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FAMILY PLANNING: LEGAL REGULATIONS AND PRACTICE IN SLOVENIA

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Abstract Family planning allows individuals to achieve their desired number of children, and to control the timing of their pregnancies. This can be accomplished through contraception, with reducing the need for abortion, and infertility treatments. Pregnancy and childbirth are related to maternal mortality, which can be reduced with the prevention of unintended pregnancies. Access to contraception and safe abortion is crucial. At the 1968 International Conference on Human Rights in Teheran, family planning was declared a basic human right. In 1974, Yugoslavia was the first country in the world declaring the constitutional right to freedom of choice in childbearing. The safety of artificial pregnancy termination has been greatly enhanced by the improvements of vacuum aspiration technique, developed by Slovenian doctors in 1964. In Slovenia, abortion rates are constantly decreasing since 1980 due to available contraception and established contraceptive service. The history of family planning in Slovenia and actual situation are presented.

Keywords
abortion,
human rights,
reproductive rights,
contraception,
infertility

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1 Introduction

Family planning allows individuals to achieve their desired number of children, and to control the timing of their pregnancies. This can be accomplished through contraceptive methods and infertility treatments. Providing access to information about contraception, and to contraceptive methods and services, is crucial for the health and human rights of everyone. Reducing unintended pregnancies and the need for abortion helps lower the incidence of maternal health problems and pregnancy-related deaths, e.g., maternal mortality. Family planning also offers health advantages by delaying pregnancies in young girls, who are at higher risk for health issues from early childbearing, and by preventing pregnancies in older women, who also face increased health risks (World Health Organization [WHO], 2019).

When considering the timing between births, children born within two years of an older sibling have a 60 percent higher risk of infant mortality, while those born within 2-3 years have a 10 percent higher risk compared with those born after a 3-year interval or longer. Contraception also provides various non-health benefits, such as greater educational opportunities and empowerment for women, as well as sustainable population growth and economic development for countries (WHO, 2023).

Over the last two decades, the number of women wanting to use family planning has significantly increased, rising from 900 million in 2000 to nearly 1.1 billion in 2021. During the period from 2000 to 2020, the number of women utilizing modern contraceptive methods grew from 663 million to 851 million. By 2030, an additional 70 million women are expected to adopt modern contraception (WHO, 2023).

1.1 Maternal Mortality

Key indicators of reproductive health include maternal mortality and morbidity. The World Health Organization (WHO) describes maternal mortality as "the death of a woman during pregnancy or within 42 days following the end of pregnancy, regardless of the duration or location of the pregnancy, from any cause linked to or worsened by the pregnancy or its management, excluding accidental causes. Maternal mortality is expressed as the number of maternal deaths per 100,000 live births." Maternal morbidity lacks a standard definition, but it is typically described as "the health complications of a pregnant woman, from any cause exacerbated by

pregnancy or its management, excluding accidental causes." Maternal mortality rates remain alarmingly high. In 2020, approximately 287,000 women lost their lives during or following pregnancy and childbirth. Nearly 95 percent of these deaths occurred in low and lower-middle income countries, and many could have been prevented (WHO, 2024a).

Complications arising from pregnancy and childbirth are the primary causes of maternal mortality. Most of these complications emerge during pregnancy and are largely preventable or treatable. Some conditions may pre-exist pregnancy but can be exacerbated during gestation if not properly managed as part of comprehensive maternal care. The leading causes of maternal deaths, constituting nearly 75 percent of cases, include severe bleeding (mainly postpartum haemorrhage), infections (typically post-childbirth), high blood pressure disorders such as pre-eclampsia and eclampsia, complications during delivery, and unsafe abortion practices (WHO, 2024a).

1.2 Safe Abortion

To reduce maternal mortality, it is imperative to prevent unintended pregnancies. Access to contraception and safe abortion services is crucial for all women, including adolescents. Furthermore, ensuring high-quality post-abortion care is essential to safeguarding maternal health (WHO, 2024b).

There are approximately 210 million pregnancies worldwide annually, with 4 out of 10 being unintended. Approximately 73 million induced abortions are performed globally each year. Six out of 10 unintended pregnancies (61 percent; or approximately 24 percent of all pregnancies) and three out of 10 pregnancies overall (about 29 percent) result in induced abortion. Abortion is an essential healthcare procedure that is safe when performed using methods recommended by the WHO, appropriate to the stage of pregnancy, and administered by skilled professionals. It is estimated that more than 21 million women undergo unsafe abortions each year, with 9 out of 10 of these occurring in developing countries (International Federation of Gynecology and Obstetrics [FIGO], n.d.; WHO, 2024b). However, about 45 percent of abortions are unsafe, posing a significant and preventable risk to maternal health. Unsafe abortion is a leading cause of maternal deaths and complications, contributing to physical and mental health issues, as well as placing social and financial burdens on women, communities, and health systems. The lack of

accessible, timely, affordable, and respectful abortion care represents a critical public health and human rights challenge (WHO, 2024b).

The increasing adoption of contraceptive methods globally has resulted in reduced maternal and infant mortality rates, improvements in socio-economic conditions, and increased educational opportunities for girls and women. In countries where less than 10 percent of women use contraception, the infant mortality rate is 100 per 1,000 live births. This rate is halved when contraceptive use increases by 30 percent It has been projected that contraceptive use has nearly halved maternal mortality rates (FIGO, n.d.).

In Slovenia, abortion is permitted upon a request up to 10 gestational weeks, and after 10th week with the approval of commission. In 2022, there were 5,229 foetal deaths recorded in Slovenia, which equates to 12.4 cases of foetal deaths per 1,000 women of reproductive age. Of these, 57 percent were legal abortions, others foetal deaths were miscarriages, pathological and extrauterine pregnancies. The rate of legal abortions has decreased from 18.8 per 1,000 women in 1997 to 7.1 per 1,000 women in 2022 (Nacionalni inštitut za javno zdravje [NIJZ], n.d.-a).

The professional requirements in our country include written consent by the woman, pre-abortion consultation, pre-abortion laboratory tests (e.g. RhD status), pre-abortion gynaecological and ultrasound examination, post-abortion consultation and gynaecological examination, along with counselling on contraception (Abort Report, 2024).

Abortion methods practiced in Slovenia include medical and surgical procedures, both available in every hospital. For medical abortion, mifepristone and misoprostol are used. The majority of Slovenian hospitals allow medical abortion to be performed at home up to nine weeks and 0 days of gestation. Surgical abortion methods include vacuum aspiration or exceptionally dilation and curettage (hereinafter: D&C). Most abortions in Slovenia in 2022 were medical abortions, accounting for 84 percent, while surgical abortions made up only 16 percent of cases (Abort Report, 2024).

2 Historical View on Family Planning

2.1 Planning is a Basic Human Right

Throughout human history, the task of planning, avoiding, or postponing pregnancy had traditionally been a private burden borne by women and girls. However, at the 1968 International Conference on Human Rights, held in Teheran, family planning was established as a human rights imperative for all countries, governments, and policymakers. The conference's resulting document, known as the Teheran Proclamation, clearly affirmed: "*Parents have a fundamental human right to freely and responsibly determine the number and timing of their children.*" (United nations population fund [UNFPA], 2018).

2.2 Yugoslavia and Family Planning

In our region, prof. Pavel Lunaček, a member of the Federal Assembly of the Federal People's Republic of Yugoslavia, fought to liberalize attitudes towards abortion by proposing a new Penal Code in 1951. This code stipulated that only the individual performing the abortion would face punishment, while the woman undergoing or consenting to the illegal procedure would not be penalized (Lukanović, 2019).

Due to demographic pressures, the Yugoslav Congress of Gynaecologists and Obstetricians in 1953 initially prohibited abortion, citing it as a socially harmful phenomenon. However, by 1960, the Decree on the Conditions and Procedure for the Authorization of Abortion was enacted, permitting abortion in Slovenia on social grounds. In 1961, the Health Council of the Socialist Republic of Slovenia established a specialized unit within the Clinical Hospital for Obstetrics and Gynaecology, overseen by prof. Lidija Andolšek-Jeras. Renamed the Family Planning Institute in 1967 under the leadership of prof. Andolšek-Jeras, this institution aimed to protect women's reproductive health in Slovenia (Lukanović, 2019).

Prof. Andolšek-Jeras was instrumental in the adoption of the Resolution on Family Planning at the Federal Assembly of the Federal People's Republic of Yugoslavia in April 1969. That same year, the General Act on Pregnancy Termination was passed, outlining the conditions under which pregnancy could be artificially terminated. According to the Act, abortion was permissible if there was scientific belief that

severe physical or mental defects could occur due to parental illness. The Act also allowed termination upon the pregnant woman's request if she faced challenging personal, familial, financial, or other circumstances during pregnancy or after childbirth (Lukanović, 2019).

The constitutional right to freedom of choice in childbearing was established through the amendment of Article 191 in the Constitution of the Socialist Federal Republic of Yugoslavia in 1974. The Article 191 stated: *"It is a human right to freely decide on family planning. This right may only be restricted for reasons of health."* Article 233 in the constitution of the Socialist Republic of Slovenia from 1974 stated that society ensures the necessary education, appropriate social protection, and healthcare assistance in relation to the exercise of this right (Đurović, 1974; IUS-INFO, n.d.; Lukanović, 2019).

After three years of deliberation, the Health Measures in Exercising Freedom of Choice in Childbearing Act was finally adopted on April 26, 1977 (Lukanović, 2019).

2.3 Development of contraceptive methods in Slovenia

The beginning of contraception in Slovenia can be traced back to 1955 when, at the initiative of prof. Franc Novak, the then Council for Health and Social Policy of the LRS discussed the introduction of modern contraception and concurrently proposed the development of domestic contraceptives. Based on the knowledge and possibilities of the time, the most suitable methods to prevent unwanted pregnancies were diaphragms with protective creams and/or condoms. Consequently, the Sava factory in Kranj started producing diaphragms (Genofragma), while the pharmaceutical factory Lek produced contraceptive paste (Genosan). Gradually, a network of specialized clinics and counselling centres for contraception was established throughout the country – the first contraception clinic within the entire Yugoslavia was opened at the Central Gynaecological Dispensary in Ljubljana on December 1, 1955, under the leadership of gynaecologist Bogdan Tekavčič. In 1957, a contraception clinic was also established at the Gynaecological Clinic in Ljubljana. Similarly, two clinics started operating in Maribor in January 1957. By the end of 1958, there were already 41 KC clinics in Slovenia. This development can also be attributed to the resolution adopted at the 3rd Congress of Yugoslav Gynaecologists held in Ljubljana in 1956, which stated that principles for managing conception

through contraception should be adopted to protect women from unwanted pregnancies and abortions (Borko, 2012).

In April 1961, the Council for Health of the SR Slovenia established the Scientific Research Department for Abortion and Contraception Issues as a special unit of the Gynaecological Clinic, organized and led by prof. Andolšek-Jeras, tasked with guiding the development of contraception in Slovenia. Contraceptive clinics and 14 medical commissions, including a social worker to address unfavourable social conditions and provide advice on contraceptive use, were responsible for the introduction and expansion. In counselling, they primarily used the booklet "Conception by Our Will or Contraception" by prof. Franc Novak, first published in 1957 and again in 1959 (Borko, 2012).

To educate women on the benefits of contraception over abortion, systematic examinations including cytological smears and colposcopy, along with contraception lectures, were used in some places such as Maribor. They emphasized the advantages of contraception during counselling sessions. Despite these efforts, the number of induced abortions increased after 1960, prompting Maribor and other gynaecological departments to prepare specific written instructions on contraception in 1962 for women who had undergone abortions. In 1960, prof. Novak published the first Slovenian textbook "Gynaecology," with a chapter on "Contraception" written by Bogdan Tekavčič. This chapter described the procedures in the contraception clinic and biannual check-ups, as long as the diaphragm remained undamaged. Besides the diaphragm as the preferred contraceptive, doctors also recommended local chemical contraceptives (spermicides), although these often ran out on pharmacy shelves (Borko, 2012).

During this period, the Laboratory of the Abortion Prevention Department at the Gynaecological Clinic in Ljubljana evaluated the spermicidal effectiveness of various contraceptives available, including Genosan gel and Patentex gel. One of the well-known contraceptives was the EMKO foam donated to our country by the American Red Cross. Prescribing local chemical contraceptives was similar to prescribing other medications. This period concluded with prof. Novak's booklet "Motherhood to be Conscious" in 1964, describing social changes worldwide and in Slovenia, and including a new chapter on oral contraception (Borko, 2012).

The era of hormonal contraception began with the first professional contribution by prof. Andolšek-Jeras and Hren, published in 1964 in issues 1 and 2 of "Yugoslav Gynaecology and Obstetrics," reporting on a 12-month trial of Anovlar, Lyndiol, Norlutate, and Provera. This enabled the prescription of new hormonal pills starting in 1966, initially in Maribor and subsequently throughout Slovenia, beginning with Anovlar and Lyndiol, followed by Euginon and Stediril, and later Anacyclin 101, all of which contained high-dose active ingredients, with initial instructions to take a two to three-month break after nine months of use (Borko, 2012).

Almost simultaneously, intrauterine contraception began to gain acceptance. The first intrauterine device was inserted in Slovenia on September 1, 1964, at the Abortion Prevention Department of the Gynaecological Clinic, expanding across Slovenia after 1966. The number of users of modern hormonal and intrauterine contraception increased, leading to a decline in induced abortions (Borko, 2012).

In 1967, the Department for prevention of abortion [*slov.* Oddelek za prevencijo splava] was renamed into the Institute for family planning [*slov.* Inštitut za načrtovanje družine] (IND). The independence of the IND accelerated and expanded research in the broader field of human reproduction. Prof. Andolšek-Jeras also involved other centres in Slovenia in these efforts, including Koper, Celje, and Maribor. One of the first signs of this collaboration was the booklet "How to Protect Ourselves from Pregnancy [*slov.* Kako se zavarujemo pred nosečnostjo]", authored by prof. Andolšek-Jeras and prof. Borko. This booklet was distributed to women who had undergone abortion and was intended to promote the use of contraception. This motivational approach to contraception proved effective, as it began to reduce the number of abortions (Borko, 2012).

The advancement of medicine in all aspects of family planning necessitated new materials suitable for contraception counselling. Thus, in 2002, we received the booklet "Family planning [*slov.* Načrtujmo družino]", describing all significant changes essential to explaining and advising a broader circle of users. Even more important were the advisory project for biology teachers, and the brochure for high school students prepared by prof. Bojana Pinter and colleagues in 2004, "About you two: safe choice for responsible pregnancy [*slov.* O vama: varna izbira za odgovorno spolnost]", a well-illustrated and highly didactic publication for teachers and a brochure distributed annually to high school students (Borko, 2012).

2.4 Improvement of Vacuum Aspiration Technique

The safety of artificial pregnancy termination has been greatly enhanced by the introduction of vacuum aspiration. Slovenian doctors are largely credited with expanding this safer method of early pregnancy termination worldwide.

The technique of vacuum aspiration originated in Russia in twenties of previous century. Russian researchers reported that compared to traditional abortion methods (using forceps or curettage), this new method was faster, less painful, and associated with less blood loss. The concept of this new abortion method was brought to Ljubljana in 1963 by Prof. Franc Novak, as it was not accessible outside the Soviet Union. In 1964, based on Russian texts and under the mentorship of Prof. Draško Vilfan, Slovenia constructed its own vacuum aspiration device (Tomaževič, 2004).

The Institute of Electronics and Vacuum Technology developed and began serial production of a new type of vacuum aspirator, eliminating the major risk associated with the new method – the danger of air embolism. Within a few years, all Slovenian gynaecologists became familiar with this new abortion technique. By the late 1960s, vacuum aspiration completely replaced dilation and curettage (hereinafter: D&C) for pregnancies up to 12 weeks (Tomaževič, 2004).

In the late 1960s, Slovenian doctors shared their positive experiences with this new, safer technique with the Western world. In 1968, Prof. Franc Novak personally educated American doctors on the technique and advantages of vacuum pregnancy termination. His presentation and a film highlighting the simplicity and safety of vacuum aspiration over D&C were enthusiastically received by American doctors. This paved the way for vacuum aspiration technology to spread to the Western world. By the early 1970s, safe abortion technology was adopted worldwide and further simplified. The film, which prof. Novak had created in 1964 in collaboration with prof. Draško Vilfan and Vlastja Simončič, later went missing at a congress; prof. Novak subsequently saw it being presented under a foreign title at another congress (Tomaževič, 2004).

Many authors emphasized the advantages of vacuum aspiration over dilation and curettage, but until 1973, there was no prospective analysis comparing the two methods in literature. Such an analysis, conducted in collaboration with American and Yugoslav experts, was published in 1973 by prof. Novak and prof. Andolšek-

Jeras, and their colleagues. This study conclusively confirmed the scientific benefits of the new method: greater simplicity, higher safety, reduced blood loss, fewer inflammatory complications, and shorter hospital stays (Tomaževič, 2004).

2.5 History of "In-vitro Fertilization" in Slovenia

In Ljubljana, a group of experts conducted their first extracorporeal fertilization on May 25, 1983. By October 5, 1984, after four developmental periods, they reported the birth of the first twins conceived using this new method, making them the second centre in the former Yugoslavia to successfully introduce "in vitro fertilization" (hereinafter: IVF). Meanwhile, at the Gynaecological Department of Maribor General Hospital, the first embryo transfer was performed on December 24, 1983, but it did not result in pregnancy. Due to significant challenges with facilities, equipment, and experience, the Maribor group of experts reported the birth of IVF-conceived twins only in 1989, thereby becoming the third centre in the former Yugoslavia to achieve this (Borko, Radovan, & Vlaisavljević, 2011).

By 1990, both centres had gained recognition in the broader European expertise arena and had agreed to establish a unified national registry for children born using the new method (Borko, Radovan, & Vlaisavljević, 2011).

3 Family Planning in Slovenia

3.1 Fertility and Abortion Rates

The general fertility rate is the ratio between the number of live births in a calendar year and the number of women of childbearing age (15–49 years) in the middle of the same year, multiplied by 1,000 (NIJZ, n.d.-b). The highest fertility rate is characteristic of women aged 25 to 34 years. In 2022, women from the mentioned age groups gave birth to two-thirds of all children (NIJZ, n.d.-c). The permitted abortion rate per 1,000 women of childbearing age is the ratio between the number of permitted abortions and the number of women of childbearing age (15–49 years) in the middle of the same year, multiplied by 1,000 (NIJZ, n.d.-d). The abortion rates in Slovenia are decreasing since 1980 and fertility rates are stable in the last two decades (Figure 1).

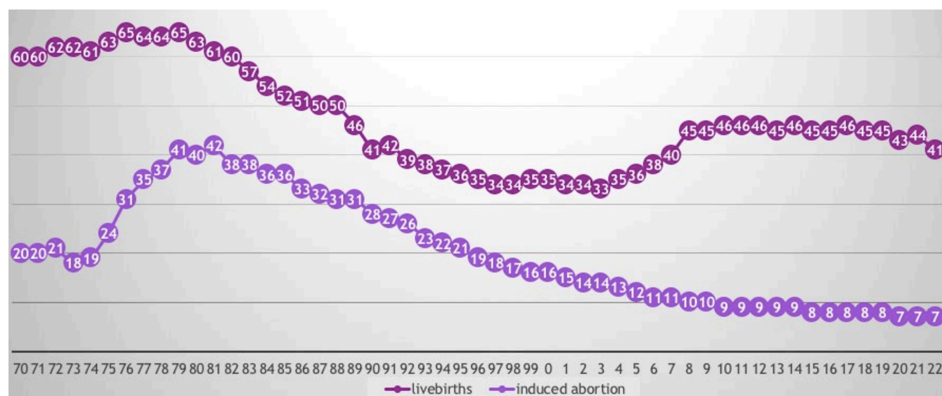

Figure 1: Fertility and abortion rates per 1000 women aged 15 to 49 between 1970 and 2022 in Slovenia.

Source: National Institute of Public Health (NIJZ, n.d.-a; NIJZ, n.d.-c)

3.2 Law on Family Planning

In the Republic of Slovenia, there are two laws directly regulating the implementation of the constitutionally guaranteed freedom to decide on childbirth:

1. Zakon o zdravstvenih ukrepih pri uresničevanju pravice do svobodnega odločanja o rojstvih otrok (en. Act on health measures in the exercise of the right to decide freely on the birth of children; hereinafter: ZZUUP), enacted in 1977, which roughly translates to the "Law on Health Measures in Exercising Freedom of Choice in Childbearing". This law focuses on ensuring health measures and procedures related to exercising the right to freely decide on childbirth.
2. Zakon o zdravljenju neplodnosti in postopkih oploditve z biomedicinsko pomočjo (en. Act on Infertility Treatment and Assisted Reproductive Techniques; hereinafter: ZZNPOB) was enacted in 2000. This law specifically addresses treatments for infertility and procedures involving biomedical assistance in reproduction, ensuring regulation and standards in assisted reproduction technologies.

These laws collectively safeguard and regulate various aspects of reproductive health and rights, ensuring that individuals have the freedom to make informed decisions about childbirth in accordance with Slovenian constitutional principles (Borko, 2012; ZZUPP; ZZNPOB).

3.2.1 Health Measures in Exercising Freedom of Choice in Childbearing Act (ZZUUP, 1977)

According to the ZZUUP, individuals possess the right to freely decide on childbearing. It is imperative that both women and men have access to all available means within the healthcare system to facilitate the exercise of this right. This statute delineates the healthcare measures necessary for the realisation of this right and specifies the limitations imposed by medical considerations.

The right to freely decide on childbearing encompasses the right to education, counselling, and comprehensive information regarding the procedures, processes, and consequences of employing modern methods and means for birth regulation. Healthcare organizations, as well as healthcare, social, and other professional personnel involved in the execution of this right, are obligated to undertake all necessary measures to ensure that women and men can exercise this right (for more see ZZUUP, 1977).

The healthcare measures prescribed by this law for birth regulation include contraception, artificial termination of pregnancy, and the diagnosis and treatment of reduced fertility. Professionals in healthcare, social services, and other relevant fields are mandated to uphold professional confidentiality throughout these procedures. Additionally, any healthcare organization that conducts sterilization, artificial termination of pregnancy, completes an initiated termination of pregnancy, or performs artificial insemination must report the procedure to the health statistics authority within thirty days (ZZUUP, 1977).

According to the ZZUUP, artificial pregnancy termination is now recognized as the individual right of the woman rather than the right of the (married) couple. The decision considers medical circumstances, criminal legislation, and social factors related to pregnancy termination. The ZZUUP dedicates 13 articles (Articles 17 to 30) specifically to artificial pregnancy termination. According to Article 17, termination can be performed at the request of a pregnant woman who is less than ten weeks pregnant. Artificial termination of pregnancy that exceeds ten weeks can be performed at the request of the pregnant woman only if the risk to her life, health, and future maternity is less than the risk posed by continuing the pregnancy and childbirth. The procedure for artificial termination of pregnancy after the tenth week of pregnancy is overseen and decided upon by first and second-stage commissions

for artificial termination of pregnancy. Slovenia has 14 first-stage commissions established under Article 21 of the ZZUUP, each serving specific municipalities or areas, depending on healthcare organization coverage. The composition of these commissions is approved by municipal administrative bodies and consists of a social worker and two doctors. One of the doctors must be a specialist in gynaecology and obstetrics, and this specialist also serves as the chair of the commission. There is one second-stage commission established in Slovenia, approved by the Ministry of Health. The second-stage commission is composed of a social worker and three physicians specialising in relevant fields, with the commission's chair being a specialist in obstetrics and gynaecology. Members of the First and Second Stage Commissions have deputies (ZZUUP, 1977).

Article 55 of the Constitution of the Republic of Slovenia upholds freedom of choice in childbearing. This constitutional provision guarantees individuals the right to decide on parenthood while ensuring state support for this freedom and the conditions necessary for informed decision-making (Lukanović, 2019; ZZUUP, 2000). Under the constitution, the decision to bear children is recognized as a fundamental human right and liberty. This freedom grants everyone the right to contraception, the right to terminate a pregnancy, and the right to diagnose and treat infertility. The state is obligated to create conditions that facilitate the exercise of these rights. Accordingly, every individual has the opportunity to consult with an appropriate specialist for pregnancy prevention, termination, and infertility treatment within the comprehensive network of healthcare centres and hospitals in Slovenia. The right to freely decide on childbearing can thus be divided into positive and negative freedoms. Negative freedom pertains to the limitation of births, while positive freedom facilitates childbirth. In both cases, the matter concerns progeny and the act of childbearing, which is always a matter of free choice by two individuals – a man and a woman (ZZUUP, 1977).

3.2.2 Law on the Treatment of Infertility and Procedures of Biomedical Assistance in Reproduction (ZZNPOB, 1977)

This law regulates healthcare measures aimed at assisting women and men in conceiving a child, thereby enabling them to exercise their freedom to decide on the births of their children. Everyone has the right to infertility treatment under the terms and conditions specified by this law. Treatment under this law includes

identifying the causes of infertility or reduced fertility and addressing these causes through expert counselling, medication, or surgical procedures (ZZNPOB, 2000).

Treatment also encompasses the retrieval and storage of a man's semen or a woman's oocytes, when there is a risk, based on medical science findings and experience, of them becoming infertile (ZZNPOB, 2000).

Assisted Reproductive Techniques (ART) are procedures involving the use of biomedical science to achieve pregnancy through methods other than sexual intercourse. The ART procedures specified by this law include intrauterine insemination procedures and in vitro fertilization procedures (ZZNPOB, 2000).

3.3 Abortion – Minors

The ZZUUP and the Law Enforcement Guidelines establish that both women and men have the right to receive advice on pregnancy prevention methods, and their doctors must recommend or prescribe the most appropriate contraceptive measures regardless of age. Additionally, a woman has the right to request an abortion if she is within the first 10 weeks of pregnancy and meets the decision-making capacity criteria, irrespective of her age (Lukanović, 2019; ZZUUP, 1977).

Under the Patients’ Rights Act (sl. Zakon o pacientovih pravicah; hereinafter: ZPacP), adolescents deemed capable of decision-making are not restricted in their rights. According to Article 35 of the ZPacP (2008), a child under 15 is generally considered unable to give consent unless the physician assesses their maturity as sufficient to do so, in which case consultation with parents or guardians is customary. A child aged 15 or older is presumed capable of giving consent unless the physician determines otherwise due to immaturity, while consultation with parents or guardians remains standard. Parental consent is required for surgical procedures or medical interventions carrying higher risks or significant consequences for the child. Article 45 of the ZPacP (2008) also ensures the confidentiality of health professionals regarding patient information (Lukanović, 2019).

However, these regulations under the ZPacP (2008) do not apply to decisions regarding childbirth, as constitutional rights regarding pregnancy prevention or termination are governed by the special law of the ZZUUP (1977). This special law

takes precedence over the more general ZPacP in such matters, establishing specific guidelines for decision-making (Lukanović, 2019).

Therefore, a minor with decision-making capacity can independently decide on contraception or abortion without parental involvement, as required by this legal framework. This legal framework acknowledges the personal nature of decisions concerning reproductive health, which are considered significant medical interventions affecting one's body and personal experiences. The constitutional right to decide on childbearing is inherently individual, and the minor, if capable of making informed decisions, independently of age, should exercise this right autonomously (Lukanović, 2019).

The latest comparable data for 2022 shows that Slovenia has one of the lowest pregnancy rates in adolescents in the European Union (Figure 2) (Sedgh et al., 2015).

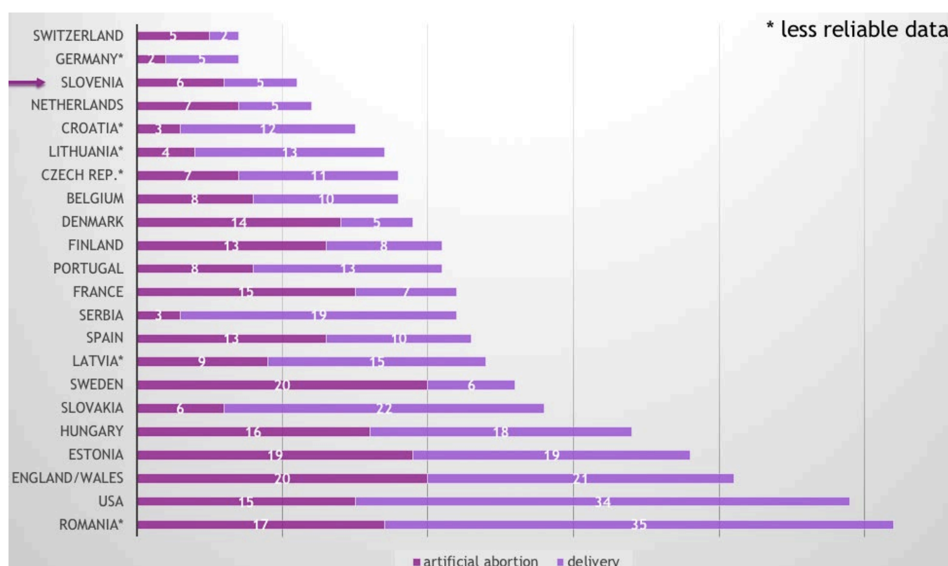

Figure 2: Adolescent pregnancies
(abortions and deliveries per 1000 women, aged 15 to 19, in 2011)
Source: (Sedgh et al., 2015)

3.4 Contraceptive Use and Sterilization

3.4.1 Contraceptive Use

In Slovenia, the utilization of hormonal contraception (hereinafter: HC) increased markedly at the end of the 20th century and the beginning of the 21st century, making it the predominant method of pregnancy prevention among women of reproductive age. However, there has been a notable decline in its use over the past decade. The prevalence of HC users, calculated based on the number of HC packs issued per 1,000 women of reproductive age (15–49 years), was 110 in 1992, increased to 182 in 2008, and decreased to 113 in 2021. From 2011 to 2021, the overall number of HC users decreased by one-third. This decline was observed across all age groups except those aged 45 to 49 years. The highest prevalence of HC use is among women aged 20 to 24 years, with one in three women in this age group using HC in 2011, compared to slightly less than one in four in 2021. Among adolescent girls (15 to 19 years), nearly one in five used hormonal contraception in 2011, whereas only one in eight did so in 2021 (NIJZ, 2024a).

In 2021, most HC users (88.7 percent) were using contraceptive pills, followed by 10.1 percent using the vaginal delivery system, and 1.2 percent using the patch. Since 2014, there has been a gradual increase in the proportion of women using the vaginal delivery system and the patch, while the proportion using contraceptive pills has slightly declined (NIJZ, 2024a).

The number of intrauterine device (hereinafter: IUD) insertions, including both initial and repeat insertions, has gradually increased over the past 20 years, rising by more than 40 percent from 2006 to 2015. From 2016 to 2020, the number remained relatively stable, with a slight decline observed in 2020 (15.7 insertions per 1,000 women of reproductive age), likely attributable to the COVID-19 pandemic. In 2021, the number of IUD insertions increased slightly to 16.9 insertions per 1,000 women of reproductive age, although it remained lower than in 2019 (18.3 insertions per 1,000 women of reproductive age). The use of IUDs as a method of contraception is generally more prevalent among women aged 30 to 49 (NIJZ, 2024a).

3.4.2 Sterilization

Sterilization is a procedure that permanently resolves the issue of contraception and is considered one of the most reliable methods of preventing pregnancy. It is more commonly chosen by women, although the sterilization procedure for men (called a vasectomy) is simpler and easier. Sterilization in women generally requires general anaesthesia and hospitalization for approximately two days, while a vasectomy is typically performed on an outpatient basis with local anaesthesia. The legal framework governing these procedures is provided by the ZZUUP (1977) (NIJZ, n.d.-d).

The legal requirements for both procedures are the same. The statutory age limit is 35 years, except in exceptional health cases. Only a competent individual for whom the procedure is intended may request it, and approval must be granted by a first or second-stage commission for artificial pregnancy termination and sterilization. Typically, the procedure can be performed only six months after approval (NIJZ, n.d.-d).

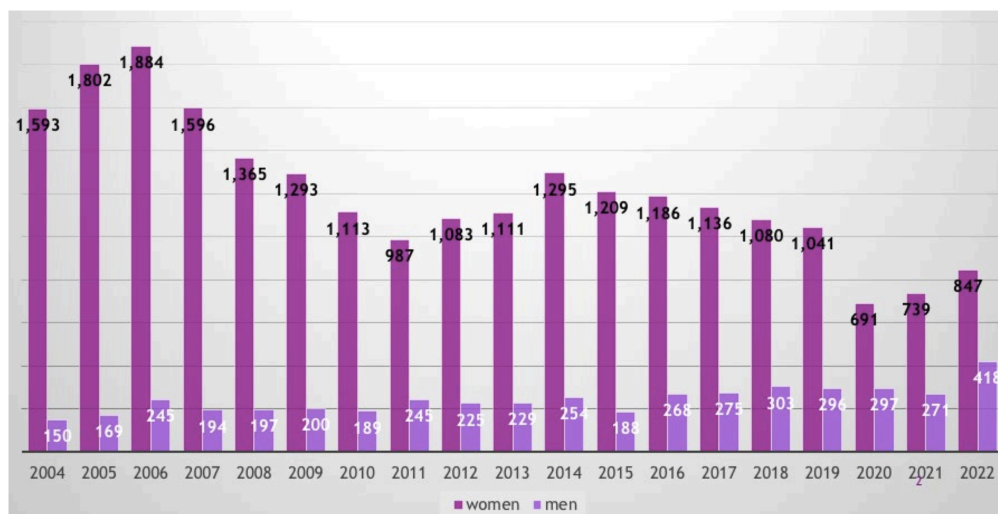

Figure 3: Sterilizations in women and men (number of procedures) in years 2004 to 2022, Slovenia

Source: (NIJZ, n.d.-d)

In 2022, there were 1,265 sterilizations performed, with a higher number of procedures being carried out on women. The annual sterilization rate is 2.0 per 1,000 women aged 15-49, compared to 0.9 per 1,000 men in the same age group (Figure 3) (NIJZ, n.d.-d).

The numbers of sterilization of women are decreasing due to more popular long-term contraception, but the numbers of sterilization of men are slowly increasing.

3.5 Conscientious Objection

The fundamental conflict revolves around the tension between the right to freely control one's body and the right to life. Conscientious objection is, according to the Article 46 of the Constitution of the Republic of Slovenia, a universal human right. Physicians have the right to conscientiously object, except in the case of a medical emergency. On the other hand, the Article 55 URS provides freedom of choice regarding childbearing (The Human Rights Ombudsman of the Republic of Slovenia, n.d.). According to the register of active doctors at the Medical Chamber of Slovenia, as of May 8, 2023, there were eight doctors in the field of gynaecology and obstetrics who had registered a conscientious objection (Lukanović, 2023). It would account for around one percent of active gynaecologists.

Considering the right to abortion, availability of safe abortion is one of the key factors in reproductive healthcare and reproductive rights, in addition to contraception in infertility treatments. Performing abortions, prescribing contraception and the like are among the duties of gynaecologists - anyone who cannot do this for reasons of conscience should be fair enough to choose another specialization.

4 Conclusions

In summary, Slovenia has made significant advancements in family planning, transitioning from traditional methods to a comprehensive system that maintains reproductive rights and provides access to healthcare services. The nation's dedication to reproductive health is reflected in its legislative framework, which guarantees access to contraception, safe abortion services, and infertility treatments. As a former part of Yugoslavia, Slovenia was a pioneer in reproductive rights, being among the first countries to constitutionally affirm the right to make informed

decisions about childbirth. This legal groundwork has enabled the formulation of healthcare policies that prioritize the health of women, mothers and children.

Since the 1980s, in Slovenia abortion rates are declining, because of accessible contraceptive methods, services, and education. The legalization and regulation of abortion, coupled with high medical standards, have ensured that abortion is safe. Slovenian healthcare policies place a strong emphasis on education and counselling as vital elements of family planning. Professional counselling services have been instrumental in providing individuals with information about reproductive health choices. The country's low rates of adolescent pregnancies further demonstrate the success of these initiatives. Additionally, infertility treatments are widely accessible, reinforcing Slovenia's commitment to comprehensive reproductive healthcare.

However, challenges remain. While conscientious objection is legally recognized, it should not impede individuals' rights to essential medical care, e.g. safe abortion. It is vital to enhance policies that guarantee timely access to abortion services for all women. Moreover, despite the widespread use of modern contraception, recent declines in the use of hormonal contraceptives emphasize the necessity for ongoing education and the availability of a variety of contraceptive methods. Ensuring that all methods remain affordable and accessible is essential.

Note

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Povzetek v slovenskem jeziku

Načrtovanje družine omogoča posameznikom, da dosežejo želeno število otrok in razmike med nosečnostmi. To je mogoče doseči s kontracepcijo, z zmanjšanjem potrebe po nevarnem splavu in zdravljenjem neplodnosti. Nosečnost in porod sta povezana z umrljivostjo mater, ki jo je mogoče zmanjšati s preprečevanjem nenačrtovane nosečnosti. Dostop do kontracepcije in varnega splava je ključnega pomena. Na mednarodni konferenci o človekovih pravicah v Teheranu leta 1968 je bilo načrtovanje družine razglašeno za temeljno človekovo pravico. Leta 1974 je Jugoslavija kot prva država na svetu razglasila ustavno pravico do svobodne izbire o rojstvu otrok. Varnost umetne prekinitve nosečnosti so močno povečale izboljšave tehnike vakuumske aspiracije, ki so jo slovenski zdravniki razvili leta 1964. V Sloveniji se od leta 1980 število dovoljenih splavov zaradi razpoložljive kontracepcije in dobrega kontracepcijskega svetovanja nenehno zmanjšuje. Predstavljena je zgodovina načrtovanja družine v Sloveniji in dejansko stanje.