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The Discourse on Social Egg Freezing in Austria: Individual Solution to a Societal Problem

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Abstract

Social egg freezing (SEF) is the process of freezing a woman's eggs for non-medical reasons to preserve her ability to become pregnant in the future. SEF is both praised as a procedure that every woman should consider to prolong fertility, and criticized for medicalizing social problems, making unrealistic promises, trivializing risks, and having a poor cost–benefit ratio. This article explores the debate surrounding SEF and societal attitudes towards it in Austria, a country currently discussing the legalization of the procedure. Ten qualitative interviews were conducted with individuals involved in the public debate on medically assisted reproduction (MAR). Thematic analysis revealed three groups of respondents—advocates, ambivalents, and one opponent—who held different views on several key themes. All groups perceived SEF as not being "the" solution to the underlying problem of balancing parenthood and work. Interviewees demanded comprehensive counseling before SEF, including information about the technical procedure and medical risks. Many interviewees characterized the Austrian debate on MAR as polarized, describing policymakers as frequently uninformed and the political system as stagnant and reluctant to reform. They also expressed a need for more public debate in an open and dialogue-driven spirit. This article contributes to existing research by investigating the Austrian discourse on SEF, a topic that has rarely been explored. It shows that the regulation of SEF remains controversial in Austria, with attitudes towards it being based not only on the right to reproductive autonomy, but also on a wide range of broader social issues in contemporary societies.

Keywords

Austria; medically assisted reproduction; qualitative interviews; social egg freezing

1. Introduction

Medically assisted reproduction (MAR) has developed immensely, increasing the range of interventions and their potential impact on individuals, children, relationships, families, and society (Inhorn, 2020). Its regulation has changed in a European trend from restrictive to more permissive policies (Griessler, 2022). Differences between countries can be explained by cultural, political, and religious variance, among other factors (Präg & Mills, 2017).

Egg freezing (EF) involves "collecting, dehydrating, and freezing unfertilized eggs to store them for future pregnancy" (Espinosa-Herrera & Pietrini-Sánchez, 2025, p. 119) and was first successful in 1986 (Rimon-Zarfaty & Schicktanz, 2022). There were only a few births thereafter because the freezing method used was inefficient. The introduction of vitrification in 1999 and intracytoplasmic sperm injection improved success rates "dramatically" (De Proost et al., 2025, p. 2). The number of women undergoing social egg freezing (SEF) has increased in recent years. In Australia and New Zealand, for example, it increased from 252 to 981 between 2010 and 2015 (Johnston et al., 2021). Without providing absolute numbers, Johnston et al. (2021) report an 866% increase in patients in the USA from 2010 to 2016. SEF is global, with egg farms in "India, South Africa, Egypt, and United Arab Emirates" (De Proost & Coene, 2019, p. 367). Yet, little is known about the practice of SEF in these countries (De Proost & Coene, 2019; Lahoti et al., 2023; Rimon-Zarfaty et al., 2021; Rimon-Zarfaty & Schicktanz, 2022). EF is differentiated based on a debated distinction as *medical* and *social* egg freezing (MEF and SEF, respectively; De Proost et al., 2025; Rimon-Zarfaty et al., 2021). Medical reasons include cancer, autoimmune diseases, and endometriosis (Egarter, 2025). Non-medical reasons include lack of a suitable partner, career development, and economic factors (Katsani et al., 2024; Rimon-Zarfaty et al., 2021). SEF is suggested as a procedure that every woman should consider, but also criticized as over-promising, exploiting "a vulnerable group of women" with "unrealistic promises," trivializing risks, and "trying to solve societal problems by medicalizing" them (De Proost et al., 2025, p. 1).

In order to achieve a later pregnancy, SEF should be performed before the age of 35 or 37, as the quality and quantity of retrieved eggs decrease after this age (Alteri et al., 2019; Egarter, 2025, p. 28). Katsani et al. (2024, p. 5) state that the ideal age for oocyte freezing is between 20 and 30–35 years, indicating that today SEF is not only a last resort for potential pregnancies, but also a way to improve the chances of future pregnancy success (De Proost et al., 2025). Egg retrieval involves a vaginal ultrasound puncture after hormonal stimulation. The optimal number of eggs for future pregnancies is around 20. Thus, two or more cycles of stimulation and retrieval are often necessary (Egarter, 2025). The eggs collected can be used years after retrieval. SEF requires in vitro fertilization (IVF; Katsani et al., 2024). Related medical risks include complications from ovarian stimulation, such as ovarian hyperstimulation syndrome (OHSS), as well as complications from the egg retrieval process, such as bleeding, infection, and injury to surrounding organs. Mild cases of OHSS occur in 3–6%, and severe cases, which may require hospitalization, in approximately 0.5–1% of cases (Egarter, 2025). The risk of egg retrieval is very low at 1/1000 (Wunder, 2013, p. 3). Risks increase with more stimulation cycles (Espinosa-Herrera & Pietrini-Sánchez, 2025). The general risks of pregnancy and childbirth also increase with the age of the woman giving birth. Therefore, SEF may increase the risk of pregnancy and childbirth complications such as gestational diabetes mellitus, preeclampsia, and ectopic pregnancy (Egarter, 2025; Katsani et al., 2024).

Austria followed the European trend towards permissiveness in MAR slowly and reluctantly (Griessler & Winkler, 2022), but currently still prohibits SEF (Egarter, 2025). Today, SEF is banned in Hungary, Lithuania, Malta, Norway, Serbia, and Slovenia. While it is not banned in Bosnia-Herzegovina and Moldova, it has not been practiced there (Calhaz-Jorge et al., 2020, p. 9). Paragraph 2b of the Reproductive Medicine Act (FMedG, 1992) permits harvesting and storage of reproductive cells only for medical indications. Indications for MEF are mentioned in the IVF Fund Act (Kostenzer, 2020; Rimon-Zarfaty et al., 2021), the guidelines of the Austrian Society of Gynecology (OEGGG et al., 2017), and a recommendation of the Austrian Bioethics Commission (Bioethikkommission, 2015), an advisory body to the Federal Chancellor.

Recently, the current regulation has been subject to public and political debate. In 2023, the self-help group Zukunft Kinder! launched a parliamentary citizens' initiative to permit SEF (Parlament Österreich, 2025a, 2025b). The Bioethics Commission considered banning SEFs as inappropriate (Bioethikkommission, 2023), in contrast to a previous opinion (Bioethikkommission, 2015). The Health Ministry was open to discussing legalization (Bundesministerium Soziales, Gesundheit, Pflege und Konsumentenschutz, 2023); the Austrian IVF Society was in favor (Österreichische IVF Gesellschaft, n.d.); the NGO Aktion Leben disapproved of legalizing SEF (Aktion Leben, 2023). In 2023, the women's organization of the Austrian Social Democratic Party (SPÖ) also discussed legalizing SEF (SPÖ Frauen, 2023). In 2025, the Constitutional Court held a hearing on a case in which the applicant challenged the constitutionality of the ban, arguing that it violated her right to respect her private and family life under Article 8 of the European Convention on Human Rights (Constitutional Court, 2025).

This article explores themes of the Austrian discourse on SEF to gain a deeper understanding of how attitudes toward SEF are embedded in a broader societal context.

2. Method

The article is based on exploratory, qualitative interviews with ten individuals on their views on the legalization of SEF. The ten semi-structured interviews were inductively analyzed using thematic analysis (Froschauer & Lueger, 2003).

This study initially focused on the SPÖ's youth and women's organizations because they are currently debating the legalization of SEF. However, the organizations' representatives declined interview requests due to a lack of time and ongoing internal discussions. Thus, the selection criteria for purposive sampling were changed to include advocates and opponents of SEF who engage in public debates on MAR. In addition to the three female SPÖ members already interviewed, four activists from a feminist NGO that addresses the societal implications of MAR were recruited. Additionally, interviews were conducted with reproductive physicians (one female, one male) and an activist from another NGO. The sample includes four physicians, two journalists, two psychotherapists, one student, and one NGO employee. To protect anonymity, information about the sample is provided in aggregate form only.

During the winter of 2024–2025, the author recruited interviewees at three occasions: two public events on MAR and reproductive autonomy, and an information event on SEF for reproductive physicians. Two respondents were recruited through snowball sampling. The semi-structured interviews included open-ended questions about interviewees' views on SEF regulation, their position towards legalization, and

perceptions of arguments for and against legalizing SEF, the Austrian SEF discourse, and its participants. Follow-up questions were asked for clarification. After ten interviews, "theoretical saturation" was reached (Strübing, 2004, p. 32). The interviews averaged 44 minutes (range 31–77 minutes) and were conducted in person (n = 9) or online (n = 1) between January and March 2025, following the events. They were audio-recorded and transcribed verbatim. Informed consent was obtained prior to interviews.

The interviews were analysed using thematic analysis (Froschauer & Lueger, 2003). Analysis started with getting familiarized with the material and continued with open coding. A total of ninety-seven codes were generated and grouped into 14 key themes for comparative analysis with the help of the Atlas.ti software program.

3. Results

The interviews revealed three groups. Three interviewees advocated legalizing SEF ("advocates"), six presented arguments both for and against it ("ambivalents"), and one opposed it ("opponent").

From the advocates, I5 considered legalizing SEF an option and did not see any valid arguments against it. The fact that it is legal in other countries was an argument in favor. While SEF would have positive effects for some, I5 did not see it as "the" solution. Yet, it could help women cope with pressure and stress. I9 also referred to permissive countries and saw no reason why women should not be able to postpone reproduction if they wish. Although approving of SEF, I9 considered arguments against it "worth discussing." I10 believed it crucial to allow SEF but considered the current demand overestimated.

From the ambivalents, I2 questioned SEF, deeming it "bizarre," yet considered a ban too severe. I2 and I3 considered SEF as permissible. This is because it is the women themselves who would be undergoing the procedure. I3 acknowledged arguments in favor of SEF and the needs of women who wish to have children, however, warned about success rates. Several respondents believed that social sperm freezing is permitted in Austria. I6 also assumed this and considered it unfair, justifying her stance with this assumption. She favored legalization but would not promote SEF as a society. Instead, she would focus on enabling self-determined reproduction for as many women as possible. She wondered why women want to use SEF and why society partly forces them to do so. She would not recommend SEF. I7 was critical of SEF and advised to consider the implications and success rates. I8 was ambivalent due to the advantages, disadvantages, risks, and societal consequences of SEF. She described it as a life-changing decision that each individual must make for themselves. It requires non-directive information and counseling that considers their specific situation and reasons.

Opponent I4 opposed SEF because it could lead to uncontrollable developments and questioned SEF as a "good solution." She described SEF as a "resignative concept" that fails to solve the underlying social problem of reconciling work and childcare. She considered SEF not as a "healthy" solution, psychologically or health-wise, but as an individual solution to a societal problem.

3.1. Themes

3.1.1. Assessing MAR

Assessment of MAR and SEF were connected. Ambivalents and the opponent were critical of MAR. I1 recognized significant opportunities in MAR, but also potential abuse, as it would be big business. She thought that those with a strong desire to become parents may be willing to do almost anything without considering medical implications for themselves, their child, or broader socio-political consequences. She said she understood the desire for a child but strongly opposed the use of methods she considered medically and psychologically questionable. I1 talked about there being a huge number of children in the world who would need to be cared for. Thus, she considered MAR "totally inhuman" and SEF "selfish" because of the underlying idea that a child must be "one's own." She believed MAR is "incredibly dangerous" and worried that designer babies will be next.

I2 did not oppose MAR because she believed that interfering with the creation of life would be wrong. She considered MAR to be a useful medical tool that was sometimes successful. Yet, she criticized surrogacy and egg donation because the involvement of third parties requires ethical reflection on their rights. She was concerned about children's rights and critical that MAR no longer focuses on treating infertile couples, but on the desire for a child. She criticizes the market's focus on expansion and profit. I2 thought that MAR raises existential questions about motherhood, parenthood, raising children, the value placed on biological children, reproduction, and the meaning of life. I3 was critical of MAR and perceived many developments that do not benefit children and mothers in terms of psychological bonding and that violate human and children's rights. I7 believed that "good parenthood" and "good family relationships" are possible in all forms of MAR, with the exception of surrogacy, as long as they are made transparent to the child, are communicated to the child according to their age, and are dealt with emotionally. I4, the opponent examined and questioned the desire for a child, the reasons given for this desire, the explanations, the motives, the concrete situation of the couple, why pregnancy does not work, and what kind of desires and imaginations exist in the desire for a child. She described MAR as a big business of "getting a child at any cost" and emphasized the psychodynamics involved in MAR and parenting. She believed that the emotional implications of MAR are being neglected. Advocates, in contrast to the ambivalents and the opponent, perceived MAR simply as "scientific" and "technological progress" (I9).

3.1.2. Risks and Success

Respondents from all groups perceived medical risks associated with SEF, especially OHSS, and the actual chances of success. Advocates mentioned risks and inconveniences of egg retrieval, such as discomfort (I5), thrombosis (I9), and overstimulation, bleeding, and infection (I10). I6 considered SEF "a relatively major intervention in a woman's body, with side effects and risks." I7 noted that SEF does not guarantee a child. Furthermore, by the time the egg is used, the body will have aged and may not be as suitable for pregnancy as it was when the woman was younger. I8 was ambivalent and did not consider SEF to be very risky. However, since it involves ovarian stimulation and a needle, there is always a risk greater than zero. I4, the opponent, noted a lack of long-term studies on the medical risks of ovarian stimulation.

3.1.3. Autonomy

Autonomy was a key theme that each group perceived differently. I5, an advocate, offered a nuanced view: First, autonomy meant not being dependent on a partner. A woman in an unhappy relationship who wants to have a child can give up her desire for a child or leave her partner. Alternatively, she can have a child in an unhappy relationship. SEF increases autonomy because it enables women to postpone pregnancy and gives them time to find a suitable partner. Autonomy also meant increased independence from nature, as it prolongs the fertility phase. Third, it meant freedom to choose whether or not to have children or to remain undecided. Fourth, autonomy meant freedom from social expectations about having children. I5 believed that autonomy has limits when others or the child are at risk. Another advocate, I9, defined "reproductive autonomy" as the right to self-determination. Women who want to use SEF should be able to do so after receiving the necessary information. I10 believed that it is illegitimate for the state to intervene in something as personal as reproduction.

Ambivalent or opposed respondents perceived autonomy differently. I1 supported the right to self-determination but believed there are limits when it comes at the expense of others. I6 stated the goal should be to give reproductive autonomy to as many women as possible, not to allow as many women as possible to have SEF. I4, an opponent, did not consider reproductive autonomy a value in itself. Autonomy is central and non-negotiable, she said, in abortion. The concept of autonomy becomes misguided when reproduction is pursued at any cost, especially at the expense of others. Autonomy from the body and biology that I5 mentioned contrasted with acceptance of nature, biology, and aging that several ambivalents and the opponent advocated. I4 noted: "Biology is such that we get older. The older we get, the fewer eggs we can produce, and at some point, it's over."

3.1.4. Feasibility

Ambivalents questioned technological feasibility, which they perceived as central to MAR. For I2 feasibility implied that individuals are responsible for realizing their wishes. This creates tremendous pressure, and if someone does not succeed, they are considered to have failed. However, achieving goals also depends on circumstances, opportunities, resources, and luck, I2 emphasized. She expressed her empathy with those who are childless but criticized the idea that everything in life should be made possible, controlled, and planned. I2 advocated accepting the limits of having children and the resulting feelings of loss while remaining open to different potentials and possibilities. I3 criticized the concept of feasibility, which leads more and more people to believe that the desire for a child can be postponed indefinitely. I7 and I4 were critical of the idea of feasibility as well. I4 believed that it opens the door to designer babies, children of choice, and eugenics.

3.1.5. Wish for a Child

Several ambivalents and the opponent argued that MAR treats the desire for a child as absolute. I6 criticized the tendency to treat the desire for a child and "biological reproduction" as absolute, given the current difficulty of finding foster parents. She felt the discourse as slightly off, dominated by the question of "self-fulfillment" when wanting a child. She noted the absence of a discourse on whether society pressures women to have children, and that women who cannot have biological children are often viewed as inferior. I2 recognized the human rights to sexuality and to private and family life as important defenses against the state and as a means

to make independent decisions. However, she emphasized that almost no human right is absolute; it must always be weighed against others, such as children's rights, as all autonomy and civil liberties have limits when they restrict others' freedom. I8 was undecided about the right to have children and to use all technical means in reproduction. I4, an opponent, believed that there is no right to a child and questioned the importance of genetic parenthood when there are so many orphans. She suggested examining why a child is considered necessary for one's purpose in life. Children should not be used, she said, to fulfill a person's purpose in life. In contrast, I10, an advocate, questioned the state's right to regulate human reproduction and considered it a human and personal right. State regulation in this area encroaches on personal rights.

3.1.6. Right Moment

The right moment for a child was another theme and encompasses ideas about biography, career, partnership, and ambivalence about becoming a parent. Respondents from all groups argued that having children and a career is difficult (I9, I8, I4). I5, an advocate, believed the right time to have a child depends on individual circumstances, such as the vocational or financial situation. She considered arguments about the challenges of late pregnancy as valid. Nevertheless, she favored opening up the strict time limit.

Another motive for SEF, cited by interviewees of all groups, was the absence of a suitable partner (I5, I3, I8, I4). I5 referred to literature showing that issues with partners and uncertainty about the current life situation are main motivations for SEF. I8, an ambivalent, noted that women today are focusing more on equality in the workplace and their careers, which is causing them to delay starting a family. I4, an opponent, viewed SEF as a safety measure for having a child with the right partner in the future. She criticized a kind of "consumerism" in partnerships, partly due to the increased use of internet platforms. She described this as investing less effort into a relationship while wondering if a better partner can be found.

I4, the opponent, stated that the desire to have a child is always ambivalent and depends on one's biography, circumstances, and resources. She thought that having a child is one of life's most challenging decisions and called for a "mature desire for a child," which encompassed motives such as wanting to pass something on, protect, and be there for the child. This contrasts, she said, with the idea that life would be meaningless without a child. A child should not serve as a substitute for a lack of meaning in life. I7, an ambivalent, noted that ambivalence is a common part of pregnancy, even when planned, because pregnancy changes one's self-image and identity. This period requires leaving the former identity behind and developing a parental identity.

Interviewees of all groups used metaphors. A "biological clock" is often referred to "fertility" (I5) and the dilemma that SEF addresses (I4, I5, I9). The clock carries meanings of inevitability and external pressure. I5, an advocate, believed that popular media and movies convey this metaphor and create a sense of stress. SEF would reduce the psychological burden and social pressure on women who want to have children, are unsure about having children, or are unsure about the timing of having children. SEF would extend the time span of female fertility, thus reducing the stress of getting pregnant immediately (I5). SEF is not a guarantee, but it enables an extension of the time frame for having a child (I5).

Other images used were connected with economy, calculation, planning, and agency. I8 describes SEF as an "egg bank" to store eggs if later needed. Another ambivalent, I2, perceived SEF as part of a mindset involving feasibility, consumption, and security. I3, an ambivalent, noted that questions of consumer protection and

cost–benefit analysis should be raised because young women would see SEF as an insurance. I4, an opponent, likened SEF to a "security rucksack" for having a child "at some point, when I want to, whether I have a partner or not." I10 and I5, both advocates, described SEF as security or insurance.

3.1.7. Potential Pressure

Interviewees from all groups perceived potential pressure from employers on women to perform SEF. They referred to U.S. internet companies as examples (I2, I4, I5, I9, and I10). I6, an ambivalent, believed that such companies avoid the actual problem of balancing family and work. They, she said, reduce or eliminate the risk of female employees of reproductive age taking leave or being absent from work due to childcare responsibilities by covering SEF.

3.1.8. Commercialization

Several ambivalents and the opposed were particularly critical of the commercialization of MAR (I1, I2, I3, I4, I6). I1 perceived MAR as a capitalist system that makes money at the expense of people experiencing high levels of psychological stress because of childlessness. I2 described MAR as a massive international business that has expanded its scope beyond infertility treatment to include fulfilling the desire to have a child. Thus, MAR targets almost everyone and focuses solely on expansion and profit. The influence of business and vested interests, she said, can lead to overpromising. MAR has been completely commercialized, I2 noted, as technology that replaces natural processes is always big business in a capitalist system. Consequently, ethical boundaries are given less consideration. In her view, reproductive doctors in public hospitals are more critical of MAR than those in private ones. I6 pointed out that MAR in Austria is mainly organized in private clinics. Doctors may have different attitudes, she said, but in her view, MAR is an absolute "money printing press." I4, an opponent, perceived MAR as a heavily lobbied business and a product of the pharmaceutical industry and reproductive physicians. Other respondents qualified the commercialization argument. I8, an ambivalent, recognized that medicine in general is a business and MAR an expensive treatment. I9, an advocate, acknowledged the argument that permitting SEF would lead to commercialization. However, while it is widely known that medicine is a multi-billion-dollar business, this, she said, is less often discussed in other medical areas.

3.1.9. Cost/Benefit, Inequality, and Causes of Infertility

I5, an advocate, was uncertain about the cost/benefit of SEF. Stimulating ovaries and retrieving eggs is physically and emotionally demanding. Yet not all women actually use these eggs later. Therefore, the question arises whether the effort is proportionate to the outcome. I10 did not see the market for SEF because not many women between 20 and 25 years of age can invest €10,000. I3 and I7, both ambivalents, also addressed economic aspects of SEF, i.e., the costs associated with cryopreservation.

Respondents from all groups raised economic and social inequality (I1, I3, I4, I9). I9, an advocate, perceived unequal access to MAR as problematic because wealthy people can use services across borders. I3, an ambivalent, was concerned that if SEF is permitted, demands on public health insurance will rise because of equality arguments. I4, an opponent, perceived SEF not as a solution for everyone, but limited to "educated individuals in managerial positions" who can afford it. Ambivalents and the opponent observed that Austrian

regulations are circumvented by cross-border health services. Some were critical of the "obvious ways" in which legislation is avoided (I1) and that some providers would "exploit all possibilities" (I4). Others accepted it as a matter of fact (I6, I8).

The ambivalents and the opponent identified rising infertility as another driver of MAR that society needs to address. I1 and I7, two ambivalents, called for more research into the causes of increased infertility in Western countries. I4, an opponent, anticipated future problems with decreasing fertility in men and women and late motherhood.

3.2. How to Regulate SEF

Respondents had different positions on how to regulate SEF.

3.2.1. Reconciling Work and Care

Advocate I5 believed that legalizing SEF could have a positive impact on some people's lives, but she would not place too much emphasis on technical solutions to the problem of reconciling work and having children. Childcare facilities and paternity leave, she said, would be more useful than SEF. She did not perceive widespread late parenthood as positive either and would rather make it easier for people to have children before turning thirty. Another advocate, I9, believed both support for parents and SEF are necessary, as many women want to have children later because they have not yet found the right partner. She demanded equal distribution of care work, as well as the adaptation of work to people's realities, rather than the other way around.

I3, an ambivalent, believed that state and society should do everything possible to encourage people to have children at an early age. Another ambivalent, I6, said that radical financial and legal changes are needed to reconcile family and work and achieve gender equality in care work. This would prevent women from suffering a career break due to pregnancy and prevent men from panicking about taking extended parental leave for fear of professional disadvantages. Childcare facilities and the financial security of single parents need improvement. This would reduce pressure on women and allow people to decide when to have children. I7, also ambivalent, called for better opportunities to have children and to balance work and family. She advocated gender equality in childcare, more support, and, above all, appropriate out-of-home care for children of all ages. I4, an opponent, supported closing the gender pay gap, equally sharing housework, and providing widespread childcare facilities. Additionally, she called for new male role models who view fatherhood and caregiving positively. In summary, she said she would like to see a society that appreciates having children and creates social and economic conditions that enable people to be "good enough parents."

3.2.2. Awareness, Counseling, and Public Debate

I2, an ambivalent, called for independent information and psychological support for couples in MAR treatment from the start. It should address risks, chances, ethical considerations, and children's rights and include medical and psychodynamic dimensions of MAR (I7). Current law, I7 explained, only requires physicians to mention psychological counseling as an option. Therefore, couples often seek it only after several unsuccessful cycles. The aspect of the child, she said, as well as counseling, is often omitted in the

MAR debate. I7 believed that, if SEF is allowed, parents and others involved should be well informed about its implications, especially the psychological consequences and the welfare of the child. I8, an ambivalent, considered counseling in SEF challenging because of the serious future implications. It requires talking to the person, understanding their individual situation, reasons, and motivations. I8 noted that a physician who perceives SEF as part of reproductive rights may advise differently than one who considers specifics such as a woman's age, health, chances of finding a partner and getting pregnant in the next few years, the possible psychological effects of SEF, and the woman's desire to avoid the small risks of egg retrieval. I10, an advocate, also highlighted the important influence of counselors. On the other hand, he said that patients today have access to a wealth of information from the Internet. They have ideas about the treatment they want, which might not always be possible. I10 advocated providing realistic information that includes alternatives. He emphasized mandatory and documented information, an obligatory waiting period of 14 days, and recognized the necessity of psychological counseling in certain cases. Yet, he opposed mandatory psychological counseling, which he perceived as coercive. In contrast, I4, an opponent, insisted on mandatory psychological counseling and the opportunity to discuss the psychological implications of MAR. Psychological counseling should be offered to discuss patients' desires and ideas and to enable them to reflect before treatment starts. She explained that professional, neutral, and non-directive psychological counseling, in which the counselor acts as a "sparring partner" provides a space to reflect on the situation and decision. It would be important, she said, to give the psyche more space in MAR treatment because it is during this process that the foundation of the relation to the child is formed. An "inner dialogue" is important for this.

Interviewees differed on whether SEF should be covered by public health insurance. I5, an advocate, thought that SEF would be too expensive for many. Coverage by public health insurance would be justified because of the low birth rate. I9, another advocate, believed that women in the first phase should have to pay for the service. Later, public health insurance could cover some of the costs. I2, an ambivalent, opposed public funding of SEF, and I6, another ambivalent, thought public funds should cover expenses for those who need financial support.

3.2.3. Public Debate

Respondents had different perspectives on the Austrian public debate of MAR. I10, a MAR provider, had a positive view of the discourse and believed the public still finds MAR exciting. He advocated dialogue and exchange, noting a positive culture in this regard. He was satisfied with the openness of the discourse and the treatments that are legally available. He highlighted that public information on SEF is necessary.

Ambivalents and opponents were more critical. I1 thought that, as with other technologies, more public debate on medical and ethical issues are needed to avoid overlooking potential negative impacts. Another ambivalent, I2, said public debate tends to be overly black-and-white. She noted that, in the past, media coverage was often imbalanced, focusing primarily on the suffering of childless couples and the perspective of reproductive physicians. I3 believed that NGOs critical of MAR would be perceived as "spoilsports" because they contradict the positive portrayals of MAR on service providers' websites. I6 criticized romanticized ideas about MAR in traditional and social media that promise "long-term fertility" and downplay the risks and discomforts of MAR. I4 argued that public debate never addresses fundamental issues of women's and children's psychosocial and physical well-being. I2 and I7 perceived public debate as distorted because it focuses on reproductive autonomy and the right to start a family instead of the rights

and needs of children. I7 stated that children's needs are often trivialized, especially by some MAR professionals. She called for public discussion and systematic studies on the long-term effects of ovarian stimulation. If SEF were to be permitted, I2 believed awareness should be raised among women of childbearing age, specifically those between 20 and 25 years old. I6 noted that SEF requires public discourse to avoid pressuring women to undergo SEF. She called for a proper public discussion about reproduction, the desire to have children, abortion, and prenatal diagnosis. I4, an opponent, believed that MAR is a serious issue that deserves more sociopolitical, sociological, and psychological consideration. If SEF was permitted, it would be just another issue of research being conducted without prior consideration of possible negative consequences, which would then need to be addressed later.

3.2.4. Policymaking

Interviewees criticized how MAR policy is made in Austria, noting policymakers' unwillingness or inability to reform. I9, an advocate, pointed out that legislation is quite outdated and, she believed, has never been revised. She attributed this to the conservative party's decades-long dominance of politics. She also noted that, in politics, reproductive medicine is perceived as a "women's issue." Despite affecting so many people, it is not a priority for the Social Democratic Party of Austria (SPÖ) either. Although the motion to lift the ban on SEF was well received within the party's youth organization, the issue remains controversial and marginal within the party as a whole. Advocate I10 mentioned that the FMedG was designed in the early 1990s to prevent practices that opponents had considered to be "evil." The law was created when many procedures common today had not yet been invented, and, since then, it has only been amended in a piecemeal manner. Although he viewed the 2015 reform as liberalizing many things, he believed that the Austrian legislative process lacks a comprehensive approach that brings all stakeholders together. He perceived no public discussion in 2015 about how to comprehensively reform the law. The legislature was forced to reform due to decisions made by European and Austrian courts. However, leading politicians were only willing to change the law to the bare minimum. I10 perceived the Ministry as reactive and driven solely by political mandate, which he believes is lacking.

I2, an ambivalent, noted that SPÖ labeled critics of MAR as being associated with the Church, refusing to engage with them. Criticism of MAR was perceived as coming solely from the Catholic Church and the political right. She said that she fails to understand this position because leftist and anti-capitalist views, which were ignored and neglected in the Austrian MAR discourse, have also criticized MAR in the past. However, she believed this has changed in recent years, as SPÖ and Greens have slightly altered their views. She noted that several politicians have studied the issue since then, and that there are now more critical left-wing views on MAR in politics.

Several interviewees from all groups criticized the level of information about MAR among politicians. I6 felt that many policymakers lack basic knowledge of MAR and, to a certain extent, rely on their gut feeling. In her view, political discourse lacks individuals with expertise on the complex issue. I8 believed that politicians are unable to define basic MAR concepts and lack in-depth knowledge to understand the risks. I2 expressed the impression that a few years ago, even leading politicians knew very little about MAR. I10 recognized expertise with civil servants but not with politicians. I4 criticized the Austrian Bioethics Commission for never being very feminist and lacking a well-founded consideration of the psychological aspects of MAR. Decision-makers also fail to consider, she said, the psychological consequences of MAR.

I8 thought that since medicine is a business, committees will consider different aspects if they include people who benefit financially from MAR. I10, an advocate and provider of MAR, stated that physicians were involved in the initial FMedG negotiations in the 1990s but not in the drafting of legal texts. Infertility patients have little impact on policymaking, he said. They do not have a strong patient group, as MAR patients are a transient group. I6, an ambivalent, mentioned that MAR negotiations take place behind closed doors and are mainly determined by what is medically possible and what the social security system can afford. There is little general discussion about "what we actually want as society." I7, another ambivalent, criticized that none of the demands of the Austrian Children's League, which concerned children's and adolescents' health, were accepted during the FMedG reform in 2015. I4, an opponent, criticized that the demands of the Association of Psychotherapists were not considered.

4. Discussion

Analysis revealed advocates, ambivalents, and opponents of legalization. They raised issues that align with the extant literature and include the assessment of MAR, risk and success rates, autonomy, feasibility, the desire for a child, timing, biography, career, partnerships, potential pressure, costs, commercialization, unequal access, causes of infertility, public debate, and policymaking.

The opponent and ambivalents rejected MAR entirely or partially for various reasons, including potential abuse, commercialization of reproduction, and a lack of consideration for potential negative societal impact. They criticized medical and psychological risks, the idea of a right to have a child, and the prioritization of the desire for one's own child. Some criticized surrogacy and egg donation, the risk of creating "designer babies" and neglecting children's rights. Some ambivalents perceived SEF as acceptable, as it would be performed on the women themselves. Advocates viewed MAR as scientific and technological progress. Respondents from all groups mentioned medical risks and the actual chances of success.

Autonomy was a key theme. Interviewees' understanding differed: Autonomy meant being able to become a parent later, regardless of a present partner's wish for a child, and to gain independence from age-related decrease in fertility. It was also the freedom to decide whether or not to have children and independence from societal expectations. Autonomy also meant the right to make self-determined decisions about abortion. Ambivalents and the opponent perceived autonomy from nature rather critically and emphasized limits of autonomy more strongly when the rights of third parties, particularly children, are concerned.

Literature on SEF also debates reproductive autonomy. De Proost et al. (2025, p. 1) define it as "the power to decide if, when, and how to have children," which is constrained by scarce resources and "pressures (by family members, medical professionals, and others) and other personal and societal constraints" (p. 1). Pape and Tschudin (2023) suggest that SEF could be a step toward gender equality, yet it could also entrench existing role patterns. Wunder (2013) qualifies reproductive autonomy by considering the well-being of the child. It would be in the child's best interests to have "young and vigorous (or healthy) parents" (Wunder, 2013, p. 3; see also Schochow et al., 2018).

De Proost et al. (2025) are skeptical that permitting SEF alone increases reproductive autonomy. Considering the low cost–benefit ratio of SEF and the existing success rates, the increase in autonomy depends not only on the procedure's availability but also on patient characteristics and the context in which

the decision to undergo SEF is made (De Proost et al., 2025, p. 3). Interviewees' diverging views on whether SEF means more autonomy or additional pressure mirror a controversy among feminists about whether EF contributes to women's liberation, as summarized by De Proost and Coene (2019). Liberal feminists, in alliance with bioethicists and clinicians, argue that SEF increases gender equality by providing women with more choices. Others argue that SEF supports women's compliance with "male-oriented labor market and pronatalist ideologies" (De Proost & Coene, 2019, p. 358). De Proost and Coene criticize the traditional concept of autonomy that highlights the "liberating potential" of SEF, ignoring that reproductive choices happen within a social environment. They propose the broader concept of "reproductive justice" developed by the "Asian Communities for Reproductive Justice" which defines reproductive justice as "the complete physical, mental, spiritual, political, economic, and social well-being of women and girls, which will be achieved only when women and girls have the economic, social, and political power and resources to make healthy decisions about our bodies, sexuality, and reproduction for ourselves, our families, and our communities in all areas of our lives" (ACRJ, 2005, as cited in De Proost & Coene, 2019, p. 364).

The idea of independence from nature mentioned in interviews is linked to technical feasibility. One ambivalent connected the critique of feasibility to a broader critique of coercive aspects of individualization. Several ambivalents and the opponent saw feasibility connected with strongly believing in technology. They warned against hubris and the desire to "make children" and "control everything." While sympathizing with those seeking to have children via MAR, they emphasized the limits of feasibility and advocated alternatives, including adoption and fostering. They encouraged reflection on the desire to have a child and acceptance of biological limitations, as well as finding meaning in life apart from having a biological child. Advocates portray SEF as techno-social development that could reduce pressure on women and contribute to gender equality and autonomy. Literature also discusses technical feasibility. Wunder (2013, p. 3) perceives SEF as part of a societal trend of rejecting the "finiteness and unavailability of human life."

Several interviewees expressed concern that employers could pressure women into SEF if offered as an employee benefit. The extant literature also points in this direction: Dowling (2021) reports that, in 2015, 5% of large US companies with over 500 employees offered SEF as an employee benefit. By 2022, this figure had increased to 40% (Davidovic, 2022). Espinosa-Herrera and Pietrini-Sánchez (2025, p. 126) argue that offering SEF as an employee benefit would "maintain current workplace inequalities and impose an option for women with multiple risks and externalities, while distracting them from addressing pernicious gender-based (unconscious) bias and attitudes in the workplace" (see also Pape & Tschudin, 2023). A survey in Germany states that 63% of female respondents and 52% of male respondents did not think it was appropriate for women to use SEF, if offered by their employer (Institut der deutschen Wirtschaft Köln, 2014).

Advocates, ambivalents, and opponents viewed the desire and right to have a child differently. Several ambivalents criticized placing an absolute value on the desire to have a child, arguing that children should not be used for self-fulfillment and to fulfill one's purpose in life. Many ambivalents opposed the concept of a "right to a child."

Another key theme was the right moment to have a child. Advocates viewed this as an individual decision based on one's life circumstances. Conversely, several ambivalents and the opponent emphasized that pregnancy is always associated with ambivalence because new roles and identities must be established.

Wunder (2013) notes that "pregnancy, delivery, and raising children never really fit into a woman's career plan, regardless of age. There is no 'ideal time' " (Wunder, 2013, p 4; see also Pape & Tschudin, 2023).

Ambivalents argued that SEF would increase social inequalities because it is expensive and only affordable for a small part of the population. In 2019, the cost per cycle was, e.g., $3,200 in Israel, $10,000 in the United States, and up to $7,500 in Australia in 2015 (Johnston et al., 2022). The prohibitive SEF costs would pose the greatest barrier. The high cost of SEF may exacerbate social inequalities in healthcare (Egarter, 2025; Katsani et al., 2024). In line with this, De Proost and Coene (2019, p. 359) characterize the ideal-typical user of SEF as "mostly from Europe, the United Kingdom, and America" and "predominantly white, heterosexual, and middle class." Myers and Martin (2021, p. 2) point out discrimination in SEF of "some raced and classed populations." As discussed in the literature, respondents also had different views on cost coverage by public health insurance, financial support for those in need, and self-payment. In a non-representative survey of Australian women, Johnston et al. (2022) found that, consistent with previous research in other countries, there was more support for MEF than for SEF. 87% of participants supported full or partial public funding of MEF, while 42% supported full or partial public funding of SEF. Egarter (2025) argues that the unfavorable cost–benefit ratio speaks against financing SEF through the public health insurance. Given the high costs and the current financial pressure on the Austrian public social insurance system, which may limit its ability to cover SEF, there is a risk that, if permitted, SEF may only be available to socio-economically privileged groups who are well informed about this option, rather than to marginalized groups.

Several interviewees criticized that only a small proportion of eggs are used. Egarter (2025) indicates a collection rate of frozen eggs ranging from 6% to 12% (see also Alteri et al., 2019). Thus, the cost–benefit ratio of SEF is poor, estimated at approximately $600,000 to $1,000,000 per additional live birth in 2018 (Egarter, 2025; Wunder, 2013). Reasons for not using frozen eggs include pregnancy without MAR, feeling too old to be a parent, not having a partner, and not feeling ready for a child (De Proost et al., 2025). Johnston et al. (2022) criticize the use of cost-effectiveness because it does not consider the complexity of SEF.

Interviewees used time metaphors such as "clock," "biological clock," and "ticking clock," which carry the notion of inevitability and pressure. SEF would help to "expand the time frame" and to gain "time." This indicates that SEF is connected with changing ideas of "temporality" and how to deal with time in reproduction (Rimon-Zarfaty & Schicktanz, 2022). Metaphors like "insurance" or "bank" are linked to economy, pointing at a "neoliberal ethos" that makes women "responsible for risk-managing their own reproductive futures by forms of self-investment" and is connected to liberal values such as "responsibility, self-actualization, and self-determined action" (De Proost & Coene, 2019, p. 360; see also Myers & Martin, 2021; Rimon-Zarfaty & Schicktanz, 2022).

Those who were ambivalent or opposed MAR perceived it as useful at times, but they also criticized its commercialization and focus on expansion. However, an advocate mitigated this criticism by pointing out that MAR, like any other form of modern medicine, is commercialized. The academic literature discusses commercialization of reproduction: EF is one of the fastest-growing MAR techniques worldwide (De Proost et al., 2025). In the US, 15% of fertility clinics are in academic research centers; the rest are "private, for-profit companies" (Espinosa-Herrera & Pietrini-Sánchez, 2025, p. 124). Wunder (2013) criticizes commercial practices of advertising SEF. On the other hand, Egarter (2025) recognizes the economic

interests of IVF centers, which usually are in favor of the general approval of SEF. Myers and Martin (2021, p. 2) portray the "expansive process" of "medicalization" of SEF that underlies the commercialization of MAR and turns SEF into a "prophylactic technology" (Myers & Martin, 2021, p. 3). In medicalization, natural life processes and social problems are recast as medical conditions to be treated by medical practitioners (Myers & Martin, 2021, p. 2).

One reason for SEF mentioned in interviews was that today's women are more focused on their careers. Having a child means taking time out from work. Other reasons included a lack of suitable partners. Changing attitudes toward partnerships and family life have also been cited as drivers of SEF; for example, partnership stability and the desire to start a family are less important today. Baldwin et al. (2019, p. 171) found little empirical evidence that women were postponing motherhood to advance their careers. Instead, their motives were "age, relationship status, concerns about current intimate relationships, and fears of future regret." Respondents felt that postponement was not a deliberate decision; rather, they "had not yet been in a position where motherhood was an option" due to lack of the right partner, someone "they felt could commit to the parenting project" (Baldwin et al., 2019, p. 171).

Ambivalents and the opponent criticized the prevailing practice of MAR of paying little attention to the psychological impact on women, partners, third parties, and children. Some treatments would particularly neglect and/or violate the rights of third parties and children. The literature suggests potential psychological burden due to freezing and later use of eggs (Egarter, 2025). There is a lack of research on the long-term effects of SEF on children and families. Examples include the earlier onset of the burden on children caring for their elderly parents due to SEF and the increased likelihood of orphanhood due to delayed motherhood (Espinosa-Herrera & Pietrini-Sánchez, 2025).

All groups assessed SEF not as "the" solution to balancing parenthood and work. The ambivalents and the opponent argued that SEF fails to address the underlying problem of reconciling women's lives with parenthood. Interviewees from all groups agreed that it would be best to provide widespread, child-friendly childcare facilities that enable a better balance of work and care. SEF might even have a reverse effect of reducing government efforts to provide widespread childcare. Additionally, respondents demanded equal sharing of domestic care responsibilities, closing the gender pay gap, and promoting male caregiving role models. These changes would make it easier to have children at the peak of fertility. However, while ambivalents viewed this as an alternative to SEF, advocates perceived them as additional measures, that are more important than legalizing SEF. The ambivalents and the opponent also advocated alternatives such as facilitating adoption and fostering, addressing the causes of declining male and female infertility, and accepting infertility and finding other meaning in life. In line with these findings, De Proost et al. (2025, p. 3) note that SEF does not address gender inequality but would only be a "palliative solution" failing to deal with the underlying causes of "delayed childbearing." SEF could be a quick fix that inhibits structural changes toward solidarity and equality (Espinosa-Herrera & Pietrini-Sánchez, 2025). Egarter (2025) discusses how SEF could negatively impact the state's efforts to provide widespread childcare facilities if it becomes more common.

Interviewees called for comprehensive counseling before SEF, including information about the technical procedure and medical risks. It should provide space for women to reflect on their situation and the psychological aspects of MAR. According to literature, informed consent should include the medical risks of

SEF, the fact that SEF does not guarantee pregnancy after the stored eggs are used, and the medical risks of pregnancy at advanced age (Egarter, 2025). Wunder (2013, p. 5) considers it crucial to provide "information about the risk of failure, judicial, ethical, and psychological issues, and, last but not least, the high costs." Katsani et al. (2024) conclude that counseling requires an interdisciplinary team of specialists, including a gynaecologist/obstetrician, an embryologist, and a psychologist.

Many interviewees described the Austrian political system as immobile to reform. Often, individual citizens force regulatory change by taking court action and claiming that existing legislation violates human rights. Politicians were described as reactive, conceding only the minimum required by the courts. MAR was described as controversial and a marginal women's issue within the SPÖ. Interviewees noted strong power asymmetries between actors. Negotiations were described as taking place behind closed doors, providing privileged access for jurists. Often, stakeholders, such as patient organizations, psychotherapists, and child rights advocates, were perceived as excluded from decision-making and remaining unheard. In contrast to some ambivalents, an advocate perceived only limited influence on lawmaking by reproductive physicians. In general, respondents did not perceive a willingness of Austrian policy makers to engage in a broad public debate and comprehensive reform. Politicians were described as uninformed, and the political debate as polarized with little constructive dialogue and willingness to engage in discussion with those who hold different viewpoints.

5. Strengths and Limitations

The design of this study has limitations. Rather than portraying the attitudes of the general population or the political debate, it depicts in detail the discourse of individuals who actively participate in public debate on MAR. These individuals are more knowledgeable about MAR, have a higher level of formal education, and are more politically active than the average population. All are from Vienna's urban area, and none are part of a minority group. With nine females and one man, the sample is also heavily biased towards women. Yet, this reflects the gender composition of most events at which participants were recruited. Public and political debate, as well as the media and marginalized groups, are often less well-informed about MAR and SEF than the respondents and tend to focus only on limited aspects of MAR. A qualitative research design was chosen since quantitative surveys, which are often used to investigate the general public's attitudes towards MAR (e.g., Marketagent, 2021), are of limited value since many respondents are unfamiliar with MAR and its complexities. Furthermore, surveys often limit respondents to closed questions, failing to provide a nuanced picture of their attitudes and motives. Therefore, to obtain meaningful results regarding the attitudes of the general public and/or marginalized groups towards MAR and SEF, future research should first thoroughly inform participants about SEF and MAR, as well as their medical, individual, and societal implications, before exploring their attitudes and discourse. The nuanced findings from this research could enrich and support public debate.

6. Conclusion

The themes identified in this study are similar to those in international literature. SEF is controversial, and attitudes and opinions about it, as well as about MAR, vary. Arguments focus not only on the moral permissibility of SEF, but also encompass broader social issues concerning life planning, partnership, work, family, and commercialization of medicine in a capitalist society. Interviews reveal a multifaceted web of arguments that is rarely addressed in its complexity in public debates or politics. Instead, the latter often

focuses on reproductive autonomy. Austrian policymakers are described as reluctant or unable to discuss and regulate the rapidly advancing area of MAR with its tremendous individual and societal impact (Griessler, 2010; Griessler & Winkler, 2022). Opinion polls, which are often used to support particular positions, interests, and policies (e.g., APA, 2021; Marketagent, 2021), can be misleading if they ask overly simplified questions that fail to address the medical, social, ethical, and psychological complexity of SEF. In order to address them, it is necessary to create forums for political discussion that open up public discursive spaces. Formats of deliberative democracy, such as citizen assemblies, in which randomly selected citizens systematically investigate and discuss a topic, could facilitate discussions that do justice to the complexity of the issues at stake (OECD, 2020).

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Data Availability

Interview data on which this article is based is not available because of data protection.

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