Chapter 10

Slovakia: The Regulation and Practice of Assisted Reproductive Technologies and the Best Interests of the Child[1]

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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 The research highlights the limitations of Slovakia's outdated legal provisions, particularly the lack of comprehensive ART legislation.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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