

To have or not to have a child

Ethical and legal aspects of contraception, abortion, sterilisation and assisted reproduction

Practical Class 7 · Social Medicine and Medical Ethics I · 2026/2027

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Two parts, one question: whose decision is it?

Part I · Contraception, abortion, sterilisation

- reproductive autonomy and its limits
- contraception, minors, coercion
- abortion: moral positions, Bulgarian regime, conscience
- sterilisation: irreversibility, law, history

Part II · Assisted reproduction

- definition, methods, access and funding
- donation of gametes and embryos
- number of embryos and “surplus” embryos
- death of a partner, mother and father, family forms
- surrogacy

The physician informs, assesses risk and secures a safe and lawful choice — but does not make the reproductive decision on the patient's behalf.

Part I

Contraception, abortion and sterilisation

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1. Reproductive autonomy

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Reproductive autonomy: freedom, but also the conditions for choice

Reproductive autonomy is a person's capacity to decide freely and on an informed basis **whether, when and under what circumstances** to have children. It presupposes reliable information, accessible services, confidentiality and protection from coercion.

Everyone has the right to information and freedom of decision regarding their reproductive health.

— Health Act (Bulgaria), Art. 126(2)

Intervention	Timing	Reversibility	Key ethical question
Contraception	before pregnancy	usually reversible	informed choice, access, proportionate risk
Sterilisation	before future pregnancies	intended to be permanent	sustained voluntary consent, protection from coercion
Abortion	after pregnancy is established	irreversible for that pregnancy	bodily autonomy, status of the fetus, limits of intervention

Is there a “right to a child”?

Negative right — freedom from interference

The state must not coerce, prohibit or arbitrarily control the decision to become a parent: forced sterilisation, forced pregnancy or forced abortion are among the gravest violations of bodily integrity.

Positive right — a claim to assistance

A right to treatment, funding or donor material. It is **limited**: it depends on medical appropriateness, the law and public resources. No one can demand a child from medicine.

The notion of “private life” (Art. 8) incorporates the right to respect for both the decisions to become and not to become a parent.

— ECtHR, *Evans v. the United Kingdom* [GC], no. 6339/05, 10.04.2007, § 71

The wide margin of appreciation in assisted reproduction was confirmed in *S.H. and Others v. Austria* [GC], no. 57813/00, 03.11.2011.

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Contraception: counselling, not just prescribing a product

Contraception — behavioural, barrier, hormonal or intrauterine methods for preventing pregnancy.

Good counselling clarifies:

- effectiveness with **perfect and with typical** use;
- when protection starts and what to do after a missed dose;
- contraindications, interactions, serious adverse reactions;
- what matters to the patient: reversibility, discretion, control, protection from STIs (condoms only).

Emergency contraception is not abortion

It acts **before** an established pregnancy — it prevents or delays ovulation. Calling it an “abortion pill” is misinformation that delays access and causes needless guilt.

Fair access

It is unethical to offer only the most expensive method — or to impose a cheap one without discussion because the patient is poor.

Minors: evolving autonomy and the limits of confidentiality

Where the patient is a minor ..., medical activities require, in addition to the minor's informed consent, the consent of a parent or guardian.

— Health Act, Art. 87(2)

Parental consent ... is not required for health consultations, preventive examinations and tests of persons who have reached 16 years of age.

— Health Act, Art. 87(3)

- Counselling an adolescent respects evolving autonomy but **applies the consent rules**.
- The limits of confidentiality are explained **in advance** — absolute secrecy is not promised.
- The physician tactfully checks whether contact is voluntary and whether there is an age or power asymmetry, violence or exploitation.
- For a child at risk there is a duty to report (Child Protection Act, Art. 7).

Reproductive coercion and decision-making capacity

Reproductive coercion

Someone else controls whether and when the patient becomes pregnant: sabotaged condoms, hidden pills, threats, contraception as a condition for housing or a service.

Disability $\neq$ incapacity

Capacity is assessed **for the specific choice** and supported: plain language, visual aids, time, a trusted person chosen by the patient. The least restrictive approach takes priority.

Values and faith

The physician helps match the method to the patient's values but **does not attribute** beliefs on the basis of ethnicity or religion.

Relatives' fear that a woman "will not cope" with a child deserves a conversation — but it does not entitle anyone to control her body for the carers' convenience.

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Abortion: the three main moral positions

Conservative position

Human life has full moral worth **from conception**. Intentional termination is as a rule impermissible — with narrow exceptions when the woman's life is at risk.

Gradualist position

Moral significance **grows with development**: nervous system, capacity to feel, viability. Early abortion is more easily justified than late abortion.

Bodily autonomy

Even if the fetus has moral status, it develops **inside a particular woman's body**. A right to life does not include a right to use another's body without consent (Thomson, 1971).

Modern law combines these positions: **freedom of decision in early pregnancy** and **increasing protection of the fetus** as pregnancy advances. The partner and the parents of an adult woman have a morally relevant perspective but **do not consent** to an intervention on her body.

The Bulgarian regime: the time limit is a medical and a legal fact

Up to 12 weeks — on request

At the request of any pregnant woman, if she has no condition in which abortion would threaten her health or life (Ordinance No. 2/1990, Art. 7).

Up to 20 weeks — medical grounds

A condition threatening the woman's life or health or the viability of the offspring; decision of a **special medical commission** (Arts 12–14).

After 20 weeks

Only for **urgent reasons** to save the woman's life or for proven gross morphological changes or severe genetic damage of the fetus (Art. 12(2)).

- A refusal by the commission may be appealed **within 7 days** to a commission at the “Maichin Dom” obstetric hospital, which decides finally (Art. 15).
- For women lacking legal capacity, abortion requires the consent of their legal representatives or guardians (Art. 4); for minors, Health Act Art. 87(2) applies.
- On discharge, the physician gives advice on effective contraception (Art. 6).

Health Act, Art. 128(1); Ordinance No. 2 of 1.02.1990 (State Gazette 12/1990, amended 89/2000)

Criminal-law protection: whom does the law punish?

Whoever, with the consent of a pregnant woman, kills her fetus outside an accredited health facility or in breach of the approved medical standards and rules of good medical practice shall be punished by imprisonment of up to five years.

— Criminal Code (Bulgaria), Art. 126(1)

Situation (Criminal Code, Art. 126)	Penalty
Offender without higher medical education, or two or more women (para 2)	up to 8 years
Without the pregnant woman's consent (para 5)	3 to 8 years
Without consent, followed by the woman's death (para 6)	5 to 12 years

The woman is not punished

The pregnant woman bears no criminal liability, including for instigation or aiding (Art. 126(4)).

Suspected criminal abortion

Notification within 24 hours (Ordinance No. 2/1990, Art. 19) — **without** refusing or delaying emergency care.

Prenatal diagnosis: information, not an automatic decision

Before testing the woman should know what the test can show, how certain it is, and whether it is **screening** (a probability) or **diagnostic**.

After an unfavourable result counselling is **non-directive**: prognosis and range of manifestations, treatment and social support, continuing the pregnancy, palliative care for a lethal anomaly, and lawful termination.

Tension

Respecting the woman's decision does not exclude a critical conversation about the message sent to people with disabilities and about insufficient social support.

Sex selection

Non-medical sex selection reproduces inequality. In assisted reproduction it is prohibited except to prevent sex-linked hereditary diseases (Health Act, Art. 135(1)).

Conscientious objection: the physician's right, not an obstacle for the patient

On the strength of his or her convictions (moral, religious, etc.), the physician has the right to refuse to terminate a normal pregnancy.

— Code of Professional Ethics of Physicians in Bulgaria, Art. 32

Acceptable

- the refusal is declared **in good time**;
- the patient receives **accurate information** and referral to another specialist;
- continuity of care is preserved.

Unacceptable

- misinformation, humiliation, withholding results;
- “waiting” until the legal time limit expires;
- refusal on medical grounds, in an emergency or when life is at risk.

ECtHR: the state must ensure effective access to lawful services — *Tysiāc v. Poland*, no. 5410/03, 2007; *R.R. v. Poland*, no. 27617/04, 2011.

Comparative view: from first-trimester freedom to near-total prohibition

Country	Regime (summary)
Bulgaria	on request up to 12 weeks; on medical grounds up to 20 weeks; thereafter only on serious grounds
France	on request up to 14 weeks (since 2022); since 2024 the freedom to have an abortion is in the Constitution
Great Britain (excl. Northern Ireland)	up to 24 weeks on statutory grounds certified by two doctors (Abortion Act 1967)
Netherlands	up to viability (about 24 weeks) in licensed clinics
Poland	only when life or health is at risk or the pregnancy results from a crime (Constitutional Tribunal, K 1/20, 2020)
Malta	only when the woman's life is at risk or her health in grave danger (amended 2023)

The ECHR contains no “right to abortion”, but requires the law to be clear and access to what is lawful to be real (A, B and C v. Ireland [GC], no. 25579/05, 2010).

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Sterilisation: contraception intended to be permanent

Sterilisation — a medical intervention intended to create a **permanent inability** to conceive naturally:

- in women — interruption or occlusion of the fallopian tubes;
- in men — vasectomy.

Reconstruction or later assisted reproduction do not make the intervention easily reversible. Consent must rest on the understanding that the person **may never conceive** naturally again.

Quality of consent

- reversible alternatives and the failure rate discussed;
- a reasonable reflection period — a safeguard, not an obstacle;
- no decision in acute crisis or immediately after a difficult delivery;
- the partner may take part if the patient wishes, but **has no veto**.

The more irreversible, the stricter

A relative's consent cannot replace the will of a capable adult patient.

Bulgaria: sterilisation only on medical grounds

Permanent removal of the capacity to reproduce shall be carried out under conditions and by a procedure determined by an ordinance of the Minister of Health.

— Health Act, Art. 128(3)

How it is applied in Bulgaria

- sterilisation is performed on **medical grounds** — when pregnancy is contraindicated by disease or would endanger the woman's life;
- **voluntary contraceptive sterilisation** without medical grounds is not regulated by law and is **not permissible** as a routine service;
- written informed consent is required (Health Act, Arts 87–89).

Criminal-law context

Causing **loss of reproductive capacity** is grievous bodily harm (Criminal Code, Art. 128(2)). Without a statutory basis, the patient's consent does not exclude the physician's liability.

Comparative view: voluntary sterilisation in other countries

Country	Conditions for sterilisation without medical grounds
France	adults; a mandatory four-month reflection period and written confirmation; prohibited for minors (Public Health Code, Art. L2123-1)
Germany	permitted for adults with informed consent; prohibited for children (Civil Code, § 1631c)
Spain	the valid, express and free consent of an adult excludes criminal liability (Criminal Code, Art. 156)
England	lawful for adults with informed consent; professional counselling guidance
USA	lawful; with federal funding — age 21 and 30 days between consent and surgery (42 CFR § 50.203)

The common model: adulthood, informed consent, time to reflect — and absolute protection of children and persons without decision-making capacity.

Forced sterilisation: the lesson of the 20th century

The eugenic policies of the 20th century — from the US Supreme Court decision **Buck v. Bell** (1927) to Sweden's laws of 1934–1976 — led to the sterilisation of people with disabilities, mental illness, the poor and ethnic minorities in the name of “the public good”.

The language of “responsible parenthood” can mask discrimination. Sterilising a person with limited decision-making capacity is **not justified** by institutional convenience, the risk of pregnancy or the guardian's wish.

ECtHR, **V.C. v. Slovakia**, no. 18968/07, 2011

A Roma woman was sterilised during a caesarean section after signing a form in the delivery room, without genuine informed consent. The Court found a violation of **Art. 3** (inhuman and degrading treatment) and **Art. 8**.

The Istanbul Convention (Art. 39) requires forced abortion and forced sterilisation to be criminalised.

Case 1 · A decision after a difficult delivery

The case

A 36-year-old woman delivers her third child by emergency caesarean section after severe pre-eclampsia. Twelve hours later, exhausted and on analgesics, she “quietly confirms” her husband’s insistence on permanent sterilisation before discharge. In private she admits that they never discussed irreversibility and that she fears he will leave her if she refuses. Her condition allows the decision to be postponed and a reversible method to be used.

1. Is consent given in exhaustion, under medication and in fear of the partner valid?
2. What weight does an earlier “family intention” carry? Does the husband have a say in the decision?
3. Why does irreversibility require discussion of reversible alternatives?
4. Is postponement a protection of autonomy or paternalism? What follows from the Bulgarian rules?

Case 2 · Conscience and an expiring time limit

The case

A patient at the end of her 11th gestational week requests abortion on request. The physician says that for religious reasons he does not perform abortions, does not tell her where she can have it, and books a follow-up in two weeks so that she has “time to think”. Another specialist in the area accepts only with a referral. When the woman finds information on her own, the legal time limit has almost expired. The physician claims he broke no rule because he is not obliged to take part personally.

1. What is the difference between refusing personal participation and obstructing access?
2. What duties of information and continuity of care does Art. 32 of the Code leave in place?
3. Can “waiting” be a medical recommendation when it aims to change the decision?
4. How should the service be organised so that conscience is respected and the patient protected?

Part II

Assisted reproduction and family law

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Assisted reproduction in Bulgarian law

“Assisted reproduction” means diagnostic and therapeutic methods aimed at overcoming infertility, carried out in specialised centres.

— Health Act, supplementary provisions, § 1, item 21

Assisted reproduction shall be applied when the condition of the man or the woman does not allow their reproductive functions to be achieved naturally.

— Health Act, Art. 129

- **written informed consent** of the persons wishing to have offspring (Art. 130(1));
- medical tests safeguarding the health of the offspring (Art. 130(2));
- medical standard — **Ordinance No. N-2 of 12.07.2023** on assisted reproduction;
- authorisation, registers and supervision — **Executive Agency “Medical Supervision”** (Arts 131–132b);
- **fertility preservation** is allowed for medical and social reasons (Ordinance N-2, Annex 1, section IV, item 1.2).

Main methods and staged consent

Method	What is done	Ethical focus
Intrauterine insemination	prepared sperm placed in the uterus	indications, origin of gametes, stimulation
In vitro fertilisation (IVF)	fertilisation outside the body and embryo transfer	status of embryos, multiple pregnancy
ICSI	a single sperm injected into the egg	justification of the more invasive technique
Cryopreservation	freezing of gametes or embryos	storage period, separation, death, disposal
Preimplantation genetic testing (PGT)	analysis of embryo cells before transfer	prevention versus selection

Consent to IVF is not a blanket authorisation: every significant step — fertilisation, PGT, freezing, donation, transfer — needs its own informed decision.

Access and public funding

Assisted Reproduction Centre (Bulgaria)

- funds procedures on **medical indications**;
- applicant: a woman **under 43**, Bulgarian citizen or permanent resident;
- up to **four attempts**; second to fourth are not approved after the age of 43.

Three different limits

Medically appropriate ≠ **legally permissible** ≠ **publicly funded**. The Centre's age limit is a funding rule, not a ban on treatment.

Fair access requires transparent, medically justified and consistently applied criteria — and an honest conversation about the chance of success, whoever pays.

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Egg and sperm donors

Eggs

- adult, not under guardianship; **notarised** written consent; informed of the risks; a commission of **three physicians** outside the team (Health Act, Art. 130(5));
- anonymous or **related** donors — sister, cousin (Ordinance N-2, Art. 12);
- recommended age up to 38; from 38, PGT-A is mandatory (Art. 13);
- withdrawal possible **until fertilisation** (Art. 14); at most 5 donations, at least 4 months apart.

Sperm

- adult donor with informed consent;
- **180-day quarantine** and repeat tests for HIV, HBV, HCV, syphilis; fresh donor inseminations prohibited (Ordinance N-2, Annex 1, item 5.6);
- up to 20 insemination cycles per donor (item 5.7.1);
- a donor related to the woman in direct line or collateral line to the 4th degree is prohibited (Health Act, Art. 133).

Embryos as a gift; non-remuneration and anonymity

Embryo donation (Ordinance N-2, Annex 1, section VI)

- donors may be couples with **cryopreserved embryos** who meet donor requirements, with a notarised declaration (item 11.6);
- donated embryos are given **anonymously** — from one couple to only one couple or one recipient (item 11.7);
- donor embryos are not recommended for recipients over 51 (item 13.3).

Offering material benefit to a donor of eggs or sperm, and accepting material benefit by the donor, is prohibited.

— Health Act, Art. 130(7)

- only **reasonable expenses** may be reimbursed (Ordinance N-2, item 5.7.4);
- the identity of an anonymous donor and the data of recipients are **official secrets** for 30 years (Health Act, Art. 132(2); Ordinance N-2, Art. 13).

Anonymity or the right to know one's origins?

For anonymity: protecting the donor's privacy, easier donor recruitment, avoiding mistaken expectations of parenthood.

For the right to know: the medical relevance of genetic information, building identity, avoiding unwitting relationships between genetically related people.

Genetic testing

Relative matches in private databases make the promise of “permanent” anonymity uncertain in practice. This must be discussed honestly with donors and parents.

Country	End of anonymity
Sweden	1985
Netherlands	2004
United Kingdom	2005 — information at 18
Germany	2018 — donor register
France	2021/2022 — access at 18
Bulgaria	anonymity — 30-year official secret

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How many embryos? A ceiling, not a target

Woman's age	1st and 2nd cycle	3rd and later cycles
under 38	1 embryo	up to 2 embryos
38–41	up to 2 embryos	up to 3 embryos
over 41	up to 3 embryos	

Post-compaction embryos — Ordinance No. N-2/2023, Annex 1, section IV, item 5.5.

Multiple pregnancy

Preterm birth, low birth weight, maternal complications. Success means **a healthy child at minimal risk**, not just implantation.

Embryo reduction

A permissible medical intervention, but it raises moral questions close to abortion. The better ethics is **prevention** through a reasonable number of transferred embryos.

“Surplus” embryos: four possible fates

Freezing

The period is set in the informed consent — **recommended up to 5 years** (Ordinance N-2, Art. 24(5)).

Donation

To another couple or recipient, anonymously (Ordinance N-2, items 11.6–11.7).

Research

For scientific, educational and therapeutic purposes — with the written consent **of both** (Health Act, Art. 134(2)).

Destruction

On request; on expiry of the period; if unclaimed, 6 months after it (Ordinance N-2, Art. 71).

The moral status of the embryo is assessed differently — from full protection from fertilisation to potential life of significant but not equal value. The clinic does not impose a philosophical position but helps make **decisions about creating and storing** embryos consistent with the patients’ values — before fertilisation.

ECtHR, Parrillo v. Italy [GC], no. 46470/11, 27.08.2015: a ban on donating embryos to scientific research falls within the state’s margin of appreciation.

Separation: when the two want different things

ECtHR, *Evans v. the United Kingdom* [GC], no. 6339/05, 10.04.2007

After cancer treatment, the embryos were Ms Evans's last chance of a genetic child. Her former partner withdrew his consent. English law allowed withdrawal until implantation; the ECtHR found **no violation** of Arts 2, 8 and 14 — the embryos were destroyed.

- Embryos are created with **joint** consent; no transfer takes place after required consent has been withdrawn until the dispute is resolved.
- Prior consent must anticipate **separation, death, loss of capacity and expiry of the storage period**.
- The ethical conflict: the last chance of genetic motherhood versus the right not to become a parent against one's will.

Case 3 · The embryos after the separation

The case

A married couple created four embryos before the woman's cancer treatment. One was transferred without success, three were frozen. Two years later the couple separate. The woman no longer has a realistic chance of using her own eggs and asks for a transfer. The man withdraws his consent. The form contains a general consent to storage but does not say what happens on divorce, and the storage period is about to expire.

1. Which weighs more: the last chance of genetic motherhood or the refusal of genetic parenthood?
2. Can the original consent be read as an irrevocable promise?
3. What should the clinic do while the dispute is unresolved?
4. How could staged consent reduce such conflicts?

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If one partner dies and frozen embryos remain

Not allowed (Ordinance N-2, Annex 1, section IV)

- retrieving gametes from a **deceased** or **brain-dead** person (item 5.2);
- assisted reproduction with **frozen gametes** after the death of one partner (item 5.8);
- disposal by **third parties**, including the deceased's parents, or use with a new partner (item 5.10).

Transfer of a frozen embryo — only if all of the following (item 5.9):

1. a **written statement by the deceased man**, made during life in the informed consent;
2. the recipient is **the same partner**, expressly named in that document;
3. **no less than 12 and no more than 36 months** have passed since the death;
4. the woman has had **psychological counselling** and has been informed in writing of the consequences for parentage and inheritance.

Outside this situation the partner's death is a ground for destroying the embryos regardless of a wish declared during life (Ordinance N-2, Art. 71, items 6–7).

Posthumous conception: a child without a father and without inheritance

The mother's husband is deemed the father of a child born during the marriage or before the expiry of three hundred days from its termination.

— Family Code (Bulgaria), Art. 61(1)

- The minimum wait of **12 months** means the child is born after the 300-day period — **no legal parentage from the deceased**.
- Only a person alive or conceived when the succession opens inherits (Inheritance Act, Art. 2) — the child is **not an heir**.

Country	Posthumous use
Bulgaria	embryos only, under Ordinance N-2, item 5.9; no parentage and no inheritance
United Kingdom	allowed with written consent; the deceased may be registered as father (HFE Act 2008, ss. 39–40)
Spain	with consent, within 12 months of death, with parentage (Law 14/2006, Art. 9)
Germany, France	prohibited

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Who is the mother and who is the father

The mother — the woman who gave birth

The mother of the child is the woman who gave birth to it, including in assisted reproduction.

— Family Code, Art. 60(2)

Maternity of the birth mother **cannot be contested** merely because assisted reproduction or a donor egg was used (Art. 60(5)).

The father — the marital presumption

- the mother's husband is deemed the father of a child born during the marriage or within 300 days of its end (Art. 61(1)); this also applies to assisted reproduction (para 4);
- **paternity cannot be contested** if the husband gave written informed consent (Art. 62(6));
- outside marriage — **acknowledgement** (Art. 64); the donor **does not become** a parent.

Single women and female couples

Bulgaria

- the law requires a **medical basis** (Health Act, Art. 129) and the consent of “the persons wishing to have offspring” (Art. 130);
- a **single woman** may be treated with donor sperm; the Assisted Reproduction Centre funds “any woman” with indications;
- in a **female couple** only the birth mother is a legal parent (Family Code, Art. 60) — the second woman has no parental link.

European context

- France (bioethics law, 2021), Spain, Belgium, the Netherlands and the United Kingdom allow treatment of single women and female couples;
- **CJEU, C-490/20 “Pancharevo”** (2021): a child with two same-sex parents under another Member State’s act has the right to free movement;
- **ECtHR, Koilova and Babulkova v. Bulgaria** (2023): the state must provide legal recognition for same-sex couples.

“The interest of the child” is no ground for the team’s personal morality: criteria must be specific, medically relevant and applied without discrimination.

Surrogacy

Terms

- **traditional (partial)** — with the egg of the woman who carries the pregnancy;
- **gestational (full)** — an embryo without her genetic material;
- **altruistic** (expenses only) or **commercial** (paid).

Bulgaria — prohibited

Ordinance No. N-2/2023 prohibits “achieving surrogate pregnancies” (Annex 1, item 5.7.9); the mother is the birth mother (Family Code, Art. 60(2)) — a contract with “intended parents” **has no legal effect**.

Regime	Countries (examples)
Altruistic, regulated	United Kingdom (parenthood through a court “parental order”), Greece (prior court authorisation), Canada (unpaid only)
Commercial	Ukraine, some US states (e.g. California)
Prohibited	Bulgaria, Germany, France, Spain, Italy (since 2024 also when carried out abroad)

ECtHR, *Mennesson v. France*, no. 65192/11, 2014: the child’s right to identity requires recognition of parentage from the genetic father, even where surrogacy is banned.

Ethical questions in surrogacy

Exploitation

Poverty, dependence and pressure from relatives can turn a “voluntary” decision into a forced one. Payment risks turning the body and the child into commodities.

Autonomy of the pregnant woman

The woman carrying the pregnancy remains a **patient**. A clause obliging her in advance to undergo abortion, embryo reduction or caesarean section is **ethically unacceptable**.

The interest of the child

Where countries have different rules, the child may be left without recognised parents or citizenship. The right to identity and origins must be protected.

A clear legal framework protects all three parties — the woman, the intended parents and the child; its absence leaves the most vulnerable unprotected.

Case 4 · The family that does not fit the form

The case

A 30-year-old woman asks for treatment with donor sperm. She has lived with another woman for eight years and the two will raise the child together. The specialist says the child “needs a father” and the clinic does not want a “social experiment”. The form has fields only for “husband” and “wife”, but the clinic’s rules exclude no one expressly. The patient asks which medical or legal grounds require the refusal and how the donor’s identity will be protected.

1. Which criteria are medically relevant and which express a personal family ideal?
2. Can a vague appeal to “the interest of the child” justify different treatment?
3. What are the legal consequences for the child’s parentage, and how can they be explained without moral judgement?
4. How should donor anonymity and future disclosure to the child be discussed?

Summary

Part I

1. Contraception is an **informed choice**; emergency contraception is not abortion.
2. Abortion: on request up to 12 weeks, on medical grounds up to 20 weeks, thereafter only on serious grounds; the woman is not punished.
3. Conscience is a physician's right not to take part, **not a right to block** access.
4. In Bulgaria sterilisation is performed **only on medical grounds**; in most Western countries it is available to adults with consent and reflection.

Part II

1. Assisted reproduction requires a **medical basis, written and staged consent** and compliance with Ordinance N-2/2023.
2. Donation is **unpaid and anonymous**; embryos may be donated.
3. After a partner's death — embryos only, under strict conditions; **no parentage, no inheritance**.
4. The mother is the birth mother; the father — the husband by presumption; surrogacy in Bulgaria is **prohibited**.

Thank you for your attention!