Text consolidated by Valsts valodas centrs (State Language Centre) with amending laws of:

29 January 2004 [shall come into force on 25 February 2004];

22 September 2005 [shall come into force on 26 October 2005];

29 March 2007 [shall come into force on 1 May 2007];

21 June 2018 [shall come into force on 18 July 2018].

If a whole or part of a section has been amended, the date of the amending law appears in square brackets at the end of the section. If a whole section, paragraph or clause has been deleted, the date of the deletion appears in square brackets beside the deleted section, paragraph or clause.

The *Saeima*1 has adopted and

the President has proclaimed the following law:

**Sexual and Reproductive Health Law**

**Chapter I**

**General Provisions**

**Section 1. Purpose of the Law**

The purpose of this Law is to define legal relations within the field of sexual and reproductive health with the aim to protect unborn life and the sexual and reproductive health of every person.

**Section 2. Sexual and Reproductive Health**

Sexual and reproductive health is the physical, mental, and social wellbeing related to the human sexual and reproductive system.

**Section 3. Sexual and Reproductive Health Care**

Sexual and reproductive health care is a set of measures for birth assistance, the prevention, diagnosis, treatment, and observation of sexually transmitted diseases, human immunodeficiency virus (HIV) infection, AIDS, diseases of reproductive organs and infertility, and for birth control, pregnancy termination, and medically assisted insemination performed by a medical practitioner.

[*22 September 2005*]

**Section 4. Principles of Sexual and Reproductive Health Care**

(1) The priority of sexual and reproductive health care is birth assistance and also the provision of information on sexual and reproductive health.

(2) The State shall implement the principles of sexual and reproductive health care by providing free-of-charge birth assistance and the possibility to obtain basic knowledge on sexual and reproductive health promotion and care at medical treatment and educational institutions.

[*22 September 2005*]

**Section 5. Competence of State and Local Governments in the Field of Sexual and Reproductive Health**

(1) [22 September 2005]

(2) The Cabinet shall determine the organisational procedures for pregnancy termination, medically assisted insemination, restriction of the spread of human immunodeficiency virus (HIV) and AIDS, and the treatment of persons living with HIV and AIDS patients.

(3) Procedures for the establishment of infertile families registers, medically assisted insemination registers, and a joint gamete donor register, and also for the establishment of gamete donor banks shall be determined by the Cabinet.

(4) The local government shall provide pregnant and postnatal women in a crisis situation with social care and social rehabilitation services.

(5) The State shall ensure the possibility for a pregnant woman who wishes to artificially terminate the pregnancy to receive a consultation of a general practitioner or another specialist (a psychotherapist, gynaecologist or another medical practitioner) trained to provide such a consultation. The content of this training program and the procedures for providing the training shall be determined by the Cabinet.

(6) The procedures for obtaining, processing, storing, distributing (also exporting and importing) gametes and for traceability of gametes, and also quality and security requirements shall be determined by the Cabinet.

[*29 January 2004; 22 September 2005; 21 June 2018 /* *The amendment to Paragraph three regarding the replacement of the words “gamete donor registers” with the words “joint gamete donor register” and Paragraph five shall come into force on 1 July 2019.* *See Paragraphs 1 and 2 of the Transitional Provisions*]

**Section 6. Person’s Rights and Obligations in the Field of Sexual and Reproductive Health**

(1) A person has the right to obtain information from a medical practitioner on the basic principles of sexual and reproductive health promotion and care, birth planning, and contraception.

(2) The obligation of a person in the field of sexual and reproductive health care is to obtain a basic knowledge of sexual and reproductive health promotion and care, to take care of his or her own sexual and reproductive health and that of his or her family, to plan for a birth, undergo health observation prior to the conception of a child, avoid the termination of a pregnancy, and choose birth control means not detrimental to one’s reproductive health.

(3) A person infected with a sexually transmitted disease has the obligation to inform his or her sexual partner of the risk of infection.

**Section 7. Financing of Sexual and Reproductive Health Promotion and Care**

Expenses resulting from sexual and reproductive health promotion and care services shall be covered from the State budget and the resources of legal and natural persons in accordance with the procedures specified in laws and regulations.

**Chapter II**

**Organisation of Birth Assistance**

[*22 September 2005*]

**Section 8. Birth Assistance**

Birth assistance is a set of measures for the promotion of family reproductive health, female health promotion, and health care within the period of pregnancy, birth, and the postnatal period (42 calendar days following birth), and also for clinical monitoring, examination, health promotion, and treatment measures for an unborn child prior to and during birth, and also infant care during the postnatal period.

[*22 September 2005*]

**Section 9. Provision of Birth Assistance**

(1) Birth assistance shall be provided by a relevant medical practitioner within their competence and in conformity with the by-law of a speciality.

(2) Birth assistance during birth shall be provided by a gynaecologist (childbirth specialist), a midwife.

(3) The procedures for providing birth assistance shall be determined by the Cabinet.

[*29 January 2004; 22 September 2005*]

**Chapter III**

**Sexually Transmitted Diseases**

**Section 10. Prevention, Diagnosis, Treatment, and Monitoring of Sexually Transmitted Diseases**

(1) Prevention measures, diagnosis, treatment and monitoring of patients with sexually transmitted diseases [with the exclusion of syphilis, infection with human immunodeficiency virus (HIV) and acute immunodeficiency syndrome (AIDS)] shall be carried out by a dermatovenerologist, urologist or gynaecologist (childbirth specialist).

(2) Diagnosis of sexually transmitted diseases is confirmed by laboratory testing.

[*29 January 2004; 22 September 2005*]

**Section 11. Diagnosis of Syphilis, HIV, and AIDS, the Treatment and Monitoring of Patients**

(1) Measures for the prevention of syphilis, diagnosis of the disease, the treatment and monitoring of a patient shall be carried out by a dermatovenerologist.

(2) The examination, treatment, and monitoring of persons living with HIV and AIDS patients shall be carried out by an infectiologist at a medical treatment institution.

**Chapter IV**

**Infertility**

**Section 12. Diagnosis and Treatment of Infertility**

(1) Infertility is the inability of two sexually mature persons of the opposite sex (hereinafter – the heterosexual couple) to have a child within a year whilst having a regular sex life without any contraception.

(2) Infertility shall be diagnosed and treated by a gynaecologist (childbirth specialist), urologist, sex-pathologist or a genetic expert.

(3) The procedures for diagnosis of infertility shall be determined by the Cabinet.

[*29 January 2004; 22 September 2005*]

**Section 13. Medically Assisted Insemination**

(1) Medically assisted insemination is an artificial fusion of male and female gametes.

(2) Medically assisted insemination is carried out upon request of the heterosexual couple or a woman on the basis of a written application submitted to the medical treatment institution by the heterosexual couple or the woman.

(3) Medically assisted insemination is carried out by using the gametes of a donor or of the genetic parents.

(4) Prior to the medically assisted insemination, the gynaecologist (birth specialist) has the obligation to inform the potential parents of the nature of the medically assisted insemination and possible complications, and also of genetic and medical complications which could occur to the child.

**Section 14. Secrecy of Medically Assisted Insemination**

(1) It is prohibited to disclose any data on potential parents to a gamete donor.

(2) Potential parents may only obtain information on the genetic and anthropometric data of the gamete donor.

**Section 15. Restrictions on Medically Assisted Insemination**

It is prohibited to:

1) fuse human and animal gamete nuclei for the purpose of insemination;

2) introduce a human embryo into the system of a primate or animal of any other class;

3) obtain a human embryo or fetus for scientific research, and also to use it as a tissue and organ donor;

4) use gametes of the donor or the embryo for commercial purposes;

5) import or export an embryo;

6) choose the sex of the child during medically assisted insemination, except for the case of an inherited genetic disorder related to the sex;

7) simultaneously implant more than three fertilised ova in a woman’s body.

[*22 September 2005; 21 June 2018*]

**Section 16. Prohibition of Human Cloning**

It is prohibited to use any medically assisted insemination and other technologies which could result in the birth of a human being genetically identical to another living or deceased human.

**Section 17. Selection of a Gamete Donor**

(1) A gamete donor may be a healthy person: male between the age of 18 to 45 years and female between the age of 18 to 35 years.

(2) The potential gamete donor shall be medically examined according to the procedures specified by the Cabinet.

[*29 January 2004; 22 September 2005*]

**Section 18. Rights of a Gamete Donor**

(1) Gametes may be used for medically assisted insemination only upon written consent of the donor.

(2) The donor may revoke his or her consent for the use of gametes prior to the initiation of the medically assisted insemination.

**Section 19. Restrictions on the Use of Donor Gametes**

There can be no more than three children born in the State as a result of medically assisted insemination with gametes from a single gamete donor, except for the cases of multiple pregnancy.

**Section 20. Destruction of a Donor’s Gametes**

A donor’s gametes shall be destroyed in the following circumstances:

1) if the gametes have been stored in the gamete bank for more than 10 years or have become defective for any other reason;

2) if, as a result of medically assisted insemination, three children have been born in the State, except for the cases of multiple pregnancy, and also in the cases where gametes are exported to other countries;

3) if a child born from such gametes or a fetus created as a result of medically assisted insemination has been diagnosed with a genetic disorder or a congenital pathology;

4) in the event of the death of the donor, except for the case when the donor has given written consent to the use of the gametes after his or her death;

5) upon written request of the donor.

[*21 June 2018*]

**Section 21. Legal Status of a Child Born as a Result of Medically Assisted Insemination**

(1) A child born as a result of medically assisted insemination is considered to be born of the marriage if the marriage of the potential parents was duly registered at the time of medically assisted insemination.

(2) In the cases where the marriage of the potential parents is not registered, the provisions of the Civil Law shall be applied for determination of the legal status of a child born as a result of medically assisted insemination, insofar as they are not contrary to the provisions of this Law.

**Section 22. Non-recognition of Paternity Rights**

(1) Potential parents, their parents, and guardians do not have the right to request the recognition of paternity of the gamete donor for a child conceived as a result of medically assisted insemination.

(2) A child born as a result of medically assisted insemination, his or her parents and guardians do not have the right to request recognition of paternity of the gamete donor.

(3) A gamete donor shall not have the right to recognise paternity himself or herself or to request recognition of paternity of a child born as a result of medically assisted insemination. The parents of the gamete donor also cannot request recognition of paternity.

[*21 June 2018*]

**Chapter V**

**Birth Control**

**Section 23. Contraception**

(1) Contraception is a set of measures for the prevention of unintended pregnancy.

(2) Surgical contraception is the prevention of ovum fertilisation by means of a surgery.

(3) The medical practitioner has the obligation to explain the importance of contraception for birth control and the preservation of reproductive health to patients having reached reproductive age and to advise contraception in order to prevent undesirable pregnancy.

[*21 June 2018*]

**Section 24. Choice and Provision of Contraception**

(1) The use of contraception is a person’s voluntary choice.

(2) Only a gynaecologist (childbirth specialist) or a general practitioner is permitted to prescribe any medicinal contraceptives or the use of contraceptive medical technologies (except for surgical contraception), by providing for the further medical observation of the patient.

(3) Surgical contraception is applicable in the following cases:

1) to a patient of more than 25 years of age – upon his or her written consent;

2) in the case of medical indications, to a patient (also less than 25 years of age) on the basis of an opinion of the doctors’ council [the council consists of a gynaecologist (childbirth specialist) or a urologist, depending on the sex of the patient, and two doctors – specialists of the relevant field of medicine] and upon written consent of the patient but, if the patient’s capacity to act is restricted by a court decision, upon joint written consent of the patient’s trustee and the patient (if according to the court decision the trustee and the person under trusteeship act jointly) or upon written consent of the trustee (if according to the court decision the trustee acts independently in the relevant field).

(4) Surgical contraception may be administered to a patient by a gynaecologist (childbirth specialist), a urologist or a surgeon.

[*29 January 2004; 22 September 2005; 21 June 2018*]

**Chapter VI**

**Termination of Pregnancy**

**Section 25. Termination of Pregnancy at a Woman’s Request**

(1) The termination of pregnancy at a woman’s request is an artificial termination of pregnancy upon request of a woman up to the 12th week of the pregnancy.

(2) A referral for termination of pregnancy at a woman’s request shall be issued by a gynaecologist (childbirth specialist) or a general practitioner, simultaneously informing the woman of the nature of pregnancy termination, possible medical complications, and also of the possibility to preserve the life of the unborn child and to receive the consultation laid down in Section 5, Paragraph five of this Law.

(3) The termination of pregnancy may be performed by a gynaecologist (childbirth specialist) in an in-patient unit of a medical treatment institution not earlier than 72 hours after the issue of the referral for termination of pregnancy, and prior thereto the woman must be repeatedly informed of any possible complications resulting from the termination of pregnancy.

[*29 January 2004; 22 September 2005; 21 June 2018 /* *Amendment to Paragraph two shall come into force on 1 July 2019.* *See Paragraph 2 of Transitional Provisions*]

**Section 26. Termination of Pregnancy Due to Medical Indications or in the Case of a Pregnancy Resulting from Rape**

(1) Pregnancy termination due to medical indications or in cases of a pregnancy resulting from rape is an artificial termination of pregnancy on the grounds of medical indications or a certificate on a case of rape issued by a law enforcement institution.

(2) Termination of pregnancy due to medical indications is allowed up to the 24th week of the pregnancy. Termination of pregnancy resulting from rape is allowed up to the 12th week of the pregnancy.

(3) Termination of pregnancy due to medical indications or in the case of a pregnancy resulting from rape is allowed if there is a confirmation of the doctors’ council and a written consent of the woman.

(4) Termination of pregnancy due to medical indications or in the case of a pregnancy resulting from rape may be performed only by a gynaecologist (childbirth specialist) at an in-patient medical treatment institution.

[*29 March 2007; 21 June 2018*]

**Section 27. Termination of Pregnancy for a Patient Younger than 16 Years**

(1) If a pregnant patient is younger than 16 years, the doctor who has established the fact of pregnancy has the obligation to consult the patient and pay full regard to her views, taking into account the age and maturity of the patient. The doctor has the obligation to inform the parents or guardian of the pregnant patient of the fact of pregnancy.

(2) A referral for termination of pregnancy at her request may be issued to a patient younger than 16 years if at least one of her parents or a guardian has given written consent for termination of pregnancy.

(3) Termination of pregnancy for a patient younger than 16 years due to medical indications or in the case of a pregnancy resulting from rape is allowed only if there is a confirmation of the doctors’ council or a certificate on a case of rape issued by a law enforcement institution, and if at least one of the patient’s parents or her guardian has given written consent.

(4) It is necessary to obtain a decision of the Orphan’s and Custody Court (Parish Court) in order to terminate the pregnancy if there is any dispute between a patient younger than 16 years and her parents or her guardian regarding the preservation of the pregnancy.

**Section 28. Pregnancy Loss up to the 22nd Week of Pregnancy**

In the event of pregnancy loss up to the 22nd week of pregnancy, the medical treatment institution shall issue an extract and inform the patient in writing of the possibility to receive the remains of the stillborn fetus (if this is physically possible) for burial. If the patient refuses burial of the remains of the stillborn fetus, the medical treatment institution shall ensure that the remains of the stillborn fetus are treated with due respect of human dignity.

[*21 June 2018*]

**Transitional Provisions**

[*21 June 2018*]

1. Amendment to Section 5, Paragraph three of this Law regarding a joint gamete donor register shall come into force on 1 July 2019.

[*21 June 2018*]

2. Section 5, Paragraph five of this Law and the amendment regarding the supplementation of Section 25, Paragraph two of this Law with the words and figure “and to receive the consultation laid down in Section 5, Paragraph five of this Law” shall come into force on 1 July 2019.

[*21 June 2018*]

3. The Cabinet shall, by 1 January 2019, issue the regulations referred to in Section 5, Paragraph five of this Law.

[*21 June 2018*]

The Law shall come into force on 1 July 2002.

The Law has been adopted by the *Saeima* on 31 January 2002.

President V. Vīķe-Freiberga

Rīga, 19 February 2002