

## CAN IMPROVEMENTS IN THE ROMANIAN LEGISLATION ON MEDICALLY ASSISTED REPRODUCTION ALLEVIATE THE DEMOGRAPHIC CRISIS?

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### ABSTRACT

Romania, in line with the other European countries, has a country-wide demographic problem due to a below-replacement level fertility rate and decline in the total number of children. Infertility is a major societal problem that plagues numerous families. This unfulfilled potential of infertile couples and single women to have children has contributed to the demographic crisis, which can be alleviated by helping willing parents have children instead of trying to persuade reluctant childless adults to have children or to have more children than they originally planned to have. Fertility treatments and in-vitro fertilisation are expensive procedures that are not covered by public health insurance; consequently, government policy and financing can play a major role in helping couples pay for fertility treatments, thereby increasing Romania's birth rate. Public funds remain limited in this regard, so legal norms are defining which couples or single women are eligible to receive money for fertility treatments. The purpose of public policy should be to increase the efficiency of spending public funds for the best fertility results, without an ideological bias in regard to the recipients' traditional or non-traditional family structures.

### KEYWORDS

family  
fertility  
parents  
children  
medically assisted reproduction

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## 1. OECD Report on the Living Arrangements of Children and the Ideal Number of Children

The Social Policy Division of the 38-country international Organisation for Economic Co-operation and Development (OECD) has published several studies, through its Directorate of Employment, Labour, and Social Affairs, on family structures and attitudes regarding the ideal number of children in its member and partner countries.<sup>3</sup> The most recent OECD data on family structures in Romania mostly pertain to 2021. The data show a below-replacement level total fertility rate of 1.81 (still one of the highest in Europe, surpassed only by Czechia and Iceland at 1.82), a mean age of women at childbirth of 28.2 years, a growing share of births outside marriage (32.5% in 2020), a declining crude marriage rate of 4.2 marriages per 1,000 people in 2020 (between 5.2 and 7.4 in the pre-pandemic decades since 1995, with the exception of the European Union (EU) accession year of 2007 when it reached 9.1), and a crude divorce rate of 1.2 per 1,000 people in 2020, with 85.9% of children living with both parents and 11% living with a single parent in 2018.<sup>4</sup>

A 2016 OECD study on the mean personal ideal number of children, based on the Eurobarometer surveys from 2011, found that Romanian women and men between 15 and 64 years of age considered having two children as ideal, with less than 2% of women considering childlessness as a personal preference, 8% declaring a single child as preferable, and about 70% considering two children as their ideal. Additionally, 10% of women between 15 and 64 years old considered three or more children to be their ideal, while an equal number of women expressed no preferred or ideal number of children.<sup>5</sup> The same study found considerable discrepancies between the ideal and current number of children across all the surveyed countries, with many women between 25 and 39 years old having not yet realised their childbearing intentions.<sup>6</sup> We can only speculate that one of the reasons for this discrepancy might be infertility.

## 2. Increase in the number of infertile couples in Romania

The Romanian Association for Human Reproduction conducted two sampling or polling studies on infertility in 2018 and 2023. The 2018 poll was conducted online and included 4,680 respondents, of which 3,331 were considered the fertile demographic contingent: women between 25 and 45 years of age and men between 25 and 60 years of age in relationships with partners in the appropriate age range. In the fertile demographic group, 16.8% were affected by infertility, either currently or in the past. Considering only

3 | All studies in the OECD Family Database [Online]. Available at: <https://www.oecd.org/els/family/database.htm> (Accessed: 21 January 2024).

4 | OECD Family Database [Online]. Available at: <https://stats.oecd.org/Index.aspx?DataSetCode=FAMILY> (Accessed: 21 January 2024).

5 | OECD, 2016, pp. 2–3.

6 | *Ibid.*, p. 3.

those who wanted children as soon as possible (29.1%), 27% of the couples failed to have a child despite trying for between one and five years, while 11% failed to have a child despite trying for more than five years.<sup>7</sup>

The 2023 follow-up study on infertility in urban environments reached similar conclusions. On average, 18% of pregnancies between 2018 and 2023 were the result of some form of fertility treatment, and 17.1% of the responding couples were either still or had been in an infertility situation. Only 21% of the interviewed couples wanted a child as soon as possible; among them, 40% had been trying unsuccessfully for children between one and five years, while 10% had been trying for more than five years.

In January and February 2023, 23% of extant pregnancies were the result of fertility treatments. Between 2018 and 2023, there were approximately 102,000 successful fertility treatments, leading to an average of 20,000 per year. We can assume that the total number of fertility treatments required to get this result was at least twice or possibly three times higher (40,000–60,000 per year) because the reasonable target success rate for public funding is 30%.<sup>8</sup>

### 3. The legal concept of infertility

Infertility is caused by both woman- and man-related factors. For women, the most common medical issues causing infertility are vaginal infections, endometriosis, obstructed or surgically removed fallopian tubes, lack of ovulation, high levels of prolactin, polycystic ovaries, uterine fibrosis, the side-effects of medication, and thyroid issues. For men, the most common medical issues are a lack of sperm cells, reduced number of sperm cells, reduced mobility or structurally deficient sperm cells, and genetic disease. Other issues that can affect fertility are related to lifestyle: nutrition, stress, radiation exposure, or exposure to toxic factors.<sup>9</sup> Infertility is medically defined for a woman below 35 years of age as not having conceived after one year of vaginal sexual activity without contraception.<sup>10</sup>

The Work and Social Solidarity Minister and Family, Youth, and Equal Opportunities Minister gave a joint order (no. 2155/20917/2022) on regulations concerning the implementation of the social national interest programme to support couples and single individuals to increase the number of childbirths. This order broadly defines infertility as having an affliction that is incompatible with natural reproduction, diagnosed by an obstetrician gynaecologist with a further specialisation in medically assisted reproduction (Art. 4).

7 | Asociația Pentru Reproducere Umană Din România, 2018.

8 | Neagu, 2023.

9 | Iordăchescu, 2020, p. 169.

10 | Vlădăreanu and Onofriescu, 2019, p. 8.

## 4. Legality and accessibility of assisted reproductive procedures

In Romania, assisted reproductive procedures (ARPs) are disparately regulated mainly by the Civil Code of 2009, the Law on Healthcare Reform no. 95/2006, the Law on the Rights of the Patient no. 46/2003, as well as lower-level regulations such as the Health Minister's Order on Therapeutical Transplants no. 1763/2007; the Health Minister's Order no. 377/2017 on the Implementation of National Public Health Programmes; the Work and Social Solidarity Minister and Family, Youth, and Equal Opportunities Minister's joint Order no. 2155/20917/2022 on regulations concerning the implementation of the social national interest programme to support couples and single individuals to increase the number of childbirths; Government Decree no. 423/2022 on the approval of national health programmes; and the Health Minister's Order no. 964/2022 on the approval of technical norms for implementing the national health programmes. There is no coherent and cohesive statute in Romanian domestic law regarding fertility treatments and assistive reproductive procedures, so their legal regime has to be inferred from a host of regulations pertaining to adjacent issues.

Assisted reproductive procedures are not extensively regulated – neither in primary legislation, which comprises laws enacted by the parliament and governmental decrees or emergency decrees, nor in secondary legislation such as ministerial orders. Therefore, we could not identify any bans on specific ARP techniques and concluded that both intracytoplasmic sperm injection and in-vitro fertilisation (IVF) are allowed. Most restrictions pertaining to ARPs are the general restrictions included in the Civil Code of 2009, which came into force on 1 October 2011.

The relatively recent Romanian Civil Code has a special section on natural persons' rights to life, health, and physical integrity.<sup>11</sup> Art. 61 guarantees the 'inherent' rights of a human being by equally safeguarding the life and physical and psychological health of any human being. The well-being and interests of any human being should take precedence over the sole interests of society.<sup>12</sup> Art. 62 of the Civil Code bans eugenics and any attempts to alter the human species, which is understood to refer to the altering of the human genome. Eugenics is legally defined as any practice that intends to manage the selection of persons, while the scientific definition refers to the practical application of hereditary biology in the genetic improvement of individuals.<sup>13</sup>

The Civil Code also bans any medical interventions on genetic characteristics to modify the person's descendancy, with the sole exception of curative and preventative interventions for genetic diseases (Art. 63 para. 1). The legal ban extends to human cloning with the purpose of creating an identical human being and creating human embryos solely for research purposes (Art. 63 para. 2). Human medically ARPs are not allowed for choosing the sex of the future child unless it is to avoid a gender-related genetic disease (Art. 63 para. 3).<sup>14</sup>

11 | Diaconescu and Vasilescu, 2022, pp. 303–307.

12 | Chelaru in Baias et al., 2021, pp. 77–78.

13 | Chelaru in Baias et al., 2021, pp. 78–79.

14 | Chelaru in Baias et al., 2021, pp. 79–81.

The contemporary civil regulation also regulates the sanctity of the human body (Art. 64); restricts the examination of genetic characteristics only for medical, research, and judicial purposes (Art. 65); and forbids attributing a monetary value to the human body or to its component parts (Art. 66). It also states the broad principles for medical interventions on a person and transplants from a living person (Arts. 67–68 Civil code).<sup>15</sup>

## 5. Medically assisted reproduction with a third-party donor

The Civil Code of 2009 includes a specific seven-article section on medically ARPs with a third-party donor. These general provisions were supposed to be followed by a new special and detailed law on medically ARPs with a third-party donor, but more than a decade has passed to no avail.<sup>16</sup> The general provisions of Art. 441 para. 3 of the Civil Code specifically determine that both heterosexual couples and single women have access to medically assisted reproduction with a third-party donor. The law does not distinguish between a male or female third-party donor, so it can be broadly construed to include both and simultaneous donations of sperm and oocytes for the same receiving couple or single woman.<sup>17</sup>

## 6. The history of failed attempts to legislate on medically assisted reproduction

Prior to the most recent Civil Code of Romania, one of the first contemporary attempts to adopt a comprehensive statute concerning medically assisted reproduction was from 2009 (PL-x no. 690/2009<sup>18</sup>). This 26-article project affirmed the right to reproduction as the right of couples and individuals to ‘freely and responsibly decide the number, frequency, and time when they wish to have children’ as well as their right to have access to information, education, and the means to reach such a decision Art. 2). Medically assisted human reproduction was reserved only for married couples or consensual partners who could prove at least two years of cohabitation; moreover, both individuals had to be alive (inseminating a woman with her dead husband’s sperm being expressly forbidden) and fulfil the general health and biological age criteria for procreation (Art. 4).

This project included a list of allowed human medically assisted reproduction techniques, such as artificial insemination, IVF, and embryo-transfer (ET), and a list of banned techniques, such as *post-mortem* artificial insemination, *post-mortem* ET, interventions when infertility is due to old age, and fertility interventions for couples who cannot prove a stable cohabitation (Art. 8). The 2009 project regulated both endogenous fertilisation

15 | Chelaru in Baias et al., 2021, pp. 82–87.

16 | Florian and Floare, 2024, p. 468; Avram, 2022, p. 309.

17 | Motica, 2021, p. 224; Florian in Baias et al., 2021, pp. 594–595; Hageanu, 2023, pp. 211–212.

18 | The 2009 project, in its senate-approved version [Online]. Available (in Romanian) at: <https://www.cdep.ro/proiecte/2009/600/90/0/se690.pdf> (Accessed: 29 January 2024).

and reproduction with a third-party donor (Arts. 10–12). Filiation was established, according to this project, by the simple declaration of parents at the time of birth, with the child having the same rights as a naturally conceived child (Art. 14). This 2009 project was rejected by the lower Chamber of Deputies in 2010, with the Health Committee's rejection report<sup>19</sup> stating that the project had serious technical drafting deficiencies and gaps in its rules about a sensitive topic – gaps that could lead to constitutionality issues. There were at least two attempts to regulate this area in greater detail since the Civil Code came into force on 1 October 2011, but both law projects were rejected, despite being initiated by the government and as a cross-party private members' bill.

The first project to be promoted after the new Civil Code came into force originated from the government in 2012 (PL-x no. 63/2012). This project was quite short (12 articles)<sup>20</sup> and stated that human medically assisted reproduction with a third-party donor is organised and controlled by the Health Ministry and supervised and coordinated by the National Transplant Agency. The purpose of the procedure is either to be a remedy for pathological infertility or to prevent the passing on of a serious affliction to the offspring (Art. 5).

The crucial question of who would be eligible to take part in this kind of medical procedure remained unanswered because the medical criteria for both physical and mental health were supposed to be adopted later by a Health Minister's Order (Art. 6). Infertility cases that allowed someone to take part in this kind of procedure were exemplified as including immunological incompatibility between parents, unknown causes, or the impossibility of contact between two reproductive cells (Art. 7). Medically assisted reproduction with a third-party donor covers both artificial insemination with biological material from said donor or IVF with reproductive material from a third-party donor (Art. 9). Parents who wished to take part in such a procedure had to demand it from an authorised medical facility; undergo counselling from medical professionals regarding the chances of success, the risks, and adoption possibilities; and be checked for their motives (Art. 8). The project subjected a woman's access to medically assisted reproduction with a third-party donor to the written consent from both her and her husband.

The medical criteria for selecting the third-party donor regarding the quality and quantity of reproductive material as well as the physical and mental health of the donor that could influence the offspring were delegated by the law project in a later Health Minister's Order Art. 10). Confidentiality of the procedure was mentioned specifically only in relation to the health personnel involved in the procedure (Art. 11).

This project was finally rejected by the lower house of parliament in 2016 because the draft was considered poorly written from a technical point of view, with the rejection report of the parliamentary commission drawing from the objections of the Legislative Council. This project was considered too vague and confusing, with no practical solutions to a delicate and important societal issue.<sup>21</sup>

19 | Available (in Romanian) at: [https://www.cdep.ro/comisii/sanatate/pdf/2010/rp690\\_09.pdf](https://www.cdep.ro/comisii/sanatate/pdf/2010/rp690_09.pdf) (Accessed: 29 January 2024).

20 | The failed 2012 project, in its senate-approved version [Online]. Available (in Romanian) at: <https://www.cdep.ro/proiecte/2012/000/60/3/se99.pdf> (Accessed: 29 January 2024).

21 | The joint rejection report of the Chamber of Deputies' Judiciary and Health Committees [Online]. Available (in Romanian) at: [https://www.cdep.ro/comisii/juridica/pdf/2016/rp063\\_12.pdf](https://www.cdep.ro/comisii/juridica/pdf/2016/rp063_12.pdf) (Accessed: 29 January 2024).

A later project, the cross-party private members' bill PL-x no. 462/2013<sup>22</sup>, was made up of 19 articles. It had similar provisions regarding the roles of the Health Ministry and the National Transplant Agency as the previous project (Art. 2). The project generously stated fundamental principles such as the parents' right to access medically assisted human reproductive techniques; right to informed consent; respecting the best interests of the child; safeguarding human dignity and body autonomy; and preserving the human species, individuality, and diversity (Art. 3).<sup>23</sup>

The allowed reproductive techniques were artificial insemination, IVF, and ET (Art. 7). This project specifically banned the simultaneous transfer of embryos from different donors (Art. 7 para. 4). The project included a more expansive list of banned activities in the field of medically assisted human reproduction: altering the human genome and species cross-breeding, selecting the sex of the future child except for reasons related to a sex-related genetic disease, creating human embryos only for research purposes, human cloning, using reproduction embryos that were previously used in research, using eugenics criteria to select the donor, harvesting reproductive material from a deceased person, and intentionally using reproductive material from donors closely related to the beneficiary (Art. 8).

A novelty of this later project, compared with the previous one, was an age restriction for oocyte harvesting by limiting the woman's age to between 18 and 45 years (Art. 10 para. 2). The law project also stipulated that ETs and IVFs were only allowed for women between 18 and 50 years of age (Art. 10 para. 3). There was also a novel 10-year time limit for embryo and gamete storage (Art. 13), after which the parents had to express an option about what to do with the stored biological products.

This 2013 project was also structurally incomplete, with the statute requiring further details about the enforcement of the law that would have been provided by later governmental decrees drafted by the Health Ministry (Art. 19). It was also rejected by the lower house of parliament in 2022, with a similar reasoning as for the previous project: too vague, lacking enforcement sanctions, being elliptically written, not offering practical solutions to a delicate social problem, and lacking specific financing resources for the stipulated expenses.<sup>24</sup>

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## 7. Lower-level ministerial regulations on reproductive techniques

Regarding the regulation of reproductive techniques other than medically assisted reproduction with a third-party donor, we could only identify secondary legislation concerning transplants, such as the Health Minister's Order no. 1763/2007, which

22 | The failed 2013 project, in its senate-approved version [Online]. Available (in Romanian) at: <https://www.cdep.ro/proiecte/2013/400/60/2/se790.pdf> (Accessed: 29 January 2024).

23 | See also Irinescu, 2014, pp. 16–18.

24 | See the joint rejection report of the Chamber of Deputies' Judiciary and Health Committees [Online]. Available (in Romanian) at: [https://www.cdep.ro/comisii/sanatate/pdf/2021/rp462\\_13.pdf](https://www.cdep.ro/comisii/sanatate/pdf/2021/rp462_13.pdf) (Accessed: 29 January 2024).

tangentially references access to these procedures. This secondary legislation only mentions different-sex couples in a (declared) intimate relationship as having access to reproductive cell transplants between partners.

Romanian legislation is extremely traditional and restrictive with regard to civil partnerships or same-sex marriages. The Civil Code only recognises traditional marriage between a man and a woman and specifically bans (Art. 277) the recognition of any effects of a foreign civil partnership of any kind or a foreign same-sex marriage in Romania, with the exception of freedom of travel provisions derived from European Union law. There are no specific legal limitations on access to ARPs besides the broad Civil Code restrictions on eugenics (Art. 62) and genetic alteration (Art. 63) as well as general transplant regulations and general patient consent requirements.

Publicly funded IVF with ET is subject to a national public health subprogramme since 2011,<sup>25</sup> with extended funding from 2022. It is restricted to infertile heterosexual couples, defined as couples diagnosed (by a certified specialist MD) with an affliction incompatible with natural reproduction or unable to reproduce after one-year of unprotected sexual relations, with no third-party donations allowed for sperm or oocytes and excluding surrogacy in what is perhaps the only specific mention of this procedure in Romanian domestic law.<sup>26</sup> To receive public funding for IVF, both partners must have public health insurance and the woman must be between 24 and 40 years of age, with a body mass index between 20 and 25 and an ovarian reserve determined to be within the normal limits.<sup>27</sup>

The 2009 Civil Code specifically allows for third-party donations of reproductive material, but this is a general regulation comprising merely seven articles to be detailed by a special ulterior statute, which has as yet not been adopted. The Civil Code (Art. 441 para. 3) defines parents for the purposes of ARPs with third-party donations as either a couple or a single woman. This provision is not restricted to married couples but specifically refers to heterosexual couples (a man and a woman).<sup>28</sup> The legal doctrine debates whether a single woman refers only to women that do not have a partner or if it also includes women whose partner has not consented to the medical procedure. Further provisions that allow the husband to deny paternal filiation if he had not previously agreed to the medically assisted reproduction with a third-party donor tend to suggest that this procedure is also available for women who are not technically single but whose partner does not wish to agree to such procedures.<sup>29</sup>

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## 8. Anonymity in third-party donations

All ARPs are considered confidential according to the general provisions of Art. 445 para. 1 of the Civil Code – requirements which were construed to safeguard the identity of the parents or the single parent, the identity of the child born out of these procedures or the identity of the third-party donor, as well as the notarised parental agreement to

25 | Brodeala, 2016, p. 64.

26 | Brodeala, 2016, pp. 64–65; Florian and Floare, 2024, p. 473.

27 | Florian and Floare, 2024, p. 473.

28 | Motica, 2021, p. 224.

29 | Florian and Floare, 2024, pp. 474–475; Avram, 2022, pp. 310–311.

undergo the procedure; this confidentiality was considered an integral part of the constitutional right to private life.<sup>30</sup> Because it is also a medical procedure, the assisted reproduction is covered by the right of the patient to the confidentiality of medical information, which is stipulated by Art. 21 of Law no. 46/2003 on the rights of the patient.<sup>31</sup>

The only specified exceptions to the confidentiality requirements are made in Art. 445 para. 2 of the Civil Code for the court-authorized transmission of information to a physician or the competent authorities to prevent serious harm to the health of the children born from these procedures or to their descendants.<sup>32</sup> Confidentiality can also be curtailed on the request of the descendants of the child born out of this procedure to avoid serious harm to their health or their close ones, according to Art. 445 para. 3 of the Civil Code. The legal doctrine has interpreted this provision as only the children or their descendants having the legal standing to demand this kind of information.<sup>33</sup>

All the details about ensuring the confidentiality pertaining to medically assisted reproduction should have been included, according to Art. 447 of the Civil Code, in a special statute on the matter of ARPs with third-party donors, which has yet to be adopted even after 13 years since the Code came into force on 1 October 2011.

For transplants of reproductive cells (other than from the recipient's partner), the Health Minister's Order on transplants mentions the requirement to register information about the donor's age, health, medical history, medical risks for themselves or others, tests for transmissible diseases (which specifically include HIV, syphilis, hepatitis B or C, human T-cell lymphotropic virus, and chlamydia), supplemental tests depending on risk factors (which could include malaria, cytomegalovirus, and *Trypanosoma cruzi*), and genetic screening for autosomal-recessive genes.

Currently, there are only the general regulations on patient information confidentiality and the Civil Code provisions on the court-authorized transmission of information to a physician or authority to prevent serious harm to the children or their descendants because the specific regulations on information transmission with regard to this procedure have not yet been enacted.

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## 9. Public funding of assisted reproductive procedures

Assisted reproductive procedures have been financed intermittently from public funds with special national health programmes since 2011<sup>34</sup> as they are not normally covered by the standard public health insurance. To date, existing financing programmes do not distinguish between public and private fertility facilities. The national health programmes that have financed IVF with ET for couples were targeting a 30% success rate. Health facilities that had previously received public funding for IVF continued to be included in the programme only if they had reached the 30% success rate in previous years when they had received public funding.

30 | Florian and Floare, 2024, pp. 470–471; Hageanu, 2023, p. 216.

31 | Florian and Floare, 2024, p. 471.

32 | Avram, 2022, p. 312.

33 | Florian and Floare, 2024, p. 471.

34 | Brodeala, 2016, p. 64.

Public funding from 2022 onward is theoretically available for three procedures per year for each couple or single woman, depending on the very limited availability of funding. Funding was usually limited to 1,000 procedures per year in previous fiscal years, but in 2022, Government Decree no. 1103/2022 disbursed funding for at least 2,500 procedures per year and a further 10,000 procedures per year from 2023 onward on a 'first come, first served' basis. Between 2017 and 2021, public funding was available only for IVF with ET and only for couples, with no financing whatsoever provided for gamete donations or surrogacy.

The joint Work and Social Solidarity Minister and Family, Youth, and Equal Opportunities Minister's Order no. 2155/20917/2022 on regulations concerning the implementation of the social national interest programme to support couples and single individuals in order to increase childbirths defines the conditions under which the state will help pay for fertilisation treatments. The beneficiaries are defined as couples or single infertile women who were diagnosed by a fertility specialist as having an affliction that is incompatible with natural reproduction (Art. 4). They can receive financial support of up to 15,000 lei (the equivalent of 3,000 euros), with 5,000 lei (approximately 1,000 euros) for the necessary medicines and 10,000 lei (approximately 2,000 euros) for medical procedures. The beneficiary can get this special financial support up to three times a year for the duration of the programme. The cumulative conditions for receiving the financial support are as follows: both members of the married or unmarried couple or the single woman have to be Romanian citizens domiciled in Romania; they all have to be insured in the Romanian public health insurance system; the fertility treatment and procedures must take place in an authorised medical unit in Romania that is a partner in the programme; and the age of the participating women must be between 20 and 45 years at the time of the request filing (Art. 5).

The publicly funded fertility programme started in December 2022 with 2,500 beneficiaries for the current year, with a further 10,000 beneficiaries for each subsequent year, starting in 2023 (Art. 6). The financial support is granted on a 'first come, first served' basis (Art. 7). The funded procedures include the harvesting of oocytes from the beneficiary woman, the processing of sperm, artificial insemination, embryo cultivation for between 72 and 120 hours, ET, the health monitoring of the case evolution, and the necessary drug treatments (Art. 16).

This social fertility programme explicitly excludes several fertility-related medical procedures from public funding: preliminary laboratory investigations; genetic diagnosis of the embryos; the cryopreservation of oocytes, sperm, or embryos; the surgical harvesting of sperm; general intra-venous anaesthesia for oocyte harvesting; intracellular sperm injection; and the harvesting of donated oocytes (Art. 26). If the costs of the specific medical procedures are greater than the publicly funded allowance, the beneficiaries have to bear the supplemental costs (Art. 27).

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## 10. Issues regarding the preservation of biological material

The cryopreservation of gametes or embryos is legally allowed in Romania, although it is specifically excluded from public funding from the IVF with ET national public health programmes since 2017, even in the more generous recent fertility programme that

started in 2022. In Romania, there are no specific legal conditions for the cryopreservation of gametes or embryos. The only general conditions are the informed consent of the donor and a contract with the authorised medical institution that harvests and deposits the biological material.<sup>35</sup>

This lack of regulation gave rise to serious legal issues when the 'ownership' of the frozen embryos was questioned in a case involving a criminal inquiry and asset seizure implicating a fertility clinic: were the embryos mere material goods or living beings?<sup>36</sup> This case (*Knecht v. Romania*, application no. 10048/10) reached the European Court of Human Rights,<sup>37</sup> which rendered a decision in 2012 stating that the case involved the applicant's (the mother) right to a private life, not her property rights.

## 11. Legal parenthood as a consequence of medically assisted reproduction

The gamete donor can only be the parent of a child conceived through ARPs if there is a reproductive cell transplant between partners, which can be construed as IVF. Third-party gamete donations – male or female – do not give rise to the issue of legal parenthood because maternal filiation depends solely on giving birth to a child, in a similar manner to natural motherhood.<sup>38</sup> The fatherhood of the third-party donor (genetic father) is specifically excluded by Art. 441 para. 1 of the Civil Code, which states, in broad terms, that medically assisted reproduction with a third-party donor does not give rise to any filiation between the child and donor.

There are no special presumptions of parenthood for ARPs: the mother is the person giving birth; and the father is presumed to be the mother's husband at the time of birth,<sup>39</sup> the former husband at the time of conception, or the mother's cohabiting partner at the time of conception (the latter presumption is applied only during paternity trials). The true source of paternal filiation in the case of medically assisted reproduction with a third-party donor is the consent given by the mother's husband or consensual partner to undergo the procedure. Paternal filiation can be contested only for the lack of prior consent from the father or if a pregnancy did not arise from the medically assisted procedure.<sup>40</sup> A consensual partner who gave his consent to this procedure is liable to recognise paternal filiation after birth<sup>41</sup> if there is no intervening marriage between the parents.

35 | Tec, 2017, p. 246.

36 | Tec, 2017, pp. 236–239.

37 | Case of *Knecht v. Romania*, European Court of Human Rights, Application no. 10048/10 – Decision [Online]. Available at: <https://hudoc.echr.coe.int/#{%22fulltext%22:%22knecht%22,%22documentcollectionid%22:%22GRANDCHAMBER%22,%22CHAMBER%22,%22itemid%22:%22001-113291%22}> (Accessed: 29 January 2024).

38 | Florian and Floare, 2024, p. 475.

39 | *Ibid.*

40 | Florian and Floare, 2024, pp. 476–477; Motica, 2021, p. 228.

41 | Florian and Floare, 2024, pp. 478–480.

## 12. Controversies regarding the legal status of surrogacy in Romania

Surrogacy is not expressly forbidden, but neither is it specifically allowed or regulated in Romania.<sup>42</sup> The provisions that the mother is the one giving birth (irrespective of genetic relationship), even in medically ARPs,<sup>43</sup> and parental authority cannot be voluntarily transferred to another person make surrogacy legally difficult.<sup>44</sup> Art. 408 para. 1 of the Civil Code makes no distinctions in stating that motherhood is derived from the fact of birth, thus making no special provisions for medically assisted pregnancies, artificial insemination, or IVF.<sup>45</sup> The source of the biological material is not relevant, and genetic testing for motherhood is used only as a proxy for determining who gave birth to a certain child.

Parental authority is usually exercised by both biological parents, and they can usually agree between themselves how to 'divide' it in practice; however, a mere parental agreement cannot voluntarily relinquish parental authority or transfer it to a third party. Only through court-approved adoption can parental authority be permanently transferred from the biological parents to the adoptive parents. All other court decisions regarding the exercise of parental rights, even the most dramatic ones concerning the removal of the exercise of parental rights, are essentially temporary in nature and can later be reversed when the parents' situation improves. Thus, there are no certain legal means to 'contractually' transfer parental authority from the birth mother to another woman, even if she is the genetic parent of the child.

Both types of surrogacies, gestational and traditional,<sup>46</sup> are equally impeded by the legal provisions on birth motherhood and the impossibility of voluntarily relinquishing or transferring parental authority. Altruistic surrogacy is not explicitly banned but heavily impeded. Commercial surrogacy falls foul of multiple legal bans on trading the products of the human body, trading biological products,<sup>47</sup> or human trafficking. Surrogacy is heavily impeded in all cases, but medical infertility or gestational impediments sometimes bring undeclared sympathy from the courts in trying to overcome the legal hurdles to its recognition.

A few published court cases have recognised the effects of surrogacy.<sup>48</sup> Here, a circumvented legal reasoning is observed, with the paternal filiation (fatherhood) usually being voluntarily recognised by the genetic parent and maternal filiation (motherhood) being recognised, on demand, as an effect of the possession of civil status (status by habit and repute) and genetic filiation, with a special regard to the provisions of Art. 8 of the European Convention of Human Rights regarding the right to private and family life.<sup>49</sup>

42 | Sztranyiczki, 2020, p. 268.

43 | Florian and Floare, 2024, p. 469.

44 | Dobozi, 2013, pp. 64–65.

45 | Sztranyiczki, 2020, p. 268.

46 | Predescu, 2020, p. 477.

47 | Sztranyiczki, 2020, pp. 269–270.

48 | Brodeala, 2016, pp. 70–73.

49 | Irinescu, 2019, pp. 213–214.

### 13. Issues regarding cross-border surrogacy for Romanian parents

Filiation in Romanian private international law, regulated by Book VII, Chapter 2, Section 2 of the Civil Code, is subject to either the law that governs the general effects of the parents' marriage for children born or conceived during marriage (Art. 2.603) or to the national law of the child at the time of birth for children born out of wedlock (Art. 2.605).<sup>50</sup> There are no special provisions in Romanian private international law for surrogacy because there are scant references to this procedure in the entire domestic legislation.

In cases concerning surrogacy performed abroad or with a foreign element, Romanian courts would probably apply either the national law of the woman giving birth, which would be the surrogate mother, if she is single or the law that governs the general effects of her marriage. If these foreign laws allowed for surrogacy and the voluntary transfer of parental authority from the birth mother to the intended parents owing to their previously concluded agreement, we could speculate that only international public order grounds could lead to the refusal to recognise the lawful consequences of these procedures in Romania.

In Romanian domestic law, a genetic link is required only for paternal filiation (fatherhood) out of wedlock, while maternal filiation (motherhood) is intrinsically dependent on giving birth. Paternal filiation (fatherhood) is legally presumed for the current husband at the time of birth or the former husband at the time of conception, which is presumed to be between 300 and 180 days prior to giving birth. An apparent maternal filiation, even if it is based on a birth certificate, coherent with habit and repute could still be challenged if the listed mother is not the woman who gave birth. On a domestic birth certificate, the woman having given birth is automatically listed as the mother of the child, while her current or former husband or the person who voluntarily recognises the child is listed as the father. The civil status of a person is subject to their national law according to Art. 2.572 para. 1 of the Civil Code.<sup>51</sup> Foreign birth certificates are registered in Romania if they concern any person born abroad.

### 14. The Romanian criminal law approach to surrogacy issues

Because it is not a regulated procedure, surrogacy could give rise to criminal charges for each of its constituent acts for the participating parties (surrogate mother, gamete, donor, and facilitator), either as an author, instigator, or accessory. The Healthcare Reform Law no. 95/2006 criminalises donating cells or tissues for material gain (Art. 156 para. 1), advertising for cell or tissue donation for material gain (Art. 156, para. 3), and organising or harvesting cells or tissues for transplant for material gain for either the donor or the person who organises the process (Art. 157, para. 1).

50 | Macovei, 2017, pp. 343–345; Popescu and Oprea, 2023, pp. 463–480.

51 | *Ibid.*, p. 195.

There were several well-publicised cases involving oocyte trafficking in 2009–2014, some culminating in jail time for the owners of private fertility clinics in Bucharest and Timisoara that were carrying out IVF procedures without proper authorisations. They were found guilty of purchasing oocytes from poor women and using IVF to implant them in foreign infertile couples. The most common publicly recorded unlawful practices were related to the remuneration of gamete (female) donors and selling the gametes to couples for IVF procedures. There were also attempts to circumvent the restrictions on surrogacy by making the surrogate mother give birth outside medical institutions and declaring the birth in the special procedure for the late registration of births, which involves a DNA-test for the mother that could allow for the genetic mother to be registered as such by hiding the fact that she did not give birth to the child.<sup>52</sup>

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## 15. Conclusions

In Romania, the regulation of human reproductive procedures tends to be limited and general. Although the Civil Code attempted to go further by regulating medically assisted reproduction with a third-party donor while banning eugenics and genetic manipulation without a therapeutic purpose, the special legislation that was meant to implement these generous principles is lagging behind. There are detailed provisions on transplants, including reproductive cell transplants, and firm regulations on patient confidentiality and informed consent for any medical procedure, but these regulations lack a specific focus on reproductive issues. The public financing for reproductive procedures is limited, and the regulations that surround it tend to be very restrictive and with a traditionalist approach to reproductive health.

In relation to Romania's demographic challenges, derived from strong emigration and the below-replacement level fertility, medically assisted reproduction represents an insufficiently valued resource. For all families to reach their desired numerical composition, the widespread infertility issues must be tackled head on. For an ageing parental population, overcoming infertility is one of the major answers to the demographic challenge.

The state cannot assert that it has done everything in its power to tackle the issue of its decreasing indigenous population as long as there are couples or single women who cannot afford medically recommended fertility treatments. The current annual funding for only 10,000 fertility treatments seems to be insufficient for a total population of approximately 19 million. By estimating a 30% success rate for fertility treatments, the 10,000 publicly funded treatments per year will result in only 3,000 children yearly. The public demand for state-funded fertility treatments and the demographic requirements of a decreasing population of 19 million cannot be fulfilled with only 30 million-euro funds every year.

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