Consolidated text: Journal of Laws of 2022, item 1575.
11 Jasudowicz, 2018, pp. 14–36; Instruction Dignitas Personae of the Vatican's Congregation for the Doctrine of the Faith concerning selected bioethical problems, Vatican.
12 European Treaty Series (ETS) / *Série des traitéseuropéens* (STE) No. 164; Grzymkowska, 2009; Tobaszewski, 2022, pp. 129–130.
13 Sporniak, 2024, pp. 118–126; Krasiński, 2023.
14 Grzymkowska, 2009, pp. 158–207; Śledzińska-Simon, 2013, pp. 66–107.

expressed in society.[15] Attitudes towards ART have become a criterion for political affiliation and ideological identity for individuals and social groups, similar to positions on abortion, the legal regulation of same-sex unions, the free market, ecology and environmentalism and several other issues.

In Polish society, acceptance of stable cohabitation by same-sex couples is increasing, while the proportion of opponents to adoption by such couples remains consistently high. There is a positive correlation between data on this topic and societal attitudes towards the permissibility of using ART for same-sex couples and single individuals. In the latter case, reservations often stem from suspicions that a formally single person may be in a stable same-sex relationship.[16] Over time, in Polish society, the percentage of people rejecting ART in general has been gradually declining.[17]

Additionally, public debates assume the form of street demonstrations. As the activism of progressive circles opting for social changes, including the liberal attitude towards ART, has intensified, street marches have been organised and petitions have been written to not allow same-sex couples to adopt children or access ART or to entirely reject the possibility of using ART in surrogacy or other methods.

3. Infertility and Its Types

According to WHO (and the Polish law), infertility is a condition that requires treatment only after a couple has regular sexual intercourse for a year without any birth control (which implies that they are ready to accept pregnancy), yet they cannot conceive a child. Before this period expires, they can use other methods or are allowed to undergo any *in vitro* infertility treatment, if, based on current medical knowledge, achieving pregnancy through these methods is deemed unfeasible.[18]

Infertility can be classified as social if there are objective causes why children cannot be conceived naturally, which is the case in same-sex couples. On the grounds of Polish law, such a circumstance does not render a couple eligible to access ART infertility treatment.

15 The Public Opinion Research Centre, 2015, Opinions on access to in vitro, Study Report No. 96; Kuczyńska et al., 2013, pp. 279–283; Mariański, 2022, pp. 59–79; Gałęziowska and Bogusz, 2013, pp. 300–304.

16 Gałązka, 2018, p. 163.

17 Polish Press Agency, 2016.

18 Art. 5 (2) ITA. Bidzan, 2010, p. 19.

Medical literature provides a list of precise causes of infertility,[19] among which social factors assume centre stage. Few of them concern women, while few apply only to men, and others are found in couples.[20]

The scale of infertility as a phenomenon is unknown. This conclusion can be drawn from the significant discrepancies in the numbers of infertile individuals and couples reported by different sources such as scientists, research institutes, as well as international organisations. The reports rarely detail the methods employed to calculate or estimate these figures. Therefore, reports on the scale of infertility, such as those from United Nations agencies claiming that it affects between 60 and 168 million couples globally, should be approached with caution and scepticism. Similarly, distrust arises when authors state that 'it is said' that the scale of infertility is such and such (most often indicating that it affects around 15% of couples) and possibly cite other authors who report the same figures without providing any details on the methodology of the calculations.[21]

Nonetheless, examining the phenomenon of childlessness from within a circle of one's friends and colleagues raises a red alert. However, childlessness may result from both infertility and reluctance to have children by people not affected by infertility.[22]

4. ART Procedures and Human Rights

4.1. Introductory Remarks

An analysis of the current regulations in Poland suggests that both individuals and institutions wrestle with the issue of how to resolve the conflict between two goods that clash with each other: human dignity commanding respect for human embryos and reproductive freedom, which may further involve a desire to become a parent.[23]

Consequently, Polish legislative work on legal regulation of *in vitro* fertilisation heads in three directions. The first direction prioritises effectiveness (measured by the number of births), as it underscores reproductive freedom. The second and third directions emphasise the protection of human dignity, yet – while the second seeks a compromise between the protection of dignity and the use of ART – the third one

19 Bidzan, 2010, pp. 21–39.
20 Jędrzejczak and Jósiak, 2005, pp. 6–18; Niżnik-Mucha, 2016, pp. 12–13.
21 Bidzan, 2010, p. 15, pp. 18–21.
22 Andrzejewski, 2024, pp. 515–516.
23 Gałązka, 2016, pp. 42–43.

dismisses ART altogether, claiming that despite sincere attempts to limit threats posed by *in vitro* fertilisation, legal approval is not solicited.[24]

Agreeing with this synthetic approach to the currents of thought regarding ART, it is necessary to indicate how they address the fundamental category related to the protection of children's rights, such as the obligation to undertake all actions concerning children with regard to their best interests[25] (Convention on the Rights of the Child, hereinafter, CRC).

When discussing ART, for few, the optimal option is to abandon them, as they are considered as violating the dignity of the child to be born and, above all, the dignity of those embryos that perish during the procedures. For others, the best interest of a child conceived through ART lies in ensuring that the child is born. For yet another group, the best interest is that the child grows up in optimal (model) conditions from the perspective of psychological, educational, and physical well-being, ideally in a family formed by a man and a woman, preferably married.

4.2. ART Procedure and the Right to Decide Regarding the Number of Children (A Right to Reproductive Health, the Reproductive Human Rights)

Regarding the issue at hand, international documents are significant as they state that the right to infertility treatment is part of the implementation of human reproductive rights, which are based on the recognition that all individuals and couples have a fundamental right to decide freely and responsibly on the number, timing, and spacing of their children – or to decide to not have children at all.[26] The issue of the right to freely decide on the number of children is often framed as the right to reproductive health or as a human reproductive right.[27] According to proponents of this approach to fertility, this right encompasses unrestricted access to adoption, ART (including *in vitro* fertilisation), pre-implantation testing, surrogacy, as well as abortion and voluntary sterilisation. Advocates who consider all these practices as human rights argue that this right is complemented by state obligations to adopt measures to meet all related expectations. Moreover, individuals are entitled to initiate claims against the state for the fulfilment of these obligations.[28]

Contrary to the phrasing of the title of this section, reproductive rights cannot be classified as human rights. If they were, it would imply that the inherent dignity of the human person – the source of human rights – could be interpreted to justify

24 Ibid.

25 Art. 3 of the Convention for the Rights of the Child of 1998, adopted by the General Assembly of the United Nations on 20 November 1989. Journal of Laws of 1989, item 526.

26 United Nations, Programme of Action of the United Nations International Conference on Population and Development, Cairo, Egypt, 5–13 September, 1994, para. 7.2. after Różyńska, 2013, pp. 333–335.

27 Różyńska, 2016, p. 801; Dobrowolska, 2016, pp. 164–181; Dzonikowska-Godula, 2019, pp. 133–157; Bassa, 2012, pp. 363–377.

28 Różyńska and Chańska, 2013, p. 334.

a human right to deprive another human being of life, particularly an unborn child (including an embryo), and that individuals could claim a right and approach the state to ensure access to abortion, including abortion on demand, which requires no justification beyond the woman's will to terminate the pregnancy. According to those who advocate for the recognition of such a human right, this right should be respected at any stage during the prenatal life of the child (including up to the end of pregnancy). Another feature of this concept is the assumption that a child can be the subject of a surrogacy agreement and that there can be a demand for adoption regardless of whether it serves the best interests of the child. Such an understanding of the idea of reproductive human rights opts for unrestricted access to ART (without any limitations regarding eligibility).

Critics of this stance argue that the term 'reproductive human rights' is ungrounded and stems from a rejection of natural law as the source of human rights. They contend that the idea of human rights arises from incorporating the concept of human rights into an agenda driven by gender ideology, which, in its deepest essence, seeks to deconstruct the family and all associated concepts, drawing inspiration from Marxist ideology. Thus, this idea is promoted by those who deny natural law as the source of human rights. The claim of the existence of reproductive human rights is considered as an intellectual, legal, and political misuse, ultimately leading to the erosion of the idea of human rights.[29] From this perspective, almost anything (including the most unusual demands) can be – and often is – labelled as a human right, including actions that contradict the very essence of this idea, such as the right to abortion on demand.[30]

In Polish legal science, an objection has been voiced to the thesis of the existence of the right to have or not to have children,[31] aptly inferring that there is the right of a child to live in a family built based on the bond of a man and a woman; however, there is no right of an individual (an adult) to have a child, nor is there a right of an individual to annihilate another human being.[32]

Criticism of the progressive approach to reproduction – particularly in the form of supposed reproductive human rights or the right to procreative freedom – can be observed in the jurisprudence of the Polish Constitutional Tribunal. The Tribunal has stated that the right to parenthood 'does not include a right not to give birth to a child'.[33] Moreover, this approach is difficult to reconcile with the content of Art.

29 Andrzejewski, 2012, pp. 41–58.

30 Kołakowski, 2010.

31 Haberko and Olszewski, 2008, p. 67; Czujek, 2014, pp. 123–130; Chyrowicz, 2002, p. 298.

32 Sylva, 2008, pp. 165–170; Łączkowska, 2005, pp. 70–79.

33 The judgement of the Constitutional Tribunal of 18 April 2018, Sign. K50/15, The Jurisprudence of the Constitutional Tribunal, ref. No. series A 2018, item 19; The judgement of the Constitutional Tribunal of 18 April 2018, ref. No. S 2/18, The Jurisprudence of the Constitutional Tribunal, ref. No. series A 2018, item 20; The judgement of the Constitutional Tribunal, from 28 May 1997, ref. No. K 26/996, the Tribunal Jurisprudence of 1997, ref. No. 2, item 19, point 4.3; Gałązka, 2018, pp. 138–145.

1 of the Oviedo Convention (Convention on Human Rights and Biomedicine), which states: 'The Parties to this Convention shall protect the dignity and identity of all human beings and guarantee everyone, without discrimination, respect for their integrity and other rights and fundamental freedoms with regard to the application of biology and medicine'.

The fundamental ethical principles regarding infertility treatment are articulated in Art. 4 of the Act on Infertility Treatment (ITA), which states: 'Infertility treatment is conducted with respect for human dignity, the right to private and family life, with particular regard to the legal protection of life, health, welfare, and the rights of the child'.

It is widely accepted that this provision fundamentally affirms the reproductive freedom of individuals affected by infertility, a value that several more specific legal provisions further and more explicitly prioritise. The limitations to this freedom are symbolic since the regulations do not exclude the instrumental treatment of embryos created through ART.[34]

Modern law does not prohibit married couples or other partnerships (cohabiting or non-cohabiting individuals) from having any number of children, nor does it impose an obligation to have a specific number of children or abstain from having them altogether. However, such scenarios have been recorded in history. An example includes restrictions on the number of children and administrative penalties for violating such restrictions (e.g., China's one-child policy). According to the consensus of various tribunals, the laws and practices of numerous countries aimed at depriving certain groups of their reproductive abilities for eugenic reasons have been deemed criminal. This notably includes not only Nazi Germany during the Nuremberg Laws era, but also, over more extended periods, Sweden, the United States, and Japan.[35] During World War II, Germany implemented the 'Lebensborn' programme, motivated by racial ideology, where German men impregnated women from conquered countries who met racial criteria under racist legislation. Additionally, the issue of eugenic motives in procreation is associated with the practice of pre-implantation testing within what is termed 'individual eugenics' (as opposed to state-driven eugenics).

4.3. The Right to Refuse Medical and Scientific Experiments in the Context of ART

Medicine advances through scientific experimentation, among other manners. The permissibility of such experiments is governed by moral and legal rules and is subject to review by ethical or bioethical committees. These committees operate within universities, scientific institutes, grant-awarding bodies, ministries, and other

34 Art. 25(1), Art. 9(2), and Art. 26(1) ITA. Gałązka, 2016, pp. 154–155; Rylski, 2020, pp. 152–154.

35 Piątek, 2019; Lifton, 2024; Zaremba-Bielawski, 2011; Catte, 2024; Conroy, 2012; Albański and Krywult-Albańska, 2010, pp. 407–413.

entities. Art. 39 of the Constitution of the RP addresses the issue of medical experiments, stating: 'No one shall be subjected to scientific experiments, including medical ones, without voluntarily expressed consent'.

Since the Act on Infertility Treatment (ITA) does not contain provisions regarding medical experiments, ART is governed by the provisions of the Act on the Profession of a Doctor and Dentist of 5 December 1996 (PDDA).[36] The PDDA distinguishes between 'therapeutic medical experiments' and 'research experiments'. The former involve the introduction of new or only partially tested diagnostic, therapeutic, or preventive methods by a physician, aimed at achieving direct health benefits for the patient. Such experiments may be conducted if currently available medical methods are ineffective.[37]

However, the latter (i.e., scientific experiment) aims at expanding medical knowledge. Therapeutic medical experiments are permitted when participation does not anticipate any risk, or when the risk is minimal and not disproportionate to the potential positive outcomes.[38]

Art. 23a of PAAD concerns ART and it forbids conducting experiments on a conceived child. The freedom from being subjected to experiments stems from the human dignity inherent in the embryo.[39] The law does not entitle parents to grant their permission to conduct experiments on *nasciturus*, to apply for them; neither does it grant such permission to any medical institutions to suggest such an experiment to a mother (a pregnant woman).

According to Art. 21(5) of PAAD, a participant in a medical experiment is defined as the person on whom the experiment is directly conducted. This provision determines that during ART, medical experiments can only be conducted on the woman who is the beneficiary of the procedure and not on the child to be born. Thus, any permissible experimentation must concern the mother and must not be directly related to the ART itself. Furthermore, it may only involve the conceived child to the extent that the woman undergoing the experiment becomes pregnant using the procedure.

In a medical experiment, before a participant provides consent, they must be informed regarding several key aspects, including the purpose and plan of the experiment, associated risks and potential benefits, scope and duration of the experiment, inconveniences and health risks involved, their rights as a participant, legal protections guaranteed by law, including the right to refuse consent and withdraw it at any time without providing a reason and without facing negative legal consequences or discrimination, particularly regarding access to healthcare.[40]

36 Consolidated text: Journal of Laws of 2024, item 1287.
37 Breczko, 2007, pp. 171–192.
38 Ibid.
39 Rylski, 2020, p. 152.
40 Art. 24 PAAD.

A medical experiment may only proceed after obtaining the consent of the participant or the individual directly affected by its consequences.[41] If a pregnant woman who has full legal capacity is unable to give consent owing to her condition, permission for a therapeutic experiment must be granted by a guardianship court.

The participant or another entity authorised to provide consent for participation in a medical experiment has the right to withdraw consent at any stage of the experiment. In such cases, the entity conducting the medical experiment is obliged to immediately discontinue it.[42]

4.4. ART and the Protection of Children's Rights in Polish Law

4.4.1. Introductory Remarks

ART aim at the conception and birth of a child and grant their beneficiaries the possibility to experience parenthood. The fulfilment of both aims involves numerous issues of varying scientific and societal significance, particularly in medicine, ethics, and law. Among the legal and ethical aspects, the protection of the dignity of all entities involved in these procedures stands out, with particular emphasis on safeguarding the rights of the child from the very first moments of their life in the prenatal phase. Despite the paramount importance of dignity, it is this very good – legally protected within the context of ART– that is most at risk. This risk stems from the instrumental treatment of the child who is to be conceived and born, which includes, among others, denying the humanity of the embryo or treating the child as an object of transaction, as observed in agreements for surrogate motherhood, or from other manifestations of the commercialisation of services related to ART, where profit is prioritised over the ethical complexity of the issue.

4.4.2. A Child From the Onset

Addressing the protection of children's rights in the context of ART requires an initial declaration that in this analysis, following biological findings, embryos are regarded as children – human beings in the earliest stages of life.[43] From an ontological perspective, various views exist regarding the moment a child comes into being. These include a delayed recognition of humanity (postponing its acceptance by several hours, days, or weeks after fertilisation),[44] a complete denial of the humanity of embryos, and a recognition that human existence begins at birth. Each of these views, when used as the basis for lawmaking, leads legislators to adopt

41 Art. 25(1) PAAD.
42 Art. 27(1) PAAD.
43 Rylski, 2020, p. 152; Gałązka, 2018, p. 145; Lis, 2022, pp. 189–226; Szymański, 2009, pp. 61–78.
44 Szymański, 2009, pp. 67–78; Singer and Wells, 1988, pp. 118–126; Sporniak, 2024, pp. 118–126; Krasiński, 2023.

differing legal frameworks. For instance, recognising embryos as human from the moment of conception or an early developmental stage could result (although not necessarily) in a total prohibition on ART, permission of ART with strict limitations, such as prohibiting the creation of embryos for purposes other than their existence and development or a prohibition on medical experiments on embryos.[45]

When discussing the protection of children and their rights in the context of ART, considering their situation both before and after birth is essential from the perspective of legal regulations. This necessitates a discussion regarding the legal protection of the child-embryo (see Sec. 4.4.3) and the legal provisions governing the status of a child after birth as regulated by PAAD and other regulations (see Sec.5, 10). Moreover, the identification of beneficiaries of ART is a significant issue.

4.4.3. Protection of the Embryo

The legal status of the embryo has been and continues to be a central focus for ethicists, theologians, medical professionals, legal experts, and other researchers involved in ART. The issue is highly controversial owing to compelling arguments supporting the view that the embryo is a human being, contrasted with the widespread practice of abortion, which is a legally sanctioned termination of its life. For instance, France recently elevated the right to abortion to constitutional status, while in many other countries, restrictions on abortion are considered as violations of women's rights. Simultaneously, the pro-life stance has a significant number of advocates; therefore, progressive circles, including countries where they dominate legislative bodies, must often consider the perspectives to a certain degree. Consequently, ART legislation frequently reflects political compromises that fail to satisfy either side of the broader cultural and ethical debate.

The legal status of the embryo is defined by several provisions within the Polish legal system. It is essential to begin with Art. 38 of the Constitution of the RP, which states that 'The Republic of Poland ensures legal protection of life to every human being'.

The Constitutional Tribunal has interpreted the protection of life to extend to the child from conception.[46] Furthermore, Art. 6 of the CRC and its Preamble guarantee the protection of the child's life; the latter mandates protecting the rights of the child 'both before and after birth'. According to Art. 2 of the Commissioner for Children's Rights Act of 6 Jan. 2000,[47] the Commissioner is tasked with safeguarding these rights from the moment of conception.

45 Art. 27(1) PAAD.

46 Judgement of the Constitutional Tribunal of 22 October 2000, ref. No. sig. K1/20, Journal of Laws f 2021, item 175; Judgement of the Constitutional Tribunal of 28 May 1997, ref. No. sig. K26/96; Jurisprudence of the Constitutional Tribunal of 1997, No. 2, item 19.

47 Consolidated text: Journal of Laws of 2023, item 292.

Considering these provisions, the legal definition of an embryo[48] is notably surprising. It is defined as: 'A group of cells formed by the extracorporeal union of the female and male reproductive cells, from the completion of the fusion of the reproductive cell nuclei (karyogamy) to the moment of implantation in the uterine lining'.

This definition raises significant concerns, as it deprives the embryo of recognition of its dignity. It overlooks the fact that the embryo possesses a unique DNA code and other individual characteristics, establishing it as a separate organism.[49]

The adoption of such a legal definition of the embryo foreshadowed the introduction of detailed resolutions in the ITA in the spirit of progressivism. This is exactly what happened, although several regulations were adopted that set the framework for the full realisation of the idea of procreative freedom. Among these are prohibitions on: (a) the creation of human embryos for purposes other than a medically assisted reproductive procedure,[50] (b) creation of chimeras and hybrids, (c) interventions to cause heritable changes in the human genome that can be passed on to future generations,[51] and (d) creation of an embryo whose genetic information in the cell nucleus is identical to the genetic information in the cell nucleus of another embryo, foetus, human being, corpse or cadaver.[52]

The law prohibits the destruction of embryos capable of normal development that were created using ART but not transferred to the recipient.[53] These embryos must be stored under conditions that provide them with adequate protection until they are transferred to the recipient's body. The weakness of this provision is the stipulation that an embryo capable of normal development is an embryo whose development is probable by the rate and sequence of cell division, the degree of development in relation to the age of the embryo, and the morphological structure render normal development probable, and furthermore has not been found to have a defect that would result in severe and irreversible handicap or incurable disease.[54]

Embryos that do not fulfil the criteria are not under protection and can be destroyed.

To pre-empt the possibility that some ART beneficiaries may be guided by a motivation that objectifies a child, pre-implantation genetic diagnosis was limited only to cases with clear medical indications preceded by genetic counselling as part of medical counselling.[55] This type of diagnosis is not permitted for the selection of

48 Art. 2(28) ITA.
49 Biesaga, 2004, pp. 231–238, 257-264; Haberko, 2016, pp. 56–58; Rylski, 2020, pp. 132–161; Lis, 2022, 189–226; Szymański, 2009, pp. 76–78; Rudziewicz, 2004, pp. 257–264
50 Art. 25(1) ITA.
51 Art. 25(2) ITA.
52 Art. 25(3) ITA. Haberko, 2016, pp. 161–163.
53 Art. 23(3) ITA.
54 Art. 23(2) ITA.
55 Art. 26(1) ITA.

phenotypic characteristics, including the sex of the child, except when such selection avoids a severe, incurable hereditary disease.[56]

Behaviour that violates the listed restrictions is regarded as a criminal act (see Sec. 9). The criminal sanction is intended to prevent the use of preimplantation activities for what has been labelled liberal eugenics, that is, decisions made by individuals regarding the genetic selection of embryos in the case of ART (in addition to such examples of eugenics as abortion performed based on prenatal testing, or interference with the genotype of the offspring),[57] as well as to limit the possibility of actions aimed at commercialising ART.

To obtain a stand on the legal status of an embryo, addressing the legal status of surplus embryos is necessary that is the spare embryos left after performing ART. If the genetic parents will neither use them nor give them for adoption, then after 20 years, the embryos are transferred for adoption by default.

At this time, they are subjected to cryopreservation, that is, the process of storing in the temperature of –196 degrees Celsius (boiling liquid nitrogen) to freeze biological activity. This is a dangerous situation for embryos and can lead to their damage. In 2019, a project to prohibit the cryopreservation of embryos was under consideration.[58] It was highlighted that the procedure of cryopreservation violates human dignity, since it implies freezing, and considering current knowledge, approximately 15% of embryos die during this procedure. The general position that prevailed at the time was that both ART fertilisation and cryopreservation do not in themselves constitu te justification for considering that in such cases, there is instrumental treatment of a human being, constituting a violation of dignity. Assessment of the violation of this value depends on the totality of the circumstances of the particular case.[59]

The definition of an embryo, the possibility of creating surplus embryos, and the impossibility of providing full protection to embryos subjected to cryopreservation are all issues that form the basis of a critical assessment of Poland's ART law. In the literature, critical assessments are formulated:

> ... the Polish state, in regulating the use of the *in vitro* procedure to date, has not addressed fundamental issues, which include guaranteeing respect for the constitutional rights of unborn beings, which are commonly and drastically violated under the current legislation. This demonstrates that the Polish authorities have not adopted a responsible attitude to the threats to human life and health that arise in the wake of a dynamic development of medical science.[60]

56 Art. 32(2) ITA.
57 Soniewicka, 2010, pp. 83–84; Soniewicka, 2018.
58 The project and its justification can be accessed on the Polish Parliament [*Sejm*] website.
59 A letter from the Commissioner for Human Rights of 25 March 2015.
60 Rylski, 2020, p. 154.

It is stressed that the provisions of the ITA do not provide sufficient legal protection of the viability of the embryo, as they allow the creation of excess embryos or under-determine the fate of surplus embryos. Additionally, it is stressed that only those embryos qualified as capable of normal development have a chance to be born, which in essence is a manifestation of eugenic selection.[61]

The right to life is inherent, and it is not within the competence of the legislature to grant or abolish it. It can reasonably be argued that the legal protection of reproductive health is insulated in the law. The guarantee of its protection emerged at the expense of the other constitutional value, which is human life (emphasis in original- FS). Legal protection of human life should be extended to every form of life, including the human embryo. The legislator on the grounds of the law in question, does not realise this right.[62]

Consequently, a firm view was expressed:

> The human embryo, referred to as 'zygote' in the current legislation, is protected only to the extent that it can serve the overarching goal of ensuring the effectiveness of *in vitro* fertilization, which is the birth of a healthy child.[63]

4.5. The Right to Health Protection of the Embryos and Children Born With the Uses of ART

Empirical data suggests that the threat posed to the health of embryos and children born using ART is much higher than that for children conceived in a natural manner or *in vitro* ART.

> [C]hildren born with the use of ART are 1.7 times more likely to need qualified medical attention; the risk of cerebral palsy is 3.7 times higher, suspected developmental delay – four times higher; the risk of intrauterine and perinatal complications increases; defects in uterine development are found more often in boys. From Scandinavian data: multiple pregnancies after ART occur 27 times more often than after natural insemination, premature babies are born five times more often, and underweight babies are born six times/.../. Perinatal mortality is almost twice as high, malformations occur in 5.4 children.[64]

When discussing the issue of the health of children born through ART it is vital to consider a circumstance that is often downplayed:

61 Haberko, 2016, pp. 153–157; Sztandera, 2016, p. 254.
62 Sztandera, 2016, p. 254.
63 Gałązka, 2016, p. 44.
64 Cebrat, 2008, pp. 51–52.

> [T]he vast majority of research is conducted on children born; as a consequence, the influence of *in vitro* fertilization on the survival of embryos prior to placement in the woman's body and shortly thereafter is overlooked. However, there are many indications that within the IVF cycle, a certain percentage of embryo mortality is caused by the transfer of conception and development of the early embryo to *in vitro* conditions.[65]

The cited information highlights the requirement to intensify efforts to improve the protection of the health and lives of children conceived and born using ART. Information on the incidence of certain diseases should be associated with the obligation to monitor the development and health of children.

From the perspective of the legal aspects of ART, the issue under discussion is directly related to the expression of consent to particular medical actions, which – if it is to meet the criteria for statements of consent – must be based on the fullest possible knowledge of the issues related to the subject to which consent is to be given (see Sec. 6). The referenced information should be presented by doctors to those intending to undergo ART.

4.6. Prohibition of Discrimination Against Children Born Using ART

The status of children conceived using ART, in the prenatal phase of their life, is related to the dangers posed to surplus embryos (point 4.4), as well as manifestations of the commercialisation of these procedures, which may involve the objectivisation of embryos displayed in trading in embryos, contracting surrogacy and others. Some of these behaviours have been penalised (see Sec. 9). The objectification of embryos is to be countered, in part, by preventing discrimination against children with disabilities through the prohibition of eugenically motivated preimplantation testing, as well as the prohibition of abortion of children because their characteristics do not match the expectations of ART beneficiaries.

While criticising the commercial approach to ART, it should be borne in mind that in Poland this phenomenon is recognised both in the literature and in the practice of law enforcement agencies,[66] whereas, in the United States of America, ART regulations are placed under consumer regulations.[67]

However, after birth these children are not threatened with any harassment associated with them being conceived using ART. Children born using ART have the same legal status as all other children. This fact was emphasised in Poland, particularly by those who raised objections to the passage of the ITA and the legal

65 Gałązka, 2016, p. 41; Gałązka, 2022, pp. 228–234; Gałązka, 2018, pp. 143–144.
66 Breczko, 2007, pp. 257–273.
67 Cerbat, 2008, pp. 43–44.

permissibility of ART. They had no doubts regarding the personal dignity of children born using this procedure.[68]

Consequently, there is no compelling requirement for protection against discrimination against a child born using ART by others, including peers, much less by institutions. This issue is not reflected in any manner in documents such as civil status records, nor are there any records of these children, which could be used against them. Professionals involved in the application of ART are bound by secrecy, and medical records are not released, except exceptionally and based on a decision issued in a special procedure. Thus, in practice, the fact of conception through using ART is known only to those who learn about it from those who are the beneficiaries of ART programmes, that is, the parents of the child.[69]

4.7. The Right of a Child Born Through ART to Know Their Roots

A universal standard for protecting a child's right to know their origins is articulated in Art. 7 of the CRC. This Art. obligates states to ensure, whenever possible, that a child has the right to know their parents and be cared for by them from the moment of birth. This standard recognises human identity as a highly significant good from psychological, social, biological, and medical perspectives. Legally, it is considered a personal right and a fundamental element of an individual's right to privacy.[70]

Until recently, the issue of a child's knowledge of their origins directly concerned only adopted children. When Poland ratified the UN CRC in 1991, it initially made a reservation to this provision, citing Polish traditions opting for the secrecy of adoption concerning the adopted child. In 2013, this reservation was withdrawn. Subsequently, on 28 November 2014, the Registry Office Records Act was enacted,[71] introducing regulations regarding access to the new birth certificate prepared for anonymously adopted children (with the consent of the biological parents who did not identify the adoptive parents). A new birth certificate is prepared based on a court order issued at the request of the adoptive parents (with the consent of the adoptee aged 13 or older) or at the request of the adoptee (with the consent of the adoptive parents) pursuant to Art. 71(1) and Art. 72(1) of the Act. In both cases, an additional annotation is attached to the original birth certificate of the adoptee, which is not disclosed, indicating the issuance of the new birth certificate.[72] A crucial provision in this context is Art. 72(3)(1) of the Act on Registry Office Records, which states: 'Upon the request of the adoptee after reaching adulthood, a complete copy of the original birth certificate shall be issued'.

68 Kaliszuk, 2022.
69 Gromek, 2022, pp. 517–518.
70 Kuźnica, 2016, pp. 181–198.
71 Consolidated text: Journal of Laws of 2023, item 1378.
72 Króliński, 2023, pp. 429–439.

This provision serves as the formal basis for the argument that, under Polish law, adopted underage children are not fully assured the ability to learn regarding their origins.[73]

Further, in Polish legal practice, the right to know regarding one's roots is significant in the context of the protection of children's lives in the windows of life. Leaving a child at the window, usually a newborn infant, is usually an act of a desperate mother. It saves the life of a child; however, it deprives them of the possibility of learning of their roots. Children's Rights Committee criticises the existence of such windows in Poland; however, this opinion was commonly dismissed as the value of life exceeded any other personal rights of a human being.

The issue of a child's right to know their origins has adopted a new dimension with the introduction of regulations concerning ART. These regulations raise numerous questions regarding the relationships between gamete donors and the child born consequently. The key question centres on selecting between two values: protecting the anonymity of the gamete donor and safeguarding the child's right to knowledge regarding their origins. The issue of a child's identity is particularly relevant in cases of heterologous artificial insemination and surrogacy.

In homologous artificial insemination, the gamete donors are the spouses or long-term partners who subsequently raise the child.[74] However, in heterologous insemination, additional individuals participate in ART. This is particularly complex in cases of surrogacy, where multiple individuals may be involved.

When ART was legalised, a register of gamete and embryo donors was established to monitor medically assisted reproduction[75] and to enable the identification of donors and recipients of gametes. The register is managed by the Minister of Health. The data collected in the register is confidential and can only be accessed by authorised individuals.[76] Among those with authorised access are adults born through ART using non-partner gamete or embryo donations. The information available to them includes the health status of the gamete or embryo donor, their year and place of birth, and the results of medical and laboratory tests. However, legal representatives of children born through ART have significantly more limited access, confined to the health status of the donors and test results – and only when such information could help avert an immediate threat to the child's life or health.[77]

Additionally, the possibility of determining their origins by children born through ART is significantly more restricted compared with adopted individuals and could be described as illusory.

It is widely agreed that the functioning of this register does not fulfil the right to know one's genetic identity. This is evident from the type of data accessible to

73 Ignatowicz and Nazar, 2016, pp. 494–496.
74 Kuźnicka, 2016, pp. 191–192.
75 Art. 37(1) ITA.
76 Art. 38(1) ITA.
77 Wojewoda, 2021, pp. 38–51; Haberko, 2016, pp. 242–249.

authorised individuals, which excludes identifying information regarding the gamete or embryo donors.[78] For individuals born through heterologous reproduction, access to data identifying gamete or embryo donors is explicitly excluded.[79]

4.8. The Child's Right to Have Parents and to be Under Their Care

The right of a child born to a family using ART and parental care is closely tied to the determination of the beneficiaries of these procedures (referenced in Sec. 5). The Act on Infertility Treatment permits the use of ART exclusively for married couples and cohabiting partners. This regulation can be interpreted as derived from Art. 18 of the Constitution of the RP (protection of the family and familial relationships) and Art. 48 (the primacy of parents in raising their children). Additionally, it aligns with the right of a child to live in a family, as outlined in the preamble, Art. 5, and Art. 18 of the CRC.[80] The provisions of the CRC, in turn, draw upon Art. 16(3) of the Universal Declaration of Human Rights (UDHR) of 10 December 1948, and Art. 23(1) of the International Covenant on Civil and Political Rights (ICCPR) of 1966, both of which state: 'The family is a natural and fundamental group unit of society and is entitled to protection by society and the State'.

Apart from a child's right to life, the other most important right is the right to a family (to live in a family).[81] In the Polish context, it is required to be specified that from the perspective of the legislators, the model setting for having (including with the use of ART) and raising a child is a family understood as a group unit of society based on a union between a man and a woman, married or cohabiting. The arguments in support of making ART accessible to heterosexual informal unions (the cohabiting couples) include a commonness of such unions and negative demographic tendencies (dramatically low birth rates, decreasing number of contracted marriages, increase in divorces).

To guarantee the best interest of a child yet to be born, model solutions that best support their development should be sought. Far from the model solutions are scenarios where a child is raised by a single individual or within a union composed of any constellation other than a heterosexual couple, whether involving two or more individuals.[82] This solution may be deemed conservative as it accords to ART beneficiaries the traditional roles of a husband/wife or cohabiting heterosexual partners or parents;[83] however, in this context, the author believes the word conservative is unequivocally positive.

78 Haberko, 2016, pp. 246–247; Bączyk-Rozwadowska, 2018, pp. 367–394.
79 Gałązka, 2018, pp. 161–162.
80 Justification of the judgement of the Constitutional Tribunal of 18 April 2018, ref. No. sign. K 50/16 [Online].
81 Andrzejewski, 2025.
82 Haberko, 2013, pp. 157–159.
83 Drapalska-Grochowicz, 2023, pp. 59–64.

The provisions of ITA align with the constitutional principles of the Republic of Poland and international law. They permit the use of ART exclusively for married couples or heterosexual partners in stable relationships (cohabitation), and only in cases where these couples face medically diagnosed infertility (see Sec. 3). ART are not allowed for individuals or couples facing social infertility, such as those in stable homosexual relationships or single individuals.

Considering that the status of being in a stable relationship is determined solely based on declarations made by a man and a woman, with no mechanisms in place to verify the truthfulness of these statements, it has been rightly noted that this allows for relatively easy access to ART by both single individuals and same-sex couples.[84]

4.9. The Right to Citizenship (The Right not to be Stateless)

The issue of a child's citizenship and the problem of statelessness are strongly emphasised in Art. 8 of the CRC, which sets a standard for the protection of children's rights in this regard. Under the Polish law, a minor acquires Polish citizenship by birth if at least one parent is a Polish citizen. Moreover, citizenship is granted if the child is born on the territory of the Republic of Poland and their parents are either unknown, stateless, or of undetermined nationality, or if the child is found on the territory of Poland and their parents are unknown. These provisions are outlined in Arts. 14 and 15 of the Polish Citizenship Act of 2 April 2009.[85] The process for acquiring Polish citizenship for children born using ART is identical to that for all other children.

4.10. Protection of Private and Family Life in the Context of ART

Every medical procedure should be conducted with discretion, particularly in the sensitive patient-doctor relationship. This relationship emphasises the confidentiality of information shared by the patient and the obligation of the doctor to maintain secrecy regarding what they learn during consultations and diagnostic procedures. A doctor may disclose information regarding a patient's health only to individuals designated by the patient, while being bound by confidentiality concerning all others.[86] Considering the intimate nature of procreation-related matters, the issue of privacy is particularly significant in the context of ART.

The Act on Infertility Treatment contains numerous provisions aimed at safeguarding patient privacy, particularly regarding how consent is given and revoked for specific ART-related actions (see Sec. 6). These processes must be preceded by comprehensive information on all aspects of the procedure, including the obligation

84 Gałązka, 2018, p. 163.
85 Consolidated text: Journal of Laws of 2023, item 1989.
86 Kubiak, 2010, pp. 267–298, Nesterowicz, 2007, pp. 215–220.

to maintain medical confidentiality.[87] Medical confidentiality must be upheld in several cases specified by the Act, and patients must always be informed of this obligation before providing consent to proceed with ART. According to ITA provisions, such information may be revealed to the following people: (a) candidates for gamete donation for partner donation purposes;[88] (b) candidates for gamete donation for non-partner donation purposes;[89] (c) candidates for gamete donation to preserve fertility for future use;[90] (d) recipients of gametes for use in medically assisted reproduction, whether through partner or non-partner donation.[91]

The data collected in the register of gamete and embryo donors is subject to confidentiality and can only be disclosed to authorised individuals and within a scope regulated by the provisions of the law.[92] Additionally, medical centres involved in assisted reproduction and sperm and egg banks (see Sec. 12) are required to retain documentation related to the activities performed in connection with ART procedures. This includes information regarding the donors, recipients of gametes and embryos, the handling of gametes and embryos, and all related actions. All this data is protected by confidentiality, and its disclosure is allowed only as stipulated by the ITA or in connection with legal proceedings authorised by judicial authorities.[93]

Finally, all individuals involved in ART, including those not typically bound by confidentiality under other legal provisions, are required to maintain the confidentiality of information regarding candidates for gamete donation, donors, recipients, and children born using assisted reproduction.[94]

5. ART Beneficiaries – A Limited Circle – (Non)Discrimination

Under the provisions of the ITA, it is permissible to conduct ART on spouses or a man and woman living in cohabitation (cohabiting couples). This applies to both in vivo and *in vitro* procedures. The ITA rules out infertility treatment for single women, as well as those in same-sex relationships. The basis for such regulation can be found in the Constitution of the RP and in standards for the protection of children's rights in Sec. 4.8. Until now, the evolution of the ITA under the influence of progressive ideas has come to a halt in the face of the thesis that the optimal living

87 Haberko, 2016, pp. 182–187.
88 Art. 29 ITA.
89 Art. 30 ITA.
90 Art. 31 ITA.
91 Art. 32(1) ITA.
92 Art. 38 ITA.
93 Art. 47(5) ITA. Haberko, 2016, pp. 274–275.
94 Art. 50 ITA. Haberko, 2016, p. 291.

environment for a child is a family composed of parents of both sexes. It is difficult to judge whether, in time, demands for legal regulation of the use of ART for single people and same-sex couples would be articulated. Such demands are being made, and opinion polling centres are probing public attitudes. In 2019, a proposal to limit access to ART to married couples only was rejected.[95]

The author believes that in statements grounded on the erroneous thesis that there is a human right to reproductive health (see Sec. 4.2), it was argued that the regulations adopted on who is (should be) the beneficiary of ART are discriminatory against single people and same-sex couples who cannot undergo ART. The discussion of this issue was a reflection of the state of the law and society's views on cohabitation, single parenthood[96] and the status of same-sex unions in Poland (see Sec. 2).

Statutory restrictions are sometimes claimed to be a form of discrimination against people who are prevented or restricted by law from accessing these procedures. The prohibition of discrimination has a strong axiological justification, since violating it proves the inequality of citizens before the law, which in turn allows the accusation that the state is undemocratic. However, not every differentiation of the legal situation of citizens constitutes discrimination. We deal with discrimination only when the law treats people in the same situation differently.[97] If persons are not in the same situation, then the legislator has the opportunity to regulate an issue differently for each group. Therefore, if the legislation specifies prerequisites of a subject indicating the required characteristics of those entitled to something, or making the emergence of a right conditional on the occurrence of a certain event, then people who do not meet the statutory criteria are not discriminated against, because they are in a different situation from those who are not subject to restrictions or exclusions. For example, the prerequisites for marriage do not discriminate against those who do not meet them and cannot be married. The same applies to the requirements for adoption, acquiring property, becoming a foster family, and many others. Certainly, one can question the relevance and rationality of the existence of one or another prerequisite, as well as the legitimacy of their absence, and one can debate proposals for change; however, the charge of discrimination is false. This is because the legislator is acting within the scope of his powers.

95 The Commissioner for Human Rights, 2019, The Commissioner against limiting IVF to married couples only. This is one of the changes proposed by a group of MPs.

96 Kwiecień, 2016, p. 52.

97 Borysiak and Bosek, 2016, pp. 838–839. On many occasions, the Polish Minister of Justice, Adam Bodnar overused the argument of discrimination. Cf. Application of the Commissioner for Human Rights to the Constitutional Tribunal of 12 May 2015, which was rejected by the 22 November 2016 Judgement of the Constitutional Tribunal, ref. No. ZU A/20166, item 83.

6. Expressing Consent for Actions Within ART

Expressing consent is a declaration by a legal entity whose validity depends on meeting several conditions. First and foremost, the concept of consent inherently includes the autonomy and freedom of action of the legal entity – a characteristic of any declaration of intent. This is of such fundamental importance that the phrase 'informed consent' is a typical example of redundancy. Without awareness– on a sufficiently high level of understanding of the issue to which the consent pertains – one cannot speak of genuine consent at all.

As consent concerns future events and, thus, shapes the future of the legal entity, the importance of autonomy must be strongly emphasised. Autonomy, particularly within medical procedures, derives from obtaining full and truthful information regarding the matter in question. This information must be sufficiently comprehensive 'to enable the individual to acquire the necessary knowledge to make a decision'.[98] Without adequate knowledge, prudent choices cannot be made.

The information provided should address the purpose, plan of action, risks, and benefits associated with adopting a specific option. The method of delivering this information must be adapted to the patient's capacity for understanding. The patient must be able to ask questions, and the physician is obligated to clarify any ambiguities. The person giving consent must be in a state of mind that enables rational decision-making. The consent recipient is responsible for ensuring that the consenting party understands the situation. This person must not exert coercion, persuasion, or manipulation.[99]

This last aspect appears particularly significant in the context of consents given in ART procedures, owing to the understandable emotions of the beneficiaries. Concealing full knowledge from those giving consent – such as information regarding the potential health consequences for the children born using these procedures – would constitute manipulation. Without such transparency, the notion of consent in the legal sense cannot apply, and the ART process is reduced to a transaction in which embryos are treated as commodities and ART as a service – components of commercial activity and the consumer market.[100]

As the conditions under which consent is given differ, ITA provisions account for the differences. For example, if the cell donor is a man unrelated to the recipient, then prior to the procedure he must be informed regarding its legal aspects. For example, he must be informed that he will not receive any information on the method of usage of the cells, or the information regarding him that the recipient or the person born using ART will receive.[101]

98 Czarkowski, 2018, pp. 154–155.
99 Ibid.; Kubiak, 2010, pp. 331–450.
100 Cebrat, 2008, pp. 43–53.
101 Art. 30(1) item 5c; Art 38(2) ITA.

In the framework of ART procedures, the following consents must be given under the circumstances: (a) consent of the reproductive cells donor to use them in ART; (b) consent of the recipient to receive the reproductive cells within ART (in a partner or non-partner donation); (c) consent of a donor of reproductive cells obtained for partner donation to use them in ART for non-partner donation (i.e. anonymous donation); (d) consent of the recipient and her husband or a cohabiting partner for transfer to the organism the embryos created from reproductive cells obtained from her husband or cohabiting partner; (e) consent of the recipient and her husband or a cohabiting partner for transfer to the organism the embryos obtained from non-partner donation (when the donor of reproductive cells is anonymous); (f) consent of the recipient and her cohabiting partner for a transfer of an embryo created using anonymous donation when her cohabiting partner acknowledges paternity of the child born using ART with the use of this embryo, and the recipient confirms that the man will be the father of the child.[102]

In cases where it is not possible to directly use embryos created from the gametes of the husband or partner, and it becomes necessary to transfer them for storage, all previously expressed consents must be repeated 'prior to resuming the medically assisted reproductive procedure in which the stored embryos are to be used'.[103] However, the use of cells originally collected for non-partner donation in an ART procedure as part of partner donation requires the donor to withdraw their consent for the original purpose for which their gametes were intended.[104]

A declaration of consent for conducting a particular action can usually be withdrawn later. However, there are limitations in this regard. Whether consent was given within the framework of partner donation or non-partner donation, consent can be withdrawn until the commencement of ART for the recipient. In the case of intrauterine insemination (*inseminatio*), this refers to the use of reproductive cells within the woman's body. For *in vitro* fertilisation, it refers to the commencement of the process of creating an embryo from those cells.[105] Proper withdrawal of consent results in a prohibition on using the donor's reproductive cells in the ART[106] and a prohibition on using embryos created from those cells.[107]

However, there is an exceptional situation concerning the withdrawal of consent for the transfer of an embryo. As stated, such withdrawal constitutes a negative condition for transferring the embryo into the recipient's body.[108] Nevertheless, in this situation, Art. 21, Sec. 2 ITA may apply, allowing the will of the individual who withdrew consent to be overridden. This provision states:

102 Art. 75(1) FGC – for more, see Sec. 10.
103 Art. 20(3) ITA.
104 Art. 18(2) ITA.
105 Arts. 29(3) and 30(3) ITA.
106 Art. 18(1) ITA.
107 Art. 22 ITA.
108 Art. 22, Point 1 ITA.

If the husband or the donor of reproductive cells collected for the purpose of partner donation, from which the embryo was created, does not consent to the transfer of the embryo, permission for the transfer is granted by the family court.[109]

7. Legal Status of the Gamete and Embryo Donors

The legal status of gamete and embryo donors involves several aspects. The first concerns the type of ART – *in vivo* or *in vitro*, in either a homologous or heterologous version. In a homologous procedure, the gamete donor is the recipient's husband or is in a stable relationship (cohabitation) with her. After the child is born, the donor assumes parental authority and a range of responsibilities, including child support obligations. In a heterologous procedure, the donor does not become the legal father of the child born through ART using his gametes. Information regarding the donor's health may be provided to the recipient and the child when they reach adulthood. However, this information does not provide the child with knowledge of their origin from a specific individual.

For details on providing consent for specific actions related to ART and withdrawing such consents, see Sec. 6.

Embryo donation is permitted for an anonymous recipient when the health risks associated with using the embryo are not excessive, and the recipient has given informed consent after being thoroughly briefed on all medical and legal aspects.[110]

Further, embryo donors must consent to ART involving the embryo. This consent can only be given after receiving detailed information regarding the legal consequences of donating embryos (e.g., no access to information regarding the subsequent use of the donated embryos, no rights or responsibilities regarding the child born using ART), and the scope of information regarding the donors to which the person born from the procedure or their legal representative will have access upon reaching adulthood.

Embryo donors may withdraw their consent for the embryo's use until the commencement of the medically assisted reproductive procedure in which the embryo is to be used.[111]

109 The possibility of replacing the consent of a reproductive cells donor by court's judgement raises serious concerns, whose gravity and complexity transcend the scope of the paper. For more explanation, see Haberko, 2016, pp. 148–151; Smyczyński and Andrzejewski, 2024, pp. 234–238.

110 Art. 36(1) ITA.

111 Art. 36(4)–(5) ITA.

8. Scope of ART: Legally Permissible Methods of Assisted Reproduction

The procedure of medically assisted reproduction comprises actions aimed at obtaining and utilising gametes or embryos, either in vivo or ex vivo, in a recipient to facilitate procreation.[112] This includes both direct and indirect use of gametes and embryos.

As previously mentioned, the treatment of infertility through ART procedures may be undertaken: after exhausting other treatment methods conducted for a period of no less than 12 months unless according to current medical knowledge, achieving pregnancy through those methods is not possible.[113]

The Infertility Treatment Act provides for the use of gametes in the recipient either for partner donation, where the donor is a man in a marital relationship or cohabitation with the woman, or for non-partner donation, where gametes from an external donor are used.[114]

Based on the location of fertilisation, ART is categorised into *in vivo* (intrauterine fertilisation methods) and *in vitro* (fertilisation outside the woman's body, ex vivo). *In vivo* fertilisation, known as artificial insemination, involves intrauterine insemination, where sperm is directly transferred to the recipient's fallopian tube. Its variations include: (a) Homologous Insemination (AIH), that is, fertilisation of the donor's egg using the sperm of her husband, (b) Heterologous Insemination (AID), that is, fertilisation of the donor's egg using sperm from an anonymous donor, and (c) Mixed Insemination (AIC), that is, the use of sperm from both the husband and another man for physiological purposes.

In vitro fertilisation (IVF) involves fertilising an egg outside the woman's body, followed by the transfer of the embryo to her uterus. There are two variants of IVF: homologous IVF: where both gametes are from the spouses, and heterologous IVF, where genetic material is procured from external donors. During *in vitro* fertilisation, the initial stages of embryonic development occur outside the woman's body.

Among the variations of ex vivo fertilisation, the following are notable: (a) Surgical Embryo Transfer (SET); (b) Intravaginal Culture (IVC); (c) Multivariable Methods: Transfer of fertilised eggs or embryos into the fallopian tubes.

In vitro method is often applied in surrogacy, which is the most controversial ART.[115]

112 Art. 2(21) ITA.

113 Art. 5(2) ITA.

114 Gałązka, 2018, pp. 155–165; Kwiecień, 2016, pp. 152–154; Czujek, 2014, pp. 79–101; Haberko, 2016, pp. 121–176.

115 Mostowik, 2019; Soniewicka, 2020, pp. 5–24; Mirocha, 2018, pp. 165–188; Fras and Abłażewicz, 2008, pp. 31–67; Gałązka, 2016, pp. 36–44; Breczko, 2015, pp. 257–273.

This term encompasses both fertilisation within the womb of the woman who is the egg donor and *in vitro* fertilisation followed by the transfer of the embryo, after several days, to the body of another woman.[116]

Under an agreement, an embryo created from gametes originating either from the commissioning individuals or from donors unrelated to them is implanted into the body of a woman who will carry the pregnancy to term, give birth to the child, and subsequently hand the child over to the commissioning parties. Surrogacy is regulated in a specific manner under Polish law. Notably, the term 'surrogacy' does not appear in the ITA or FGC. However, there are indirect regulations pertaining to this method. When the Family and Guardianship Code was amended in 2008 to include provisions regarding the determination of maternity, a new rule was introduced: 'The mother of the child is the woman who gave birth to it'.[117]

It has decisively influenced the outcome of potential court disputes arising from the surrogate's failure to fulfil her obligation to hand over the child she gave birth to for the commissioning individuals. This provision determines the child's civil status as the child of their mother (the woman who gave birth to them) and renders any surrogacy agreements invalid, as they conflict with this mandatory provision of the FGC.

Prior to 2008, the prevailing view in Poland was that surrogacy agreements were invalid.[118] The principle of freedom of contract in civil law has its limits, as contracts that conflict not only with legal provisions but also with the principles of social coexistence are deemed invalid (Arts 56 and 353^1 of the Civil Code[119]). Previously, when there were no specific legal provisions regarding surrogacy agreements, the permissibility of entering into such contracts was assessed from an ethical perspective by considering whether such an agreement violated the principles of social coexistence. Legal acts are considered to conflict with these principles if their content and purpose contradict universally recognised values and moral rules relating to interpersonal relationships.[120]

In the debates held by lawyers, particularly civilists,[121] arguments rejecting the permissibility of surrogacy have prevailed and continue to dominate (claiming that ethics should be prioritised over technological capabilities), and therefore not everything that is technologically feasible should or must be realised. It is noteworthy that surrogacy is related, or at least can be, to human trafficking; a human being cannot be subject to a trade agreement; a woman's agreement to become a surrogate objectifies her irrespective of the fact whether she is willing to do it or not; surplus

116 Kwiecień, 2016, p. 54.
117 Art. 61 FGC.
118 Lis, 2019, pp. 490–493; Nesterowicz, 2007, pp. 257–263.
119 The Act of 23 April 1964. The Civil Code, consolidated text: Journal of Laws of 204, item 1061.
120 Radwański and Olejniczak, 2023, p. 311; Doliwa, 2021, pp. 9–17, pp. 46–90.
121 Nesterowicz, 2007, pp. 257–263; Soniewicka, 2020, pp. 5–24.

embryos are at risk of trade or destruction; separation from their mother directly after birth is a traumatic experience for the infant.[122]

Additionally, it has been noted that the parties to a contract cannot determine in the agreement who will be the mother of the child, as a contract cannot establish a person's civil status nor influence the content of a court ruling regarding the determination of such status.[123]

Doctrine and jurisdiction unequivocally consider surrogacy agreements to be invalid when they involve financial compensation.[124]

The aforementioned Art. 61 of the FGC clarifies that the identification of the mother is definitive, including cases where the child is born to a woman who has entered into a surrogacy agreement and has received payment for it. If the surrogate mother, intending to fulfil the contract, wishes to consent to the adoption of the newborn child, she cannot designate the commissioning individuals as adoptive parents (designated adoption). This is because, in 2019, adoption laws were amended to stipulate that parents may now only designate close family members as candidates for the adoption of their child.

For more on the idea of penalising surrogacy agreements, see Sec. 9.

9. Criminal and Administrative Sanctions For Violations of ART Legal Provisions

The enforcement of fundamental requirements to ensure the highest standards of protection for the rights and interests of individuals involved in ART is supported by provisions in criminal law. These provisions, outlined in the ITA (Arts 76–90), emphasise the importance of proper implementation of ART, the necessity of effective protection for participants, and respect for the significant values at stake in such procedures.[125]

Prohibited under penalty of law are actions marked by the commercialisation of ART, which could lead to the development of a 'black market for human gametes' and 'serve as a temptation for some to acquire financial resources easily', potentially involving the creation of organised criminal groups.[126]

122 Kornas-Biela, 2017, pp. 43–64; Kornas-Biela, 2010, pp. 149–173.
123 Domański, 2017, pp. 1048–1062; Smyczyński and Andrzejewski, 2024, pp. 222–223, pp. 234–238; Lis, 2019, pp. 490–491.
124 Fras and Abłażewicz, 2008, pp. 94–119, Nesterowicz, 2007, p. 218.
125 Haberko, 2016, p. 377.
126 Wojewoda, 2021, p. 45.

With a degree of caution, it can even be assumed that exploiting women and men of reproductive age to obtain gametes could become a new area of human trafficking operations.[127]

In this context, the ITA prohibits the following: (a) the dissemination of advertisements for the paid sale, purchase, or mediation in the paid sale or purchase of gametes or embryos;[128] (b) the purchase or sale of an embryo, mediation in its purchase or sale, or participation in the use of an embryo obtained in violation of the provisions of the law on embryos;[129] (c) the export or import of reproductive cells or embryos from the territory of Poland to a country outside the European Union and vice versa, without the permission of the Minister of Health;[130] (d) the purchase or sale of a reproductive cell, mediation in its purchase or sale, or participation in the use of a reproductive cell obtained in violation of the provisions of the law on reproductive cells.[131]

The values protected under Art. 77 of the ITA include the personal dignity and bodily integrity of donors of reproductive cells, the unimpeded flow of information concerning the donation of gametes, and monitoring of ART. Additionally, it safeguards the 'integrity of assisted reproductive medicine as a specialised branch of medicine',[132] and 'the proper course of activities in assisted reproduction'.[133]

Empirical research indicates that in Poland, there have been instances that meet the criteria of the criminal offences described in Art. 76 of the ITA and related behaviours specified in Art. 77 of the ITA.[134]

Several actions constitute criminal offences owing to their attack on the health or life of an embryo. These include: (a) The use of preimplantation genetic diagnosis in medically assisted reproductive procedures for purposes other than medical indications, including sex selection, except in cases where such selection prevents a severe, incurable hereditary disease.[135] (b) The destruction of an embryo capable of normal development created using ART.[136] (c) The creation of an embryo for purposes other than ART.[137] (d) The creation of chimeras or hybrids using ART, or conducting interventions aimed at causing hereditary changes in the human genome that could be transmitted to subsequent generations.[138] (e) The creation of an embryo with nuclear

127 Ibid.
128 Art. 76 ITA.
129 Art. 79 ITA.
130 Art. 88 ITA.
131 Art. 77 (1) ITA. Wojewoda, 2021, pp. 38–51.
132 Wojewoda, 2019, pp. 338–340.
133 Nazar, 2021, pp. 46–48.
134 Wojewoda, 2019, pp. 369–414.
135 Art. 82 ITA.
136 Art. 83 ITA.
137 Art. 85 ITA.
138 Art. 86 ITA.

genetic information identical to that of another embryo, foetus, human, corpse, or human cadaver.[139]

The protection of an embryo's life, primarily owing to the possibility of creating surplus embryos and other weaknesses in their protection described in point 4.4.3, as well as the lack of absolute protection ensured in Art. 83 of the ITA, is critically assessed in legal doctrine.[140]

Further, prohibited acts include behaviours that violate administrative and organisational prohibitions or requirements, such as follows: (a) Conducting activities stipulated by the ITA that are exclusively reserved for a medically assisted reproductive centre or a reproductive cell and embryo bank, without the required permit or in violation of the conditions specified in the permit.[141] (b) Failing to provide information and data concerning donors and recipients of reproductive cells used for non-partnered donations, as well as donors and recipients of embryos, despite being responsible for submitting this information to the registry of reproductive cell and embryo donors.[142]

Moreover, it is punishable to harvest reproductive cells from human corpses for use in medically assisted reproductive procedures.[143]

Additionally, several administrative fines have been established for administration-related misconduct related to the functioning of ART procedures.

Criminal law literature has favourably evaluated the penal provisions of the ITA that safeguard against the uncontrolled trade of reproductive cells and prevent the commercialisation of human gametes. Particular emphasis has been placed on the importance of registry tools that allow for the identification of donors and recipients of gametes used for non-partnered donations, as well as donors and recipients of embryos.[144]

In discussions regarding the commercialisation of artificial reproduction, strong criticism of the practice of surrogacy can be heard, leading some countries to impose restrictions, including outright prohibition on the use of this ART.[145] Additionally, controversies arise regarding the legal and criminal liability for entering into surrogacy agreements and conducting ART involving surrogacy.

It has been argued that fulfilling a surrogacy agreement – handing over a child as the object of the agreement in exchange for financial gain – constitutes the crime of human trafficking.[146] According to another view, this act is considered a crime only when it involves giving or receiving financial or personal benefits, or the promise of such benefits, to a person in charge of care or supervision over another person for

139 Art. 87 ITA.
140 Gałązka, 2022, pp. 243–263; Wojewoda, 2024, p. 343.
141 Art. 80 ITA.
142 Art. 81 ITA.
143 Art. 84 ITA.
144 Wojewoda, 2021, p. 48.
145 Breczko, 2007, pp. 266–270.
146 Art. 189a(1) of the Criminal Code. Lis, 2019, pp. 492–493.

the purpose of the person's exploitation, even with their consent. Forms of exploitation mentioned include, in particular, prostitution, pornography, or other forms of sexual exploitation; forced labour or services; begging; slavery or other degrading practices; or the procurement of cells, tissues, or organs in violation of statutory provisions.[147]

The critical evaluation of surrogacy served as the basis for a proposed law to criminalise this form of ART. The draft law included criminal penalties for surrogate mothers, intended parents, and individuals involved in assisted reproductive methods aimed at bearing and abandoning a child through transfer to others (surrogacy), as well as those organising or participating in surrogacy, regardless of whether it is commercial or altruistic. It was acknowledged that, although surrogacy conflicts with human rights protection standards and surrogacy agreements themselves stem from the objectification of children and surrogates, introducing criminal penalties would be an overly harsh measure– particularly against individuals seeking to become parents through this route and against surrogate mothers.[148]

10. Family Law Regulations on Assisted Reproductive Technologies

The enactment of the ITA was accompanied by amendments to the FGC concerning issues of filiation, specifically: (a) the presumption of a child's origin from the mother's husband,[149] (b) the recognition of paternity of a child conceived outside of marriage through ART procedures,[150] (c) the presumption of paternity for children born outside of marriage.[151]

The presumption of a child's origin from the mother's husband, which is the evident basis for identifying the father of a child born to a married woman, was modified with the enactment of the ITA. This presumption applies during the marriage and for 300 days following its dissolution. However, if the child is born before the expiry of 300 days from the termination or annulment of the marriage, after the mother enters into a second marriage, it is presumed that the child originates from the second husband. This presumption does not apply if the child was born using a medically assisted reproductive procedure to which the mother's first husband consented.[152]

147 Art. 115 (22) of the Criminal Code. Burdziak and Pohl, 2019, pp. 574–604.
148 Haberko, 2016, pp. 435–436; A 25 March 2019 letter of the Commissioners of Human Rights to the Speaker of the House (Sejm).
149 Art. 62(1) FGC.
150 Art. 75FGC.
151 Art. 84 FGC.
152 Art. 62(2) FGC.

The presumption of a child's origin from the mother's husband can be challenged through a paternity denial suit. However, the use of ART necessitated a significant limitation on the ability to bring such a suit. Art. 68 FGC was amended to state that a paternity denial claim is inadmissible if the child was born using a medically assisted reproductive procedure to which the mother's husband consented.

It should be assumed that neither spouse has standing in this situation – neither the husband nor the wife who gave birth to a child using ART. This provision references an earlier doctrine that held that a woman undergoing artificial insemination without her husband's knowledge is acting disloyally, thus providing the husband grounds to deny paternity.[153] Similarly, disloyal behaviour, inconsistent with principles of social coexistence and therefore undeserving of protection, is further attributed to a husband who consents to his wife's participation in the artificial insemination procedure, yet later seeks to deny his paternity. Biologically, the husband is not the father. However, he bears moral responsibility for his participation in the procedure through his consent and must accept the associated legal consequences.

The most controversial interference in the hitherto established and stable construction of filial law, simultaneously the most frequently criticised, was brought by the ITA provisions concerning paternity acknowledgment.[154] The institution of paternity acknowledgment involves making a declaration by the father of a child born outside marriage that he is indeed the father of the child. This declaration has legal consequences once the mother of the child confirms it. Both declarations are made in the Civil Registry Office. As a consequence of acknowledging paternity, the man is treated as the father of the child, and this status is reflected in the child's birth certificate, which is a document determining their civil status. The person acknowledging paternity has parental authority over the child and is obligated to provide financial support for the child. Declarations of paternity can be made during the prenatal phase of the child's life, which has consequences, such as the father's participation in decisions related to medical procedures for the unborn child,[155] as well as the creation of an economic obligation to support the child's mother during pregnancy and postpartum.[156]

Acknowledging the paternity of a child conceived using ART significantly differs from the above-described scheme. According to Art. 75 of the FGC, paternity is acknowledged upon the birth of the child, even if, before the transfer of reproductive cells from an anonymous donor or an embryo created from reproductive cells from an anonymous donor, or from embryo donation, the man declares before the head of the civil registry office that he will be (in the future, not now – emphasis mine – M.A.) the father of the child that will be born using the medically assisted reproduction

153 Radwański, 1979, pp. 171–184.

154 Particularly Art. 75FGC. Smyczyński and Andrzejewski, 2024, pp. 222–223, 234–238; Ignatowicz and Nazar, 2016, pp. 438–440, pp. 444–448; Kwiecień, 2016, pp. 49–68; Haberko, 2023, pp. 224–226.

155 Haberko, 2010, pp. 111–182.

156 Art. 141 FGC. Sokołowski, 2008, pp. 383–398.

procedure using these cells or this embryo, and the woman confirms – simultaneously or within three months of the man's declaration – that the father of the child will be this man.[157]

The declarations of ART beneficiaries deposited in such a manner are valid if a child is born using ART specified in the declarations within two years following the deposition of the declaration by the man (emphasis mine – M.A.).[158] This construction of paternity recognition is inconsistent with the hitherto construction of acknowledgment understood as a declaration confirming the fact of being a father, not as a declaration of the intention of becoming (in the future) the father of a child who is not genetically related to him.[159] Moreover, the period between making declarations and the birth of the child can be much longer than the duration of this pregnancy, and it is possible that conception and birth may never occur at all. Thus, for the duration of these two years, uncertainty will persist regarding the legal situation of the ART beneficiaries, the child to be born, and other persons, particularly the heirs of the man if he dies during these two years after the creation of the embryo to which the paternity acknowledgment applies. According to the Civil Code provisions on inheritance after the death of a parent, his children inherit, including children conceived, provided they are born alive.[160] The literal wording of Art. 927 of the Civil Code leads to the conclusion that since an embryo is a conceived child, it inherits from the deceased father if born alive. However, there are questions that transcend the rules of linguistic interpretation and refer to functional interpretation, as there are no clear and detailed legal provisions addressing these issues. Therefore, the doctrinal dispute concerns the question: does a newborn child inherit from a father who died two years earlier, if, after making the paternity declaration, the man dies, and the woman decides to give birth to the child created from the reproductive cells of her and an anonymous donor? Or, should such inheritance proceedings be suspended until the two-year period expires, using the institution of a guardian to protect the interests of the conceived yet unborn child?[161]

Another issue that has attracted criticism is that, as a result of the paternity recognition regulated in Art. 75 of the FGC, it became possible to determine the identity of the father before fertilisation (the fusion of reproductive cells) occurs. This leads to the breach of the principle that paternity is secondary to maternity.[162] In the situation in question, paternity is recognised before maternity is established, since the declarations of the man and the woman can be made before the embryo is transferred into the woman's body.

157 Art. 75(1) FGC.
158 Art. 75(2) FGC.
159 Smyczyński and Andrzejewski, 2024, p. 236.
160 Art. 927(2) of Civil Code.
161 Art. 182 of the FGC. Haberko and Załucki, 2023, pp. 33–57; Księżak, 2017, 99–101; Ostojska, 2012, pp. 32–46; Sylwestrzak, 2024, p. 1525; Borysiak, 2013, pp. 107–109.
162 Kwiecień, 2016, pp. 60–61.

The final aspect of filial law modified by the introduction of ART is the presumption of paternity of a child born out of marriage. According to the wording of Art. 85 (1) of the FGC, it is presumed that the father of a child is not only the man who had intercourse with the mother during the conception period but also 'the man who was the donor of the reproductive cell in the case of a child born as a result of partner gamete donation in a medically assisted reproductive procedure'.

11. Financing ART

The financing of ART can take several forms. The procedure may be fully paid for by the individuals undergoing ART, either in private or public healthcare institutions. In both types of facilities, the cost of the procedure may reflect the cost of its service, along with the operational costs of the institution providing the service. Further, the cost can be determined commercially, that is, according to market rules. Additionally, it is possible to imagine that the cost of a specific ART and the scope of funding the beneficiaries receive (from the state or local government budget) would be determined based on their income. Humanitarian reasons supported by ideological or demographic arguments may encourage public authorities (central or local) to reimburse the costs of ART.

Opponents of the permissibility of ART argue that as taxpayers, they do not want to participate in the financing of something they firmly disagree with on moral grounds. However, this is not a strong argument, considering that those in power, with a democratic mandate, initiate many controversial outlays that various social groups may criticise.

The issue of financing *in vitro* procedures was contentious in Poland already during the work on the ITA. In the initial version of the Act (June 2015), it was adopted that these procedures would not be reimbursed for ART beneficiaries from the state budget. However, local governments were authorised to fully or partially reimburse them. The conservative government, which assumed office in the autumn of 2015, was not supportive of artificially assisted reproduction. *In vitro* reimbursement programmes were introduced in large cities governed by left-wing and liberal parties and organisations. The same groups then advocated for the introduction of appropriate solutions when adopting their own (local) budgets. Moreover, they called for the introduction of state-funded *in vitro* procedures.[163] After the government change (in December 2023), the method of financing ART was modified.[164] This issue is reg-

163 An opinion of the Commissionaire of Human Rights on the Senate's (Upper Chamber of Polish Parliament – Sejm) on the draft concerning invitro financing of 18 August 2023.

164 Financing of invitro procedures from 1 June 2024. Government program of invitro financing in Poland between 2024-28 – principles and criteria of screening couples.

ulated by provisions related to publicly funded healthcare services,[165] which ensure reimbursement for infertility treatment costs.

The ITA contains provisions addressing economic issues, such as the prohibition of the paid sale, purchase, or mediation of paid sales or purchases of reproductive cells or embryos, as well as a prohibition to demand or accept payment or other financial or personal benefits for donated reproductive cells or used embryos. However, refunds for the costs of collection, storage, processing, distribution, and use of reproductive cells, as well as refunds for the costs of obtaining, storing, processing, distributing, and using embryos, are not considered payments or financial or personal benefits. These costs are determined based on the actual expenses incurred for their execution. The resolutions opposing the trend towards the commercialisation of ART were considered sufficiently significant to reinforce them with criminal sanctions (see Sec. 9).

12. Conducting ART – The Administrative Aspect

The enactment of the ITA imposed numerous obligations on the Minister of Health and local government authorities, as well as established the foundation for the creation and functioning of specialised institutions necessary to maintain standards in conducting ART. The most significant development is the establishment of infertility treatment centres, which were created by the decision of the Minister of Health after consulting the Infertility Treatment Council.[166] If an infertility treatment centre fails to perform its statutory tasks, the Minister may revoke its status.

Infertility treatment centres in Poland (currently their number is ca. 70) include entities that perform: (a) as banks of reproductive cells and embryos, which are units responsible for collecting, storing, and distributing reproductive cells and embryos; (b) activities related to infertility treatment using all methods provided for in the ITA, including through a medically assisted procreation centre, defined as: a medical entity performing medical activities in the field of medically assisted reproductive procedures, including the collection, processing, testing, preservation, and distribution of reproductive cells and embryos; (c) educational and research activities associated with providing health services and promoting health, including the implementation of new medical technologies and methods for diagnosing and treating infertility.[167]

165 Act of 29 November 2023 on the change of the act on health care financed from public funds, Journal of Laws of 2023, point 2730.

166 Art. 14 ITA.

167 Art. 12–16 ITA.

Moreover, a medically assisted reproductive centre is responsible for marking reproductive cells or embryos in a manner that ensures their identification and the identification of their donor or donors through unique labelling.[168]

Additionally, the centre manages reproductive cells and embryos to properly conduct ART. This responsibility involves collecting reproductive cells from donors and using these cells and embryos in ART, such as processing, testing, preserving, and distributing them.[169]

The role of the bank of reproductive cells and embryos is to collect, store, and distribute reproductive cells and embryos intended for use in ART on humans. Additionally, the bank is tasked with entering into agreements with donors for the storage of their donated reproductive cells or embryos.[170]

All documentation created in connection with ART, as well as all information regarding donors and recipients of reproductive cells and embryos, and procedures involving reproductive cells and embryos is confidential. Such information may only be disclosed within the scope provided by the ITA or to judicial authorities in relation to ongoing legal proceedings.

Infertility treatment, the most important issue regulated under the ITA, is conducted in accordance with current medical knowledge. All activities associated with it must respect human dignity, the right to private[171] and family life,[172] and give particular consideration to the legal protection of life, health, interest, and the rights of the child.[173]

Infertility treatment includes: (a) medical counselling, (b) diagnosis of infertility causes, (c) non-invasive pharmacological treatment, (d) surgical (invasive) treatment, (e) fertility preservation for the future, and, most notably, (f) medically assisted reproductive procedures, including *in vitro* fertilisation conducted at medically assisted reproductive centres.[174]

This broad concept of treatment encompasses several elements that are not inherently 'treatments' (e.g., counselling, diagnosis, fertility preservation for the future). This approach is somewhat difficult to reconcile with the definitions of these terms and the principles of legislative drafting. It can be inferred that such a wide formula was intended to embed ART within a range of other activities, thereby reducing criticism of the ITA from opponents of artificial procreation.[175]

Further, it is noteworthy that government administrative bodies are obligated, and local governments are authorised, to undertake actions for the protection and

168 Art. 39 ITA.
169 Art. 44 ITA.
170 Art. 46 ITA.
171 Sec. 4.10.
172 Sec. 10.
173 Arts. 4 and 3(1) ITA.
174 Art. 5(1) ITA.
175 Haberko, 2016.

promotion of reproductive health.[176] These actions particularly include education on lifestyles that protect human reproductive potential and increase the chances of giving birth to a healthy child, the importance of preconception care, and providing information regarding factors 'affecting human reproductive potential'.[177]

176 A statutory term – Art. 11(1) ITA.
177 Art. 11(3) ITA.

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Chapter 8

Romania: The Patchwork of Statutory Provisions Concerning Assisted Reproduction



Emese Florian and Marius Floare

Abstract

Romania has never had a comprehensive statute on medically assisted reproduction (MAR). Despite this deficiency, assisted reproduction technologies (ART) have taken hold within a statutory framework comprising general Civil Code provisions, cell and tissue transplant legislation, and several general statutes on patients' rights or public health programmes.

Although the transplant and patient's rights legislation can answer some of the technical questions regarding ART, the lack of an ART-specific statute implies that several legal questions either remain unanswered or are answered solely by legal doctrine based on general principles or norms employed in other areas of law.

By employing a black-letter law approach, this study attempts to draw a clearer picture of applicable Romanian law to ART situations and organise disparate relevant provisions in a semi-coherent framework and identify those insurmountable deficiencies that absolutely require a legislative intervention. The legal doctrine and relevant statutes referred here were the existing legal provisions as in December 2024.

Keywords: family, fertility, parent, child, assisted reproduction, filiation

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1. Introduction

Although Romania has never had a comprehensive statute on ART, the statutory landscape is not devoid of applicable provisions. A careful examination of Romanian legislation provides several statutes or lower-level ministerial regulations that are applicable to ART situations. First is the Civil Code,[1] with its chapter on medically assisted reproduction with a third-party donor, and other relevant provisions such as those concerning the inherent rights of the human being or filiation. Other major sources include the Law no. 95/2006 on healthcare reform, the Law no. 46/2003 on patient's rights and several ministerial orders or government decrees concerning transplants or public funding of *in vitro* fertilisation (IVF). Using patience and diligence, these scattered provisions can continue to be assembled in a semi-coherent framework for ART.

2. Policies Regarding Medical Help Through ART

The only explicit and current public policy that is relevant to ART is the one from 2023 concerning the justification for the expanded public funding of *in vitro* fertilisation procedures, from the previous 1,000 procedures per year to the current 10,000 procedures per year. This policy can be inferred from the June 2022 memorandum of the Ministry for Families, Youth and Equal Opportunities, justifying the Government Decree on enhanced funding for a social public health programme concerning IVF.[2]

This governmental policy is justified by two reasons: fighting Romania's demographic decline and helping alleviate the consequences of infertility as a disability.[3] The policy focuses on increasing the level of public funding for IVF with embryo transfer (ET) procedures for 10,000 couples or infertile single women. The recipients are eligible to receive public funding for up to 3 procedures per year, however, they must have a specialist M.D. recommendation for the procedure; the single woman or at least one member of the infertile couple must have public health insurance; the woman must be between 20 and 45 years old; and they must be Romanian citizens and be domiciled in Romania.[4]

Traces of a governmental policy about ART can also be observed in the 2012 memorandum of justification for the failed government-initiated law project on

1 Civil Code (Law no. 287/2009) first published in the Official Gazette (Monitorul Oficial) no. 511/24 July 2009, republished with new Art. numbers in the Official Gazette no. 505/15 July 2011.

2 Ministry for Families, Youth and Equal Opportunities, Memorandum of justification for Government Decree no. 1103/2022, pp. 1–9.

3 Ibid., pp. 1–2.

4 Ibid., pp. 3–4.

medically assisted reproduction with a third-party donor.[5] This policy memorandum justifies the necessity of ART on demographic grounds and is an answer to widespread infertility issues in society. Moreover, infertility treatments and supporting medically assisted reproduction are considered first, as an answer to demographic decline, and only thereafter, as an answer to a specific societal problem.[6]

Since 2011, the treatment of couples' infertility has been one of the objectives of the national health programme for organ, tissue and cell transplant.[7] IVF and embryo transfer were considered as the primary methods to achieve this objective, and thus, the national health subprogramme for IVF with ET was approved.

3. Constitutional Provisions

The Romanian Constitution has several provisions on human rights that are relevant to assisted reproduction matters. Additionally, international treaties on human rights, which Romania has ratified, prevail against domestic law provisions, thus having a quasi-constitutional power. When discussing the constitutionality of legal provisions, the Constitutional Court frequently refers both to the national Constitution and to the international treaties on human rights which Romania has ratified, particularly the European Convention on Human Rights, which was ratified in 1994.

One of the first relevant provisions of the Constitution is regarding non-discrimination, provided in Art. 4, para. 2, which prohibits discrimination based on race, nationality, ethnic origin, language, religion, sex, opinion, political membership, wealth or social origin by proclaiming that Romania is the common and indivisible fatherland of all its citizens, without discrimination based on the aforementioned criteria.

The 39-article Title II of the Constitution directly refers to fundamental rights, liberties and duties. Several of these are pertinent to assisted reproduction.

Art. 16, para. 1 proclaims that citizens are equal before the law and public authorities, without privileges or discrimination. Art. 20, para. 2 confers a superior power to international treaties on human rights compared with domestic statutes. Art. 22, para. 1 establishes and guarantees the right to life, physical and mental integrity.

Art. 26 establishes the right to intimate, family and private life. Para. 1 provides that public authorities respect and protect the intimate, family and private life. Para.

5 Memorandum of justification for the law project on medically assisted reproduction with a third-party donor, pp. 1–8.

6 Ibid., pp. 1–2.

7 Art. IV.5h of the Annex to the Government Decree no. 1388/2010.

2 mentions that the natural person has the right to decide upon everything regarding themselves, if they do not breach the rights and liberties of others, public order or good morals.

Art. 34 guarantees the right to protecting health. It establishes the right to health protection, compels the State to take measures for ensuring hygiene and public health, provides that organising medical care, social health insurance system for diseases, maternity and recovery, controlling the actions of medical professions and paramedical activities, as well as other means for protecting the physical and mental health of the person shall be done only according to the law.

Another constitutional provision relevant to ART is Art. 48, pertaining to the family. The most relevant is para. 3, which states that all children are equal before the law, either born during marriage or out of wedlock.

The Constitutional Court case law frequently refers to Art. 8 of the European Convention of Human Rights (ECHR), regarding the right to private and family life, however, it rarely had the opportunity to examine ART provisions owing to their scarcity in Romanian primary legislation.

One of the very few instances in which the Constitutional Court directly addressed ART legislation was the preliminary examination in 2005 of a 2003 law project, initiated long before the current Civil Code was adopted in 2009, regarding reproductive health and human medically assisted reproduction. This preliminary examination of the constitutionality of a law project is performed by request, before it comes into force. The Court observed that 21 out of the 34 articles of the law project had constitutionality issues[8] and the project was later abandoned by Parliament.[9]

In addition to the technical legal writing issues of the law project, the Constitutional Court observed that several core provisions of the law project were unconstitutional. The provisions regarding the compulsory preliminary surrogacy contracts between the surrogate mother and the intended parents, about relinquishing parental rights, were deemed to be unconstitutional because they breached the outer limits of a person's rights to decide about themselves and were contrary to good morals, insofar as they were allowing transactions regarding life, health and the unborn child.[10] The confidentiality requirements of the law project were deemed to breach the person's right to their own image.[11] Further, the court observed that decreasing the criminal penalties for genetic embryo alteration and embryo trade to a mere fine and decriminalising harvesting gametes without consent, gametes trafficking, violating the confidentiality of donations, abusive embryo production and insemination without consent or proper authorisations were all unconstitutional because they were trivialising the protection of fundamental constitutional values.[12]

8 Decision No. 418/2005 of the Romanian Constitutional Court.
9 Predescu, 2022, pp. 219–222.
10 Constitutional Court Decision No. 418/2005, para. 3b.
11 Ibid.
12 Ibid., para. 3d.

The court struck down all the provisions of the law project that would require a person to be part of a couple to access assisted reproduction and the delegation of statutory powers regarding assisted reproduction to the Minister of Health instead of enacting a more comprehensive law.[13]

4. Medical Regulation of ART

4.1. Regulations on Clinics Performing ART

The general health system statutes, such as Law no. 95/2006 on healthcare reform, do not render ART a State monopoly. More specific legislation, regarding the public health programmes on fertility, provide more precise criteria for the clinics receiving public funding for IVF.

The joint Work and Social Solidarity Minister's and Family, Youth and Equal Opportunities Minister's Order no. 2155/20917/2022, on the Regulations concerning the implementation of the social national programme of supporting couples and single persons for increasing childbirths, defines the conditions that must be fulfilled by any clinic aiming to be a partner in this publicly funded programme. The clinic must be authorised by the National Transplant Authority for cell transplants and as a reproductive cell bank for the processing, preservation, stockpiling and distribution of reproductive cells; it must declare that its prices for the publicly funded procedures will not exceed its own six-month average before entering the programme; both the clinic and the hired medical personnel must be insured for malpractice liability for the duration of the programme; it must be up to date with its contributions to the National Social Health Insurance Fund and the fund for medical leaves; it must prove that its medical personnel is fully authorised and they are legally hired; and the OB-GYN physicians must be accredited for infertility treatment and medically assisted reproduction.[14]

The 2022 norms on the national public health programmes, more precisely the subprogramme on *in vitro* fertilisation with embryo transfer, specify that only prior participating clinics with a 30% success rate from 2017-2021 or new clinics can join the programme.[15] The new clinics must fulfil the same criteria as the ones aforementioned for the social national programme.

13 Ibid., para. 5.

14 Art. 20 of Annex no. 1 to the joint Work and Social Solidarity Minister's and Family, Youth and Equal Opportunities Minister's Order No. 2155/20917/2022.

15 Annex no. 9, Section IX.3, Subsection F to the Health Minister's Order No. 964/2022.

4.2. Provisions on Medically Assisted Reproduction Technologies

ART technologies are regulated in detail primarily by Annex no. 30 of the Health Minister's Order no. 1241/2019, regarding the approval of official guides for gynaecology and obstetrics. It specifically mentions and thus allows the following assisted reproduction techniques: intra-uterine (artificial) insemination, IVF, ET, intracytoplasmic sperm injection (ICSI) and artificial insemination with sperm or oocytes from a third-party donor.[16]

The Civil Code prohibits, using general language, eugenics, organising the selection of human individuals and any 'infringement' against the human species.[17] Moreover, it prohibits any interventions on the genetic traits and altering human descendance, human cloning and creating embryos solely for research purposes.[18] Interventions on the genetic traits of a person or using medically assisted reproduction techniques for sex selection are allowed only for the purpose of avoiding or treating genetic afflictions.[19]

Medically assisted reproduction with a third-party donor is specifically mentioned by the Civil Code,[20] however, it is not regulated in detail, contrary to the requirements of Art. 447 of the Civil Code.[21] This seven-article section of the Civil Code deals only with the principles of who can be the parents, the requirements for parental consent to the MAR procedure, how filiation is established and confidentiality requirements.

Surrogacy as an ART technique is not regulated in Romanian law. The only cases where the concept is used are the regulations regarding the public funding of IVF with embryo transfer, which have specifically mentioned since 2011 that no public funding is provided for surrogacy, although these norms also deny public funding for any type of medically assisted reproduction with a third-party donor, which is a technique expressly allowed by both the Civil Code and medical regulations.[22]

Medically assisted reproduction is primarily performed using transplant regulations, as expressly provided by the Law no. 95/2006 on healthcare reform regarding

16 Irinescu, 2024, pp. 348–349.

17 Art. 62 of Civil Code: 'Nobody can threaten the human species. Any eugenic practice that tends to organise the selection of persons is forbidden'; Chelaru in Baias et al., 2021, pp. 78–79.

18 Art. 63, paras. 1 and 2 of Civil Code: 'Any medical interventions on genetic characteristics with the purpose of modifying a person's descendance, except those regarding the prevention and treatment of genetic ailments, are forbidden. Any intervention with the purpose of creating a human being who is genetically identical to another living or deceased human being is banned, as well as creating human embryos for research purposes'; Chelaru in Baias et al., 2021, pp. 79–80.

19 Art. 63, paras. 1 and 3 of Civil Code: 'Using human medically assisted reproduction techniques for choosing the sex of the future child is not allowed, except for the purpose of avoiding a hereditary disease related to the sex of the child'; Chelaru in Baias et al., 2021, pp. 79–80.

20 Arts. 441–447 of Civil Code.

21 Florian in Baias et al., 2021, p. 602.

22 Art. 2f of the Annex to the Health Minister's Order No. 765/2011.

IVF,[23] with no specific regulations for ART. Therefore, posthumous fertilisation can technically be construed to be legally possible if the deceased oocyte or sperm donor consented to cell harvesting before death, although this would bring forward questions about violating the rights to private life of the deceased donor. The use of harvested cells, tissues or organs from a live donor is not conditional on the donor's survival until the effective use of the donated biological material. The only legal situation where death renders consent ineffective is the medically assisted reproduction with a third-party donor, where the intended father's consent to the procedure becomes ineffective if the man dies before conception.[24] Despite this, medically assisted reproduction with a third-party donor can continue to proceed, practically as a new procedure, if the woman consents to becoming a single mother or opts for a different male partner for the purposes of this medical procedure. The previous husband cannot be the father in this situation, because his consent was rendered ineffective by death and he is not biologically related to the child, therefore, the mother can either be the single parent with a third-party donor or the father can be another man who had consented to the procedure before conception.

The official guide on infertility approved by Annex no. 30 of the Health Minister's Order no. 1241/2019, regarding the approval of official guides for gynaecology and obstetrics, specifically mentions the following assisted reproduction techniques: intra-uterine (artificial) insemination, IVF, ET, intracytoplasmic sperm injection (ICSI), artificial insemination with sperm or oocytes from a third-party donor. This guide is technical, addressing primarily health professionals, containing medical recommendations and best practices. It rarely defines the medical concepts it uses, and it cannot address most of the legal issues that may arise out of medically assisted reproduction situations. As it is a lower-level regulation, it should only more clearly define the used concepts and techniques from a technical perspective and leave the more controversial issues of parental eligibility, informed consent, liability, prohibited techniques, and parental filiation to a higher-level statute enacted by parliament.

The Health Minister's Order no. 1763/2007 on transplants is tangentially referencing access to ART procedures. This secondary legislation only mentions different-sex couples in a declared intimate relationship as having access to reproductive cell 'transplants' between partners.

23 Art. 142u of Law No. 95/2006: 'transplant – medical activity in which, for therapeutic purposes, an organ, tissue or cell harvested from another person, called the donor, is implanted in the body of a patient, called the recipient. The regulations in this statute are also applicable to in vitro fertilisation techniques'; Guțan, 2011, pp. 85–86.

24 Art. 442, para. 2 of Civil Code: 'Consent becomes ineffective in cases of death, filing a divorce petition or factual separation, prior to the moment of conception during human medically assisted reproduction. It can be revoked at any time, in writing, including before the physician tasked with ensuring assistance for reproduction with a third-party donor'; Florian in Baias et al., 2021, p. 596.

4.3. Financial Support for ART

Assisted reproductive procedures have been financed intermittently from public funds with special national health programmes since 2011[25] and they are not normally covered by the standard public health insurance.[26] All the existing financing programmes up to date have not distinguished between public and private fertility facilities.

The general Law on Healthcare Reform no. 95/2006 specifically exempts from funding by the national social health insurance fund: IVF,[27] high performance medical services[28] and medical care on demand.[29]

Publicly funded IVF with ET is subject to a national public health subprogramme since 2011,[30] with extended funding from 2022. It is restricted to infertile heterosexual couples defined as couples diagnosed, by a certified specialist M.D., with an affliction incompatible with natural reproduction or who could not reproduce after one-year of unprotected sexual relations, with no third-party donations allowed for sperm or oocytes, as well as specifically excluding surrogacy in one of the few specific mentions of this procedure in Romanian domestic law.[31] To receive public funding for IVF, initially both partners had to have public health insurance; the woman had to be between 24–40 years of age, with a body mass index (BMI) between 20–25 and with an ovarian reserve determined to be within the normal limits.[32]

Public funding since 2022 has been theoretically available for three procedures per year for each couple/single woman, depending on the limited funding availability. Funding was usually limited to 1,000 procedures per year in previous fiscal years, however, for 2022, Government Decree no. 1103/2022 stipulated funding for at least 2,500 procedures/year and a further 10,000 procedures/year from 2023, on a 'first come, first served' basis. Between 2017–2021, public funding was available only for IVF with ET, only for couples, with no financing whatsoever provided for gamete donations or surrogacy. The 2022 Government Decree has also extended the age range for public funding eligibility to 20–45 years for the women.[33]

The joint Work and Social Solidarity Minister's and Family, Youth and Equal Opportunities Minister's Order no. 2155/20917/2022, on the Regulations concerning the implementation of the social national programme of supporting couples and single persons for increasing childbirths, defines the conditions in which the State assists in paying for fertilisation treatments. The beneficiaries are both couples and

25 Brodeala, 2016, p. 64.
26 Art. 248, para. 2h of Law No. 95/2006.
27 Ibid.
28 Art. 248, para. 2b of Law No. 95/2006.
29 Art. 248, para. 2i of Law No. 95/2006.
30 Brodeala, 2016, p. 64.
31 Ibid., pp. 64–65, Florian and Floare, 2024, p. 473.
32 Florian and Floare, 2024, p. 473; Annex IX.3, Section C to Health Minister's Order No. 964/2022.
33 Art. 2, para. 3 of Government Decree No. 1103/2022.

single infertile women diagnosed by a fertility specialist for having an affliction that is incompatible with natural reproduction.[34] They can receive financial support of up to 15,000 lei, the equivalent of 3,000 Euro, of which 5,000 lei, approximately 1,000 Euro, is for the necessary medicines and 10,000 lei, approximately 2,000 Euro, for medical procedures. Each beneficiary can receive this special financial support up to three times a year for the duration of the programme. The cumulative conditions for receiving the financial support are: both members of the married or unmarried couple or the single woman have to be Romanian citizens domiciled in Romania; they all have to be insured in the Romanian public health insurance system; the fertility treatment and procedures must occur in a Romanian authorised medical unit which is a partner in the programme; and the age of the participating women must be between 20 and 45 years at the time of filing the request.[35]

The publicly funded fertility programme began in December 2022 with 2,500 beneficiaries for 2022, with a further 10,000 beneficiaries each year, from 2023.[36] The financial support is granted on a 'first come, first served' basis.[37] The funded procedures include the harvesting of oocytes from the beneficiary woman, the processing of sperm, artificial insemination, embryo cultivation for between 72 and 120 hours, embryo-transfer, the health monitoring of the case evolution and the necessary drug treatments.[38]

This social fertility programme explicitly excludes several fertility-related medical procedures from public funding: preliminary laboratory investigations, genetic diagnosis of the embryos, the cryopreservation of oocytes, sperm, or embryos; the surgical harvesting of sperm, general intra-venous anaesthesia for oocyte harvesting; intracellular sperm injection; and harvesting of donated oocytes.[39] In case the cost of the specific medical procedure is greater than the publicly funded allowance, the beneficiaries must bear the supplemental costs out-of-pocket.[40]

4.4. The Beneficiaries of ART

To define who can be a beneficiary of an ART procedure in Romanian law, one needs to examine three different and non-comprehensive regulations, which target the issue from different angles: the Civil Code chapter on medically assisted reproduction with a third-party donor, the Health Minister's Orders on transplants and the most recent Minister's Orders on the social programme for the public financing of IVF.

34 Art. 4 of Joint Order No. 2155/20917/2022.
35 Art. 5 of Joint Order No. 2155/20917/2022.
36 Art. 6 of Joint Order No. 2155/20917/2022.
37 Art. 7 of Joint Order No. 2155/20917/2022.
38 Art. 16 of Joint Order No. 2155/20917/2022.
39 Art. 26 of Joint Order No. 2155/20917/2022.
40 Art. 27 of Joint Order No. 2155/20917/2022.

The general provisions of Art. 441, para. 3 of the Civil Code specifically determine that both heterosexual couples and single women have access to medically assisted reproduction with a third-party donor.[41] As the law does not distinguish between a male or female third-party donor it can be broadly construed to include both types, as well as simultaneous donations of both sperm and oocytes for the same receiving couple or single woman.[42] This provision allows for the use of purely foreign genetic material, simultaneously from both male and female third-party donors, which would imply that the only legal parent who would have a biological connection to the child would be the mother giving birth.[43]

Art. 441, para. 3 of the Civil Code defines the parents, for the purposes of assisted reproductive procedures with third-party donations, as either a man and a woman or a single woman.[44] This provision is not restricted to married couples, however, implicitly refers to heterosexual couples, stipulating a man and a woman.[45] Despite the apparent broad nature of the provision, it excludes same-sex couples,[46] where both cannot participate in the procedure, although one of them could be involved as a single prospective mother or as a fictitious male partner to a woman.

Legal doctrine debates whether the legal concept of a single woman refers only to women that do not have a partner at all or if it also includes women whose partner has not consented to the medical procedure. Further, provisions in Art. 443, para. 2, which allow the husband to deny paternal filiation if he had not previously agreed to the medically assisted reproduction with a third-party donor,[47] tend to suggest that this procedure is also available for women who are not technically single, but whose partner does not wish to agree to such a procedure.[48] According to current regulations, even a married woman could consent to the procedure without her husband's joint agreement, a fact which would probably later be a well-founded reason for divorce owing to the lack of a joint decision about a serious matter that concerns the marriage.

Moreover, this Civil Code provision does not compel the man and the woman who consent to this procedure to be an actual couple, consensual or otherwise.[49] They do not have to prove or even assert a relationship of any sort and their mutually agreed consent to the procedure could lead to them becoming the mother and father of a child without any other prior connection: emotional or social. This deficiency

41 Irinescu, 2024, p. 354.
42 Motica, 2021, p. 224; Florian in Baias et al., 2021, pp. 594–595.
43 Neamț, 2022, p. 642.
44 Irinescu, 2024, p. 354.
45 Motica, 2021, p. 224.
46 Neamț, 2022, p. 643.
47 Art. 443, para. 2 of Civil Code: 'The mother's husband can nonetheless challenge the child's paternity, according to the law, if he had not consented to the medically assisted reproduction with a third-party donor'.
48 Florian and Floare, 2024, pp. 474–475; Avram, 2022, pp. 310–311.
49 Neamț, 2022, p. 643; Art. 441, para. 3 of Civil Code: 'Parents, for the purposes of this section, can only be a man and a woman or a single woman'.

would allow for the legal circumvention of the rules on adoption,[50] by allowing the intended father's real spouse to later adopt the child, using the simplified procedure for adopting the other spouse's natural child, or even as a stand-in for the non-existent rules on surrogacy, by allowing the intended father to consent to medically-assisted reproduction with a third-party donor together with the surrogate mother, allowing them to use the oocytes donated by the father's spouse as the third-party donor, with a subsequent adoption.

Although the Civil Code does not use the term 'couple' for the man and the woman involved in the medically assisted reproductive procedure with a third-party donor, few scholars have discussed whether the only requirement for these prospective parents is that they are of different sex, or if it is prohibited for them to be relatives who could not marry each other.[51] The tentative answer to this question, based solely on the complications that may arise in relation to succession and other family relationships and which we consider as more of a *de lege ferenda* suggestion, is that the same prohibitions that apply to marriage between relatives should extend to the members of the reproductive couple.[52] The criminalisation of incest is not beneficial here, because it only narrowly prohibits sexual intercourse between ascendants and descendants or between brothers and sisters,[53] while leaving outside its legal scope the mere parenthood of the same child, involving two close relatives, with the help of a medical procedure that does not involve any types of sexual intercourse between the parents.

4.5. Informed Consent Regarding ART

The issue of consent regarding ART is dealt with briefly in the Civil Code and more thoroughly in the general law on patients' rights and the transplant regulations which are used occasionally as general norms for artificial insemination and IVF.

The Civil Code deals only with consent regarding medically assisted reproduction with a third-party donor, both through artificial insemination and IVF.[54] The statutory framework for parental consent comprises Art. 442 of the Civil Code, which stipulates the procedure for parental consent and the situations when this consent becomes ineffective. Legal doctrine has discussed at length[55] the various situations that may arise regarding consent in this type of medical procedure.

Art. 442, para. 1 of the Civil Code requires prior notarised consent from both parents for the medically assisted reproduction with a third-party donor. This consent must be given in a confidential manner, and the notary has a legal duty to explicitly inform both prospective parents about the consequences of their agreement

50 Neamț, 2022, p. 643.
51 Ibid., p. 648.
52 Ibid.
53 Art. 377 of Criminal Code.
54 Neamț, 2022, pp. 635, 638.
55 Ibid., pp. 649–658.

regarding filiation.[56] Prior written consent is relevant primarily for paternal filiation, while maternal filiation remains tributary to the fact of giving birth, with scant regard for the deficiencies or the lack of consent to the procedure from the mother.[57] The M.D. performing the procedure is responsible for checking the existence of the notarised prior consent from the single mother or both members of the couple.[58]

A legal scholar has recently noted that these general provisions on consent to medically assisted reproduction reveal no details about age or legal capacity requirements.[59] As this consent involves a legal act, extant legal provisions would exclude minors under fourteen years and people lacking legal capacity owing to guardianship.[60] Even if minors above fourteen years of age could exercise parental rights regarding the person of their child,[61] the paramount importance given by extant law to notarised parental consent as the beginning point of an assisted reproduction procedure would suggest that neither a regular fourteen-year-old with limited legal capacity, nor an emancipated or married minor with full legal capacity could legally consent to assisted reproduction owing to their reasoning abilities not being fully developed.[62] As this expressed consent and the underlying reasoning are purely personal, the minor's consent is not susceptible in this situation to be confirmed by their parent's or legal guardian's assent.[63]

The opinion in favour of the exclusion of fully capable minors from MAR is not widely shared,[64] particularly if this full capacity is reached as a consequence of marriage.

One of the legal issues raised by parental consent to medically assisted reproduction is who should be a parent in a procedure that is intrinsically more susceptible to State control and interference than natural reproduction. This question becomes more pressing when it involves parents that were previously stripped of parental authority as a civil penalty or were prohibited from exercising their parental rights as an accessory or complementary punishment to a criminal conviction.

De lege ferenda, a future detailed law on assisted reproduction should stipulate that people who were stripped of parental authority owing to their misconduct or were prohibited from exercising parental rights because of a criminal conviction should also be precluded from being part of an assisted reproduction procedure, at least for the duration of their civil or criminal sanctions.[65]

56 Irinescu, 2024, p. 356.
57 Neamț, 2022, p. 650.
58 Ibid.
59 Ibid.
60 Ibid.
61 Art. 490 of Civil Code: 'The underage parent who is 14 years of age has solely the parental rights and duties relating to the person of the child. The rights and duties regarding the child's assets belong to the child's legal guardian or to another person, according to the law'.
62 Neamț, 2022, pp. 650–652.
63 Ibid., p. 651.
64 Irinescu, 2024, p. 356.
65 Neamț, 2022, p. 652.

The parents' consent to assisted reproduction must be given, prior to conception, in a notarised form. The notary must explain to the potential parents the consequences of their consent regarding filiation. The future father must be made aware that, if fertilisation is made with third-party male genetic material, he would not be able to challenge the paternity, and that he can withdraw his consent up until the moment of conception. Moreover, the mother must be informed that maternal filiation is established by giving birth and cannot be challenged even if the genetic material comes from a third-party female donor. Legal doctrine mentions that even if the law does not specifically compel to include all this prior information in the parents' consent form itself, it should be included in a detailed manner.[66]

One of the particularities of consent to medically assisted reproduction with a third-party donor is that it is revocable, by either parent, until the moment of conception.[67] It could be revoked, in a dissimilar manner to its prior notarised written format, even verbally before the M.D. who assists the reproduction with a third-party donor.[68] The revoked consent can stop the procedure if it is revoked by the mother herself, however, it could also simply lead to reconfiguring the procedure as involving only a single woman, if the consent is withdrawn by the father, the male reproductive material does not belong to him and the woman decides to carry it out by herself, without a partner[69] or even with a different consenting male partner.

Art. 442, para. 2 of the Civil Code also stipulates that prior consent to medically assisted reproduction with a third-party donor is ineffective in case of death, filing for divorce or factual separation before conception.

Death of the mother implies the unavoidable end of the assisted reproduction procedure and the ineffectiveness of her prior consent. While the death of the consenting father before conception would not render medically assisted reproduction with a third-party donor technically impossible, the law renders his consent ineffective owing to both its very personal nature, particularly if it involves the use of the prospective father's biological material, and the difficulties that will arise for establishing paternal filiation when birth occurs sufficiently outside the legal timeframe for paternity presumptions.[70]

Filing for divorce is relevant for the ineffectiveness of prior consent to assisted reproduction only when it involves a married couple who had both consented to the procedure. If a married woman has consented to the procedure without involving her husband, filing for divorce by either spouse would not render the women's consent ineffective.[71] Recent legal doctrine opined,[72] more as a *de lege ferenda* suggestion, that in cases where both spouses had consented to the procedure before one of them

66 Ibid., pp. 652–653.
67 Irinescu, 2024, p. 356.
68 Neamț, 2022, pp. 654–655.
69 Ibid., pp. 655–656.
70 Neamț, 2022, pp. 656–657.
71 Ibid., p. 657.
72 Ibid.

filed for divorce, the mere filing of the divorce petition has the immediate effect of stopping the procedure only if the wife is the plaintiff; otherwise the husband's petition must be communicated to the respondent wife for it to have any legal effect. Filing for divorce from either spouse will not stop the assisted reproduction if the woman decides to carry it out by herself, as a single mother, without involving her husband as a potential father.[73]

The most controversial of all the three ineffectiveness-of-consent situations is the one concerning mere factual separation of the prospective parents. This situation involves both married and unmarried couples, without it being necessary to have a formal divorce petition. This factual separation involves both the material element of not living together and the intentional element of having no intention of continuing a relationship with the other.[74] Unlike the other situations, where consent is rendered ineffective, however, there is always a written document to that effect, due of its subjective nature, the exact moment of a couple's separation would be difficult to prove, particularly in relation to the exact moment of medically assisted conception. Thus, it is advisable for the separating partner to notify the other and the attending M.D. an explicit consent revocation, particularly because it is also technically possible, although unlikely, for a separated couple to continue to wish to jointly have a child through a medical procedure.[75] A single woman could continue to decide to carry on with the procedure, particularly if the used biological material is not from her former partner.

The Law on patients' rights No. 46/2003 deals with informed consent in any medical procedure, which includes, however, is not limited to any type of medically assisted reproduction.

A patient is defined by law as including healthy individuals who use health services.[76] This statute has a nine-article Chapter II regarding the patient's right to be informed and an eight-article Chapter III on the patient's consent to a medical intervention. Moreover, it has a three-article Chapter V about the patient's rights regarding reproduction.

The most relevant provisions of the Law No. 46/2003 regarding consent to ART involve the necessity of the patient's prior consent for any medical intervention and their right to stop it at any time by signing a written liability waiver.[77] Moreover, patient consent is mandatory for any harvesting, storage and usage of any biological products of their body,[78] as well as for their participation in medical research or clinical education.[79]

73 Ibid.
74 Neamț, 2022, pp. 657–658.
75 Ibid., p. 658.
76 Art. 1a) of Law No. 46/2003.
77 Art. 13 of Law No. 46/2003.
78 Art. 18 of Law No. 46/2003.
79 Art. 19 of Law No. 46/2003.

Regarding the information requirements for consent to ART, the law on patients' rights stipulates the patient's right to be informed regarding the available medical services and their usage,[80] the identity and professional status of the medical service providers,[81] their health, suggested medical interventions and their risks, extant alternatives to suggested medical procedures, diagnosis and prognosis,[82] the right to receive medical information in a respectful manner with minimal technical terms and in a language they understand[83] and the right to a second medical opinion.[84]

The general statute on patients' rights has a brief three-article section specifically on the rights of the patient concerning reproduction, although it is not targeted towards medically assisted reproduction. The woman's right to life takes precedence when the pregnancy represents a major and immediate risk for the life of the mother.[85] The patients also have the right to receive information, education and the required services, which are necessary for a normal sexual life and healthy reproduction, without discrimination.[86] Women have a guaranteed right to decide whether to have children, however, only without endangering their own life.[87] All patients have the right to select the safest methods for healthy reproduction[88] and to use efficient and risk-free methods for family planning.[89]

Lacking a specific statute on medically assisted reproduction, legal doctrine and medical practice frequently refer to the extant regulations on cell and tissue transplants as a proxy for any type of assisted reproduction which involves the transfer of reproductive cells from a donor, either third-party or the recipient's partner, to a recipient. Law no. 95/2006 on health reform has a section, Title VI, on the harvesting and transplant of human organs, tissues and cells for therapeutic purposes. Its requirements on consent applicable to ART include the requirements for consent from both the live donor and the recipient.

The live donor must be at least eighteen years old, with full legal capacity and unimpaired judgement.[90] Their consent must be informed, written, freely given and prior to harvesting. The information must be given by a physician, social worker or another medical professional and it must include the risks and physical, psychological, familial, professional and social consequences of harvesting. Consent is

80 Art. 4 of Law No. 46/2003.
81 Art. 5, para. 1 of Law no. 46/2003.
82 Art. 6 of Law No. 46/2003.
83 Art. 8 of Law No. 46/2003.
84 Art. 11 of Law No. 46/2003.
85 Art. 26 of Law No. 46/2003.
86 Art. 27 of Law No. 46/2003.
87 Art. 28, para. 1 of Law No. 46/2003.
88 Art. 28, para. 2 of Law No. 46/2003.
89 Art. 28, para. 3 of Law No. 46/2003.
90 Art. 68, para. 2 of Civil Code: 'The harvesting of human organs, tissues and cells from minors or living persons with impaired judgement due to a mental handicap, a serious mental disorder or another similar reason is banned, except for cases explicitly provided by law'; Chelaru in Baias et al., 2021, p. 87.

revocable, the donation and transplant may not be conducted under duress and it must be altruistic and not carry any material benefits.[91]

Further, the recipient must consent to the cell or tissue 'transplant' in written form, after being informed about the risks and benefits of the procedure.[92]

Human cell or tissue harvesting or transplant without the living donor's and the recipient's legal consent is a criminal act and carries a penalty between two and seven years in prison, while the attempt itself is a punishable crime.[93]

The Health Minister's Order No. 1242/2007 requires consent from the living donor of tissue or cells, after being informed about the clinical and laboratory tests to exclude any possible contamination, infectious disease or any other afflictions that present a risk for the recipient. The donor must also be informed in a clear and easily understandable manner about the donation process, the purpose of prelevation, consequences and risks, medical confidentiality, therapeutic purpose and potential benefits and personal data protection.[94] Another provision on transplants, the Health Minister's Order no. 1763/2007, has several provisions requiring the human tissue and cell banks to check for the donor's consent for harvesting as part of their due diligence.

4.6. Regulation of Donor's Status

The status of the donor in ART procedures in Romanian law can only be inferred from disparate provisions of the Civil Code and the regulations on transplants. These regulations allow for the donor to be any person who is at least 18 years old, with unimpaired judgement, no transmissible diseases or autosomal-recessive genes. There are no specific requirements on kinship between donor and recipient.

The Civil Code regulations on medically assisted reproduction with a third-party donor stipulate that this procedure does not lead to filiation between the offspring and the donor[95] and there is no liability of the donor.[96] Nobody can challenge the child's filiation for reasons that pertain to its medically assisted reproductive nature.[97] Moreover, the donor benefits from the blanket legal provisions on the confidential nature of the entire procedure, although the veil of secrecy can be pierced,

91 Art. 144 of Law No. 95/2006.
92 Art. 150 of Law No. 95/2006.
93 Art. 154 of Law No. 95/2006.
94 Art. 2 of Annex No. 1 to Health Minister's Order No. 1242/2007.
95 Art. 441, para. 1 of Civil Code: 'Human medically assisted reproduction with a third-party donor does not generate any parental relation between the child and the donor'; Florian in Baias et al., 2021, pp. 594–595.
96 Art. 441, para. 2 of Civil Code: 'In this case, any legal action for liability cannot be brought against the donor'; Florian in Baias et al., 2021, pp. 594–595.
97 Art. 443, para. 1 of Civil Code; Florian in Baias et al., 2021, pp. 596–599.

with prior court authorisation, to avoid serious damage to the health of the offspring or their descendants.[98]

There are other Civil Code provisions, referring to the respect owed to the human being and their inherent rights, which are particularly relevant to a donor involved in an ART procedure. For example, the personality rights, which are non-transferrable, include the donor's rights to life, health, physical and mental integrity, dignity, own image and private life.[99]

A donor's right to life, health or physical and mental integrity prevails over the interests of society or science.[100] Eugenic practice and the organised selection of people are prohibited,[101] as well as the interventions on the genetic characteristics of a donor, for the purpose of altering the descendants of a person, with the sole exception of those that are meant to prevent or cure genetic illnesses.[102]

Donors in ART procedures cannot be cloned[103] and the integrity of their body and mind cannot be affected, except in limited cases prescribed by law.[104] The examination of the genetic characteristics of an ART donor can also be performed if it involves a medical purpose, as prescribed by law.[105]

One of the most relevant Civil Code provisions, pertinent to the status of ART donors, is the general prohibition on ascribing a monetary value to the products of the human body, with any exception to this principle having to be expressly defined by law.[106] The Law on Healthcare Reform no. 95/2006 criminalises donating cells or tissues for material gain,[107] advertising for cell or tissue donation for material gain,[108]

98 Art. 445 of Civil Code: 'Any information regarding human medically assisted reproduction is confidential. Nevertheless, in cases in which the lack of information leads to a risk for serious damage to the health of a person thus conceived or of their descendants, the court can authorise the information to be transmitted, in a confidential manner, to the physician or the relevant authorities. Any of the descendants of the person thus conceived can use this right if the lack of information can seriously damage their health or the health of a close person'; Florian in Baias et al., 2021, p. 601.

99 Art. 58 of Civil Code: 'Any person has the right to life, health, physical and mental integrity, dignity, self-image, respect for private life and any other such rights recognised by law. These rights are non-transferrable'; Chelaru in Baias et al., 2021, pp. 73–76.

100 Art. 61 of Civil Code: 'Life, health and physical and mental integrity of any person are equally guaranteed and protected by the law. The interests and well-being of the human being must prevail over the sole interest of society or science'; Chelaru in Baias et al., 2021, pp. 77–78.

101 Art. 62 of Civil Code; Chelaru in Baias et al., 2021, pp. 78–79.

102 Art. 63, para. 1 of Civil Code; Chelaru in Baias et al., 2021, pp. 79–80.

103 Art. 63, para. 2 of Civil Code; Chelaru in Baias et al., 2021, p. 80.

104 Art. 64 of Civil Code: 'The human body is inviolable. Every person has the right to physical and mental integrity. The integrity of the human being can be affected only in cases and under the conditions explicitly and limitatively prescribed by law'; Chelaru in Baias et al., 2021, p. 82.

105 Art. 65, para. 1 of Civil Code: 'The examination of the genetic characteristics of a person can only be performed for medical or scientific research purposes, done according to the law'; Chelaru in Baias et al., 2021, p. 83.

106 Art. 66 of Civil Code: 'Any acts for the purpose of attributing a monetary value to the human body, its components or products, are void, with the exception of cases explicitly prescribed by law'; Chelaru in Baias et al., 2021, pp. 83–84.

107 Art. 156, para. 1 of Law No. 95/2006.

108 Art. 156, para. 3 of Law No. 95/2006.

organising or harvesting cells or tissues for transplant for material gain for either the donor or the person who organises the process.[109]

As there are no current statutory provisions that would allow for paying a donor for participating in an ART procedure, such payments would fall foul of both civil and criminal law.

Other general Civil Code provisions that are relevant to the ART donors require a prior written and explicit consent for harvesting human cells,[110] prohibiting harvesting of cells from a minor or a person with impaired judgement.[111] Any medical intervention, including the harvesting of reproductive cells from a donor, must be conducted only according to the limits prescribed by law.[112]

The most delicate area of donor's rights in Romanian law is that concerning the respect of their private life[113] and human dignity.[114] These rights appear to be heavily dependent on the confidentiality of the procedure, because any public exposure of the identity of the donor would infringe both on their right to an intimate life and their dignity or public reputation.

Regarding medically assisted reproductive procedures with a third-party donor, the Civil Code of 2009 includes a specific seven-article section in this regard (Arts. 441 to 447). These general provisions were supposed to be followed by a new special and detailed law on medically assisted reproductive procedures with a third-party donor, however, more than thirteen years have passed to no avail.[115]

All assisted reproductive procedures are considered confidential according to the general provisions of Art. 445, para. 1 of the Civil Code requirements which were construed to protect the identity of the parents or of the single parent, the child born out of these procedures or the third-party donor, as well as the notarised parental agreement to undergo the procedure, this confidentiality being considered

109 Art. 157, para. 1 of Law No. 95/2006.

110 Art. 68, para. 1 of Civil Code: 'The harvesting and transplant of human organs, tissues and cells from living donors are done exclusively in cases and conditions prescribed by law, with the written, free, prior and explicit agreement of the donors and only after they were previously informed about the risks of the intervention. In all cases, the donor can revoke their consent up until the moment of harvesting'; Chelaru in Baias et al., 2021, pp. 85–87.

111 Art. 68, para. 2 of Civil Code; Chelaru in Baias et al., 2021, pp. 85–87.

112 Art. 67 of Civil Code: 'No person can be subjected to experiments, tests, harvestings, treatments or any other interventions for therapeutic or scientifical purposes except in cases and conditions explicitly and limitatively prescribed by law'; Chelaru in Baias et al., 2021, p. 85.

113 Art. 71 of Civil Code: 'Every person is entitled to respect for their private life. Nobody can be subjected to interference in their intimate, personal or family life, nor in their domicile, residence or correspondence, without their consent or the respect of the limits provided by Art. 75. It is also forbidden to use in any way the correspondence, manuscripts or other personal documents as well as the information from a person's private life without their consent or the respect of the limits provided by Art. 75'; Chelaru in Baias et al., 2021, pp. 89–91.

114 Art. 72 of Civil Code: 'Every person has the right for their dignity to be respected. Any infringement to a person's honour or reputation is forbidden without their consent or the respect of the limits provided by Art. 75'; Chelaru in Baias et al., 2021, pp. 91–93.

115 Florian and Floare, 2024, p. 468; Avram, 2022, p. 309.

an integral part of the constitutional right to private life.[116] As it is also a medical procedure, the assisted reproduction is also covered by the right of the patient to the confidentiality of medical information, which is stipulated by Art. 21 of the Law no. 46/2003 on the rights of the patient.[117]

The only specified exceptions to the confidentiality requirements are made in Art. 445, para. 2 of the Civil Code, for the court-authorised transmission of information to a physician or to the competent authorities, to prevent serious health harms to the children born from these procedures or to their descendants.[118] Moreover, confidentiality can be curtailed on the request of the descendants of the child born out of this procedure, to avoid serious health harms to them or their close ones, according to Art. 445, para. 3 Civil Code. Legal doctrine has interpreted this provision as meaning that only the children or their descendants have legal standing to demand this type of information.[119]

All the details about ensuring the confidentiality pertaining to medically assisted reproduction should have been included, according to Art. 447 of the Civil Code, in a special statute on the matter of assisted reproductive procedures with third-party donors,[120] which is yet to be adopted for the thirteen years since the Civil Code came into force, on 1 October 2011.

The Health Minister's Order no. 1763/2007 on the technical requirements for human tissue and cells for transplants mentions, for transplants of reproductive cells, other than from the recipient's partner, the requirement to register information about the donor's age, health, medical history, medical risks for themselves or others, tests for transmissible diseases, which specifically include HIV, syphilis, Hepatitis B or C, Human T-cell Lymphotropic Virus, Chlamydia, supplemental tests depending on risk factors, which could include malaria, cytomegalovirus, *Trypanosoma cruzi*, genetic screening for autosomal-recessive genes.[121]

4.7. Cryopreservation of Embryos

The cryopreservation of gametes or embryos is legally allowed in Romania, although it is specifically excluded from public funding from the IVF with ET national public health programmes since 2017, even in the more generous recent fertility programme that has commenced in 2022. In Romania, there are no specific legal conditions for the cryopreservation of gametes or embryos. The only general conditions

116 Florian and Floare, 2024, pp. 470–471.
117 Ibid., p. 471.
118 Avram, 2022, p. 312.
119 Florian and Floare, 2024, p. 471.
120 Art. 447 of Civil Code: 'Medical assisted reproduction, its legal regime, ensuring the confidentiality of information pertaining to it, as well as the way in which information can be transmitted will be established by special statute'.
121 Annex III to the technical requirements in Health Minister's Order No. 1763/2007.

are the informed consent of the donor and a contract with the authorised medical institution that harvests and deposits the biological material.[122]

This lack of regulation led to serious legal issues when the 'ownership' of the frozen embryos was questioned in a case involving a criminal inquiry and asset seizure implicating a fertility clinic: whether they are mere material goods or living beings.[123] The case of *Knecht v. Romania*, No. 10048/10, 2 October 2012, reached the European Court of Human Rights,[124] establishing that the case involved the applicant's, that is the mother, right to private life, not her property rights.

A subsequent case, *Nedescu v. Romania*, No. 70035/10, 16 January 2018, was based on the breach of the right to private life by the Romanian authorities' incoherence and unpredictable administrative procedures for giving back frozen embryos to a parental couple, after they were seized during a criminal investigation concerning the fertility clinic where they had stored their frozen embryos.[125]

4.8. Provisions on the Protection of the Embryo

The 2009 Romanian Civil Code has a special section on the rights to life, health, and physical integrity of natural persons.[126] Art. 61 guarantees the 'inherent' rights of the human being by equally safeguarding the life, physical and psychological health of any human being. The wellbeing and the interests of any human being should take precedence over the sole interests of society.[127] Art. 62 of the Civil Code prohibits eugenics and any attempts to alter the human species, which is understood to refer to the altering of the human genome. Eugenics is legally defined as any practice which tends to organise the selection of persons while the scientific definition of the concept refers to the practical applications of hereditary biology in the genetic improvement of individuals.[128]

The Civil Code also prohibits any medical interventions on genetic characteristics with the purpose of modifying the person's descendance, with the sole exception of curative and preventative interventions for genetic diseases.[129] The legal prohibition extends to human cloning with the purpose of creating an identical human being and creating human embryos solely for research purposes.[130] Human medically assisted reproductive procedures are not allowed for the purpose of selecting the sex of the future child, unless it is to avoid a gender-related genetic disease.[131]

122 Tec, 2017, p. 246.
123 Ibid., pp. 236–239.
124 European Court of Human Rights, 2012.
125 European Court of Human Rights, 2023.
126 Diaconescu and Vasilescu, 2022, pp. 303–307.
127 Chelaru in Baias et al., 2021, pp. 77–78.
128 Ibid., pp. 78–79.
129 Art. 63, para. 1 of Civil Code.
130 Art. 63, para. 2 of Civil Code.
131 Art. 63, para. 3 of Civil Code; Chelaru in Baias et al., 2021, pp. 79–81

Additionally, the current Civil Code regulates the sanctity of the human body,[132] restricts the examination of genetic characteristics only for medical, research and judicial purposes[133] and forbids giving a monetary value to the human body or to its component parts.[134] Further, it states the broad principles for medical interventions on a person and for transplants from a living person.[135]

4.9. The Rights of the Child Born out of ART

Romanian law does not distinguish between the legal status of children born out of ART and those born out of natural conception. Art. 446 of the Civil Code explicitly states that fathers have the same rights and duties towards children born out of medically assisted reproduction with a third-party donor as towards a child born through natural conception,[136] while the Romanian Constitution itself provides, in Art. 48, para. 3, that all children born outside marriage are equal to the children born during marriage.

The only specific rights of a child born out of ART concern their prerogative to demand the piercing of the veil of confidentiality that surrounds it, with prior court authorisation, when it is necessary to prevent serious harm to the health of the child or their descendants caused by the lack of information.[137] This right also passes to the child's descendants, who can enquire in the same manner for information about the assisted reproduction to prevent harm to their health or their own descendants' health.[138]

The breadth of the confidentiality principle in relation to MAR with a third-party donor and the exceptions to this principle should have been regulated by the future specific statute on MAR with a third-party donor specifically required by Art. 447 of the Civil Code which has not yet been approved. Art. 445 only has the broad strokes of the required regulation, stating that all information regarding MAR is confidential and the sole exceptions are for health reasons.

The right to know their origin is a fundamental right of all children, either conceived naturally or through ART. This right is part of the more extensive right to private life, regulated by both Art. 8 of the ECHR and Art. 26 of the Romanian Constitution.[139] Some authors have suggested doing away with the absolute anonymity of third-party donations to implement this right of the child.[140] The children's right to establish their identity clashes with the ambiguous and broad principle of

132 Art. 64 of Civil Code; Chelaru in Baias et al., 2021, p. 82.
133 Art. 65 of Civil Code; Chelaru in Baias et al., 2021, p. 83.
134 Art. 66 of Civil Code; Chelaru in Baias et al., 2021, pp. 83–84.
135 Chelaru in Baias et al., 2021, pp. 82–87; Arts. 67–68 of Civil Code.
136 Irinescu, 2024, p. 353.
137 Art. 445, para. 2 of Civil Code; Irinescu, 2024, p. 353.
138 Art. 445, para. 3 of Civil Code; Irinescu, 2024, p. 353.
139 Florian and Floare, 2024, pp. 470–471.
140 Guțan, 2011, pp. 3–4.

confidentiality. Moreover, unrestrained confidentiality can endanger the children's right to health by only providing a cumbersome judicial procedure for obtaining vital information about the donor or the procedure itself.

As children born through ART may be the result of medically assisted reproduction with a third-party donor and a single female parent, they will unavoidably be discriminated against compared with children having two parents, because they could never establish paternal links to their genetic father owing to the legal prohibition in MAR with a third party donor and they also lack an intended father, while normally all other children have at least the potential to establish both maternal and paternal filiation. *De lege lata,* the only way in which the child of a single mother, born through MAR with a third-party donor, can have a father is through the subsequent adoption by the mother's husband, naturally with the birth mother's consent. The mother's consensual male partner can only legally become a non-adoptive father by consenting to the procedure before conception had occurred. Therefore, the legal restrictions of MAR with a third-party donor also imply that the children of a single mother who has used the procedure can never legally have a 'biological' father.

Romanian law establishes human rights only after birth. Legal capacity begins at birth, however, as a traditional exception, few legal rights are recognised for a child from conception if they are born alive,[141] which implies that they could be theoretically entitled to certain civil rights for 300 days before their birth. Embryos have no rights and legal status by themselves, however, they are recognised as an intrinsic part of their intended parents' rights to private and family life as defined by Art. 8 of the ECHR.[142]

The 1989 Convention on the Rights of the Child was ratified by Romania in 1990.[143] Most of its provisions are implemented in the Law no. 272/2004 on the protection and furthering of the rights of the child. Romanian law defines the child as a person who has not yet reached the age of 18 and who has not attained full legal capacity by other means.[144]

The Law no. 272/2004 on the rights of the child recognises the child's specific right to dignity,[145] compelling both the parents[146] and public authorities to respect their dignity,[147] particularly when taking disciplinary action regarding the child or dealing with disabled or abused children. The Civil Code general provisions that prohibit eugenics,[148] interventions on the human genome without a medical reason[149]

141 Art. 36 of Civil Code.
142 Tec, 2017, pp. 239–240.
143 Law No. 18/1990.
144 Art. 4a of Law No. 272/2004.
145 Art. 6g of Law No. 272/2004.
146 Art. 33, para. 2 and Art. 37b of Law No. 272/2004.
147 Art. 49, para. 5 and Art. 90, para. 2 of Law No. 272/2004.
148 Art. 62 of Civil Code; Chelaru in Baias et al., 2021, pp. 78–79.
149 Art. 63 of Civil Code; Chelaru in Baias et al., 2021, pp. 79–81.

and giving a monetary value to the human body and its parts[150] are also indirectly safeguarding the interests of the embryos.

Children have the right to establish and keep their identity.[151] Moreover, they have the right, if possible, to know their parents and to be raised, cared for and educated by them.[152] Children must be registered immediately after birth and have the right to receive a name and a citizenship.[153] The first name and family name of a child are selected by their parents[154] and the children have the right to keep their citizenship, name and family relations.[155] If a child is illegally missing any one of the elements of their identity, public authorities have a duty to take any necessary measures to re-establish the child's identity.[156]

Even children who are estranged from their parents and extended family have the right to have personal relationships and direct contacts with their family members, except in cases where a court decides that such contacts could endanger the child's physical, mental, intellectual or moral development.[157] This right does not extend to the biological donor-parent or their side of the family in cases of medically assisted reproduction with a third-party donor.

Romanian law promotes raising the children in their natural family, with their parents, as a priority, except when this is not in the best interests of the child.[158]

The child's right to health is considered as one of the pillars in defining their best interests.[159] Health concerns are one of the reasons that could trigger an investigation by child protection services.[160] Children have the explicit right to reach the best health level they can achieve[161] and to receive free healthcare paid for by the National Health Insurance Fund.[162] Further, they must be protected against work exploitation or any other activities that endanger their health.[163] Endangering the physical or mental health of a child can be considered as abuse or neglect.[164]

One of the core principles of child protection is providing equal opportunities and non-discrimination.[165] All children have the same rights, without regard to their, their parents' or their legal guardians' race, skin colour, language, religion, political

150 Art. 68 of Civil Code; Chelaru in Baias et al., 2021, pp. 85–87.
151 Art. 9, para. 1 of Law No. 272/2004.
152 Art. 9, para. 2 of Law No. 272/2004.
153 Ibid.
154 Art. 9, para. 3 of Law No. 272/2004.
155 Art. 9, para. 4 of Law No. 272/2004.
156 Art. 9, para. 5 of Law No. 272/2004.
157 Art. 17, para. 3 of Law No. 272/2004.
158 Art. 5, para. 2, Art. 6c and d, Art. 35 para. 1, Art. 36 para. 1, Art. 38 of Law No. 272/2004.
159 Art. 2, para. 6a of Law No. 272/2004.
160 Art. 41, para. 1 of Law No. 272/2004.
161 Art. 46, para. 1 of Law No. 272/2004.
162 Art. 46, para. 2 of Law No. 272/2004.
163 Art. 91, para. 1 of Law No. 272/2004.
164 Art. 94 of Law No. 272/2004.
165 Art. 6b of Law No. 272/2004.

or any other type of opinion, nationality, ethnicity, social origin, material status, disability, birth or achieved status, or developmental difficulties.[166]

The protection of the private and family life of the child is recognised against both their parents, authorities or other parties.[167]

Lesbian and gay couples continue to have no formal recognition in Romanian law, despite the recent 2023 ECHR decision in the case of *Buhuceanu and others v. Romania*, no. 20081/19, 23 May 2023,[168] where the lack of even a legally defined registered partnership for same-sex couples was deemed to be a violation of their Art. 8 right to private and family life. *De facto* same-sex couples are not prohibited by Romanian law, therefore, a child can actually be raised by a same-sex couple if any of them has parental rights. Current family law would usually simply disregard the presence of the same-sex partner of the biological or adoptive parent of the child, although the child could later acquire a visitation schedule and a personal relationship with a non-related person who happens to be his biological parent's current or former same-sex partner, in a similar manner to any other person towards whom the child had become factually attached.[169]

Contrary to the precarious status of same-sex couples raising children in Romania, single mothers have better defined rights at least since 1954, when the prior Family Code came into force. Either parent can exercise parental rights, and the child's residence can be established at either one of them. The preferred option of the Civil Code is the joint exercise of parental authority,[170] which includes the major decision-making powers,[171] while the law on the rights of the child defines the criteria for establishing the residence of the child, when there is no joint parental agreement, as being the best interests of the child, the parent's residential situation and the distance to the child's school, the parent's personal history and capacity to respect and support the other's parental rights.[172] Single parents of either gender have well-defined social protection rights, their situation being expressly recognised as a family for the purposes of social protection law.

The right of the child to know their origin is recognised by Romanian legal doctrine as being primarily an effect of Art. 8 of the European Convention on Human Rights[173] and of Arts. 7 and 8 of the 1989 Convention on the Rights of the Child.[174] This fundamental right frequently clashes with the confidentiality provisions specific both to ART and medical procedures in general.[175]

166 Art. 7 of Law No. 272/2004.
167 Art. 27, para. 2, Art. 37b of Law No. 272/2004.
168 Applications No. 20081/19 and 20 others, 23 May 2023.
169 Art. 17, para. 1 of Law No. 272/2004.
170 Art. 483, para. 1 of Civil Code; Irimia in Baias et al., 2021, pp. 642–646.
171 Art. 36, para. 3 of Law No. 272/2004.
172 Art. 21, para. 1 of Law No. 272/2004.
173 Florian and Floare, 2024, pp. 470–471.
174 Irinescu, 2024, p. 352.
175 Ibid.

The confidentiality principle of third-party donations by itself would preclude the child from knowing the identity of the donor, male or female, who contributed biological material to their conception, and it would also prevent the child from knowing that they are a product of medically assisted reproduction.[176] The Civil Code's explicit exceptions to confidentiality are circumscribed solely to health reasons for the direct offspring and their descendants.[177]

Several authors have argued that the confidentiality of the ART procedure is not equivalent to complete anonymity and that the best middle ground approach would be to allow the child, at a certain legally predefined age, such as 14, 16 or 18 years, to receive certain information about their origin, even without specific health reasons, such as the age, physical characteristics or medical history of their biological parents, without actually revealing the identity of the third-party donor.[178] Nonetheless, a complete cancellation of the confidentiality principle would imperil the availability of third-party donations; therefore, we can presume that not all information about the donor's identity can be freely available.

4.10. Sanctions for Malpractice regarding ART

Medical malpractice in general is regulated by Title XVI of the Law no. 95/2006 on healthcare reform. Malpractice is legally defined as a professional error in the exercise of a medical act, which has caused damage to the patient, involving the civil liability of medical personnel or the provider of medical services or products.[179] Medical personnel are liable for negligence, recklessness or insufficient medical knowledge in the exercise of their profession, including any preventative, diagnostic or curative procedures[180] such as ART. They are also liable for damages caused by breaches of confidentiality, informed consent or the obligation to provide medical care[181] or if they exceed the limits of their medical competence in any cases that are not emergencies involving the unavailability of competent personnel.[182] The primary civil sanction for malpractice is the payment of material or moral damages, however, these do not preclude criminal liability if the deed is also a criminal act,[183] or liability for professional misconduct either with the employer or professional organisations.

Civil liability for ART malpractice is shared between all those involved in the medical act, proportionately with everyone's degree of guilt.[184] Medical personnel is exempt from civil liability if the damages to the ART patient are the result of

176 Art. 445, para. 1 of Civil Code; Irinescu, 2024, pp. 352–353.
177 Art. 445, para. 2 and 3 of Civil Code; Irinescu, 2024, p. 353.
178 Nicolescu, 2021, pp. 693–694; Nicolescu, 2023, p. 466; Florian, 2018, pp. 128–129.
179 Art. 653, para. 1b of Law No. 95/2006.
180 Art. 653, para. 2 of Law No. 95/2006.
181 Art. 653, para. 3 of Law No. 95/2006.
182 Art. 653, para. 4 of Law No. 95/2006.
183 Art. 653, para. 5 of Law No. 95/2006.
184 Art. 654, para. 1 of Law No. 95/2006.

in-hospital infections, generally accepted adverse effects, complications and risks of investigative or treatment methods, hidden defects of medical goods, equipment, medical devices, technologies or of the medical substances that were used.[185] Civil liability for ART malpractice passes to the private or public health facility when damages are the consequence of in-hospital acquired infections, known defects of medical devices which were not repaired, or using medical devices, medicines or materials which were expired or out of warranty.[186]

5. Family Law Regulations

5.1. Filiation and ART

Family law rules about filiation have specific provisions relating to ART only regarding medically assisted reproduction with a third-party donor. In all other situations, general rules on natural filiation completely apply.

The specific rule on filiation from medically assisted reproduction with a third-party donor is that paternity is established based on the husband's or male partner's consent to the procedure,[187] without the possibility of challenging it for biological reasons.[188] The paternity can be challenged if the pregnancy was not the result of the medical procedure[189] or if the father's consent was ineffective.[190]

Initially, the paternity would continue to be registered in the birth registry according to the common rules for children born or conceived during marriage, however, it can be afterwards struck out by court decision if the alleged father, the mother's actual or former spouse who is not biologically related to the child, successfully challenges it owing to his lack of prior consent or his ineffective consent for MAR with a third-party donor. According to Art. 442, para. 2 of the Civil Code, consent becomes ineffective owing to death, filing for divorce, factual separation or

185 Art. 654, para. 2 of Law No. 95/2006.

186 Art. 655, para. 1 of Law No. 95/2006.

187 Art. 444 of Civil Code: 'The person who, after having consented to medically assisted reproduction with a third-party donor, does not acknowledge the child thus born out of wedlock is liable towards the mother and the child. In this case, the paternity of the child is established by judicial decision, according to Arts 411 and 423'; Florian in Baias et al., 2021, pp. 599–601.

188 Art. 443, para. 1 of Civil Code: 'Nobody can challenge a child's filiation for reasons pertaining to medically assisted reproduction and neither the child thus born can challenge their own filiation'; Florian in Baias et al., 2021, pp. 596–599.

189 Art. 443, para. 3 of Civil Code: 'In cases in which the child was not conceived this way, the provisions regarding challenges to paternity remain applicable'; Irinescu, 2024, p. 357.

190 Art. 443, para. 2 of Civil Code: 'Nevertheless, the mother's husband can challenge the child's paternity according to the law, if he had not consented to the medically assisted reproduction with the help of a third-party donor'; Irinescu, 2024, p. 357.

consent revocation before artificial conception. For consensual partners, acknowledgement of paternity after birth or a judicial decision for establishing paternity is required even in MAR cases, however, an acknowledgement which has no basis in either biological filiation or prior consent to MAR can be challenged in court, at any time, by any interested party.[191]

In all other ART situations, where no third-party donor was involved, paternity is presumed in favour of the mother's husband either at the time of birth or during the legal timeframe for conception,[192] between 300 and 180 days before birth.[193] If the mother was not married either at birth or during the timeframe for conception, paternity can be established either by voluntary acknowledgement from the father or by court decision.[194] Moreover, the latter provisions apply if the husband or former husband had successfully challenged paternity by proving that it was impossible for him to be the biological father.[195]

Maternity in all ART situations is the result of giving birth,[196] with no legal regard given to genetic maternal filiation. Genetic maternal filiation is examined only as a proxy for proving who gave birth to the child, particularly if there is no medical registration of birth.[197] Maternal filiation, which is affirmed both by a birth certificate and the child's status by habit and repute, cannot be legally challenged, unless a court had previously found that a child substitution had occurred or that the woman registered as a mother was not the one who gave birth.[198] If the birth registration and the status by habit and repute do not concur, any interested party, including the child, can challenge the registered maternal filiation.[199]

191 Art. 420, para. 1 of Civil Code: 'The acknowledgement which is not truthful can be challenged at any time by any interested party'.

192 Art. 414, para. 1 of Civil Code: 'The child born or conceived during marriage has the mother's husband as a father'; Florian in Baias et al., 2021, pp. 556–559.

193 Art. 412, para. 1 of Civil Code: 'The time interval between the three hundredth and the one hundred eightieth day before the child's birth is legal timeframe for conception. It is calculated day by day'; Florian in Baias et al., 2021, p. 555.

194 Art. 408, para. 3 of Civil Code: 'The filiation towards the father outside marriage is established by acknowledgement or by judicial decision'; Florian in Baias et al., 2021, pp. 550–551.

195 Art. 414, para. 2 of Civil Code: 'Paternity can be challenged if it is impossible that the mother's husband is the child's father'; Florian in Baias et al., 2021, pp. 556–559.

196 Art. 408, para. 1 of Civil Code: 'Maternal filiation results from the fact of birth; it can also be established by acknowledgement or judicial decision'; Florian in Baias et al., 2021, pp. 550–551.

197 Art. 14, para. 2 of Law No. 119/1996.

198 Art. 411, para. 3 of Civil Code: 'Nonetheless, if a judicial decision establishes that a child substitution had taken place or that another woman has been registered as the child's mother than the one who has given birth, the true filiation can be proved by any means'; Florian in Baias et al., 2021, pp. 554–555.

199 Art. 411, para. 1 and 2 of Civil Code: 'No person can claim another maternal filiation than the one resulting from their birth registration and the status by habit and repute which corresponds to it. Nobody can challenge the maternal filiation of the person who has a status by habit and repute concurring with their birth registration'; Florian in Baias et al., 2021, pp. 554–555.

The status by habit or repute is the factual expression of the underlying filiation and kinship that exists between the child and their family or relatives.[200] It constitutes the reciprocal behaviour of the parent and the child by treating them as their own, the public acknowledgement from the family itself of the child as being part of it, from society and authorities or the child carrying the name of the person who claims to be their parent.[201]

The person giving away the gametes to another person in a medical procedure can be the parent of a child conceived through assisted reproductive procedures if there is a reproductive cell transfer between partners, which can be construed as IVF. Third-party gamete donations, either male or female, do not give rise to legal parenthood because maternal filiation depends solely on giving birth to the child, similar to 'natural' motherhood,[202] while the 'fatherhood' of the third-party donor, the 'genetic' father, is specifically excluded by Art. 441, para. 1 of the Civil Code, which states in broad terms that medically assisted reproduction with a third-party donor does not give rise to any filiation between the child and the donor.

There are no special presumptions of parenthood for the assisted reproductive procedures, the mother is the person giving birth and the father is presumed to be either the mother's husband at the time of birth[203] or the former husband at the time of conception, identical to natural conception, or the mother's cohabiting partner at the time of conception, the latter presumption being applied only during paternity trials. For children born out of wedlock, either through natural conception or ART, fatherhood is established either by voluntary acknowledgement or by judicial decision for establishing paternity.[204] In the latter case, during the trial, proven cohabitation during the timeframe when conception was possible is considered sufficient proof of paternity,[205] unless the respondent man proves that it is impossible for him to be the father.[206]

The true source of paternal filiation in case of medically assisted reproduction with a third-party donor is the consent given by the mother's husband or consensual

200 Art. 410, para. 1 of Civil Code: 'The status by habit and repute is the factual situation which indicates filiation and kinship relations between the child and the family to which they allegedly belong. It consists mainly in any of the following circumstances: a person treats the child as their own, taking care of their upbringing and education, and the child behaves towards this person as if they were their parent; the child is acknowledged by the family, society and, when the case may be, by public authorities as belonging to the person who is alleged to be their parent; the child carries the name of the person who is alleged to be their parent'; Florian in Baias et al., 2021, pp. 552–553.

201 Art. 410, para. 2 of Civil Code: 'The status by habit and repute must be continuous, peaceful, public and unequivocal'; Florian in Baias et al., 2021, pp. 553–554.

202 Florian and Floare, 2024, p. 475.

203 Ibid.

204 Art. 424 of Civil Code: 'If the father out of wedlock does not acknowledge the child, paternity can be established by judicial decision'.

205 Art. 426, para. 1 of Civil Code: 'Paternity is presumed if it is proven that the alleged father has lived together with the child's mother during the legal timeframe for conception'.

206 Art. 426, para. 2 of Civil Code: 'The presumption is inapplicable if the alleged father proves it is impossible for him to have conceived the child'.

partner to undergo the procedure. Paternal filiation can be contested only for lack of prior consent from the father or if the pregnancy did not arise from the medically assisted procedure.[207]

A consensual partner who gave his consent to this procedure is liable to recognise paternal filiation after birth,[208] if there is no intervening marriage between the parents. Although the Civil Code section on MAR with a third-party donor does not elaborate what this 'liability' indicates, legal doctrine recognises that it should mean establishing fatherhood by judicial decision,[209] as well as requiring the father to pay half of the mother's expenses during pregnancy and immediately after childbirth, including the mother's maintenance expenses.[210] If MAR is involved, establishing paternity by judicial decision implies proving the alleged father's prior and effective consent to the procedure, not biological conception.

5.2. The Right to Decide on the Fate of an Embryo

The fate of frozen human embryos and the right to decide on it have been examined by Romanian legal doctrine,[211] without reaching a satisfactory conclusion. The questions are difficult to answer particularly when examining the legal status of frozen embryos between the moment of conception and the date of their transfer into the mother's body. Issues may arise not only among the intended parents, who may later divorce, separate, or one of them could become legally or mentally incapacitated, but also between the parents and institutions that have physical custody of the frozen embryos, which may be either private fertility clinics who are contractual partners or State institutions who happened to seize those embryos during criminal or administrative investigations.[212]

Owing to the lack of a proper statute which may answer the questions about legal status of embryos in assisted reproduction, the only sources of inspiration are two landmark European Court of Human Rights' rulings concerning Romania and the fate of human embryos,[213] as well as the general principles of law, professional customs or the legal provisions for similar situations used through analogy.[214] Romanian private law can use not only the statutes enacted by Parliament, but also the general principles of law, analogy with similar regulations and customs.

The most significant legal issue concerning frozen embryos is whether they should be treated as mere assets or as human beings. The ECtHR has mostly sidestepped

207 Florian and Floare, 2024, pp. 476–477; Motica, 2021, p. 228.
208 Florian and Floare, 2024, pp. 478–480.
209 Ibid., pp. 479–480; Avram, 2022, p. 311; Nicolescu, 2023, pp. 470–471; Irinescu, 2024, p. 358.
210 Florian and Floare, 2024, p. 480; Avram, p. 311.
211 Tec, 2017, pp. 234–248.
212 Ibid., pp. 235, 240.
213 *Knecht v. Romania*, No. 10048/10, 2 October 2012, *Nedescu v. Romania*, No. 70035/10, 16 January 2018.
214 Art. 1 of Civil Code; Baias et al., 2021, pp. 1–3.

the issue and treated the authorities' ineptitude regarding the fate of seized frozen embryos belonging to the plaintiffs as violations of their rights to private and family life, under the aegis of Art. 8 of the European Convention on Human Rights, and not as violations of their property rights protected by Art. 1 of the First Additional Protocol to the Convention.[215] The European Court has stopped short of recognising full personhood for frozen embryos, treating them only as a constitutive part of the genetic patrimony and biological identity of the person who has contributed to their creation.[216] Strong arguments have been brought to the fore for recognising embryos as distinct beings from their parents, although such a conclusion would unavoidably make abortions a crime, the preservation of frozen embryos a violation of human dignity and disputes between parents over the fate of embryos as similar to child custody litigations.[217]

The courts have not recognised the personhood of embryos and any litigation in their regard would be solved according to the intended parents' rights to private life and the provisions of the extant contracts between the parents and the fertility establishments.[218] ECHR case law leads to the conclusion that, in cases of divorce and separation, the fate of the embryos would be decided according to the parents' agreed decision or, in cases of disagreement, either parent's decision to not become a parent should take precedence, based on their right to personal autonomy, which would lead to the destruction or donation for research purposes of the embryos.[219]

Contractual issues bring a host of intractable problems regarding the fate of frozen human embryos. Unused embryos during the contractual timeframe, unpaid storage fees, the death of both intended parents are all scenarios that will lead to the destruction or even the possible unauthorised trafficking of the embryos. In the absence of a statutory provision allowing for the 'adoption' of abandoned embryos by infertile couples, their destruction is the only legal means which respects the parents' rights to personal autonomy.[220] Legal scholars have severely criticised the parental focus of extant legislation and case law, arguing for some recognition of the unused embryo's right to life or some form of protection, similar to the one for a vulnerable human being.[221]

The *de lege ferenda* suggestions[222] for a future statute dealing with the fate of frozen human embryos include the necessity for it to regulate the execution, performance and cessation of contracts between the intended parents and the medical establishment, the parties' contractual duties; the options in cases of divorce, separation and death of one of the parents and the timeframe for exercising the option,

215 Tec, 2017, pp. 238–239.
216 Ibid.
217 Ibid., pp. 239–240.
218 Ibid., p. 240.
219 Ibid., p. 244.
220 Ibid., p. 245.
221 Ibid.
222 Ibid., p. 247.

which may include the use by only one of the spouses, post-mortem use, donation to another couple, consent revocation; the fate of abandoned embryos and parental liability for embryo abandonment; liability for the destruction or disappearance of frozen embryos, liability for implantation errors; the particular effects of frozen embryo use on filiation and inheritance.

5.3. Surrogacy Arrangements and Romanian Law

Surrogacy is not expressly forbidden, however, it is neither specifically allowed nor regulated in Romania.[223] The provisions that the mother is the one giving birth, irrespective of genetic relationship, even in medically assisted reproductive procedures,[224] and that the parental authority cannot be voluntarily transferred to another person make surrogacy legally difficult.[225]

Art. 408 para. 1 of the Civil Code makes no distinctions in stating that motherhood is always derived from the fact of birth, thus, making no special provisions for medically assisted pregnancies, artificial insemination, or IVF.[226] The source of the biological material is not relevant and genetic testing for motherhood is employed only as a proxy for determining who gave birth to a certain child in cases of late birth registration when there is no medical certificate of birth.[227]

Parental authority is usually exercised by both biological parents, and they can agree between themselves how to divide it in practice. However, a mere parental agreement cannot voluntarily relinquish parental authority or transfer it to a third party. Only through court-approved adoption can parental authority be permanently transferred from the biological parents to the adoptive parents.[228] All other court decisions regarding the exercise of parental rights, including the most drastic ones concerning the removal of the exercise of parental rights, are essentially temporary in nature and can later be reversed when the parents' situation improves. Thus, there are no defined legal means to contractually transfer parental authority from the birth mother to another woman, even if the latter is the genetic parent of the child.

Both types of surrogacies, gestational and traditional,[229] are equally impeded by the legal provisions on birth motherhood and the impossibility of voluntarily relinquishing or transferring parental authority.

One of the only legal ways to circumvent the underlying scepticism of Romanian legislation regarding surrogacy is by using a simplified adoption procedure, where the biological father first voluntarily recognises paternity and then his wife adopts the child, with the consent of the surrogate mother, who was legally registered

223 Hageanu, 2023, p. 222.
224 Florian and Floare, 2024, p. 469; Nicolescu, 2023, p. 474; Irinescu, 2024, p. 361.
225 Dobozi, 2013, pp. 64–65.
226 Nicolescu, 2023, p. 474.
227 Art. 14, para. 2 of Law No. 119/1996.
228 Nicolescu, 2023, pp. 478–479; Irinescu, 2024, p. 365.
229 Predescu, 2020, p. 477; Nicolescu, 2023, p. 472.

as the child's biological mother. This option implies that the male gametes come from the father, with a compulsory DNA test to verify paternity, and that the surrogate mother agrees to adoption after giving birth, without any financial reward.[230] Compulsory DNA testing is required under Art. 7, para. 4 of the Law No. 273/2004 on adoption procedure only when the declared father's wife wants to adopt the child in a simplified procedure, with the birth mother's consent, and paternity had been previously established by extrajudicial acknowledgement or by a non-contested judicial procedure where the father merely acknowledged paternity or agreed with the mother's petition for establishing paternity.

Altruistic surrogacy is not explicitly prohibited, although it is heavily impeded by the current legal framework, while commercial surrogacy falls foul of multiple legal bans on trading the products of the human body, trading biological products or even human trafficking.

Surrogacy is heavily impeded in all cases; however, medical infertility or gestational impediments occasionally bring an unspoken sympathy from the courts in attempting to overcome the legal hurdles to recognition of its effects. There were a few published court cases where the effects of surrogacy have been recognised[231] with a circumvented legal reasoning, usually with the paternal filiation being initially voluntarily recognised by the genetic parent and maternal filiation being recognised afterwards, by special request, as an effect of the 'possession of civil status or status by habit and repute', and genetic filiation, frequently also referring the provisions of Art. 8 of the European Convention of Human Rights in regard to the right to private and family life.[232]

The best known and most discussed domestic case involving surrogacy involves the 2013 decision rendered by the Court of Appeals in Timișoara, sitting on an appeal on points of law (*recurs*) and reversing the lower courts' decisions by recognising the effects on maternal filiation of an altruistic gestational surrogacy, where the woman giving birth was the sister of the intended mother, the latter providing the genetic material but lacking an uterus to carry the pregnancy to term.[233] While the effects on paternal filiation were recognised even by the lower county court owing to the extant genetic link between the father providing the biological material and the child, the recognition of maternal filiation went against the clear national rule that the mother is the one giving birth, with maternal genetic links being relevant only insofar as they serve as proof of birth. The court's decision heavily referenced Art. 8 and the right to private and family life from the European Convention on Human Rights. This type of judge-made law is unusual in a statute-based justice system such

230 Nicolescu, 2023, pp. 478–479.
231 Ibid., pp. 482–485; Brodeala, 2016, pp. 70–73.
232 Irinescu, 2019, pp. 213–214; Hageanu, 2023, pp. 221–222.
233 Decision No. 1196/26.09.2013, detailed by Nicolescu, 2023, pp. 482–485; Motica, 2021, pp. 229–230; Avram, 2022, p. 274; Irinescu, 2024, pp. 362–363.

as the Romanian system, and it cannot sustainably cancel the explicit statutory rules on maternal filiation being *de lege lata* inextricably tied to birth.

5.4. Issues Regarding Cross-border Surrogacy for Romanian Parents

Filiation in Romanian private international law, regulated by Book VII, Chapter 2, Section 2 of the Civil Code, is subject to either the law that governs the general effects of the parents' marriage, for children born or conceived during marriage,[234] or to the national law of the child at the time of birth, for children born out of wedlock.[235] There are no special provisions in Romanian private international law for surrogacy because there are scant references to this procedure in the entire domestic legislation.

In cases concerning surrogacy performed abroad or with a foreign element, Romanian courts would probably apply either the national law of the woman giving birth, which would be the surrogate mother, if she is single, or possibly the law that governs the general effects of her marriage. If these foreign laws allowed for surrogacy and the voluntary transfer of parental authority from the birth mother to the intended parents owing to their previously concluded agreement, there is a risk that international public order grounds could lead to the refusal to recognise the lawful consequences of these procedures in Romania. However, ECtHR case law in surrogacy situations, based on Art. 8, including *Menneson and Labassee v. France*, No. 65941/11, 26 June 2014, and *Paradiso and Campanelli v. Italy*, No. 25358/12, 24 January 2017, would compel the courts to affirm the child's right to private and family life by recognising parental filiation when there is a factual basis for the child being treated as the intended parents' offspring.[236]

In Romanian domestic law, a genetic link is required only for paternal filiation (fatherhood) out of wedlock, while maternal filiation (motherhood) is intrinsically dependent on giving birth. Paternal filiation (fatherhood) is legally presumed for the current husband at the time of birth or the former husband at the time of conception, which is presumed to be between 300 and 180 days prior to giving birth. An apparent maternal filiation, even if it is based on a birth certificate, coherent with habit and repute, could continue to be challenged if the listed mother is not the woman having given birth. On a domestic birth certificate, the woman having given birth is automatically listed as the mother of the child, while her current or former husband, or the person who voluntarily recognises the child, is listed as the father.

234 Art. 2.603 of Civil Code: 'The filiation of the child born in wedlock is established according to the law which, at the time of their birth, governs the general effects of their parents' marriage. If, before the child's birth, the parents' marriage had ceased or had been dissolved, the law which had governed the effects of marriage at the time of its cessation or dissolution is applicable. The law thus established is also applicable to the challenges to the child's paternity as well as to the acquisition of a family name by the child'; Macovei and Dominte in Baias et al., 2021, pp. 3042–3043.

235 Macovei, 2017, pp. 343–345; Popescu and Oprea, 2023, pp. 463–480.

236 Nicolescu, 2023, pp. 475–478.

The civil status of a person is subject to their national law according to Art. 2.572, para. 1 of the Civil Code.[237] Foreign birth certificates are registered in Romania if they concern any person born abroad.

6. The History of Failed Attempts to Legislate on Medically Assisted Reproduction

Slightly prior to the most recent Civil Code of Romania, one of the first contemporary attempts to adopt a comprehensive statute concerning medically assisted reproduction was from 2009 (PL-x No. 690/2009[238]). This 26-article project affirmed a right to reproduction as a right of couples and individuals to 'freely and responsibly decide the number, frequency and time when they wish to have children', as well as their right to have access to information, education, and the means to reach such a decision. The medically assisted human reproduction was reserved only for married couples or consensual partners who could prove at least a two-year cohabitation. Moreover, they would have had to be both alive, inseminating a woman with her dead husband's sperm being expressly forbidden, and fulfil the general health and biological age criteria for procreation.

This project had a list of allowed human medically assisted reproduction techniques, such as artificial insemination, IVF, ET, and a list of prohibited techniques, such as *post-mortem* artificial insemination, *post-mortem* embryo transfer, interventions when infertility is owing to old age, fertility interventions for couples who cannot prove a stable cohabitation. The 2009 project regulated both endogenous fertilisation and reproduction with a third-party donor.

Filiation was established, according to this project, by the simple declaration of parents at the time of birth, the child having the same rights as a naturally conceived child.

This 2009 project was rejected by the lower Chamber of Deputies in 2010;[239] the Health Committee's rejection report[240] stating that the project had serious technical drafting deficiencies, and it had serious gaps in its rules about a sensitive topic, gaps that could lead to constitutionality issues.

There were at least two attempts to regulate this area in greater detail since the Civil Code came into force on 1 October 2011, however, both law projects were

237 Popescu and Oprea, 2023, p. 195.
238 The 2009 project, in its Senate-approved version, is available (in Romanian) at Romanian Parliament, 2009.
239 Predescu, 2022, p. 222.
240 Health Committee, 2010.

rejected, even if they were initiated by the government or as a cross-party private members' bill.

The first project to be promoted, after the new Civil Code came into force,[241] originated from the government, in 2012.[242] This project was considerably short, comprising 12 articles,[243] and it stated that the human medically assisted reproduction with a third-party donor is organised and controlled by the Health Ministry, and it is supervised and coordinated by the National Transplant Agency. The purpose of the procedure is either to be a remedy for pathological infertility or to prevent the passing of a serious affliction to the offspring.

The crucial question of who is eligible to participate in this type of medical procedure had remained unanswered because the medical criteria for both physical and mental health were supposed to be adopted later by a Health Minister's Order. The cases of infertility that allowed someone to participate in this type of procedure were exemplified as including immunological incompatibility between parents, unknown causes, or the impossibility of contact between two reproductive cells. Medically assisted reproduction with a third-party donor covers both artificial insemination with biological material from said donor or the IVF with reproductive material from a third-party donor. The parents who aimed to participate in such a procedure had to demand it from an authorised medical facility, undergo counselling from medical professionals regarding the chances of success, the risks, adoption possibilities and to be checked for their motives. The project subjected a woman's access to medically assisted reproduction with a third-party donor to the written consent from both her and her husband.

The medical criteria for selecting the third-party donor, regarding the quality and quantity of reproductive material, as well as the physical and mental health of the donor that could influence the offspring, were also delegated by the law project to a subsequent Health Minister's Order. Confidentiality of the procedure was mentioned specifically only in relation to the health personnel involved in this procedure.

This project was finally rejected by the lower house of parliament in 2016 because the draft was considered poorly written from a technical perspective, the rejection report of the parliamentary commission drawing from the objections of the Legislative Council. This project was considered as being too ambiguous, confusing, and as not really offering practical solutions to a delicate and important societal issue.[244]

A subsequent project, the more comprehensive cross-party private members' bill PL-x No. 462/2013,[245] comprised 19 articles.[246] It had similar provisions regarding the role of the Health Ministry and of the National Transplant Agency as the

241 Predescu, 2022, p. 222.
242 PL-x no. 63/2012.
243 Romanian Parliament, 2012.
244 Chamber of Deputies' Judiciary and Health Committees, 2016.
245 Romanian Parliament, 2013.
246 Predescu, 2022, p. 222

previous project. The project was generously stating fundamental principles such as the parents' right to access to medically assisted human reproductive techniques, right to an informed consent, respecting the best interests of the child, safeguarding human dignity, body autonomy, preserving the human species, individuality, and diversity.[247]

The allowed reproductive techniques were artificial insemination, IVF and ET. It specifically prohibited the simultaneous transfer of embryos from different donors. The project had a wider list of prohibited activities in the field of medically assisted human reproduction: altering the human genome and species cross-breeding, selecting the sex of the future child except for reasons related to a sex-related genetic disease, creating human embryos only for research purposes, human cloning, using embryos previously used in research for reproduction, selecting the donor by using eugenic criteria, harvesting reproductive material from a deceased person and intentionally using reproductive material from donors closely related to the beneficiary.

A novelty in this subsequent project, compared with the previous one, was an age restriction for oocyte harvesting by limiting the woman's age to between 18 and 45 years. The law project also stipulated that embryo-transfers and artificial insemination were allowed only for women between 18 and 50 years of age. There was also a novel ten-year time limit for embryo and gametes storage, after which the parents had to express an option about what to do with the stored biological products.

This 2013 project was also structurally incomplete, the statute requiring further details about the enforcement of the law that would have been provided by future governmental decrees drafted by the Health Ministry.

Thus, it was finally rejected by the lower house of parliament in 2022, with a similar reasoning to the previous project, for being not only too ambiguous, lacking enforcement sanctions, being elliptically written and for not offering practical solutions to a delicate social problem, but also for lacking specific financing resources for the stipulated expenses.[248]

7. Conclusion

In Romania, the regulation of human reproductive procedures tends to be extremely scant and general. Although the Civil Code attempted to go further by regulating medically assisted reproduction with a third-party donor, alongside prohibiting eugenics and genetic manipulation without a therapeutic purpose, the special legislation that aimed to implement these generous principles continues to be missing. There remain detailed provisions on transplants, including reproductive

247 Irinescu, 2014, pp. 16–18.
248 Chamber of Deputies' Judiciary and Health Committees, 2021.

cell transplants for IVF, and firm regulations on patient confidentiality and informed consent for any medical procedure, however, these lack a specific focus on reproductive issues. The public financing for reproductive procedures is limited and the regulations that surround it tend to be restrictive and with a traditionalist approach to reproductive health.

Additionally, the haphazard nature of ART regulations affects the rights of the children born out of these medical procedures. Their right to establish their identity clashes with the ambiguous and broad principle of confidentiality. The legal restrictions of MAR with a third-party donor also imply that the children of a single mother who has used the procedure can never legally have a 'biological' father. Unrestrained confidentiality can also endanger the children's right to health by only providing a cumbersome judicial procedure for obtaining vital information about the donor or the procedure itself.

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Chapter 9

Serbia: Assisted Reproductive Technologies – Liberal or Restrictive Approach

Gordana Kovaček Stanić

Abstract

In this chapter, the author analyses Serbian legislation on Assisted Reproductive Technologies (ART) in comparison with the regulation of some European countries, especially where there are discrepancies in regulation. In particular, the following issues are presented: which institutions can perform ART and who covers the costs, which procedures are allowed and which are not, and who the beneficiaries (subjects) of ART are. Special attention is given to children's rights and interests in relation to ART (e.g. the child's right to know his/her biological origin, and the child's right/interest in having two parents).
The court practice on ART in Serbia and comparatively, as well as the court practice of the European Court for Human Rights, is presented.

Keywords: ART, child, rights, motherhood and fatherhood, origin

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1. Policies and Social Attitude Regarding Medical Help Through ART

In 2009, the Law on Treating Infertility by Biomedically Assisted Fertilisation Procedures[1] was adopted, followed by the adoption of the Law on Biomedically Assisted Fertilisation[2] in 2017. What is characteristic of both the 2009 law and the current one is that there was no 'public discussion on the issues raised by the application of biology and medicine, and the answers that should be given to them', as foreseen by the Convention on Human Rights and Biomedicine,[3] to which Serbia is a signatory. Given that these are sensitive issues that require education about the possibilities and benefits they offer, they also necessitate public awareness campaigns to prevent the stigmatisation and discrimination of children born through ART techniques.

In Serbia, certain issues in the field of assisted reproductive technology (ART) were initially regulated by the Family Act 2005.[4] In 2015, Serbia adopted the Draft Civil Code, which also includes provisions related to ART. The most important of these is the provision allowing for the possibility of surrogate motherhood.[5] This procedure would be permitted only if conception is not possible between the intended parents through natural means (sexual intercourse), or with the help of other biomedically assisted methods, or if natural conception or other assisted methods are not desirable due to the serious risk of transmitting a hereditary disease to the child.

Since the publication of the Draft, several public debates have been held, with the issue of surrogacy provoking the most controversy and diverging opinions. Some even argue that the failure to adopt the draft law was primarily due to the inclusion of surrogacy. In response to conflicting public reactions, an expert meeting on surrogacy, titled 'Surrogate Motherhood – Pro et Contra', was held in 2019, organised by the Ombudsman of the Province of Vojvodina.[6] The goal of the meeting was not to take sides in the debate but rather to provide a balanced overview of the key arguments for and against surrogacy. No concrete or final consensus on surrogacy emerged from the discussions.

1 *Zakon o lečenju neplodnosti postupcima biomedicinski potpomognutog oplođenja*, Official Gazette of the Republic of Serbia No. 72/2009.

2 *Zakon o biomedicinski potpomognutoj oplodnji*, Official Gazette of the Republic of Serbia No. 40/2017 and No. 113/2017.

3 Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (ETS No. 164).

4 Family Act, Official Gazette of the Republic of Serbia No. 18/2005, No. 72/2011, and No. 6/2015.

5 See Arts 2272–2281 of the Draft Civil Code, Government of the Republic of Serbia, Commission for Drafting the Civil Code, Belgrade, May 29, 2015.

6 Ombudsman of Autonomous Province of Vojvodina, 2019. The author of this report participated in the expert meeting.

This lack of clarity may not be surprising, considering that the Serbian public is not sufficiently familiar with certain ART-related issues. This conclusion is supported by a 2018 research study conducted in Serbia, which aimed to assess public attitudes toward basic issues related to various assisted reproductive techniques.[7]

A sample was drawn from the adult population of the Republic of Serbia that can be considered highly representative, both quantitatively and qualitatively. Specifically, the sample included more than one thousand respondents, reflecting the true and complete demographic picture of Serbian society across a range of sociodemographic criteria. The following section presents some of the results from this research.

To better understand the social reality surrounding the issue of surrogacy in Serbia, the information gathered in the research is particularly significant. About 42% of respondents support the introduction of this procedure, while 31% are opposed. However, 27% of respondents stated that they 'don't know exactly what it is'. This suggests that, before surrogacy is potentially introduced into the Serbian legal system, there would need to be broader public awareness campaigns to educate and familiarise the public with the issues surrounding surrogacy.

Among those who were unsure about what surrogacy entails, the majority were men, respondents over 60 years old, and those with only an elementary school education. Among citizens who are familiar with surrogate motherhood, 31% do not support its introduction in Serbia, while 42% are in favour of it. Support for the introduction of surrogacy is higher among women under 45 years of age, those with at least a high school diploma, and those living in urban areas.

Given the predominantly traditional views in Serbian society, where even the issue of infertility is often not openly discussed, the results regarding the use of donated materials are not surprising.

One of the questions addressed women's willingness to use donated eggs. Nearly half of the female respondents (49%) indicated they would use someone else's egg if no other method of conception were possible. A third of women (33%) stated that they would not use someone else's egg, while 18% of women were unsure on this matter.

In contrast, men expressed more divided opinions on the issue of using someone else's sperm if no other method of conception were possible. 34% of men said they would use someone else's sperm, 31% were undecided, and 35% of men answered negatively.

If a child were conceived using donated genetic material, a third of the respondents would not tell their child the truth about it. Interestingly, 41% of respondents stated that they would tell their child the truth about the method of conception.

A step further in communicating the truth about conception through the use of donated genetic material to the immediate environment (i.e. relatives and friends) is

7 The research was conducted for the purpose of the doctoral dissertation titled 'Child's Rights in the Field of Medically Assisted Reproduction', by candidate Sandra Samardžić. See Samardžić, 2019.

as follows. About 37% of respondents would not tell their friends and relatives that their child was conceived using donated genetic material. 35% of respondents would share this information with friends and relatives – with support being more common among respondents under 45 years of age. As the level of education increased, so did the percentage of respondents willing to share this information. 28% of respondents were unsure how to answer this question.

Given the relationship between the previous two questions – one concerning disclosure to the child and the other concerning disclosure to relatives and friends – it is important to compare the responses. The discrepancy between those willing to tell the child but not the wider social circle could create significant developmental challenges for the child. There is a noticeable difference, ranging from 5 to 7 percentage points (about 10–15% of the sample), indicating that people are more willing to share the truth with the child than with the broader social environment.

While the Serbian Law on Biomedically Assisted Fertilisation permits the use of donated genetic material, this form of assisted reproduction has only recently been implemented. The primary reason for this delay was the lack of a central bank for reproductive material; another important factor, which persists even today, is the shortage of donors. While it is difficult to accept that no individuals are willing to donate their genetic material, the issue largely stems from public ignorance about the existence of such a possibility in Serbia, in addition to insufficient technical infrastructure. Currently, Serbia imports most of its reproductive material from Spain.

The research also concluded that 31% of Serbian citizens believe it is unjustified for a woman without a partner to use donated genetic material to become pregnant. This opinion is more common among respondents over 60 years old. Just over half of respondents, however, believe that it is justified for a woman to use donated genetic material in such a case. This view is more common among women and respondents under 60 years of age.

Concerns that the ability to choose a child's gender could lead to gender discrimination are justified by the fact that, if given the option, parents may choose male children. Based on the survey data, these concerns appear to be valid. Specifically, 22% of respondents would choose the gender of their child if they could, with 8% preferring a boy and 14% preferring a girl. A more dramatic gender disparity appears when examining the responses of men versus women. As many as 20% of male respondents would choose a male child, while only 4.4% would prefer a girl. Among women, a significantly higher percentage (almost 12%) would choose a girl, compared to just 8.6% who would choose a boy. As shown, men are almost five times more likely to prefer a male child, while the difference for women is much less pronounced.

Finally, just over a fifth of respondents (21%) would choose specific characteristics for their child (e.g. hair colour, eye colour, IQ, etc.). 60% of respondents would not do this, while 19% of citizens were unsure how to answer this question.

2. Constitutional Provisions

One of the most important constitutional principles in connection with ART is the principle of free decision regarding childbirth. Art. 63 of the Serbian Constitution of 2006[8] stipulates: 'Everyone shall have the freedom to decide whether they shall procreate or not. The Republic of Serbia shall encourage the parents to decide to have children and assist them in this matter'.

The principle of free decision regarding childbirth encompasses the right to have children or not, the decision on the number of children, and the interval between births.

This principle was introduced for the first time by the 1974 Constitution of the Republic of Yugoslavia. Art. 191 provided for free decision regarding childbirth as a human right, which could be restricted only on the grounds of health protection.

The principle of free decision regarding childbirth in contemporary society is exercised in accordance with advancements in medicine and technology. In this regard, it is important to note that the Serbian Constitution explicitly stipulates one restriction on the use of biomedicine, which is the cloning of human beings.[9]

The principle of free decision regarding childbirth is also stipulated in the Family Act. Art. 5(1) states: 'The woman has the right to freely decide on birth'.

It should be noted, however, that this formulation encompasses only the woman's right, whereas other rights that constitute family planning are not stipulated. Men, as subjects of particular rights, are not mentioned (e.g. the right to medical treatment to cure infertility). Additionally, the rights of women and men which they exercise jointly, such as access to artificial reproduction technologies, are also not stipulated. Given the formulation accepted in the Constitution – 'everyone shall have the freedom to decide whether they shall procreate or not' – it is obvious that the provision in the Family Act is not sufficiently comprehensive. The provision is accurate only if the right to free decision regarding childbirth actually means free decision if the woman is already pregnant.

Another important principle is that every child has a right to know his/her origins.[10]

In comparative European law, the right to know one's biological origin is recognised as a constitutional category. For example, in Switzerland,[11] there is a provision which guarantees this right. In Germany, in a case concerning a child's right to contest parentage, the Constitutional Court expressed the opinion that children have the right to know who their parents are.[12]

8 The Constitution of the Republic of Serbia was adopted in 2006, Official Gazette of the Republic of Serbia No. 98/2006.
9 Art. 24(3). More on cloning in: Macintosh, 2005. p. 272.
10 Art. 64(2).
11 Guillod, 1993.
12 Frank, 1993.

The Serbian Constitution does not contain a provision on the right to respect for private and family life. Historically, during the period when the state was Serbia and Montenegro, the Constitution Charter on the State Union of Serbia and Montenegro, specifically the Charter on Human and Minority Rights and Civil Freedoms (which was part of the Constitution Charter), contained a provision on this right.[13] It is not clear why a similar provision was not stipulated in the 2006 Constitution of Serbia.

Nevertheless, the importance of the right to respect for family life is recognised in the Family Act. Art. 2(2) states: 'Everyone has a right to have his/her family life respected'.

The respect and protection of human dignity is stipulated in Art. 23 of the Constitution: 'Human dignity is inviolable and everyone shall be obliged to respect and protect it. Everyone shall have the right to free development of his personality if this does not violate the rights of others guaranteed by the Constitution'.

The prohibition of discrimination is stipulated in Art. 21 of the Constitution:

> All are equal before the Constitution and law.
>
> Everyone shall have the right to equal legal protection, without discrimination.
>
> All direct or indirect discrimination based on any grounds, particularly on race, sex, national origin, social origin, birth, religion, political or other opinion, property status, culture, language, age, mental or physical disability shall be prohibited.
>
> Special measures which the Republic of Serbia may introduce to achieve full equality of individuals or group of individuals in a substantially unequal position compared to other citizens shall not be deemed discrimination.

The inviolability of physical and mental integrity is stipulated in Art. 25 of the Constitution: 'Physical and mental integrity is inviolable. Nobody may be subjected to torture, inhuman or degrading treatment or punishment, nor subjected to medical and other experiments without their free consent'.

It is very important, with regard to the application of ART, that the Constitution forbids using medical experiments without the free consent of the individual who is the subject of medical experiments.

The Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, adopted by the Council of Europe (Oviedo Convention), was ratified in 1997. In Serbia, the Oviedo Convention has been in force since 2011. The purpose and object of the Convention are the protection of the dignity and identity of all human beings and the guarantee

13 Art. 24. Charter on Human and Minorities Rights and Civil Freedoms, Official Journal of Serbia and Montenegro No. 1/2003 and No. 6/2003.

of respect for their integrity and other rights and fundamental freedoms, without discrimination, in the context of biology and medicine.[14]

The Convention stipulates that the interests and welfare of the human being shall prevail over the sole interest of society or science.[15]

Parties to the Convention, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality.[16]

Any intervention in the health field, including research, must be carried out in accordance with relevant professional obligations and standards.[17]

Such interventions may only be carried out after the person concerned has given free and informed consent.[18]

This person shall be provided with appropriate information beforehand regarding the purpose and nature of the intervention, as well as its consequences and risks.[19]

3. Medical Regulation of ART

The Law on Biomedically Assisted Fertilisation from 2017 defines the health services authorised to perform ART. These include both state clinics and private clinics. Specifically, they comprise: a health institution from the Health Institutions Network Plan adopted by the Government that performs health activities in the field of gynaecology; a privately owned health institution that performs health activities in the field of gynaecology; and private practice clinics operating in this field.[20] Applications to perform ART shall be submitted by a health institution or private practice to the Directorate for Biomedicine. The Director of the Directorate for ART can revoke the licence if, among other situations, during continuous quality monitoring, it is determined that the quality of ART activities of the health institution or private practice is below the established national quality standards. The national quality standards are adopted by the Minister for Health, on the proposal of the Republic Expert Commission for ART.[21] The Centre for ART and the Bank must establish and manage a quality system according to the principles of good practice. The quality system must contain at least standard operating procedures, guidelines, a training

14 Art. 1 of the Convention.
15 Art. 2 of the Convention.
16 Art. 3 of the Convention.
17 Art. 4 of the Convention.
18 Art. 5(1) of the Convention.
19 Art. 5(2) of the Convention.
20 Art. 14, Law on Biomedically Assisted Fertilisation.
21 Art. 16(5), Law on Biomedically Assisted Fertilisation.

manual, reporting forms, donor records, and data on the final destination of reproductive cells, tissues, and embryos.[22]

Since 2020, procedures under the Law on Biomedically Assisted Fertilisation have become more widely available. Stimulation procedures are now free of charge without limitation, as are three embryo transfers for women until the age of 43 (now extended to 45).[23] For a second child, two stimulation procedures and one embryo transfer are free of charge.

3.1. Medical Technologies

The Law on Biomedically Assisted Fertilisation (2017) defines biomedically assisted fertilisation as a controlled procedure of female fertilisation, conducted in compliance with current medical science standards, and distinct from sexual intercourse.[24]

Assisted reproductive technologies (ART) include *in vivo* fertilisation and *in vitro* fertilisation with embryo transfer. There are two forms of insemination: with sperm from a husband or partner (homologous procedure) and with donor sperm (heterologous procedure).[25] Ova donation, embryo donation are permitted; surrogate motherhood is prohibited, and posthumous fertilisation is not regulated.

The Serbian Law on Biomedically Assisted Fertilisation stipulates which ART procedures are prohibited.[26] These include: the donation and use of reproductive cells or embryos without the written consent of the donor; creation of embryos via *in vitro* fertilisation for the purpose of conducting scientific research; generation or maintenance of an embryo in order to obtain genetic material, cells, tissues, and organs for therapeutic purposes and transfer into the human body; use of embryo parts obtained in ART procedures, except in cases when the law expressly permits this; the creation of embryos with identical genotypes, or embryos that are genetically identical to another living or dead individual (cloning); the creation of hybrids or chimeras with the aim of reproduction or transplantation into a human being or a living form of non-human origin; the transplantation of sperm, ova, embryos or foetuses of a non-human form into a human being, or vice versa; transplantation of nucleotide strings into the human genome; the use of a combination of sex cells from two or more donors (e.g. combining sperm from multiple men or using ova from more than one woman) during ART; ART procedures that involve the simultaneous use of donated egg and sperm cells; the creation of *in vitro* embryos for a purpose other than the creation of a human being; the creation of an embryo out of a cell or a cell fragment taken from embryos or foetuses, or transplanting such an embryo into

22 Art. 18, Law on Biomedically Assisted Fertilisation.
23 State Instructions for Conducting Biomedical Assisted Fertilisation, Official Gazette of Serbia No. 06/2020.
24 Art. 3(1).
25 Art. 13.
26 Art. 49.

a woman's body; merging of human gametes with cells not of human origin (except for the hamster test); the development of a human being outside the womb; inclusion of a woman intending to give the child to a third party, with or without receiving a fee or achieving any tangible or intangible benefits; or the offering of surrogacy services by a woman or other individual, with or without charges or other tangible or intangible benefits; implementation of preimplantation genetic diagnosis, or the selection or artificial alteration of the genetic structure of gametes or embryos for the purpose of selecting the child's sex; the creation of identical twins by artificially splitting early embryos; using sperm or ova from a donor who is closely related by blood to the woman being fertilised, regardless of the degree, including collateral relatives up to the fourth degree of consanguinity, in-laws, and adoptive relatives.

It is forbidden to fertilise an egg using a specially selected sperm sample to influence the child's sex, or to conduct a procedure designed to increase the possibility of obtaining an embryo of a particular sex and to determine the gender of the *in vitro* embryo, unless this can prevent a serious genetic disease that is related to the sex of the child.

The Serbian Law on Biomedically Assisted Fertilisation states that the Centre for Biomedically Assisted Fertilisation or the Bank may not give or distribute reproductive cells, tissues, or embryos to an institution or person contrary to the provisions of this law. Persons from whom the stored reproductive cells, tissues, or embryos originate can, for justified reasons, request their transfer to another centre in the territory of the Republic of Serbia, as well as to another institution outside the territory of the Republic of Serbia that is registered to perform biomedically assisted fertilisation procedures, for the purpose of their own treatment.[27]

Semen, ova, and early embryos are kept for no longer than 5 years, with the possibility of a 5-year extension on the request of the persons from whom the genetic material originates. After that, semen cells and egg cells should be destroyed, and early embryos should be spontaneously decomposed and destroyed. After the storage period, the donor should decide on the future of the reproductive material, with the option of donating it to others or consenting to its use in scientific research.[28]

However, the creation of human embryos for research purposes is prohibited under the Convention on Human Rights and Biomedicine.[29] Scholarly literature on research involving human embryos also emphasises the ethical justification of clinical trials in this area.[30]

Three criminal offences are defined in connection with ART in the Serbian Law on Biomedically Assisted Fertilisation. The punishment is from 2 to 10 years; if the consequences are more serious, the punishment is more stringent. If the consequence is death, then the punishment is at least 15 years. The first criminal offence

27 Art. 52 (4,5).
28 Art. 51. More in: Deech and Smajdor, 2007, p. 159.
29 Art. 18.
30 On ethical justification of clinical trials, more in: Živojinović, 2012, pp. 331–347.

is conducting commercial acts with reproductive cells or embryos.[31] The second includes performing ART without written agreement related to the use of reproductive cells or embryos.[32] The third is conducting surrogate motherhood.[33]

3.1.1. Surrogate Motherhood

The legislation of Serbia does not permit surrogate motherhood. The provisions on motherhood in the Family Act do not create the conditions necessary for the use of surrogate motherhood. In the Family Act, there is an explicit stipulation that the mother of a child conceived through biomedical assistance is the woman who has given birth to the child.[34] The Law on Biomedically Assisted Fertilisation prohibits surrogate motherhood.[35] Besides, it is a crime to include in the ART procedure a woman who has the intention of handing over the child to a third party after birth, or offers surrogate motherhood services, regardless of whether financial or any other kind of gain is involved. It is stipulated that the prison sentence is between 3 and 10 years.[36,37] If the criminal offence is committed against a minor, the perpetrator will be sentenced to three to twelve years in prison. If the consequence is serious physical injury to the donor of the reproductive cells, i.e. embryos, the perpetrator will be punished with imprisonment ranging between 5 and 15 years. If the consequence is the death of the donor of the reproductive cells, i.e. the embryo, the perpetrator will be punished by imprisonment for at least 15 years. If the act was committed by an organised group, the punishment is imprisonment for at least 10 years.[38] In comparison to the prior Law on Treating Infertility by Biomedically Assisted Fertilisation from 2007, the prison sentences are now higher.

There is a great difference between a sperm or egg donation and surrogate motherhood, because the latter includes carrying and giving birth to a child. Pregnancy and giving birth to a child lead to the creation of emotional ties between the mother and the child, which can be difficult to break. Problems that may appear, legal and existential, are extremely sensitive and complicated, and in extreme cases, are

31 Art. 64.
32 Art. 65.
33 Art. 66.
34 Art. 57.
35 Art. 49 (18).
36 Art. 66.
37 It further provides: 'If the act from point 1 of this Art. was done to an underaged person, the perpetrator will receive a prison sentence from three to twelve years. If the act from point 1 and 2 of this Art. caused a serious bodily injury to the donor of reproductive cells, i.e. the embryo, the perpetrator will receive a prison sentence for five to 15 years. If the act from point 1 and 2 of this Art. caused death of the donor of reproductive cells, i.e. the embryo, the perpetrator will receive a prison sentence of at least 15 years. The person who occupies him/herself with the criminal activities from points 1 and 2 of this Art., or the act was committed by an organised group, will receive a prison sentence of at least ten years', Art. 73 (2, 3, 4, 5).
38 Art. 66.

opposed to the principle of the child's best interest. Still, surrogate motherhood is, for some couples, the only possible way to have a biologically related child, which may constitute their most important goal in life. Surrogate motherhood could be permitted only in medically justified cases, where it is the sole means for an individual to have his/her own child. All other motives are unacceptable and prohibited, such as aesthetic reasons or professional obligations that make a woman unwilling to undergo pregnancy and delivery. In life, there are often different interests, and the law often has to decide which interests it wants to protect. Which interest will be protected depends on many circumstances, starting with ethical aspects, social acceptability and, in this case, the advancement of reproductive medicine. By permitting surrogate motherhood, we would be choosing to protect the interest of the infertile couple, i.e. the woman who cannot carry out a pregnancy and her husband/partner.

Negative consequences may arise for children born through international surrogacy, particularly if the child was born in a country that allows surrogate motherhood, but the commissioning parents reside in a country where it is prohibited. The most severe consequence in such cases is that the child may become parentless and stateless.

It is important to stress that allowing surrogate motherhood in Serbia might cause ethical problems. Keeping in mind that Serbian society faces significant economic challenges, financial need could become the primary motivation for women to act as surrogate mothers. In contrast, a woman's economic vulnerability might foster reproductive tourism in a negative sense, which could lead to the exploitation of women. If, *de lege ferenda*, the legislator decides to introduce surrogate motherhood into Serbian law, all these facts should be considered and mitigated. For instance, it may be necessary to permit surrogate motherhood only between women who have a strong connection to Serbia (e.g. through nationality, habitual residence, or domicile).

3.1.2. Posthumous Fertilisation[39]

Posthumous fertilisation refers to the situation where a woman wishes to be fertilised using her husband's/partner's sperm after his death, or to have a frozen embryo transferred into her body after the death of her husband/partner.[40]

Some countries have accepted the practice of posthumous fertilisation; on the other hand, some countries explicitly forbid it. There are countries that do not have explicit regulation, so it is not clear at first glance whether the practice is allowed or not. This procedure is allowed in, for instance, the United Kingdom, Spain, Belgium, Greece, and North Macedonia. However, it is forbidden in, for example, France, Italy, and the states of the region of former Yugoslavia (except North Macedonia).

39 Kovaček Stanić, 2019.
40 Ibid.

Serbian Law on Biomedically Assisted Fertilisation does not have explicit stipulations on whether posthumous fertilisation is allowed or forbidden. Thus, it is necessary to keep in mind relevant Arts that exist in this Act. One of the conditions for performing these procedures is that the couple must be cohabitating at the time the ART procedure is performed.[41] Another requirement is to obtain written consent from all persons who are involved in the procedure, especially before starting each procedure.[42] The consent may be withdrawn in writing until the sperm, unfertilised eggs, or early embryos are transplanted into the woman's body. Prior to inserting sperm, unfertilised eggs, or early embryos, the responsible physician should make sure to check whether there is consent or if it has been withdrawn.[43]

There is another provision that should be mentioned in the context of posthumous fertilisation. This provision states that in the ART process, it is permissible to use reproductive cells and embryos that belong to donors who are alive.[44] Although the Law refers to donors, it is difficult to understand why it is necessary for the donors to be alive – particularly since it is very difficult or sometimes impossible to find out whether the donor is still alive, especially if the donation occurred some time ago and the bank (possibly a foreign one) does not have up-to-date information. It is conceivable that the legislator had in mind the use of the husband's or partner's cells or embryos in posthumous fertilisation when drafting this provision.

One of the arguments against posthumous fertilisation is that the interest/right of the child to have two parents in this procedure is not respected. Under Serbian law, single women have access to AID. Thus, in both cases, the child will not have a father *de facto*, but will have only one parent – the mother. *De iure*, in the situation of posthumous fertilisation, the child will have a father – namely the mother's husband or partner. So, the argument that the child will not have a father to take care of him/her in the situation of posthumous fertilisation is not justifiable, as this is equally applicable in the situation of a single woman as the subject of the process. Considering that Serbian law allows single women to have access to assisted reproduction procedures, it could support a *de lege ferenda* argument in favour of permitting posthumous fertilisation.

It has to be noted that succession law in Serbia does not recognize posthumously conceived children as descendants of their deceased biological parents.[45] If a child has the right to inherit from his biological parents, it is necessary for the legislator to take appropriate action to change the existing law in order to clarify whether

41 Art. 25(1).
42 Art. 27.
43 Art. 28.
44 Art. 41.
45 Art. 3 (2) of the Law on Inheritance of Serbia stipulates that a child can inherit the testator only if the child was already conceived at the time of his death and born alive. Zakon o nasleđivanju, Official Journal of the Republic of Serbia No. 46/1995.

such a child would inherit from the deceased parent and their relatives in the case of posthumous fertilisation.[46]

In Serbian court practice, two cases concerning posthumous fertilisation occurred in 2022. The first case concerned a couple named Marković, who wanted a second child using *in vitro* fertilisation. Five embryos were created, two of which were transferred to the uterus, where they did not survive, and three embryos were frozen. However, the husband died as a consequence of Covid 2019. The Primary Court (*Osnovni sud*) in Belgrade (P. 462/22) denied the wife's petition to retrieve the frozen embryos from the clinic. The wife claimed that she had a right to the embryos on the basis of an inheritance decision.

Later, the Higher Court in Belgrade overturned the judgment of the Primary Court and returned the case for retrial to the Primary Court. The Higher Court stated that the wife did not inherit ownership rights over the embryos in question, but rather the rights and obligations arising from the inheritance documents (Gž. 4356/23 Higher Court Belgrade). The Higher Court noted that nothing in the agreements indicated that the plaintiff's late husband had agreed that the plaintiff could independently use and dispose of the embryos, including transferring them to another institution. Thus, the Court was of the opinion that any disposition, use, and transfer of embryos from one institution to another would be contrary to the will of her husband and contrary to Art. 49(1)(1) of the Law on Biomedically Assisted Fertilisation, which prohibits the donation and use of embryos without the written consent of the donor. In addition, the Court was of the opinion that the inheritance decision cannot be used instead of the husband's consent. Besides, the Higher Court stated that an embryo as the result of the voluntary genetic contribution of two persons can be viewed as a 'thing' under civil law, over which a man and a woman have the right to a kind of co-ownership. However, the Court stated that the embryo represented a *sui generis* thing, i.e. a thing of a special kind, so it cannot be completely subsumed under the rules that regulate the legal status of things in civil law. The Higher Court expressed the opinion that the embryos cannot be in the actual possession of the potential parents or third parties, but only in the Laboratory for cryopreservation.

In a subsequent court procedure, the Primary Court (P. No. 4307/23) issued a new decision, which the Higher Court in Belgrade later amended (Judgment of 18/01/2024). In this decision, the Higher Court adopted the claim of the plaintiff and obliged the defendant, Jevremova Hospital, to hand over two frozen embryos to the plaintiff. This transfer was to be executed in such a way as to enable the Woman Health and IVF Centre, North Cyprus, to take over the embryos and store them in Cyprus. The Court expressed the opinion that the plaintiff had acquired the right to independently make decisions related to the disputed embryos. The Higher Court stated that she has the right to request a transfer to another institution registered for the ART procedure based on the fact that she was declared the heir to the rights

46 Kovaček Stanić, Vidić-Trninić and Samardžić. 2017.

and obligations from the Agreements by a final inheritance decision of the Notary Public.

Regarding the Court's opinion that the wife acquired the right to independently make decisions related to the disputed embryos, the question concerning the legal status of the will expressed in the Agreements should be raised. Does the will constitute some kind of right, and is it heritable or not? It has to be stressed that in inheritance law, only rights and obligations of a proprietary nature are considered heritable. On the contrary, consent is an expression of will, and not in itself a property right. In addition, inheritance law holds that only rights and objects existing at the time of death form part of the estate. It is therefore questionable whether embryos fall into the category of property, given their potential to become a human being. The potential of the embryo to become a human being should affect the legal status of an embryo as a 'thing' in law. In addition, it has to be noted that in inheritance law, there is a rule that legacy consists of all inheritable rights that belonged to the testator at the time of death.[47] If the will and embryo are not inheritable, they actually do not consist of the legacy of the testator. Keeping in mind inheritance law and its rules, it seems the argument on which the Higher Court based its decision is not valid.

The second case involved a married couple named Prizrenac.[48] They chose the ART procedure because the husband was diagnosed with testicular cancer. Ten healthy embryos were created, but the husband died in the meantime. The husband made a last will in which he bequeathed the use of the embryos to the wife. The legal process lasted for several years, and at the end, the Higher Court in Niš made a decision in September 2024, which stated that the frozen embryos belonged to the plaintiff (the wife) and that she would be able to use them in Serbia.

It must be said that it is a pity that Serbian courts in these two cases did not use the opportunity to analyse whether posthumous fertilisation is allowed in Serbia or not, but rather analysed whether the wife has the right to get the frozen embryos after the death of her husband.

3.1.3. Donorship of the Genetic Material

According to the Law on Biomedically Assisted Fertilisation, a donor's reproductive cells or embryos can be used restrictively. The single donor's reproductive cells (or embryos of one pair of spouses or extramarital partners) can be used for only one pair of spouses or extramarital partners, or one single woman. In cases where a child or children are born with donated reproductive cells, that is, embryos, the donor's remaining reproductive cells can only be used exclusively for repeated

47 Art. 1(2), Law on Inheritance.
48 More in: Barać, 2023, pp. 438–475.

ART procedures for the same spouses, that is, extramarital partners, or the same single woman.[49]

In Serbian law, the criteria for becoming a donor include being of optimal reproductive age (men up to 40, women between 21 to 34) and being in physical and mental health. The regulations concerning donors' health are very detailed. In addition, the donor cannot be: the owner of the health institution, the doctor who performs the procedure, the embryologist, or another employee of the institution where ART is performed.[50]

At this moment in Serbia, genetic material banks are not established, so genetic material has to be obtained from abroad (e.g. Spain).

There are examples of children being conceived by donated sperm obtained in licensed clinics, only for it to later be discovered that the medical condition of the donor was not fully investigated. One such case was that of 'Donor 9623'. This case concerned Angela Collins and her partner, who used reproductive material offered by a sperm bank in Georgia. The sperm bank described Donor 9623 as a 'man with an I.Q. of 160 who was healthy and working toward his Ph.D'. However, after seven years, Ms. Collins discovered the man's identity through a donor sibling group and found that the donor had a history of mental illness and a criminal record, and had exaggerated his educational accomplishments.[51] The data available to sperm banks can be incomplete and incorrect. Still, a dilemma remains: how can potentially harmful donor information be reliably verified, if at all? For some children born using donated genetic material, the entire procedure is seen only as a question of money: 'There is a huge monster of money and people desperate for children, who don't want me to make it harder for them to buy and sell children'.[52]

3.1.4. Legal Status of Genetic Material and Embryos

According to Serbian Law on Biomedically Assisted Fertilisation, in the ART procedure, all ova taken in the same procedure can be fertilised. The total number of early embryos that are introduced into the woman's body must not exceed the number that, in accordance with modern medical science, professional experience and practice, promises the success of the ART procedure and, as far as possible, limits the risk of multiple pregnancies. The remaining high-quality early embryos obtained in one procedure are stored and can later be introduced into the woman's body in a new ART procedure, in accordance with this law. The number of early embryos that are introduced into the woman's body requires the joint written consent of both spouses or extramarital partners.[53]

49 Art. 30.

50 Regulations on Detailed Conditions, Criteria and Methods of Selection, Testing and Assessment of Donors of Reproductive Cells and Embryos, Official Gazette of Serbia No. 27/2019 and No. 41/2021.

51 See Kovaček Stanić and Samardžić, 2019, pp. 235–250; Samardzic, 2017, pp. 295–312.

52 Alana, the child of a sperm donor and the activist behind Anonymous.

53 Art. 47.

Sperm, ova and early embryos can be cryopreserved and kept no longer than five years, with the possibility of a five-year extension upon request by the genetic material's originators. After that, sperm and ova should be destroyed, and early embryos should be spontaneously decomposed and destroyed. After this period, individuals must decide how to proceed – whether to donate their genetic material to others or to consent to its use in scientific research.[54] However, the creation of human embryos for research purposes is prohibited in Serbian Law on Biomedically Assisted Fertilisation,[55] as well as by the Convention on Human Rights and Biomedicine.[56] One of the important issues connected with research (including research on human embryos) is the ethical justification of clinical trials.[57]

Under Serbian Law on Biomedically Assisted Fertilisation, persons from whom the stored reproductive cells, tissues or embryos originate can, for justified reasons, request their transfer to another centre in the territory of the Republic of Serbia, as well as to another institution outside the territory of the Republic of Serbia that is registered to perform ART procedures, to be used for their own assisted reproduction.[58]

3.2. Beneficiaries (Subjects) of ART

Under Serbian law, married or extramarital (heterosexual) partners should be considered as subjects of medically assisted fertilisation procedures, since there is no regulation for same-sex partnerships in Serbia. It seems that the rights of homosexual partners should not start from reproductive rights. Exceptionally, the right to a biomedically assisted fertilisation procedure is granted to an adult and legally competent woman living alone, provided she is capable of performing parental duties in the best interests of the child.[59] In the case of donor insemination (AID) for single women, the resulting child will not have a father. This outcome is due to a legal rule that paternity cannot be established for the donor. From the family law aspect, the interest/right of the child to have both parents should be considered. If a single woman has access to AID, this interest/right of the child would not be respected. On the other hand, one can argue that a single woman has reproductive rights, including the right to AID. Whether a single woman would have the right to AID or not depends on which of these conflicting rights the legislator of a particular legislation considers more important: the interest/right of the child to have both parents, or the single woman's right to AID.

Serbian legislation stipulates conditions for beneficiaries: potential parents. These conditions are: majority and legal capacity, cohabitation between beneficiaries

54 Arts. 35(2), 51(6), 51.
55 Art. 49(1), item 2.
56 Art. 18.
57 On ethical justification of clinical trials, more in: Živojinović, 2012, pp. 331–347.
58 Art. 52(4), (5).
59 Law on Biomedically Assisted Fertilisation, Art. 25.

(potential parents), and the capacity to exercise parental rights.[60] The ability of a person to exercise parental rights is assessed by considering whether the person is in such a psychosocial state that it can be reasonably expected that he/she will be able to exercise parental rights, in accordance with the law, in the interest of the child.

There is no doubt that spouses/extramarital partners should meet the above conditions. A question arises, however: what will be the way to determine whether these conditions are met or not? It is extremely important that the persons who are authorised to check the fulfilment of the conditions are competent, and it should be ensured that the process does not burden the ART procedure.

In addition to these conditions, under the previous Law on Treating Infertility by Biomedically Assisted Fertilisation of Serbia from 2009, it was forbidden to include in the procedure of biomedical assisted fertilisation a woman who, due to her age and general state of health, was not capable of giving birth, if she was of an age unsuitable for childbearing.[61] The Law from 2017 does not stipulate this condition.

It can be questioned whether this condition was unjustifiably omitted from the current Law or not. Biomedicine is at such a scientific and technological level that it is possible to apply the procedures of biomedically assisted fertilisation to a woman who is not of an age suitable for childbearing, or rather, an age at which childbirth could not happen naturally. However, keeping in mind social circumstances at the present time and the child's best interests, it seems that the decision to perform ART for a woman who is of an unsuitable age for childbearing should be made very carefully. In the Serbian practice of ART, the official opinion of the Directorate on Biomedicine is that the age limit for a woman who uses donor reproductive cells is 50 years.[62]

3.2.1. Informed Consent to ART

In Serbian law, in order to perform ART, the written consent of all individuals involved in the procedure is required before it is started. Consent is given separately for each ART procedure.[63]

The subjects of ART (spouses, extramarital partners or single women) may withdraw their previously given statement of consent prior to inserting sperm, ova, or early embryos into the woman's body (continuing consent). After the withdrawal of consent, spouses, extramarital partners, or single women must give written consent regarding further procedures with reproductive cells, tissues, or embryos. Prior to inserting sperm, zygotes, or early embryos, the responsible physician should ensure that all parties still consent.[64]

60 Law on Biomedically Assisted Fertilisation, Art. 25(1).
61 Art. 26.
62 Information No. 450-310/23-1 from 6 February 2023.
63 Art. 27(1).
64 Art. 28.

In comparison, there are national laws that similarly stipulate that consent can be withdrawn at any time until the embryo is implanted in the woman's body (legislation of Denmark, France, Greece, Switzerland, the UK, by-laws of the Netherlands, clinical practice in Belgium, Germany, and Finland, etc.).

There are national laws that stipulate that a man can withdraw consent only until the moment of fertilisation, and after that, the woman decides for herself whether and when to continue the procedure, for example in Estonia and Italy. Before amendments, Austria permitted withdrawal of the man's consent only until fertilisation. Now, it is possible to withdraw consent until the implantation of the cells into the woman's body.[65] In Spain, a man can withdraw consent only if he is married to the woman undergoing treatment. The Israeli Supreme Court, in the *Nachmani* case, prohibits the withdrawal of a man's consent after egg fertilisation. In Hungary, a woman can continue fertility treatment even after her husband's death or divorce, unless the contrary was stated in previously given consent.

The case of Mrs. Blood is an important instance involving consent for performing the procedure. The facts of the case are as follows. The husband became ill (meningitis) and fell into a coma.[66] At the wife's request, the doctor took sperm from the husband's body. After the death of her husband, Mrs. Blood asked for his sperm to be given to her, with the desire to have his child. The hospital's response was that the sperm had been taken illegally, and the Human Fertilisation and Embryology Agency in the UK (HFEA) refused to allow its use because there was no written consent from the person it was taken from. In the end, after the media accused HFEA of being a bureaucratic institution, Mrs. Blood obtained the sperm and the insemination was carried out abroad. She now has two children. After this case, the law changed to require explicit consent.

Another famous UK case is *Evans v. UK*. The facts of the case are as follows:

> Ms. Evans decided to have some of her eggs removed prior to cancer treatment, and fertilised with her partner's sperm. The embryos were kept in storage while she underwent her treatment. However, the relationship broke down, and Ms. Evans' partner decided that he no longer wanted to have a family with her. He requested that the couple's embryos be destroyed. Ms. Evans embarked on a lengthy court battle to save her embryos and her right to implant them. At each successive turn, she was turned down, despite the sympathy that judges had with her case. In April 2007, her final appeal was rejected... For the man, the judgment was welcomed as an indication that fatherhood is taken as seriously as motherhood, and that reproductive technology is not to be allowed to reduce the role of men to that of mere fertilisation.[67]

65 *Gesamte Rechtsvorschrift für Fortpflanzungsmedizingesetz, Fassung vom* 04.09.2023.
66 Deech and Smajdor, 2007, pp. 101–106, 217.
67 Ibid., pp. 78–79.

The European Court of Human Rights rendered its decision with reference to the margin of appreciation, noting that the issues raised by the case were undoubtedly of a morally and ethically delicate nature. In addition, there was no uniform European approach in the field. Certain states had enacted primary or secondary legislation to control the use of in vitro fertilisation (IVF) treatment, whereas in others, that was a matter left to medical practice and guidelines. While the United Kingdom was not alone in permitting the storage of embryos and in providing both gamete providers with the power freely and effectively to withdraw consent up until the moment of implantation, different rules and practices were applied elsewhere in Europe. It could not be said that there was any consensus as to the stage in IVF treatment when the gamete providers' consent became irrevocable. While the applicant contended that her greater physical and emotional expenditure during the IVF process, and her subsequent infertility, entailed that her Art. 8 rights should take precedence over J.'s, it did not appear that there was any clear consensus on that point either. In conclusion, therefore, since the use of IVF treatment gave rise to sensitive moral and ethical issues against a background of fast-moving medical and scientific developments, and since the questions raised by the case touched on areas where there was no clear common ground among the Member States, the margin of appreciation afforded to the respondent State had to be a wide one. The margin extended, in principle, both to the State's decision whether or not to enact legislation governing the use of IVF treatment and, once having intervened, to the detailed rules it laid down in order to achieve a balance between the competing public and private interests.[68]

4. Family Law Regulation of ART

4.1. Establishment of Motherhood and Fatherhood

For a long time in legal history, the question of who the mother of a child was raised rarely. The principle from ancient Roman law, *mater semper certa est etiam si vulgo conceperit*, was broadly accepted.[69] The mother was the woman who gave birth to the child. In contemporary family law, statutory provisions often establish or define motherhood. This is so in Serbian family law as well. Motherhood resulting from ART in Serbia is regulated in the Family Act.[70] There is an explicit stipulation that the mother of the child conceived with biomedical assistance is the woman who has given birth to the child.[71] The legislator has given primacy to the fact of carrying

68 *Evans v. The United Kingdom* (2007) 46 EHRR 34.
69 Corpus Juris Civilis, Dig. 2.4.5: '*quia semper certa est, etiam si vulgo conceperit*'.
70 More in: Kovaček Stanić, 2010, pp. 147–161.
71 Art. 57(1).

and delivering the child over genetic origin. Regardless of the fact that the child can be conceived with a donated ova (or embryo), the legal mother is the woman who has given birth to the child. That means that even if the child is not carrying her genetic characteristics, the woman who has given birth to the child is the legal mother. The other rule concerns the prohibition of establishing the motherhood of the woman who has donated the ova.[72] The purpose of donating genetic material is that the woman who wants the child, and whose ova cannot be fertilised, obtains an ova from another woman, which is then fertilised with the sperm of her partner. After the transfer of the embryo into the body of the woman who wants the child, she carries and gives birth to the child. In that case, the child carries the genetic characteristics of the woman donor and the partner of the woman who wants the child. Considering that the child will be raised by the woman who delivered the child, establishing the motherhood of the woman who donated the *ova* would not have any purpose. However, if there is a (covered up) case of surrogate motherhood, this stipulation has a much greater significance, because the very mother whose ova is fertilised wants to be the mother.

Serbian legislation does not permit surrogate motherhood. The relevant acts are the Family Act of Serbia and the Law on Biomedically Assisted Fertilisation. The Family Act has not created conditions for the use of surrogate motherhood, as it is stated that the mother is the woman who gave birth to the child. The Law on Biomedically Assisted Fertilisation explicitly prohibits this practice.[73]

The previous law regulating ART in Serbia – the Law on Treating Infertility by Biomedically Assisted Fertilisation – had a provision that stipulated that the woman who gave birth to the child was to be considered as the child's mother.[74] This Law also forbade the establishment of the donor's maternity.[75] In addition, this Law explicitly established who the mother of the foetus was, stating that the mother was the woman who was carrying the foetus, or was carrying the foetus as the result of an implantation of the embryo or sperm or ova in her body/womb in the process of a biomedical assisted conception.[76] It might be said that this kind of solution is unusual in comparative law. The reason for incorporating this provision in the Law by the Serbian legislator is questionable, as it seems unnecessary and legally inexplicable. In addition, the Law forbade contesting motherhood in situations where the ova of the same woman (or early embryo) was used, if she gave consent to this procedure.[77] This provision seems unnecessary because if the ova from the same woman was used for the conception, this woman was the mother, both genetic and gestational, and she did not have any interest in contesting maternity. It would be logical to forbid contesting maternity if the ova of another woman (donor) was used, so if the woman

72 Art. 5(2).
73 Art. 49(18).
74 Art. 65(2).
75 Art. 65(4).
76 Art. 65(1).
77 Art. 65(3).

who gave birth to the child consented to the use of donor ova, she should not have a right to contest biological (genetic) motherhood. The Serbian legislator failed to regulate this situation, however.

In comparative law, the Human Fertilisation and Embryology Act of 1990 of the UK specifically regulates maternity in relation to ova and embryo donation. It is stipulated that a woman who carries or has carried a child born as a result of placing an embryo or sperm and ova cells in her body, and no other woman (27.1), is considered a mother. The bio-ethical laws of France allow and regulate the donation of gametes – both male and female – and embryos. The gamete donation procedure includes giving consent in the presence of a notary or a judge, who informs the parties about the consequences related to the parenthood of the future child.[78] If the embryo of another couple is used, the written consent of all persons is required, and in addition, the judge decides on the use of the embryo, basing the decision on the interests of the future child.[79] Gamete donors (woman or man) must live in a heterosexual union and have children within that union, and consent must also be given by the other member of the couple.[80]

Swedish law, starting in 2005, allows heterologous artificial insemination and in vitro fertilisation for lesbian partners, in addition to partners of different sex. In that case, the woman who gives birth to the child is the child's mother, and the other woman gets the status of parent. The condition is that the procedure is carried out in a state hospital. Consent to the procedure – given either in a registered or de facto partnership – leads to legal parenthood for the consenting woman, equivalent to that of the birth mother. The parenthood of a woman who has given consent must be established in a special way, based on her written acknowledgment with the presence of witnesses or on the basis of a court decision, if there is no acknowledgment. Recognition can be given even before the birth of the child and must be confirmed by the council for social care and the mother who gave birth to the child.[81]

The most recent procedure of ova donation is a donation of only a part of an ova – mitochondrial DNA. In this case, there are three genetic parents of the child: two genetic mothers and a father. Legally, the child has one mother (the woman who delivers the child) and a father. One of the potential outcomes of the recent research is the ability to create a human embryo without any male genetic contribution – by transferring the nucleus of a somatic cell from one woman into an enucleated ovum of another. In that case, the child would not have a genetic father at all.

Marital fatherhood is established based on the legal presumption that the mother's husband is the father of the child (*pater is est quem nuptiae demonstrat*),

78 Art. L152-5.

79 Ibid.

80 Art. L673-2.

81 Provisions of the Children and Parents Code (1949:381) (Föräldrabalken), in particular Section 1, Part 9 as amended by the Act (SFS 2005:434), and the Insemination Act (1984:1140) (amended SFS 2005:443) and the Law (1988:711) on Fertilization Outside the Body (amended SFS 2005:445); Jänterä-Jareborg, 2005.

while non-marital fatherhood is established with acknowledgment or through court proceedings. In other words, according to Serbian law, marital fatherhood is established *ex lege*, while non-marital fatherhood must be established with the acknowledgment of the father or through court proceedings.

The Serbian Family Act regulates the fatherhood of the child conceived through biomedical assistance as well, stating that the mother's husband (or the mother's partner) is to be considered the father of a child conceived through biomedical assistance, provided he has granted written consent to the procedure of biomedical assisted fertilisation.[82] That means, if the mother's husband has not granted written consent to the procedure of biomedical assisted fertilisation with donated sperm, he can contest his fatherhood. If the mother's partner has not granted written consent to the procedure of biomedical assisted fertilisation, he will not be considered as father, as there is no legal presumption that the mother's partner is the father of the child born in non-marital cohabitation.

The fatherhood of the man considered to be the child's father may not be contested, except if the child was not conceived through the procedure of biomedical assisted fertilisation. If a child is conceived through biomedical assistance by donated semen, the fatherhood of the man who donated the semen may not be established.[83] A man considered to be the father of a child conceived through biomedical assistance may initiate action to contest his fatherhood within one year from the day of learning that the child was not conceived through a procedure of biomedical assisted fertilisation, and no later than ten years from the birth of the child.[84]

The ground for establishing legal fatherhood in a case of using the donor's semen (or donated embryo) is consent of the husband/partner to AID (or using embryo donation). The genetic link does not have any impact on establishing fatherhood.

The previous law regulating ART in Serbia – the Law on Treating Infertility by Biomedically Assisted Fertilisation – had stipulated that the father of the child conceived by biomedical assisted fertilisation is the mother's husband or partner if he has consented in writing to the procedure in which his sperm be used. In addition, this Law forbade establishing the paternity of the donor if the donor's sperm was used in the procedure.[85] This Law forbade contesting paternity in the situation of using sperm of the mother's husband or partner, unless there was reasonable doubt that he was not the father, as his sperm was not used in the procedure.[86] This Law, though, omitted to regulate situations where the mother's husband or partner consented in writing to the procedure in which donor's sperm would be used. There is no provision that would forbid contesting paternity in this situation. This omission enables the mother's husband or partner to change his mind regarding AID and initiate

82 Art. 58(1, 2).
83 Art. 58(3, 4, 5).
84 Art. 252(5)
85 Art. 66(1, 3).
86 Art. 66(2).

court proceedings to contest his paternity, leaving the child fatherless, as the Law forbids establishing the donor's fatherhood. Unfortunately, Serbian legislators show a lack of understanding of family law relations that might arise from AID. It is a kind of relief that the existing Law abandoned such controversial solutions on parenthood using ART, as some of them were not just theoretically inconsistent, but contrary to the best interest of a child.

5. Rights of the Child and ART

The use of artificial reproductive technologies for the conception of a child leads to situations where it is necessary to review the traditional postulates of family law. One such rule originates from Roman law, and it concerns protecting the interests of a conceived but unborn child: '*Infans conceptus pro iam nato habetur quoties de commodo eius agitur*'.[87]

In the context of ART, the question arises whether it is possible to consider the protection of the interests of a child who has not even been conceived yet. Should society take into account the interests of the future child, considering the fact that conception occurs through the use of ART, which is regulated by law?

In family law literature, the best interest of the future child is considered in terms of assessing the suitability of future parents; thus, the conditions that future parents should meet are prescribed by national laws. These conditions enable future parents to access ART.

5.1. The Child's Right/Interest to Have Two Parents

When it comes to the interests of a future child conceived through the use of ART, a question can be raised as to whether it is in the interest of the child to have the parental care of two parents. This question is raised in the context of the situation of a woman without a partner using ART. A child born in this way will have only one parent – the mother, both in terms of legal and factual parenthood. In the Law on Biomedically Assisted Fertilisation of Serbia from 2017, as already mentioned, it is stipulated that a woman who lives alone has the right to these procedures, even though this possibility is only exceptional.[88] The law, however, does not specify which cases should be considered exceptional, nor does it state the reasons that would justify exceptionality.

87 Stojčević and Romac, 1980, p. 199.
88 Art. 25(2).

There are examples of legislation that take into account the child's interest in having two parents and provide solutions for its realisation.[89]

The child's psychological interest in having two parents, in the sense of identification with the parents, and developmental interest, in the sense of being brought up by two different people, can be satisfied by the solution that exists in the law of the UK.

This solution is 'supportive parenting'. Single women have to meet the requirement of supportive parenting to have access to ART.[90] To implement this requirement, UK guidelines state:

> Where the child will have no legal father, the centre should assess the prospective mother's ability to meet the child's/children's needs and the ability of other persons within the family or social circle willing to share responsibility for those needs.

Supportive parenting seems like a good solution that enables two persons to be involved in raising the child, and in that way, to respect the interest/right of the child to have both parents.

In Serbian society, family relations are very important for family members and very well developed. Thus, it would not be difficult for a single woman to find a relative who would be able to help her in raising a child. In Serbia, social relations are developed as well. Thus, friends of a single woman would help her. This is the reason why I would suggest introducing the supportive parenting solution in Serbian law *de lege ferenda*.

The material interest of the child to have two parents is reflected in the right to maintenance and the right to inheritance. The right to maintenance is taken into account in German practice. In Germany, this is regulated by professional guidelines issued by the medical boards of provinces (*Landesärztekammern*), which refer to the Model Guidelines on Assisted Reproduction issued by the Federal Medical Council of Germany (*Bundesärztekammer*) in 2006, revised significantly in 2017.[91] According to Art. 3.1.1., assisted reproduction is generally reserved for married couples. A woman without a spouse can be allowed access to ART techniques, but only if the doctor is assured that the woman has a permanent male partner who is willing to acknowledge the paternity of the child to be born.[92] The practice, however, differs significantly from the current regulations. Thus, in Germany, there are clinics that allow access to ART to women who do not have a partner, and the usual practice is

89 More in: Kovaček Stanić, 2020, pp. 121–135.

90 Section 14 (2) (b) of the Code of Practice developed under the HFEA.

91 Richtlinie zur Durchführung der Assistierten Reproduktion of February 17, 2006, para. 3.

92 It is interesting that same-sex partners in Germany have the right to conclude a marriage and to adopt children. Single persons have the right to adopt children as well. However, neither same-sex partners nor single parents have access to adoption under Art. (§ 1741 II 1 BGB).

that medical assistance is conditional on the woman specifying a person who agrees to pay child maintenance; very often, it is the woman's parents.[93]

In some countries, there is a strong opinion that the child's interest in having two parents through the application of ART does exist. As a consequence, a woman without a partner is not allowed access to these procedures (for example, in France and Austria).[94]

In some countries, access to ART is allowed for persons in a same-sex union, bearing in mind the fact that in those cases, the child will have two parents (albeit of the same sex). If it is about two women, the child will have a mother and a second parent, and if it is about two men, the child will have a father and a second parent. Such is the situation, for example, in Sweden and Austria. Swedish law has allowed heterologous artificial insemination and *in vitro* fertilisation for lesbian partners since 2005.[95] In contrast, a woman without a partner did not have the right to access ART until 2016.[96]

The Austrian Constitutional Court, while considering the solution of the Austrian law on which persons have access to ART, made a decision enabling access to *in vitro* fertilisation for women who are in a same-sex union, through donated sperm cells. However, that possibility was not provided to women without a partner (decision of the Constitutional Court from January 2015).[97]

As far as posthumous fertilisation is concerned, one of the arguments against it is the fact that the child would not have a *de facto* father. *De iure*, the father is the mother's husband or partner. So, the interest of the child to have two parents who will take care of him/her is the reason why some countries do not allow posthumous fertilisation. One of the arguments in favour of posthumous fertilisation is the respect of the reproductive right of a woman to have a child, regardless of the fact that her husband/partner is not alive.

As said before, in Serbian law, apart from married or heterosexual partners who are considered as subjects of medically assisted fertilisation procedures, exceptionally, an adult and legally capable woman living alone who is able to perform parental duties in the best interest of the child is entitled to the right to a biomedical assisted fertilisation procedure.[98] Donor insemination (AID) for a single woman results in a child who legally has no father, as paternity of the donor cannot be established. The child thus has only one legal parent – the mother. From the family law aspect,

93 Lettmaier, 2019, p. 30.

94 Kovaček Stanić, 2018.

95 *Föräldrabalken* (1949:381), Chapter 1, Part 9 (SFS 2005:434); Law on insemination (1984:1140) (amended SFS 2005:443); and Law on Fertilisation Outside the Body (1988:711) (amended SFS 2005:445); *Jänterä-Jareborg*, 2006.

96 Assisted Pregnancy for Single Women, Parliamentary Committee Report, 2015/16, SoU3. 22.01.2012.

97 *Fortpflanzungsmedizingesetz* § 14: Donor sperm cells can be used for ART for at most three married couples or couples in unions similar to marriage.

98 Art. 25.

the interest/right of the child to have both parents should be considered. If the single woman has access to AID, this interest/right of the child would not be respected. On the other hand, one can argue that a single woman has reproductive rights, including the right to AID. This situation has some similarities with posthumous fertilisation. In both cases, the child will not have a father *de facto*, he/she will have only one parent – the mother. *De iure*, in the situation of posthumous fertilisation, the child will have the father as the father is the mother's husband or partner. So, the argument that the child will not have a father to take care of him/her in the situation of posthumous fertilisation is not justifiable, as this is the same in the situation of a single woman as a subject of the process. Bearing in mind that Serbian law allows a single woman to have access to assisted reproduction procedures, it could be argued that posthumous fertilisation in Serbian law should be allowed *de lege ferenda*.

In the case of posthumous conception of the female partner with the fertilised cells of the deceased spouse/partner, the father of the child is to be considered the man whose sperm cells were used for fertilisation, and who is also the biological father of the child, provided that he agreed to this type of fertilisation.[99] However, succession law in Serbia does not recognize posthumously conceived children as descendants of their deceased biological parents.[100] Arguing that the child should have the right to inherit from biological parents, we consider it necessary for the legislator to take appropriate action to change the existing law in order to guarantee the right of the child to inherit from his deceased parent and his relatives if posthumous fertilisation in Serbian law *de lege ferenda* would be allowed.[101]

5.2. The Child's Right/Interest to Know His/Her Biological Origin

There are three basic interests of an individual in knowing his or her genetic origin: a psychological need for identity, a desire to know medical history, and an interest connected to the bloodline, which is material rather than psychological. The psychological interest is expressed in the desire and need to know one's parentage. This interest is most pronounced during adolescence, when the person's identity is formed. The medical interest is essential in starting a family, because of the potential genetic defect that may be inherited by the future child of a particular person. This interest gains importance with the realisation that, if a way of life is adopted according to the potential risk of hereditary diseases running in certain families, the occurrence of disease may either be prevented or delayed, or the disease may occur in a less aggravated form. Information on the course of the disease and the results of its treatment, provided to the relatives of the deceased can be of great use to doctors.

99 Kovaček Stanić 1997, Kovaček Stanić, 2010; Kovaček Stanić, 2021.

100 Art. 3, para. 2 of the Law on Inheritance of Serbia stipulates that a child can inherit the testator only if the child was already conceived at the time of his death and born alive. Law on Inheritance, Official Journal of Serbia No. 46/1995.

101 Kovaček Stanić and Samardžić, 2019.

The third, material interest is expressed in the right of the child to receive maintenance and inherit property from the parents and other relatives. It may be said that the medical and material interests are by nature rational, while the psychological interest is predominantly irrational.

The provisions of the Convention guarantee the right of the child to identity formation[102] and preservation.[103] Art. 7(1) states:

> The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents.

The Convention was ratified by former Yugoslavia in 1990 and is in force today in the Republic of Serbia.

The Act on Insemination of Sweden, back in 1984, introduced the right of a child whose conception was the result of artificial insemination by donor sperm to know the identity of the donor. That was a departure from the principle of donor anonymity, and such a solution may be called revolutionary in its approach to ART. In Sweden, the donation of ova was introduced in 2002, and the child also had the right to know the identity of the donor of the ova. A number of countries have also introduced the right of a child to know the identity of the donor. For instance: the UK, Austria, the Netherlands, and Switzerland.

Sweden stipulated that a child obtains the right to get information on donor identity when he/she reaches the necessary level of maturity. Other countries have also introduced this law, with ages varying: from the age of 14 in Austria, 16 in the Netherlands, and at 18 without any conditions – or at another age if material interest is proved – in Switzerland. The data on the donor should be kept for up to 80 years from the birth of the child in the Netherlands and Switzerland.

There are a number of countries that have retained the principle of secrecy regarding information on donors. For example, Serbia, Russia, and France. In Russia, under the Federal Law on the Basic Health Protection of the Citizens in the Russian Federation, it is stipulated that in the usage of donor reproductive cells and embryos, citizens have the right to obtain information on the medical, medical-genetic examination of the donor, his race, nationality, and outward appearance, according to Art. 55(8).

In Serbia, the 2006 Constitution stipulates that every child has the right to know his/her origins.[104] However, according to the Law on Biomedically Assisted Fertilisation of Serbia, the child has the right to obtain only medical data of the donor. In the Law,[105] it is stipulated:

102 Art. 7.
103 Art. 8.
104 Art. 64(2).
105 Art. 57.

The child conceived by biomedically assisted fertilisation (ART) with reproductive cells of the donor has a right to ask for medical reasons to get data on donor from the Board of Directors for Biomedicine kept in the State Registry. This right the child obtains when reaches 15 years of age if is able to reason.

These data are not on personal nature of the donor, but only the data of medical importance for the child, his future spouse or partner, or their future offspring.

Legal representative or guardian of the child may ask for these data form the Board of Directors for Biomedicine on the permission from the court in extra civil procedure given if justifiable medical reasons exist.

The medical doctor of the child may ask, for medical reasons, information from the State registry to prevent risk to child's health…

5.3. The Interest of the Ill Child: Preimplantation Genetic Diagnosis and Saviour Siblings

There are specific cases of using medically assisted reproduction that pose moral and ethical concerns, which result in diametrically opposite views. One of them is the use of preimplantation genetic diagnosis[106] to obtain a perfectly matching donor for an already born child who is ill – saviour siblings.

However, pre-implantation genetic diagnosis (PGD) is primarily used in conjunction with IVF to reduce the risk of passing on inherited conditions. For couples that have a history of genetic diseases, this procedure could be lifesaving, as they will use only healthy genetic material that is free from any condition. It was not until recently that states began to regulate this technique and allow it only in cases when there is a strong likelihood that parents will pass on a genetic disease. However, this possibility served as an option for parents who have a child with a condition that requires donation of bone marrow or stem cells, but neither the parents nor anyone else in the family is a matching donor. With the use of PGD, they can choose only embryos that have been found to be perfect donors.

Two cases concerning saviour siblings have become very well known: the *Hashimi case* and the *Whitaker case*. In the first case, the child Zain was born with a blood disorder known as Thalassemia Major. His condition could be cured by stem cells from a compatible donor. The probability of having a child who would be an adequate donor was one in four, and Mrs. Hashimi decided to give birth to another child, given that existing siblings could not be donors to little Zain. However, as the pregnancy revealed that the baby was also a carrier of the disease, Mrs. Hashimi decided to terminate the pregnancy. As a result of the next pregnancy, a healthy boy was born,

106 Pre-implantation genetic diagnosis (PGD or PIGD) is the genetic profiling of embryos prior to implantation (as a form of embryo profiling), and sometimes even of oocytes prior to fertilisation.

but he was not a compatible donor. Subsequently, Mr. and Mrs. Hashimi managed to obtain embryos through the IVF procedure, but only two embryos were found not to be carriers of the disease and suitable to be donors to Zains. However, although one embryo was implanted, the pregnancy was not successful. In the second case, a boy named Charlie Whitaker suffered from a rare form of anaemia, which was the result of a genetic mutation, and that was the decisive fact for the court. Namely, their request was rejected by the Human Fertilisation and Embryology Authority in the UK, on the basis that, unlike the Hashimi case, Charlie's disease was not hereditary but caused by a spontaneous genetic mutation. This means that the chances of Mr. and Mrs. Whitaker having another child with the same form of anaemia were negligible. This, however, raises the question of whether it is morally justified to conceive and give birth to a child for that purpose only. Of course, those parents claim that they will love the other child the same way as the previous one, and that the specific conditions under which the child will be born will have no effect on the child's future life. Very often, parents and judges are prone to view this issue as a conflict between a sick child and an embryo and to conclude that academic principles are not enough to forbid the only possible solution for treatment. In addition, they see that embryo as enormously advantaged by the intervention, since it would never have been selected or born if this procedure had not occurred.[107] However, indeed 'you have got to have a very powerful reason to resist the means by which [a child's] life can be saved'.[108]

In Serbia, it is explicitly stated that the PGD procedure is permitted, but only when there is a risk of passing on inherited conditions, for the diagnosis of chromosomal and genetic diseases, or if it is necessary due to a repeated unsuccessful ART procedure.[109]

6. Concluding Remarks

It is not easy to establish whether Serbian legislation follows a liberal or restrictive approach regarding ART. It could be said that whether the approach is defined as liberal or restrictive depends on the following main issues: which institutions can perform ART and who covers the costs, which procedures are allowed and which are not, and who are the beneficiaries (subjects) of ART.

Regarding health services that perform the activity of ART in Serbia, the approach is liberal, as both state clinics and private clinics are able to perform ART.

107 Foster, 2009, p. 58.
108 Doctor plans 'designer baby' clinic. See BBC News, 2001.
109 Art. 47 (1), Law on Biomedically Assisted Fertilisation.

The license for the performance of ART is issued by the Directorate for Biomedicine (Law on Biomedically Assisted Fertilisation 2017).

ART has been more widely available since 2020, as the procedures for stimulation are free of charge without limitations, and three embryo transfers for women until the age of 45 are also free of charge. For the second child, two procedures for stimulation and one embryo transfer are free of charge (State Instructions for Conducting Biomedical Assisted Fertilisation 06/2020). In this sense, the approach to ART is liberal.

The Serbian Law on Biomedically Assisted Fertilisation 2017 regulates *in vivo* fertilisation and *in vitro* fertilisation with embryo transfer, insemination by husband/partner, insemination by donor sperm (heterologous procedure – AID), and procedures involving ova and embryo donation. Surrogate motherhood is not allowed, and posthumous fertilisation is not regulated. It could be concluded that the approach is more liberal than restrictive. The only explicit restriction is that surrogate motherhood is forbidden. One of the arguments against posthumous fertilisation is that the interest/right of the child to have two parents in this procedure is not respected. Under Serbian law, single women have access to AID, so the interest/right of the child to have two parents is not respected. Thus, in both cases, the child will not have a father *de facto*; he/she will have only one parent – the mother. *De iure*, in the situation of posthumous fertilisation, the child will have a father, as the father is the mother's husband or partner. So, the argument that the child will not have a father to take care of him/her in the situation of posthumous fertilisation is not justifiable, as this is the same in the situation of a single woman as the subject of the process. It should be noted that the law is not coherent in the regulation of these two procedures, so this is an issue for *de lege ferenda* to solve.

Beneficiaries (subjects) of ART in Serbia are married persons, heterosexual extramarital partners, and single women. Same-sex partners do not have access to ART, as there are no regulations for same-sex partnerships in Serbia. It could be concluded that the approach is more liberal than restrictive, as heterosexual extramarital partners and single women are considered eligible for ART.

Serbian law is restrictive regarding donor ART, as a single donor's reproductive cells or embryos of one pair of spouses or extramarital partners can be used for only one pair of spouses or extramarital partners, or one single woman. In cases where a child or children are born with donated reproductive cells, that is, embryos, the donor's remaining reproductive cells can be used exclusively for the repeated ART procedure in the same couple of spouses, that is, cohabiting partners, as well as the same single woman.

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Chapter 10

Slovakia: The Regulation and Practice of Assisted Reproductive Technologies and the Best Interests of the Child[1]

Lilla Garayova

Abstract

Assisted Reproductive Technologies (ART) have transformed family-building options globally. However, their regulation remains a complex and evolving legal and ethical challenge. In Slovakia, ART operates within a fragmented legal framework, shaped by constitutional principles, family law provisions, medical ethics, and public policy. This study examines the current state of ART regulation in Slovakia, focusing on key issues such as access to fertility treatments, legal parentage, embryo protection, and the rights of children born through ART. The research highlights the limitations of Slovakia's outdated legal provisions, particularly the lack of comprehensive ART legislation. Furthermore, the study analyses the role of constitutional protections, the intersection of ART with bioethics, and Slovakia's obligations under international human rights law. Public discourse and policy debates reveal a tension between traditional family values and the need for a more inclusive approach to ART.

1 This chapter was finalised in December 2024, with the peer reviews concluded in March 2025. It therefore reflects the state of Slovak legislation prior to the constitutional amendment adopted in September 2025 and in force since 1 November 2025 (Constitutional Law No. 255/2025 Coll.), which, *inter alia*, introduced a constitutional ban on surrogate motherhood (Art. 15), enshrined the recognition of only the two biologically determined sexes of man and woman (new Art. 52a), constitutionalised the definition of parents as mother (a woman) and father (a man), tightened the rules on adoption of minors in favour of married couples (Art. 41), and added a national identity / cultural-ethical sovereignty clause (Art. 7(6)–(7)). While these changes largely elevate to constitutional rank principles that already existed in Slovak statutory law, their entrenchment at constitutional level is nonetheless significant.

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1. Introduction

Assisted Reproductive Technologies (ART) have revolutionised the possibilities for family-building, offering hope to individuals and couples facing infertility. In Slovakia, as in many other countries, the increasing use of ART has given rise to complex legal and ethical challenges that must be navigated with care. Slovakia's particular legal framework – influenced by strong protections for unborn life and traditional notions of family – makes the governance of ART especially complex. The significance of this topic is evident: it touches on fundamental rights (such as the right to found a family and the rights of the child), sensitive moral questions, and pressing social needs amid demographic changes.

One of the central tensions in the Slovak ART debate revolves around the status of the human embryo and the scope of reproductive choice. The Slovak Constitution's pro-life ethos has prompted questions about how far the state should go in shielding embryonic life. Notably, the Constitutional Court has intervened to balance these interests: in a landmark 2007 decision on abortion law,[2] it ruled that while prenatal life is indeed 'worthy of protection', embryos do not enjoy the full rights of born persons.

Beyond the debates surrounding embryonic life, broader ethical and legal dilemmas persist concerning the eligibility criteria for accessing ART and under what conditions such access should be granted. Slovak legislation, influenced by traditional notions of parenthood, currently limit access strictly to infertile heterosexual couples. These measures are often justified by invoking the public interest – such as protecting the welfare of children, the sanctity of the family, or public moral values. However, they also provoke debate over the appropriate extent of government intervention in dictating deeply personal reproductive choices.

These issues do not exist in a vacuum. Slovakia's restrictive approach to ART carries significant implications in light of the nation's demographic challenges and the broader European context. Given these demographic pressures, one might expect a shift toward more permissive reproductive policies or greater state support for infertility treatment as a pronatalist strategy. Yet, Slovakia remains one of Europe's most conservative jurisdictions in the ART domain. Across Europe, there is a patchwork of ART regulations – from countries that openly allow single women or

2 Decision of the Constitutional Court of the Slovak Republic, PL. ÚS 12/01-297 (4 December 2007).

LGBTQ couples to pursue ART, to those that impose strict limitations. Slovakia firmly aligns with the latter group.

Ultimately, the complexity of ART regulation in Slovakia raises critical questions about the future. How can Slovak law strike an optimal balance between protecting embryos as well as reproductive autonomy? Should access to fertility treatments remain restricted to certain social groups, or is there room for a more inclusive approach that reflects evolving definitions of family? Furthermore, to what extent should the state intervene in personal decisions to create a family, especially as medical advances continue to expand what is possible? These questions are not only legal and policy-oriented but also profoundly philosophical. As demographic realities evolve and international human rights standards develop, the Slovak debate on assisted reproduction will undoubtedly intensify, inviting societal reflection on how best to navigate the delicate boundaries between life, law, and liberty in the context of human reproduction. This chapter uses doctrinal analysis of Slovak legislation, relevant European and international instruments and case law to examine whether the regulation of access to ART, legal parentage and children's rights forms a coherent protective framework. Its contribution is to identify the legal consequences of the mismatch between these regulatory domains and to distinguish existing legal obligations from proposals for reform.

2. Policies Regarding Medical Help Through ART

ART has revolutionised family planning, providing new hope to those who cannot conceive naturally. In Slovakia, however, the conversation surrounding ART is shaped by a delicate balance of tradition, ethics, and law. This raises fundamental questions such as – who should have access? How do we protect the rights of the child? Where do we draw the line on practices such as surrogacy? These are the questions that have fuelled policy debates, divided public opinion, and shaped legislation in the country.

On the one hand, there is strong attachment to the traditional concept of family as rooted in marriage and biological ties. Slovak society has long valued family stability and views marriage between a man and a woman as the ideal foundation for raising children. This perspective influences both policy and public support, favouring access to ART for heterosexual married couples. On the other hand, modern realities – including increased infertility, evolving family structures, and international human rights obligations – have challenged these long-standing norms.

Public discussions on ART in Slovakia reveal tensions between innovation and tradition. Supporters of expanded access advocate for a more inclusive approach, one that recognises the rights of single women, same-sex couples, and those experiencing social infertility. Critics, however, often highlight ethical concerns regarding

embryo manipulation, donor anonymity, and the commodification of human life. These ethical dilemmas have made certain practices, such as surrogacy, especially controversial.

In 2020–2021, conservative lawmakers in the governing coalition sparked public debate by proposing to restrict access to *in vitro* fertilisation (IVF). For instance, MP Anna Záborská and her colleague Katarína Hatráková argued that 'artificial fertilisation is not a health procedure' and pushed to discontinue its public insurance coverage. Their view was that infertility treatment is not medically necessary and that taxpayers should not 'finance' it, thereby framing IVF as an elective procedure or even an unethical practice. These statements drew criticism from medical professionals and demographers. Branislav Bleha, a prominent Slovak demographer, called the debate 'misguided, unsubstantiated, and argumentatively unfounded'.[3]

Even more contentious are the debates surrounding access to ART for individuals outside the traditional male–female partnership. *De jure*, single women and LGBTQ couples are largely excluded from assisted reproduction in Slovakia. Moreover, Slovak public opinion on allowing ART for single women or same-sex couples is mixed and has been influenced by broader attitudes on LGBTQ rights. As Slovakia has no legal recognition of same-sex partnerships, there is no legal basis for a gay or lesbian couple to apply jointly for fertility treatment or to be recognised as co-parents of an IVF child. Surveys consistently exhibit Slovaks as relatively conservative on issues such as same-sex marriage and adoption. This caution extends to ART as well. For example, as of 2021 more than half of the European countries allowed single women or lesbian couples access to ART. However, Slovakia was among the countries that prohibited IVF for these groups in its national policy.[4]

Underlying these discussions is the distinction between medical infertility (a diagnosed reproductive impairment) and social infertility (the inability to conceive due to one's social situation, such as lacking an opposite-sex partner). Slovak law and insurance policies currently address only medical infertility. Conservative voices insist that public resources should go solely toward treating medical conditions, not 'lifestyle choices'. This was evident in the 2020 parliamentary debate, where MPs argued that IVF should not be funded for those who are not physiologically infertile – implying that single women or same-sex couples should not have a claim to fertility treatment.

State policies reflect these competing values, offering limited financial support for ART while restricting its availability based on strict eligibility criteria. The role of the Slovak ombudsman and human rights organisations has become increasingly important in this debate. Their recommendations emphasise children's rights, including the right to know their biological origins and the right to family life, while advocating for clearer legal protections in ART-related cases. The Public Defender of Rights has weighed in on ART-related issues primarily in the context of broader

3 DENNÍK, 2020.
4 CIVIO, 2021.

human rights – notably the rights of LGBTQ individuals and children. In a formal statement in 2017, the Ombudswoman (Mária Patakyová) addressed the lack of legal recognition for same-sex couples in Slovakia. She noted that certain family rights contingent upon relationship recognition – such as the ability to adopt children or access assisted reproduction – remain under the purview of each state's laws. The European Court of Human Rights had affirmed that these 'supplementary' rights (such adoption by same-sex partners or ART access) are not guaranteed and fall within states' margin of appreciation.[5] In essence, her recommendation was that Slovakia should at least legally recognise same-sex unions – a step that would lay the groundwork for discussing related rights such as ART. While the Ombudsman's statement stopped short of explicitly urging immediate access to IVF for gay couples, it underscored that denying them recognition (and by extension any avenue to family-building rights) is inconsistent with human rights commitments.

Official documents and strategies have treated ART as part of healthcare and demographic policy (given low fertility rates), while legal reforms specifically addressing ART ethics or access criteria have experienced slower development. The Health Ministry's clinical guidelines on infertility (updated in 2023) also emphasise improving patient awareness and preserving fertility (e.g. egg freezing for oncology patients), reflecting a policy focus on reproductive health services as legitimate medical care.[6]

Slovakia's legal framework for assisted reproduction is riddled with inconsistencies, ambiguity, and a lack of coherent policy direction. This fragmented approach results in misinterpretation and circumvention, allowing assisted reproduction clinics to operate in a regulatory grey area. Without clear guidelines and enforcement mechanisms, clinics can shape their practices in ways that may not fully align with ethical or legal standards. The absence of a comprehensive legal foundation creates uncertainty for patients, medical professionals, and policymakers alike.

At the international level, key human rights instruments offer critical guidance in the regulation of assisted reproduction. One such instrument is the Universal Declaration on the Human Genome and Human Rights,[7] adopted by UNESCO in 1997 and subsequently endorsed by the United Nations General Assembly in 1998. This declaration emphasises the protection of human dignity in the application of genetic science, setting a precedent for ethical medical practices globally. A cornerstone of European biomedical law is the Oviedo Convention on Human Rights and Biomedicine (commonly referred to as the Oviedo Convention).[8] Adopted in 1997, it establishes fundamental rights in the field of biomedicine, including the principles

5 Verejný Ochranca Práv, 2017.
6 Ministry of Health of the Slovak Republic, 2023.
7 UNESCO, 1997.
8 Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (ETS No. 164. Oviedo, 4 April 1997).

of informed consent, protection against discrimination, and the prohibition of genetic manipulation except for strictly therapeutic purposes. Slovakia demonstrated its commitment to these principles by signing the Convention on 4 April 1997 and becoming the first Eastern European country to ratify it on 15 January 1998. The Convention entered into force for Slovakia on 1 December 1999 and was promulgated by Notification No. 40/2000 Coll. of the Ministry of Foreign Affairs of the Slovak Republic.[9] This legal framework has since served as a reference for legislative improvements in Slovakia's biomedical and reproductive health laws.

The right to access infertility treatment is increasingly recognised as a fundamental human right, linked to Art. 14 (prohibition of discrimination) and Art. 8 (right to respect for private and family life) of the European Convention on Human Rights (ECHR).[10] Additionally, the European Parliament resolution on the demographic future of Europe emphasises that infertility treatment should be accessible without discrimination based on factors such as religion, belief, disability, age, or sexual orientation. However, in Slovakia, restrictive conditions continue to impede access to assisted reproduction for certain groups. One notable barrier is the requirement for an intimate relationship between a man and a woman, which effectively excludes single women and same-sex couples from accessing ART services. Critics have pointed out that this policy is discriminatory and inconsistent with Slovakia's human rights obligations under international and European law.

These international conventions and resolutions have played a significant role in shaping Slovakia's legislative processes. Beyond highlighting shared European values centred on human rights, they have prompted ongoing political debate and legal reform efforts. The incorporation of the Oviedo Convention into Slovak law has led to heightened awareness of the need to strengthen legal protections in the field of reproductive health. This has encouraged lawmakers to consider aligning national laws more closely with European human rights standards, particularly in areas where existing regulations fall short of ensuring equal access to assisted reproduction technologies.

Slovakia's commitment to ethical considerations in the realm of biomedicine is underscored by its ratification of the Additional Protocol to the Convention Council of Europe for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, specifically on the Prohibition of Cloning Human Beings.[11] This protocol, in force since 1 March 2001, unequivocally

9 Notice of the Ministry of Foreign Affairs of the Slovak Republic on the conclusion of the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine – Convention on Human Rights and Biomedicine, Collection of Laws No. 40/2000.

10 Convention for the Protection of Human Rights and Fundamental Freedoms (Council of Europe Treaty Series 005, Council of Europe, 1950).

11 Additional Protocol to the Convention Council of Europe for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, specifically on the Prohibition of Cloning Human Beings.

prohibits any intervention seeking to create a human being genetically identical to another human being, whether living or deceased. Furthermore, Slovakia has ratified the Additional Protocol on Biomedical Research, emphasising the crucial role of ethics committees, thorough evaluation of research merits, the duty of care, and the necessity of informed, free, express, specific, and documented patient consent, as articulated in Art. 14 of this protocol.[12] These ratifications affirm Slovakia's dedication to upholding human dignity and rights in the context of biomedical research and underscore its alignment with international standards and principles.

In 1983, Slovakia achieved its first successful artificial insemination at the Gynaecology and Obstetrics Clinic of the Faculty Hospital in Bratislava.[13] Despite this significant milestone in the advancement of reproductive medicine, there was no specific legal regulation in place at the time to govern the procedure or related medical practices. Healthcare professionals operated within an environment largely defined by expert guidelines and ethical principles rather than formal legislation. The absence of a legal framework reflected broader limitations under the socialist regime, where medical advancements were not always accompanied by corresponding regulatory development. In spite of this milestone, up until 1983, Slovakia lacked a specific legal framework governing artificial insemination and IVF. At the time, healthcare professionals and clinics relied primarily on expert guidelines and ethical principles, rather than legislation, to regulate medical practices in this field. These guidelines were not legally binding and often reflected the prevailing medical understanding and ethical standards of the era. The absence of codified legal provisions reflected broader systemic limitations in healthcare regulation under the socialist regime. Furthermore, ART were still relatively new and largely experimental, which further contributed to this regulatory void.

The first regulatory efforts in assisted reproduction in what was then Czechoslovakia emerged shortly after initial successes with ART. In 1982, the Ministry of Health of the Czech Socialist Republic issued Measure No. OP-066.8.-18.11.1982 concerning the conditions for artificial insemination.[14] This measure was issued as sub-legislative norms under Act No. 20/1966 Coll. on the Care of People's Health,[15] which served as the overarching legal framework for public health services in Czechoslovakia.

Despite these measures, regulation in the area of medically assisted procreation techniques remained fragmented and limited. These early provisions, while offering some legal structure, did not address the full scope of reproductive technologies, such as IVF, embryo transfer, or cryopreservation. Furthermore, the measures were

12 Additional Protocol to the Convention on Human Rights and Biomedicine, concerning Biomedical Research, CETS No. 195, Strasbourg, 25 January 2005, Article 14; promulgated in Slovakia by Notification No. 494/2007 Coll.

13 Soukupová and Budayová, 2009, p. 26.

14 Ministry of Health of the Czech Socialist Republic, Measure No. OP-066.8.-18.11.1982 concerning the conditions for artificial insemination.

15 Act No. 20/1966 Coll. on the Care of People's Health.

restrictive, applying artificial insemination only to married couples and imposing stringent conditions on eligibility. As a result, much of the regulatory landscape continued to depend on the discretionary practices of medical professionals.

In respect to Slovakia's domestic legislation, the first comprehensive legal act pertaining to Medically Assisted Procreation (MAP) techniques within Slovak jurisdiction is embodied in the Measure of the Ministry of Health of the Slovak Socialist Republic, numbered 24/1983 (hereinafter, Measure No. 24/1983), which delineates the conditions governing MAP.[16]

Notably, this measure still exists without repeal, and several of the stipulations it prescribes have been supplanted by subsequent legislation. It is worth noting that the legal framework governing ART in Slovakia has been critiqued by numerous experts, including those not directly engaged its implementation. According to prevailing expert consensus, this regulatory framework is deemed insufficient, antiquated, and lacking in conceptual clarity. Remarkably, this regulation, which has endured for four decades, operates as a sub-legislative norm with relatively limited legal force. Obtaining access to the text of this measure requires considerable patience and research enthusiasm, given its age and relative obscurity. Indeed, despite its historical significance and the fact that it is still in force, compliance with this measure is frequently overlooked. However, in a state governed by the rule of law, adherence to such regulatory frameworks is imperative.

Although never officially repealed, Measure No. 24/1983 appears to be largely disregarded in practical applications. Nevertheless, it delineates certain parameters and reasonable limits that merit attention. First and foremost, it restricts artificial insemination to married couples, mandating joint application by both spouses. Under Measure No. 24/1983, the approach to artificial insemination was explicitly defined in Section 1 (1) as a medical procedure accessible only to married couples. While artificial insemination was strictly linked to marriage, the measure permitted the use of either the husband's semen or that of an unrelated male donor when necessary. This stipulation reflected the measure's attempt to balance the protection of traditional family structures with the practical realities of infertility treatment. Furthermore, it confines artificial insemination to instances where medical reasons – such as fertility disorders in the husband, female genitalia disorders, the risk of hereditary diseases or developmental defects, and other impediments preventing the couple from conceiving healthy offspring together – necessitate intervention. Crucially, artificial insemination, as per Measure No. 24/1983, is sanctioned solely for women of full age, typically under the age of 35. In cases where the husband's sperm is unusable, the measure allows for the use of donor sperm selected by a medical professional, contingent upon the consent of the spouses. Anonymity between the spouses and the donor is stipulated, with the doctor responsible for ensuring that the donor has no blood relation to the woman. The criteria for the admissibility

16 Measure of the Ministry of Health of the Slovak Socialist Republic No. 24/1983 of the Bulletin on the modification of conditions for artificial insemination (No. Z-8600/1983-D/2).

of artificial insemination were outlined in Section 2 (2) of the measure. It stipulated that the procedure could only be performed for medically justifiable reasons. These included fertility disorders in the husband, anatomical abnormalities or other disorders of the female reproductive system, risks of hereditary diseases or developmental defects, and other medical impediments preventing the couple from conceiving healthy offspring together. Before any assisted reproduction procedure could proceed, a comprehensive assessment of both spouses' health was required, with a focus on evaluating fertility and genetic risks. Furthermore, the regulation imposed an age limit for women, typically under the age of 35, alongside the requirement for both spouses to possess full legal capacity.

Measure No. 24/1983 defines artificial insemination as 'a medical procedure whereby insemination is carried out on a woman with her husband's semen or the semen of another man'. This definition confines artificial insemination to the specific act of insemination and excludes considerations for practices such as insemination outside the mother's body, embryo transfer, cryopreservation, and so on. Significantly, these advanced practices were not contemplated when this measure was created, reflecting the evolution and expansion of ART beyond the scope initially envisaged by this regulatory framework.

Moreover, the measure addressed the donation of sperm, which was permissible under certain conditions. It mandated strict anonymity between the donor and the recipient couple to protect privacy and prevent any potential conflicts of interest. Donors were prohibited from having any direct blood relation to the woman or being her sibling. Additionally, a donor had to be under the age of 40 to ensure the quality and viability of the genetic material.

According to Section 6 (3) of the Measure, the decision to perform artificial insemination had to be approved by the department's chief physician, based on a recommendation from the attending physician who would perform the procedure. This hierarchical decision-making process underscored the emphasis placed on medical oversight and accountability within the socialist healthcare system.

Additionally, the measure provided for public health insurance coverage for assisted reproduction procedures, reflecting the socialist state's commitment to ensuring access to healthcare services. An essential component of the regulation was a standardised template for the couple's informed consent, a precursor to the modern concept of informed medical consent. This document formalised the couple's agreement to the procedure, demonstrating early recognition of patients' rights to participate in decisions concerning their reproductive health.

In the subsequent development of Slovakia's legal framework for assisted reproduction, Act No. 362/2011 Coll. on on Medicinal Products and Medical Devices and Amending Certain Acts, adopted in 2011, played a key role.[17] This act established regulations for the use of medical devices, which are crucial to the field of assisted reproduction. These devices include technologies such as embryonic culture media

17 Act No. 362/2011 Coll. on Medical Devices.

and other specialised equipment used in IVF procedures. The law provided much-needed oversight and safety standards for medical devices, ensuring that advancements in reproductive technology adhered to stringent quality and safety protocols.

Complementing this legal framework, additional regulatory measures were introduced through Government Regulation of the Slovak Republic No. 20/2007 Coll. on details on procurement, tissue and cell donation, criteria for selection of tissue and cell donors, laboratory tests required for tissue and cell donors, and procedures for procurement of cells or tissues and their acceptance by a health care provider,[18] which was amended in 2014 and subsequently repealed by Section 35 of Act No. 317/2016 Coll. This regulation addressed crucial processes surrounding tissue and cell donation, including the necessary medical and laboratory tests for donors, thereby reinforcing procedural safety and compliance with EU standards.

A further addition to the regulations were accompanied by Government Regulation No. 622/2007 Coll. of 12 December 2007,[19] which establishes details regarding the processing, preservation, storage, or distribution of tissues and cells, as well as the reporting and investigation of adverse reactions and events, and the implementation of corrective measures. This regulation provided essential guidelines for the management of tissues and cells, including measures to monitor and address any complications or adverse events.

Both regulations were introduced to transpose key provisions of Directive 2004/23/EC of the European Parliament and the Council,[20] as well as Commission Directive 2006/86/EC,[21] into Slovak law. These directives set comprehensive standards for donor selection, tissue processing, and distribution to ensure the safety and ethical handling of human tissues and cells, including those used in assisted reproduction.

Another key regulation relevant to assisted reproduction, particularly from the perspective of determining parentage, is Act No. 36/2005 Coll. on the Family, as amended. This Act outlines the legal principles and procedures for establishing parentage in cases involving assisted reproduction. However, since this study will address family law provisions separately, a detailed examination of these aspects will

18 Government Regulation of the Slovak Republic No. 20/2007 Coll. on details on procurement, tissue and cell donation, criteria for selection of tissue and cell donors, laboratory tests required for tissue and cell donors, and procedures for procurement of cells or tissues and their acceptance by a health care provider.

19 Government Regulation of the Slovak Republic No. 622/2007 Coll., detailing the processing, storage, warehousing, or distribution of tissues and cells and the reporting and investigation of adverse reactions and events and the measures taken.

20 Directive 2004/23/EC of the European Parliament and of the Council of 31 March 2004 on setting standards of quality and safety for the donation, procurement, testing, processing, preservation, storage, and distribution of human tissues and cells.

21 Commission Directive 2006/86/EC of 24 October 2006 on implementing Directive 2004/23/EC of the European Parliament and of the Council with respect to traceability requirements, notification of serious adverse reactions and events and certain technical requirements for the coding, processing, preservation, storage and distribution of human tissues and cells.

be deferred to a later section, where their impact on parentage, custody, and adoption will be analysed comprehensively. This separation allows for a clearer focus on the regulatory framework specific to medical and procedural aspects of assisted reproduction in the current section.

In Slovakia, multiple centres specialising in assisted reproduction offer a diverse array of services. However, the expansive scope of care furnished by these centres is incongruent with the quality of the legal regulation governing these intricate techniques. Until 2017, MAP was only regulated in secondary legislation.[22] Given the myriad moral, ethical, and legal complexities intertwined with the implementation of MAP techniques as well as with their profound impact on human rights, the preservation of dignity, and the obligations emanating from international conventions binding the Slovak Republic, relying solely on norms possessing lesser legal force for such an extended duration is untenable within a state governed by the rule of law. Indeed, until 2017, this area was governed solely by secondary legislation – a significant shortcoming given the serious ethical, moral, and legal implications involved.

In 2016, Act no. 317/2016 Coll., titled on Requirements and Procedures for the Collection and Transplantation of Human Organs, Human Tissues and Human Cells and on Amendments to Certain Acts,[23] was enacted to align the transposition of six binding EU directives.[24] This legislation is commonly referred to as the Transplantation Act. Despite the incorporation of this legislation, a conspicuous void persists as Slovakia's legal framework lacks a precise definition for assisted reproduction, resulting in a regulatory landscape characterised by fragmentation and disarray. It is worth noting that, in the absence of a dedicated legal definition, the regulation of ART in Slovakia's jurisdiction is marred by an inherent lack of coherence.

Human rights possess an internationally recognised nature that transcends state recognition, as states determine the extent of legal protection rather than the existence of these rights. In the context of legislation in Slovakia and its implications for the protection of unborn life, various approaches can be considered. A critical aspect is the absence of a clear legislative definition of embryos, which has led to

22 Key secondary legal acts: Government Regulation of the Slovak Republic No. 20/2007 Coll. on details on procurement, tissue and cell donation, criteria for selection of tissue and cell donors, laboratory tests required for tissue and cell donors, and procedures for procurement of cells or tissues and their acceptance by a health care provider, as amended by Government Regulation No. 119/2014 Coll.; Government Regulation of the Slovak Republic No. 622/2007 Coll, detailing the processing, storage, warehousing, or distribution of tissues and cells and the reporting and investigation of adverse reactions and events and the measures taken, as amended by Government Regulation No. 9/2016 Coll.

23 Act No. 317/2016 Coll. on Requirements and Procedures for the Collection and Transplantation of Human Organs, Human Tissues and Human Cells and on Amendments to Certain Acts.

24 European Parliament, Council of the European Union Directive 2004/23/EC; European Commission Directive 2006/17/EC amended by European Commission Directive 2012/39/EU; European Commission Directive 2006/86/EC amended by European Commission Directive 2015/565; European Parliament, Council of the European Union Directive 2010/53/EU; European Commission Directive 2012/25/EU; European Commission Directive (EU) 2015/566.

ambiguity in the treatment of surplus embryos resulting from MAP techniques. The legal framework addressing the activities of MAP techniques is primarily found in the Transplantation Act. Specifically, Art. 2(5) of the Transplantation Act defines reproductive human cells as human tissue or human cells intended for the purpose of assisted reproduction. However, there is a notable gap in the legislation, namely, the lack of a specific definition clarifying whether human cells intended for assisted reproduction encompass embryos.

This legislative void leaves the handling of surplus embryos in the domain of ART without explicit legal guidance. The absence of a distinct definition for embryos in the Transplantation Act contributes to the broader challenge of determining the legal status and protection afforded to unborn life in Slovakia. Clarifying this conceptual ambiguity is imperative for establishing a comprehensive legal framework that aligns with the principles of human rights and ethical considerations associated with ART. The legislative process behind the development of the Transplantation Act, especially the inter-ministerial comment procedure, is of particular significance. Notably, a substantive comment of considerable significance emerged during this process. The petitioner introduced a distinctive definition in Art. 2(15) of the draft Transplantation Act, asserting that 'Reproductive cells are tissue or cells intended for the purpose of assisted reproduction. A human embryo shall not be considered as reproductive cells'. This proposed provision was then submitted to the Legislative Council of the Government of the Slovak Republic, a perpetual advisory body to the government. During its fifth meeting, held on 12 July 2016, the Council advocated for a modification to the proposal, documented under reference number 22125.[25] The revised version was recommended for submission to the Government of the Slovak Republic for deliberation. However, a twist emerged during the Government's meeting on 16 August 2016, where a modified and entirely new iteration of the Transplantation Act secured approval. Notably, the initially proposed provision of Section 2 (5), encompassing the essential comment from the inter-ministerial comment procedure, was omitted. Instead, the original definition of reproductive cells was reinstated in the draft, emphasising that 'Reproductive human cells are human tissue or human cells intended for the purposes of assisted reproduction'. This turn of events meant that the question of whether embryos can be considered reproductive human cells was left unanswered. This is significant because according to the European directives that the Transplantation Act transposes, the reproductive cells intended for assisted reproduction encompass not only ova and sperm but also embryos. This interpretation introduces additional layers of complexity to the laws surrounding ART, necessitating thorough scrutiny and clarification.

The fate of unused reproductive cells in cases of partner donation is addressed in Section 4 (3) of the Transplantation Act. This provision stipulates that unused reproductive cells may be handled in one of three ways: they may be utilised for

25 Minutes of the fifth meeting of the Legislative Council of the Government of the Slovak Republic in VII. election period held on 12 July 2016, see Žitňanská, 2016.

other reproductive purposes, allocated for scientific research, or disposed of under regulated conditions. The act does not impose rigid restrictions but instead provides a framework within which decisions can be made, balancing reproductive rights, medical ethics, and scientific needs. In reproductive contexts, this provision allows flexibility for couples who have undergone assisted reproduction. For example, if surplus reproductive cells remain after a successful procedure, these cells may be preserved for potential future use by the same couple or for another reproductive process involving different recipients, provided that consent and relevant legal conditions are met. This aligns with the principle of maximizing medical resources while respecting patients' autonomy and informed consent. Alternatively, the law permits the use of these reproductive cells in scientific research. This option is significant in advancing medical knowledge and improving reproductive health treatments, particularly in the areas of fertility preservation, embryo development, and genetic research. However, the allocation of cells for research purposes is subject to ethical oversight to ensure compliance with international standards on the use of human biological materials. Lastly, if neither reproductive nor research purposes are pursued, the law requires the disposal of unused cells in a manner that complies with medical and ethical guidelines. This ensures that the handling of human tissues, even in cases where no further use is intended, is conducted with respect for human dignity and public health standards.

Overall, the Transplantation Act is a significant piece of legislation addressing cell, tissue, and organ donation, emphasising the quality and safety of donated cells to mitigate the risks of infection and disease transmission during transplantation. The Transplantation Act serves as a conduit for transposing six EU directives, some of which touch upon the donation of gametes for assisted reproduction purposes. Consequently, amendments have been incorporated into national law, recognising that the donation of reproductive human cells between partners in an intimate relationship, regardless of marital status, constitutes partner donation. Moreover, the written informed consent of the donor for partnered donation extends to encompass the potential use of unused reproductive cells for other reproductive purposes, scientific research, or disposal.

This legislative shift marks a departure from the earlier mandatory measures that exclusively mentioned spouses in the context of artificial insemination. Influenced by EU directives, the Transplantation Act extends the provision of assisted reproduction to unmarried partners who declare an intimate physical relationship. However, it is crucial to note that while the Transplantation Act is often regarded as a legal basis for assisted reproduction for non-marital couples in practice, the directives themselves should not be interpreted as an overarching legal foundation for the legalisation of specific assisted reproduction procedures. Directive 2004/23/EC, which establishes quality and safety standards for donated human tissues and cells, explicitly states that it should not conflict with Member States' decisions regarding the use or non-use of specific types of human cells, including germ cells and embryonic stem cells. Consequently, if national legislation does not permit certain methods of

gamete use, the directive cannot be construed as a basis for altering such legislation. Nonetheless, the prevailing practice in Slovakia suggests that artificial insemination is performed on individuals beyond the confines of marital relationships.

Paradoxically, the absence of a comprehensive legal framework notwithstanding, these techniques continue to receive financial support through public health insurance mechanisms. The provision of assisted reproduction services funded by public health insurance is contingent upon adherence to indications delineated in secondary legislation. Government Regulation No. 776/2004 Coll., as amended, prescribes the Catalogue of Health Performances, delineating distinct health care procedures for assisted reproduction. This regulatory framework[26] outlines the parameters for one cycle prior to oocyte retrieval, one cycle encompassing oocyte retrieval for IVF without embryo transfer, and one comprehensive cycle involving embryo transfer. These specified cycles are established as integral health care procedures within the realm of assisted reproduction. However, the current regulatory framework lacks precise terminology when addressing the specific methods offered by assisted reproduction centres. The existing language within the regulation does not provide a detailed and comprehensive elucidation of the various ART available at these centres.

The regulatory framework governing assisted reproduction in Slovakia is further delineated by Government Regulation No. 777/2004 Coll., which is instrumental in determining the extent of coverage provided by public health insurance for various treatments. This regulation identifies a list of diseases and specifies the treatments that fall under different coverage categories, including full coverage, partial coverage, or no coverage at all. In the context of artificial insemination, IVF, and other assisted reproduction methods, the public health insurance system extends coverage for a maximum of three cycles of assisted reproduction procedures. This coverage is applicable to women up to the age of 39, contingent upon specific medical conditions. The enumerated medical reasons that warrant public health insurance coverage for assisted reproduction procedures include: missing fallopian tubes or irreversible damage to the fallopian tubes (excluding conditions resulting from previous sterilisation or abortion); endometriosis in women; irreversible damage to the ovaries, excluding damage resulting from an abortion; idiopathic sterility; male sterility factors such as azoospermia, asthenospermia, ejaculatory dysfunction, and conditions related to chemotherapy or post-traumatic situations; immunological causes of sterility; and the risk of hereditary diseases preventing the couple from conceiving healthy offspring, and endocrine causes of sterility.

As a result of this government decree, the public contributes to the co-payment of artificial insemination procedures for the specified medical reasons, including techniques such as IVF with embryo transfer. This approach ensures that individuals with certain medically recognised conditions have access to assisted reproduction procedures with financial support from the public health insurance system. The

26 Government Regulation No. 776/2004 Coll.

regulation reflects a targeted and nuanced approach to coverage, aligning with medical necessity and contributing to a more inclusive and accessible assisted reproduction framework in Slovakia.

Since April 1, 2016, health insurance companies in Slovakia have no longer required prior approval for covering IVF procedures under public health insurance. Unlike in the past, patients no longer need to submit a formal request to obtain approval for assisted reproduction treatments. Health insurance providers now automatically cover IVF procedures in accordance with applicable legislation. Similarly, from August 1, 2017, prior approval is not required for medications used in IVF treatment. This change was implemented based on a decision by the Ministry of Health's Categorisation Commission.

Health insurance coverage for assisted reproduction is regulated by Government Regulation No. 777/2004 Coll., which operates under Section 3 (10) of Act No. 577/2004 Coll. on the scope of healthcare services provided through public health insurance. According to this regulation, a maximum of three cycles of assisted reproduction procedures is covered for women up to the age of 39 (i.e. up to 39 years and 364 days). Coverage is granted only under specific medical conditions related to infertility, as outlined in Annex No. 2, Part V of the regulation. These conditions include: (a) Absent or irreversibly damaged fallopian tubes, confirmed by laparoscopic or laparotomic diagnosis, except where the condition results from prior sterilisation or induced abortion. (b) Endometriosis, confirmed through laparoscopic or laparotomic diagnosis. (c) Irreversible damage to the ovaries, confirmed biochemically or through laparoscopic or laparotomic examination, unless the damage is due to a previous induced abortion. (d) Idiopathic sterility, defined as unexplained infertility that has failed to respond to one year of treatment at a specialised healthcare facility. (e) Male infertility factors, including azoospermia (absence of sperm), asthenospermia (reduced sperm motility), ejaculatory dysfunction, or conditions resulting from chemotherapy or trauma, verified by an andrologist. (f) Immunological causes of infertility, confirmed through laboratory testing. (g) Genetic risks, where hereditary conditions prevent the couple from conceiving healthy offspring, verified by a genetic specialist. (h) Endocrine causes of infertility, verified by an endocrinologist.

For cross-border healthcare within other EU Member States, health insurance coverage for IVF requires prior approval from the Slovak health insurance provider before the procedure begins. This includes not only the approval of the IVF procedure itself but also the coverage of associated medications. The patient must obtain this approval in advance for the reimbursement of costs incurred abroad. The conditions and eligibility criteria for coverage remain identical to those applicable within Slovakia, as defined by Government Regulation No. 777/2004 Coll.

In addition to standard coverage, health insurance providers in Slovakia offer various supplementary benefits and discounts for reproductive medicine services. These benefits may include financial contributions toward advanced procedures such as intracytoplasmic sperm injection (ICSI), comprehensive sperm analysis, and preimplantation genetic diagnosis (PGD). These enhanced services aim to provide

patients with greater access to innovative reproductive technologies while improving the overall quality of care.

The incongruity between the absence of a clear legal definition and the concurrent financial support via public health insurance raises pertinent questions regarding the coherence and adequacy of the existing legal framework governing assisted reproduction. The coexistence of financial support within the public health insurance paradigm and the lack of a comprehensive legal definition underscores the urgency for a more systematic and coherent approach to regulating these intricate techniques.

In Slovakia, the principles of confidentiality and informed consent, along with the legal and ethical aspects of collecting and safeguarding information, are clearly defined by national law. Furthermore, the right of a patient to provide informed consent, particularly in the context of diagnostic procedures such as genetic tests, is recognised as one of the fundamental patient rights. According to national law, any intervention in the health field, including diagnostic procedures, can only proceed after the concerned individual has provided free and informed consent. This involves the individual receiving appropriate information regarding the purpose and nature of the intervention, as well as being informed about its potential consequences and risks. Importantly, the person retains the autonomy to freely withdraw consent at any point during the process. Emphasis is placed on the right to medical secrecy or confidentiality, ensuring that everyone has the right to privacy concerning information related to their health. This includes a commitment to respecting the private life of individuals in the context of their health information.

The processing of personal data and the protection of the rights of data subjects are subject to specific regulations outlined in Regulation (EU) 2016/679 (GDPR) and Act No. 18/2018 Coll. on Personal Data Protection. This legal framework sets forth provisions for the responsible handling of personal data and the safeguarding of the privacy and rights of individuals during data processing activities, aligning with contemporary standards of data protection and privacy.

Conscientious objection within the realm of assisted reproduction, as well as other medical procedures such as abortion and sterilisation, is safeguarded for healthcare professionals in Slovakia. This protection is explicitly outlined in the Code of Ethics for Healthcare Professionals, an annex to Act No. 578/2004 Coll. on Healthcare Providers. According to the Code of Ethics, healthcare professionals – including doctors, nurses, and pharmacists – are not compelled to participate in acts that go against their conscience. Per this provision, 'a healthcare professional may not be required to perform or participate in a performance that is contrary to his or her conscience, except in cases of imminent danger to the life or health of persons'. This clause acknowledges and respects the individual ethical and moral considerations of healthcare practitioners. In cases where a healthcare professional invokes conscientious objection, they are obligated to inform their employer and, if applicable, their patients. This transparency ensures that alternative arrangements can be

made to address the healthcare needs of patients while respecting the conscientious objections of the healthcare professional.

Furthermore, the legal framework in Slovakia extends beyond individual practitioners to protect healthcare facilities as a whole. Assisted reproduction procedures, as well as abortion and sterilisation, may not be provided by a healthcare facility if 'the provision of health care is prevented by the personal beliefs of the health care professional who is to provide the health care'.[27] Outlined in Art. 12(2) and (3) of Act No. 576/2004 Coll. on Health Care, this provision recognises the collective conscientious objections within a healthcare institution, ensuring that healthcare services align with the ethical considerations of the professionals involved. Essentially, if no employees within a hospital are willing to perform certain procedures due to conscientious objection, the hospital is not obligated to provide them. This legal framework seeks to strike a balance between ensuring patient access to necessary medical procedures and respecting the moral and ethical convictions of healthcare professionals and institutions.

As such, Slovakia's legal framework places significant emphasis on upholding patient rights, including the right to provide informed consent, maintaining confidentiality in health-related information, and ensuring the protection of personal data in compliance with established laws and regulations. These measures collectively contribute to fostering a patient-centric, ethical, and legally sound healthcare environment in Slovakia. Unfortunately, in the field of assisted reproduction, these measures are insufficient. The existing legal framework surrounding assisted reproduction in the Slovak Republic appears inadequate and out of sync with the evolving methods employed within the country, particularly in respect to extra-uterine insemination. Individual reproductive health centres have independently crafted their procedures to navigate legal ambiguities, highlighting the diminishing relevance of the Ministry of Health's longstanding Measure no. 24/1983.

The complex issues related to assisted reproduction can be categorised into regulated and unregulated aspects within the framework of Slovak law. Issues partially regulated by Slovak law include: (a) the accessibility/admissibility of assisted reproduction, which is addressed by the Measure of the Ministry of Health of the SSR 24/1983; (b) the determination of parental rights, which is governed by the Family Act (No. 36/2005 Coll., as amended); (c) the informed consent of applicants, which is regulated under the Health Care Act (No. 576/2004 Coll., as amended); and (d) gamete donation, which is covered by the Health Care Act and government regulations. Unregulated issues include: (a) the inadequate legal definition of assisted reproduction and its purpose; (b) the lack of explicit legal definition of embryonic cells (embryos); (c) ambiguity surrounding the storage of gametes and embryos, particularly in respect to the ethical and legal concerns arising from the unspecified conditions for storage duration and destruction of surplus embryos; (d) embryo donation, which remains undefined within the legal framework; and (e) unresolved

27 Act No. 576/2004 Coll. on Health Care.

coordination of the rules on unused reproductive cells with the statutory restrictions on embryo research.

The current legal vacuum not only raises bioethical and legal dilemmas but also challenges established legal categories. Scientific advancements in assisted reproduction challenge traditional legal norms rooted in the Roman law, necessitating legislative adaptation. The legislature needs to make critical decisions on whether to criminalise, prohibit, severely restrict, or permit and regulate assisted reproduction. Addressing the legal status and capacity of embryos in accordance with the Slovak Constitution further complicates the legislative process. The recognition of reproductive rights as fundamental and inviolable, especially in respect to the rights to privacy and health, prompts a nuanced approach to regulation.

While the adoption of legislation could enhance legal certainty, there is a delicate balance that needs to be upheld. Overly restrictive regulations may prompt patient migration to other EU states, akin to the Italian experience.[28] Striking a balance between paternalistic and liberal approaches is crucial for effective legislation. Despite a previous attempt via the Biomedicine Bill in 2006, the absence of a comprehensive regulatory framework at the national level is considered an unsatisfactory state of affairs. The impending decision by the Slovak legislator warrants careful consideration of various options, keeping in mind the broader implications for individual freedoms and medical research.

Globally, there has been an exponential surge in the adoption of ART, which have become an integral facet of people's lives. Furthermore, this burgeoning field has experienced a notable expansion in the Slovak Republic. However, the legislative framework governing these techniques within the country remains markedly inadequate, raising justifiable concerns regarding the effective implementation of the constituent acts that delineate the procedures of individual techniques. Within this legal landscape, human life conceived through assisted reproduction is often treated as a consumable material subject to disposal if it fails to meet unspecified quality criteria, a lacuna that remains unaddressed by the existing legislation. Although individuals undergoing ART are required to provide written informed consent, arguably, this compliance typically only adheres to formal criteria. The instructional and consensual documentation fails to adequately capture the ethical and moral quandaries inherent in the procedures.

The current legal regulation of ART in Slovakia is inadequate – the existing framework lacks a robust safeguard for conceived human life and fails to establish clear legal boundaries governing its implementation. This legislative deficiency raises ethical and moral concerns, necessitating the re-evaluation and enhancement of the regulatory framework to align more closely with the imperatives of protecting human life within the context of assisted reproduction.

The aforementioned deficiencies in the legal regulation of ART are longstanding issues, with the enactment of the Transplantation Act failing to resolve these

28 Fenton, 2006, p. 74.

shortcomings. In light of *de lege ferenda* considerations, the ethical and moral dilemmas associated with MAP techniques and the surplus production of embryos should be addressed. Considering the Slovak Republic's commitment to the protection of life before birth, embryos should be expressly excluded from the categorisation of reproductive cells as outlined in the Transplantation Act. This would mitigate ethical concerns, enhance clarity in legal definitions, and foster a more conscientious application of ART within the framework of prevailing laws.

An additional noteworthy criticism concerning the moral and ethical quandaries associated with ART is the absence of alternatives for individuals who decline such methods within the current legislation and the financing options available through public health insurance in Slovakia. Despite the existence of alternatives, individuals rejecting ART are not provided with viable options. For instance, a notable alternative is Restorative Reproductive Medicine (RRM), which encompasses lifestyle modifications for enhanced health and reproductive function. This includes educating individuals or couples on understanding fertility cycles, and medical interventions supporting various physiological processes related to fertility. Moreover, RRM includes surgery to rectify pathologic issues and restore normal anatomy and function. Central to the RRM approach is the identification of underlying causes or contributing factors. A specific model within RRM is Natural Procreative Technology, also known as NaPro Technology (NPT), a holistic and natural approach to reproductive medicine that focuses on identifying and addressing the underlying causes of fertility issues. Developed at Creighton University School of Medicine and the Saint Paul VI Institute for the Study of Human Reproduction, NPT involves various methods and treatments to support conception while respecting the natural processes of the human body. This model incorporates the Creighton Model Fertility Care System for educating couples about the fertility cycle and medical and surgical treatments to support conception in vivo. First gaining popularity in Slovakia in 2005, NPT has been available as a treatment option since 2012, although not one financed from health insurance. In line with the situation in Slovakia, the availability of NPT is generally not covered by public health insurance and is not actively promoted or financed in most European countries. However, noteworthy exceptions exist in countries with a significant Catholic influence, such as Ireland and Poland. For instance, NPT is widely available and financed by public health insurance in Ireland, where numerous active doctors and facilities offer treatments in major cities across the country. As one of the key benefits of this methodology lies in identifying and addressing the underlying causes of infertility, NPT is a genuine therapeutic modality. By valuing the human dignity of couples investigating the roots of their infertility, this approach ensures that, once the underlying causes are addressed, conception can occur naturally, thereby preserving the dignity of the conceived life. Given these considerations, public health insurance should encompass this method as a viable alternative to conventional ART.

Similar to all medical interventions, assisted reproduction carries both potential benefits and risks. Precision in regulations is imperative to maximise advantages

while minimising potential harm. To this end, it is crucial to engage all relevant stakeholders in the development of health policies governing assisted reproduction practices.

3. Constitutional Provisions

ART in Slovakia operate within a constitutional framework that defines fundamental rights and values. Several provisions of the Slovak Constitution are especially relevant to ART regulation, including human dignity and equality,[29] the prohibition of inhuman or degrading treatment,[30] the right to privacy and family life[31] and protections related to marriage, parenthood, and reproductive decision-making.[32] These principles shape how laws govern ART – from determining who can access treatments to defining protections for embryos – and inform legal debates on contested issues. This section examines each of these constitutional principles in turn and how they influence Slovak ART law. Furthermore, it reviews key case law, notably a 2007 Constitutional Court decision (PL. ÚS 12/01-297) on the status of embryos, and relevant cross-border cases involving Slovakia (including decisions of the European Court of Human Rights) to illustrate the practical interpretation of these principles. The goal is to provide a comprehensive understanding of how Slovakia's Constitution[33] frames the legal practice of ART, balancing the rights of individuals seeking to form families with the state's interest in protecting human life and dignity.

Art. 12 of the Slovak Constitution establishes the inherent dignity and equality of every individual. It proclaims that 'people are free and equal in dignity and in rights' and that fundamental rights are inviolable and inalienable. Moreover, Art. 12 contains an expansive non-discrimination clause: rights are guaranteed 'to everyone regardless of sex, race, colour of skin, language, faith and religion, political or other opinion, national or social origin, affiliation to a nation or ethnic group, property, descent, or any other status', and no one may be privileged or discriminated against on these grounds. In the context of ART, the principles of human dignity and equality have several implications. Laws and policies on ART must not unjustifiably discriminate among persons or couples who seek fertility treatment. For example, if only married heterosexual couples were permitted access to IVF by law, this could be viewed as discrimination based on marital status or sexual orientation, potentially conflicting with Art. 12's guarantee of equality. In Slovakia, the

29 Art. 12.
30 Art. 16.
31 Art. 19.
32 Art. 41.
33 Constitution of the Slovak Republic, Constitutional Act No. 460/1992 Coll., as amended by later constitutional laws.

law historically limited ART to different-sex couples (married or long-term partners), effectively barring single women and same-sex couples from treatment.[34] This could be interpreted as privileging certain family forms over others. While the Slovak Constitution does not explicitly list sexual orientation, the catch-all phrase 'any other status' provides a basis to argue for inclusive interpretation. Indeed, in a comparable regional development, Slovenia's Constitutional Court in 2022 struck down a ban on single women accessing ART as unconstitutional discrimination.[35] No such constitutional challenge has (so far) succeeded in Slovakia, but Art. 12 provides a strong framework to question exclusions that lack a sound justification in terms of public interest or child welfare. The principle of equality suggests that if the state offers assistance to overcome infertility, it should do so without arbitrary distinctions. Any differential treatment – for instance, an age limit for IVF funding (Slovak public insurance covers a limited number of cycles for women up to 39 years old) – must be reasonable and evidence-based to comply with Art. 12(2)'s requirements.

The concept of human dignity[36] requires that patients undergoing ART are treated with respect and that their bodily integrity and mental well-being are protected. This intersects with informed consent and medical ethics: procedures such as IVF, egg retrieval, or sperm donation must uphold the dignity of all participants. For example, any practice that exploits or commodifies the human body could raise dignity concerns. In Slovakia, surrogate motherhood remains legally unregulated and largely discouraged on moral grounds. One reason often cited in ethical debates is that commercial surrogacy might violate the dignity of the surrogate (treating her body and reproductive capacity as a means for profit) and of the child. While no explicit constitutional ruling exists on surrogacy, the dignity principle would require lawmakers to ensure that if surrogacy were permitted in the future, it be carefully regulated to avoid degrading or exploitative conditions. Conversely, dignity can also be invoked to support would-be parents: denying an infertile person the chance to have a biological child when medical help is available might be seen as disregarding an important aspect of their human dignity – the desire to found a family. Thus, dignity arguments cut both ways in ART debates, and the law must strike a balance that respects the dignity of all involved (intended parents, egg or sperm donors, surrogates, and children).

Art. 12's equality guarantee, together with Art. 41(3), ensures that children have equal rights regardless of the circumstances of their birth. This means a child born through IVF, with donated gametes, or via surrogacy (even if not legally regulated) should be treated no differently under the law than a child conceived naturally. Slovak law (and practice) respects this – for instance, birth registration and citizenship for children born to Slovak parents through ART are handled the same as for any other child. Art. 41(3) explicitly states that 'children born in and out of

34 Busardò et al., 2014.
35 Slovenia Times, 2024.
36 Art. 12(1).

wedlock enjoy equal rights', a provision that by analogy protects children born via assisted reproduction from any stigma or lesser legal status. A normative argument in the literature links respect for human life to the protection of 'the smallest among us' and to equality in dignity and rights.[37] In practice, this requires that the law not discriminate against embryos or children based on their origin – for example, inheritance rights of a child conceived with donor sperm must be the same as any biological child of the mother and her husband (who is legally presumed father if he consented to the procedure). Slovak family law treats the husband of a woman who gives birth as the father even if donor gametes were used, provided he consented, thereby ensuring the child's equal status in the family.

Art. 19 of the Slovak Constitution safeguards personal privacy and family life. It provides that 'everyone has the right to the preservation of human dignity, personal honour, reputation and the protection of good name'. Further, 'everyone has the right to protection against unauthorised interference in private and family life'. These clauses echo the protections of Art. 8 of the ECHR, enshrining a right to respect for one's private and family life. In addition, Art. 16(1) of the Constitution reinforces that 'the inviolability of the person and its privacy is guaranteed', underscoring bodily integrity and decisional privacy as fundamental values. Together, these provisions establish that intimate personal decisions – including decisions about reproduction – belong to a protected zone that the state should not interfere with unless there are compelling reasons.

The right to privacy and family life directly shapes the legal framework of assisted reproduction in several ways. Decisions about whether or not to have a child are central to the notion of private life. This has been affirmed both domestically and by the European Court of Human Rights. In *I.G. and Others v. Slovakia*,[38] for example, the ECHR recognised that a woman's ability to bear children is a fundamental aspect of her private and family life, such that sterilising her without consent violated Art. 8 of the Convention. By analogy, the choice to pursue pregnancy through medical assistance is an aspect of private life for those facing infertility. The Slovak Constitutional Court, in its landmark 2007 decision, explicitly linked reproductive decisions to privacy. It held that recognising an absolute foetal right to life from conception would 'directly contradict women's constitutional rights to … privacy', among other rights.[39] In other words, a woman's right to privacy encompasses the freedom to make decisions about pregnancy and by extension, should encompass decisions about attempting to become pregnant via ART. Thus, the legislature must ensure that any regulation of IVF, artificial insemination, or related technologies does not amount to an 'unauthorized interference' in the private life of individuals or couples seeking to form a family. Thus far, Slovak law has permitted ART within certain bounds rather than prohibiting it, which aligns with respecting

37 Čunderlík Čerbová, 2022, pp. 107–138.

38 *I.G. and Others v. Slovakia*, No. 15966/04.

39 Decision of the Constitutional Court of the Slovak Republic, PL. ÚS 12/01-297 (4 December 2007).

private life. If, hypothetically, a law outright banned IVF, it would likely face serious constitutional challenge under Art. 19 unless justified by very strong state interests (as was the case in some other countries, such as Ireland's historical ban on IVF,[40] which would be untenable today in most of Europe).

Furthermore, Art. 19(1)–(3) covers protection of personal data and confidentiality. In ART, this is relevant to the handling of sensitive information such as donor identities, medical records, and the privacy of those involved in surrogacy arrangements. Slovak law, similar to that of many European countries, preserves gamete donation anonymity by default to protect the private life of donors and recipients (though this raises debate about the child's right to know their genetic origins). The constitutional right to privacy provides a backdrop for these rules – any disclosure of identifying information (for example, a sperm donor's identity) must be carefully controlled. In *K.H. and Others v. Slovakia*,[41] the ECHR underscored that access to medical records is part of private life, ruling that women suspected of being involuntarily sterilised had a right to obtain copies of their health records. By extension, individuals undergoing ART have a right to access their medical data and to expect confidentiality. Slovak law on healthcare and personal data (Act No. 576/2004 Coll. And Act No. 18/2018 Coll.) reflects these privacy imperatives by requiring informed consent and protecting patient information. Any breach of confidentiality in ART services (e.g. publicizing a person's fertility treatment without consent) could be challenged as a violation of Art. 19.

The right to family life in Art. 19 means that the state should not interfere arbitrarily in existing family relationships. This has implications for how ART-conceived families are legally recognised. Once a child is born via ART, the constitutional interest shifts to protecting that family unit's integrity. For instance, if a Slovak couple uses a surrogate mother abroad (since domestic surrogacy is not regulated), upon returning to Slovakia they may face legal hurdles in establishing parentage. A refusal by authorities to recognise the intended parents as the legal parents could be seen as interfering with family life. While no known Slovak case has yet reached the ECHR on this point, analogous cases against other states (e.g. *Mennesson v. France*, 2014) have held that children born via surrogacy have a right to recognition of their parent-child relationship as part of their family life rights. In Slovakia, one recent case touched on these issues indirectly – *Hájovský v. Slovakia* (ECtHR, 2021).[42] Mr. Hájovský, a single man desiring to become a father, placed an advertisement seeking a surrogate. An undercover journalist exposed him in a televised report, and Slovak courts initially ruled that because surrogacy is a matter of public concern (and remains unregulated), the exposure was justified. The European Court of Human Rights disagreed, finding that the Slovak courts failed to properly protect the applicant's private life under Art. 8 of the ECHR. The *Hájovský case* underscores

40 Ronan et al., 2022.
41 *K.H. and Others v. Slovakia*, No. 32881/04.
42 *Hájovský v. Slovakia*, No. 7796/16.

two points: the very decision to become a parent (even via unconventional means) is an intimate matter of private life, deserving protection; and Slovakia's lack of surrogacy legislation leaves a gap where individuals' family life rights may come into conflict with other interests (such as, media freedom and public interest in an 'unregulated' practice).

Art. 19's guarantees of privacy and family life form a constitutional foundation for reproductive autonomy. They require that individuals be free to make personal decisions about procreation and family formation without undue state interference, and that once families are formed (with the help of ART or otherwise), the law respects and protects those familial bonds. Restrictions on ART must therefore be carefully justified (for example, regulations to ensure medical safety or prevent abuse can be legitimate, whereas an intrusive ban on all IVF would not withstand the test of proportionality under Art. 19). The Slovak Constitutional Court in PL. ÚS 12/01-297 explicitly emphasised that any protection of unborn life must not 'interfere with the essence of [a] woman's freedom and her right to privacy',[43] emphasising the fundamental significance of this right in the reproductive context. Slovak ART laws, as they stand, largely comport with privacy rights – IVF and related treatments are permitted and accessible (within a regulated medical setting), and personal data is protected. The continuing challenge is addressing new scenarios (such as surrogacy or embryo disposition) in a manner that upholds the privacy and family life of all parties involved.

Art. 41 of the Slovak Constitution, part of the section on 'Basic Rights and Freedoms', is dedicated to marriage, parenthood, and the family. Several clauses of Art. 41 are relevant. Marriage and Family Protection:[44] 'Marriage is a unique bond between a man and a woman. The Slovak Republic comprehensively protects and cherishes its good. Marriage, parenthood and family shall be protected by law. Special protection for children and adolescents is guaranteed'. This clause, amended in 2014 to entrench the heterosexual definition of marriage, affirms the state's commitment to protect family life. While it elevates marriage as an institution, it also broadly recognises parenthood and family as values protected by law. The mention of 'special protection' for youth demonstrates the state's interest in the welfare of the next generation.

Protection of Pregnant Women:[45] 'A pregnant woman shall be guaranteed special treatment, protection in employment, and adequate working conditions'. Here the Constitution mandates extra care for expectant mothers, reflecting an understanding that pregnancy and maternity require societal support. This ties into reproductive autonomy by acknowledging that women's reproductive role merits state protection, not coercion. For example, an employer must not penalise a woman for undergoing

43 Decision of the Constitutional Court of the Slovak Republic, PL. ÚS 12/01-297 (4 December 2007).
44 Art. 41(1).
45 Art. 41(2).

fertility treatment or being pregnant – to do so would violate this constitutional promise of special protection.

Equality of Children:[46] 'Children born in and out of wedlock enjoy equal rights'. As noted, this ensures no discrimination based on the circumstances of a child's conception or birth, which by extension covers children born via ART or surrogacy.

Parental Rights:[47] Parents have the right to care for and raise their children, and children have the right to parental care. The state can only interfere by court decision and law in extreme situations (e.g. abuse). Additionally, 'Parents taking care of their children shall have the right to assistance from the state'. These clauses indicate that the ability to have and raise children is not just a private matter but one where the state may owe supportive duties (financial assistance, maternity benefits, etc.).

Although Art. 41 does not explicitly state a 'right to reproduce' or a right to access fertility treatment, its emphasis on protecting parenthood and providing state assistance to families provides a supportive backdrop for reproductive autonomy. The notion that the state 'cherishes' the good of marriage and parenthood can be interpreted as endorsing policies that help citizens form and sustain families – including helping infertile couples to conceive if possible. In practice, Slovakia does subsidise a limited number of ART cycles for couples through public health insurance, aligning with the idea of assisting parents (or prospective parents) in Art. 41(5).

Reproductive autonomy – the ability to decide freely whether and when to have children – is a concept derived from several rights (privacy, personal liberty, dignity) rather than a single explicit clause. However, Art. 41's provisions reinforce this concept by valuing the result of reproductive autonomy (family and children) and by prohibiting state action that undermines it (such as treating unmarried mothers or ART-born children unequally).

Art. 41(5) states that parents caring for children have a right to state assistance, which has been realised in laws providing parental leave, child allowances, and so on. A question raised in academic debate is whether this supportive stance could extend upstream to the process of becoming parents. Given that infertility is recognised by the World Health Organization as a medical condition, providing public funding for infertility treatment could be seen as part of the state's duty to help individuals realise their right to found a family. In Slovakia, public health insurance does cover certain ART procedures for women up to a specified age, indicating a policy commitment to help citizens overcome infertility. While this is framed in health terms, it resonates with Art. 41's encouragement of parenthood. Conversely, critics argue that unlimited ART on demand might conflict with other values (such as the special status of marriage in Art. 41(1) or ethical concerns about embryo use).

Art. 41(1) does define marriage in heterosexual terms and does not recognise same-sex partnerships. This constitutional definition has implications for ART: for instance, female same-sex couples in Slovakia cannot marry or register, and as

46 Art. 41(3).
47 Art. 41(4)–(5).

individuals they are treated as single applicants for ART (which, under current guidelines, effectively disqualifies them, since clinics generally require a male partner or donor sperm with the woman not being single). Some contend that this infringes upon equality and privacy rights, but others point to Art. 41(1) to justify a preference for traditional family structures. The Constitutional Court has not been required to directly address whether denying lesbian couples access to ART is constitutional. However, should such a case arise, the Court would need to reconcile Art. 41(1)'s traditional view of marriage with Arts 12 and 19. Given European trends and Strasbourg case law emphasising that the mode of conception falls within private life, a blanket exclusion might be hard to defend purely on the basis of the constitutional marriage clause, especially since Art. 41(1) protects family and parenthood broadly, not just marriage. Additionally, if a Slovak citizen has a child via surrogacy abroad, Art. 41(4) and (5) could be invoked to argue the state must recognise that parent-child relationship and possibly extend assistance, lest the child be left legally vulnerable – a situation that would contradict the principle of protecting family and children.

Art. 41 anchors the Slovak constitutional value placed on family life and implicitly supports reproductive self-determination. Furthermore, it must be read in harmony with the rights to dignity, privacy, and equality. The Constitutional Court's jurisprudence (though sparse specifically on ART) suggests that the essence of these rights cannot be infringed upon. As the Court stated, 'the constitutional value of unborn human life can…be protected only to such extent that this protection does not cause an interference with the essence of a woman's freedom and her right to privacy'.[48] That freedom encompasses deciding if and how to become a parent – the crux of reproductive autonomy.

Art. 16(2) of the Constitution provides that 'No one may be tortured, or subjected to cruel, inhuman, or humiliating treatment or punishment'. This mirrors Art. 3 of the ECHR (prohibition of torture and inhuman or degrading treatment). Moreover, Art. 16(1), as noted, protects the inviolability of the person. These provisions ensure a basic level of humane treatment and respect for physical and mental integrity in all contexts, including healthcare. While one might not immediately associate ART regulation with the torture clause, this constitutional safeguard has been highly relevant in cases of reproductive rights abuses – most notably, the involuntary sterilisation of Romani women in Slovak hospitals approximately from 1999 to 2002, which led to several judgments against Slovakia in the European Court of Human Rights.

The prohibition of inhuman or degrading treatment means that medical procedures must be carried out with informed consent and with respect for the patient's personhood. In the context of ART, this underscores the importance of obtaining fully informed consent from all participants – women undergoing egg retrieval, men providing sperm, surrogate mothers (if it were allowed), and so on. Performing any

48 Ibid.

invasive reproductive procedure without consent or through coercion would violate Art. 16. The egregious examples are the forced sterilisations that occurred in Eastern Slovakia. In the case of *V.C. v. Slovakia* (2011),[49] the ECHR found that a Roma woman sterilised without her informed consent during childbirth had been subjected to inhuman and degrading treatment, violating ECHR Art. 3. The Court highlighted how this permanently robbed her of reproductive capacity, causing immense psychological trauma. Similarly, in *N.B. v. Slovakia* (2012)[50] and *I.G. and Others v. Slovakia* (2012),[51] additional victims of coerced sterilisation obtained judgments confirming the violation of both Art. 3 (inhuman/degrading treatment) and Art. 8 (private/family life).

After the Strasbourg decisions, Slovakia amended its healthcare laws to strengthen informed consent requirements for sterilisations, including mandating a waiting period and counselling, which aligns with ensuring no treatment of women that could be deemed degrading or coercive.

An important moment for Slovak constitutional jurisprudence on reproductive issues was the Constitutional Court's decision in case PL. ÚS 12/01-297, delivered on 4 December 2007. This case directly addressed the legal status and protection of embryos under the Constitution, in the context of a challenge to Slovakia's abortion law. The outcome of this case has significant implications for ART as well, because it clarified how the Constitution views 'unborn life' and how that interfaces with the rights of women and would-be parents.

A group of deputies of the National Council filed a petition in 2001 challenging several provisions of the abortion law (then Act No. 73/1986 Coll., as amended) as unconstitutional. That law allowed abortion on request up to 12 weeks of pregnancy and for medical indications later. The petitioners argued that Art. 15 of the Constitution, which states that, 'Everyone has the right to life. Human life is worthy of protection already before birth' should be interpreted to confer a right to life on the unborn from conception, thus rendering abortion (at least on request in early pregnancy) unconstitutional. Essentially, it was a bid to overturn the liberal abortion regime by constitutional mandate, elevating embryonic/foetal rights above statutory law. This inevitably required the Court to expound on when constitutional rights begin and how to balance prenatal life with other rights.

Art. 15(1) was central to this decision. Notably, Art. 15(1) has two clauses – the first sentence guarantees a right to life to 'everyone', and the second acknowledges that 'human life is worthy of protection already before birth'. This phrasing was a compromise in the 1992 Constitution, intended (as historical records indicate) to avoid the strict anti-abortion language that would equate 'protection' with an absolute right. Other relevant provisions were Art. 16 (inviolability of the person), Art. 19 (privacy), and Art. 41 (special care for pregnant women), since the case inherently

49 *V.C. v. Slovakia*, No. 18968/07.
50 *N.B. v. Slovakia*, No. 29518/10.
51 *I.G. and Others v. Slovakia*, No. 15966/04.

involved a clash between the foetus's status and the woman's rights to bodily integrity and privacy.

The Constitutional Court upheld the challenged provisions of the abortion statute, including termination on request within the first 12 weeks, but found Section 2(3) of implementing Decree No. 74/1986 Coll. unconstitutional because the relevant time limit had to be prescribed by statute. In its reasoning, the Court made several key determinations. The Court drew a critical distinction between 'everyone' as used in the Constitution and the unborn. It held that it was 'beyond any doubts that the concept of 'everyone'…should be understood as everybody who is born such that the capacity to have rights arises by birth and ends by death'.

In other words, constitutional rights – including the right to life in Art. 15 – vest only in born persons. An embryo or foetus, while 'worthy of protection', is not a bearer of fundamental rights equal to a person. This aligns with the civil law principle (enshrined in the Civil Code) that legal subjectivity begins at birth (*nasciturus pro iam nato habetur*). The Court reinforced this by referencing comparative jurisprudence (e.g. the U.S. *Roe v. Wade*[52] and decisions from other countries) and noting the widespread legal understanding that prenatal life, though protected, does not enjoy full personhood status.

Even as it acknowledged the state's interest in protecting unborn life, the Court emphasised that this interest cannot override the fundamental rights of women. It stated plainly that granting an absolute right to life to a foetus 'would directly contradict women's constitutional rights to health and privacy'.

By not recognizing the embryo/foetus as a rights-holder, the Court implicitly allowed the legislature considerable discretion in regulating embryos – both *in utero* and, by extension, outside the womb (as in IVF). The decision mentioned that answering the philosophical question of when life begins was 'not the task' of the judiciary. Instead, the Court focused on legal norms already in place that protect unborn life in various ways short of personhood: for example, provisions protecting pregnant employees (labour law), criminal penalties for illegal abortion after 12 weeks or for causing the miscarriage of a woman without consent, and so on.

The Court noted that Slovak law protects the foetus primarily through the rights and health of the pregnant woman, not as an independent entity. This point is crucial for ART – it suggests that an embryo outside a woman's body has even less claim to protection, since much of the legal protection is mediated via the pregnant woman's status. Therefore, practices inherent in ART – such as creating embryos *in vitro*, freezing them, discarding non-viable or unused embryos, or selecting the best embryos for transfer – are not per se unconstitutional, because the Constitution does not recognise those embryos as persons with a right to life.

The PL. ÚS 12/01-297 decision, though about abortion, effectively sets constitutional parameters that extend to ART. It confirmed that embryos do not enjoy a constitutional right to life. This means that activities such as IVF, which involve

52 *Roe v. Wade*, 410 U.S. 113 (1973).

creating multiple embryos with the knowledge that some may not result in birth, are not unconstitutional per se. Furthermore, it means that embryo research or stem-cell derivation, if carefully legislated, would not automatically violate the Constitution's right to life clause. However, other ethical statutes (and international treaties such as the Oviedo Convention, which Slovakia has ratified) may impose restrictions. Currently, Slovakia's law is relatively strict on embryo research (banning research without direct therapeutic purpose on embryos), but this is a policy choice rather than a constitutional requirement. In fact, the Constitutional Court's reasoning could invite reconsideration of whether such strict limits are necessary or if they unduly hamper scientific progress, given that the Constitution itself does not demand treating a days-old embryo the same as a born child.

4. Medical Practice of ART in Slovakia

As ART has become a vital tool in addressing infertility, the legal framework surrounding its practice has grown increasingly inadequate. This means professionals often grapple with questions as who can access these procedures, what techniques are permissible, and how medical professionals are held accountable. This section explores how both private and state clinics navigate the regulatory framework, including the licensing requirements and standards for providing ART services. At the heart of this legal discourse is the question of which reproductive technologies are allowed, regulated, or prohibited. Slovakia's legal provisions distinguish between procedures using the genetic material of the couple (homologous techniques) and those involving third-party donors (heterologous techniques). Certain practices, such as surrogacy and posthumous fertilisation, occupy a contentious space in Slovak law. The regulation of embryo cryopreservation and its ethical implications, including the conditions under which embryos may be stored or disposed of, also reveal broader concerns about the protection of human dignity and potential abuses in reproductive medicine.

The previous sections explored how ART was regulated in law, this section focuses on the practical implementation of these legal provisions and examines how the medical practice of ART operates in Slovakia. Historical data from the 1980s and 1990s reported an infertility rate of 12–13% in Slovakia. Today, almost 20% of couples in Slovakia are reportedly experiencing infertility.[53] For one out of every six infertile couples, the issue of infertility is resolved through alternative means. However, for 9% of couples, assisted reproduction is the sole viable path to achieve parenthood. The first child conceived via ART in Slovakia was born in 1983. In 2004, only 0.3% of children were born through the implementation of ART. According to

53 Statistical data provided by the Health Insurance Company Union.

2023 estimates, approximately 2% of children in Slovakia are born via ART each year.[54]

The most recent data specific to Slovakia reveals that, on average, 50% of infertility cases are attributed to male factors, and this percentage is consistently increasing. Conversely, in instances of female infertility, approximately 40% of women face childlessness due to functional ovarian hormonal disorders. Additionally, a substantial cohort of women exhibits positive antibodies to their partner's sperm, emphasising the complexity and multifaceted nature of infertility issues. The observed demographic trends and the prevalence of infertility underscore the importance of continued research and comprehensive approaches to address the evolving landscape of reproductive health in Slovakia.

As noted, Slovak legislation is chaotic and outdated and still largely reliant on Measure No. 24/1983, which was enacted approximately four decades ago, while more recent legal acts only partially regulate artificial reproduction. As a result of this legislative gap, medical facilities have been creating their own guidelines, making it difficult to evaluate how artificial reproductive techniques operate in practice. Measure No. 24/1983 passed by the Ministry of Health, only uses the term 'artificial insemination', with no mention of 'artificial reproduction' or 'medically assisted reproduction'. That said, it does define fundamental prerequisites for the conduct of artificial insemination, many of which are analogous to various forms of assisted reproduction. Nonetheless, aside from the regulations articulated in the Health Care Act and the Transplantation Act or other legislative frameworks, Slovakia lacks an effective mechanism to compel individual assisted reproduction centres to rigorously adhere to these stipulations.

The first successful artificial insemination in Slovakia was achieved in 1983 at the Gynaecology and Obstetrics Clinic of the Faculty Hospital in Bratislava.[55] This milestone marked a pivotal moment in the development of reproductive medicine in the country. Shortly afterward, Slovakia celebrated the birth of its first 'test-tube baby' through the technique of IVF, a procedure that was still considered a last resort for couples who had exhausted all other options for natural conception. At the time, IVF was an emerging method in many Eastern Bloc countries, reflecting the gradual adoption of ART in this part of Europe.

Prof. MUDr. Peter J. Horňák, is recognized as the pioneer of assisted reproduction in Slovakia, and is widely regarded as the founding figure of ART in the country.[56] Prof. Horňák played a crucial role in introducing IVF to Slovakia, leading the efforts to perform the first successful IVF procedures in the 1980s. His leadership and vision were instrumental in advancing both the scientific and clinical aspects of reproductive medicine in the region. His team at the Gynaecology and Obstetrics Clinic

54 Ministry of Health of the Slovak Republic, 2025.
55 Soukupová and Budayová, 2009, p. 26.
56 Erdősová, 2025, p. 126.

conducted ground-breaking experiments that laid the foundation for ART services, which have since become a cornerstone of infertility treatment in Slovakia.

Initially, ART was primarily intended for couples facing infertility due to various medical conditions, including blocked fallopian tubes in women or poor sperm quality in men. During this early phase, the majority of procedures used the couple's own gametes – eggs and sperm – reflecting a cautious approach to reproductive technology. The focus remained on treating infertility through techniques that closely adhered to ethical and medical standards, ensuring that ART was applied only in cases of medical necessity.

Prof. Horňák's contributions went beyond IVF, as he and his team also explored other methods of infertility treatment, helping to expand the scope of assisted reproduction in Slovakia. His work not only improved access to ART but also helped destigmatise infertility, fostering greater acceptance of medical intervention for reproductive health issues. Over time, these pioneering efforts shaped Slovakia's assisted reproduction framework, paving the way for the regulatory and technological advancements that followed in subsequent decades.

Building upon the legal framework explored in the previous sections, this section examines the practical implementation of ART within Slovak reproductive clinics. The practice of ART in Slovakia is constantly evolving, influenced by advancements in reproductive science and the individual needs of patients. Clinics offer a wide array of services that adhere to both national and international medical standards, focusing on maximizing success rates while minimizing health risks to both patients and future offspring.

One of the key techniques employed in ART is PGD. This procedure is critical for preventing genetically inherited diseases and recurrent miscarriages. Through PGD, embryonic cells are analysed, and only healthy embryos are selected for transfer. Depending on the patient's age and medical condition, clinics typically transfer between one and three embryos per cycle. This highly selective process aims to increase implantation success while reducing the risk of multiple pregnancies and associated complications.

Furthermore, clinics perform IVF using a variety of options, including the patient's own eggs, donor eggs, or even donor embryos. The success rate for fertilisation through IVF ranges between 50% and 70% at Slovak clinics, depending on several factors, including patient health and the quality of gametes.[57] For cases where more precision is required, clinics utilise ICSI, a micro-manipulation method in which a single sperm is directly injected into an egg. This method, performed using specialised equipment called a micromanipulator, boasts a fertilisation success rate of up to 90%.[58]

An advanced modification of ICSI, known as Physiological Intracytoplasmic Sperm Injection, enhances the selection process by using only mature sperm that

57 REPROFIT, 2025.
58 Ibid.

bind to a hyaluronan gel. Hyaluronan is a substance naturally surrounding the egg, facilitating the egg-sperm binding process during natural conception. Sperm capable of this binding are typically mature and have a significantly lower incidence of chromosomal abnormalities. For patients with higher instances of sperm DNA fragmentation, clinics employ microfluidic sperm sorting (MFSS). This method mimics natural selection processes to gently isolate high-quality sperm without subjecting them to damaging laboratory procedures. MFSS is recommended for couples with repeated embryo development failure, recurrent miscarriages, or failed implantation attempts in previous cycles, particularly when the female partner is of advanced reproductive age.

For cases involving severe male infertility, clinics may use magnetic-activated cell sorting (MACS) to improve sperm quality. MACS is designed to remove defective sperm cells, even when these defects are not visible under a microscope. The primary cause of sperm DNA damage is oxidative stress, which increases with age and is exacerbated by factors such as inflammation, smoking, medication use, environmental pollution, and elevated testicular temperature. By selectively removing damaged cells, MACS enhances the overall quality of sperm samples, improving the likelihood of successful fertilisation.

Another widely-used technique in Slovak clinics is intrauterine insemination (IUI), which involves placing prepared sperm directly into the uterus to increase the chances of fertilisation. IUI is often employed in cases where less invasive methods are preferred or where the underlying causes of infertility are less severe.

Moreover, some clinics offer cryopreservation services, including egg freezing (social freezing), sperm freezing, and embryo freezing. Social freezing allows women to preserve their eggs at an earlier stage, maintaining their reproductive potential and egg quality for future use. This option is increasingly sought after by women who wish to delay childbearing for personal or medical reasons.

For men with azoospermia (the absence of sperm in the ejaculate), Slovak clinics utilise surgical sperm retrieval techniques such as Microsurgical Epididymal Sperm Aspiration (MESA) and Testicular Sperm Extraction (TESE). These procedures are recommended when no sperm is present in the ejaculate or when the sperms that are present exhibit severe morphological abnormalities or are found only in developmental stages. MESA and TESE provide viable alternatives for obtaining sperm directly from the reproductive organs, thereby enabling fertilisation through IVF or ICSI.

In addition to these core techniques, Slovak clinics are continually integrating new innovations to improve outcomes and patient care. The practical implementation of these methods reflects not only the medical expertise within the country but also the broader commitment to supporting patients facing infertility.

In Slovakia, the practice of ART operates within a framework characterised by both legal ambiguity and evolving medical advancements. Despite significant progress in reproductive medicine, including techniques such as IVF, embryo transfer, and cryopreservation, the country's legal system still largely relies on the Transplantation Act

and an outdated regulation – Measure No. 24/1983 of the Ministry of Health – which narrowly defines artificial insemination. This regulation was enacted decades ago and reflects only a rudimentary understanding of ART, recognising only the methods of homologous and heterologous insemination. In practice, however, Slovak fertility clinics have adopted a wide range of modern ART procedures to address infertility, including IVF, embryo culture, and pre-implantation genetic diagnosis. These procedures, though widely applied, operate without detailed legislative oversight. Clinics have developed their own protocols to navigate legal uncertainties, which has resulted in inconsistencies across the country in how ART is provided.

In practice, the most commonly offered methods of ART in Slovak clinics are: (1) Artificial insemination: Either homologous (using the partner's sperm) or heterologous (using donor sperm). (2) IVF: Fertilisation takes place outside the body, followed by the transfer of embryos to the uterus. (3) Cryopreservation: The freezing of sperm, oocytes, or embryos for future use, including subsequent procedures like cryo-embryo transfer. (4) PGD: Used to detect genetic disorders before implantation to prevent genetically inherited conditions.

The legislation we have explored on the previous pages, however does not reflect this. Notably, Slovak legislation lacks a clear definition of the term 'assisted reproduction'. Instead, it appears indirectly within our Transplantation Act. Section 2(5) of Act No. 317/2016 Coll. defines reproductive human cells as human tissue or human cells intended for assisted reproduction.[59]

However, the regulation does not clarify whether reproductive cells include both gametes (sperm and eggs) and embryonic cells. The law neither explicitly regulates nor excludes embryonic cells from this definition. This ambiguity highlights the lack of clear legal boundaries regarding the status and categorisation of reproductive materials within Slovak ART legislation.

By contrast, the Czech Republic's Act No. 227/2006 Sb. Act on Research on Human Cells in its Section 2(d) explicitly defines a human embryo as a 'totipotent cell or a group of such cells capable of developing into a human individual'.[60] In Slovakia, however, legislators have so far avoided providing a legal definition of an embryo or its status, leaving this crucial issue open to interpretation. The absence of a precise legal definition creates legal uncertainty in areas such as embryo research, cryopreservation, and the rights associated with embryos.

Moreover, Slovak legislation seems to conceptualise artificial reproduction narrowly, focusing primarily on artificial insemination rather than encompassing the broader spectrum of ART techniques, such as IVF. This is in contrast to the Czech approach, which includes all forms of artificial fertilisation under a unified legal

59 Government Regulation of the Slovak Republic No. 20/2007 Coll. on details on procurement, tissue and cell donation, criteria for selection of tissue and cell donors, laboratory tests required for tissue and cell donors, and procedures for procurement of cells or tissues and their acceptance by a health care provider.

60 Act No. 227/2006 Sb. Act on Research on Human Cells.

definition. As a result, the concept of assisted reproduction in Slovakia remains vague and undefined, with legal provisions failing to reflect the full range of medical advancements in reproductive technology.

When it comes to access to ART, the 1983 Measure states that only married couples may access artificial insemination procedures, requiring both spouses to apply jointly. Single women and same-sex couples are effectively excluded from accessing ART based on this measure. This restriction is rooted in the societal aim of ensuring that children conceived through ART are born into stable and legally defined family structures. The intent behind this provision is to prevent situations where a child might grow up with only one parent (e.g. in cases involving single applicants) and to provide children conceived under 'exceptional circumstances' with a secure family environment. However, the mere existence of a marriage at the time of application does not guarantee long-term family stability. Marriages may dissolve after the child is conceived, undermining the rationale of requiring marriage as a prerequisite for ART access. Interestingly, Slovak Family Law (Act No. 36/2005 Coll.) allows for the establishment of legal parenthood outside of marriage. According to this law, paternity can be established by the joint declaration of both parents, without the need for a marital relationship. This provision grants unmarried partners similar parental rights to those of married couples, which has implications for ART access. In practice, ART clinics often extend their services to unmarried partners despite the legal preference for married applicants. This discrepancy between the law and clinical practice highlights the gap between traditional legal norms and contemporary social realities. Critics argue that restricting ART access based on marital status is discriminatory and does not reflect the diversity of modern family structures. They point out that the law fails to account for the rights of single women or same-sex couples, leaving these groups without equal access to reproductive services.

Additionally, the Law requires the existence of medical reasons. This criterion aims to prevent the misuse of artificial insemination by women whose medical condition would not inherently hinder natural conception. Health grounds are enumerated in Art. 2(2) of the 1983 Measure and include disorders of the husband's fertility, anatomical or other disorders of the female genitalia, the risk of hereditary disease or developmental defect, and other impediments preventing spouses from having healthy offspring. This stipulation remains relevant today.

Measure no. 24/1983 necessitates a written request from both spouses in order to preclude the execution of an assisted reproduction procedure against the parties' will, especially that of the husband, who might be unaware of the procedure in certain circumstances. The applicant spouses are also obliged to sign a declaration acknowledging their awareness of the legal consequences, potential complications during pregnancy and maternity, and family law implications of the artificial insemination procedure.

Slovak law imposes age-related restrictions on applicants for assisted reproduction, which can be categorised into two types:

(1) Health-related restrictions (upper age limit) – These restrictions are based on biological fertility, applying primarily to women. Assisted reproduction is not available once a woman reaches an age at which natural fertility typically declines. This upper age limit is justified as a medical safeguard, taking into account the health risks associated with advanced maternal age as well as the likelihood of successful treatment. *De jure,* the upper age limit for ART reimbursement from public health insurance is 39 years of age, however when it comes to a general upper age limit the 1983 measure referred to artificial insemination in adult women normally up to the age of 35. This measure was never repealed, however it is also not being enforced - in practice many clinics have set their own age limits, often up to 52 years, as endorsed by their respective ethics committees. Based on our consultations with ART clinics in Slovakia, the majority perform ART procedures up until the age 50–52.[61]

(2) Legal restrictions (lower age limit) – applicants must have full legal capacity, meaning they must be of age and capable of making independent legal decisions.

Compared to restrictions based on marital status, age restrictions are generally less controversial. The health-related upper limit is widely seen as reasonable, as it aligns with medical best practices aimed at protecting the health of both mother and child. However, the legal lower age limit raises certain concerns. A notable issue arises in cases where a woman has entered into marriage before reaching legal adulthood. Under Slovak family law, women who marry before the age of 18 are granted full legal capacity, allowing them to exercise rights and responsibilities associated with adulthood. Despite this, the Ministry of Health's regulation does not make exceptions for such cases, effectively barring underage married women from accessing assisted reproduction services. We found no reports of cases involving clinics performing ART on individuals below the lower age limit.

Another significant gap in ART practice is the data collection. The National Registry of Assisted Reproduction (NRAR), established under Act No. 153/2013 Coll., is part of the broader system of National Health Registries managed by the NCZI within Slovakia's National Health Information System (ISZI). This registry was planned to be operational by 2015, but its implementation was delayed for years. It was finally launched in 2022. The registry collects and analyses data related to assisted reproduction, including IVF cycles. The specifics of the registry, such as reporting procedures, data collection methods, and the roles of reporting units, are defined by Decree No. 74/2014 Coll. of the Ministry of Health.

61 Consultations with all major ART clinics conducted during the writing of the monograph Garayová, L., Erdősová, A. and Rybasnaka, L., Aktuálne medicínske a právne aspekty asistovanej reprodukcie. Current Medical and Legal Aspects of Assisted Reproduction. Bratislava: SOLEN.

The indicators tracked by the registry are outlined in the ZR_AS_REP report and were developed in collaboration with clinical experts. These indicators also incorporate data requirements from the European Society of Human Reproduction and Embryology (ESHRE). The scope of the reports is expected to expand in the future to reflect the continuous development of ART techniques, ensuring that new methods are adequately monitored and regulated.

The registry aims to provide detailed information on various aspects of IVF cycles, including: (1) Procedures: Techniques used during the treatment process. (2) Outcomes: Treatment results and pregnancy success rates. (3) Complications: Any adverse events or medical issues encountered during ART.

The collected data is intended to serve multiple stakeholders, including healthcare professionals, the Slovak Ministry of Health, and international organisations. Despite its intended role, the NRAR faces significant challenges in collecting reliable and comprehensive data. We contacted the NCZI to gain insights into the current state of IVF data collection in Slovakia. According to its representatives, the data reporting system is largely self-reported by practitioners and lacks the enforceability of mandatory, precise data collection. This approach reduces the accuracy and reliability of the data, as compliance with reporting requirements is inconsistent across clinics.

Additionally, because the registry's data collection process functions more as a recommendation than a strictly regulated obligation, it fails to provide a complete and standardised overview of ART practices in Slovakia. As a result, policymakers and researchers may struggle to obtain data for the analysis of ART outcomes, complication rates, and the long-term effectiveness of different treatment protocols.

In Slovakia, the relevant authorities overseeing matters related to assisted reproduction include the Ministry of Health of the Slovak Republic[62] and the Institute of Medical Ethics and Bioethics.[63] These institutions play a pivotal role in the regulatory and ethical dimensions of assisted reproduction within the country. The Central Ethics Committee of the Ministry of Health[64] actively engages in the formulation of and commentary on new health legislation, particularly with respect to assisted reproduction issues. Its involvement in the legislative process underscores its significance as a key body in shaping the ethical framework surrounding reproductive health practices.

In accordance with Slovak law, each inpatient health care facility is mandated to have an ethics committee. These committees are entrusted with providing opinions and decisions on a range of ethical dilemmas that may arise in the context of assisted reproduction. This responsibility is guided by ethical guidelines established to navigate the complex questions and challenges inherent in assisted reproduction procedures. The presence of ethics committees at the institutional level reflects a

62 Ministry of Health of the Slovak Republic, 2025.
63 Institute of Medical Ethics and Bioethics, 2025.
64 Ministerstvo zdravotníctva, 2025.

commitment to ensuring that ethical considerations are integral to decision-making processes in the realm of reproductive health.

5. Family Law Regulation

Slovak family law draws its foundations from the Constitution of the Slovak Republic and the Family Act of 2005.[65] The initial provision of the Family Act outlines a set of fundamental principles that serve as the bedrock upon which national family law is constructed. These principles are amongst the most pivotal components of national family law, except, perhaps, for Art. 41 of the Slovak Republic's Constitution, which serves as the overarching framework for the entire family law system. The primary function of these fundamental principles is to serve as shared guidelines for interpreting family law. They require that all family law relationships be viewed and assessed through the prism of these principles, shaping the rights and responsibilities of each party involved. An intriguing aspect of these principles is that, despite family law's intrinsic private nature, they extend beyond the typical scope of private law principles. These principles not only govern the relationships between private entities but also define the roles and obligations of the state and society concerning family and its protection. They offer clear directives regarding the preferred or prioritised types of family relationships as perceived by the state and the expectations associated with them. Consequently, no public authority may exercise discretion in interpreting family law relationships such as to deviate from the foundational tenets of family law. These basic principles are enshrined in Arts. 1–5 and represent the values and principles of family law in Slovakia. As described in Art. 1:

> Marriage is a union of a man and a woman. The society comprehensively protects this unique union and helps its welfare. Husband and wife are equal in their rights and responsibilities. The main purpose of marriage is the establishment of a family and the proper upbringing of children.

Marriage, defined as the bond between two individuals who are intimately connected and uniquely significant to each other, continues to be the most coveted mode of human companionship. Research conducted by psychologists underscores the paramount significance of marriage in enhancing an individual's physical and mental well-being.[66] These studies have depicted that people in marriage live longer and happier lives,[67] and that there is less violence in marriage than in unmarried

65 Act No. 36/2005 Coll. on Family and on Amendments and Supplements to Certain Acts.
66 Uecker, 2012, 67–83.
67 Stavrova, 2019.

cohabiting relationships or among single individuals.[68] Marriage necessitates an emotional commitment to a relationship, and this commitment tends to have a positive impact on an individual's personal welfare, leading to the forging of new social connections, assimilation of individuals into social circles, and fortification of their social standing. Marriage holds significant importance within the confines of family life and exerts a direct influence on the broader community. It is imperative to note that these positive roles are fulfilled solely within a functional marriage.

The Family Act interprets the functionality of marriage through the principle of spousal equality. This equality extends beyond rights and encompasses responsibilities. Each spouse is expected to contribute to the family's well-being in accordance with their capabilities, skills, and financial circumstances. The equality of spouses is manifested in their roles as partners and parents, and neither gender should face discrimination when evaluating the legal status of a marriage. In assessing disputes, each case should be individually scrutinised to determine how the spouses exercise their rights derived from their marriage and fulfil their obligations.

Marriage under Slovak law is still a union of a man and a woman. This provision has even been incorporated into Art. 41 of the Constitution of the Slovak Republic, being the only legislative change that this Art. went through since the Constitution has been in effect. To date, no legal alternative to marriage exists in the Slovak legal order, and it is rooted in the traditional view of family law in the Slovak legal order, emphasising the biological-reproductive function of the family.

As described in Art. 2: 'Family founded by marriage is the basic cell of society. Society comprehensively protects all forms of the family'. When it comes to the concept of 'family', it encompasses a broader scope than solely a 'marriage-based family'. The state extends its protection and support to all types of families, regardless of their method of formation, as long as they provide their members with feelings of security and solidarity. Even under the International Covenant on Civil and Political Rights,[69] the 'family is the natural and fundamental group unit of society and is entitled to protection by society and the State'. The Covenant further declares the right of every man and woman of a marriageable age to marry and to found a family. This right is closely linked to the right to respect for private and family life, as outlined in the European Convention on Human Rights.[70] As described in Art. 3:

> Parenting is a mission of men and women recognized by society. The society recognizes that a stable family environment formed by the child's father and mother is the most suitable for the all-round and harmonious development of the child. Therefore,

68 Kenney and McLanahan, 2006, pp. 127–140.

69 Art. 23 of the International Covenant on Civil and Political Rights, Adopted and opened for signature, ratification, and accession by General Assembly resolution 2200A (XXI) of 16 December 1966, entry into force 23 March 1976, in accordance with Art. 49.

70 Art. 8 of the Convention for the Protection of Human Rights and Fundamental Freedoms. Council of Europe Treaty Series 005, Council of Europe, 1950.

> the society provides parents not only with its protection, but also with necessary care, especially with material support for parents and assistance in the exercise of parental rights and responsibilities.

Among the most crucial roles of the family is its educational role. Assuming the role of a parent entails the responsibility of ensuring the proper upbringing of a child. When analysing Art. 3 of the Family Act, the comparison with its predecessor from 1963 is quite telling. The 1963 Family Act stated that 'Motherhood is a woman's most honest mission. Society provides motherhood not only with its own protection, but also with all its care, especially with material support for mothers and children and assistance in their upbringing'.[71] As opposed to the 1963 wording, the 2005 legislation no longer refers to motherhood or the woman's mission, clearly reflecting a shift in societal values by using terms such as parenthood and parenting. This further supports the principle of the equality of spouses in marriage both in their rights and responsibilities.

Slovak family law does not explicitly define motherhood and fatherhood, but it establishes clear procedures for the determination of both maternity and paternity, contestation rights, and restrictions on agreements that contradict the legal framework.

Under Section 82 of the Family Act: 'The mother of a child is the woman who gives birth to the child' (§ 82(1)).

Any agreements or contracts attempting to alter this rule are considered null and void (§ 82(2)).

This provision reflects the long-standing legal principle *of mater semper certa est*. By strictly enforcing this rule, the law excludes the possibility of recognizing surrogacy agreements. Therefore commercial or altruistic surrogacy is not legally recognised in Slovakia. The absence of a legal framework for surrogacy leaves intended parents vulnerable, particularly in cases of cross-border arrangements where children are born through surrogates abroad. If doubts arise regarding the identity of the birth mother, the court has the authority to determine maternity based on evidence related to the birth (§ 83). This provision ensures that legal parenthood can be established even in exceptional cases where the birth mother's identity is in question. The explanatory report to this provision refers to the state of medical science and its rapid progress. As with many other European states, defining the term 'mother' became essential to ensure clarity and reduce disputes over the establishment of maternity. It still bears mentioning however, that with IVF, the woman who gives birth to a child (gestational mother) is not necessarily the biological or genetic mother of the child, having no common DNA with the child. This is a fact that most jurisdictions tend to overlook, focusing solely on the circumstances of the child's birth to determine maternity. Section 2 of Art. 82 of the Family Act explicitly warns that any agreements contrary to section 1 are void. This appears to be a

71 Family Act No. 94/1963 Coll.

direct response to surrogacy and effectively renders all surrogacy contracts void. In addition to the reasoning provided by the Family Act, it can also be concluded that surrogacy contracts are *contra bonos mores* in our legal environment, and therefore, would not be afforded legal protection under Slovak jurisdiction.[72]

Paternity is determined based on legal presumptions established by Act No. 36/2005 Coll. on Family Law. This outlines three primary methods for determining paternity: (1) Presumption of the mother's husband's paternity, (2) Joint declaration by the parents, (3) Court determination of paternity.

1st presumption of paternity: According to Section 85 of the Family Act, if a child is born during a marriage or within 300 days of its dissolution or annulment, the husband of the mother is presumed to be the legal father. This presumption applies even if the couple is no longer living together or has separated. The presumption remains valid without requiring an official registry entry. Moreover, an entry is considered purely administrative and does not establish or confirm legal paternity.

If a woman remarries and gives birth to a child within 300 days after the termination of her previous marriage, the law presumes that the new husband is the father, even though the child was conceived during the previous marriage (§ 85(2)). In cases where a spouse has been declared deceased, the marriage is deemed to have ended on the date specified in the court's declaration of death (§ 85(3)).

The presumption of paternity based on marriage is one of the most frequently applied principles in Slovak family law. It reflects the societal and legal assumption that a child born within a marital union is the offspring of both spouses. This presumption aligns with traditional values that emphasise family as the cornerstone of a stable and healthy society, with marriage serving as the formal bond that supports reproduction and the upbringing of children. Historically, this concept is deeply rooted in Christian moral principles, where the reproductive function of a family is perceived as a natural result of the intimate and sexual relationship between two individuals united by marriage. Within this framework, the birth of a child during a marriage or shortly after its dissolution is seen as a natural extension of this bond. This legal framework aims to prevent disputes over paternity and ensure that children born within marriage have a legally recognised father. However, paternity can be contested under specific conditions, particularly when evidence exists that challenges the biological relationship between the husband and the child.

2nd presumption of paternity: If paternity cannot be determined through the presumption of the mother's husband's paternity, it may be established by a joint declaration of both parents before a civil registry office or a court, as outlined in Section 90 of Act No. 36/2005 Coll. on Family Law. Modern societal shifts have led to a decline in the traditional institution of marriage. In past generations, marriage was often entered into due to the expectation of a child. Couples, sometimes under familial or societal pressure, would formalise their relationship to provide their child with a stable family environment. The stigma surrounding unmarried cohabitation

72 Júdová and Piry, 2019.

often influenced these decisions, with concerns about 'what people might say' playing a significant role. Today, this perspective has shifted, and it is common for couples to live together without formalising their relationship through marriage. Many such couples raise children in stable, long-term partnerships without legal recognition of their union. In these circumstances, the law cannot presume paternity based on marriage, making the joint declaration of paternity a critical legal mechanism to secure the child's rights and parental responsibilities.

According to the Family Act, a man can declare paternity jointly with the mother, even if he is not the biological father. This declaration is made before a civil registry office or a court. Moreover, the civil registry has no obligation to verify the biological truthfulness of the claim; its role is to record the declaration in the birth registry. The process involves both parents appearing before the registry or court and declaring their agreement. This declaration is then documented in the birth record. While the two parents do not need to be present at the same time, registry offices typically require both to appear simultaneously to finalise the declaration, including an agreement on the child's name. The act is not subject to administrative fees and serves as a declaratory legal act, meaning it establishes legal rights and duties without needing further approval.

The joint declaration is recorded in the book of births, and the registry office creates an official record. This record must include the date of the declaration, as the start of the limitation period for contesting paternity depends on this date. The declaration can be made at any time after the child's birth and even for a child not yet born if conception has occurred (Section 92). If the parents make their declarations on different days, the date of completion is when the second parent confirms their agreement. In cases where the mother's declaration is waived, the date of the father's declaration is considered the official date of recognition.

3rd presumption of paternity: If paternity is not established through the presumption of the mother's husband or by a joint declaration of the parents, it may be determined by a court ruling. This legal procedure is defined in Section 94 of Act No. 36/2005 Coll. on Family Law. This third presumption of paternity is applicable only when neither the presumption of paternity by marriage nor the joint parental declaration has been established. According to the law, the court may declare as the father a man who engaged in sexual intercourse with the mother during a period of 180 to 300 days prior to the birth of the child, provided there are no serious circumstances that would exclude paternity (Section 94(2)).

This legal process requires initiative from one of the involved parties: the child, the mother, or a man claiming to be the father. Unlike the previous presumptions, this third option mandates a formal judicial proceeding, with the court having exclusive jurisdiction over such matters. Proceedings to determine paternity are governed by the Code of Civil Non-Contentious Procedure (Act No. 161/2015 Coll.), notably Sections 105–110. The right to initiate proceedings is granted to the child, the mother, or the man who claims to be the father. Furthermore, the child may initiate proceedings later in life, even as an adult. During the court proceedings, the child

is represented by a guardian ad litem (conflict guardian), typically a representative from the authority for the social and legal protection of children.

The guardian's primary role is to safeguard the best interests of the child and ensure the child's perspective is considered, provided it is in the child's best interest. The guardian participates as a full party in the court proceedings, advocating for the child's rights and legally protected interests.

The court must ascertain the actual facts and, where necessary, take evidence beyond that proposed by the parties (Sections 35–36 of the Code of Civil Non-Contentious Procedure), including genetic evidence where appropriate. Additionally, the court may deny paternity if significant evidence proves the biological impossibility of paternity, such as the infertility of the alleged father. Once the court determines paternity, the ruling is recorded in the birth registry. The father's name and surname are entered in the official records. However, if the proceedings involve a deceased alleged father, the court does not address matters related to child custody, upbringing, or the father's obligations, such as financial support. Instead, the focus is solely on determining paternity.

The presumptions of maternity and paternity, as outlined in Act No. 36/2005 Coll. on Family Law, are directly relevant to the legal recognition of parenthood in cases involving ART. The legal framework, however, does not fully reflect the complexities and unique situations arising from ART procedures such as IVF, gamete donation, and surrogacy. As outlined above, according to Section 82 of the Family Act, the mother of the child is the woman who gives birth to the child. This principle has significant implications for ART, particularly in cases of surrogacy. In Slovakia, surrogacy is not explicitly regulated, and contracts that contradict this presumption (e.g. an agreement transferring maternity to an intended mother) are considered invalid under Slovak law. In ART scenarios involving a surrogate mother: (a) The woman who gives birth (the surrogate) is legally recognised as the mother, even if she has no genetic link to the child. (b) The intended mother, whether she contributed an egg or not, cannot be legally recognised as the mother unless she adopts the child after birth.

This legal stance creates significant obstacles for intended parents who utilise surrogacy or egg donation, leaving many unresolved legal issues surrounding parental rights, custody, and the child's welfare.

Under Section 85, the law presumes that the husband of the child's mother is the father if the child is born during the marriage or within 300 days of its dissolution. This presumption applies even in cases where ART is used with donated sperm or embryos, provided the husband consents to the procedure. However, the Family Act explicitly states that a husband cannot challenge paternity if the child is conceived through ART with his consent (Section 87). This provision provides stability and legal certainty for children born through ART within a marital context. For non-marital couples or single women using ART, paternity can be established through a joint declaration of parenthood (Section 90). However, this process may raise several legal and practical challenges: (a) There is no mechanism to prevent a man who is

not the biological father from making the declaration. (b) In cases of donor-conceived children, the biological donor has no legal rights or obligations toward the child.

If neither presumption is applicable, the court can determine paternity through judicial proceedings, though this option is rarely relevant to ART unless disputes arise regarding the intended father's role or the timing of conception.

ART complicates traditional parentage rules due to the involvement of third parties (e.g. sperm or egg donors, surrogates). The Slovak legal framework does not explicitly address: (a) The status of genetic donors (whether they are considered parents or have any legal responsibilities). (b) The right of the child to know their genetic origins, which is recognised in some countries as a fundamental right under the Convention on the Rights of the Child (CRC) but remains unregulated in Slovakia. (c) The legal resolution of disputes in cases where ART procedures fail, are incomplete, or involve multiple jurisdictions.

In practice, these gaps often leave ART participants without adequate legal protection or clarity. For instance, if a couple separates after creating cryopreserved embryos, the current law offers no clear guidance on the disposition of those embryos. Slovakia has no specific law limiting how long embryos can be kept frozen or the procedures for the disposition of unused embryos. There is no central record of stored embryos – the National Health Information Center (NCZI) confirmed that it does not track the number of frozen embryos in clinics. In practice, this means each fertility centre sets its own policies on embryo storage duration and disposal. An embryologist at a Bratislava clinic likewise confirmed[73] the storage period is unlimited – most patients decide within approximately five years whether to use their frozen embryos, but there is no fixed legal deadline. In practice, couples typically either use their frozen embryos in subsequent IVF cycles, donate them to other patients, or request their destruction, usually within a few years.

With no clear legal procedure for discarding embryos, clinics have developed their own protocols. Before an embryo can be destroyed, clinics require formal consent from the patients. For example, one clinic mandates a signed statement (verified by a notary) from the couple if they decide to stop storing their embryos. This ensures the clinic has documented permission for the disposal of embryos, given the sensitive nature of destroying potential life. If patients discontinue paying storage fees or cannot be contacted, the path is murky – there is no explicit law on declaring embryos 'abandoned', therefore, clinics must tread carefully. In practice, however, most couples make a decision – approximately 98% choose to have excess embryos disposed of once they have completed their families. Additionally, merely 2% donate their remaining embryos to other infertile couples.[74] Embryo donation is legally allowed in Slovakia and some clinics facilitate it. However, it requires advanced planning (extensive blood tests and screenings for both partners at the time of donation).

73 Potocká, 2024.

74 Data from Sanatorium Helios in Bratislava.

A further gap is the posthumous use of embryos (or gametes) – what happens if one or both genetic parents die with embryos still in storage. Slovak law and guidelines are silent on this issue.

6. Rights of the Child and ART

Despite the patchwork regulatory system, Slovak law affirms several key rights of children that apply equally to those born via ART.

Every child in Slovakia, irrespective of the circumstances of birth, enjoys the constitutional protection of human dignity. This means a child born through IVF, surrogacy, or donor conception must be treated with the same respect for their intrinsic worth as any other child.

The Family Act explicitly guarantees no discrimination based on the marital status of the parents, which by extension covers children born to unmarried couples via ART or single mothers. Their dignity is upheld by ensuring they have the same rights to support, inheritance, and social status as a child born naturally within marriage. No stigma or diminishment of personhood is legally tolerated.

Although not a person in law, an embryo is afforded a certain protective dignity under Slovak law. The constitutional phrase that 'human life is worthy of protection before birth' is essentially a statement about the dignity of nascent human life. The Constitutional Court underscored that embryos are not holders of rights, but they are entitled to respectful treatment and protection appropriate to their stage of development. This ethos translates into specific prohibitions – creating embryos for commercial or industrial purposes is forbidden, as is their sale or purchase. There is no legal market for embryos or gametes in Slovakia – donations must be altruistic (though reasonable expense compensation is allowed). The ban on cloning and on non-therapeutic embryo research further reflects concern for the embryo's dignity.

In contrast to some jurisdictions, Slovak law does not treat an embryo as mere property of the parents or clinic. For instance, intended parents cannot 'contract away' an embryo to a surrogate or another couple without following legal processes (such as adoption if the child is born). This insistence that a child (born or unborn) cannot be the object of a contract is grounded in human dignity and the inalienability of personal status. Even in divorce or separation, parents cannot make binding agreements that would pre-emptively allocate embryos or unborn children – such matters would be decided with the child's welfare in mind at the time.

Children's right to health is protected by both general health care provisions and specific practices in ART that prevent serious genetic conditions. Article 40 of the Slovak Constitution expressly guarantees the right to protection of health and provides, subject to statutory conditions, for citizens' access to free healthcare and medical aids on the basis of health insurance. It does oblige the state to protect

health and support medical care through laws (and international covenants such as the CRC, which affirm the child's right to the highest attainable standard of health). In the context of ART, this right manifests in two phases: pre-birth (embryo health) and post-birth (child's health).

One benefit of the IVF and related technologies is the ability to screen for genetic diseases. While Slovak law does not expressly mention Pre-Implantation Genetic Diagnosis (PGD), it does not prohibit it either. In practice, clinics likely offer PGD or at least pre-implantation genetic screening in cases of known hereditary risk – for example, where parents carry genes for cystic fibrosis or other serious disorders. There appears to be no legal restriction on examining embryos for medical conditions, as long as the purpose is to select a healthy embryo for implantation (which can be seen as a 'therapeutic purpose' benefiting the future child). The Oviedo Convention, which Slovakia follows, only permits genetic testing of embryos for health reasons and forbids selection of an embryo's sex except to avoid a sex-linked hereditary disease. Thus, sex selection for non-medical reasons is prohibited, but using PGD to prevent the birth of a child with a grave genetic illness is allowed (and arguably mandated by the child's best interests).

Similarly, donor gamete screening is mandatory under EU law: sperm and egg donors must be tested for infectious diseases (HIV, hepatitis, etc.) and certain genetic conditions. This protects the health of the resulting child by minimising transmission of diseases through ART.

During pregnancy (regardless of natural or ART conception), the child's health is guarded by standard prenatal care. The state provides for prenatal medical monitoring and certain benefits; and labour laws protect pregnant women from hazardous work, indirectly safeguarding the foetus. Once the child is born, they enter the public health system as any child, with rights to paediatric care and immunisations. There is no discrimination in access to health services based on being born via ART.

Non-discrimination is a core principle in Slovak law and international conventions. The Slovak Constitution and Family Act ensure that no legal distinctions are drawn between children born in wedlock, out of wedlock, or by any assisted method. Section 4 of Art. 41 of the Constitution explicitly states that 'children born in and out of wedlock enjoy equal rights'. This provision was originally meant to abolish the old stigma and lesser inheritance rights for 'illegitimate' children, but in modern application it means a child conceived via donor sperm to an unmarried woman, for example, has exactly the same rights as a child of a married couple. The law cannot discriminate regarding inheritance, support, citizenship, or status. If a birth certificate initially lists only a mother (with no father named), that child is not penalised; the mother has sole parental responsibility and the child has rights to maternal support and maternal family inheritance and may later have paternity established or an adoptive father, but at no point is the child considered of lesser 'status'. In court proceedings (custody, adoption, etc.), a child's ART origins should not influence decisions – the criterion is always the child's best interests, not the method of conception.

One of the clearest stances Slovak law takes in the ART context is the prohibition on the sale or trafficking of children (born or unborn). This aligns with the child's right not to be treated as a commodity or subject of trade – a right derived from human dignity and explicitly protected by criminal law in Slovakia. The Family Act voids any agreement that effectively 'cedes' a child from the birth mother to someone else. This was a deliberate legislative choice to pre-empt the possibility of surrogacy turning into baby-selling. If a surrogate mother were paid beyond reimbursement of her expenses – essentially a fee for the baby – that could be construed as trafficking in human beings. The Slovak Criminal Code criminalises human trafficking, including the transfer of a child for payment or other gain. Specifically, it is a criminal offense to hand over a child to another person for the purpose of adoption or other purposes in exchange for payment or reward (analogous to 'illegal adoption' offenses elsewhere). Thus, any commercial surrogacy arrangement would violate both civil and criminal law.

The infamous *Hájovský case*[75] illustrates this: a Slovak man advertised offering payment to a woman to be a surrogate and give him the baby. Not only was the surrogacy agreement unenforceable, but when the case became public, it was noted that trafficking in unborn children is illegal in Slovakia. The man's actions prompted public condemnation precisely because they were seen as trying to buy a child, contravening moral and legal norms.

The Family Act excludes the contractual disposition of the child's personal status. In other words, who is a child's parent or who will raise the child cannot be decided by a private contract – only by operation of law and judicial proceedings. This protects the child from being treated as an object of a deal. Even embryo donation is tightly constrained by this principle – the genetic parents cannot 'sell' an embryo to another couple.

In practice, Slovakia thus only countenances altruistic surrogacy (and even that only *de facto*, not *de jure*). If no money other than expenses changes hands, it is not trafficking. But even then, the surrogate arrangement is unenforceable, serving again to ensure the child's placement will be determined by the child's needs and legal adoption, not by contract.

The right to know one's parents is a sensitive issue in ART, especially in cases of donor conception or surrogacy. Art. 7 of the Convention on the Rights of the Child provides that as far as possible, a child has the right 'to know and be cared for by his or her parents'. Slovak law strongly protects a child's right to be cared for by their parents – as noted, the Constitution says 'children have the right to parental care and upbringing'.

Under current Slovak law, the right to know one's genetic origins is not yet well-established. Donor anonymity is the norm, meaning that if a child was conceived with donated sperm or ova, the identity of the donor is typically kept confidential by the clinic. There is no statutory mechanism for the child at 18 (or any age) to access

75 *Hájovský v. Slovakia*, No. 7796/16.

donor information, because legally the donor is not recognised as a parent at all. The Family Act's presumption (Section 87(2)) prevents disturbing the legal fatherhood of the mother's husband in donor cases, and there is no exception that would allow the child to challenge paternity to reveal a donor.

In a consented donor scenario, the law's view is that the 'father' is known – it is the husband (or male partner who acknowledged the child). The genetic progenitor is deliberately obscured to secure the family unit. By contrast, in adoption, Slovak law does allow an adoptee, upon reaching adulthood, to access information about their biological parents (with some procedures).

In conclusion, the legal right of a child to know their biological parents in Slovakia is limited. The law ensures the child knows who their legal parents are and is cared for by them, but if those are not the genetic parents, the law does not presently compel disclosure or enable contact with genetic progenitors. This is perhaps the one aspect of children's rights in ART where Slovak law lags behind evolving international norms. The principle of the child's best interests might call for more openness, but that conflicts with the long-held practice of donor anonymity. As of now, the scales are tipped toward confidentiality and the social family unit.

The principle of the best interests of the child is paramount in Slovak family law. In ART-related matters, applying 'best interests' can be complex because decisions often have to be made before a child exists (e.g. who can access ART, how to handle embryos) or immediately after birth (e.g. surrogacy handovers).

Under Slovak law, a 'child' (*dieťa*) usually means a person under 18 who has been born. The Family Act and other laws consistently use 'child' to mean an already born individual (for example, in custody, adoption, maintenance contexts). However, the unborn have certain protected interests – often phrased in terms of 'nascent life' or simply as the object of protection rather than as a rights-holder. The Constitutional Court, in the 2007 abortion law case, essentially ruled that the Constitution does not confer the status of 'child' with independent rights on an embryo/foetus. That said, the law does consider the welfare of the future child in some decisions. For example, in that case, the Court acknowledged the protection of the foetus through provisions ensuring care for pregnant women during first 12 weeks of pregnancy. Additionally, when restricting access to ART (such as not allowing access to single women), one rationale implicit is the purported best interests of the potential child – that is, the child should have two parents (a mother and father). Therefore, while an embryo or future child is not a legal person, policymakers invoke the 'child-to-be's' interests to justify certain rules.

Direct Slovak case law on ART and children's rights is limited. The Constitutional Court has indirectly set guiding principles (embryos do not have full rights; legislature should regulate reproductive issues in law; women's and children's rights must be balanced). Ordinary courts have handled a few surrogacy-related adoptions in the best interest of the child. There is a general judicial acknowledgment that while Slovak law does not endorse surrogacy, once a child is born, the child's status must be resolved in a way that protects them – an approach consistent with human rights

obligations. No ground-breaking Supreme Court or Constitutional Court precedents have yet emerged on donor conception anonymity or same-sex parenting via ART. This likely reflects that the judiciary has not yet been compelled to directly address these legal questions in Slovakia to date.

Children born through ART are fully protected under Slovak law – from the moment of conception (with the Constitution ensuring their life is 'worthy of protection') through birth and into upbringing. The Family Act and other statutes work to guarantee that every such child has legal parents, citizenship, and equal status, regardless of the unconventional path to their birth. Key rights – dignity, health, non-discrimination, freedom from sale, identity, nationality, and family life – are addressed though not always in explicit 'ART-specific' terms. Instead, general principles of family and child law are applied to ART situations.

7. Conclusion

The legal and regulatory framework for ART in Slovakia remains fragmented and outdated, failing to keep pace with medical advancements and societal changes. While ART is widely practiced and partially regulated under various legislative provisions, the absence of a comprehensive legal framework creates significant gaps and inconsistencies. Clinics are left to interpret vague or outdated rules, developing their own internal policies to address legal uncertainties, particularly in the areas of IVF, embryo storage, and donor gamete procedures. As a result, the Ministry of Health's 1983 regulation has largely lost its relevance; however, it remains in force, illustrating the outdated nature of Slovakia's ART regulation. This legal vacuum is increasingly filled by international norms and self-regulation by clinics, rather than clear domestic legislation, leaving both medical professionals and patients in a precarious legal position.

Despite partial regulation in areas such as access to ART, determination of parentage, informed consent, and gamete donation, Slovakia lacks legal clarity on critical issues. Among the most urgent challenges is the lack of a legal definition for ART itself – the existing definition of artificial insemination does not encompass the full spectrum of ART procedures. Similarly, no explicit definition of an embryo exists in Slovak law, raising ethical and legal dilemmas about its status, protection, and permissible uses. Regulations on storage, use, and disposal of embryos remain insufficiently developed, leaving questions about the legal status of frozen embryos, their fate in cases of parental death, and their potential use in research or therapeutic applications unanswered.

Slovakia's lack of ART legislation is increasingly untenable in the context of EU membership and international legal obligations. Unlike common law systems, where judicial precedent can gradually refine reproductive laws, Slovakia follows

the continental legal tradition, where detailed statutory regulation is essential. Slovakia's long history of state-directed legal control and its obligation to align with European legal standards make the current regulatory vacuum a legal and policy failure. Even leading Slovak ART specialists have publicly expressed frustration with the lack of domestic regulation, arguing that an updated legal framework would improve legal certainty for doctors and patients while aligning Slovakia with international bioethics standards.

Despite past legislative attempts, such as the failed 2006 Biomedicine Bill, Slovak lawmakers have yet to develop a coherent ART policy. If regulation is pursued, lawmakers face two competing approaches: a paternalistic model that heavily regulates ART to protect embryos and traditional family structures, or a liberal model that prioritises reproductive rights and access to ART for all individuals. The paternalistic approach defines an embryo as a rights-bearing entity under constitutional law, leading to restrictions on embryo creation, storage, and research.

In contrast, a liberal approach would view reproductive rights as fundamental, ensuring that access to ART is protected under constitutional guarantees of privacy and health. Slovakia must carefully determine where it stands on this spectrum. While the protection of human life and dignity is a legitimate state interest, equally important is ensuring that reproductive medicine operates within a legally sound, scientifically informed, and ethically responsible framework.

In conclusion, Slovakia's current ART regulation is inadequate, inconsistent, and unable to address the realities of modern reproductive medicine. The absence of a clear legal framework leaves medical professionals, patients, and policymakers navigating uncertain legal and ethical terrain, with international regulations and self-governance by clinics compensating for domestic legislative gaps. Future legislative efforts must strike a balance between protecting human dignity and ensuring access to safe and effective ART, recognizing that reproductive technologies are an essential part of modern medicine and family life.

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Chapter 11

Slovenia: Assisted Reproduction – Law, Policy, and Practice

Suzana Kraljić

Abstract

Slovenian law, particularly the Infertility Act, establishes strict regulations to ensure that assisted reproductive technologies are carried out ethically and legally. The law mandates that all assisted reproductive technology procedures, including egg and sperm donation, must be performed with the explicit, written consent of both the donors and the intended parents. This ensures that all parties are fully aware of the legal and ethical implications involved. Additionally, the law requires the establishment of detailed medical records for every assisted reproductive technology procedure. These records document critical information such as the identities of donors, the methods used in the procedures, and other relevant medical data. The purpose of these records is to ensure the transparency and ethical use of assisted reproductive technologies while also protecting the rights of the children conceived through such methods. The Infertility Act aims to prevent any misuse of assisted reproductive technologies and ensure that the interests of all individuals involved, especially the children born from these procedures, are protected. These measures contribute to both legal clarity and ethical standards within the practice of assisted reproductive technologies in Slovenia. According to the CCRS ruling from October 2024, changes to the Infertility Act are anticipated. These changes will focus on expanding the eligibility for ART to include same-sex couples and single women. This will also present an excellent opportunity to incorporate other improvements and updates, such as the transfer of embryos between centres and the expansion of the child's right to know their origin.

Suzana Kraljić (2026) 'Slovenia: Assisted Reproduction – Law, Policy, and Practice'. In: Aleksandra Korać Graovac (ed.) *The Best Interests of the Child Conceived by ART – Law in Book and Law in Action*, pp. 399–433. Miskolc–Budapest, Central European Academic Publishing.

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1. Policies Regarding Medical Help Through ART

1.1. Introduction

Fertility and reproduction are important for each individual, as well as for the family, society, and the State, as they represent a key element of the reproductive system. Fertility is also one of the key components of demographic development,[1] as it enables the continuation of the human race of the individual as well as the human species in the broadest sense. Both have received special attention both in the past and at present.[2] It is not surprising that infertility was viewed negatively, considered a social stigma, and often treated as a socially, mentally, and physically harmful experience for infertile women. Fatherhood was perceived more as a social concept than a biological one, and thus, the entire burden of infertility fell on women. Infertility was also a legitimate reason for divorce and a source of shame for women.[3]

Infertility is encountered in all parts of the world. The World Health Organization (hereinafter: WHO) defines infertility as 'a disease of the male or female reproductive system defined by the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse'.[4] Infertility can further be divided into primary and secondary infertility. Primary infertility in a woman is defined as one who has never been pregnant and in a man as one who has never impregnated any partner. Secondary infertility in women refers to the inability of a woman to conceive again after a previous successful pregnancy. In men, it refers to the inability to fertilise a woman again after a successful fertilisation of the same or any previous partner.[5]

Achieving Sustainable Development Goals (SDGS 3) (ensure healthy lives and promote well-being for all at all ages) and SDGS 5 (achieve gender equality and empower all women and girls) is also related to infertility topics. Infertility is also acknowledged as being essential to fulfilling the human rights to the enjoyment of the

1 Bratuž Ferk, 2024, p. 3.
2 The importance of fertility and reproduction is also seen in the Bible, where it is written in Genesis 1:27-28: '...Then God blessed them, and God said to them, 'Be fruitful and multiply...'.
3 Sharma, Saxena and Singh, 2018, p. 10.
4 World Health Organization, 2024.
5 World Health Organization, 2023a; see also Kraljić, 2024, p. 711.

highest attainable standard of physical and mental health and to decide the number, timing, and spacing of one's children.[6]

Globally, the World Birth Rate (hereinafter: WBR) has been continuously declining. The first statistical data dates back to 1950, when the WBR was 37.844 births per 1,000 people. Interestingly, since 1950, there has been a consistent decrease. Since then, the WBR has not increased but has declined each year. For example, in 1960, there were 35.346 births per 1,000 people. In 1976, the WBR dropped to 29.682 births – this was the first time the WBR fell below 30,000. In less than 25 years, the WBR fell below 20,000, with only 19.991 births per 1,000 people recorded in 2010. By 2024, the WBR had further decreased to 17.134 births per 1,000 people. Predictions indicate that the decline will slow down, but it is still expected that the WBR will reach 11.497 births per 1,000 people by 2100.[7]

In the past 100 years, the number of live births in Slovenia has more than halved. The highest number of births occurred in 1923, while the lowest was recorded in 2024. The total fertility rate reached its last value of 2.1 in 1980, which is the rate essential for simple population replacement. After that year, it began to decline sharply.[8] The last generation with more than 30,000 births was born in 1979. In 2023, however, fewer than 17,000 children were born in Slovenia for the first time. By 2024, the number decreased further, with only 16,735 births recorded.[9]

Globally, or even just within Slovenia, it is important to note that more and more couples are facing challenges related to infertility. The causes of infertility are diverse and can affect both men and women, or even both partners. These causes can be temporary or permanent. The cause of infertility may be organic, functional, or environmental. An unhealthy lifestyle, such as smoking, excessive alcohol consumption, underweight, obesity, poor diet, and sexually transmitted infections, can negatively impact the fertility of both men and women. Additionally, reduced fertility can result from exposure to environmental pollutants, such as chemicals that disrupt the endocrine system or pesticides that can directly harm reproductive cells (eggs and sperm).[10]

It is therefore not surprising that reproductive medicine, or assisted reproductive technologies (hereinafter: ART), represent one of the rapidly developing fields of medicine. Although being a medical field, the impact of its development is of significant importance to both individuals and society. The regulatory approaches of countries to regulating ART vary greatly. Differences may exist regarding the eligibility criteria, the criteria for entitlement to (co)financing of reproductive technologies, the availability of reproductive technologies in the chosen country, etc.

6 World Health Organization, 2023b, p. 9.
7 Macrotrends, 2025.
8 Bratuž Ferk, 2024, p. 3.
9 M. Z., 2025.
10 Bart et al., 2024; Carson and Kallen, 2021; Sorensen et al., 2024.

1.2. Slovenian Policies

As referred to earlier, fertility is a key demographic element. In Slovenia, we are facing a decline in the overall fertility rate, which has more than halved in the past 100 years. The highest number of births occurred in 1923 (40,710 births).[11] In 2023, it was the first time in history that fewer than 17,000 children were born in Slovenia. A total of 8,677 boys and 8,312 girls were born, amounting to 16,989 children.[12] In 2024, we recorded an additional decline, with only 16,735 births.

Fertility in Slovenia is declining. Some people do not want to have children or do not want more than one or two. However, there are still many couples who have the desire for a child but are unable to achieve this due to infertility issues. Because of the failure to conceive naturally, they seek hope and solutions in the available reproductive technologies. The desire for a child can be powerful, and infertility can severely impact mental health, leading to anxiety, depression, and relationship difficulties.[13]

A key milestone for such couples (also including Slovenian ones) was the birth of Louise Joy Brown ('the first test-tube baby'), born on July 25, 1978.[14] Her birth was based on reproductive technology that, in the following years, allowed many couples who could not conceive naturally to have children. Despite the fact that scientists Patrick Steptoe and Robert Edwards made history with their achievements, the medical community at the time rejected their success, claiming that the procedures were unethical.[15] Regardless of the negative connotation, Louise's birth immediately received widespread public attention worldwide, as it was a medical phenomenon. Much less attention was given to the challenges that this medical phenomenon and the new possibility of having children posed for legislation, as courts and lawmakers had to confront these issues quickly.[16]

11 Bratuž Ferk, 2024, p. 3.
12 Žnidaršič, 2024.
13 Yusuf, 2016, p. 1340.
14 Petrushko, Piniaiev and Yurchuk, 2021, pp. 316, 318; Laurie, 2024, p. 143.
15 However, the origins of artificial insemination can be traced back even further. Sharma, Saxena, and Singh (2018) mention the earliest signs of artificial insemination techniques as far back as the ancient period (3500 BCE – 500 CE). They reference Vedic literature, which shows that the general population was familiar with the concept of artificial insemination, involving the manual injection of semen into the woman's reproductive tract. The creation of magical concoctions by sages for childless queens to help them conceive was a common practice during this time (Sharma, Saxena and Singh, 2018). A key milestone in the development of reproductive medicine is attributed to the priest and scientist Lazzaro Spallanzani, who discovered that the embryo develops as a result of physical contact between the egg and sperm. In 1780, he performed artificial insemination on a dog, resulting in the birth of puppies (Sharma, Saxena and Singh, 2018). In 1790, Scottish physician John Hunter used this same technique to treat the infertility of a married couple. He injected sperm into the wife's genitalia, and she became pregnant and gave birth to a healthy child (Petrushko, Piniaiev and Yurchuk, 2021, p. 316; see also Seiz et al., 2023, p. 24).
16 Crockin, Altman and Edmonds, 2021, p. 23.

The development of reproductive medicine has also influenced the policies of states, which have approached the issue in various ways. The diversity of approaches among individual states can be attributed to factors such as the political system of the country, the level of healthcare development and the accessibility of health services, historical and religious foundations, and the moral, philosophical, and other beliefs that prevail in a particular society or country.

The range of ART is currently comprehensive. For example, it can include gamete (sperm and eggs) and embryo donation, pre-implantation genetic testing of embryos, surrogacy, as well as seemingly endless combinations of ART. ART has increased the number of people who can become parents, as well as the number of individuals, both men and women, who can genetically or gestationally contribute to the creation of children they do not intend to raise. These revolutionary ART techniques now enable many infertile couples, same-sex couples, and single individuals to become parents with a certain degree of genetic and/or gestational connection to the resulting child.[17]

Slovenia adopted its first law related to assisted reproduction even before the birth of Louise Joy Brown. The Act on Health Measures in the Exercise of the Right to Decide Freely on the Birth of Children'[18] (hereinafter: Childbearing Act) was already adopted in 1977 and is still partly in force today. The rapid development in the field of reproductive technologies, which also raised new legal questions, led in 2000 to the transfer of chapter IV. The Detection and Treatment of Reduced Fertility of the Childbearing Act into the newly enacted Infertility Treatment and Procedures of Medically-Assisted Reproduction Act[19] (hereinafter: Infertility Act).

Art. 1 stipulates that the Infertility Act governs the medical measures intended to assist eligible persons in conceiving a child and thereby enable them to exercise their freedom to decide on the birth of their children. According to Art. 2(1) of the Infertility Act, everyone has the right to infertility treatment in the manner and under the conditions specified by the Infertility Act. Art. 3 of the Infertility Act defines what constitutes treatment. Treatment under the Infertility Act includes diagnosing the causes of infertility or reduced fertility and medication, surgical interventions and the donation of reproductive cells. Treatment also includes the retrieval and storage of male and female reproductive cells where, according to the findings and experience of medical science, there is a risk that the person concerned will become infertile (Art. 3(2) of the Infertility Act).

The ART procedures are defined in Art. 4(1) of the *Infertility Act*, specifying that these are procedures for the insemination of a woman, carried out with the help of

17 Crockin, Altman and Edmonds, 2021, p. 23.

18 Act on Health Measures in the Exercise of the Right to Decide Freely on the Birth of Children (Childbearing Act – Slovene: *Zakon o zdravstvenih ukrepih pri uresničevanju pravice do svobodnega odločanja o rojstvu otrok*): Uradni list SRS, št. 11/77, 42/86; Uradni list RS, št. 70/00 – ZZNPOB; 90/25.

19 Infertility Treatment and Procedures of Medically-Assisted Reproduction Act (Infertility Act – Slovene: *Zakon o zdravljenju neplodnosti in postopkih oploditve z biomedicinsko pomočjo*): Uradni list RS, št. 70/00, 15/17 – DZ, 100/24 – odl. US.

biomedical science, with the aim of conception through means other than sexual intercourse. It is, therefore, evident from this that ART procedures under Slovenian legislation will be applied in cases where sexual intercourse is excluded and replaced by medical diagnostics and laboratory procedures. This, in turn, leads to the removal of intimacy between the prospective parents.[20]

In April 2001, an amendment to the *Infertility Act* was adopted, which, among other things, allowed artificial insemination for women without a partner. This provision was the main reason for the referendum held on June 17, 2001. The referendum question was: 'Are you in favour of the enactment of the Act on Amendments and Additions to the Infertility Treatment and Procedures of Medically-Assisted Reproduction Act (EPA 1318-II), adopted by the National Assembly on April 19, 2001?' In the referendum, which had a turnout of only 35.66%, 26.38% of voters (149,799) voted in favour, while 72.36%, or 410,856 voters voted against. Therefore, the majority of voters voted against the implementation of the Act on Amendments and Additions to the Infertility Treatment and Procedures of Medically-Assisted Reproduction Act (EPA 1318-II).[21]

In October 2020, a constitutional review of the *Infertility Act* was initiated. According to the applicants, the existing legislation was discriminatory toward single women and, therefore, unconstitutional. Despite three prior requests for constitutional review, the Constitutional Court of the Republic of Slovenia (hereinafter: CCRS) had never addressed the substance of the Infertility Act. The previous requests (of February and March 2013 and December 2014) were all rejected by the CCRS on procedural grounds. The applicant (Levica) argued that the existing legal framework was discriminatory because it forced women to go abroad for treatment. Treatment abroad is only available to those who can afford it. According to the applicant, this is a right that should not depend on the social or financial status of a woman.[22] The applicant argued that it was high time to eliminate the discrimination against single women, thus aligning Slovenia with European countries that have already done so (e.g., Belgium, Croatia, Germany, Finland, Hungary, Iceland, the Netherlands, Denmark, Spain, Portugal, Sweden, and the United Kingdom). However, Austria, Belgium, Denmark, Finland, France, Germany, Iceland, Ireland, Luxembourg, Malta, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland and the United Kingdom have already granted this right to lesbian couples.[23] The CCRS ruled on 16 October 2024 in the constitutionality review procedure:

1. Arts 5, 6, 8, 12, 22, 23, and 24 of the *Infertility Treatment and Procedures of Medically-Assisted Reproduction Act* (Official Gazette of the Republic of Slovenia,

20 Zadravec, 2023, p. 7.
21 Državna volilna komisija, no date.
22 Al. Ma., 2020.
23 Constitutional Court of the Republic of Slovenia decision ECLI:SI:USRS:2024:U.I.418.20, 16 October 2024, para. 36.

No. 70/2000) are in conflict with the Constitution, insofar as women who live in same-sex marriages or civil unions, and single women, are not entitled to medically-assisted reproduction.

2. The National Assembly shall abolish the identified inconsistency referred to in the preceding point within one year after the publication of this Decision in the Official Gazette of the Republic of Slovenia.[24]

The CCRS decision has thus opened the door to access to ART procedures for women living in same-sex marriages or civil unions, as well as for single women. The non-compliance of the existing legislation must be remedied within one year of the CCRS decision.[25] The CCRS decision thus also entailed a derogation from the principle of subsidiarity of ART procedures. ART procedures were only to be used if a couple could not conceive a child through sexual intercourse and there was a medical indication for their use (the so-called concept of medical infertility).[26] However, the CCRS decision of October 2024 derogated from this principle by allowing ART to be made available to women living in a same-sex marriage or civil partnership as well as to single women.

It is also important to mention the CCRS decision of 21 January 2021, which repealed the provision of the 'Rules on Compulsory Health Insurance'[27] (hereinafter: RCHI) setting the age limit for the right to assisted reproduction. Art. 37 of the RCHI sets an upper age limit of 43 years for women to be eligible for ART procedures. However, the Infertility Act did not provide for such age restrictions, stating only that 'a woman shall be in an age range that is suitable for childbirth'. Therefore, the Infertility Act did not exclude the possibility of granting (at least exceptionally) ART for a woman who had reached the age of 43, as long as there were no other proficiently justified (recognised) obstacles preventing the implementation of ART. The approval of ART for women aged 43 or older was, however, disallowed by Art. 37(2) of the RCHI. The argument for such an age restriction was based on medical expertise. The CCRS thus took the position that the subsidiary regulation[28] restricted

24 Constitutional Court of the Republic of Slovenia decision ECLI:SI:USRS:2024:U.I.418.20, 16 October 2024.

25 Since the inconsistency must be resolved by October 2025, the presentation and analysis of the legislative framework is based on the current legal arrangement as of December 28, 2024.

26 Constitutional Court of the Republic of Slovenia decision ECLI:SI:USRS:2024:U.I.418.20, 16 October 2024.

27 Rules on compulsory health insurence (RCHI – *Slovene Pravila obveznega zdravstvenega zavarovanja*): Uradni list RS, št. 79/94, 73/95, 39/96, 70/96, 47/97, 3/98, 3/98, 51/98 – odl. US, 73/98 – odl. US, 90/98, 6/99 – popr., 109/99 – odl. US, 64/00 – popr., 91/00 – popr., 61/00, 59/02, 35/03 – popr., 18/03, 30/03, 78/03, 84/04, 44/05, 86/06, 90/06 – popr., 64/07, 33/08, 7/09, 88/09, 30/11, 49/12, 106/12, 99/13 – ZSVarPre-C, 25/14 – odl. US, 25/14, 85/14, 10/17 – ZČmIS, 64/18, 4/20, 42/21 – odl. US, 61/21, 159/21 – ZZVZZ-P, 183/21, 196/21 – ZDOsk, 142/22 – odl. US, 163/22, 124/23, 82/24; 102/25; 601/26.

28 Art. 37 of the RCHI.

the right to ART[29] and therefore prevented the fulfilment of the right to decide freely about the birth of children, as guaranteed by Art. 55(1) of the CRS.[30] Consequently, the CCRS annulled the upper age limit for infertility treatment with assisted reproductive technologies.[31]

Consequently, the National Commission for ART has to assess on a case-by-case basis whether a woman falls within the age range acceptable for childbirth. However, it is essential to avoid procedures that are absolutely ineffective, where the treatment and consequently, the likelihood of success (in our case, due to age) are negligible. It is particularly important to consider the ethical unacceptability of such procedures (e.g., giving false hope). It would be rational to formulate such a legal provision and incorporate it into the Infertility Act.

According to the European Atlas of Fertility Treatment Policies,[32] Slovenia was rated significantly better in 2021 than in 2024. In 2021, Slovenia scored 71 points (71%) out of 100 attainable points, which placed it in the 'very good' category. In 2024, however, Slovenia was rated considerably lower, reaching only 59.6 points (59.6%).[33] Both in 2021 and 2024, Belgium ranked first. Given the decision of the CCRS, which opened the path to ART procedures for same-sex partners (spouses and cohabitants) and single women, we assume that Slovenia could regain some points in 2025, which could potentially improve its ranking again.

2. Constitutional Provisions

The Constitution of the Socialist Federal Republic of Yugoslavia,[34] stipulated in Art. 191, adopted on February 21, 1974, that 'it is the right of a person to decide on the birth of their children freely. This right may be restricted only for health reasons'. This constitutional provision of 1974 on the right to decide freely on the birth of children formed the basis of the adoption of an appropriate legislation in Slovenia in 1977 – namely, the Childbearing Act. At that time, the legal framework

29 Art. 6 of the Infertility Act.

30 Constitutional Court of the Republic of Slovenia decision Up-459/17–19, 21 January 2021, para. 19.

31 See also Rajgelj, 2021, pp. 39–41.

32 The European Atlas of Fertility Treatment Policies is designed to compare ART regulations across various perspectives: the presence of ART legislation, available treatments, public funding, and patients' perspectives. Each country is assigned a score between 0 and 100, with a score of 100 representing an ideal country. This includes having specific ART laws, a broad range of treatments accessible to most of the population (not just heterosexual couples, but also single women and same-sex couples), and coverage for multiple fertility treatments (Seiz et al., 2023, p. 26).

33 European Parliamentary Forum for Sexual and Reproductive Rights, 2024.

34 Constitution of the Socialist Federal Republic of Yugoslavia (*Slovene Ustava Socialistične federativne republike Jugoslavije*): Uradni list SFRJ, št. 9/74.

was among the most liberal ones not only in Yugoslavia but also in the European and global contexts.[35]

With the independence of Slovenia in 1991, a new Constitution of the Republic of Slovenia (hereinafter: CRS) was adopted.[36] The notion in the area of decision-making regarding the birth of children is already present in Art. 14, which refers to 'Equality before the law'. The first paragraph of this Art. lays down that 'In Slovenia, everyone shall be guaranteed equal human rights and fundamental freedoms irrespective of... birth... or any other personal circumstances'.

The principle of equality before the law[37] is also associated with constitutional provisions in Art. 54(2) of the CRS, which explicitly states that children born outside of marriage are granted the same rights as children born within marriage.

This is followed by Art. 55 of the CRS, which defines the freedom to decide on the birth of children. The State shall guarantee the opportunities for exercising this freedom and shall create conditions that will enable parents to decide on bearing children. The provision of Art. 55 of the CRS thus regulates a fundamental freedom rather than a right, the realisation of which is provided by the State by creating conditions that allow parents to decide on the birth of their children freely.[38] Art. 55(1) of the CRS guarantees the individual the freedom to decide whether to have children during their lifetime, when to become a parent, and how many children to have.[39]

Furthermore, the CCRS emphasised that the right to freely decide on the birth of children, as outlined in Art. 55 of the CRS, is counterbalanced by the State's positive obligation to provide individuals and couples with access to reliable techniques developed by medical science in the field of ART. The legislator enjoys a certain degree of discretion when regulating the area of ART. However, the CRS does not impose a positive obligation on the legislator to provide everyone with (at a certain point in time, based on the state of science and expertise) all biomedically feasible ART procedures. Neither Art. 8 of the European Convention on Human Rights[40] (hereinafter: ECHR) nor Art. 55 of the CRS do not guarantee a 'right to a child'. Moreover, the ECHR does not explicitly refer to the concept of reproductive health or reproductive rights.[41] However, legislators must respect the principles of equality, the prohibition of discrimination, the protection of human dignity, and the protection of the best interests of the child when regulating ART.

35 Ženski lobi Slovenije, 2024.

36 Constitution of the Republic of Slovenia (CRS – *Slovene Ustava Republike Slovenije*): Uradni list RS, no. 33/91-I, 42/97 – UZS68, 66/00 – UZ80, 24/03 – UZ3a, 47, 68, 69/04 – UZ14, 69/04 – UZ43, 69/04 – UZ50, 68/06 – UZ121, 140, 143, 47/13 – UZ148, 47/13 – UZ90, 97, 99, 75/16 – UZ70a, 92/21 – UZ62a; 98/25 – UZ74a.

37 Art. 14 of the CRS.

38 VSRS sodba I Uv 22/96-4, 7 November 1996.

39 Constitutional Court of the Republic of Slovenia decision ECLI:SI:USRS:2024:U.I.418.20, 16 October 2024, para. 32.

40 European Convention on Human Rights: Uradni list, št. 33/94.

41 Schultz, 2024, p. 193.

Based on Art. 55 of the CRS, this is a general provision regarding the free decision on the birth of children. A significant step forward was made on March 3, 2024, when France enshrined the right to abortion in its constitution as a 'guaranteed freedom'. This was supplemented by Art. 66-2, stating: 'No one shall interfere with the right to voluntary termination of pregnancy and contraception. The law ensures free and effective access to these rights for anyone who requests them'.[42] This clearly communicated France's commitment to upholding the right to abortion, and that regression will not be possible. A regression did, however, occur in the United States, where it was decided that, as of June 24, 2022, each State could decide whether to retain the right to abortion or not. Within a year, 14 States had banned the right to abortion entirely, while seven others imposed restrictions.[43]

Thus, Art. 55 of the CRS grants individuals, regardless of their gender, the right to decide freely whether, when and how many children they wish to have. It is for the State to provide the conditions for the individual to decide on starting a family and to offer various ways of exercising this right, without hindering them. This provision enacts the positive aspect of the right to respect for family life and the right to privacy.[44] The State is obliged to provide the individual with conditions enabling him/her to decide freely on establishing a family. This obligation also derives from the provision of Art. 53 of the CRS. This concerns particular conditions in the areas of health, social protection, education, employment, labour law and housing. The State may not, however, interfere with the freedom to decide on the birth of children in order to implement a specific population policy.[45]

It is also important to mention Art. 17 of the CRS, which stipulates that human life is inviolable. However, this does not apply to the foetus, as its existence depends on the will of the mother. Nevertheless, although direct protection is not guaranteed, civil law already grants certain rights to the foetus, provided that the child is born alive.[46]

3. Medical Regulation of ART

The Slovenian legal framework for ART procedures is defined by the Infertility Act, which in Art. 2(1), stipulates that everyone has the right to infertility treatment

42 In French language: 'Art. 66-2. – *Nul ne peut porter atteinte au droit à l'interruption volontaire de grossesse et à la contraception. La loi garantit à toute personne qui en fait la demande l'accès libre et effectif à ces droits*'; for more on this, see Berlinger and Xu, 2024; Schultz, 2024, p. 193; Mujović and Šobot, 2024, p. 208.

43 See more Heller and Ziyirova Abdijalilovna, 2024, pp. 29–30.

44 Art. 35 of the CRS.

45 Končina Peternel, 2002.

46 See VSM sodba I Cp 102/2018, 14 February 2018.

in the manner and under the conditions specified by the Infertility Act. This infetility Act governs the healthcare measures aimed at assisting eligible persons in conceiving a child and thereby enabling them to exercise their freedom of decision regading the birth of their children.

3.1. Medical Technologies

Based on Art. 3 of the Infertility Act, treatment includes (a) determining the causes of infertility or reduced fertility; (b) eliminating these causes through professional counselling, surgical procedures, and the donation of reproductive cells; (c) the collection and storage of male sperm cells or female egg cells when, based on the findings and experience of medical science, there is a risk that the individual may become infertile.

Art. 4(1) of the Infertility Act defines ART procedures as ones for the insemination of a woman achieve with the help of biomedical science for the purpose of conception in a manner other than through sexual intercourse. It distinguishes between: (a) intrauterine insemination (also IUI; in vivo): (aa) insertion of sperm cells into the woman's reproductive organs; (ab) insertion of egg cells together with sperm cells into the woman's reproductive organs; (b) extra-corporal fertilisation procedures (also IVF; *in vitro*): (ba) the union of egg cells and sperm cells outside the woman's body; (bb) the insertion of early embryos into the woman's reproductive organs.[47]

ART procedures can thus also be divided into: (a) procedures in which the reproductive cells of the woman and the man who are involved in the ART procedure are used (homologous fertilisation); and (b) ART procedures in which the reproductive cells (either egg or sperm) are donated by a third party (heterologous fertilisation).

The Slovenian Infertility Act does not provide an exhaustive list of ART procedures, thus not precluding the possibility of performing other procedures that may be developed or will be developed in the future by biomedical science.

Art. 4(3) of the Infertility Act stipulates that an embryo is created by fertilising an egg cell. An early embryo is a zygote and an embryo that develops outside the uterus for less than 14 days or until the appearance of the primitive streak. However, the provisions regarding early embryos also apply, mutatis mutandis, to embryos of the same age obtained by uterine flushing and to isolated omnipotent stem cells, if they are capable of developing into a viable new embryo.[48]

As a general rule, for ART procedures, the reproductive cells (gametes) of the woman and man who are married to each other or who are cohabiting partners are used[49] (so-called, endogenous techniques). In this case, there is no differentiation between parenthood, which is regulated based on the provisions for motherhood

47 Art. 4(2) of the Infertility Act.
48 Art. 4(4) of the Infertility Act.
49 Art. 8(1) of the Infertility Act.

and fatherhood under the Slovenian Family Code[50] (hereinafter: FC). In this case, the parents are also the biological parents of the child, and the child is considered the biological descendant of the father and mother, as defined in the FC.

ART techniques can also involve a third party. For ART procedures, donor egg cells or donor sperm cells (i.e., exogenous techniques) can be used, provided that, pursuant to Art. 14(1) of the Infertility Act, the donor must be of legal age, healthy, and of sound mind. Starting out fom the Slovenian legal regulations, donor reproductive cells (ova or sperm) will be used if: (a) according to the experience of biomedical science, there is no possibility of achieving pregnancy using the reproductive cells of the eligible persons; (b) where other ART procedures provided by Infertility Act have been unsuccessful; (c) if a woman and a man who are married to each other or are unmarried partners, where such procedures may prevent the transmission of a serious hereditary disease to the child; (d) a same-sex female couple who are married to each other or are unmarried partners; or (e) a single woman.[51]

Although the Slovenian Infertility Act does not provide an exhaustive list of ART techniques, leaving it open to developments in the field, it does define which ART techniques are prohibited under Slovenian law: (a) donation of human embryos is prohibited;[52] (b) the use of a mixture of sperm cells from two or more men, or egg cells from two or more women in ART procedures is not permitted either;[53] (c) the use of the donor's sperm cells to fertilise a woman who, due to consanguinity, could not legally marry the donor is prohibited. Similarly, egg cells from a donor may not be fertilised with sperm cells from a man who, due to consanguinity, could not legally marry the donor.[54]

Furthermore, Art. 3(2) of the Infertility Act provides that the collection and storage of sperm or egg cells shall also be considered as a treatment if, based on the knowledge and experience of medical science, the individual is at risk of becoming infertile. The collection and storage of reproductive material is, therefore, permitted only if there are medical indications that a person may become infertile. In Slovenia, so-called 'social freezing'[55] is not permitted, which involves the storage of egg cells by women who wish to delay motherhood for an indefinite period.

The Infertility Act also does not allow posthumous fertilisation. It is prohibited to perform ART with the sperm or egg cells of a donor who is no longer alive at the time of the insertion of the donated cells or early embryos into the woman's body. Before a doctor inserts the donated sperm or egg cells, or early embryos formed using the

50 Family Code (Slovene: *Družinski zakonik*): Uradni list RS, št. 15/17, 21/18 – ZNOrg, 22/19, 67/19 – ZMatR-C, 200/20 – ZOOMTVI, 94/22 – odl. US, 94/22 – odl. US, 5/23, 34/24 – odl. US.

51 Art. 8(2) of the Infertility Act.

52 Art. 13(1) of the Infertility Act.

53 Art. 13(2) of the Infertility Act.

54 Art. 14(2) of the Infertility Act.

55 Social freezing (also Elective egg freezing – EEF) allows young women to freeze their eggs as a way to prevent age-related infertility, giving them the option to have children when they are prepared later in life (Nakou, 2024, p. 11).

donated cells, into the woman's body, they must determine whether the donor is still alive.[56]

3.2. The Beneficiaries of ART

The Slovenian Infertility Act explicitly provides that ART procedures can only be performed with the intention of achieving the birth of a child.[57] According to Art. 5(2) of the Infertility Act, the beneficiaries of ART procedures are: (a) a woman and a man who are married to each other or are unmarried partners and who, according to the experience of medical science, cannot reasonably expect to achieve conception through sexual intercourse and cannot be assisted by other infertility treatments; (b) a woman and a man who are married to each other or are unmarried partners, where such procedures may prevent the transmission of a serious hereditary disease to the child; (c) a same-sex female couple who are married to each other or are unmarried partners; (d) a single woman.The marriage or cohabitation must exist at the time of the insertion of the sperm cells or early embryos into the woman's body.[58]

However, on October 16, 2024, the CCRS found that the Infertility Act is inconsistent with the CRS insofar as it excludes women living in same-sex marriages or cohabitation, as well as single women, from access to assisted reproductive technology procedures. On the other hand, the identified inconsistency will only be resolved through an amendment of the Infertility Act. Until the identified inconsistencies are remedied, the current legislative framework will continue to apply. The CCRS has mandated that the identified inconsistency should be rectified within one year from the publication of the decision in the Official Gazette of the Republic of Slovenia.[59]

Furthermore, beneficiaries of ART procedures must be of legal age, mentally competent, and of an appropriate age for undertaking parental responsibilities, as well as in a psychosocial condition according to which they can reasonably be expected to be able to exercise parental care in the best interest of the child. Additionally, a woman must be in an age range suitable for childbirth.[60]

The concept of 'age of eligibility for childbirth' represents an undefined legal term, which is to be determined in each specific case. The CCRS has annulled the provision of Art. 37(2) of the 'Rules on Compulsory Health Insurance' (hereinafter: RCHI), as well as the judgement of the Supreme Court of the Republic of Slovenia (hereinafter: SCRS), which had rejected a claim for the reimbursement of ART procedure costs incurred abroad.[61] The annulled provision of the RCHI stipulated that only women up to the age of 43 were eligible for ART procedures. The CCRS, in its

56 Art. 28(3) of the Infertility Act.
57 Art. 5(1) of the Infertility Act.
58 Art. 5(4) of the Infertility Act.
59 Constitutional Court of the Republic of Slovenia decision ECLI:SI:USRS:2024:U.I.418.20, 16 October 2024, para. 65.
60 Art. 6 of the Infertility Act.
61 Constitutional Court of the Republic of Slovenia decision Up-459/17–19, 21 January 2021, para. 19.

reasoning, emphasised that the by-law act (RCHI) had went beyond its authority, which could only derive from the law itself. A by-law can only regulate in more detail the rights derived from the law, but does not have the power to establish an absolute age limit. Such a limit would be permissible only if the legislator had delegated this authority to the Health Insurance Institute of Slovenia, which did not happen in the present case.[62] With the removal of the upper age limit, there is no restriction at the legislative level. However, the suitability of the candidate is determined through clinical analysis in each individual case.

The ART procedures, as defined by the Slovenian Infertility Act in Art. 4, can only be performed with the written consent of the beneficiaries.[63] Before providing a written consent for ART, the beneficiaries must be informed by the doctor about the ART procedure, the chances of success, the potential consequences, and the risks of the procedure for the beneficiaries and child, and receive counselling. The doctor will also inform them of the purposes for which their personal data will be collected and processed and explain that it will be protected as professional confidentiality.[64] If necessary, the doctor will refer the beneficiaries to psychological-social counselling regarding the intended ART procedure.[65]

The doctor must also explain the rules on the storage of reproductive cells (gametes) and embryos, ask about their intents concerning the duration of storage, and their decisions regarding any unused embryos.[66] Additionally, the doctor must explain other options that might resolve or bypass their infertility cause, including those not provided by the centre, and reveal non-medical choices such as adoption or the cessation of treatment.[67]

Written consent is required for each ART procedure individually.[68] The consent form for the ART procedure shall include, in cases where donated reproductive cells are used, a statement of the legal consequences of such procedure.[69]

Each of the beneficiaries of ART procedures may withdraw their consent and withdraw from the ART procedure before the sperm cells, unfertilised eggs, or early embryos have been inserted into the woman's body.[70] The centre must record the statement of revocation and, at the request of either of the spouses or cohabiting partners, issue a certificate to this effect.[71] The doctor must ensure that the consent has not been revoked before inserting the sperm cells, unfertilised eggs, or early embryos into the woman's body.[72]

62 Rajgelj, 2021, p. 39.
63 Art. 22(1) of the Infertility Act.
64 Art. 22(2) of the Infertility Act.
65 Art. 22(3) of the Infertility Act.
66 Art. 22(4) of the Infertility Act.
67 Art. 22(5) of the Infertility Act.
68 Art. 22(6) of the Infertility Act.
69 Art. 22(7) of the Infertility Act.
70 Art. 23(1) of the Infertility Act.
71 Art. 23(2) of the Infertility Act.
72 Art. 23(3) of the Infertility Act.

3.3. Providers of ART

ART procedures in Slovenia are carried out in public health services – in centres for ART's procedures (hereinafter: centres), which are specifically licensed for this activity.[73] A team of biomedical experts shall carry out the ART procedures under the direction of a medical doctor who shall be responsible for ensuring that the ARTs are performed in accordance with the Infertility Act. Currently, these procedures are carried out at three public centres located in UKC Ljubljana,[74] UKC Maribor, and the Hospital for Women's Diseases and Obstetrics in Postojna.

Every first ART procedure shall be subject to the prior approval of the Centre's expert advisory body.[75] The decision of the Centre's expert advisory body on ARTs may be appealed. The appeal shall be decided upon by the National Commission for ARTs, deciding on the appeal within 90 days. The National Commission for ARTs may reject the appeal as unfounded or overrule the decision of the expert advisory body of the Centre for ARTs and decide itself.[76] The laboratory part of the ART procedures may only be carried out on the basis of a decision by a medical practitioner.[77]

3.4. Financial Support of the State

Based on Art. 37(3) of the RCHI, a woman has the right to assisted reproduction under the conditions set out in the Infertility Act within the framework of specialised outpatient services. In the case of *in vitro* fertilisation, a woman is entitled to a maximum of six procedures for the first live birth and a maximum of four procedures for each subsequent birth. For women under 35 years of age, the first two *in vitro* fertilisation procedures involve the elective transfer of one high-quality embryo. The assisted reproduction procedure with frozen embryos counts as part of the *in vitro* fertilisation procedure in which the embryos were frozen. However, this issue should be transferred from the RCHI by-law and included in the Infertility Act.

73 Art. 15(1) of the Infertility Act.

74 Statistical data for the UKC Ljubljana centre: from 2001 to 2018, the centre obtained 139 sperm donors. A total of 286 recipient couples were involved in the procedures. By 2017, 217 children were born to 159 recipient couples through ART procedures with donated sperm in procedures involving the transfer of 'fresh' or 'frozen' embryos. Additionally, from 2001 to 2017, the centre obtained 66 egg donors. A total of 113 recipient couples were included in these procedures. By that time, 21 children had been born through ART procedures using donated egg cells in procedures with the transfer of 'fresh' or 'frozen' embryos, benefiting 18 recipient couples (Univerzitetni klinični center Ljubljana, no date).

75 Art. 15(2) of the Infertility Act.

76 Art. 15(3) of the Infertility Act.

77 Art. 15(4) of the Infertility Act.

The fundamental regulation for mandatory health insurance in Slovenia is the 'Health Care and Health Insurance Act'[78] (HCHIA). Under the compulsory health insurance, insured individuals are entitled to be reimbursed for healthcare services, including those related to reproduction, such as contraception, healthcare services related to pregnancy, childbirth, infertility treatment, artificial insemination, sterilisation, and abortion.[79] In these cases, the payment is guaranteed at a minimum rate of 99 percent.[80] Compulsory health insurance also covers healthcare services provided abroad,[81] reimbursed at a rate of 95 percent.[82] However, the Slovene Health Insurance Institute (ZZVZZ) does not have any additional provisions regarding the provision and treatment of reduced infertility or assisted reproductions.

3.5. Surrogacy

Surrogacy covers a practice where the surrogate mother agrees to become pregnant and give birth for the purpose of then forfeiting any parental rights over the child in favour of another person or couple (so-called 'intended parents').[83] A pre-conception agreement is based on the assumption that the child will pass to the intended parents at or shortly after birth.[84] A distinction is therefore also assumed between the 'positive' intention of the intended parents to acquire legal parenthood and the 'negative' intention of the surrogate not to become a parent.[85]

Surrogacy can be divided into two categories: (a) traditional surrogacy, (b) gestational surrogacy (also 'IVF surrogacy' or 'host surrogacy'). In traditional surrogacy, a surrogate mother is artificially inseminated, either by the intended father or an anonymous donor, and carries the baby to term. The child is thereby genetically related both to the surrogate mother, who provides the egg, and to the intended father or anonymous donor. In gestational surrogacy, an egg is removed from the intended mother or an anonymous donor and fertilised with the sperm of the intended father or anonymous donor. The fertilised egg, or embryo, is then transferred to a surrogate who carries the baby to term. The child is thereby genetically related to the

78 Health Care and Health Insurance Act (HCHIA – *Slovene Zakon o zdravstvenem varstvu in zdravstvenem zavarovanju*): Uradni list RS, št. 72/06 – uradno prečiščeno besedilo, 114/06 – ZUTPG, 91/07, 76/08, 62/10 – ZUPJS, 87/11, 40/12 – ZUJF, 21/13 – ZUTD-A, 91/13, 99/13 – ZUPJS-C, 99/13 – ZSVarPre-C, 111/13 – ZMEPIZ-1, 95/14 – ZUJF-C, 47/15 – ZZSDT, 61/17 – ZUPŠ, 64/17 – ZZDej-K, 36/19, 189/20 – ZFRO, 51/21, 159/21, 196/21 – ZDOsk, 15/22, 43/22, 100/22 – ZNUZSZS, 141/22 – ZNUNBZ, 40/23 – ZČmIS-1, 78/23; 32/25 – ZZDej-N.

79 Art. 23(1)(2) of the HCHIA.

80 Art. 104(1)(1) of the HCHIA.

81 Art. 23(1)(3) of the HCHIA.

82 Art. 104(1)(2) of the HCHIA.

83 European Court of Human Rights, 2024, p. 1; Horsey, 2024.

84 Kneebone, Hammarberg and Beilby, 2024, p. 1.

85 Lima, 2024, p. 246.

woman who donated the egg and the intended father or sperm donor, but not the surrogate.[86]

Greece was the first European country in 2002 to legalise surrogacy and establish a legal framework for the rights of parents involved in the process.[87] The Greek legal framework for surrogacy provides an exception to the traditional rule '*mater semper certa est*', which states that the biological mother of a child is always the one who gives birth to the child. Greek law stipulates explicitly that the parents who commission the child (so-called commissioning parents) become the legal parents of the child immediately upon its birth, just like the biological parents.

According to Art. 1464 of the Greek Civil Code, in cases of artificial insemination using a surrogate mother, the commissioning mother can obtain a court decision recognising her as the mother of the child even before his/her birth, provided that the conditions of Art. 1458[88] are met.[89] However, both the surrogate mother and the commissioning mother have the right to challenge the legal recognition of motherhood within six months after the child's birth, if they can prove that it is a case of traditional surrogacy, where the surrogate mother contributes both the womb and the egg cell, while the commissioning mother's partner contributes the sperm.[90]

In the event the either the surrogate mother or the commissioning mother challenges the legal parentage, the court will decide on the case, and if the decision becomes final, the surrogate mother will be recognised as the legal mother of the child retroactively, i.e., from the child's birth (*ex tunc*).[91] This provision allows for a precise determination of parental responsibility, even in cases of traditional surrogacy, where the biological parents are actually different individuals from the ones who carried and gave birth to the child.

Unlike Greek legislation, Slovenian legislation is negative towards surrogacy, as Art. 7 of the Infertility Act explicitly mentions surrogacy, but with a negative connotation. This is because a woman who intends to give her child to a third party for free or without compensation after birth (i.e., surrogacy) is not entitled to ART procedures.

86 European Court of Human Rights, 2024, p. 1; Horsey, 2024.

87 Greece was followed by Cyprus (2015) and Portugal (2016).

88 See Art. 1458 of the Greek Civil Code: 'Art. 1458. The transfer of a fertilised ova into the body of another woman (the ova should not be hers) and the pregnancy by her is allowed by a court authorisation granted before the transfer, given that there is a written agreement, without any financial benefit, between the persons wishing to have a child and the surrogate mother and in case that the latter is married, of her spouse, as well. The court authorisation is issued after an application of the woman who wants to have a child, provided that evidence is adduced not only in regard to the fact that she is medically unable to carry the pregnancy to term but also to the fact that the surrogate mother is in good health and is able to conceive'.

89 Lowe, 2016, p. 120.

90 Hatzis, no date.

91 Ibid.

Surrogacy is also referred to in Art. 121(3) of the Slovene Criminal Code,[92] which stipulates that anyone who unlawfully carries out a procedure of assisted reproduction for surrogacy will be punished with imprisonment for up to three years. Slovenia, therefore, belongs to the group of countries that do not allow surrogacy through ART procedures.[93] However, following the wording of the law, it can be concluded that surrogacy is therefore not explicitly prohibited in Slovenia. What is forbidden or criminalised is biomedical assistance in performing surrogacy, which means that, in practice, it is impossible to carry out surrogacy. However, it is not a criminal offence for a Slovenian couple to go abroad and, if the surrogacy procedure is admissible there, to have a child with the help of surrogacy.[94]

Slovenia, in terms of its approach to surrogacy, follows the stance of most European Union countries, but this does not mean that the issue has not arisen in Slovenian judicial practice. The Supreme Court of the Republic of Slovenia (hereinafter: SCRS) has also encountered a case involving surrogacy. A same-sex couple adopted a girl in the United States, who was born through surrogacy. The couple then sought recognition of the foreign court decision in Slovenia. The District Court in Ljubljana recognised the legal validity of the foreign judgement based on the submitted evidence. However, the Supreme State Prosecutor's Office filed a request for the protection of legality against the judgement, arguing that recognising a foreign court decision contradicts the public order of the Republic of Slovenia, as the country does not allow adoption by same-sex couples. In its judgement, the SCRS clarified that recognition of the foreign court decision did not imply that the court was ruling on the adoption of the child by two same-sex partners, but rather that it was solely recognising and protecting the already acquired rights.[95] The amendment to the FC, which took effect on January 31, 2023, legalized same-sex marriage and extramarital partnerships, thereby granting same-sex couples in Slovenia the right to jointly adopt children.

3.6. Handling Gametes or Early Embryos

The Infertility Act provides a relatively high level of protection for embryos, as it protects them from the zygote stage onward. Specifically, Art. 2(2) of the Infertility Act explicitly states that special care must be taken to protect the health, welfare, and rights of the future child in infertility treatments and ART procedures. Furthermore, Art. 4(4) of the Infertility Act defines an embryo as one created through the fertilisation of an egg cell. An early embryo, according to the Infertility Act, is a

92 Criminal Code (Slovene: *Kazenski zakonik*): Uradni list RS, št. 50/12 – uradno prečiščeno besedilo, 6/16 – popr., 54/15, 38/16, 27/17, 23/20, 91/20, 95/21, 186/21, 105/22 – ZZNŠPP, 16/23, 107/24-odl. US; Deisinger, 2017, p. 145.

93 Constitutional Court of the Republic of Slovenia decision ECLI:SI:USRS:2024:U.I.418.20, 16 October 2024, para. 25.

94 Jerič, 2018.

95 VSRS sklep II Ips 462/2009, 28 January 2010.

zygote or an embryo developing outside the uterus for less than 14 days or until the primitive streak appears.

Sperm cells, unfertilised egg cells, and early embryos can only be used for ART procedures. They must be handled and examined in such a way that, based on the current state of biomedical science and experience, pregnancy is achieved.[96]

However, sperm cells, unfertilised egg cells, and early embryos may also be used for scientific research.[97] Scientific research on gametes and early embryos obtained for the purpose of performing ART is permitted solely for the purposes of protecting and improving human health.[98] Early embryos may be subject to research only with the written consent of the beneficiaries undergoing ART procedures, with the permission of the National Commission for ART, and with the approval and under the supervision of the Medical Ethics Commission.[99]

Early embryos can only be researched with the written consent of the beneficaries undergoing ART procedures, with permission from the National Commission for ART, and with the approval and under the supervision of the Medical-Ethical Commission.[100]

Based on the listed permissions, research on early embryos is permitted if, according to the findings and experience of biomedical science, they are not suitable for implantation into the woman's body or for storage, as well as those stored embryos that would otherwise need to be discarded.[101] In the research of early embryos, the contemporary findings of medical science, experience, and established global practices must be taken into account, as well as the principles of general medical ethics.[102] Approval and supervision by the designated committees are also required for the introduction and use of any new ART methods as long as they are considered to be in the experimental phase.[103]

Art. 35(1) of the Infertility Act stipulates that sperm cells, unfertilised egg cells, and unused early embryos are to be stored for as long as the beneficaries undergoing ART procedures wish, but for no longer than ten years. If the beneficaries do not agree on the duration of the storage, the National Commission for ART will make a decision. Upon expiry of the ten years period, the storage of sperm cells, unfertilized ova, and early embryos may, with the permission of the National Commission for ART, be extended until the age considered appropriate for childbearing and the performance of parental responsibilities. Such an extension shall be granted on the basis of medical or other justified reasons, such as serious illness, medical treatment, or other exceptional personal circumstances. An application for an extension shall

96 Art. 30(2) of the Infertility Act.
97 Art. 30(2) of the Infertility Act.
98 Art. 38(1) of the Infertility Act.
99 Art. 38(2) of the Infertility Act.
100 Art. 38(3) of the Infertility Act.
101 Art. 38(4) of the Infertility Act.
102 Art. 38(5) of the Infertility Act.
103 Art. 38(6) of the Infertility Act.

be submitted by the eligible person from whom the reproductive cells originate.[104] After the specified period, sperm cells and unfertilised egg cells must be discarded, and early embryos must be left to perish.[105]

An egg cell must not be fertilised with a sperm cell that is specifically chosen to determine the child's sex unless it is intended to prevent a severe sex-linked hereditary disease (Art. 31(1) of the Infertility Act). Interference with the hereditary composition of sperm cells or embryos to alter the genetic changes of the child is not permissible.[106] The genetic testing of early embryos is only permitted in the case of the risk of a severe hereditary disease or if it is necessary for the success of the ART procedure.[107]

All egg cells obtained in one procedure may be fertilised outside the body. The number of early embryos that are transferred to the woman's body must not exceed the number, based on professional findings and experience, that is expected to lead to a successful ART outcome and the risk of multiple pregnancies must be limited as much as possible. No more than three embryos may be implanted into the woman's uterus in one procedure.[108] Any remaining early embryos from the initial procedure are to be stored and may later be implanted into the woman's body. The implantation may be carried out only upon the joint written request of the beneficiaries or upon a written statement by the eligible person (a single woman) who has given her own written consent to the commencement of the ART procedure.[109]

Art. 33 of the Infertility Act stipulates that the following actions are prohibited in ART procedures: (a) allowing the external development of an embryo that is older than 14 days, or after the primitive streak has developed; (b) creating an embryo solely for research purposes; (c) creating human embryos from gametes with induced changes to the genetic composition and transferring such embryos into a human or animal body; (d) using parts of embryos obtained in ART procedures unless explicitly specified; (e) creating embryos with identical genetic composition or embryos genetically identical to another living or deceased individual (cloning); (f) fertilising a human egg cell with animal sperm or animal egg cells with human sperm, or altering embryos by transplanting parts of other human or animal embryos (creating hybrids and chimeras); (g) implanting an embryo created through the processes described under items e) and f) into a human or animal body; (h) introducing human gametes or a human embryo into an animal; (i) introducing animal gametes or an animal embryo into a human; (j) intentionally altering the genetic composition of cells that are part of the embryo.

Sperm cells, unfertilised egg cells, and early embryos are stored for ART procedures as defined by the Infertility Act. They may only be stored by specially

104 Art. 35(2) of the Infertility Act.
105 Art. 35(3) of the Infertility Act.
106 Art. 31(2) of the Infertility Act.
107 Art. 31(3) of the Infertility Act.
108 Art. 32(1) of the Infertility Act.
109 Art. 32(2) of the Infertility Act.

authorised centres. In doing so, they must consider modern medical findings and established medical practice.[110]

Neither the individuals from whom sperm cells, unfertilised egg cells, and early embryos originate, nor any third parties are entitled to dispose of or handle these. The centre is not permitted to hand them over to anyone.[111] The transfer of such reproductive material between ART centres requires the consent of the National Commission for ART. The beneficiaries from whom the reproductive cells originate shall submit a written application for the transfer to the ARTcentre storing them. In the case of the transfer of early embryos, the two beneficiaries shall submit a joint written application, whereas a single woman shall submit an application on her own. The ART centre shall forward the application, which shall also contain the consent of the receiving ART centre, to the National Commission for ART.

It is not permissible to mediate the collection, storage, and use of sperm cells, unfertilised egg cells, and early embryos. Furthermore, it is prohibited to trade in stored sperm cells, unfertilised egg cells, and early embryos.[112]

3.7. Gametes Donations

For ART procedures, the gametes of a woman and a man who are in a marital or cohabiting partnership are typically used. However, donor eggs or sperm may be used when, based on the experience of biomedical science, pregnancy is not possible using the gametes of the couple or if previous ART procedures have failed, or if it is necessary to prevent the transmission of a severe hereditary disease to the child.[113]

A sperm donor is a man whose sperm is used for the fertilisation of a woman who is not his wife or cohabiting partner. An egg donor is a woman whose eggs are used for the fertilisation of another woman.[114]

It is not permitted to give or receive payment or any other benefit for donated gametes. Agreements to this effect are void. However, the donor of gametes has the right to reimbursement for the costs incurred in connection with travelling to the ART centre, for the accommodation, for the return trip, for examinations, and gamete retrieval and reimbursement of expenses due to lost earnings for the duration of the ART procedures.[115] Gamete donors may donate their eggs or sperm only to one and the same ART centre.[116]

Each ART procedure using the gametes of a donor is carried out at the request of a specialist in gynaecology and obstetrics (hereinafter: the doctor) after obtaining the consent of the professional advisory body of the ART centre and with the

110 Art. 34 of the Infertility Act.
111 Art. 36 of the Infertility Act.
112 Art. 37 of the Infertility Act.
113 Art. 8 of the Infertility Act.
114 Art. 9 of the Infertility Act.
115 Art. 10 of the Infertility Act.
116 Art. 11(2) of the Infertility Act.

permission of the State Commission for ART procedures. This professional advisory body consists of a doctor, an expert in embryology, a social worker, and a lawyer appointed by the director of the ART centre.[117] Before the ART procedure is performed using the gametes of a donor, the beneficiaries must attend psychological and social counselling.[118] The beneficiaries must be informed about the legal consequences of their consent to ART with the gametes of a donor and the legal consequences of the birth of a child conceived through ART. They must be informed about these legal consequences by a lawyer.[119]

Art. 13 of the Infertility Act stipulates that the donation of human embryos is not permitted. Additionally, the use of a mixture of sperm from two or more men, or egg cells from two or more women is not allowed in ART procedures.

The egg donor and sperm donor must be of legal age, healthy, and of sound mind. The sperm of the donor cannot be used to fertilise a woman whom, due to consanguinity, he could not legally marry. The egg of the donor cannot be fertilised with sperm of a man whom, due to consanguinity, she could not legally marry.[120]

4. Family Law Regulation

4.1. General

National legal frameworks of parenthood, that is, the legal rules governing the legal relationship between parents and children, still largely rely on the idealised image of the standard/traditional family – a married man and woman with their biological children. English terminology has also adapted to these changes. The term 'parentage' is used to refer to the genetic connection between a child and the person who provided the gametes that led to the child's conception. Thus, the term

117 Art. 12(1) of the Infertility Act.
The Supreme Court of the Republic of Slovenia, in its 2021 ruling, decided: 'The approval of the State Commission for Biomedical Assistance (ART) is not a condition that limits access to treatment abroad in terms of prior approval, but rather represents a condition required by national legislation for the authorisation of any heterologous ART procedure in the home country. If this condition is not met – if there is no approval, because the request for it has been rejected or has not been issued – heterologous ART cannot be performed in the Republic of Slovenia, regardless of the age of the insured person, nor at the expense of compulsory health insurance, nor in any other way (as it is not freely available). This means that, due to the link between the right to reimbursement for treatment abroad and the recognition of the right under national regulations, non-fulfilment of the conditions for access to heterologous ART in the home country indirectly constitutes a condition for obtaining the right to reimbursement for treatment abroad'. (Supreme Court of the Republic of Slovenia, judgment VIII Ips 21/2021, 21 December 2021).

118 Art. 12(2) of the Infertility Act.

119 Art. 12(3) of the Infertility Act.

120 Art. 14 of the Infertility Act.

'parentage' focuses on genetic truth or the presumed genetic truth. On the other hand, the term 'parenthood' refers to the person who raises the child. In addition to these two terms, the concept of 'legal parenthood' pertains to the person whom the law recognises as a parent.[121]

The development of reproductive medicine, and consequently ART procedures, has significantly shaped the field of family law as well. ART procedures allow couples and individuals to fulfil their desire for a child, something that once seemed impossible. However, advancements in reproductive medicine and the involvement of third parties in the fertilisation/conception process have called into question long-standing fundamental legal principles of family law, including the legal presumptions of motherhood and fatherhood and genetic relatedness as a prerequisite for parenthood. In this context, we can highlight the axiom that while the ART procedure can create children that were previously unimaginable, only family law can create a legally recognised family, including defining the ensuing rights and responsibilities among the various individuals involved and the descendants arising therefrom.[122]

4.2. Affiliation

The field of family law in Slovenia is governed by the FC, which was adopted in 2017 and came into effect in April 2019. The issue of parentage (motherhood and fatherhood) of children born through ART procedures is now regulated in the FC. Previously, these provisions were included in the Infertility Act, but with the enactment of the FC, they were transferred into it.

4.2.1. Motherhood

While in the past the presumption of motherhood was considered irrebuttable, the development of medical science in the field of biomedicine and reproductive medicine concretely led to the understanding that a mother who gives birth to a child is not necessarily the child's biological mother. A woman who is expecting a child (a pregnant woman) typically shows physical changes on her body that have historically been recognised as signs of pregnancy (e.g., a large belly, awkward gait, weight gain, childbirth, etc.). Although deviations from the legal presumption of motherhood could have occurred even in the past (e.g., a child being swapped in a hospital, a deliberately swapped or substituted child), it is only with the development of biomedicine that significant deviations from this classic legal presumption have emerged. With the development of biomedicine and the revolution in reproductive medicine, various ART procedures (e.g., *in vitro* fertilisation (IVF), egg and embryo donation, and surrogate motherhood) have also developed.[123]

121 Gilmore and Glennon, 2018, p. 351.
122 Crockin, Altman and Edmonds, 2021, p. 23.
123 D'alton Harrison, 2015.

The meaning of motherhood is already rooted in the CRS, as Art. 53(3) stipulates that the State protects motherhood and creates the necessary conditions thereof. This constitutional provision concerning motherhood is further supplemented by the content of Art. 55 of the CRS, which states that the decision regarding the birth of one's children is free and that the State shall ensure the possibilities for realising this freedom and create conditions that allow parents to decide on the birth of their children.

Regarding the legal regulation of motherhood, the FC follows the traditional framework, where the legal affiliation of a child to the mother, or motherhood, has traditionally been based on natural circumstances that led to such a conclusion based on certain natural experiences.[124] Motherhood, as the legal bond between a mother and a child, was traditionally established with the birth of the child. Therefore, the FC, regarding motherhood, is still based on the classic legal presumption *mater semper certa est*[125] (the mother is always certain).

Art. 112 of the Family Code stipulates: 'The mother of the child is the woman who gave birth to him/her'. This is a novelty, as its predecessor, the Marriage and Family Relations Act[126] (hereinafter: MFRA) of 1976, did not contain a legal presumption of motherhood at all. In 1976, there was generally no doubt regarding motherhood. Traditionally, this legal presumption was considered irrefutable. The mother was the one from whose womb the child came.

In most cases, someone observed or attended the birth of the child. Birth thus represented the constitutive element of the legal relationship between the woman (mother) and the child. Therefore, the woman who gave birth to the child was, as a rule, genetically, legally, and socially connected to her child. The legal presumption of motherhood was absolute, as it was not possible to provide evidence to the contrary.

This is precisely why the previous Slovenian MFRA did not contain the legal presumption of motherhood in its provisions, as it was assumed that the biological mother was the woman who gave birth to the child. Additionally, earlier family law textbooks showed that little attention was given to motherhood, as it stemmed from the irrefutability of the legal presumption *mater semper certa est*.[127] The current provision in Art. 112 of the FC, therefore, represents a cogent provision, as it does not allow for autonomy (e.g., spouses cannot determine for themselves who will be the mother of the child).[128]

The development of reproductive medicine has, as referred to previously, made it possible for many to fulfil their desire for a child. On the other hand, it has led to

124 Lüderitz, 1999, p. 243.

125 Paulus: Digeste 2.4.5; see also Scherpe, 2016, p. 85.

126 Marriage and Family Relations Act (Slovene *Zakon o zakonski zvezi in družinskih razmerjih*): Uradni list RS, št. 69/04 – uradno prečiščeno besedilo, 101/07 – odl. US, 90/11 – odl. US, 84/12 – odl. US, 82/15 – odl. US, 15/17 – DZ, 30/18 – ZSVI.

127 Kraljić, 2022, p. 43.

128 Lüderitz, 1999, p. 243.

what is known as 'split motherhood' (German: *gespaltene Mutterschaft*[129]). This means that a woman can give birth to a child, even though she is not genetically related to it. This is particularly relevant in the case of egg donation, embryo donation, and surrogate motherhood. Donating female gametes (eggs) and donating embryos allow a woman to give birth to a child who is not genetically connected to her. This has led to a separation between 'genetic motherhood' and 'gestational or medical motherhood'. The first is related to the origin of the egg, while the second concerns pregnancy and carrying the child to birth.[130] This distinction is particularly prominent in the case of surrogate motherhood.

As referred to earlier, with the enactment of the FC, the provisions relating to the motherhood of a child conceived through ART procedures were transferred. A woman who has consented to an ART procedure and signed a corresponding declaration is considered to be the mother of the child, and her motherhood cannot be contested. The prohibition against contesting motherhood applies to anyone, not just the mother herself.

4.2.2. Fatherhood

On the other hand, fatherhood was long believed to be unviable to verify. In verifying or contesting fatherhood, courts relied on both expert opinions and actual facts (for example, fatherhood could be disputed if it was proven that the father was not in the country at the time of conception). On the other hand, if the father had sexual intercourse with the mother at the time of conception, he was considered the father, even if it was proven that the mother had relations with several men (e.g., 20).[131]

Regarding the fatherhood of a child born within marriage, the Slovenian FC also follows the classic legal presumption *pater est quem nuptiae demonstrant* (the father is the one designated by marriage). Art. 113(2) of the FC stipulates, 'The husband of the child's mother is considered the father of a child born in marriage'. This legal presumption also applies to a child born within 300 days of the dissolution of the marriage. However, this only applies if the dissolution took place due to the death of the child's mother's husband and the child is born within 300 days after the dissolution of the marriage. In this case, the deceased husband of the mother is considered the father of the child.[132] The case may be that the mother enters into a new marriage within 300 days after the dissolution of the previous marriage, and a child is born in this new marriage. In that case, the mother's new husband is considered the father of the child, regardless of the reason for the dissolution of the previous marriage.[133]

129 Adapted from Dethloff, 2015, p. 282.
130 Lüderitz, 1999, p. 243; Dethloff, 2015, p. 282; Kraljić, 2019, p. 383.
131 Cretney, 2000, pp. 193–194.
132 Art. 113(2) of the FC.
133 Art. 113(3) of the FC. Kraljić, 2019, p. 386.

The father of a child who is not born in marriage or within 300 days after the dissolution of the marriage due to the death of the child's father is the man who acknowledges paternity or whose paternity is established by a court decision.[134]

For the father of a child conceived with biomedical assistance, the mother's husband or her cohabiting partner is considered the father, provided that both have appropriately consented to the ART procedure.[135] It is not surprising that the mother's husband or cohabiting partner is regarded as the father of a child conceived through ART, as the execution of an ART procedure requires written consent from both prospective parents. It is not sufficient for only one partner to consent. If a partner decides to withdraw his/her consent, this decision must be respected.[136] Before the ART procedure is carried out, the doctor must ensure that mutual consent still exists.

The paternity of a child conceived through ART procedures cannot be contested except in cases where it is claimed that the child was not conceived using ART.[137] If the child was conceived using donor sperm, the paternity of the donor cannot be established.[138] It should be emphasised that the legal presumption of paternity is conditional upon valid expressed consent. If it turns out that the consent was not in accordance with the provisions of the Infertility Act, the legal presumption will not apply. In the case of heterologous ART procedures, it is not permitted to establish the paternity or maternity of the donors. Legal and social bonds, therefore, exist only within the family.

The Slovenian Infertility Act and the FC remain silent on the fate of embryos in the event of a separation between partners. The only reference to this issue is related to the consent required from both partners at the time of the embryo transfer into the woman's body. Furthermore, a marriage or a cohabitation must exist. The doctor is required to verify that both the partnership and the consent exist at the time of the transfer. The current regulation thus provides a satisfactory situation. However, it would be appropriate for the legislator to address this issue explicitly, particularly considering the decision of the CCRS from October 2024, which opens the possibility of ART procedures also for single women and same-sex partners. In such cases, a situation may arise where the partnership has dissolved, but the woman still wishes to proceed with fertilisation through ART. In this case, only her consent would be required for fertilisation. Therefore, the legislator should also address, *de lege ferenda*, the situation regarding the fate of embryos in the event of the dissolution of a partnership. This would further ensure predictability and legal certainty.

134 Art. 114 of the FC.

135 Art. 134(1) of the FC.

136 The European Court of Human Rights also addressed this issue in the case of *Evans v. the United Kingdom* (App. No. 6339/05, 10 April 2007).

137 Art. 134(2) of the FC.

138 Art. 134(3) of the FC.

4.3. Right of the Child to Know His/Her Origin

The right to know one's origins is considered a fundamental right of the child, yet it has not been explicitly recognised in either the CRS or the FC since 2017. It seems as though the Slovenian FC prioritises the interests of biological parents, allowing them to maintain anonymity. However, in 2007 the CCRS already took a clear position, stating that an individual's right to know their origins is part of personal rights, which are protected by Arts. 34 and 35 of the CRS. Human personality is a composite of various personal goods that are protected by specific personal rights inherent to an individual. By guaranteeing personal rights, elements of an individual's personality not protected by other provisions of the CRS are safeguarded, and together with them, the individual is provided with the opportunity to freely develop and shape their life according to their own decisions. One of the key elements crucial to the development of an individual's personality is knowing their own origins, meaning knowing who their biological parents are. This is an essential aspect of an individual's self-conception and their place in society. Knowing one's origins also significantly influences family and kinship bonds. The inability to determine one's own origins can impose a severe burden and uncertainty on the individual. Therefore, the right to know one's origins falls under the scope of personal rights.[139]

The State bears the responsibility of adopting appropriate legislation in the field of family law. It must ensure that gamete donors do not bear parental responsibilities for children conceived with their gametes. Following Art. 27 of the Infertility Act, donors have no legal or other obligations or rights to children conceived through ART procedures. On the other hand, the State has an obligation to ensure the maintenance of registries and records, such as those of donors.[140]

Donors must be fully informed about the consequences of donating with an open identity and the fact that they may be committing to updating their records for life and potentially meeting their genetic offspring one day. This also means that parents must be advised and made aware that they should carefully consider the implications of having a child conceived with donated gametes. They should also consider allowing their children access to such information, should they desire it, and reflect on the potential impact disclosure may have on their family.[141]

So Art. 18(3) of the Infertility Act further stipulates that the child may request medically necessary information about the donor after reaching 15 years of age, provided that he/she is mentally competent. The child's legal representative may be given such information only with permission issued by a court in cases of exceptionally important medical reasons (for example, in the case where a child has leukaemia and needs a bone marrow transplant to survive, the donor could be anonymously

139 Constitutional Court of the Republic of Slovenia Decision, No. U-I-328/05-12, 18 October 2007, para. 8.

140 Art. 39 of the Infertility Act.

141 Ravitsky, 2017, p. 3.

asked to donate bone marrow, but they would not be obligated to help). The child's doctor has the right to access information in the donors' registry for reasons related to health. The court and administrative body have a right to access information in the registry if that is absolutely necessary for carrying out their official obligations under this law.

The consideration of removing the anonymity of donors raises the question of how this would impact donation rates in Slovenia. The concern is that this could lead to a shortage of potential donors, which would not be in the best interest of individuals who require third-party assistance to conceive a child. However, the positive experiences of other countries have shown that much can be achieved through carefully managed campaigns that promote the altruism of donors.[142]

5. Rights of the Child and ART

5.1. Before Birth

The Slovenian legal framework (outside of the Infertility Act) is quite limited in terms of specific provisions related to the protection of embryos. There are no provisions regarding the healthcare of embryos in the RCHI or HCHIA. An embryo's healthcare is achieved through the mother, not independently, as it is not yet a child and thus does not possess legal subjectivity.

Embryo protection can, for example, be found in Art. 17 of the Childbearing Act, which allows for the artificial termination of pregnancy as a medical procedure that can be performed at the request of the pregnant woman if the pregnancy does not surpass ten weeks.

In general, embryos, according to Slovenian law, are not bearers of rights and obligations. However, there are exceptions. For example, Art. 119(2) of the FC refers to the prenatal acknowledgment of paternity or the recognition of the *nasciturus*. The acknowledgment of paternity of an unborn child shall have legal effect only if the child is born alive. A special provision is found in Art. 119(2) of the FC, which also allows for the acknowledgment of a stillborn child or a child who died immediately after birth (i.e., posthumous recognition). A stillborn child does not acquire legal subjectivity; however, there may be a need and legitimate interest to establish a legal relationship between the parents and the stillborn child this way. This can have certain legal consequences, especially in the area of personal rights regarding parental care for the deceased (e.g., exercising religious rights in relation to the proper

142 Ravitsky, 2007, p. 3.

burial of the deceased child). The recognition of paternity for a stillborn child also allows for registration in the civil registry.[143]

Art. 125(2) of the Slovene Inheritance Act[144] states that a child who has already been conceived at the time of the initiation of inheritance shall be deemed to be born, provided they are born alive. Art. 202 of the Inheritance Act also refers to an unborn child:

> If the birth of a child who would be entitled to inheritance is anticipated, the probate court shall inform the competent social services centre thereof. 2. Unless the aforementioned centre decides otherwise, one of the child's parents shall take care of the child's rights.

Additionally, it is important to highlight the wording of Art. 35(3) and Art. 38(4) of the Infertility Act. Both Arts. use the phrase referring to 'allowing early embryos to die'. This phrasing is appropriate and reflects respect for the dignity of embryos, as it does not use terms such as 'destroy' or 'terminate'.

5.2. After Birth

An embryo is thus considered to have the potential for life, and even constitutional theory recognises certain rights for it (e.g., the right to dignity). However, the Slovene FC, apart from the cited Arts., refers to a child, which is defined in Art. 5 of the FC: 'For the purposes of this Code, a child shall be a person under the age of 18 unless they have obtained full capacity to contract before that age'. The FC follows the definition of a child provided by the Convention on the Rights of the Child. In this context, legal protection, except in the mentioned cases, applies to the child from his/her birth onward.

Once a child is born, their birth must be registered in the civil register within 15 days. This is followed by an entry in the civil register.[145] The birth of a child shall be entered in the civil register by the registrar of the competent authority in whose territory the place of birth is located.[146] This ensures the implementation of Art. 7(1) of the Convention on the Rights of the Child, which stipulates that a child shall be registered immediately after birth and shall have the right from birth to a name. The provision on the determination of a child's personal name is contained in the

143 Kraljić, 2019, p. 403; Novak IN Novak, 2019, p. 380; Felc IN Weber, 2024, p. 335.

144 Inheritance Act (Slovene Zakon o dedovanju): Uradni list SRS, št. 15/76, 23/78, Uradni list RS, št. 13/94 – ZN, 40/94 – odl. US, 117/00 – odl. US, 67/01, 83/01 – OZ, 73/04 – ZN-C, 31/13 – odl. US, 63/16, 102/24.

145 Art. 8(1) of the Register of Deaths, Births, and Marriages Act (hereinafter: Register Act). Register of Death, Births and Marriages Act (Register Act – Slovene *Zakon o matičnem registru*): Uradni list RS, št. 11/11 – uradno prečiščeno besedilo, 67/19.

146 Art. 6(1) of the Register Act.

Personal Name Act,[147] specifically in Art. 6. The personal name of a child shall be determined by their parents, who must report the name to an administrative unit within 30 days of the child's birth.

Art. 7 of the Slovene FC defines the fundamental principle of the best interests of the child. According to this principle, parents shall consider the best interests of the child in all their actions concerning the child. They are obliged to raise the child in a manner that respects their person, individuality, and dignity.[148] Parents have priority over any other person in terms of responsibility and actions in the best interests of the child.[149] It is considered that parents act in the best interests of the child if, particularly taking into account the child's personality, age, developmental stage, and wishes, they meet the child's material, emotional, and psychosocial needs appropriately through actions that demonstrate their care and responsibility towards the child, providing proper educational guidance, and encouraging the child's development.[150] State authorities, public service providers, holders of public powers, local government bodies, and other natural and legal persons must ensure the best interests of the child in all activities and procedures related to the child.[151] The State must provide special protection to children whenever their healthy development is at risk or when it is necessary to safeguard other interests of the child.[152] These provisions underscore the paramount importance of the child's well-being and the obligation of both parents and the State to ensure their protection and development.

147 Personal Name Act (*Slovene Zakon o osebnem menu*): Uradni list RS, št. 20/06, 43/19.
148 Art. 7(1) of the FC.
149 Art. 7(2) of the FC.
150 Art. 7(3) of the FC.
151 Art. 7(5) of the FC.
152 Art. 8 of the FC.

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Chapter 12

Ukraine: Surrogacy as Human Reproductive Procedure



Sibilla Buletsa

Abstract

Ukraine's changing ART landscape offers medical opportunities and ethical debates around IVF, AI, and surrogacy. These technologies address Ukrainian and European couples' rising infertility rates, but scientists, religious groups, and policymakers argue about women's rights, exploitation, and ethics. The state balances reproductive autonomy with medical control, especially for Family Code maternal/paternal rights. Reproductive rights legislation is lacking. Critics say surrogacy and gamete donation markets require stricter protections against exploitation, while current policies emphasise informed consent and medical ethics.

Ukraine's assisted reproductive technology (ART) sector operates within a carefully regulated medical framework yet faces significant regulatory gaps that require urgent attention. While the country maintains strict clinic accreditation standards mandating at least two years of operational experience and proper technological capabilities for ART providers, several critical areas remain underregulated. The surrogacy industry, though legally recognised under the Family, Civil Code and Ministry of Health Order No. 787, lacks comprehensive oversight mechanisms to prevent potential exploitation and ensure ethical practices across all surrogacy arrangements. Ukraine's legal system currently fails to clearly define reproductive rights in primary legislation, creating ambiguity around fundamental issues like access, consent, and governmental limits on reproductive autonomy. In Ukraine, there are legal restrictions that only recognise heterosexual married couples as eligible for treatments like surrogacy. The absence of a centralised donor tracking system presents risks of genetic material misuse and complicates long-term health monitoring for donor-conceived individuals. These regulatory shortcomings persist despite Ukraine's

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otherwise progressive stance on ART technologies, including the full legalisation of IVF, intrauterine insemination, and preimplantation genetic testing. The growing international demand for Ukrainian surrogacy services and increasing domestic infertility rates underscore the pressing need for legal reforms that would establish proper safeguards, expand access rights, and implement robust monitoring systems while maintaining the country's position as a regional leader in reproductive medicine. Current legislative proposals aim to address some of these gaps, particularly concerning surrogacy oversight and data protection, but fail to comprehensively tackle issues of discrimination in access or establish clear reproductive rights frameworks that would bring Ukraine in line with international human rights standards and modern medical ethics practices.

Keywords: rights, obligation, surrogacy, child, mother, family, responsibility, assisted reproductive technologies, spouse, contract

1. Policies Regarding Medical Help Through ART in Ukraine

Assisted Reproductive Technology (hereafter referred to as ART) is a modern medical breakthrough that helps couples and individuals fulfil their dream of having a child. Around the world, thousands of families face difficulties getting pregnant naturally, and ART is becoming an effective solution to overcome many forms of infertility. The problem of infertility is becoming more acute every year, not only for Ukrainian families, but also for European couples. At the same time, it is not uncommon for the use of reproductive technologies to result in the inability to use a partners' biological material due to their health status and the need for gamete donation. Since 2024, Ukraine has been operating an ART infertility treatment programme, which is part of the Medical Guarantees Programme.

The National Health Service of Ukraine (hereafter referred to as NHSU) enters contracts for the provision of medical services for the treatment of infertility using assisted reproductive technologies (*in vitro* fertilisation) with healthcare institutions regardless of their form of ownership. The tariff for medical services for *in vitro* fertilisation (full cycle), which is provided for by the specifications, is defined as the rate for a medical service, which is UAH 84826.1.[1]

According to the World Health Organisation, approximately 1 in 6 women in the world suffer from infertility. The treatment of infertility using assisted reproductive technologies (ART, or *in vitro* fertilisation) gives a moderately high chance of becoming parents. But ART infertility treatment is expensive. This makes reproductive

1 *Deiaki pytannia realizatsii prohramy derzhavnykh harantii medychnoho obsluhovuvannia naselennia u 2025 rotsi*. Postanova Kabinetu Ministriv Ukrainy vid 24.12.2024 No. 1503.

health services almost inaccessible for many people, not only in Ukraine, but across the world. Given the current situation in Ukraine and to increase the chances of Ukrainians attaining their dream of parenthood, the NHSU is introducing a new package, the 'Treatment of infertility with the help of assisted reproductive technologies (*in vitro* fertilisation)',[2] which starting in 2024. This means better access to reproductive health services, since these services will be paid for by public funds under the Medical Guarantee Programme. According to preliminary forecasts, this decision will allow more than 10,000 little Ukrainians to be born every year. Today, this ART programme is available in 20 facilities across Ukraine, including 15 private, three municipal, and two state institutions. To use it, a patient must contact her doctor and have a consultation with a gynaecologist who will confirm the diagnosis of infertility. After that, the necessary preparations can begin. By 2025, there have been 1100 successful pregnancies under this programme.[3]

In the context of maternity and paternity protection, the state must establish legal regulation of the reproductive function. In Ukraine, Art. 281 of the Civil Code of Ukraine establishes the right to provide for artificial termination of pregnancy in part 6, and the right to use assisted reproductive technologies in part 7. Art. 49 of the Family Code of Ukraine guarantees the right to motherhood, and Art. 50 the right to fatherhood, which persons outside of family relations can exercise. These Arts. guarantee the right to motherhood and fatherhood, and are addressed specifically to 'a woman'[4] and 'a man',[5] respectively, in the context of their marital relationship, rather than generally to any woman or man. While the wording of these Arts. refers to the rights of a wife and husband within marriage, the Ukrainian legal system, through subsequent legislation and judicial interpretation, has expanded the practical application of these rights to encompass a broader understanding of parenthood, including in the context of assisted reproductive technologies (ART) and specific circumstances such as the ongoing war. While primarily framed within marriage, these provisions, combined with other legal acts, form the basis for recognising and protecting the broader right to parenthood in Ukraine, including through ART, even for unmarried individuals in specific circumstances, such as those related to the war, where the broader state interest in maintaining family ties and population is at play. The key difference from the ECHR jurisprudence regarding 'no right to become a parent' lies in the Ukrainian approach to interpreting these foundational rights in conjunction with other legal instruments (e.g., specific laws on ART, decrees related to martial law) and the state's interest in supporting procreation and family formation. For instance, post-mortem ART procedures, permitted under specific Ukrainian regulations during wartime, illustrate this more extensive approach, allowing individuals to become parents even after the death of their spouse, which

2 Government Portal, 2024.
3 Vpershe v Ukraini, 2025.
4 Art. 49.
5 Art. 50.

aligns with the spirit of securing the 'right to motherhood' or 'right to fatherhood' for the surviving partner.

Ukrainian law presently lacks a definition of reproductive rights and their extent. This definition is instead found in the bylaws. The Unified Clinical Protocol of Primary, Secondary (Specialised), and Tertiary (Highly Specialised) Medical Care 'Family Planning', sanctioned by the Ministry of Health Decree dated 21st January 2014,[6] asserts that

> reproductive rights are predicated on the acknowledgement of the fundamental right of all couples and individuals to make autonomous and responsible decisions regarding the number of children they wish to have, the timing of their births, the intervals between births, and access to the information and resources necessary to facilitate such decisions, as well as the right to select their preferred method of childbirth.

This definition directly translates a paragraph from the Programme of Action of the International Conference on Population and Development.[7] It is crucial to delineate the boundaries of state intrusion into women's private lives, namely their freedom to make autonomous decisions without arbitrary involvement in designated matters.

In Ukraine, ART is a method of infertility treatment in which manipulations with reproductive cells, some or all stages of reproductive cell preparation, fertilisation, and embryo development before transfer to the patient's uterus, are carried out *in vitro*.[8]

1.1. Types of ART in Ukraine

Currently, the legislation of Ukraine allows the use of the following ART methods: (1) *In vitro* – the technique of performing an experiment or other manipulations in special laboratory glassware or in a controlled environment outside a living organism. (2) Intracytoplasmic sperm injection (ICSI – Intra Cytoplasmic Sperm Injection) is a technique of assisted reproductive technologies, in which a husband's or donor's sperm is injected into the cytoplasm of an oocyte (intracytoplasmic sperm injection). (3) Testicular Sperm Aspiration Procedure (TESA) is a technique of assisted reproductive technologies, in which the sperm of the man or a donor is obtained (aspirated) from the testicular tissue by needle biopsy of several areas of the testicles. It is an invasive procedure for obtaining spermatozoa. Surrogate motherhood (method of assisted reproductive technologies), during which a human embryo

6 Decree of the Ministry of Health of Ukraine No. 59, 21.01.2014.

7 United Nations High Commissioner for Refugees, 1993, pp. 40–41.

8 *Pro zatverdzhennia Poriadku zastosuvannia dopomizhnykh reproduktyvnykh tekhnolohii v Ukraini*, 09.09.2013, No. 787.

conceived by genetic parents is transferred to another woman's body for childbirth. (4) Donation of oocytes, gametes, and embryos (a procedure by which donors donate their gamete germ cells (semen, oocytes) or embryos for written use in treating infertility in others). (5) Cryopreservation of oocytes, sperm, and embryos. (6) Preimplantation diagnostics.

Assisted reproductive technologies are methods of infertility treatment in which manipulations with reproductive cells, some or all stages of preparation of reproductive cells, fertilisation and development of embryos before transfer to the patient's uterus, are carried out *in vitro* (experimental techniques or other manipulations in special laboratory glassware or a controlled environment outside the living organism). In 2017, a team of researchers from the Children's Hospital of Philadelphia spent four weeks supporting the life and development of a sheep's foetus in an amniotic sac designed to mimic the womb from which the foetus was removed prematurely. Scientists note that the emotional bond between mother and child is essential for prenatal development.

When analysing the legal regulation of assisted reproductive technologies, the greatest number of unresolved ethical and legal issues arises from the use of surrogacy programmes. In Ukraine, the use of this method is possible only on medical grounds, so a situation where a woman who is able to bear children naturally does not want to bear and give birth to a child herself but wants to use a surrogate mother for this purpose cannot take place. Mykola Kuleba (Plenipotentiary of the President of Ukraine for Children's Rights) stated in 2020 that surrogacy in Ukraine is unregulated, violates children's rights, and is a form of exploitation of women.[9] It should be recalled that the first case of *in vitro* fertilisation was carried out in the city of Kharkiv, where a baby girl named Katya was born in 1995: the pregnant woman was granted the status of mother, thus becoming both mother and grandmother of the younger person at the same time.[10] On 28th April 2020, Ukrainian Parliament Commissioner for Human Rights Lyudmyla Denisova noted that she sees the provision of surrogacy services to foreigners as a violation of children's rights, as Ukraine cannot control and protect them. Therefore, the Ombudsman proposed to amend the legislation and allow surrogacy in the country exclusively for its citizens. In 2022, in the second round of dialogue between Ukraine and the UN Committee on the Rights of the Child, it was noted that Ukraine remained the largest surrogacy hub in Europe. That is why legislative regulation of the specifics and procedures of this type of assisted reproductive technology should be a priority for Ukraine.[11] All this led to the fact that in 2023, the Verkhovna Rada of Ukraine registered several bills directly aimed at improving, in the opinion of their authors, the regulation of various aspects of surrogacy. For example, members of the Parliamentary Committee on National Health, Medical Care and Health Insurance proposed to ban foreigners from

9 We do not know how many children Ukraine 'supplies' abroad.
10 Surohatne Materynstvo, 2023.
11 Ombudsman of Ukraine, 2022.

using surrogacy services during the period of martial law and for three years after its end. This in particular, was envisaged in the draft law on assisted reproductive technologies,[12] prepared on the basis of three alternative draft laws[13] and supported by the Committee. This proposal had objective reasons for its existence but did not solve the problematic issues. Therefore, on 3rd May 2023, the draft law was rejected and withdrawn from consideration. The draft laws were rejected because they had different approaches, sometimes even opposing ones. The balance of interests between the genetic parents and the surrogate mother was not established, and there are different requirements for surrogate mothers and the form of the agreement. There is no single approach to resolving the legal consequences in the event of force majeure, such as the birth of a sick child or the death of a surrogate mother. There are no guarantees for the natural child in the case of the surrogate mother's death. M.V. Mendzhul noted that the main value of the new law should be to guarantee the balance of interests of all parties and to guarantee the priority of the best interests of the child, which should be the basis of the legislative act. Such an act should clearly define the possibilities of using surrogacy by foreigners and guarantee special legal protection for children born to surrogate mothers. It is also important to clearly regulate the procedure for exporting reproductive material abroad, as well as the liability of all parties in the failure of fulfilment of the contract, unless it has been proved impossible to do so due to force majeure.[14] Lilla Garayová also noted that the principle of the child's best interest required a delicate balance between technological possibilities, ethical considerations, and the child's overall welfare. The principle serves as an ethical framework to navigate the complex terrain of modern reproductive technologies, ensuring that the physical, emotional, and psychological needs of the child remain the central concern in all decisions. As ART continues to evolve, so too must the legal and ethical frameworks that uphold the best interests of children born through these technologies.[15] And also to define surrogacy.[16]

We agree that legal relations in reproductive technologies include: (1) a special subject composition: relations arise between patients (women, men) and healthcare institutions that provide assisted reproductive technologies; (2) subject number: these are the relations between at least two subjects. Two-subjectivity is characteristic, for example, of sperm donation, and multi-subjectivity is characteristic of surrogacy; (3) obligatory subject: a healthcare facility that provides assisted reproductive technologies; (4) spectral regulatory basis of occurrence: relations arise based on both legal provisions and contractual provisions; (5) dynamism: the existence of one legal relationship gives rise to the possibility of other legal relationships. For example, the provision of unused cryopreserved embryos by patients in an

12 *Pro dopomizhni reproduktyvni tekhnolohii: proekt Zakonu*, 27.07.2021, No. 1607.
13 Nos. 6475, 6475-1 and 6475-2.
14 Mendzhul, 2023, p. 157.
15 Garayová, 2024, p. 80.
16 Bizonia and Atamanchuk, 2021, p. 87.

in vitro fertilisation programme after the birth of a child for donation to an infertile patient/couple recipient, as well as to unmarried women recipients. The algorithm of the legal relationship is as follows: the relationship existed between the patients of the *in vitro* fertilisation programme and the healthcare facility, which under certain conditions may give rise to a relationship between the healthcare facility and, for example, an infertile couple regarding embryo donation; (6) binding nature: reciprocity of rights and obligations of the subjects of legal relations; (7) duality of will: the emergence of relations is conditioned by the will of the state, expressed in legislation, and the will of the subjects of legal relations in the field of medical care.[17]

Thus, legal relations in reproductive technologies involve special subject composition, spectral regulatory basis of occurrence, dynamism, binding nature, and duality of will. These relationships arise between patients and healthcare institutions providing assisted reproductive technologies and can be influenced by legal provisions and contractual provisions. The algorithm of these relationships includes the existence of relationships between patients and healthcare facilities, the binding nature of rights and obligations, and the duality of will in medical care.

2. Constitutional and Legal Framework Provisions of ART in Ukraine

At the current level of medical development, the use of assisted reproductive technologies is a direct implementation of human reproductive rights. The Constitution of Ukraine[18] states that 'fundamental human rights and freedoms are inalienable', 'everyone has the right to life', 'the state shall preserve the dignity of the individual', and 'no one shall be subjected to interference with his or her private and family life'. The state must take all economic, social, cultural, scientific, medical, hygienic, and epidemiological steps to protect and improve reproductive health under the Constitution. Promoting reproductive rights requires the state to shape demographic policy by changing social institutions and reviving family, spiritual, and moral traditions, the value of human life, motherhood, and fatherhood. Reproductive rights are a subset of Constitutional personal rights. However, the current legislation does not fully guarantee Ukrainian residents' reproductive rights and reproductive health. Reproductive rights are complicated and comprise a variety of personal rights incorporated in international human rights and freedoms, laws, and other legal acts. Reproductive rights are strongly tied to the right to life, health, bodily integrity, privacy, personal and family life, human dignity, and gender equality. The most

17 Seniuta, 2017, p. 267.
18 Constitution of Ukraine, 28.06.1996.

fundamental human right at birth is personal integrity, which underpins reproductive rights. Living, being well, and having moral and spiritual integrity all form integrity. The right to personal integrity entails that forced marriage, surgery, sterilisation, etc., cannot deprive a person of their reproductive capacities. Women can refuse risky contraception, an undesirable pregnancy, and surgery.

Section II of the Constitution of Ukraine enshrines not only fundamental human and civil rights and freedoms but also provides for appropriate constitutional and legal guarantees of their observance and protection. In particular, this concerns the prohibition of the abolition of constitutional rights and freedoms[19] and the impossibility of restricting constitutional rights and freedoms of a person and a citizen, except for restrictions on certain rights and freedoms in conditions of martial law or a state of emergency.[20] Reproductive rights are guaranteed for Ukrainian citizens also during martial law, but within the limits defined by law. On 22nd November 2023, the Law of Ukraine 'On Amendments to Certain Laws of Ukraine on Ensuring the Right of Military Personnel and Other Persons to Biological Paternity (Maternity)' was adopted.[21] No. 3496-ix, which raises the issue of ensuring the right to reproductive health care, including the right to biological parenthood (motherhood). It is important to emphasise that the state should facilitate the implementation of reproductive health programmes in every possible way, including by ensuring that certain services in this area are provided by the budget, based on the provisions proclaimed in the Constitution of Ukraine, namely that 'a person, his or her life and health are recognised in Ukraine as the highest social value',[22] 'family, childhood, maternity and paternity are protected by the state'.[23] At the same time, it is fundamentally necessary to introduce special programmes to create state cryobanks for the storage of human reproductive cells.[24] The provision of such programmes (projects) at public expense will facilitate the exercise of the right to biological parenthood (motherhood) of the above-mentioned persons who put their health at risk in connection with the performance of their duties to protect the state or gave their lives for the defence of Ukraine. Following their death, the state must bear the moral obligation to ensure the possibility (enshrined as a right) of their descendants to be born, and above all, conceived, which is the human right to procreation. Reproductive rights include the decision to conceive a child, the number of children, the intervals between their births, and the use of advanced reproductive technologies if pregnancy cannot occur naturally. The constitutional right to life is clearly implemented via reproductive rights. These rights apply to each natural person capable of procreation and aim to promote childbirth as humanity's highest benefit. The Ukrainian Constitution links

19 Art. 22, Part 2.
20 Art. 64.
21 *Pro vnesennia zmin do deiakykh zakoniv Ukrainy shchodo zabezpechennia prava viiskovosluzhbovtsiv ta inshykh osib na biolohichne batkivstvo (materynstvo) Zakon Ukrainy*, 22.11.2023, No. 3496-IX.
22 Art. 3.
23 Art. 51; Ostrovska, 2024a, p. 115.
24 Ostrovska, 2022, pp. 66–69.

reproductive rights to the most fundamental human right, the right to life. A person's right to privacy, personal, and family life is guaranteed by the state and allows them to control information about themselves and prevent the disclosure of personal and intimate information. This is crucial to citizens' reproductive rights. In heterologous assisted reproduction procedures, the fact of the medical intervention and donor information are medical secrets, which are personal and make up family life, and the people required to keep them must not disclose them. These laws comply with the European Convention for the Protection of Human Rights and Fundamental Freedoms,[25] which guarantees everyone the right to privacy and family. State-protected personal dignity underpins reproductive rights. The Constitution prohibits torture, violence, and other inhumane treatment. Medical, scientific, and other investigations require consent. Every individual, official, and state employee must follow this constitutional rule. This involves seeing women and women's organisations as active participants in social, economic, and political life, shaping demographic and health policies and reproductive rights decisions. At the individual level, this means a woman has the right to be treated with respect by doctors and specialists with whom they consult for reproductive health advice, since respect for human dignity requires not only attentive consideration of the individual's rights and legitimate interests but also ethical communication by such bodies' employees.

The Ukrainian Constitution guarantees gender equality, in accordance with Art. 3 of the International Covenant on Civil and Political Rights.[26] Part 3 of Art. 19 states that men and women have equal rights. Equality between men and women in reproductive rights means equal access to reproductive health information, family planning tools, and reproductive choice. Reproductive rights are linked to health care, motherhood, childhood, and family protection. A reproductive health protection scheme is the state's most indispensable demographic policy tool. According to the Ukrainian Constitution, state protection of maternity, childhood, and the family is crucial to citizens' reproductive rights. A woman's ability to reproduce and perpetuate the human race must be ensured by socio-economic, legal, and other conditions and preventive measures that promote family life, motherhood, and the rights of mothers, fathers, and children. N.V. Paramonov notes that reproductive rights show that they have a special place in the system of constitutional rights and freedoms because they include the right to life, health care, personal integrity, privacy, and family life. To sum up, reproductive rights are the rights of married couples and individuals to achieve the highest possible level of sexual and reproductive health, including the right to freely and responsibly make decisions about offspring reproduction without discrimination, coercion, or violence, to have the necessary information and access to the most effective and safe family planning and infertility prevention methods.[27] It should be noted that when deciding when and from what moment the constitutional

25 Rome, 4 November 1950, Art. 8.
26 International Covenant on Civil and Political Rights, Art. 6(1).
27 Paramonov, 2023, p. 86.

protection of the life of a particular individual arises, international law and foreign legislation, as a rule, legally and de facto protect human life even before the birth of a child. Ukrainian legislation in this area is rather controversial. According to the Constitution, the human embryo is not a holder of the right to life, as it states: 'Fundamental human rights and freedoms are inalienable and belong to everyone from birth'. However, in some cases, the life and bodily integrity of the embryo are protected by criminal, civil and other branches of law. The peculiarities of legal regulation of the status of the human embryo and reproductive rights determine the approaches to the regulation of artificial termination of pregnancy and high reproductive technologies. The use of assisted reproductive technologies is permitted only for therapeutic purposes and only by a doctor's decision. Human life is recognised in Ukraine as the highest social value. The rights and interests of a child born through surrogacy programmes are no less valuable and require special protection and guarantees from the state. In Ukraine, donation issues are regulated primarily by civil law; in particular, Art. 290 of the Civil Code of Ukraine, which provides for the right of a person to be a donor of reproductive cells.[28] In addition, the donation of reproductive cells is regulated by the decree of the Ministry of Health of Ukraine 'On approval of the Procedure for the use of assisted reproductive technologies in Ukraine' from 9th September 2013, No. 787.[29] It is positive to establish precise requirements for embryo donors at the regulatory level (they can be patients of *in vitro* fertilisation programmes who have cryopreserved embryos after the birth of a child and have not used them. Let us suppose the informed, voluntary consent of such patients is provided in writing. In such a case, these embryos can be donated to an infertile couple or woman), oocyte donors (women who are close relatives of the patient, anonymous voluntary donors or patients of an ART programme, of a certain age (18–36 years) with a living healthy child, with no negative phenotypic manifestations, hereditary diseases, bad habits, contraindications and sufficient somatic health) and sperm donors (men aged 20–40 with a healthy child, no negative phenotypic manifestations, somatic and hereditary diseases, contraindications). Gamete and embryo donation is a procedure by which donors donate their gametes (sperm, oocytes) or embryos with written voluntary consent for use in the treatment of infertility in others. Unlike in Ukraine, the donation of embryos and gametes is not allowed in all countries.

The approach in which gamete donations in Ukraine are anonymous should be considered as being positive. According to Clause 5.19 of the Decree of the Ministry of Health of Ukraine,[30] the selection of a sperm donor is based on phenotypic characteristics (information on age, height, skin, eye and hair colour, etc.). At the same time, a separate legislative act should stipulate whether embryo and gamete donations may be anonymous (in the case of embryo and gamete donations by close

28 Human germ cells that are suitable for use in the treatment of infertility through the use of ART.
29 Decree of the Ministry of Health of Ukraine, No. 787, 09.09.2013.
30 Ibid.

relatives). The donor's anonymity may be disclosed under a procedure provided for by law. Spouses have the right to information about the assisted reproductive technologies procedure and the medical and legal aspects of its consequences, the results of the donor's medical and genetic examination, his or her external data, nationality (if the donor's sperm is used for fertilisation), the use of prescribed hormonal drugs and other medicines by the wife, transvaginal puncture under ultrasound control to obtain one or more oocytes from the wife, and the insemination of eggs obtained in this way with the husband's (donor's) sperm. The law also provides for the right to keep the embryo(s) under the control of medical personnel until they are transferred to the wife, for the personnel to select the embryo(s) most suitable for transfer, for the transfer of the selected embryo(s) to the wife, for possible complications arising from the method, and for additional surgical measures that may be necessary during the procedures. It is important to inform the woman that children born through *in vitro* fertilisation may have developmental disabilities as often as those born through natural fertilisation, and that there may be complications during pregnancy that are also typical of pregnancies that occur naturally. Despite the list of spouses' rights set out in the Order, the law does not establish the child's rights, the need for which may arise in the future. The Order defines the conditions and procedure for assisted reproductive technologies, methods, and requirements for the donor and the expectant mother. An important aspect is that the spouses to whom this method is applied are provided with information by the doctor who performs the medical intervention. Both the husband's and the donor's sperm are used for ART, and information about ART and the identity of the donor constitutes medical confidentiality. In addition, the future parents assume equal rights and obligations towards the unborn child concerning its upbringing and maintenance, as well as the obligation not to identify the donor (when using donor sperm). According to the Order,[31] a doctor ensures compliance with the principles by strictly adhering to the principles of medical ethics and deontology, namely the adherence to the principles of professional ethics, the preservation of medical secrecy, confidentiality, and anonymity under the current legislation of Ukraine. Thus, the legislator's repeated emphasis on the confidentiality of the ART procedure is only declarative, as it is not difficult to establish the identity of the codes in the cards mentioned above.

In Ukraine, in connection with the spread of assisted reproductive technologies, to prevent errors in the calculation of genetic risk during medical genetic counselling, a geneticist relies on information about the child's biological parents following the current legislation. Ethicogenetic care for pregnant women with high genetic risk includes: medical genetic counselling, including clinical and genealogical analysis of the family; study of biochemical markers of congenital and hereditary pathology in the mother's blood serum; ultrasound examination of the foetus; if necessary, invasive prenatal diagnostic methods using cytogenetic, biochemical, molecular

31 Decree of the Ministry of Health of Ukraine No. 383, 02.06.2009.

studies; bacteriological and virological studies of the pregnant woman's biological material to detect intrauterine infection of the foetus.

Accordingly, reproductive rights should be implemented based on: the respect for human and civil rights; the impossibility of forcible deprivation of reproductive properties and the deterioration of reproductive function; the prevention of discrimination in the sphere of the implementation and protection of reproductive rights in all its manifestations; the prohibition of the humiliation of human dignity, including that based on gender, the ability to perform reproductive function; the equality of men and women, if this does not contradict their biological nature; and confidentiality when considering and resolving issues related to the implementation and protection of reproductive rights.[32] At an international level, the legal aspects of medical genetics are regulated by the Regulations on Genetic Counselling and Genetic Engineering adopted by the World Medical Assembly in Madrid in 1987. It is necessary to create legal norms that would prevent the possibility of their uncontrolled use by Ukrainian or foreign reproductive medicine clinics from the moment they are transported abroad as donor biomaterial or for other illegal (commercial or experimental) purposes. It is the absence of a clearly defined legal status of human reproductive cells, and especially of the human embryo, in national legislation that leads to abuses in this delicate area of human rights, including of the unborn.[33] The state's concern for future generations is a long-term investment in human capital as the basis of the country's national wealth.[34] Reproductive rights are drawn from the Constitution of Ukraine's fundamental rights and freedoms.

3. Medical Regulation of ART in Ukraine

ART should be used in private and state-funded health care facilities licensed to conduct medical practice, with appropriate equipment and facilities. These clinics are regulated by the Law of Ukraine 'Fundamentals of the Legislation of Ukraine on Healthcare' No. 2801-XII of 19th November 1992, which establishes standards for medical technologies, procedures, and patient safety. According to Art. 16 of the Law, state authorities and local self-government bodies shall promote the development of healthcare institutions of all forms of ownership. The network of state and municipal healthcare institutions of Ukraine is formed by taking into account the development plans of hospital districts, the needs of the population for medical care, the need to ensure the proper quality of such care, timeliness, accessibility to citizens, and the efficient use of material, labour and financial resources. The existing network of such

32 Dzhochka, 2007, p. 132.
33 Ostrovska, 2024b, p. 77.
34 Ostrovska, 2024a, pp. 107–110.

institutions cannot be reduced. In order to ensure territorial accessibility of quality medical and rehabilitation care to the population, a hospital district is defined. A hospital district is divided into hospital clusters, within which comprehensive access to inpatient medical care is organised. The boundaries of hospital districts and hospital clusters, the procedure for their definition and functioning, as well as the procedure for determining cluster, supercluster and other types of healthcare institutions that are part of a capable network of healthcare institutions of a hospital district, are determined by the Cabinet of Ministers of Ukraine based on the needs of the population for comprehensive inpatient healthcare.[35] A healthcare institution carries out its activities on the basis of a charter (regulation) approved by the owner of the institution (its authorised body). The heads of state and municipal healthcare institutions are appointed by the authorised executive body of the owner of the healthcare institution on a competitive basis by concluding a contract with them for a term of three to five years. The procedure for conducting a competition for the position of head of a state or municipal healthcare institution and the procedure for concluding a contract with the head of a state or municipal healthcare institution, as well as the standard form of such a contract, shall be approved by the Cabinet of Ministers of Ukraine.[36] Healthcare institutions can be state, communal, private, or mixed-ownership. Communal and state hospitals are not privatised. State-owned healthcare institutions might be non-profits or institutions, depending on their structure. Communal healthcare facilities can be non-profit or institutional, depending on their organisation and legal status. In accordance with the law, territorial communities can create and operate communal healthcare institutions as joint ventures. Private healthcare institutes can choose any organisational and legal shape. The owner or permitted management body can reorganise and reform community and state-owned healthcare establishments.

Accreditation certificates are also required for healthcare facilities that have been performing medical practices for over two years.[37] ART must be carried out in an accredited healthcare facility using methods approved by the Ministry of Health of Ukraine, at the request of a woman of legal capacity and upon written application of the spouses, with a full medical examination of both spouses. The age limit for a woman to undergo this procedure is unlocated in Ukraine, in line with the European Court decision *in Case of Lia v. Malta*[38] in which the court stated that there was a violation of Art. 8 Convention, namely that the refusal of the couple's request for a self-funded second homologous *in vitro* fertilisation procedure, on the basis of the wife's age (43), was not in accordance with a law of sufficient quality. The interpretation

35 *Poriadok funktsionuvannia hospitalnykh okruhiv i hospitalnykh klasteriv ta vstanovlennia yikh mezh*, No. 174, 28.02.2023.

36 *Poriadok provedennia konkursu na zainiattia posady kerivnyka derzhavnoho, komunalnoho zakladu okhorony zdorovia*, No. 1094, 27.12.2017, *Poriadku ukladennia kontraktu z kerivnykom derzhavnoho, komunalnoho zakladu okhorony zdorovi*, No. 792, 21.08.2019.

37 *Poriadok akredytatsii zakladu okhorony zdorovia*, No. 765, 15.07.1997.

38 Case EctHR of Lia v. Malta, 05.08.2022.

and application of the impugned age-limit provision by administrative and judicial authorities lack the required foreseeability.

Allowed and regulated technologies include homologous techniques, such as IVF using gametes from the intended parents, and heterologous techniques, such as sperm or egg donation, which are legally permitted under specific conditions. Certain advanced technologies such as genetic manipulation or embryo editing are restricted or forbidden due to ethical concerns and safety issues, and surrogacy is legally permissible primarily for married heterosexual couples, with specific regulations governing surrogate agreements. Informed consent from all parties, donors, recipients, and surrogates, is a mandatory legal requirement, ensuring the voluntary participation and understanding of procedures, risks, and rights.

A donor's status is regulated to ensure anonymity or transparency depending on the procedure, and cryopreservation of embryos is allowed with clear guidelines on the storage duration, use, and disposition, including provisions for embryo destruction or donation. Concerning embryo protection, Ukrainian law emphasises the dignity of the embryo, setting restrictions on sex selection, genetic manipulation, and the number of embryos cryopreserved, aiming to prevent unethical practices. In Ukraine, donor anonymity is the general rule. The current legislation[39] stipulates that information about the donor (gametes or embryos) is confidential and should not be disclosed to the recipient parents or the child. The rights of children born through IVF include the right to health and to be cared for by both parents, with legal provisions ensuring their protection and welfare. However, under current Ukrainian legislation, anonymity of donors is maintained, which generally precludes the child's right to know their genetic origin from donors.

3.1. Posthumous Fertilisation

The Law of Ukraine 'On Amendments to Certain Laws of Ukraine on Ensuring the Right of Servicemen and Other Persons to Biological Parenthood (Motherhood)', which took effect on 23rd March 2024, raised the issue of posthumous reproductive cell use in November 2023. According to Subpara. 3 of para. 2 of Sec. II of this Law, if a person whose reproductive cells are stored in accordance with the law dies or is declared dead by a court, their storage shall be free of charge for three years. After this period, the individual's reproductive cells may be stored at the expense of another person selected in their will in accordance with the law in the case of their death or court declaration of death. On March 6th 2024, Appendix 24 to the Decree of the Ministry of Health of Ukraine 'On Approval of the Procedure for the Use of Assisted Reproductive Technologies in Ukraine' was amended to establish the form of application for thawing sperm, oocytes, ovarian tissue, or biological material from the testicle or its appendage. This application can now be signed by the person designated

39 Primarily Order No. 787 of the Ministry of Health of Ukraine, 'On the Procedure for Application of Assisted Reproductive Technologies' from 2013.

in the 'application (order) of another person for the disposal of reproductive cells in the event of death or declaration of death'. Before the aforementioned regulations, there was no legal mechanism for posthumous conception and birth in Ukraine, but judicial practice in resolving disputes over cryopreserved reproductive material was developed. Today, the National Children's Specialised Hospital '*Ohmatdyt*' has a cryobank that stores children's cells and other biomaterials for free of charge, and the military can store them in any of the 12 cryobanks in Ukraine. The Ukrainian Cabinet of Ministers approved the Procedure for the collection, cryopreservation and storage of reproductive cells of military personnel and other persons in case of the loss of reproductive function while performing duties related to the defence of the state, defence of the Fatherland and other duties assigned to them in accordance with the law, Resolution No. 78 on January 24th 2025, allowing the program to begin. This project received UAH 190 million (4.1 million euros) in the 2025 state budget. Resolution No. 78 applies to military, State Emergency Service, Special Operations Department, State Criminal-Executive Service, and police officers who are directly involved in combat operations or ensure the implementation of measures for national security and defence, repelling and deterring arms. Medical facilities having NHSU agreements can let military personnel donate and store reproductive cells. Those who have given biological material and are storing it at their own expense might apply to a healthcare facility for free storage.[40]

In case No. 759/265/23 of 14th April 2023, the Svyatoshinsky District Court ordered a healthcare facility to give the plaintiff *in vitro* fertilisation services using her husband's cryopreserved reproductive material. The Svyatoshinsky District Court considered that the plaintiff's husband had left a statement during his lifetime stating that he consciously and voluntarily agreed to the thawing and use of his cryopreserved biological material within the limits of the assisted reproductive technologies specified in his statement.[41] In case No. 947/7597/24 of 18th June 2024, the Kyiv District Court of Odessa ruled that the plaintiff's husband's statements, in accordance with the Procedure in force at the time of his application to the healthcare facility (the defendant) for the cryopreservation and storage of his biological material, did not allow for the consideration of the disposal issue. Given the aforesaid, the claimant was granted the right to dispose of and use her deceased husband's biological material, which was preserved in a healthcare institution.[42] Even without lifetime consent to the creation and birth of a joint child, the Ukrainian courts have satisfied claims for the posthumous use of cryopreserved reproductive material by a wife. The Ukrainian courts have also developed a case law of satisfying claims for

40 *Pro zatverdzhennia Poriadku zdiisnennia zaboru, kriokonservatsii ta zberihannia reproduktyvnykh klityn viiskovosluzhbovtsiv ta inshykh osib na vypadok vtraty reproduktyvnoi funktsii*, 24.01.2025, No. 78.

41 Case No. 759/265/23 the Svyatoshinsky District Court, 14.04.2023.

42 Decision of the Kyiv District Court of Odessa in case No. 947/7597/24, 18.06.2024.

the posthumous use of a man's cryopreserved reproductive material by his wife, even in the absence of a lifetime consent to conceive and give birth to a child together.

Another important point in the context of the study of the legislative regulation of the status of frozen reproductive cells is the fact that a private reproductive medicine centre has the right to export patient biological material abroad, namely cryopreserved embryos and reproductive material (sperm and oocytes) for preservation purposes. This provision is regulated by the states in which biological material (including embryos or oocytes, sperm, ovarian/testicular tissue or its epididymis) may be transported to another healthcare facility both within and outside Ukraine at the request of the patient/patients.[43] Such transportation may take place only if it is provided for in the agreement on the storage of embryos (reproductive material) or by an additional agreement to this agreement and upon a written application of the patient/patients who transferred them for storage to this healthcare facility, and the written consent of the head of the relevant healthcare facility.[44]

3.2. In vitro Fertilisation

According to Clause 3.6 of Decree No. 787, *in vitro* fertilisation is performed using sperm prepared using appropriate technology from a husband or donor. However, Clauses 3.1.–3.6 of the Procedure, which deal with the procedure for *in vitro* fertilisation, do not require that persons wishing to use this programme be married. At the same time, in Annex 2 to the Decree No. 787, in the Application of the patient/patients for the use of assisted reproductive technologies, there is a box that mentions the husband/partner of a woman who wishes to use *in vitro* fertilisation. However, by applying a systematic interpretation of the legislation, it can be concluded that this application is intended for all types of ART programmes (*in vitro* fertilisation, intrauterine insemination, surrogacy, etc.), and in some of them, marriage is mandatory (surrogacy programme). However, a single woman can use an *in vitro* fertilisation programme, as Art. 48 of the Law of Ukraine 'Fundamentals of the Legislation of Ukraine on Healthcare' refers to Clauses 3.1.–3.6. of Decree No. 787, which does not contain such a marriage requirement. In addition, Clause 1.7 of Decree No. 787 guarantees the possibility for adult women and/or men to undergo ART treatment programmes on medical grounds. Clause 3.6. of the Decree mentions that the use of husband's sperm in IVF is intended for cases when a female patient is married. Therefore, if such a woman is unmarried or falls under other circumstances, donor sperm can be used in her case. It is possible that a situation may arise when pregnancy does not occur, in which case it is possible to hold the healthcare facility liable and invalidate the contract for the provision of medical services for the treatment of infertility using ART methods and recover double material damages. Explanations can be found in the Resolution of the Kyiv Court of Appeal in

43 Sub-clause 11.3. of the Decree for the Application of Assisted Reproductive Technologies in Ukraine.
44 Yakubenko, 2023, p. 239.

case No. 760/20309/20 of 22th December 2022,[45] where it is stated that by signing the agreement, the plaintiff has agreed to its terms and conditions, has taken actions related to the fulfilment of obligations under the agreement, which indicates that she was aware of its legal nature and legal consequences at the time of the transaction. In addition, the Court of Appeal takes into account the irrefutable denials of the clinic's representative that the plaintiff's disease did not exclude the possibility of her pregnancy and childbearing; and that the clinic had selected embryos in accordance with the terms of the agreement.

The current framework for assisted reproductive technologies (ART) in Ukraine, as outlined in Decree No. 787, offers various fertility treatment programmes – such as IVF, egg donation, and embryo transfer – to individuals and couples. However, these programmes are structured in a way that primarily accommodates single women or cohabiting unregistered couples (de facto unions), effectively excluding single men from accessing the same reproductive rights. This restriction stands in direct conflict with Art. 24 of the Ukrainian Constitution, which guarantees gender equality and prohibits discrimination based on sex. Furthermore, Section 1.7 of Decree No. 787 explicitly acknowledges a man's right to use ART for infertility treatment, yet the absence of legal mechanisms enabling single men to exercise this right creates a clear legislative contradiction.[46]

3.3. Surrogacy Motherhood in Ukraine

Surrogacy, as defined under Decree No. 787,[47] is an assisted reproductive technology (ART) designed to help married heterosexual couples to become the biological parents of their child, and overcome infertility caused by congenital or acquired medical conditions. Ukraine permits only gestational surrogacy, meaning the surrogate mother carries an embryo created through *in vitro* fertilization (IVF) using: (a) An egg from either the intended mother or an anonymous donor, (b) Sperm from either the intended father or a donor.

3.4. Subjects of Surrogacy of ART

The subjects of civil legal relationships arising from surrogacy are: (1) The client: an infertile married couple. They may be Ukrainian citizens or foreigners, but the mandatory condition is that they must be married men and women. Only spouses registered according to the procedure established by law may engage in surrogacy. Single or unmarried individuals, as well as cohabiting couples, cannot take advantage of this possibility. (2) Surrogate mother: A woman who agrees to undergo the *in vitro* fertilisation procedure. A surrogate mother may be a woman who has: an

45 *Postanova Kyivskoho apeliatsiinoho sudu u spravi*, No. 760/20309/20, 22.12.2022.
46 Trynova, 2022.
47 Order of the Ministry of Health of Ukraine, 09.09.2013, No. 787.

age between 18 and 36 years, good physical, mental, and social health, the absence of bad habits, a child of her own in good health, with at least one year having passed since the last birth, Ukrainian citizenship, the submission of a voluntary written application, and the absence of medical contraindications.[48] Pregnancy is also permitted for close relatives of the future parents (mother, sister, cousin, etc.). In addition, a married surrogate mother must present her husband's informed consent to participate in the programme. (3) A medical institution accredited by the Ministry of Health, Ukraine, can only conduct such procedures. Only medical establishments with a licence to conduct business in the medical sphere, adequate equipment and facilities, and all requirements set by the Decree may perform the procedure.

The necessary conditions for surrogacy are: (1) The presence of medical indications relating to the couple: absence of the uterus (congenital or achieved); serious somatic diseases for which the pregnancy threatens the health or life of the biological mother, but not of the unborn child; multiple (4 or more) attempts at ART, using assisted fertilisation techniques, with production of high quality embryos, the transfer of which, however, did not lead to pregnancy), etc; (2) Foreign and native citizens who use surrogacy must be a married heterosexual couple; (3) The list of necessary documents: the surrogate mother's application; a copy of the surrogate mother's passport; a copy of the surrogate mother's marriage or divorce certificate (except for single women); a copy of surrogate mother's birth certificate(s); the consent of the surrogate mother's husband to participate in the surrogacy program; a declaration of the patient(s) (biological parent(s)) regarding the use of assisted reproduction techniques; copies of the biological parents' passports; a copy of the marriage certificate of the couple resorting to surrogacy; a certified copy of the joint written contract between the surrogate mother and the spouses. The list of documents that, under the Rules for State Registration of Civil Status Records in Ukraine, have been approved by Decree of the Ministry of Justice of Ukraine No. 52/5 of 18th October 2000,[49] must be submitted as an original copy to the body responsible for the state transcription of civil status records, remains unchanged: the passports of genetic parents (spouses of foreigners); the marriage certificate of genetic parents, which must be appropriately legalised, i.e., apostille-stamped or undergoing the consular legalisation procedure; a medical certificate of birth model No. 103/o issued by the maternity hospital; a certificate of the child's genetic relationship with the spouse of the genetic parents, issued by the reproductive medicine clinic where the embryos were transferred to the surrogate mother; a notarised statement by the surrogate mother on the consent to the registration of the genetic parents' spouses by the child's parents. (1) One of the spouses (future parents), in whose interest the surrogacy is carried out, must have a genetic link with the child; (2) The surrogate mother must not have a direct genetic link with the child.

48 Ibid.

49 *Nakaz Ministerstva yustytsii Ukrainy*, 18.10.2000, No. 52/5.

3.5. Genetic Link in Surrogacy Motherhood

In particular, para. 6.1. Sec. VI of Decree No. 787 on the use of ART stipulates that the spouse (or one of the future parents) in whose interests the SM is carried out must have a genetic relationship with the child. Clause 6.9. Sec. VI of Decree No. 787 on the use of ART states that in order to register the birth of a child, the spouses in respect of whom surrogacy was used shall submit to the civil registry office, together with the relevant application, a certificate of genetic relationship between the parents (mother or father) and the foetus. The form of the certificate of genetic relatedness of the parents (mother or father) to the foetus, issued by the healthcare facility where the surrogacy procedure is performed, is approved by the said Decree. Similar requirements for a certificate of genetic relatedness are contained in clause 11 of Chapter I of Section III of the Rules for State Registration of Civil Status Acts in Ukraine.[50] This approach of meeting the genetic relationship criterion does not guarantee that surrogacy children will not be genetically unrelated to their parents. Hospital or service provider abuse could result in violations. The genetic relationship criteria are usually violated when foreigners participate in surrogacy operations without a genetic link. DNA testing is requested by authorities in the country where the surrogate parents wish to take the child. The guardianship and custody authority decides what will happen to the child after erasing their birth papers. Children are placed in orphanages, their parents are held accountable even if abroad, medical staff are charged with crimes, and parents' and ART-born children's rights are infringed.

The deputy prosecutor of Kyiv sued the civil registration authority of the District Department of Justice in Kyiv, the guardianship and custody authority, to amend the birth record on 6th October 2010, in the Solomyansky District Court on behalf of a minor child. A claim to exclude information about the parents from the child's birth record and an obligation of the guardianship and custody authority to prepare a decision to enter information about the child and his/her parents was based on Part 2 of Art. 135 of the Family Code of Ukraine. A crime had been committed and the child's registered parents were not the child's biological parents. A surrogate mother fertilised with anonymous female and male donor material had borne the child. The court found the claim's facts true, including the fact that the child's contested birth record listed people who were not the child's parents and had no genetic relationship with the child, so the information should be removed as false. The prosecutor's child-interest claims were granted.[51] It should also be noted that the Supreme Court of Ukraine in the case of No. 344/1962/19[52] remarked that a father's consent to the use of donor embryos for infertility treatment is fundamental

50 *Pro zatverdzhennia Pravyl derzhavnoi reiestratsii aktiv tsyvilnoho stanu v Ukraini*, 18.10.2000, No. 52/5.

51 *Rishennia Sudu*, 06.10.2010, No. 2-2283-1/10.

52 *Postanova Verkhovnoho Sudu*, 03.08.2022 u spravi No. 344/1962/19.

to his parental rights and responsibilities, as this treatment method excludes any blood relationship between the father and the child. Respect for human dignity and freedom of will forms the basis of Legal Decree No. 787, which does not allow any exceptions to the use of parties to ART for infertility treatment without the patient's consent. This is why the plaintiff had to be informed about this treatment methodology in order to make a voluntary decision to become the father of a child who he was not genetically related to, which would be in line with Art. 8 of the Convention. In July 2018, a case involving Italian citizens who used a Kyiv clinic's 2011 surrogacy program went viral. A married couple from Italy signed a surrogacy deal with a Kyiv hospital in early 2011. The couple did not donate DNA and registered the child as their own after the birth, using medical institution paperwork. Italy received the child in October 2011. Law enforcement organisations in the Italian Republic discovered that the child's background had been misrepresented, and testing showed that the youngster had no genetic link to the married couple. The infant was placed in an orphanage and the parents prosecuted under Italian law. In Ukraine, employees of the medical institution were notified that they were suspected of committing a criminal offence under an Art. providing for the liability for human trafficking (Art. 149(3) of the Criminal Code of Ukraine), and the chief physician was also notified of the forgery of documents combined with human trafficking.[53]

In September 2019, another surrogacy case with a child born without a genetic relationship to the 'intended' parents was revealed. Chinese citizens contracted surrogacy services at a Kyiv hospital. The father's biological material and a donor egg were used. Following the birth, the couple performed a DNA test (a PRC legislation requirement for bringing a kid into China), which indicated no genetic link between the child and the father. The medical centre denied all fault. The parents and kid were deprived of their family rights and legitimate interests. However, such decisions conform with Ukrainian and prospective parents' home nation's regulations. The issue here was that current laws often do not guarantee the rights of ART-born children. Many ECHR decisions, particularly Art. 8 of the Convention for the Protection of Human Rights and Fundamental Freedoms, are based on the idea of ensuring the best interests of the child. Considering the ECHR's reproductive rights practice when providing legal assistance to foreign citizens is necessary to fully clarify the legal consequences of surrogacy and the possibility of difficulties upon return to the country of origin after the child's birth.[54]

The surrogate mother does not acquire parental rights over the child. Therefore, she cannot refuse to give custody of the child after birth. If penalties for such violations are stipulated in the contract, the surrogate mother may also be held civilly liable.[55]

53 Art. 149(3), Art. 366(1) of the Criminal Code of Ukraine.
54 Haro et al., 2020, p. 54.
55 Nakaz MOZ, 09.09.2013, No. 787.

A significant novelty is that, under Clause 14, Part 1, Section II of the Rules, in the case of the introduction of martial law in Ukraine or some of its localities, under the Law of Ukraine 'On the Legal Regime of Martial Law',[56] any state body carries out state registration of civil status records at the request of the applicant. Thus, currently a birth certificate in Ukraine may be obtained, not necessarily based on the territorial affiliation of the maternity hospital to the civil status registration authority, but in any department of the civil status registration authority in a settlement where there are no active hostilities.

In addition, on 4th March 2022, the Ukrainian Ministry of Health approved the Ordinance 'Concerning the Registration of Newborns under Martial Law'.[57] The decision allows a child's birth to be registered if the birth took place outside a health institution. In this case, the document on the child's birth in the form of a medical certificate of birth[58] can be issued by the health workers who were present at the time of the birth or who performed the first examination of the newborn.

3.6. Contract Between the Spouses and the Surrogate Mother

The Family Code of Ukraine does not stipulate the surrogacy procedure or the essence of the contract between the spouses and the surrogate mother. In practice, surrogacy in Ukraine is regulated by contracts.[59] Talanov defines a surrogacy contract as a contract under which a surrogate mother (the contractor), following the implantation or transplantation into her body (without using her biological material) of an embryo of a married couple who have provided their genetic material (the customers), undertakes to bear, give birth and deliver a child to the customers.

The customers undertake to pay the contractor the actual costs associated with the performance of the contract and remuneration, unless otherwise provided by the contract.[60] Private law theorists consider surrogacy to be carried out by mutual contract between the persons who have the right to use this ART method, the implantation of an embryo, which is the property of the couple and has been created as a result of *in vitro* fertilisation, to carry and give birth to a child, with its subsequent transfer to the persons concerned.[61]

The decision of the Kharkiv Regional Court of Appeal in case No. 645/9412/14 on 25th June 2015[62] states that the surrogacy relationship is contractual. It consists of a type of reproductive technology whereby some or all the stages of conception and embryo development are performed outside the body of the biological mother:

56 *Pro pravovyi rezhym voiennoho stanu*, 12.05.2015, No. 389-VIII.
57 Nakaz MOZ, 04.03.2022, No. 407.
58 Form No. 103/o.
59 Mendzhul, 2019, pp. 78–79.
60 Talanov, 2012, pp. 360–368.
61 Basai, 2014, p. 60
62 Sprava No. 645/9412/14-ц, 25.06.2015.

> According to the official definition, surrogacy is the process of ART, gestation and delivery of a child by a woman (surrogate mother) to entrust the newborn child to the intended parents, under the contract with or without payment. A surrogate mother is a woman who has voluntarily agreed to undertake gestation on behalf of others, to carry and give birth to a genetically unrelated child, who will be entrusted to other persons – the biological parents – for growth and upbringing.

The surrogacy contract provides for the transfer of the child to its parents after birth; however, in the event of armed aggression, the safe crossing of the border by the genetic parents and the transport of the child abroad is a separate issue.[63] In the new wartime circumstances, when all flights to Ukraine were cancelled and governments around the world advised their citizens to leave Ukraine, parents could no longer enter the country as normal to pick up their children, as this would mean entering the war zone. At the same time, since the use of DRT for surrogacy usually involves the creation of 'spare' embryos, there is a need to legally export reproductive cells, reproductive tissue, and embryos of foreign clients, as well as Ukrainian citizens, outside the territory of Ukraine. Often, the national legislation of persons requesting surrogacy services in Ukraine prohibits or does not regulate the issue of commercial surrogacy. Thus, such parents face legal obstacles that must be resolved at the Ministry of Foreign Affairs of Ukraine, the State Migration Service of Ukraine, and the Ministry of Justice of Ukraine.[64] Therefore, the surrogacy agreement is an unnamed civil law contract under which one party (the surrogate mother) provides services for the gestation and birth of a child and transfers the newborn child to the other party (the intended parents). The surrogacy contract has the following characteristics: it is a risky (aleatory) contract; this contract can be either paid or gratuitous; the surrogacy contract is a type of service contract; this contract is bilateral and, as a rule, real. Contingent conditions that should be stipulated in the surrogacy contract are: the settlement of the situation of multiple births, the divorce of the future parents, or cases when the surrogate mother does not become pregnant, etc.

If genetic parents will not venture to Ukraine in person, following their government's advice on the risks of travelling during martial law, there is the possibility of obtaining a birth certificate from their duly authorised representative in Ukraine. To do this, after the birth of a child, the spouses of the genetic parents must take the following steps at their place of residence or stay: issue notarised copies of their passports, give power of attorney for a representative and an application for registration of the child's birth; submit these documents to the competent authorities of the state where they were signed, for apostille, or to pass the consular legalisation procedure; send the original documents to Ukraine.

63 Kramer and Varenikova, 2022.
64 Ostrovska, 2022, p. 77

The world's first official contract on surrogacy was signed in 1976.[65] This was a traditional surrogacy, which means that the surrogate mother carrying the child was also the biological mother. The woman received no compensation for the pregnancy. In 1980, a woman first received compensation of $11,500.[66] In practice, the use of surrogacy in Ukraine is regulated by treaties. Women are paid between 20 and 27,000 euros. When multiple pregnancies occur, the rate increases by another 3,000. During the transportation of the child, the surrogate mother also receives $400 per month. This amount should cover board, lodging, travel to the clinic chosen by the agency, and other small things.[67] Homosexual couples or stateless persons cannot use the surrogacy method in Ukraine.

The surrogacy contract is a service contract. This carries risks because the result can be unpredictable (miscarriage, death of the *foetus*, birth defects, etc.).[68] According to the Decree No. 787, the contract between the surrogate mother and the parents must be notarised, which provides an additional guarantee of its proper execution, as there have been cases of the surrogate mother not fulfilling her duties (refusal to give the child to the biological parents, or requesting additional remuneration) and likewise with the genetic parents (refusing to take the child). But one author[69] says that if the parties fail to comply with the law on notarisation of an agreement, such an agreement will be deemed null and void, as the law provides for the possibility of recognising such an agreement as valid in court. For example, the legislation in Croatia clearly prohibits surrogacy, gestational motherhood, and any agreements related to bearing children for another, as noted by A. Korać Graovac, contracts, agreements, and other legal transactions of bearing children for another (surrogacy, gestational motherhood) and handing over a child after a fertility treatment, with or without pecuniary remuneration, are null and void.[70] This strict stance aims to protect the rights of both the surrogate mother and the child involved in such arrangements.

If the surrogate mother is married, her husband's consent (written and notarised) to this procedure is required before a contract between the surrogate mother and the biological parents can be signed. Only after the contract between the surrogate mother and the spouses has been signed can the subsequent medical procedures be carried out in a medical institution accredited by the Ministry of Health. The type, form, and essential terms of the contract between the agency (medical institution) and the genetic parents are not laid down by law, which requires the conclusion of such a contract in simple written form without notarisation. The unresolved problem is the lack of legal regulation covering a unilateral withdrawal from the surrogacy contract. It is stated that unilateral refusal is only possible until the embryo is

65 The History of Surrogacy, 2021.
66 Ibid.
67 Surrogacy, 2023
68 Dziubenko, 2020, pp. 141–152; Holovashchuk, 2017, pp. 66–71; Buletsa, 2014, pp. 129–134.
69 Hofeld, 2024, p. 97.
70 Korać Graovac, 2024, p. 114.

implanted in the surrogate mother's body. Early termination of the contract is possible by mutual contract between the parties before the embryo is introduced into the woman's body; and due to unforeseen circumstances (e.g., termination of the pregnancy for reasons not attributable to the parties or due to threat to the surrogate mother's life, the death of the surrogate mother, etc.).

In the event of the death of one of the spouses, the contract remains valid. The intervening death of a biological parent does not affect the parties' obligations. In the event of the death of both biological parents, they are registered as parents of the newborn child, and custody is decided under the provisions of Ukrainian law.

Thus, we can note that a surrogacy contract is a contract between a surrogate mother, her husband and an infertile couple (genetic parents) in which a woman allows the implantation or transplantation of an embryo into her uterus of a married couple who have provided their genetic material for carrying their child, the surrogate mother undertakes to inform the parents about her health and the health of the child after implantation, follow all the doctor's advice aimed at giving birth to a healthy child, bear, give birth and immediately hand over the child after its birth to the genetic parents. The genetic parents undertake to accept the child regardless of gender, pay the surrogate mother the actual expenses related to the performance of the contract and remuneration, unless otherwise provided for in the contract. The parties must undergo a psychological examination to determine whether they are psychologically capable of fulfilling the required terms of the contract.[71] The creation and further use of embryos for any purpose other than reproduction is illegal and should be prohibited by law with the imposition of appropriate criminal penalties. The right to dispose of embryos for research purposes may be granted by the woman and the man for whom the embryo was created, subject to informed consent and personal data processing consent.[72]

Current Ukrainian legislation does not fully protect the rights and legitimate interests of surrogacy programme participants. At the same time, children born through surrogacy require the greatest protection and restoration of violated rights, especially when it comes to, for example, the need to confirm the legality of their origin (mainly in cases where surrogate programmes are run by foreigners) or to prevent the risk of child trafficking. Children born to surrogate mothers are often subject to human trafficking, and thus the Concept of the State Targeted Social Programme for Combating Human Trafficking for the period up to 2025 has been developed.[73] On the day of discharge from the maternity hospital/department, the children's polyclinic (at the child's house) receives the surrogate mother's child's information via phone. A surrogate mother's parents may be foreigners. They must

71 Buletsa, 2014, pp. 129–134.
72 Kvit, Buletsa and Kopcha, 2021.
73 Rozporiadzhennia Kabinetu Ministriv Ukrainy, 14.07.2021, No. 800-p.

notify the child's temporary domicile until the documents are completed and the child leaves the country for medical care and supervision.[74]

3.7. Sanctions for Malpractice or Violations of ART

Sanctions for malpractice or violations of ART regulations are detailed in Ukrainian legislation, including penalties, license revocations, and criminal liability for violations such as unauthorised procedures, the misuse of donor material, or a breach of consent. Overall, Ukrainian regulation of ART seeks to balance technological advancement, ethical standards, and the protection of the individual's rights within a legal framework that is continuously evolving to address emerging challenges. Ukraine's legal framework for assisted reproductive technologies (ART) combines progressive medical access with strict ethical safeguards, though gaps remain in enforcement and inclusivity. The system, anchored by Ministry of Health Decree No. 787 and supported by civil and criminal codes, establishes clear protocols for IVF, surrogacy, and gamete donation while imposing severe penalties for violations, including fines of up to 170,000 *grivnya*, clinic license revocations, and imprisonment of up to 15 years for trafficking-related offenses. Regulatory oversight falls to multiple agencies, including the MoH and State Service on Medicines, with bioethics committees providing additional review. While Ukraine has become a regional leader in reproductive medicine, particularly in gestational surrogacy services, challenges persist around unregulated 'reproductive tourism', the lack of a centralised donor registry, and the exclusion of LGBTQ+ individuals from accessing ART services. Recent legislative developments like 2023's Draft Law No. 8254 aim to strengthen protections against exploitation while maintaining Ukraine's position as an ART destination. The legal landscape continues evolving to balance technological advancement with patient rights, though reforms are still needed to ensure full compliance with constitutional equality principles and international human rights standards, particularly regarding access for single men and same-sex couples. Ongoing modernisation efforts are focussing on improving data protection, increasing transparency in surrogacy arrangements, and aligning with EU medical regulations while preserving Ukraine's competitive advantages in reproductive healthcare.

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4. The Establishment of Parentage in Assisted Reproductive Technologies Under Ukrainian Family Law

According to Part 2 of Art. 3 of the Family Code of Ukraine, a family consists of spouses and persons living together, connected by everyday life and having mutual

74 Nakaz MOZ Ukrainy, 09.09.2013, No. 787.

rights and obligations. The current legislation of Ukraine clearly defines marriage as a family union between a woman and a man, so same-sex marriage in Ukraine has no legal consequences. It has been proposed to expand the legislative regulation of the circle of entities entitled to use assisted reproductive technologies in Ukraine. Thus, the list of such subjects is proposed to include married couples who are not classified as discordant, that is, in which one partner is HIV-positive and the other is HIV-negative, in order to avoid possible discrimination against certain members of society in the context of the latter's exercise of their reproductive rights.[75]

According to the Family Code of Ukraine, women are guaranteed the right to motherhood, and men are guaranteed the right to fatherhood.[76] The Law of Ukraine Basics of the Legislation of Ukraine on Health Care,[77] Art. 48 stipulates that artificial insemination and the implantation of an embryo shall take place by the medical indications of the adult woman with whom the operation is carried out, provided that there is the written consent from the spouses, guaranteeing the anonymity of the donor and maintaining medical confidentiality. Clause 10 of Sec. 3 of the Decree of the Ministry of Justice of Ukraine[78] establishes the procedure for the registration of children born as a result of reproductive programmes:

> In the case where a child is born to a woman to whom an embryo conceived by a spouse has been implanted, the registration of the birth is carried out at the request of the spouses, who have given their consent to the implantation. In this case, at the same time as the document attesting to this woman's birth of a child, her written consent to the spouses' registration by the child's parents, certified by a notary public, is presented.

This specific provision (likely from the Rules for State Registration of Births approved by Order of the Ministry of Justice of Ukraine No. 52/5 of October 18th 2000, with amendments) primarily addresses surrogacy arrangements. So to break it down: (1) 'A child is born to a woman to whom an embryo conceived by a spouse has been implanted': This refers to the surrogate mother. The 'embryo conceived by a spouse' can mean either an embryo created from the genetic material of the commissioning spouses (homologous for them) or an embryo created using donor gametes but intended for the commissioning spouses. The key is that the embryo belongs to the commissioning spouses, not the surrogate. (2) 'The registration of the birth is carried out at the request of the spouses, who have given their consent to the implantation': 'The spouses' here refer to the commissioning parents (intended parents), not the surrogate and her husband. They are the ones whose request initiates the birth registration, based on their prior consent to the ART procedure involving the

75 Yakubenko, 2023, p. 240.
76 Art. 4, para. 1; Art. 49, para. 1; Art. 50.
77 Law of Ukraine, 19.11.1992, No. 2801-XII.
78 Decree of the Ministry of Justice of Ukraine, 26.02.2022, No. 606/5.

surrogate. (3) 'At the same time as the document attesting to this woman's birth of a child, her written consent to the spouses' registration by the child's parents, certified by a notary public, is presented'. 'This woman' refers to the surrogate mother. This critically confirms that for surrogacy, the surrogate mother, despite giving birth, must provide her written, notarised consent for the commissioning spouses to be registered as the legal parents. This is a crucial step to transferring legal parentage from the birth mother (surrogate) to the intended parents.

Therefore, this provision indeed resolves affiliation in cases of surrogacy, ensuring that the intended parents are registered directly on the birth certificate. It is not for donor-conceived children born to the intended mother, but specifically for situations where a gestational carrier (surrogate) is used.

If the commissioning spouses would not request the registration, it would create a significant legal lacuna and potential dispute. In practice, the contract with the surrogate and the clinic usually mandates this. If they fail to request it, the child's legal status would be uncertain, and the surrogate (the birth mother) would technically remain the legal mother, potentially leading to court proceedings to determine parentage and the child's best interests. This is an extreme and highly problematic scenario.

A situation may arise when a man who was not married to a woman wants to challenge his paternity and demand the exclusion of information about him as a father if he has consented to the use of ART, on this point the Supreme Court in case No. 520/12514/18[79] stated that a person registered as the child's father, if at the time of registration as the child's father knew that he was not the child's father, as well as being a person who consented to the use of ART, would have no right to challenge paternity. Such legal guarantees for the protection of children's rights are quite logical and reasonable. If a man voluntarily acknowledges his paternity, knowing that he is not the biological father, his rights are not considered violated. By analogy, it can be concluded that the emergence of legal relations regarding the use of ART between spouses or unmarried persons should not give rise to grounds for the denial of paternity, since the issue of consent was agreed upon by the person registered as the child's father.

Ukrainian legislation does not regulate the surrogacy procedure in detail. Only Art. 123[80] of the Family Code sets out the rules for determining the origin of a child born as a result of the use of assisted reproductive technologies. In this country in particular, if an embryo conceived by a married couple is transferred into the body of another woman, they are recognised as the child's parents. Individuals (a man or a woman) or couples living in a civil marriage are deprived of this possibility. Therefore, only spouses registered in accordance with the procedure established by law may participate in surrogacy relationships. In Ukraine, there is a presumption of the paternity of biological parents who are the clients of a surrogacy programme.

79 Decree of the Supreme Court, 28.04.2020 in the case of No. 520/12514/18.
80 Family Code of Ukraine, 10.01.2002, No. 2947-III.

The spouse, together with the document confirming the birth of the child from a surrogate mother, submits the surrogate mother's declaration of consent to the registration of the child's biological parents, the authenticity of whose signatures must be certified by a notary public, as well as a certificate of genetic link. In the 'For annotations' column of the civil status register of registration bodies, the following is entered: 'The mother of the child according to the medical certificate of birth is the citizen (surname, first name)'. The name of the institution that issued the certificate, the date of issue and the number, the notary's details (surname and initials, notary district or state notary's office), the date, the registration number of the woman's signature on the request for consent, and the marriage certificate of the child's biological parents are indicated. This annotation is not present in the birth certificate. This contains, in fact, only information on the biological parents. The rationale here is to preserve the secrecy of the birth through the surrogacy method. Foreign citizens apply to embassies to bring their children to their own country of origin. If surrogacy is prohibited in the biological parents' country of origin, there is a risk that the paternity of a child born to a surrogate mother will not be recognised. In other cases, such as Germany, Spain, and the United Kingdom, national law requires that family ties be confirmed through a court decision regarding the child's country of birth. Without such a measure, the biological parents will not be able to regularise their parenthood in the state of which they are nationals. The Unified State Register of Judgments in Ukraine contains many examples of judgments in favour of biological parents establishing the existence of family ties with a child born by surrogacy. These proceedings take a long time, sometimes more than a month, which results in additional costs for foreign citizens, both for court fees and transport costs.

The Supreme Court of Ukraine has recognised that paternity can be recognised, and changes made to a child's birth record even if no genetic testing was carried out in the case,[81] concluding that there were grounds to satisfy the claim for recognition of paternity and amendments to the child's birth record. The Supreme Court has taken into account the following evidence to confirm the child's descent from the father: the defendant's written consent to the use of assisted reproductive technologies for the birth of a child with the plaintiff; the parties' cohabitation without marriage registration before and at the time of the child's birth in the plaintiff's apartment; and the defendant's acknowledgement of his biological paternity in the court of first instance.

On 3rd September 2019, the Svjatoshyn District Court of Kyiv heard Case No. 759/10945/19[82] on establishing family ties following surrogacy. A German citizen seized the Ukrainian court. The grounds for the decision state that the applicant and her husband had a child in Ukraine through the surrogacy method and that the child was genetically related to the spouses, who were thus the biological parents. This was also confirmed by a certificate of genetic parentage of the parents (mother

81 *Postanova Verkhovnoho Sudu u spravi*, No. 742/2669/21, 05.04.2023.
82 *Rishennia Sudu*, No. 759/10945/19.

and father), issued by the Medical Centre LLC BIOTEXCOM. The surrogate mother, who gave birth to the child, also gave her consent to the couple's registration as parents. Since the applicant and her husband were German citizens and permanently resided in Germany, a court decision had to legally register the filiation relationship in Germany. Under German law, the mother of the child is considered the one who gave birth to the child. For this reason, a birth certificate issued by the competent Ukrainian body alone is not recognised in Germany and does not change the legal situation regarding parenthood.

The Supreme Court of the Federal Republic of Germany had not recognised the registration certificate issued by the competent Ukrainian body. This refusal was justified because the recognition was applied for following an administrative act and not a court decision, so part 1 of Section 108 of the Act 'On proceedings in family affairs and matters of voluntary jurisdiction' had been violated.[83] The Ukrainian court concluded that the refusal of the authorities of the Federal Republic of Germany to recognise the applicant as the mother of the child violated her rights and the rights of the newborn child, as the status of mother is associated with several rights and duties towards the child, in particular financial support and care, rights and responsibilities that she acquired under Ukrainian law. Taking into account decision XII ZB 320/17 of 20th March 2019 of the Supreme Federal Court of Germany,[84] the Ukrainian court stated that this violation of rights could be remedied by a court decision of the child's place of birth in which the filiation relationship between the child and the biological parents was recognised. After examining the circumstances of the case and the evidence provided, the Ukrainian court satisfied the applicant's request, establishing the filiation relationship between the applicant and the child born in the surrogacy programme.

On 22nd April 2019, the Kupiansk City District Court of Kharkiv Region considered a similar case, namely No. 628/828/19. The applicant was the mother of a child born in a surrogacy programme, a citizen of the United Kingdom of Great Britain and Northern Ireland. The child's father was a citizen of the Republic of the Philippines. When the Kharkiv City Department of State Registration of Civil Status Acts registered the child's birth, the couple was listed as the child's parents. They applied to the court to establish the relationship between the biological parents and the child. The couple intended to leave Ukraine and return home. In February 2019, they applied to the Embassy of the United Kingdom of Great Britain and Northern Ireland in Ukraine for a passport for their child but were told that in addition to the child's birth certificate issued in Ukraine, they had to provide a court decision on the relationship between their spouses and the child. The reason for the refusal to accept the documents and issue a passport for the child was due the fact that under the legislation of the United Kingdom of Great Britain and Northern Ireland, in order to register and issue a passport for a child born through the use of assisted reproductive

83 Bundesministerium der Justiz und für Verbraucherschutz, 2008.
84 Bundesgerichtshof, 2019.

technologies, it is necessary to obtain a UK court order on the degree of kinship in accordance with the UK Human Fertilisation and Embryology Act (2008), despite the fact that the child's birth certificate was issued in Ukraine. As a result of the case, the court decided to satisfy the application.[85]

The Civil Code of Ukraine,[86] para. 7 of Art. 281 states that an adult woman or man has the right, based on medical indications, to carry out treatment programmes using assisted reproductive technologies under the procedure and conditions established by law. Para. 1 of Art. 290 of the Civil Code of Ukraine also states that an adult with legal capacity has the right to be a donor of blood, its components, internal organs, other anatomical materials, and reproductive cells. Para. 2 of Art. 139 of the Civil Code of Ukraine prohibits contesting maternity in cases where the procedure of transferring a human embryo conceived by the couple as a result of the use of assisted reproductive technologies into the body of another woman has been carried out. Also, in the Ruling of the High Specialised Court of Ukraine for Civil and Criminal Cases of 18th November 2015 in case No. 6-27563ск15[87] It is stated that there is no need to obtain repeated consent from the husband for multiple attempts at artificial insemination, as the husband has been explained the procedure for IVF treatment and is aware of the possibility of needing more than one attempt before pregnancy occurs. To avoid numerous lawsuits challenging paternity and maternity, there are clear restrictions that exist in the law. According to para. 11 of the Decision of the Plenum of the Supreme Court of Ukraine No. 3 dated 15th May 2006 'On the application by courts of certain provisions of the Family Code of Ukraine in cases concerning paternity, maternity or recovery of alimony',[88] a person who has consented to the artificial insemination of his wife has no right to contest paternity. Similarly, under para. 2 of Art. 139 of the Family Code of Ukraine, denial of maternity is not allowed in cases provided for in paras. 2 and 3 of Art. 123 of the Family Code. This provision is regulated by law based on moral principles. It provides for the possibility that a woman who has carried a child (surrogate mother) may develop maternal feelings towards a child who is biologically alien to her. In such a case, the rights and interests of the biological mother (and, accordingly, the child) are protected by law.

In this context, it is essential to consider the national legislation of the state of citizenship of the genetic parents, specifically whether surrogacy is permitted and what formalities must be fulfilled to legalise the status of genetic parents concerning a child born to a surrogate mother. The ECtHR's case law indicates that Art. 8 does not obligate governments to legalise surrogacy, and such matters are adjudicated based on national legislation. In *D v. France*,[89] the ECtHR stated that the requirement

85 Decision of Court No. 628/828/19, 22.04.2019.

86 The Civil Code of Ukraine, 16.01.2003, No. 435-IV.

87 *Ukhvala Vyshchoho spetsializovanoho sudu Ukrainy z rozghliadu tsyvilnykh i kryminalnykh sprav*, 18.11.2015, No. 6-27563ск15.

88 *Postanova plenumu Verkhovnoho Sudu Ukrainy*, No. 3, 15.05.2006.

89 Case *ECtHR D v. France*, 16.7.2020.

to adopt a child born via surrogacy to acknowledge the bond between the genetic mother and the child does not infringe upon her right to a private life. Regrettably, the case law of the ECHR predominantly examines the rights of genetic parents or those who have utilised the services of a surrogate mother, rather than the rights of the surrogate mother herself. The handling of information on the surrogate mother, including its disclosure or concealment from the child, as well as the parameters of her privacy in decision-making during pregnancy, is typically omitted and is generally governed by the contract between the genetic parents and the surrogate mother. In particular, in its judgments of 26th June 2014 in the case of *Mennesson v. France*[90] and *Labasse v. France*,[91] the European Court of Human Rights specifically stated that each country has the right to prohibit surrogacy on its territory. However, the Court also recognised that the prohibition of surrogacy cannot adversely affect children born in this way abroad. The court ruled that countries that ban surrogacy must recognise the family relationship between children born to surrogate mothers abroad and their biological parents, or violate the children's rights to respect for private and family life under Art. 8 of the Convention. All ECtHR cases are evaluated using proportionality criteria for state interference with private interests. However, the Court does not always state the limits of private interference with women. The ECtHR evaluates each case against its specific circumstances and national legislation; therefore, if a state prohibits or limits reproductive rights, it may not infringe Art. 8. The ECtHR recognises that countries can allow or regulate reproductive health care treatments. States have ratified the Istanbul Convention to protect women's reproductive rights. The Istanbul Convention regulates reproductive rights and upholds women's rights. Additionally, national legislation must balance public interest and private rights, minimise intrusion into women's privacy, and consider WHO recommendations to ensure access to safe medicine and women's autonomy in sexual and reproductive health decisions. The ECtHR case law protects spouses' ability to have a child and use medically available means and make family planning decisions without interference. The Court found that the lack of embryo screening, but the availability of a permit for medical abortion if the foetus has the same condition, showed legislative inconsistency and disproportionate private interference.

Respect for privacy requires that every person has an opportunity to establish the details of their background, which is important because it shapes their identity. Establishing ancestry requires obtaining information about parents.[92]

The issue of the child's right to know his or her parents also arises when a child is born to a surrogate mother. According to para. 2.2 of the Decree of the Ministry of Justice No. 140/5 of 18th November 2003 'On Amendments and Additions to the Rules for Registration of Civil Status Acts in Ukraine',[93] and also, according to

90 Case ECtHR *Mennesson v. France*, 26.09.2014.
91 Case ECtHR *Labassee v. France*, 26.06.2014.
92 Case of *Călin v. Romania*, Application No. 54491/14, 05.07.2022.
93 *Nakaz Miniustu Ukrainy*, 18.11.2003, No. 140/5.

Art. 155 of the Family Code of Ukraine, the parents' exercise of rights and duties must be based on respect for the child's rights and human dignity. The registration of a child's birth is carried out with the simultaneous determination of its origin and assignment of a surname, name, and patronymic. In the case of the birth of a child by a woman who has had a human embryo transferred into her body as a result of the use of assisted reproductive technologies, state registration of birth is carried out at the request of the spouses who have consented to such a transfer. In this case, along with the document confirming the fact of the child's birth by this woman, a statement of her consent to the registration of the spouses as the child's parents, the authenticity of the signature which must be notarised, as well as a certificate of genetic relationship between the parents (mother or father) and the *foetus*, must be submitted. At the same time, one of the following entries is made in the 'For notes' column of the birth certificate: 'The mother of the child, identified by the electronic healthcare system according to the application for consent to record the spouses as the child's parents, is a citizen (surname, first name, patronymic)' or 'The mother of the child, according to the medical birth certificate, is a citizen (surname, first name, patronymic)', the name of the institution(s) that issued the certificate, the date of its issuance and number, the notary's data (surname and initials, notary district or state notary office), the date and the registration number of the authenticity of the woman's signature on the application for her consent to the registration of the spouses as the child's parents.[94] The state registration of the child's birth must be carried out within one month of the birth. As can be seen, when using assisted reproductive technologies, the parents of a child are the spouses, although the birth record also includes information about the mother who gave birth to the child.

Disputing maternity is not allowed in cases of ART of a wife carried out with the written consent of her husband, where he is recorded as the father of the child born to his wife. If an embryo conceived by a married couple is implanted into the body of another woman, the parents of the child are the spouses. If an embryo conceived by a married man and another woman is implanted in the body of his wife, the child is considered to have been born to the spouses. In this case, there is no doubt that the child is descended from the persons registered as his or her parents. Still, his or her biological data, in particular genetic origin, will be different. Here we see a negative legal consequence that may arise in the future when entering into marriage, as it can be presumed that the future spouses will have a common biological origin.

In a few words, we explain how legal filiation is established for children born via homologous and heterologous ART for both married and unmarried couples.

General Principles of Filiation in Ukraine (Family Code):

(1) Child born to married parents: According to Art. 122 of the Family Code of Ukraine, a child born to spouses is presumed to be the child of the spouses. The origin of the child from the mother is determined by the fact of birth.

94 *Pro zatverdzhennia Pravyl derzhavnoi reiestratsii aktiv tsyvilnoho stanu v Ukraini*, 18.10.2000, No. 52/5.

The origin of the child from the father is determined by the marriage between the mother and the father. No further special acknowledgment is needed. This applies to homologous ART (using gametes of both spouses) as well.

(2) Child born to unmarried parents: Mother: The origin of the child from the mother is always determined by the fact of birth.[95] Father: If the parents are not married, the origin of the child from the father can be determined by: voluntary acknowledgment of paternity.[96] The father submits a joint application with the mother (or a separate application if the mother is deceased/incapable) to the state civil registration body. This is a common method for unmarried couples. In the absence of a statement, the right to submit, paternity of a child may be recognised by a court decision.[97] If the father refuses to acknowledge paternity, it can be established by a court decision based on an application from the mother, guardian, or the child themselves.

(3) Homologous ART (using gametes of both married spouses): Married Couple: If a wife gives birth to a child conceived as a result of ART using the gametes of her husband, the husband is recognised as the father of the child. This falls under the general presumption of paternity for married couples[98] and is confirmed by Art. 130 of the Family Code, which states that a 'spouse who has given consent in writing to the use of assisted reproductive technologies is considered the father of a child born by his wife as a result of these technologies'. No special form or acknowledgment is usually needed beyond the general birth registration based on the marriage. Heterologous ART (using donor gametes/embryos): By Married Couple: Using donor sperm: If a child is born by the wife of a married couple using donor sperm, and with the written consent of the husband to this procedure, the husband is recorded as the father. The donor has no parental rights or obligations. Art. 130 of the Family Code states: 'a spouse who has given consent in writing to the use of assisted reproductive technologies is considered the father of a child born by his wife as a result of these technologies'. Using donor egg/embryo (and the wife carries the pregnancy): If a child is born by the wife of a married couple using a donor egg or donor embryo, and with the written consent of both spouses to this procedure, the wife is recorded as the mother and the husband as the father. The donor has no parental rights or obligations. The birth mother

95 Art. 125, Family Code.
96 Art. 126, Family Code.
97 Art. 128, Family Code.
98 Art. 122, Family Code.

is always the legal mother.[99] A husband's consent makes him the legal father.[100]

(4) By Unmarried Couple (concerning fathers): This is where Ukrainian law has historically been more restrictive regarding ART. Unmarried woman using donor sperm: An unmarried woman can undergo ART using donor sperm. In this case, she is registered as the sole parent (mother). If she is in a factual cohabitation relationship, her male partner is not automatically recognised as the father. He would need to establish paternity through voluntary acknowledgment[101] or a court decision,[102] similar to children conceived naturally outside of marriage. There is no special provision in Art. 130 of the Family Code that automatically grants paternity to an unmarried male partner in cases of ART. Unmarried couple (female partner carries, male partner's gametes used): If an unmarried woman carries a pregnancy using her partner's gametes (homologous for them as a couple), the mother is established by birth. The father would need to acknowledge paternity voluntarily.[103] Unmarried couple (donor gametes used): If donor gametes are used, the birth mother is established by birth. The male partner would need to establish paternity via voluntary acknowledgment or court decision.

5. The Rights of the Child and ART in Ukraine

Ukrainian legislation ensures 'the best interests of the child'. Art. 1 of the Ukrainian Law 'On the Protection of Children' stipulates that actions and decisions must consider a child's age, gender, health, development, life experiences, familial, cultural, and ethnic backgrounds, to safeguard the child's best interests. The regulations stipulate that the best interests of the child must always be prioritised in any choice about the child, including surrogacy. Moreover, the child's opinion must be seriously considered if he or she has reached an age and level of development at which it can be expressed. Reproductive procedure laws, policies, and practices must adhere to non-discrimination, prioritise the child's best interests, uphold the child's right to life and development, and accommodate the expression of diverse perspectives. The European Court of Human Rights notes that the best interests of the child are of utmost importance. In determining the best interests of the child in

99 Art. 122, Family Code.
100 Art. 130, Family Code.
101 Art. 126, Family Code.
102 Art. 128, Family Code.
103 Art. 126, Family Code.

each case, two conditions must be taken into account: first, it is in the best interests of the child to maintain his or her family ties, unless the family is particularly unsuitable or manifestly dysfunctional; second, it is in the best interests of the child to ensure that he or she develops in a safe, secure and stable environment that is not dysfunctional.[104] Ukrainian legislation, Art. 1 of the Law of Ukraine 'On the Prevention of Human Reproductive Cloning',[105] designates an embryo as a human embryo at the stage of development of up to 8 weeks. Such a definition is overtly undetectable and slanderous; looking back at the appearance of the indications of the initial moment, for which the embryo is the germ of a person. It is interesting that the legislator sets the upper time limit of the concept – eight weeks, i.e., two months.[106] This line is important for the completion of the processes of organ formation in the embryo, and at that moment in time it is already important for the *foetus*, and not the embryo. However, the current legislation also defines the concept of '*foetus*' as an intrauterine product of conception, starting from the full 12th week of pregnancy until expulsion/removal from the mother's body. It is fixed, in particular in clause 1.4. Decree of the Ministry of Health of Ukraine dated March 29th 2006, No. 179 'On the approval of the Instructions for determining the criteria for the perinatal period, live births and stillbirths, the Procedure for registering live births and stillbirths'. Therefore, the status of a conceived but unborn child in the period between eight and 12 weeks of pregnancy remains unsettled. In addition, the current Ukrainian legislation is characterised by a lack of unified terminology, since in addition to the above-mentioned terms '*embryo*' and '*foetus*', it also uses the terms 'conceived but not yet born child',[107] 'conceived child',[108] without their definition. In the literature, it is proposed to eliminate this problem by unifying the terminology and introducing a single term 'unborn child' into legal circulation, which is proposed to be defined as 'a human individual from the moment of conception (fertilisation of an egg by a sperm) to the moment of birth'.[109] Such a definition fully covers all stages of the development of a human being from the moment of fertilisation to the moment of birth, which will also cover embryos existing outside the mother's body (*in vitro*). It seems that such an approach will ensure the protection of the human embryo regardless of the form of its existence (implanted or non-implanted) and the stage of its development (*embryo or foetus*). For example, in the cases '*Vo v. France*' and *A, B and C v. Ireland*, the European Court of Human Rights' confirmed that 'an unborn child is not considered a 'person' whose rights are directly protected by Art. 2 of the Convention'. The Court noted that the 1950 Convention does not define the term 'human being' ('person'). At the same time, he noted that there is no consensus on the status of the embryo and/or *foetus* at the European level,

104 *Mamchur v. Ukraine*, No. 10383/09, § 100, ECHR, 16.07.2015.
105 Pro zaboronu reproduktyvnoho klonuvannia liudyny Zakon Ukrainy, No. 2231-IV., 14.12.2004.
106 Buletsa, Kvit and Mendzhul, 2022.
107 Part 2 of Art. 1298 of the Civil Code of Ukraine.
108 Part 3 of Art. 110 of the Family Code of Ukraine.
109 Lyubych, 2015, p. 263

but he recognised that the *embryo/foetus* belongs to the human race ('the human race').[110]

Moreover, the norms of the Civil Code of Ukraine disclose which interests of the unborn child are protected, in particular: (1) by Part 1 of Art. Art. 1200 of the Civil Code of Ukraine states that a child born after the death of the victim has the right to compensation; (2) if a child was conceived during the life of the testator, but was born alive after his death, he or she is recognised as the heir both by will and by law. He or she belongs to the priority.[111]

The analysis of the indicated rules allows us to conclude that at the basis of any decision concerning the child, even in the case of the birth of a child through surrogacy, the best interests of the child should always be paramount. And it is for these reasons that it is essential to ensure that laws, policies, and practices in the field of reproductive procedures comply with the principles of non-discrimination, the best interests of the child, the child's right to life and development, as well as the expression of opinions.

The anonymity of donation is also related to the right of a person to know about his or her genetic consent. At the same time, there are cases in the ECHR case-law on protecting the rights guaranteed by the Convention for the Protection of Human Rights and Fundamental Freedoms regarding the establishment of biological paternity and the right of a person to know who his or her parents are.[112] Scientists note that it is necessary to establish the rights of a person to receive information about his or her genetic origin in the case of ART, including by disclosing the anonymity of the donor.[113] It should be noted that the surrogate mother may remain anonymous.

According to A.P. Holovashchuk, when deciding on the right of a child to information about genetic origin, it is necessary to take into account the psychological aspect, namely, it is difficult to predict the child's reaction to the fact that his or her genetic father (or mother) were donors. Such information can lead to a deterioration in family relationships and cause difficulties in raising a child. For these reasons, A.P. Holovashchuk concludes that it is the parents who have the right to determine whether to provide the child with information about his or her genetic origin and such information can be provided only after the child reaches the age of majority.[114] An effective tool for protecting the interests of a child born as a result of ART (surrogacy), when the parents are citizens of a foreign country, is the establishment of 'feedback' with the official bodies of that country, which is responsible for protecting children's rights. Such a tool can be introduced through the conclusion of international agreements and cooperation with international organisations. The legal concept of protecting the interests of a child born as a result of assisted reproductive

110 Case *Vo v. France* (Application No. 53924/00, Judgment of 8 July 2004) and case *A, B and C v. Ireland* (Application No. 25579/05, Judgment of 16 December 2010).

111 Part 1 of Art. 1222; Part 2 of Art. 1261; Art. 1298 of the Civil Code of Ukraine.

112 Case *Mikulic v. Croatia*, 7.02.2002; Case of *Odièvre v. France*, 13.02.2003.

113 Boldizhar, 2019, p. 15.

114 Holovashchuk, 2013, p. 296; Boldizhar, 2019, p. 15.

technologies (surrogacy) provides for the principle of the double liability of each capable subject of these legal relations. Thus, positive (prospective) responsibility consists in understanding the idea of the value of a new life, respect for the best interests of the child, and the faithful fulfilment of their duties to other participants in the programme, the state, and the child born. Negative (retrospective) legal liability is a violation of the law, the terms of the contract, the rights of other programme participants and involves suffering adverse personal, property, and organisational consequences. The practical value of the legal concept of protecting the interests of a child born as a result of assisted reproductive technologies (surrogacy) is not only in the implementation of tools, methods and responsibilities at the state level, but also in the promotion of the idea of the right of every child to a happy and carefree childhood and the priority of the best interests of the child at an international level.[115]

There were also special rules for children crossing Ukraine's state border during periods of martial law. According to the Resolution of the Cabinet of Ministers of Ukraine of 27th January 1995 No. 57 'Approval of Rules for the Crossing of the State Border by Ukrainian Citizens',[116] children under the age of 16 can leave Ukraine if they have a passport of a Ukrainian citizen or a birth certificate (in the absence of a passport of a Ukrainian citizen) / documents containing information about the person, based on which the State Border Service will allow them to cross the state border. That is, the issuance of a foreign passport is currently not a mandatory condition for a child to cross Ukraine's state border. And although this rule was written for the crossing of the state border by Ukrainian citizen children, representatives of the State Border Service of Ukraine in practice apply it during martial law by analogy to children born in Ukraine to foreigners as a result of using the surrogacy method, which allows them to cross the state border of Ukraine only based on a birth certificate. However, it is essential to remember that in the classical form, according to Art. 15 of the Law 'On the Legal Status of Foreigners and Stateless Persons', the entry into and exit from Ukraine of foreigners is carried out using a passport document with a corresponding visa, unless another procedure for entry and exit is established by legislation or an international treaty of Ukraine.

In this regard, to travel with an infant outside Ukraine, the genetic parents should have a travel document for the child issued by the diplomatic representation of the foreign country in Ukraine, and the child's birth certificate. Without this document, the border guards show great vigilance and often require the presentation of additional documents to monitor the implementation of the surrogacy programme under the current Ukrainian legislation: e.g. a contract on the provision of surrogacy services concluded between the spouses of the genetic parents and the surrogate mother; certificate of genetic parentage; a notarised statement of the surrogate

115 Mykhalchuk et al., 2019.
116 *Postanova Kabinetu Ministriv Ukrainy*, 27.01.1995, No. 57.

mother on the consent to the registration of the genetic parents by the parents of the child; newborn exchange card, etc.[117]

6. Conclusions

Legal relations arising in the field of assisted reproductive technologies (ART) are characterised by several specific features. These legal relationships emerge between clearly defined parties, primarily individuals, both women and men, who are patients, and healthcare institutions that offer ART services. Typically, ART-related legal relations involve at least two parties; two-party relations are common in procedures such as sperm donation, where the interaction is limited to the donor and the recipient or the healthcare institution. More complex processes, like surrogacy, involve multiple parties, including the intended parents, the surrogate, medical professionals, and potentially legal guardians or agencies. A mandatory subject in these relations is the healthcare institution providing ART services, acting as a key actor responsible for initiating and maintaining the legal process. The regulatory framework governing these relations is mixed, combining statutory legal norms and contractual agreements, which highlights a dual regulatory structure. These legal relations are inherently dynamic, often evolving as new obligations and rights emerge; for example, after a successful IVF and childbirth, the initial relationship between patients and the healthcare institution may develop into new legal relations concerning the donation of unused cryopreserved embryos to other recipients such as infertile couples or single women. They are marked by binding legal force, characterised by the reciprocity of rights and duties, which is fundamental to legal relationships. Establishing these relations involves dual layers of intent: public will, expressed through state legislation regulating ART procedures, and private will, demonstrated by individuals through consent and contractual agreements. Additionally, legal relations in ART are technologically dependent, closely tied to ongoing medical and biotechnological advancements such as gene editing, embryo screening, and artificial wombs, requiring legal frameworks to evolve accordingly. These relationships often have temporal complexity, lasting months or years, as seen in surrogacy or embryo storage contracts, which necessitate considerations of long-term commitments, including issues like posthumous reproduction or custody of cryopreserved embryos. Due to the international nature of ART, cross-border implications are significant; patients may travel abroad for procedures, raising questions about the recognition of contracts, parental rights, and citizenship across jurisdictions.[118] Confidentiality and data protection are also critical, given the sensitive personal and

117 Danchenko, 2022.
118 Korać Graovac, 2024, pp. 101–121.

genetic information involved, necessitating compliance with laws such as the GDPR. Ethical and public interest limitations often restrict ART procedures, reflecting societal values, including bans on sex selection or embryo research limitations. Consent and informed decision-making are central, with laws requiring full, voluntary, and informed consent, especially regarding gamete donation, embryo use, or surrogacy, including rules about withdrawal of consent. Determining legal parenthood can be complex, particularly in cases of donor conception or surrogacy, requiring clear legal definitions of who is recognised as the parent or parents under specific conditions. Finally, the legal framework must address vulnerability and inequality considerations, protecting parties from exploitation, such as low-income surrogates or egg donors, and ensuring non-discrimination and equitable access to ART services.

In addition, given the complex combination of medical, ethical, and legal aspects, developing the relevant legal act requires a balanced approach from the legislator. We hope that such a document will balance the interests of the surrogate mother, the genetic parents, and the child.[119] In addition, it is advisable to establish appropriate liability for persons who use the surrogacy programme for enrichment, turning childbirth into a business.

The current gaps in Ukraine's legal framework regarding assisted reproductive technologies include unresolved issues concerning the legal status of reproductive cells and embryos, the absence of defined legal forms for a person's will to permit posthumous use of reproductive materials, unclear criteria regarding who has access to reproductive cells after a person's death, and the lack of regulations concerning inheritance rights for children born posthumously.

As practice shows, the current legislative regulation of foreign motherhood does not fully protect the rights and legitimate interests of students of foreign motherhood programmes. At the same time, children born through such programmes require the greatest protection and redress of violated rights, especially when the mother leaves, for example, the need to confirm the legitimacy of their placement (especially in the case of foreign students in advanced programmes) or to prevent risks of child trafficking. Children's best interests in Ukraine require clear legal protections for their rights and status, especially in ART contexts, including posthumous and foreign programs. There is a need to establish legal standards that prioritise the child's well-being, protect against exploitation, and provide clarity on parental rights, inheritance, and identity. Children born through ART must have their rights recognised to prevent violations and ensure access to support and legal recognition, regardless of complex procedures. The main principles in defence of children include prioritising their best interests, ensuring non-discrimination, protecting them from exploitation and abuse, providing legal certainty and recognition of parental rights, safeguarding privacy and confidentiality, and promoting equitable access to ART services. Overall, Ukraine must develop comprehensive legislation aligned with

119 Garayová, 2024, pp. 69–84.

international standards to protect and uphold the rights and well-being of children born through ART.

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Chapter 13

Conclusion and Synthesis About ART in Nine European Countries



Aleksandra Korać Graovac and Edit Sápi

Abstract

The following chapter is a summary and conclusion part of the country reports of the nine European countries in this volume. This chapter provides a synthesis of the most important questions and cornerstones of ART in nine European countries. Therefore, it deals with three of the main parts of this topic. Firstly, the constitutional background for ART is outlined, with special regard to the dignity and ART, and the respect for private and family life and the interconnections to ART. In the second, bigger chapter the ART technologies in the legal environment are put in focus, mainly from a medical aspect. Within the framework of this topic, the ART procedures of the given countries, the state involvement in financing ART procedures, the beneficiaries of ART and the key aspects of surrogacy are affected by the authors. The third bigger part of the chapter deals with the huge area of ART and family law and put the emphasis on the questions of establishing motherhood and fatherhood, surrogacy, same-sex legal parents, contesting motherhood and fatherhood, and last but not least, the best interests of the child.

Keywords: medically assisted reproduction, assisted reproduction technologies, the best interests of the child, reproductive rights, surrogacy, origin of the child

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1. Introduction

The aim of this chapter is to make a summary of the relevant legislative and practical measures of nine European countries, namely Czechia, Croatia, Slovakia, Slovenia, Hungary, Serbia, Poland, Romania and Ukraine, which will outline the evergreen and complex topic of assisted reproductive technologies. This summary article mainly focuses on the synthesis of the country reports of this volume. Because of the synthesis-nature of this chapter, it was written based on country reports, all of them can be read in this volume. Consequently, there are only fewer scientific, literature related footnotes in this article, only the Acts and other legal sources are indicated in the footnotes, which deals with the legal environment of the topic. If the reader is interested in the sources and detailed analysis of the given legal institution, or legal solution, it can be read in the corresponding country report.

In compiling of the chapter, we did not intend to present the legal institutions in accordance with the alphabetic order of the countries, but in another, more comprehensive context. Therefore, we composed the article according to a logical line, where the similarities and differences dominate in relation to the given legal institutions and practical problems and shortcomings.

Due to their nature and aim, we did not present two introductory chapters concerning psychology and religious ethics.

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2. Constitutional Background for ART

It can be generally stated, that neither of the Constitutions of the countries analysed mention rights to ART directly or in explicit regulations. However, as most of these countries are signatory parties of the Oviedo Convention and the European Convention on Human Rights, ART procedures are affected in the Constitutions. Therefore, we shall see that the constitutions examined regulate ART indirectly through general fundamental human rights. This tendency also points to the consequence that a certain space is vested to other statutes, policy guidelines or court interpretations regarding the most important and even controversial issues of ART.

In the given nine countries, the following constitutions – or as an equivalent –, fundamental laws are in force. The next summary table demonstrates the proper Constitution of the given country and the relevant Arts., which can be functioned as backgrounds for ART.

Country	Constitution	Relevant Arts. to aspects of ART
Croatia	Constitution of the Republic of Croatia, 1990 (and amendments) Official Gazette Nos. 56/90., 135/97., 8/98., Nos. 113/00., 124/00, Nos. 28/01., 41/01, Nos. 76/10., 55/01., 5/14., 85/10.	Art. 14, Art. 21, Art. 35, Art. 40, Art. 47, Art. 58, Art. 65
Czechia	Charter of Fundamental Rights and Freedoms, 1993, Act No. 2/1993 Sb.	Art. 1, Art. 2, Art. 3. Art. 4, Art. 6, Art. 31, Art. 32
Hungary	Fundamental Law of Hungary, 2011	Art. II, Art. III, Art. VI, Art. XV, Art. L, Art. XVI
Poland	The Constitution of the Republic of Poland of 2 April 1997, Journal of Laws of 1997, no. 78, item 483 as amended.	Art. 30, Art. 38
Romania	Constitution of Romania, 1991	Art. 4, Art. 16, Art. 20, Art. 22, Art. 26, Art. 34, Art. 48
Serbia	The Constitution of the Republic of Serbia, Official Gazette of the Republic of Serbia 98/2006, 15/2021.	Art. 15, Art. 21, Art. 23, Art. 24, Art. 25, Art. 42, Art. 43/1, Art. 58, Art. 63 Art. 64, Art. 65, Art. 66, Art. 68
Slovakia	Constitution of the Slovak Republic (1992, as amended). Constitutional Act No. 460/1992 Coll., as amended by later constitutional laws.	Art. 12, Art. 15, Art. 16, Art. 19, Art. 41,
Slovenia	Constitution of the Republic of Slovenia Official Gazette, Nos. 33/91-I, 42/97 – UZS68, 66/00 – UZ80, 24/03 – UZ3a, 47, 68, 69/04 – UZ14, 69/04 – UZ43, 69/04 – UZ50, 68/06 – UZ121, 140, 143, 47/13 – UZ148, 47/13 – UZ90, 97, 99, 75/16 – UZ70a, 92/21 – UZ62a.	Art. 14, Art. 17, Art. 53, Art. 54 (2), Art. 55
Ukraine	Constitution of Ukraine, 1996	Art. 3, Art. 21, Art. 24, Art. 27, Art. 28, Art. 32, Art. 49, Art. 51, Art. 52

Table No. 1

The most important fundamental and liberty rights which can be interpreted as backgrounds or cornerstones of ART procedures, are the following in the constitutions of the countries analysed: (a) non-discrimination/the right to equality; (b) the right to dignity; (c) the right to privacy; (d) the right to consciousness; (e) the right to life; (f) right to health(care); (g) children's rights (especially, the right of the child to know his/her origin); (h) the right to the free decision of childbirth; (i) the right of

ownership; (j) the prohibition of inhuman or degrading treatment; (k) the protection of personal data and confidentiality.

The colourful palette of the abovementioned fundamental rights can reflect two aspects of this topic. On the one hand, it can be ascertained that the possibility or the privileged procedures of ART cannot be protected directly in any of the constitutions, and therefore it cannot be seen as an 'independent fundamental right'. On the other hand, and even consequently, it might be stated that ART has several, almost untraceable connections to fundamental rights. In the following sections, we will summarise and compare the relevant provisions of the given constitutions (fundamental laws), in line with the logical order of The Charter of Fundamental Rights of the European Union (henceforward abbreviated as: Charter). Nevertheless, due to structural and content considerations, not all relevant fundamental rights are demonstrated here, only dignity and the right to private and family life, as the alphas of fundamental rights.

2.1. Dignity and ART in the Constitutions Examined

Title 1 of the Charter declares that 'Dignity covers Human dignity, Right to life, Right to the integrity of the person, Prohibition of torture and inhuman or degrading treatment or punishment, Prohibition of slavery and forced labour'.

Dignity, as one of the main roots of personality rights covers that 'Human dignity is inviolable. It must be respected and protected'.[1] The right to dignity appears in all the analysed countries' constitutions, as it is the cornerstone of the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine of the Council of Europe (Oviedo Convention) from 1997 and appears even in civil codes. Most declare this human right within the general provisions of the constitution, such as the Czech and the Polish one.[2] Dignity, the right to life and infertility have a natural relationship, which shall be highlighted. At this point it seems appropriate to quote the wording of Lilla Garayová, who emphasises

> 'By valuing the human dignity of couples investigating the roots of their infertility, this approach ensures that, upon the elimination of identified causes, conception can occur naturally, preserving the dignity of the conceived life. Given these considerations, public health insurance should encompass this method as a viable alternative to conventional assisted reproduction techniques'.[3]

At the same time, we shall also see that this system of relationships is not simple and harmonious, as several chapters highlight. The Croatian country report reflects

1 Charter, Title 1, Art. 1.
2 Králíčková, 2026.
3 Garayová, 2026.

the situation, that dignity can be interpreted in line with the protection of children and embryos, and it can relate even to the potential misuse of embryos. The protection of the dignity of a future child also connects to the prohibition of cloning, as the aforementioned chapter reveals.[4] Similarly, the Romanian report highlights that complex arguments can be ascertained regarding the preservation of frozen embryos, as a violation of human dignity.[5] Moreover, in Romania, a specified legislation, the law no. 272/2004 on the rights of the child recognises the child's specific right to dignity.[6] The wording of the Infertility Act of Slovenia is remarkable, as it uses the phrase to 'allowing early embryos to die', which phrasing reflects the respect for the dignity of embryos, as it does not use terms such as 'destroy' or 'terminate'.[7] The Hungarian chapter adds that according to the Explanatory Memorandum to Bill No. T/2627 on the Fundamental Law of Hungary, the embryo's human dignity is defined as value worth of protection through the phrasing of the Fundamental Law.[8] In Hungary, the embryo is granted relative legal protection to its right to life and dignity, for this possibility of the state to balance these rights with others.[9] With this regard, the separate Act LXXIX of 1992 on the Protection of Foetal Life shall be mentioned, which prescribes 'Foetal life, which begins at conception, deserves respect and protection'. The phrase of the act shows 'foetal life' rather than human life and defines the protection starting from conception. The chapter adds that this Act focuses on the protection of the *in vivo* embryo and does not address the status or protection of the *in vitro* embryo.[10] The Ukrainian chapter emphasises that state-protected personal dignity underpins reproductive rights, and highlights that at an individual level, this means women's right should be treated with respect by doctors and specialists who are consult for reproductive health advice, since respect for human dignity requires ethical communication also.[11]

4 Korać Graovac, 2026.
5 Florian and Floare, 2026.
6 Art. 6g Law no. 272/2004.
7 Kraljić, 2026.
8 Barzó and Nagy, 2026.
9 Jobbágyi, 1997, pp. 75–91.
10 Barzó and Nagy, 2026.
11 Buletsa, 2026.

2.2. Respect for Private and Family Life and the Interconnections to ART

Chapter II of the Charter contains many Freedoms,[12] which can be interpreted in line with ART. These are mainly the following: the right to liberty and security, respect for private and family life, the protection of personal data, the right to marry and the right to found a family.

Respect for private and family life encompasses that everyone has the right to respect for his or her private and family life, home and communications. The constitutions analysed have demonstrated that the state is obliged to provide the individual with such conditions that would enable him or her to be able to decide freely to found a family – for example as is emphasised in the Slovenian Constitution.[13] Interconnections that can be surveyed by reproductive rights are inherently connected to personal autonomy and fall within the broader framework of protections designated to private and family life – which is mentioned in the Hungarian chapter,[14] and even appears as a principle of the protection of marriage and family life in the Family Law Book of the Civil Code.[15] Regarding the legal environment, it should be mentioned that the contemporary Serbian Constitution does not contain a provision on respect for private and family life, however it has historical roots, as the former, 'Constitution Charter on state union of Serbia and Montenegro' had a provision on the right to respect of private and family life. Of course, this does not mean that the right is missing from the state order, as the Family Act of Serbia contains the right to private and family life. Still, it does not appear as a constitutional, fundamental right, rather as a civil law personality right. However, while the importance of this right and its clear connection with ART are unquestionable, some chapters – such as the Czech – point out that its content and limits can be diverse, which is not easy (or even impossible) for the legal system to handle uniformly. Králíčková points out, that 'it is therefore very difficult to create a family policy and legal framework for the protection of the family and family life that suits everyone'.[16]

Within this framework, the decision of the Slovak Constitutional Court from 2007 also explicitly linked reproductive decisions with the right to privacy. The Slovak chapter underpins that a woman's right to privacy encompasses her freedom

12 Chapter II, Freedoms, Art. 6 Right to liberty and security, Art. 7 Respect for private and family life, Art. 8 Protection of personal data, Art. 9 Right to marry and right to found a family, Art. 10 Freedom of thought, conscience and religion, Art. 11 Freedom of expression and information, Art. 12 Freedom of assembly and of association, Art. 13 Freedom of the arts and sciences, Art. 14 Right to education, Art. 15 Freedom to choose an occupation and right to engage in work, Art. 16 Freedom to conduct a business, Art. 17 Right to property, Art. 18 Right to asylum, Art. 19 Protection in the event of removal, expulsion or extradition.

13 Kraljić, 2026; Art. 35 of the CRS.

14 Barzó and Nagy, 2026.

15 Act V of 2013 on the Civil Code, Art. 4:1 §.

16 Králíčková, 2026.

to make decisions about pregnancy and by extension, should encompass decisions about attempting to become pregnant via ART.[17]

3. ART Technologies in the Legal Environment – Medical Aspects

The chapters outline the medical-legal framework of ART technologies. These chapters can be synthesised by some key questions, such as (1) What is the extent of the choice of ART, i.e. which procedures are regulated as permitted procedures and which are prohibited; (2) The next important question of the analysis is how the state can help ART by financial means; (3) The beneficiaries of ART, as who are entitled to take part in the procedure; (4) Special focus on surrogacy arrangements

3.1. ART Procedures of the Countries – Vague Boundaries Between Law and Practice

In terms of legal regulation and interpretations, three possible paths can be ascertained: the traditional one, which speaks about ART in a very narrow legal context; the permissive one, which opens up the possible solution frameworks; and the intermediate regulation, which seeks to precisely define accepted and prohibited procedures. This categorisation is based solely on a legislative technical approach, namely on the distinction as to whether there is a specific systematisation consisting of several elements in the legislation or not. Therefore, the basis of classification is not content-based, and in no way is it value-based, but rather regulatory.

A traditional approach would be the Slovak one, whereas a permissive, more open approach would be the Czech one. In Slovakia, the Transplantation Act and an outdated regulation[18] narrowly defines artificial insemination, however in practice Slovak fertility clinics have adopted a wide range of modern ART procedures to address infertility. Nevertheless, the legal situation is quite vague, as those procedures, which are widely applied, operate without detailed legislative framework. At the same time, it does not mean, that artificial insemination is the only method, which can be performed in Slovakia. *In vitro* fertilisation, cryopreservation (the freezing of sperm, oocytes, or embryos for future use, including subsequent procedures like cryo-embryo transfer), pre-implantation genetic diagnosis (the detection of genetic disorders before implantation to prevent genetically inherited conditions) are all such techniques, which can be performed in practice, and without detailed legal regulations.

17 Garayová, 2026.
18 Measure No. 24/1983 of the Ministry of Health.

This contrasts with the Czech approach, which includes all forms of assisted fertilisation under a unified legal definition. In the Czech regulation, a unified legal definition opens up the circle of ART technologies, since according to law, assisted reproduction means methods and procedures involving the collection and manipulation of germ cells, the creation of a human embryo by fertilisation of an egg with sperm outside the woman's body, the manipulation and storage of human embryos for the assisted reproduction of the woman, (a) for medical reasons in the treatment of her infertility or the infertility of a man, if it is unlikely or impossible for the woman to become pregnant naturally or to bear a viable foetus and other treatments for her infertility, or male infertility has not led to, or is highly unlikely to lead to her becoming pregnant or (b) as regards the need for early genetic testing of the human embryo, if the health of the future child is endangered because of a demonstrable risk of transmission of genetic diseases or defects carried by the woman or man.

The Czech regulation also adds that it is stressed that the assisted reproduction of a woman as a treatment of infertility is (a) the introduction of sperm into the reproductive organs of a woman; (b) the transfer of a human embryo resulting from the fertilisation of an egg by sperm outside the woman's body into the woman's reproductive organs (*in vitro* fertilisation and embryo transfer).

Compared to these two described endpoints, there are countries, where acknowledged, permitted and prohibited ART technologies are listed. These countries are Hungary, Croatia, and Serbia.

Among ART procedures there are some quite 'traditional', 'core' techniques, which are commonly acknowledged and regulated by the countries, such as intrauterine insemination (IUI), or *in vitro* fertilisation (IVF).

Serbian law[19] prescribes that ART include *in vivo* fertilisation and *in vitro* fertilisation with embryo transfer. Procedures of ova and embryo donation are allowed.

The Croatian MAR Act[20] lists the different medically assisted techniques, such as: (a) intrauterine insemination (IUI); (b) *in vitro* fertilisation (IVF); (c) intracytoplasmic sperm microinjection (ICSI); (d) cryopreservation of gametes and embryos and their defrosting, transfer of gametes or embryos into the fallopian tube, and preimplantation genetic diagnostics.

The Act on Healthcare of Hungary lists accepted procedures as follows: (a) fertilisation outside the body and embryo implantation; (b) artificial insemination performed with the germ cells of the spouse or partner, or with donated germ cells; (c) fertilisation outside the body and embryo implantation carried out with donated germ cells; (d) embryo implantation performed with embryo donation; (e) any other method facilitating the fertilisation of the female germ cell, as well as the implantation and development of the fertilised germ cell, may be applied.[21]

19 Law on Biomedically Assisted Fertilisation, 2017.
20 Art. 9 of the MAR Act.
21 Act on Healthcare Art. 166, para. (1).

The Polish legal framework also lists permissible ART techniques. Among them are *in vivo* fertilisation artificial insemination (consisting of intrauterine insemination, homologous insemination, heterologous insemination and mixed insemination). Within *in vitro* fertilisation (IVF) homologous and heterologous IVF are accepted, such as Surgical Embryo Transfer (SET), Intravaginal Culture (IVC), and Transfer of fertilised eggs or embryos into the fallopian tubes.[22]

In Romanian law, Annex no. 30 of the Health Minister's Order no. 1241/2019 covers the following acknowledged types of ART: intra-uterine (artificial) insemination, *in vitro* fertilisation (IVF), embryo transfer, intracytoplasmic sperm injection (ICSI), and artificial insemination with sperm or oocytes from a third-party donor.[23] Medically assisted reproduction with a third-party donor is specifically mentioned by the Civil Code.[24]

Slovenian law[25] specifies the applicable ART technologies, as (a) intrauterine insemination (as insertion of sperm cells into the woman's reproductive organs; or insertion of egg cells together with sperm cells into the woman's reproductive organs); (b) extra-corporal fertilisation procedures (which means IVF) as the union of egg cells and sperm cells outside the woman's body; or the insertion of early embryos into the woman's reproductive organs.

Homologous and heterologous fertilisation are also known, but in heterologous ART procedures, the simultaneous use of donated egg cells and donated sperm cells is not allowed under Slovenian law.

ART technologies are in a special situation in Ukraine – especially surrogacy, which will be mentioned below. The current framework for assisted reproductive technologies in Ukraine offers various fertility treatment programmes, such as IVF, egg donation, and embryo transfer. Allowed and regulated technologies include homologous techniques, such as IVF using gametes from the intended parents, and heterologous techniques, such as sperm or egg donation, which are legally permitted under specific conditions. Informed consent from all parties – donors, recipients, and surrogates – is a mandatory legal requirement, ensuring voluntary participation and understanding of procedures, risks, and rights. Surrogacy is legally permissible, but exclusively for married heterosexual couples.

The regulation of posthumous fertilisation is also an important question in the framework of the countries examined. In general, three approaches can be described: on the one hand it is an explicitly banned procedure, and on the other hand, the legislator does not regulate it. The explanation for such a legislative decision lies in the attitude that a child has the right to be cared for by both parents.[26] In addition, a

22 Infertility Treatment Act.
23 Irinescu, 2024, pp. 348–349 cited by Florian and Floare, 2026.
24 Florian and Floare, 2026.
25 Infertility Act.
26 Korać Graovac, 2026.

third aspect can be seen, e.g. in Romanian and Ukrainian law, which tend to allow it.

It is not possible to find precise regulation about posthumous fertilisation in Serbia, because Serbian Law on Biomedically Assisted Fertilisation does not contain concrete rules about it, however a general requirement of ART procedure is the mutual life together in the moment of performing the procedure.[27] Another regulation shall be mentioned, which shows a tendency towards the banning of posthumous fertilisation, as the use of reproductive cells and embryos which belong to living donors is allowed. Despite the fact that the law is not precise on the procedure of posthumous fertilisation, legal practice shall deal with it, as Kovaček Stanić refers to two legal cases from recent years.[28]

In Slovakia the legal interpretations of the posthumous use of embryos (or gametes) are lacking from the legal environment.[29] In Hungary the Criminal Code[30] threatens the use of a germ cell originating from a dead person or a dead foetus for a special procedure aimed at human reproduction with imprisonment from one to five years, and also orders the punishment of preparation for such an act

Posthumous fertilisation is prohibited in Croatia as well. A further rule in this manner is that if the person who has provided and stored sex cells or tissues dies, the medical institution shall destroy the person's sex cells or tissues within 30 days of its knowledge of the person's death. Law is clear only in point that superfluous embryos may be donated, but not used by one of the intended parents.[31]

Similar legislation can be found in Slovenia, where the Infertility Act also does not allow posthumous fertilisation.[32] It is prohibited to perform ART with the sperm or egg cells of a donor who is no longer alive at the time of the insertion of the donated cells or early embryos into the woman's body. Before a doctor inserts the donated sperm or egg cells, or early embryos formed using the donated cells into the woman's body, they must determine whether the donor is still alive.[33]

As a third aspect, a vague – but rather permissive – legal environment could be ascertained in Ukrainian and Romanian law.

Within the Romanian framework, posthumous fertilisation can technically be construed to be legally possible if the deceased oocyte or sperm donor had consented to cell harvesting before death. It should be noted at the same time, that a former legislation has expressly prohibited the insemination of a woman with her dead husband's sperm.

In Ukraine's legal framework regarding assisted reproductive technologies there are some gaps, which for example also affect the interpretation of posthumous

27 Kovaček Stanić, 2026.
28 Ibid.
29 Garayová, 2026.
30 Section 169 of the Criminal Code.
31 Art. 33 para. 3 of the MAR Act; Korać Graovac, 2026.
32 Kraljić, 2026.
33 Art. 28(3) of the Infertility Act.

fertilisation. However, a new law, on the 'On Amendments to Certain Laws of Ukraine on Ensuring the Right of Servicemen and Other Persons to Biological Parenthood (Motherhood)', from 2024, has raised the issue of posthumous reproductive cell use. According to this Law, if a person whose reproductive cells are stored in accordance with the law dies or is declared dead by a court, their storage shall be free of charge for three years. After this period, the individual's reproductive cells may be stored at the expense of another person selected in their will in accordance with the law in the case of their death or court declaration of death. Before the current regulations, there was no legal mechanism for posthumous conception and birth in Ukraine.[34]

34 Buletsa, 2026.

Country	Legal basis	Legislative technical approach on permitted ART procedures	Posthumous fertilization
Croatia	special act (MAR Act)	intermediate approach: Act lists the procedures	prohibited
Czechia	special act (Act on Specific Health Services)	open approach: includes all forms of assisted fertilisation under a unified legal definition)	prohibited
Hungary	Civil Code and special acts (e.g. Act on Healthcare)	intermediate approach: Act lists the procedures	prohibited
Poland	special act (Infertility Treatment Act)	intermediate approach: Act lists the procedures	prohibited
Romania	special act (Health Minister's Order) and Civil Code	intermediate approach: Act lists the procedures	no explicit rules, but technically can be performed with prior consent
Serbia	special act (Law on Biomedically Assisted Fertilisation)	intermediate approach: Act lists the procedures	no explicit rules, tend to prohibition
Slovakia	special act (Transplantation Act)	traditional approach: narrowly defines ART procedures	no explicit rules, tend to prohibition
Slovenia	special act (Infertility Treatment and Biomedically Assisted Reproductive Procedures Act)	intermediate approach: Act lists the procedures	prohibited
Ukraine	Family Code, Civil Code/ general legislation, and Ministry of Health Order No. 787/2013 on ART	intermediate/open practical approach: ART procedures are regulated in a broad medical-administrative framework	2024 legislation regulates storage of reproductive cells after death, but does not fully settle posthumous conception, parentage and succession consequences

Table No. 2
About the legal basis and most important ART procedures

3.2. State Involvement in Financing ART Procedures

Given that reproductive procedures are quite costly, there has been a demand in the countries studied for the state to support and assist the couples, partners and

eligible singles who use them in some way. This assistance basically means providing financial support. However, the forms of this vary in individual countries. There are some states that are able to provide full coverage for treatments, while in other states partial financial support is available only for certain procedures. The fundamental purpose of these subsidies is to assist reproduction and not let the lack or limitation of financial resources be the main obstacle for couples to have their desired child.

There are mainly two types of state financing: public health insurances and dedicated national programs. The former is more common, as in Czechia, Hungary, Serbia, Ukraine, Croatia, Slovenia and Poland state support – as part of public health insurance – is available for beneficiaries. The latter version – national program – can be found in Romania.

The Hungarian system is distinctive in that infertility centres provide, free of charge, all medically necessary fertility treatments, including assisted reproductive technology (ART) procedures, with funding provided by the Health Insurance Fund. Healthcare providers seeking to perform ART procedures are required to obtain an operating license from the competent healthcare authority. Thus, reproductive procedures may only be carried out upon the recommendation of an appropriately qualified specialist doctor.[35] This situation can be traced back to the nationalisation of infertility clinics. In summing up, under the current regulation,[36] only state-run centres can provide assisted reproductive techniques, but the procedure is entirely free of charge for the couples. Consequently, the currently effective text of NM Decree No. 49/1997 declares that special procedures for human reproduction may be provided free of charge only on medical indication by a healthcare provider financed for that purpose by the Health Insurance Fund.

Public funding is available up to the age of 45.[37] The legislation permits up to six procedures of ovulation induction and artificial insemination, and up to five procedures of medication-assisted stimulation for egg cell retrieval.[38]

Very similar is Slovenian law, where a reimbursement is allowed, which is a generous one, as even 99 % of the costs can be paid back to the beneficiary in the case of ART technologies. The financial coverage is also similar in Czechia, but public health insurance is available only till the age of 40.[39] On the contrary, ART is available for women until the age of 49. It means that if a woman is over 40 years old, the infertile couple must pay for the whole service according to the conditions by the provider. State health insurance covers hormonal stimulation and *in vitro* fertilisation (IVF) cycles, but no additional and above-standard services such as the cryopreservation

35 Barzó and Nagy, 2026.

36 BM Decree 34/2023 (VIII.24) amended certain ministerial decrees: on health insurance: it amended Decree No. 30/1998 (VI.24) and NM Decree No. 49/1997 (XII.17) on infertility treatment procedures available under compulsory health insurance.

37 Sápi, 2024, p. 190.

38 Barzó and Nagy, 2026.

39 Act on Public Health Insurance (Act No. 48/1997 Sb., as amended, APHI).

of gametes and embryos, their prolonged cultivation, preimplantation genetic testing and other cycles.[40]

In Serbia, stimulations are state-funded for an unlimited number of stimulations, while up to three embryo transfers are state-funded for women up to the age of 45.[41]

In Croatia, the procedure of MAR at the expense of the Croatian Health Insurance Fund includes four attempts at intrauterine insemination (IUI) and six attempts at *in vitro* fertilization (IVF), with the obligation that two attempts be in the natural cycle. Some municipalities in Croatia co-finance further costs in order to increase number of newborns.[42]

A national program is dedicated to ART in Romania, which provides a support of up to €3000 per year for the beneficiary for procedures such as IVF, embryo transfer, and insemination. The age limit is dedicated for women between 20-45 years of age.[43]

In Slovakia, partial reimbursement of costs can be available.[44]

Overall, it can be seen that countries are trying to promote participation in ART with financial support, which in each country has an age limit. This age limit is typically set at 40-45 years of age. There would be fundamentally biological reasons for this. Even if the country's rules otherwise allow participation in ART for older women, state support is usually not available.

40 Králíčková, 2026.
41 Kovaček Stanić, 2026.
42 Korać Graovac, 2026.
43 Florian and Floare, 2026.
44 Garayová, 2026.

Country	Type and circle of funding	Age limit
Croatia	Public health insurance and municipal co-fundings, covers many possibilities	up to 42 years of age under health insurance
Czechia	Public health insurance, covers many possibilities	up to 40 years of age (+up to 49 years of age in the case of self-pay)
Hungary	Public health insurance, full coverage	up to 45 years of age
Poland	Public health insurance	until childbearing age
Romania	Dedicated national program	up to 45 years of age
Serbia	Public health insurance, unlimited stimulations, 3 embryo transfers	up to 45 years of age
Slovakia	Public health insurance, reimbursement (partial)	until childbearing age
Slovenia	Public health insurance, almost full coverage (reimbursement)	until childbearing age
Ukraine	Public health insurance/ partial state funding (as regulated)	Free state programmes: Women aged up to 40 years (up to and including 40 years and 11 months)

Table No. 3
On the possible of state aids of ART procedures

3.3. The Beneficiaries of ART

A general, common feature of the legislation of the countries examined, is that ART procedures can be performed with the intention of achieving the birth of a child. Therefore, as ART procedures cannot have other intentions and aims, the circle of beneficiaries who can take part in these methods is generally narrow. In this section, the basis of the distinctions is mainly the extent to which the given country allows others besides spouses to participate in the proceedings. It is basically visible and inherently established that married couples can participate in reproductive treatment according to the law of each country examined. Given that these countries do not recognise same-sex marriage, spouses are understood to mean the marriage between a man and a woman, so heterosexual couples can participate in ART. The further question is whether couples in *de facto* partnerships (cohabitants), single women, or homosexual couples can participate in these procedures.

Based on the simplest distinction, we can talk about countries where only spouses are legally entitled to participate in ART, and countries where the range of participants is a little wider.

Slovakia belongs to the first group, i.e. the case of participation is open only to marital spouses. In Ukraine, surrogacy and other types of ART are open to married couples as clients also.

At this point, the author of the Slovak chapter might be cited, as we shall see that the mere existence of a marriage at the time of application does not guarantee long-term family stability.

> Marriages may dissolve after the child is conceived, undermining the rationale of requiring marriage as a prerequisite for ART access. In practice, ART clinics often extend their services to unmarried partners despite the legal preference for married applicants. This discrepancy between the law and clinical practice highlights the gap between traditional legal norms and contemporary social realities. Critics argue that restricting ART access based on marital status is discriminatory and does not reflect the diversity of modern family structures. They point out that the law fails to account for the rights of single women or same-sex couples, leaving these groups without equal access to reproductive services.[45]

The other countries allow *de facto* partners and single women to participate in ART, with greater or lesser restrictions.

Czechia, Slovenia, Hungary, Croatia, Poland, Serbia and Romania allow *de facto* partners (cohabitants) to be involved in ART procedures. In Czechia, an infertile couple of the opposite sex as beneficiary (married or *de facto*) shall be mentioned. However, a novelty of the legal regulation of same-sex couples shall be mentioned, as it is possible for a child to be adopted even by the same-sex partner of his or her parent, male or female, living in a marriage or a partnership. That is why the only way for a child to have two 'legal' same-sex parents would be an adoption or the recognition of the same-sex parenthood being established abroad. Notwithstanding, this regulation does not affect the beneficiary circle of ART procedures.[46] In Hungary, eligibility for ART is fundamentally designed for married couples or cohabiting heterosexual partners, which can also be reflected in paternity presumptions.[47] In Poland spouses or a man and a woman living in cohabitation are allowed to enter ART techniques.[48] In Serbia, married or cohabitating heterosexual partners are considered as subjects of medically assisted fertilisation procedures. Additionally, in Serbia there is no regulation of same-sex partnerships.[49] In Croatia, men and women who are married or cohabitating can be beneficiaries of ART.[50] Non-marital spouses must provide a statement certified by a notary that they live

45 Ibid.
46 Králíčková, 2026.
47 Barzó and Nagy, 2026.
48 Andrzejewski, 2026.
49 Kovaček Stanić, 2026.
50 Korać Graovac, 2026.

in a non-marital union.[51] This rule is similar to that in Hungary. According to Slovenian law, a man and a woman who are in a marital or cohabiting partnership are allowed to enter ART procedure[52] which can only be performed with the written consent of the spouses or cohabiting partners.[53] The marriage or cohabitation must exist at the time of insertion of the sperm cells or early embryos into the woman's body.[54] However, the Constitutional Court of Slovenia opened the door to access to ART procedures by women living in same-sex marriages or civil unions, as well as for single women. The latter was also regulated by the amendment to the Infertility Act in December 2025.[55] In Romania, heterosexual couples can enter into ART procedures. At the same time, the detailed rule can be a circumvention on the rules of adoption, as the Civil Code provision does not prescribe the man and the woman who consent to this procedure to be an actual couple. They do not have to prove or even assert a relationship of any sort and their mutually agreed consent to the procedure could lead to them becoming the mother and father of a child without any other prior connection.[56] According to Slovenian law, a man and a woman who are in a marital or cohabiting partnership are allowed to enter an ART procedure[57] which can only be performed with the written consent of the spouses or cohabiting partners.[58] The marriage or cohabitation must exist at the time of the insertion of the sperm cells or early embryos into the woman's body.[59] So basically, it can be concluded that the most permissive regulation in this area is in Slovenia.

A much more difficult and divisive issue in the legal systems of the states under study is whether single women can participate in such procedures, and if so under what conditions. As was mentioned above, single women cannot take part in ART procedures in Slovakia. According to Polish law, the situation of a single woman is the same.[60] It was demonstrated above that Slovenia has a permissive regulation, which opens up ART procedures to single women if she is in the 'age of eligibility for childbirth', which is an undefined, flexible legal term and shall be determined on a case-by-case basis. The Constitutional Court has pointed out that a decision which stated only women up to the age of 43 were eligible for ART procedures is unconstitutional.[61] According to the Romanian Civil Code, single women have access to medically assisted reproduction with a third-party donor.[62] Serbian regulation also make

51 Art. 11, para. 3 of the Infertility Act.
52 Kraljić, 2026.
53 Art. 22(1) of the Infertility Act.
54 Art. 5(4) of the Infertility Act.
55 Kraljić, 2026.
56 Floarian and Floare, 2026.
57 Kraljić, 2026.
58 Art. 22(1) of the Infertility Act.
59 Art. 5(4) of the Infertility Act.
60 Andrzejewski, 2026.
61 Kraljić, 2026.
62 Florian and Floare, 2026.

it possible for a single woman to be the beneficiary of ART.[63] In this matter we shall take into consideration the sociological feature, which is emphasised by the author of the chapter, as in

> Serbian society family relations are very important for family members and very well developed. Thus, it would not be difficult for single woman to find a relative who would be able to help her in raising a child. In Serbia the social relations are developed as well. Thus friends of a single woman would help her.[64]

In Croatia, a single woman who has the age of majority and for whom a previous treatment of infertility has ended unsuccessfully or without hope and who, because of her age and overall health condition, is capable of exercising parental care, may also seek MAR treatment. Here, there is an age limit, but this affects only the health insurance, as she must not be older than 42 years in this case.

In Hungary, single women can be beneficiaries of ART procedures only in exceptional cases, as a woman has to be justified by her age or health condition. Although this wording is rather uncertain, especially because the age limit for natural conception is difficult to determine objectively; moreover the use of assisted human reproduction procedures also has an age-related condition: it can only be used if the woman has not reached the upper limit of reproductive age.[65]

63 Kovaček Stanić, 2026.
64 Ibid.
65 Barzó and Nagy, 2026.

Country	Spouses	De facto couples	Same-sex couples	Single women
Croatia	yes	yes	no	yes, due to health reasons
Czechia	yes	yes	no	no
Hungary	yes	yes	no	yes, but only in exceptional cases with authorisation
Poland	yes	yes	no	no
Romania	yes	yes	no	yes
Serbia	yes	yes	no	yes
Slovakia	yes	no	no	no
Slovenia	yes	yes	yes	yes
Ukraine	yes	not for surrogacy; other ART depends on the procedure and legal context	no	yes, for certain non-surrogacy ART procedures; no for surrogacy

Table No. 4
On the beneficiary circles

3.4. Key Aspects of Surrogacy

Maternal status is important for every child. For a long time, the mother's status was the most obvious point in family law, because under old Roman law principles, the child's mother is the one who gave birth to the child (*mater semper certa est*). Nowadays, while this is easier to determine than the father's status, there are additional questions that must be examined in light of the mother's status in case of surrogacy. According to international obligations undertaken by the Convention on the Rights of the Child,[66] it is necessary to register a child soon after birth and to establish the motherhood in order to make the parental status clear.[67] The difficulty of this topic is evident in the fact that, in Serbia, an expert meeting on surrogacy, entitled 'Surrogate motherhood – *pro et contra*', was held in 2019 and organised by

66 Art. 7 of the CRC: '1. The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and. as far as possible, the right to know and be cared for by his or her parents. 2. States Parties shall ensure the implementation of these rights in accordance with their national law and their obligations under the relevant international instruments in this field, in particular where the child would otherwise be stateless'.

67 Barzó, 2021, p. 308.

the Ombudsman of the Province of Vojvodina.[68] However, the goal was to provide a balanced overview of the key arguments for and against surrogacy, and no concrete, final consensus on surrogacy emerged from the discussions. Surrogacy is not acknowledged in this country either.

The attitudes towards surrogacy in the countries currently under review are fundamentally balanced, but the Ukrainian legal system – and the Ukrainian chapter presenting it – should be viewed as a curiosity.

If we stick to the principle of '*mater semper certa est*', it can be seen, that Czech, Slovakian,[69] Polish, Hungarian, Croatian, Slovenian, Serbian and Romanian laws follow this principle, and do not acknowledge surrogacy. At the same time, a certain gradation can be observed, as while some countries expressly prohibit it, others tend to remain silent on the issue, even if it means a much more prohibitive approach.

In Croatia, any form of surrogacy (commercial or altruistic) is prohibited, and this rule can be found in the MAR Act of Croatia, as 'Contracts, agreements and other legal transactions of bearing children for another (surrogate gestational motherhood) and handing over a child after a fertility treatment, with or without a pecuniary remuneration, are null and void'.[70]

Surrogacy is regulated in a specific manner under Polish law. However, the phrase 'surrogacy' does not appear in the Infertility Treatment Act or the Family and Guardianship Code, there are indirect regulations pertaining to this method. According to the Family and Guardianship Code, any surrogacy agreements are invalid.[71]

Slovenian legislation treats surrogacy negatively, as the Infertility Act explicitly mentions surrogacy as a method, where a woman who intends to give her child to a third party for free or without compensation after birth is not entitled to ART procedures.[72] Besides the private law regulation, surrogacy is also part of the Slovene Criminal Code, which stipulates that anyone who unlawfully carries out a procedure of assisted reproduction for surrogacy will be punished by imprisonment. Therefore, for the first blink, a more concrete ban can be ascertained. Nevertheless, the Chapter underpins that 'following the wording of the law, it can be concluded that surrogacy is therefore not explicitly prohibited in Slovenia'.[73] The reason is that biomedical assistance in performing surrogacy is a prohibited method, but it is not a criminal offence for a Slovenian couple to go abroad and, if the surrogacy procedure is admissible there, to obtain a child through this method.[74]

Surrogacy is not permitted under contemporary Hungarian law; however, its suggestion has some historical roots. In the 1990's domestic policymakers explored ways

68 'Surrogate motherhood – Pro et Contra', 10.07.2019., Ombudsman of Autonomous Province of Vojvodina.
69 Family Act, § 82(1).
70 Art. 31, para. 3 of the MAR Act.
71 Andrzejewski, 2026.
72 Kraljić, 2026.
73 Kraljić, 2026.
74 Jerič, 2018., referred in Kraljić, 2026.

to regulate altruistic surrogacy (nanny pregnancy) and prepared detailed statutory provisions, but these rules never entered into force.[75] The consequence is similar to the other mentioned countries (Slovakia and Czechia), as surrogacy is not explicitly regulated, therefore it is neither expressly permitted nor prohibited: the legal environment remains largely silent on the matter, but there are various provisions of private and public law which highly restrict the possibility.

Surrogacy, whether commercial or altruistic, is therefore not legally recognized in Slovakia. The absence of a legal framework for surrogacy leaves intended parents vulnerable, particularly in cases of cross-border arrangements where children are born through surrogates abroad. If doubts arise regarding the identity of the birth mother, the court has the authority to determine maternity based on evidence related to birth. Any agreements or contracts attempting to alter this rule are considered *null and void*.

In Czechia surrogate motherhood has never been regulated by medical law, it is neither permitted nor prohibited in the current Czech legal system. The situations seem a bit vague again, as it is not explicitly prohibited in the Act on Specific Health Services, however the prohibition on surrogacy follows from the purpose of the Act.[76] However, surrogacy is mentioned in the Civil Code in relation to adoption as follows: 'Adoption is excluded between persons related to each other in the direct line and between siblings. This does not apply in the case of surrogacy' (Section 804, CC).

The legal situation seems similar in Romania, as surrogacy is not expressly forbidden, but it is neither specifically allowed nor regulated in Romania,[77] but the rules on parental care make surrogacy legally difficult.[78] The authors of the chapter highlights, that altruistic surrogacy is not explicitly banned, although it is heavily impeded by the current legal framework, while commercial surrogacy falls foul of multiple legal bans on trading the products of the human body, trading biological products or even human trafficking.[79]

The phenomenon of using surrogacy abroad – and its treatment in the legal system alone[80] – is one of the biggest tasks and problems in the countries examined. All country reports point out that even if the legal system prohibits 'domestic' surrogacy, couples who want a child (in many cases as a last resort) find a way to have a

75 Barzó and Nagy, 2026, citing: The constitutionality of this last-minute annulment later came before the Constitutional Court in Decision 108/B/2000. In the ruling, the Court emphasized that the right to self-determination does not oblige the state to provide access to any chosen medical intervention, and that access to ART is not a fundamental right. The Court underscored, that Surrogacy raises complex medical, ethical and legal issues that require a well-established professional consensus, which did not exist at the time. Although, the dissenting opinion sharply criticized the lack of proper consultation and the failure to establish expert bodies intended to oversee reproductive technologies, these views did not alter the outcome.

76 Králičková, 2026.

77 Hageanu, 2023, p. 222, cited by Florian and Floare, 2026.

78 Dobozi, 2013, pp. 64–65, cited by Florian and Floare, 2026.

79 Florian and Floare, 2026.

80 And there is no room here to outline – and even less to answer – the related extralegal questions.

child by using a foreign surrogate mother. The issues of the child's official status, citizenship, and the arrangement of parental custody are sometimes dwarfed by the possible criminal consequences. Despite everything, the phenomenon exists, although even Directive (EU) 2024/1712, amending the 2011 Anti-Trafficking Directive, explicitly identifies the exploitation of surrogacy as a form of human trafficking. Member States must transpose this into national law by July 15, 2026, targeting cases where women are coerced or deceived into acting as surrogates. It focuses on exploitation, not all surrogacy practices. The problem is often that surrogacy arrangements are executed abroad, and it is difficult to establish the proof that it really happened and under what conditions.

Ukrainian law is in radical contrast to the approaches described above – often vague, however – which most often express rejection, or rather tend towards it. Surrogacy, as defined under Decree No. 787,[81] is an assisted reproductive technology, designed to help married heterosexual couples to become the biological parents of their child. Within the framework of the Ukrainian legal approach only gestational surrogacy is allowed, meaning the surrogate mother carries an embryo created through *in vitro* fertilization using an egg from either the intended mother or an anonymous donor, or sperm from either the intended father or a donor. Consequently, the law shall define the parties of this legal relationship, who are the surrogate mother, the client and a medical institution. It is also important, that the Ukrainian law allows foreign citizens also, to take part in the surrogacy method – the only requirement is to be a married heterosexual couple. Regarding the genetic link, the law prescribes[82] that the spouse, in whose interests surrogacy is carried out must have a genetic relationship with the child, and the surrogate mother must not have a direct genetic link with the child. At the same time, the Chapter reveals the practical problem, that the genetic relationship criteria might be violated when foreigners participate in surrogacy operations without a genetic link. These actions can bring even criminal law consequences.[83]

Last but not least, legal approaches on surrogacy contracts shall be outlined. As a common feature of Slovak, Czech, Hungarian, Serbian, Croatian, Polish, Romanian and Slovenian law, any agreements or contracts relating to surrogate motherhood are null and void. The Slovak law[84] points out that the invalidity of such contracts shall be interpreted as a direct response to surrogacy. The author of the chapter is of the view that surrogacy contracts are *contra bonus mores* in the Slovak legal environment.[85] A similar interpretation can be observed in Czechia, as surrogacy agreements can be interpreted as prohibited contracts by the Civil Code because of immorality.[86] The Chapter adds that according to the Civil Code, 'Human body and

81 Order of the Ministry of Health of Ukraine (09.09.2013), No. 787.
82 Para. 6.1, Sec. VI of Decree No. 787.
83 Buletsa, 2026.
84 Sec. 2 of Art. 82 of the Family Act.
85 Garayová, 2026. citing: Júdová and Píry, 2019.
86 Sec. 1, Sub-Sec. 2, CC.

its parts, even if separated from the body, are not a thing',[87] which wording can also be interpreted as surrogacy contracts are not allowed.

The Polish Family and Guardianship Code stipulates that any surrogacy agreements are invalid. Regarding the Polish legal development, it is significant that in the former legislation there were no specific legal provisions regarding surrogacy agreements, therefore the permissibility of entering such contracts was assessed from an ethical perspective by considering whether such an agreement violated the principles of social coexistence. The country report reveals that even legal theory and legislation of Poland unequivocally consider surrogacy agreements invalid in the case of financial compensation.[88]

The Romanian Constitutional Court dealt with the collision of parental rights and compulsory preliminary surrogacy contracts, and was considered to be unconstitutional because they breached the outer limits of a person's rights to decide about themselves and they were contrary to good morals, insofar as they were allowing transactions regarding life, health and the unborn child.[89]

Based on what has been written so far, it is clear that Ukrainian regulations contradict these, as surrogacy is a permitted and regulated procedure in the Ukrainian legal system. Notwithstanding, the Family Code of Ukraine does not stipulate the surrogacy contract between the spouses and the surrogate mother.[90] Regardless of that, the contracting practice and other laws know the most important features of this agreement. The surrogacy contract provides for the transfer of the child to his/her intended parents after birth. The surrogacy contract is a service contract under Ukrainian law. According to Decree No. 787, the contract between the surrogate mother and intended parents must be notarised, which provides an additional guarantee of its proper execution, as there have been cases of surrogate mothers not fulfilling their duties toward genetic parents.[91]

87 Sec. 493, CC.
88 Andrzejewski, 2026.
89 Para. 3b, Constitutional Court Decision No. 418/2005.
90 Buletsa, 2026.
91 Ibid.

Country	Legal regulation	Regulation of surrogacy contracts
Croatia	prohibited both types	invalid
Czechia	grey area (not regulated)	invalid
Hungary	prohibited both types	invalid
Poland	prohibited both types	invalid
Romania	grey area (no concrete regulation, but tend to prohibition)	invalid
Serbia	prohibited both types	invalid
Slovakia	prohibited both types	invalid
Slovenia	prohibited both types	invalid
Ukraine	permitted and regulated	valid

Table No. 5
On the key aspects of surrogacy

4. ART and Family Law

Besides provisions that regulate medical aspects of assisted reproduction, there was a need to introduce provisions concerning sometimes specific rules of establishing parenthood, especially when the child is conceived by a donor.

Key questions arising from the fact that the child is conceived by medical intervention (ART) are: who is considered to be the mother of the child, who is considered to be the father of the child, and under what conditions is it allowed to contest motherhood or fatherhood.

If homologous techniques are used, the problem is quite simple: it is enough to apply general rules, ensuring the consent of the couple. When donor gametes or embryos are used, everything is more complicated. Family law aligns with the principles of the rule of law and the protection of family life, although there is no genetic link between the child and one or both legally recognised parents. In that case, family law rules concerning affiliation are led by the will of parents and donors, according to the legal regulation of the corresponding state. Donors who consented to

gametes or embryo donation should never have any family law obligations toward children and *vice versa*.

As expressed in 'the Hungarian' chapter: Ultimately, the regulation of parental status serves to ensure an orderly family structure, where the child's legal family corresponds to biological descent and is duly recognised in the birth register. This legal regularity provides the foundation for a child to grow up within a secure and recognised family environment. A clear and stable determination of the family status of a child born via ART serves not only the child's right to identity, but additional rights of social nature.[92] Also, the State bears the responsibility to adopt appropriate legislation in the field of family law. It must ensure gamete donors do not bear parental responsibilities for children conceived with their gametes.[93]

4.1. Establishing Motherhood

ART challenged family law *mater semper certa est*[94] rule, as it enables the child to be conceived by a donated egg or embryo and born by another woman. Hence, assisted reproduction does not affect the status of the mother: maternity is established exclusively by childbirth, not genetics or intention.

In principle, national family law systems offer the same rules of filiation of the children conceived naturally: the mother of a child conceived with a donated egg or a donated embryo in the procedure of medically assisted reproduction is the woman who gave birth to the child (Croatia, Czechia, Hungary, Poland, Romania, Slovakia, Slovenia, Serbia). The legislators have given primacy to the fact of carrying and delivering the child over genetic origin.[95] Some jurisdictions did not find it necessary to expressly stipulate who the mother of the child was until modern legislative changes (like the Slovenian one in 2017 and Czechia in 1998), and there was generally no doubt regarding motherhood. Traditionally, this legal presumption was considered irrefutable. The mother was the one from whose womb the child came.[96]

As an exemption, in Croatia, a woman whose eggs were used, although she did not give consent, may contest the maternity of a woman who gave birth to the child and request that her maternity be established.[97]

In Serbia, there is a rule concerning the prohibition of establishing motherhood of the woman who has donated the ova.[98] So if the mother is a woman who gave birth, it is not possible to contest maternity if the child is conceived by donated ova.

92 de Groot, 2014, p. 144, cited by Barzó and Nagy, 2026.
93 Kraljić, 2026.
94 '*Quia semper certa est, etiam si volgo conceperit: pater vero is est, quem nuptiae demonstrant*', Paulus, no date.
95 Kovaček Stanić, 2026.
96 Kraljić, 2026.
97 Korać Graovac, 2026.
98 Art. 57/2 of Family Act, Official Gazette of Serbia Nos. 18/2005, 72/2011, 6/2015.

This procedure is not explicitly regulated in the Civil Code of Czechia. There have been cases of switching babies in the maternity ward or the birth of a surrogate mother who proved her identity in the maternity hospital by the ID of her sister, a woman from the 'intended' couple.[99] Jurisprudence had to find a way to solve the arising disputes.

In Romania, maternal filiation, which is affirmed both by a birth certificate and the child's status by habit and repute, cannot be legally challenged, unless a court has previously found that a child substitution had taken place or that the woman registered as a mother was not the one who gave birth.[100] If the birth registration and the status by habit and repute do not concur, any interested party, including the child, can challenge the registered maternal filiation.[101]

4.2. Establishing Fatherhood

If the mother is married, *pater est quem nuptiae demonstrant* rule applies in all jurisdictions to the mother's husband, no matter if the child is conceived by husband's gametes or when a child is conceived by donated semen or a donated embryo in the procedure of medically assisted reproduction. The only exception is in Hungary, where Art. 4:100, para. (2) of the Civil Code precisely regulates the situation when a woman who was a *de facto* partner, gets married afterwards and gives birth to the child conceived during *de facto* partnership with *de facto* partner involved in the reproductive procedure. In such a case, the partner, not the new spouse, shall be considered the father of the child. Also, until 300 days have elapsed between the termination of the partner's mother's previous marriage and the birth of the child, and the mother concludes another marriage, the father is the spouse from the previous marriage.

The same legal rule can be found in Art. 62 (2) of the Polish Family and Guardianship Code.

Presumption always applies when a mother is married; and the previous spouse's consent for the specific assisted reproduction procedure (homologous or heterologous) is relevant for his possibility to contest fatherhood.

Special rules apply for *de facto* partners, where the key role plays consent to the assisted reproduction and endeavour that the male partner accepts parental

99 Králíčková, 2026.

100 Art. 411, para. 3 Civil Code: Nonetheless, if a judicial decision establishes that a child substitution had taken place or that another woman has been registered as the child's mother than the one who has given birth, the true filiation can be proved by any means.; Florian in Baias et al., 2021, pp. 554–555.

101 Art. 411, paras. 1 and 2 Civil Code: No person can claim another maternal filiation than the one resulting from their birth registration and the status by habit and repute which corresponds to it. / Nobody can challenge the maternal filiation of the person who has a status by habit and repute concurring with their birth registration.; Florian in Baias et al., 2021, pp. 554–555; Florian and Floare, 2026.

responsibilities after the birth of the child, no matter if he is genetically related to him/her or not.

In Croatia, consent for medical procedures and a beforehand stated acknowledgment of the child (in case of non-marital union) is requested in notarial form, so it should be ensured that the child conceived by medically assisted reproduction will have both parents. Poland, Serbia and Slovenia have similar regulations as well, although there were some criticisms expressed in Poland.[102] In Czechia, the Civil Code provides that if a child conceived through assisted reproduction is born to an unmarried woman (or the woman is registered to a partnership with another woman), the man who gave consent to the assisted reproduction is presumed to be the child's father (Section 778, CC). In Hungary, besides the consent, the law requires that the parentage must be the result of a reproductive procedure.[103]

In Slovakia, for non-marital couples or single women using ART, paternity can be established through a joint declaration of parenthood.

The Romanian legislator took an interesting approach: a consensual partner who gave his consent to a medically assisted procedure is liable to recognise paternal filiation after birth (which is difficult to enforce).[104]

To conclude, the genetic link does not have any impact for establishing legal fatherhood if all necessary consents have been legally given.

102 Andrzejewski, 2026.
103 Barzó and Nagy, 2026.
104 Florian and Floare, 2024, pp. 478–480.

Country	Motherhood	Fatherhood
Croatia	maternal filiation via birth	married couples: husband is the father *de facto* couples: consent is needed
Czechia	maternal filiation via birth	married couples: husband is presumed father *de facto* couples: consent is needed
Hungary	maternal filiation via birth	married couples: husband is the father *de facto* couples: consent is needed and the child shall be conceived during the partnership
Poland	maternal filiation via birth	married couples: husband is the father *de facto* couples: consent is needed and the child shall be conceived during the partnership
Romania	maternal filiation via birth	married couples: husband is the father *de facto* couples: consent is needed
Serbia	maternal filiation via birth	married couples: husband is the father *de facto* couples: consent is needed
Slovakia	maternal filiation via birth	married couples: husband is the father
Slovenia	maternal filiation via birth	married couples: husband is the father *de facto* couples: consent is needed
Ukraine	in ordinary birth cases, maternal filiation follows birth. Surrogacy: the intended mother is registered as legal mother (if statutory documents have been submitted, including the surrogate mother's notarised consent and proof of genetic link with at least one intended parent))	married couples: husband is the father if consented surrogacy: husband is the father (if statutory documents have been submitted, including the surrogate mother's notarised consent and proof of genetic link with at least one intended parent)

Table No. 6
On the key rules of motherhood and fatherhood via ART

4.3. Surrogacy – Who is a Parent?

Generally, as stated above, there is a restrictive legislative approach to surrogacy arrangements in most national legislations with a clear surrogacy ban – only Czechia and Romania have not regulated it. None of the presented central European legal systems has any family law provisions (regulating paternal affiliation) that directly address surrogacy, so the *mater semper certa* rule always applies initially.

Where surrogacy is not allowed, the problem arises from the fact that the intended parents travel abroad and use surrogacy arrangements. Coming back, they

often face obstacles when they try to enter the child into the domestic birth register and themselves as the legal parent/s.

Ukraine, as a hotspot for commercial surrogacy in Europe, has regulated some aspects, leaving the intending parents to solve the affiliation problem in their country of origin. This liberal approach allows the intended parents to be entered into the birth certificate of the child as the legal parents in Ukraine, but this is a temporary solution.

As Buletsa reports, the Ukrainian legislation does not regulate the surrogacy procedure in detail. Art. 123[105] of the Family Code sets out the rules for determining the origin of a child born as a result of the use of assisted reproductive technologies: if an embryo conceived by a married couple is transferred into the body of another woman, they are recognised as the child's parents. In Ukraine, there is a presumption of parenthood of biological parents who are the clients of a surrogacy program. The spouses, together with the document confirming the birth of the child from a surrogate mother, submit the surrogate mother's declaration of notarised consent to the registration of the child's biological parents, as well as a certificate of genetic link.[106]

The problem might arise when foreign citizens apply to their embassy to get official documents for the child, as the paternity or maternity may not be recognised. There were cases where the Ukrainian court accepted the applicant's request, establishing the filiation relationship between the applicant and the child born in the surrogacy program, as the court's judgment was the precondition that the parents indicated in the Ukrainian birth certificate were recognised as parents in their domicile country.[107]

In Czechia, there are judicial cases showing that informal private-law surrogacy agreements exist among relatives. The conception usually takes place in the natural manner which may sometimes disrupt a fragile family situation. If there is a 'dispute' over the child, the 'legal' mother of the child will be the woman who gave birth to the child. Furthermore, many problems are caused by the fact that Czechia is becoming a so-called promised land in this area, even for many women from countries where surrogacy is explicitly prohibited and criminalised. This is why there were some legal proposals to 'solve' the situation as follows.[108]

As reports Garayová, in Slovakia the intended mother, whether she contributed an egg or not, cannot be legally recognised as the mother unless she adopts the child after birth.

105 Family Code of Ukraine, (10.01.2002), No. 2947-III.

106 In the 'For annotations' column of the civil status register of registration bodies, is entered the mother of the child according the medical certificate of the birth, the name of the institution that issued the certificate, number of notarized consent of the woman who gave birth, and the marriage certificate of the child's genetic parents as indicated, among other data. This data contains only information on the biological parents. Buletsa, 2026.

107 Ibid.

108 Králíčková, 2026.

The one last possibility is applicable as a general rule also in other legal systems, regardless of whether they are expressly foreseen in legislation.

In Hungary, some couples pursue surrogacy abroad in jurisdictions where it is legal. However, Hungarian legal authorities may, based on legal interpretation or suspicion, refuse recognition of the parent-child relationship and, in certain cases, initiate criminal proceedings if deemed applicable.

The intended parents may try to register the foreign birth certificate in the Hungarian civil registry, managed by the competent government office under Decree No. 32/2014 (V.19.) of the Ministry of Justice, which is necessary for the child to receive Hungarian citizenship. As *mater semper certa est* rule applies, a feasible way for the intended mother to get recognised is through open adoption, and the intended father may acknowledge paternity. It is possible only if the surrogate mother was not married, or the spouse's husband has rebutted the presumption of paternity. [109]

Another way for establishing parenthood between the intended parents and the child is a case when only the implantation of the embryo takes place abroad in the surrogate mother's womb, but the actual birth occurs on Hungarian territory. The intended father can make a full declaration of acknowledgment of the child, while the birth mother, more precisely the surrogate mother, gives her consent to the open adoption of her child by the intended mother. In this way, it is not necessary to obtain the recognition of foreign official or court documents in Hungary.[110]

Other reports reveal that there is no regulation of legal consequences when a child is born by a surrogate mother abroad.

109 Barzó and Nagy, 2026.
110 Ibid.

Country	Challenges of cross-border surrogacy
Croatia	legally banned, authorities may refuse registration, Constitutional decision in favour of registration
Czechia	not explicitly regulated, not banned and surrogacy can be possible in practice
Hungary	legally banned, authorities may refuse registration or even initiate criminal procedure
Poland	legally banned, authorities may refuse registration
Romania	not explicitly regulated, so not banned, informal surrogacy can be possible in practice
Serbia	legally banned, authorities may refuse registration
Slovakia	legally banned, authorities may refuse registration, the intended mother shall adopt the child after the birth
Slovenia	legally banned, authorities may refuse registration
Ukraine	liberal approach, commercial surrogacy is allowed

Table No. 7
On the challenges of cross-border surrogacy

4.4. Same-Sex Legal Parents

Social reality, considering parentage, has rapidly changed, even in Central European countries. Nowadays, we witness that a child might have the same two same-sex parents entered into the birth certificate. ART widely opens the door to this possibility, for female and male couples. In the countries presented in this book, a child might have two same-sex parents listed in the birth certificate in Slovenia and in Czechia.

In Slovenia, since 2017, birth certificates have been issued for children of same-sex parents,[111] and also for married lesbian couples or couples who used ART.

The Constitutional Court of Slovenia has opened the door to access ART procedures for women living in same-sex marriages or civil unions (as well as for single

111 SVN-PB-01001.

women) in 2024 and Amendments to Infertility Act in 2025,[112] so it enabled the possibility that two women can become legal parents of the same child. That means that a woman who gave birth to the child by semen donation is considered to be a mother, and her female spouse or partner may adopt a child in a procedure prescribed by the Family Act. Slovenia is the only country in this survey that recognises same-sex marriage; it is not surprise that this legal fact is reflected in parental status as well.

In Czechia, on 1st January 2025, an amendment to the Civil Code came into force (Act No. 123/2024 Sb.), which establishes same-sex partnerships beside marriage, designed only for opposite-sex couples and beside same-sex registered partnership regulated by a special Act (Act No. 115/2006 Sb., on Registered Partnership, as amended). According to the novel of the Civil Code, the provisions governing marriage and the rights and obligations of spouses apply in principle to the rights and obligations of partners of the same sex entering into a partnership according to the Civil Code.[113] However, it will not concern the establishment of parenthood, except for so-called stepparent adoption. It means that it is possible for a child to be adopted even by the same-sex partner of his or her parent, male or female, living in a marriage or a partnership. That is why the only way for the child to have two 'legal' same-sex parents would be an adoption or recognition of the same-sex parenthood established abroad.[114]

Opposite politics is mirroring in Hungary: the Fundamental Law Art. L defines that a mother is a woman and a father is a man.

The Slovak parliament (National Council) in 2025 passed the 23rd amendment to the Constitution, reinforcing traditional definitions of family, marriage, and parenthood. This amendment directly impacts the legal definition of parents: 'the parents of a child are the mother and the father; the mother of the child is a woman, and the father of the child is a man' (Art. 41/2 of the Constitution of Slovakia).

In Croatia, High Administrative Court allowed adoption by same-sex partner.

The legal systems of other jurisdictions represented in this book have no possibility of two same-sex parents being entered into the birth certificate of the child.

112 Constitutional Court of the Republic of Slovenia decision ECLI:SI:USRS:2024:U.I.418.20, 16 October 2024. The non-compliance of the existing legislation must be remedied within one year of the CCRS decision. Since the inconsistency must be resolved by October 2025, the presentation and analysis of the legislative framework is based on the current legal arrangement as of December 28th 2024. Kraljič, 2026.

113 Newly, the same-sex persons entering a partnership according to the Civil Code will have for example, community property, family dwelling protection etc.

114 Králíčková, 2026.

Country	Legally possible on the birth certificate?	Recent legal changes
Croatia	no	legally not allowed, the Administrative Court allowed adoption by same-sex partner.(2026)
Czechia	only by adoption	Civil Code amendment from 2025, stepparent adoption is possible for same-sex partner, for instance parental orders from the USA – Constitutional court allows
Hungary	no	Fundamental Law declares 'Mother is a woman, father is a man'
Poland	no	no
Romania	no	no
Serbia	no	no
Slovakia	no	Constitution declares 'Mother is a woman, father is a man'
Slovenia	yes	the Constitutional Court has allowed ART for same-sex couples since 2024; Infertility Act 2025.
Ukraine	no	no recognition of same-sex marriage or same-sex legal parenthood; surrogacy is available only to married heterosexual couples

Table No. 8
On the situation of same-sex parents

4.5. Contesting Motherhood and Fatherhood

If the child is conceived by ART, it can be homologous or heterologous. In the case of homologous techniques, it is clear who the parent is. In the case of heterologous techniques, a special rule should be applied to prevent the child from remaining without a legal parent (like in adoption provisions), while it is clear that DNA would prove that the child is not genetically linked to his or her legal parents. So, as a basic rule, contesting motherhood or parenthood is not allowed.

In some jurisdictions, the possibility to contest parenthood relates to previously given consents in obligatory form – if all parties provided legally requested consents, it would not be possible to contest motherhood or fatherhood of the child (Croatia, Czechia, Hungary, Poland, Romania, Slovakia, Serbia, Slovenia). The prohibition against contesting motherhood applies to anyone, not just the mother herself.

In Croatia, besides a person entered as a mother (or a father) into the birth register, also persons from whom gametes originated, if they did not consent to their donation, have the right to contest maternity or paternity. To secure the child to have a legal parent, they need to prove in the same court proceeding that they are genetic

parents and that they did not consent to donate gametes. This provision was enacted after cases in which the third-party gametes were fraudulently used by a medical clinic.[115]

Legal provisions sometimes directly connect the possibility to contest paternity with the proof that the mother of the child became pregnant by other means than as a result of assisted reproduction (i.e. Romania, Serbia, Slovenia). In Czechia the Civil Code enables a man to deny his paternity even in the case of the assisted reproduction by donation, if he has given his consent to it, but only if he proves that the child's mother has become pregnant in a different way (i.e. if he proves in particular that she has had sex with another man and that the child is genetically linked to that man by a DNA test).[116]

5. The Best Interests of the Child

Key issues arising from assisted reproduction are: human rights and legal interests of intended parents, human rights of donors, interests of society, and, most important issue: the protection of the rights of the child.

Balancing all these rights is extremely important and a difficult task for every legislator.

As Sobczyk reveals, the development of international standards governing assisted reproductive technologies remains incomplete and conceptually fragmented, reflecting the historical reality that the foundational human rights instruments were drafted before the emergence of modern reproductive medicine. While the Universal Declaration of Human Rights and the 1966 Covenants contain no explicit references to ART, their guarantees of privacy, family life, and health have become the interpretive scaffolding for contemporary debates. Yet these adult-centred rights, when applied without qualification, risk overshadowing the interests of the most vulnerable party in ART arrangements: the child who is brought into existence through medical assistance.[117]

The Convention on the Rights of the Child (CRC) provides a crucial corrective to this imbalance. Although it does not regulate ART directly, its core principles – particularly the best interests of the child (Art. 3), the right to be entered into birth register, the right to identity (Arts. 7–8), and the right to know and be cared for by one's parents (Art. 7) – constitute binding obligations that must guide the interpretation and regulation of all reproductive practices. These provisions challenge national legal systems to move beyond a narrow focus on adult reproductive autonomy

115 Korać Graovac, 2026.
116 Králíčková, 2026.
117 Sobczyk, 2026.

and to adopt a child-centred framework that evaluates ART not merely as a matter of access to medical services but as a domain with profound implications for the rights, identity, and long-term well-being of the resulting child.[118]

Bioethical instruments such as UNESCO's Universal Declaration on the Human Genome and Human Rights reinforce this orientation by grounding reproductive interventions in the principles of human dignity and the protection of the human genome. These norms implicitly require states to consider the moral status of embryos, the integrity of genetic parentage, and the potential psychological and social consequences for children conceived through donor gametes, surrogacy, or other ART methods. Expert declarations, including the World Association for Sexual Health's statements and the Casablanca Declaration, illustrate the ongoing contestation between adult-centred reproductive rights and emerging calls for the stronger protection of children's rights – particularly in relation to surrogacy, anonymity of donors, and cross-border reproductive arrangements.[119]

Within Europe, the regulatory landscape is shaped by both the Council of Europe and the European Union. The European Convention on Human Rights, created in 1950, has no direct notion of assisted reproduction. Though, as a living instrument, it has been dynamically interpreted by the European Court of Human Rights (ECtHR). Its jurisprudence – Evans, S.H. and Others, Costa and Pavan – has expanded the scope of Art. 8 to include aspects of reproductive decision-making. A more robust integration of CRC principles into Strasbourg jurisprudence is necessary to ensure that the child's interests are not treated as secondary or derivative but as independent rights requiring affirmative protection.[120]

Nowadays, the jurisprudence of the ECtHR uses the best interests of the child principle to protect the affiliation between the intended parent(s) and the child in cross-border surrogacy cases, even though it is forbidden in the particular state.[121]

As stated in Hague Conference on Private International Law – *Conférence de La Haye de droit international privé*, that launched Parentage/Surrogacy Project

> this can have far-reaching legal consequences for all involved: for example, it may affect the child's nationality, immigration status, the attribution of parental responsibility regarding the child or the identity of the individual(s) under a duty to financially maintain the child, etc. Difficulties may also arise because the parties involved in such an arrangement are vulnerable and at risk.

118 Ibid.
119 Ibid.
120 Ibid.
121 Nagy, 2024. pp. 153–170.

Working group of the Hague Conference prepared the Final Report on the Feasibility of a possible Convention on the Recognition of Judgments on Legal Parentage.[122]

The Oviedo Convention[123] (Council of Europe) and EU secondary legislation on tissues and cells provides additional regulatory constraints. The EU's limited competence in family law preserves national diversity, but this pluralism cannot justify neglecting the universal and non-derogable rights of children. Sobczyk emphasises that the principle of subsidiarity must not be interpreted as permitting Member States to disregard the CRC's binding obligations concerning identity, parentage, and the child's best interests.[124]

Central European legal systems presented in this book have a different approach to interpreting the rights of a child conceived by ART, as was possible to notice through the national reports. Key issues, like the dignity of the child, the right of the child to parental care, the right to identity, the right to life, the right to health, and the protection of the embryo, are somehow differently regulated.

Every state has a wide margin of appreciation to regulate these sensitive issues, and there are different solutions available (for example, the right of the child (not) to know the circumstances of conception or the identity of donor), what is the best social environment that national legislation has to secure for the child (i. e. a heterosexual couple as a rule, or a single parent family is considered good enough, posthumous insemination issues, age of a woman).

Each state offered a legal framework trying to take into account the best interests of the child, at least in some aspects, although the interpretation of what the best interests of the child are may differ. Nevertheless, it seems very important to regulate as precisely as possible legal requirements and family law consequences for the sake of legal certainty. Undoubtedly, most legal uncertainty arises in legal systems conducted by *laissez faire* principle. In these cases, the intended parents and children might be stuck somewhere, which is most obvious in cross-border arrangements. Subsequently, jurisprudence has to invent solutions to protect the best interests of the individual child, but also to discourage intended parents in the future from bypassing national provisions or taking advantage of *lacunae* in them.

Obviously, such sensitive issues deserve a thoughtful and thorough public debate on which legal solutions are best suited to balancing the interests and rights of all parties involved. The final legislation should reflect society's values and broader public policy objectives.

122 WG on Parentage / Surrogacy: Final Report on the Feasibility of a possible Convention on the Recognition of Judgments on Legal Parentage, Prel. Doc. No. 1 of November 2025.

123 Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, Oviedo, 4.IV.1997, European Treaty Series – No. 164.

124 Sobczyk, 2026.

One of the most liberal approaches is the Ukrainian one, which offers commercial surrogacy to enable couples to become legal parents. Hence, rules that aim to protect the child can also be found in Ukraine.

On the other side is the traditional system of values offered by Andrzejewski, suggesting that principles protecting the best interests of the child should be:

(a) legislative actions and legal practice must adhere to the principle of prioritising the well-being of the individual, particularly the child, over societal interests, for example, those driven by demographic concerns;
(b) absolute protection of unborn life;
(c) the concept where the embryo is a human being from the moment of conception, at an early stage of development – not a 'potential' human – and no one has the right to dispose of its life;
(d) art procedures must include concern for the child's well-being after birth, ensuring health protection and the right to grow up in a family based on the union of a man and a woman;
(f) all forms of art commercialisation must be systematically opposed; (g) surrogacy agreements should be banned.[125]

It is realistic to believe that most national legislators will choose some compromise between these two approaches. Hence, national legal provisions should be drafted, placing the rights of the child at the forefront, and not the interests of adults.

6. Summary

At the conclusion of this book, which synthesizes the findings of a project presenting a comparative review of the legal, constitutional, medical, and family-law dimensions of assisted reproductive technologies (ART), as well as the best interests of children conceived through ART in nine European countries – Czechia, Croatia, Slovakia, Slovenia, Hungary, Serbia, Poland, Romania, and Ukraine – it becomes evident that these countries have adopted different approaches to the sensitive issue of creating human life through ART.

Undoubtedly, there is a deep human desire and instinct to become a parent, but many obstacles can stand in the way. Infertility is growing, and it shows many forms, such as medical or social infertility. Medicine is developing fast, and we face new possibilities as well as challenges, as medicine opens up the unimaginable ethical dilemmas of yesterday and leads to new, not yet regulated, legal areas. The responsibility of a legislator is immense, given that a new human being has been created

125 Andrzejewski, 2026.

by ART. The best interests of this new human being, a child, should be of paramount consideration in legislative procedures, but also in legal argumentation and interpretation when there are *lacunae* in legal systems.

Legal systems in most of the presented countries try to set up legal boundaries, regulating medical and family-law aspects of ART, at the same time offering help and protection to adults (intended parents), the protection of the welfare of the ART-conceived child (the best interests as it is interpreted and understood in a specific state), and the principle of the rule of law.

The comparative analysis demonstrates that medical help by ART is not recognised as an autonomous fundamental right within national constitutions but is indirectly grounded in core constitutional values, notably human dignity, respect for private and family life, the right to health, and the protection of children. These rights and values function as normative reference points through which legislatures and courts attempt to balance reproductive autonomy with the protection of vulnerable parties, particularly children born through medically assisted reproduction.

While dignity is universally affirmed as inviolable, its interpretation diverges significantly. In several legal systems, dignity is closely associated with the protection of embryonic life, leading to restrictive approaches to embryo manipulation, posthumous reproduction, and surrogacy, and is addressed primarily to the future child. In others, dignity is linked more strongly to personal autonomy and reproductive rights, emphasising the respectful treatment of adult individuals seeking fertility treatment. This diversity results in heterogeneous regulatory frameworks, ranging from permissive models (notably in Ukraine) to highly restrictive regimes that effectively discourage certain ART practices, like in Poland and Slovakia.

Regardless of how legal provisions are drafted, the legal situation is generally clearer in jurisdictions that provide comprehensive regulation of the rights, obligations, and responsibilities of all parties involved, including both individuals and medical institutions. Conversely, the absence of a comprehensive legislative framework creates legal uncertainty, particularly in cases involving the use of donor gametes. As the example of Romania demonstrates, such uncertainty may discourage the use of ART.

As new issues arise in the modern implementation of medical procedures (and they might be expected in the near future), and as the case law of the European Court of Human Rights expands, the role of jurisprudence is more and more important (especially the jurisprudence of the constitutional courts and high courts in a particular country). Sometimes it causes changes in the law, as shown in Slovenia.

Regulation of medical aspects further reveals how systems of values shape concrete policy choices. States differ markedly in defining permissible procedures, financing mechanisms, and eligible beneficiaries. While most countries allow *in vitro* fertilisation and insemination, other practices – such as embryo donation, preimplantation genetic diagnosis, or posthumous reproduction – are regulated unevenly or remain legally ambiguous.

Public funding schemes indicate an underlying value commitment to supporting reproduction as socially valuable on an individual and demographic level, yet these schemes are typically limited by the age of beneficiaries and medical criteria, reflecting a bio-medical rationality that prioritises efficiency and success rates.

Some access restrictions based on marital status, sexual orientation, or partnership form illustrate how traditional family models continue to influence ART policy in the Central European region, sometimes to the exclusion or restriction of single women and universal exclusion of same-sex couples, and consequently, the possibility of single men using surrogacy. Behind these choices is a tendency to ensure that a future child will be cared for by a traditional family (whereas some analogy can be drawn with the responsibility of the state when choosing adoptive parents).

Family law consequences of ART represent a central area where the best interests of the child intersect with competing value systems. Across all jurisdictions examined, maternal filiation is determined by *mater semper certa est* rule, and paternal status is largely determined through marital presumptions or prior consent to ART procedures. These rules aim to secure the legal certainty and stability of the ART-founded family, which is essential for the child's social identity, access to care, and protection within a legally recognised family framework.

While donors are uniformly excluded from parental status and parental responsibility, significant differences remain regarding the recognition and scope of a child's right to know the identity of the donor.

Surrogacy constitutes the most controversial domain, revealing deep normative tensions between reproductive freedom, human dignity, and the commodification of the human body. Surrogacy is mostly prohibited (or left *laissez-fair*), except in Ukraine, which regulates commercial surrogacy, including for foreign couples, grounded in a more market-oriented and intended parents' autonomy-focused value system. However, cross-border surrogacy arrangements generate profound legal uncertainty for children, particularly regarding legal parentage, nationality, citizenship and identity. In practice, courts are increasingly compelled to resolve these conflicts by prioritising the best interests of the child, even when this entails recognising parent–child relationships that originate from arrangements prohibited under domestic law.

The principle of the best interests of the child emerges throughout this book as a guiding principle and fundamental social value, although its concrete interpretation varies considerably across different legal systems. While international instruments such as the Convention on the Rights of the Child do not regulate ART explicitly, their emphasis on the child's right to identity, legal parentage, and protection provides a child-centred framework that challenges adult-centred conceptions of reproductive rights. The concluding chapter highlights that ART regulation cannot be confined to the domain of private autonomy or demographic policy but must be evaluated in light of the long-term implications for children's welfare, including their psychological well-being, social integration, and guarantee of stable family environments.

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