Резюме

Ткачук И. Д. **Соотношение религии и права как форм регуляции общественных отношений.**

В данной статье анализируются отдельные аспекты соотношения религии и права на примере ислама и мусульманского права, индуизма, иудаизма и еврейской правовой системы, а также канонического права.

Ключевые слова: религия, право, ислам, индуизм, иудаизм, каноническое право.

Summary

Tkachuk I. **Correlation of religion and law as forms of regulation of social relations.**

The article analyzes certain aspects of the correlation between religion and law on the example of islam and muslim law, hinduism, judaism and the jewish legal system, canon law.

Key words: religion, law, islam, hinduism, judaism, canon law.

UDK 34.023

O. SHRAMOVA

Oleksandra Shramova, *PhD student of Taras Shevchenko National University of Kyiv*

THE RIGHT TO HEALTH OF THE CHILD IN PRENATAL STAGE

Introduction. Was it possible to raise an issue of legal capacity of a child before birth one century ago and is it possible now? What about particular rights, such as right to health? This article is an attempt to answer these questions, and to unveil some details of what is happening right now, when such right is not legally recognized. The issue of consequences of such state of affairs is also touched, and some suggestions of what could be done to improve current situation are made as well.

Formulation of the problem. In a twosome of pregnant woman and her baby both are subject to influence of numerous factors, which affect their health. The difference between those two is that right to health of a woman is protected and guaranteed, whereas this right of a child is not recognized. Consequently, the child in prenatal stage is deprived of legal protection of its right to health.

Easy to say, but more difficult to define, what exactly is meant by the right to health of the child in prenatal stage, to what kind of violations it is exposed now and their impact on further child's life. Another objective of this paper is to suggest measures that should be taken in order to not only declare, but also to provide for protection of health of the child in prenatal stage.

Dimensions of the right to health: negative right to health and positive right to healthcare. What is meant by right to health? Legal science has filled this concept with a specific content. Numerous sources accentuate, – the right to health should not be equalized with the right to be healthy[1]. E. Riedel notes: "Good health cannot be ensured by a state, nor can states provide protection against every conceivable cause of human ill health. Thus, genetic factors, individual susceptibility to ill health or the adoption of unhealthy or risky lifestyles, albeit important, cannot be attributed to the state"[2].

According to the Article 12 of the International Covenant on Economic, Social and Cultural Rights, everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. In the General Comment no. 14, the Committee on Economic, Social and Cultural Rights notes, that right to health, like all other human rights, imposes three types or levels of state obligations: the obligations to *respect*, *protect* and *fulfil*[3].

The obligation to respect, according to the General Comment No. 14, requires States parties to refrain from interfering directly or indirectly with the enjoyment of the right to health. This is a negative obligation, which requires the States to restraint from violations of the person's right.

Obligations to protect and fulfil, in turn, are considered as positive obligations of the state, as they require active efforts from the States parties. Obligation to protect requires States to take necessary measures to prevent violations from the third parties, e.g. private actors. Obligation to fulfil requires States to adopt appropriate legislative, budgetary, judicial, promotional and other measures toward the full realization of the right to health[4].

The European Convention on Human Rights does not provide for the right to health straight out. However, its Article 8, which provides for the right to respect for private and family life, encompasses physical and moral integrity of the person.

As right to health has various dimensions, it can be concluded, that it already has its structure, established by international and national legal systems. Within this structure the components of the right to health could be clearly distinguished. In this regard, the freedom of enjoying the right to be healthy is in its nature negative, natural and absolute, whereas the right to healthcare is positive, legal and relative.

© O. Shramova, 2017

It means that every human being has an absolute right to enjoy his/her right to health without any extrinsic negative influences. However, right to healthcare is relative, as it is being protected to the extent, established by international and national standards.

Terminology. To date, science has not developed a unified interdisciplinary approach concerning terminology used for naming the child during the period between conception and birth. It can be called *an embryo* or *a fetus, unborn, nasciturus, baby* or even *fetal/abortion materials* if the child was aborted. These terms all have some specific meanings, which do not fit to the whole period from conception till birth.

In medicine the period of 40 weeks which starts from fertilization and ends with the baby's birth is called prenatal stage[5]. Not going deeply into this issue, as it is not a subject of this article, it is only necessary to denote that here in this article human at any stage between fertilization and delivery will be called *the child in prenatal stage*.

Discussion on the issue of human life beginning. European Court of Human Rights in the case of Vo v. France in 2004 pointed to the 'diversity of views on the point at which life begins'[6]. Natalia Besedkina, Russian PhD in law, in her dissertation named 'Constitutional and legal protection of the rights of unborn child in Russian Federation', wrote: 'it seems like the child who is unborn and who is already born are only stages of development of the same person. Respectively, it is acceptable to treat unborn child like a natural phase of human development, which starts in the period of foetus development in a womb, and ends with achievement of full age'[7]. Agreeing in general with the way of thinking of this researcher, it necessary to clarify, that 'the child in prenatal stage' is a broader concept than 'the foetus', as it includes earlier embryonic period. Moreover, development of the child in prenatal stage is not limited to the development in a womb only in the cases of conception *in vitro* with the use of reproductive technologies.

Hitherto legal doctrine has developed several approaches to determining initial moment of human life.

Majority of states for now have accepted the concept, where human life is considered to begin at the moment of birth. This approach is usually called *natusial* (from lat. *natus* – birth), or liberal[8]. As Russian professor S. Shyndyapin has noted, "One can say with confidence, that followers of this concept have applied liberal approach to a determinately wrong problem"[9]. Another Russian author O. Reznik in her dissertation "Right to life: civil aspects" also called this approach unsubstantiated, because it leads to ascertaining of the circumstance, that life already exists, but right to it has not emerged yet"[10]. Joining this opinion, it should be noted, that this approach should be considered as temporary, such as is being used by science until the legal status of the child in prenatal period is defined. Back in 1986 the Council of Europe has adopted Recommendation 1046 on the use of human embryos and foetuses for diagnostic, therapeutic, scientific, industrial and commercial purposes, where in points 5 and 6 there was stated: "Considering that, from the moment of fertilisation of the ovule, human life develops in a continuous pattern, and that it is not possible to make a clear-cut distinction during the first phases (embryonic) of its development, and that a definition of the biological status of an embryo is therefore necessary… progress has made the legal position of the embryo and foetus particularly precarious, and that their legal status is at present not defined by law"[11].

Moving further on the time criterion of the moment of human life beginning, one can distinguish the next approach. According to it, human life begins when the child in prenatal stage becomes viable – that is, able to live autonomously outside its mother's womb. This notion coms from famous US Supreme Court decision Roe vs. Wade (1973), where the Court explained 'viable' as 'potentially able to live outside the mother's womb, albeit with artificial aid'[12]. Approximate term of pregnancy, when a child achieves viability, is 22 weeks.

Other researches in a search for a compromise solution associate beginning of human life with the development of nervous system. This point of view, notes O. Kashyntseva, emerges from a settled in medicine concept of biological death, which comes with fading of the cerebral cortex[13]. In classical embryology formation of the nervous system of the child in prenatal stage is associated with the beginning of the embryonic period, when the nerve plate appears and the axial complex of organs is laid[14]. However, followers of this approach usually take as criteria certain stage of nervous system development – the moment of grey matter formation (6–8 weeks of pregnancy), stage of cerebral cortex formation (25–32 weeks of pregnancy), or the completed stage of brain structuring (32–36 weeks of pregnancy).

Next approach derives from the notion of *clinical death*, which in medical science is defined as heart failure. Followers of this approach associate beginning of life of a child in prenatal stage with the beginning of heartbeating. During the recent years USA have experienced the series of heartbeat protection acts (laws) – (Ohio in 2011, Arkansas and Texas in 2013, South Carolina in 2015 etc.). Initiators of those laws note, child's heartbeating is worth to be heard and consider this criteria as a compromise between pro-lifers and pro-choicers.

According to the next approach beginning of human life is associated with the end of proembryonic stage of prenatal development. Proving his position, the French scientist Etienne Bohle, in particular, stated: "During the first two weeks, the embryo cannot be considered an individual (individuals who cannot be divided), since at this stage it can share and form twins, and at the time of fertilization, from unknown so far for science reasons – instead of an embryo, there might develop a tumor – chorioepithelioma"[15]. However, these circumstances do not hamper calling human life as "human life", although describe some peculiarities of its initial stage.

Finally, according to the *embryonic* concept, which gets increasingly more followers (O. Krylova, L. Lyubytch, S. Shyndyapin, O. Vinglovska etc.), human life is believed to begin with the moment of conception. Due to the humanistic orientation of the modern society development, this approach is the most promising one.

Links between maternal and prenatal rights to life and health. Maternal and newborn lives and health are closely linked[16]. In the case of Brüggemann and Scheuten the Commission acknowledged that "… pregnancy cannot

be said to pertain uniquely to the sphere of private life. Whenever a woman is pregnant her private life becomes closely connected with the developing foetus"[17].

By the means of current legislation life and health of the child in prenatal stage is under the absolute maternal power, likewise a century ago life and health of any human was under absolute power of a state. However, any maternal lifestyle, which is harmful for the baby, is harmful for the mother also. Even decision to interrupt pregnancy negatively affects maternal health and can eventually result in absolute reproductive dysfunction, or death.

Whereas a woman has recognised and protected absolute rights to life and health, and relative right to healthcare, the child in prenatal stage does not have, from the point of view of law, none of those. Law is written by human adults, but from the point of view of natural rights the issue is quite arguable. If the child in prenatal stage is not a human, then who is it? Science does not know any case, when a human can give birth to somebody else but human.

This dilemma can be solved through the variation of degree of absolutism of the right. For example, until the child achieves its viability, its right to life is relative and not absolute. This is due to the absolute maternal rights to life and health. In a case of threat to her life or health, her absolute rights will be given a priority. However, if mother exercises her relative right to privacy by abusing substances during pregnancy, the relative right to health of the child in prenatal stage should be given priority.

The true reason for keeping silence on this issue is leaving women alone with their decision whether to keep their pregnancies or not. However, besides this, there are many problems which can be associated with the rights of the child in prenatal stage, e.g. the problem of maternal/newborn morbidity and mortality, and stillbirths.

Women's lifestyles during pregnancy as the cause of mortality and morbidity. According to The Lancet, an estimated 2–6 million stillbirths occur annually, and most of them are preventable[18]. Indeed, among the risk factors of stillbirths there are nutrition and lifestyle factors. In high-income countries, 90 % of stillbirths occur in the antepartum period, often associated with preventable lifestyle factors such as obesity and smoking[19].

Besides obesity and smoking, an enormous danger to both maternal and prenatal life and health is imposed by substance abuse. According to the Healthline[20], using drugs during pregnancy in general result in miscarriage, stillbirth, small size, low birth weight, premature birth, birth defects, sudden infant death syndrome and drug dependency in the baby.

Harold Kalter in his book 'Mortality and Maldevelopment: Part 1. Congenital Cardiovascular Malformations' had stressed, that one of the categories of extrinsic causes of cardiovascular malformations is the maternal lifestyle. The latter includes things like cigarette smoking, caffeine, cocaine, marijuana, alcohol, etc.[21]

In general substances that can cause congenital defects are called *teratogens*. Let's consider briefly the most dangerous teratogens and their impact on the mother and her baby.

Cigarette smoking. The smoker's body is imposed to the impact of cigarette smoke, which has complex chemical composition. There were found over 150 of various toxic, carcinogenic and other chemical compounds. Among these ingredients the most dangerous are nicotine and carbon monoxide[22].

Smoking has a detrimental effect on the woman's body. This effect includes toxic influence of smoking components on the reproductive function of a woman: smoking woman has only 67 % of possibility of getting pregnant of a non-smoking woman[23].

Maternal cigarette smoking was proven to increase infant mortality in a terrible way. Recently infant deaths were found it to be 40 % higher in offspring of smokers than of nonsmokers, and smoking accounted for 5 % of all infant deaths in the US[24].

It was found, that the placenta is well permeable to nicotine. It is assumed that smoking women have a multifactorial basis for placenta damage and fetal growth disorders[25]. Maternal cigarette smoking especially during about the 3rd trimester of pregnancy decreases mean birthweight and increases the frequency of LBW, in a nonlinear manner, even when associated risk factors are discounted; mostly due to retarded fetal growth and less to early delivery[26].

Another maternal smoking effect which was a subject of scientific research is cardiovascular malformations. Though some scientists say that connection between cigarette smoking and heart defects was disproven[27], others are of totally contrary opinion[28]. Some researches prove that maternal smoking during pregnancy is associated with septal and right-sided obstructive defects. This association was stronger for mothers who reported heavier smoking during this period[29].

International Classification of Diseases includes fetus and newborn affection by maternal use of tobacco (P04.2).[30]

Alcohol. The impact of alcohol on the fetus was first described in the scientific literature in the middle of XX century by P. Lemoine and co-authors (1968), who examined 127 children, who were born in families of alcoholics and had various abnormalities. In more detail this phenomenon was researched by K.L. Jones and co-authors (1973), who named it 'Fetal Alcohol Syndrome'.

Ethanol may affect the developing fetus in a dose dependent manner. With very high repetitive doses there is a 6–10 % chance of the fetus developing the fetal alcoholic syndrome manifested by prenatal and postnatal growth deficiency, specific craniofacial dysmorphic features, mental retardation, behavioural changes and a variety of major anomalies. With lower repetitive doses there is a risk of "alcoholic effects" mainly manifested by slight intellectual impairment, growth disturbances and behavioural changes[31].

Alcohol is considered to be the most common preventable cause of congenital disorders[32]. Again, this fact is disputable, as some scientists and researches deny association between alcohol consumption during pregnancy and risk of congenital heart defects[33].

International Classification of Diseases includes fetus and newborn affection by maternal use of alcohol (P04.3)[34] and fetal alcohol syndrome (Q86.0)[35], which includes fetal hydantoin syndrome (Q86.1), dysmorphism due to warfarin Q86.2) and other congenital malformation syndromes due to known exogenous causes Q86.3).

Drugs. Drugs under international control include amphetamine-type stimulants, coca/cocaine, cannabis, hallucinogens, opiates and sedative hypnotics[36]. There are two main international conventions concerning drug control: the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol[37] and the Convention on Psychotropic Substances of 1971[38].

Cannabis (marijuana) is a tobacco-like material and its smoke has many of the same chemicals as tobacco smoke and may increase chances of developmental problems of the child in prenatal stage. Some researches show that using marijuana while pregnancy can cause health problems in newborns – including low birth weight and developmental problems[39].

Use of cocaine during pregnancy leads to decreasing of uterine blood flow, which can cause the onset of fetal hypoxia. Besides that, cocaine destroys monoaminergic neurotransmitters, and that influences negatively development of brain areas, which provide for executive functions, attention and memory[40]. Cocaine use also may cause the placenta to pull away from the wall of the uterus before labor begins. This condition, placental abruption, can lead to extensive bleeding and can be fatal for both the mother and her baby[41].

Ecstasy, or MDMA (which stands for 3,4-methylenedioxymethamphetamine) is a synthetic drug that produces feelings of euphoria and emotional warmth in users. Taking the club drug Ecstasy while pregnant can interfere with the baby's motor development after birth. There have not been any studies on how widespread Ecstasy use is in pregnant women[42].

Hallucinogens, or "psychedelics", are drugs that alter users' state of consciousness and produce different kinds of hallucinations. The main types of hallucinogens are d-lysergic acid diethylamide (LSD), hencyclidine (PCP), hallucinogenic amphetamines, mescaline and psilocybe mushrooms[43]. Although research is scarce, taking hallucinogens during pregnancy may affect the development of the baby, and increase the chance of miscarriage[44].

Heroin addiction is a major health and social problem that has wide ranging adverse consequences. It is known that around one third of heroin addicts in treatment are female and nearly 90 % of them are of childbearing age. Heroin misuse in pregnancy can have an adverse impact on a woman (obstetric and non-obstetric effects) and, because heroin easily crosses the placental barrier, the baby as well. Non-obstetric adverse effects include physical (malnutrition, poor dental hygiene, infections, etc.), psychological (feelings of blame and guilt, self-harm, depression, etc) and social (relationship difficulties, domestic violence, involvement in crime, etc). Specific obstetric complications could include antepartum haemorrhage, low birth weight, and higher neonatal mortality; and non-specific complications include premature rupture of membranes, premature birth, and intrauterine growth retardation. Ongoing heroin use during pregnancy has also been shown to be associated with use of other illicit drugs, poor engagement with antenatal services, frequent use of emergency care facilities, and social adversity. Although heroin and other opioids have no specific teratogenic potential, 48–94 % of children exposed in utero will have opioid withdrawals at birth or neonatal abstinence syndrome (NAS)[45].

Methamphetamine is part of the group of drugs called amphetamine-type stimulants (ATS). Methamphetamine (MA) is one of the most commonly used illicit drugs in pregnancy, yet studies on MA-exposed pregnancy outcomes have been limited because of retrospective measures of drug use, lack of control for confounding factors: other drug use, including tobacco; poverty; poor diet; and lack of prenatal care. MA use during pregnancy is associated with shorter gestational ages and lower birth weight, especially if used continuously during pregnancy[46].

International Classification of Diseases includes fetus and newborn affection by maternal use of drugs of addiction (P04.4)[47] and neonatal withdrawal symptoms from maternal use of drugs of addiction (P 96.1)[48].

Other lifestyle factors. There are other preventable lifestyle factors of maternal and newborn morbidity and mortality, and stillbirths. International Classification of Diseases includes foetus and newborn affection by maternal use of nutritional chemical substances (P04.5)[49], foetus and newborn affection by maternal exposure to environmental chemical substances (P04.6)[50], foetus and newborn affection by other maternal noxious influences (P04.8)[51] and foetus and newborn affection by maternal noxious influence, unspecified (P04.9)[52].

Causal links between various lifestyle factors listed above and others which were not mentioned in this article, and further morbidity and/or mortality of a woman and/or of her child definitely require more sound interdisciplinary scientific researches. However, existing data is sufficiently credible for recognition of certain factors (smoking, alcohol and drugs) as unacceptable during pregnancy.

Ways of legal protection of maternal and prenatal life and health

Legal restriction of harmful maternal lifestyles. Despite of all the harmful effects of described maternal lifestyles, in most states harm to the child in prenatal stage is not prohibited by law. The reason for that is absence of recognition of legal personhood of the child in prenatal stage. Thus persuasion is the only method for prevention of such factors that cause wide range of negative consequences for mothers themselves and their babies. Unfortunately, this method is too vague and not effective enough.

However, there are some examples of legal responses to harmful maternal lifestyles. These experiences are so valuable, that definitely should be taken into consideration.

US experience

The most rich practice of legal restriction of maternal lifestyles is in the US. It is worth of noting, that unlike other international human rights treaties, American Convention on Human Rights in its Article 4 protects right to life of every person in general from the moment of conception[53].

In 2003 the Keeping Children and Families Safe Act was adopted and enacted by the Senate and House of Representatives of the United States of America. The purpose of this Act was "to amend the Child Abuse Prevention and Treatment Act to make improvements to and reauthorize programs under that Act, and for other purposes"[54]. This act requires health care professionals to notify social services if they believe an infant has been affected by illegal drug abuse or is experiencing withdrawal symptoms. While states do not have to change their existing prenatal drug abuse laws to comply with this new federal act, states must require health care professionals to identify and report children believed to be affected by prenatal drug abuse to child protective services[55].

In 2004 the Federal Unborn Victims of Violence Act was passed after Scott Peterson was convicted and sentenced to death for the murder of his wife and their unborn child. The Act provides in part that:

(1)(a) Whoever engages in conduct that violates any of the provisions of law listed in subsection (b) and thereby causes the death of, or bodily injury (as defined in section 1365) to, a child, who is in utero at the time the conduct takes place, is guilty of a separate offense under this section. (2)(a) Except as otherwise provided in this paragraph, the punishment for that separate offense is the same as the punishment provided under Federal law for that conduct had that injury or death occurred to the unborn child's mother[56].Congress recently took up this issue again, driven generally by legislators' desire to address the problems associated with increased use of opioids and specifically by a media report on the uneven application of the federal Child Abuse Prevention and Treatment Act (CAPTA) requirements around the country. The Comprehensive Addiction and Recovery Act (CARA), discussed earlier in this section, includes provisions amending CAPTA's eligibility criteria so that, in order to receive grants, states must engage in more rigorous monitoring of provider reporting and referrals of infants determined to be affected by substance use at birth[57].

The USA case law on this issue has emerged much earlier. The first woman who was prosecuted for prenatal drug abuse was a Florida woman named Jennifer Johnson in 1989. It happened after she gave birth, on two separate occasions, to drug exposed infants[58]. She was charged with one count of child abuse and two counts contributing drugs to minors (her children). This case prompted the state of South Carolina to require mandatory arrests of women who test positive for drugs directly after giving birth. The Johnson case set a precedent and was a gateway for future cases regarding prenatal drug abuse[59].

However, law enforcement practice in USA demonstrates, that in cases of livebirths punishment of mothers for substance abuse with long imprisonment causes quite a controversial reaction from society. The latter is due to leaving babies without maternal care, even if mother has repented and rehabilitated. Psychological consequences for such a child could be even more severe, comparing to the consequences from maternal substance abuse during pregnancy[60]. Moreover, the implication of this legislation may destroy the doctor-patient relationship for women who believe that they cannot be honest with their doctors for fear of punishment, or they may avoid prenatal care altogether[61].

The Committee Opinion from the American College of Obstetricians and Gynecologists is as follows:

Drug enforcement policies that deter women from seeking prenatal care are contrary to the welfare of the mother and foetus. Incarceration and the threat of incarceration have proved to be ineffective in reducing the incidence of alcohol or drug abuse. Obstetrician– gynecologists should be aware of the reporting requirements related to alcohol and drug abuse within their states. They are encouraged to work with state legislators to retract legislation that punishes women for substance abuse during pregnancy[62]. Learning the lesson from the USA experience of restricting maternal lifestyles, it is important to outline the following drawbacks that reduce positive effect from such restriction:

Punitive nature of legal response to maternal harmful lifestyles. Women in USA who expose their children in prenatal stage to drugs are prosecuted for child abuse or child neglect and exposure a minor to drugs. It seems quite possible to agree that this is a crime indeed and it is grave. However, due to the links between a mother and her baby, it is impossible to punish mother without punishing her baby. In this way, the child, initially in prenatal stage, then newborn, toddler and so on is punished twice and without guilt. First time the child is punished by exposing it to harmful substances, thus violating its absolute right to health – right to be free from extrinsic influences which are harmful to its health. Second time the child is punished by deprivation of breastfeeding, closeness with its mother, living in a family in love. Therefore it is necessary to recall, what are the functions of legal responsibility and which place punishment takes between these functions. C. Palmer wrote, 'legislative action should be directed away from punitive measures and toward increasing the variety of treatment opportunities available, including, most importantly, treatment on demand'[63].

Term of punishment. The issue is dealing with proportionality of gravity of the offence and responsibility of the offender. Usually women, accused of prenatal drug abuse, are punished with a very long imprisonment – up to 12 years. However, sometimes there are no severe consequences of their harmful behaviour or no causal link between their behaviour and consequences. For example, in South Carolina, Regina McKnight suffered a stillbirth. She was charged with homicide by child abuse, as the state alleged that McKnight caused the stillbirth as a result of her cocaine use. McKnight was sentenced to twelve years in prison. In 2008, as a result of postconviction relief proceedings, the South Carolina Supreme Court unanimously overturned her conviction, concluding that she had received ineffective assistance of counsel at her trial[64]. Another example is Amber Briana Smith, mother of seven children. For money, Smith bounced between stints at Waffle House, McDonald's, and Arby's. Occasionally, she stripped. She was accused of exposing four of her children to drugs – meth and cocaine, and sentenced to six years in prison and five on probation for felony child neglect. Her court records say that she "neglected the victim by using methamphetamines" during her pregnancy[65].

Prison conditions. Women are being incarcerated not only after giving birth to their children, but also during pregnancy. That is called 'protective incarceration' – pregnant woman can be held in confinement for the duration of her pregnancy in order to protect the fetus from drug exposure[66]. Prisons in USA are typically designed for male inmates, perhaps due to the fact that women only makeup about ten percent of the prison population. Prisons always do not provide female prisoners (and the foetuses they may be carrying) with proper nutrition, physical activity and with adequate healthcare[67].

After giving birth, the infant does not typically have the opportunity to bond with its mother during the first important months of its life because the mother is usually only given between twenty-four to seventy-two hours after delivery to spend with her child. After delivery, the child is often sent to live with a foster family or a family member. Thus, mothers cannot spend time with their children even if they wish to do so. The infant is also denied health benefits. For instance, an infant cannot breastfeed if his mother is incarcerated[68].

The question is whether prison itself is an appropriate place for a pregnant woman, who is not aware, not willing or not able to organise her life in a way that fits best interests of her child. The answer is obvious and clear – even if prison conditions are improved and adjusted for pregnant women and women with newborns, prison is certainly not the best place for a woman waiting for a baby, as well as for a baby as its first home.

Nevertheless, critics of current US policy do not challenge the need for solution of the prenatal drug abuse issue, stressing that it is possible to produce more positive results with less punitive measures[69].

Other countries' experience

Some European countries have already made some steps toward legal regulation of treatment of children in prenatal stage. According to the Article 202 of the Romania Criminal Code, harming the fetus during birth and during pregnancy is a criminal offence, punishable by no less than 3 and no more than 7 years of imprisonment. However, harming the fetus during birth by a mother who is in a state of mental disorder shall be punished by the penalty reduced to one-half. Furthermore, a fetus injury during pregnancy by a pregnant woman is not punishable under Art. 202 of the Romania Criminal Code[70].

Article 304A of the Greek Penal Code also defines physical harm to the fetus or newborn as a criminal crime[71].

Solution offered. Taken into consideration all the experiences available, it is possible to offer solution of the problem of prenatal substance abuse, which is based on the following crucial points:

– prenatal substance abuse is a problem and it requires recognition and adequate legal response;

– due to the inextricable link between a mother and her baby in utero, measures taken to restrict mother from harmful lifestyles should not be of punitive nature. However, if maternal harmful behaviour led to child's death, no matter prenatal, during birth or after it, measures should be punitive;

– legal response to maternal harmful behaviour should not be optional and depend on woman's request for help. These measures should be loyal, but obligatory and coercive;

– measures should be taken both for the interest of mother and her child in prenatal stage;

– after giving birth and after finishing of coercive measures woman should be observed by state social services for necessary period to prevent a relapse.

Forcing a pregnant woman to give up harmful lifestyles for the sake of her child in prenatal stage is possible only through restriction of her liberty. However, as it was discussed above, imprisonment of a pregnant woman is inappropriate as such, all the more so for the sake of her baby.

To avoid negative effects of imprisonment and public condemnation, but restrict women from harmful maternal lifestyles, states should create special institutions, implying providing necessary and adequate assistance and care to pregnant women in decent conditions, with restriction of their liberty for a necessary period of time.

This solution besides rights to life and to health of the mother and the child, touches such rights, as right to privacy (Article 8 of the European Convention on Human Rights), right to freedom from torture (Article 3 of the European Convention on Human Rights), and right to liberty and security of person (Article 5 of the European Convention on Human Rights). Let's consider whether offered solution is in line with international human rights standards.

As it was mentioned before, right to privacy, protected by the Article 8 of ECHR, is not absolute. It means that exercise of this right can be interfered by public authority if such interference is "with accordance with the law and is necessary in a democratic society in the interests of … public safety … prevention of disorder or crime … for the protection of health or morals, or for the protection of rights and freedoms of others"[72]. This means, that in case of states' recognition of prenatal legal personhood, restriction of maternal harmful lifestyles will be lawful and legal from the point of view of international human rights law.

Article 3 of the ECHR provides for absolute prohibition of torture, inhumane or degrading treatment or punishment. This provision deals with conditions in institutions, where pregnant women with harmful lifestyles will be placed in obligatory manner. In order to prevent possible violations of the right to freedom from torture, inhumane or degrading treatment, states should provide decent and comfortable conditions, with adequate nutrition, medical care, physical activities and psychologically friendly atmosphere.

Right to liberty, protected by Art. 5 of the ECHR, means that no one shall be deprived of his liberty. This right also is not absolute, as para. 1 of Article 5 of ECHR gives an exhausting list of a given general rule.

The second limb of Article 5 § 1 (b) allows for detention only to "secure the fulfilment" of any obligation prescribed by law. There must therefore be an unfulfilled obligation incumbent on the person concerned and the arrest and detention must be for the purpose of securing its fulfilment and not punitive in character[73]. This limb corres-

ponds to the assumed restriction of liberty of pregnant women: if their obligation to lead a healthy lifestyle during pregnancy will be established by law and unfulfilled, restriction of their liberty will be legal.

Article 5 § 1 (e) of the Convention also allows for detention of alcoholics and drug addicts. The ECHR emphasized, that "Article 5 § 1 (e) of the Convention should not be interpreted as only allowing the detention of "alcoholics" in the limited sense of persons in a clinical state of "alcoholism". There is nothing in the text of Article 5 to suggest that this provision prevents that measure from being applied by the State to an individual abusing alcohol, in order to limit the harm caused by alcohol to himself and the public, or to prevent dangerous behaviour after drinking. On this point, the Court observes that there can be no doubt that the harmful use of alcohol poses a danger to society and that a person who is in a state of intoxication may pose a danger to himself and others, regardless of whether or not he is addicted to alcohol. Therefore, under Article 5 § 1 (e) of the Convention, persons who are not medically diagnosed as "alcoholics", but whose conduct and behaviour under the influence of alcohol pose a threat to public order or themselves, can be taken into custody for the protection of the public or their own interests, such as their health or personal safety. At the same time, it means that Article 5 § 1 (e) of the Convention does not permit detention of an individual merely because of his alcohol intake"[74].

It seems like there is no necessity to determine which limb of Article 5 should be applied in this case. Firstly, Article 5 was designed without consideration of possible restriction of liberty of pregnant women because of their lifestyles being harmful for their children in prenatal stage. Secondly, these limbs could be taken in conjunction.

Medical responsibility. Another direction of improving health – and life-relating issues concerning children in prenatal stage, is responsibility of doctors for their mistakes or wilful crimes in relation to children in prenatal stage.

Currently doctors are responsible only for harm to a woman or a baby who was already born (with exception of given examples of countries, which have already established special criminal offences for that). If harm was caused to the child before it was born, in most cases there is no responsibility for medics at all or only disciplinary responsibility.

In a famous ECHR case Vo v. France as a result of confusion and doctor's mistake the pregnancy of Ms. Vo was interrupted and her child, who was in prenatal stage at that moment, between 20 and 21 weeks old, weighed 375 grams, was 28 centimetres long, healthy and viable, did not breath after delivery and died. Desperately looking for justice, Ms. Vo tried to accuse doctor of unintentional homicide, but absolutely unsuccessfully. Having lost the case in France, Ms. Vo applied to the ECHR, but lost this case as well[75].

However, in another case, which is more recent, Aydogdu v. Turkey, the Court decided in favour of two applicants – Ms. and Mr. Aydogdu, who have lost their small newborn daughter as a result of medical negligence. Ms. Aydogdu was at the 30th week of pregnancy, when there appeared signs of premature childbirth. She went to the hospital, where it was decided to make immediate caesarian operation. In such a way she gave birth to a girl of 970 g weight and 37 cm height. The girl was suffering from respiratory distress due to hyaline membrane disease, and needed special and intensive treatment, such as neonatal mechanical ventilation. This treatment wasn't given in proper and timely manner, and the newborn girl died. The actions of doctors were qualified as medical negligence[76].

So what was the difference between these two cases, which led to opposite outcomes? In first case the pregnancy term was 20–21 weeks, whereas in second case it was 30 weeks. What is even more important, in the first case the baby didn't breath after delivery, so it was born already dead. Contrariwise, in the second case it was born alive and needed treatment, which doctors failed to deliver. This demonstrates, that qualification in cases of medical negligence depends on the stage where the child was at the moment of injury – prenatal or postnatal. However, in both cases babies died as a result of medical negligence.

Very similar situation we can see in Ukrainian jurisprudence. In 2001 Judicial Chamber on Criminal Cases of the Supreme Court of Ukraine passed a decision where the defendant – the obstetrician-gynecologist was finally acquitted. When performing caesarian section the defendant has caused severe bodily injury to the baby by damaging its left eye and skin with a scalpel. The Chamber came to a conclusion that in this situation there was an incident (case), the occurrence of which was not caused by the intention or carelessness of defendant and which excludes criminal responsibility of the latter for her actions[77].

There are other decisions of lower-level Ukrainian courts, where doctors were held criminally responsible for harm caused during childbirth. For instance, Saratsky district court in Odeska oblast in 2016 held guilty the doctor, obstetrician-gynecologist, as she conducted unjustified intensification of childbirth, which led to a surgery in a form of a caesarian section and led to grieve consequences to both a woman and her newborn. Severe bodily harm to the baby was a part of qualification[78].

In another court decision, on a case of causing severe bodily harm, the baby was born prematurely because of a knee-jerk. The guilty person was not a doctor, but the reasoning of the court is very interesting for the issue that is being considered. The court held the defendant guilty for causing severe bodily harm to a woman, whose pregnancy was interrupted. The baby was born alive, but died in 35 hours after delivery. There was a proven causal link between the knee-jerk and the baby's death, occurred as a result of multiple internal hemorrhages. However, the court did not find the defendant guilty of an unintentional homicide of the baby, because 'the initial moment of life as an abject of criminal assault is the beginning of physiological childbirth. Therefore, encroachment on the fetus after the onset of the labor process is an attack on human life. It is not important that a child, which I being born, has not yet started an independent extrauterine life and has not even separated from its mother's womb… In it's turn, encroachment on the fetus before the childbirth process has started is not an encroachment on human life (regardless of the age of the fetus) and could not be qualifies as a murder[79].

This case demonstrates, that in Ukraine any harm caused to a baby's health and life in prenatal period before the childbirth process has started, does not constitute a crime. It appears that such approach, perhaps convenient for law enforcement, does not correspond to the principles of humanity, justice and equality.

Russian professor L. O. Ertel in her post-doctorate dissertation in medical sciences 'Autonomy of the child as a patient in pediatrics and neonatology', being a medic, offered to complement some Russian legislation with provisions, establishing rights of embryo and fetus: right for protection from clinical trials, right for delayed compensation for damage inflicted in the womb, and right for delayed compensation for damage inflicted during childbirth[80].

Recognition of legal personhood of the child in prenatal stage is a necessary prerequisite for adequate responsibility for intentional or unintentional harm, caused by doctors to children in prenatal stage.

Conclusion. The right to health is multi-dimensional, it includes negative and absolute right to health, as well as and positive and relative right to healthcare. Though discussion on the issue of the moment when human life begins is still ongoing, we can definitely say that maternal and prenatal lives and heath are closely interconnected by numerous links. Any in influence on mother has its unavoidable effect on her child being in prenatal stage.

The other fact which could not be denied is that a range of maternal lifestyles – cigarette smoking, alcohol and drugs use, other harmful lifestyles, such as use of nutritional chemical substances, – affect prenatal development of a baby and influence its health not only during its life in a womb, but also the rest of its after-birth life. The consequences of such lifestyles include miscarriage, stillbirth, small size, low birth weight, premature birth, different kinds of malformations, fetal alcohol syndrome, birth defects, sudden infant death syndrome and drug dependency in the baby, as well as newborn and maternal morbidity.

Some European countries, such as Greece and Romania, have already criminalized offences against the child in prenatal stage. Apparently, this is not enough and does not constitute unanimity in European community. For this reason тhe emerging ECHR case law (Vo v. France, Aydogdu v. Turkey) is quite uncertain.

The most comprehensive experience of protection of children's rights before they are born is given by the US, as American Convention on Human Rights in its Article 4 protects right to life of every person in general from the moment of conception. In the US, there is an extensive practice of prosecuting women for child abuse or child neglect by exposure them to drugs or other harmful substances during pregnancy. This approach, however, has its drawbacks, such as: a) punitive nature of legal response to maternal harmful lifestyles, b) lack of proportionality when setting a term of punishment; c) poor and unsuitable prison conditions.

Taken into consideration all the experiences available, states should address problem of violations of the right to health of the child in prenatal stage by restricting women from harmful maternal lifestyles. For this purpose there is a need of special institutions, aimed at providing necessary and adequate assistance and care to pregnant women in decent conditions, with restriction of their liberty for a necessary period of time.

Another direction of reacting to the issue raised is addressing medical negligence during pregnancy and delivery. In Ukraine any harm caused to a baby's health and life in prenatal period before the childbirth process has started, does not constitute a crime. It appears that such approach, perhaps convenient for law enforcement, does not correspond to the principles of humanity, justice and equality.

One of the determinants of this problem is lack of legal recognition of the child's in prenatal stage legal personhood and certainty in this matter.

---

[1] CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) (Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000, para. 8; *Jayawickrama N.* 'The Judicial Application of Human Rights Law: National, Regional and International Jurisprudence', USA: Cambridge University Press, 2002, p. 883 and others.

[2] *Riedel E.* 'The Human Right to Health: Conceptual Foundations', in Clapham, A., Robinson, M., Mahon, C., and Jerbi, S. (eds), Realizing the Right to Health, Swiss Human Rights Book Vol III, Zürich: Rüffer & Rub, 2009, p. 28.

[3] CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) (Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000, para. 33.

[4] Ibid, para. 33.

[5] *Mazur-Mosiewicz A., Dean R. S.* (2011) Prenatal Period, Stages of. In: Goldstein S., Naglieri J. A. (eds) Encyclopedia of Child Behavior and Development. Springer, Boston, MA.

[6] Case of Vo v. France, § 82 (Application no. 53924/00) 08 July 2004 [Електронний ресурс]. – Режим доступу: http://hudoc.echr.coe.int/eng#{"fulltext":["child"],"kpthesaurus":["449","624","625","632","77","553","50","554","318","555","595","231","4","84","111","335","394","496"],"documentcollectionid2":["GRANDCHAMBER","CHAMBER"],"itemid":["001-61887"]}

[7] *Беседкина Н. И.* Права неродившегося ребенка: личные неимущественные и имущественные // Право и жизнь. – 2005. – № 82 (5). – С. 3.

[8] *Шиндяпин С. Э.* К вопросу о моменте признания правоспособности эмбриона человека // Вестник Тамбовского университета. Серия: Гуманитарные науки. – 2014. – № 12 (140). – С. 1–2.

[9] Там само. – С. 2.

[10] *Резник Е. С.* Право на жизнь: гражданско-правовые аспекты [Электронный ресурс]: автореф. дисс. … канд. юрид. наук (12.00.03). – Екатеринбург, 2007. – Режим доступа: http://www.dissercat.com/content/pravo-na-zhizn-grazhdansko-pravovye-aspekty

[11] Recommendation 1049 (1986) [Electronic source]. URL: http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=15080&lang=en

[12] Roe vs. Wade (1973) No 70-18 [Electronic resource]. – Retrieved from: http://caselaw.findlaw.com/us-supreme-court/410/113.html

[13] *Кашинцева О. Ю.* Проблеми визначення статусу ембріона: етико-правовий аспект / О. Ю. Кашинцева // Вісник Академії адвокатури України. – 2007. – Число 3. – С. 69. – Режим доступу: http://nbuv.gov.ua/UJRN/vaau_2007_3_8

[14] *Баранов В. С., Кузнецова Т. В.* Цитогенетика эмбрионального развития человека: Научно-практические аспекты / Баранов В. С., Кузнецова Т. В. – СПб.: Издательство Н-Л, 2006. – С. 41.

[15] *Больe Етьен.* Реакция – агрессивность // Требования биоэтики: медицина между надеждой и опасением. – К.: Сфера. – 1999. – С. 12.

[16] WHO factsheet: Maternal mortality [Electronic source]. URL: http://www.who.int/mediacentre/factsheets/fs348/en/

[17] Brüggemann and Scheuten v. Germany, no. 6959/75, para. 59.

[18] 'Ending preventable stillbirths: An Executive Summary for the Lancet's Series', January, 2016, p. 2.

[19] 'Ending preventable stillbirths: An Executive Summary for the Lancet's Series', January, 2016, p. 4.

[20] Alcohol, Drugs, and Babies: Do You Need to Worry? [Electronic source]: Healthline. URL: http://www.healthline.com/health/pregnancy/alcohol-drugs#overview1

[21] *Kalter H.* Mortality and Maldevelopment: Part 1. Congenital Cardiovascular Malformations. Springer, 2007. – P. 17.

[22] *Нугманова Ж. М.* Влияние курения на беременность и плод // Журнал Национального научного центра хирургии им. А. Н. Сызганова. – 2012. – С. 61.

[23] Там само.

[24] *Kalter H.* Mortality and Maldevelopment: Part 1. Congenital Cardiovascular Malformations. Springer, 2007. – P. 163.

[25] *Нугманова Ж. М.* Вказана праця. – С. 61.

[26] *Kalter H.* Mortality and Maldevelopment: Part 1. Congenital Cardiovascular Malformations. Springer, 2007. – P. 15.

[27] *Kalter H.* Mortality and Maldevelopment: Part 1. Congenital Cardiovascular Malformations. Springer, 2007. – P. 163.

[28] *Сафиуллина А. Р., Яковлева, Л. В.* Анализ факторов риска развития врожденных септальных пороков сердца // Современные проблемы науки и образования. – 2012. – № 4. (Электронный журнал) URL: www.science-education.ru/104-6678

[29] Malik S1, Cleves MA, Honein MA, Romitti PA, Botto LD, Yang S, Hobbs CA; National Birth Defects Prevention Study. Maternal smoking and congenital heart defects (2008). URL: https://www.ncbi.nlm.nih.gov/pubmed/18381510

[30] ICD-10 Version: 2010 [Electronic source]. URL: http://apps.who.int/classifications/icd10/browse/2010/en#/P04.2

[31] *Asher Ornoy, Zivanit Ergaz.* Alcohol Abuse in Pregnant Women: Effects on the Fetus and Newborn, Mode of Action and Maternal Treatment (2010). URL: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2872283/

[32] "Facts about FASDs". cdc. gov. United States Centers for Disease Control and Prevention (CDC). April 16, 2015. Retrieved February 14, 2016.

[33] *Kalter H.* Mortality and Maldevelopment: Part 1. Congenital Cardiovascular Malformations. Springer, 2007. – P. 165; Zhongyuan Wen, Di Yu, Weiyan Zhang, Changfeng Fan, Liang Hu, Yu Feng, Lei Yang, Zeyu Wu, Runsen Chen, Ke-jie Yin, and Xuming Mo 'Association between alcohol consumption during pregnancy and risks of congenital heart defects in offspring: meta-analysis of epidemiological observational studies' (2016) [Electronic source]. URL: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4739085/

[34] ICD-10 Version: 2010 [Electronic source]. URL: http://apps.who.int/classifications/icd10/browse/2010/en#/P04.3

[35] ICD-10 Version: 2010 [Electronic source]. URL: http://apps.who.int/classifications/icd10/browse/2010/en#/Q86.0

[36] Types of drugs [Electronic source]. URL: https://www.unodc.org/drugs/en/get-the-facts/types-of-drugs.html

[37] The Single Convention on Narcotic Drugs of 1961 [Electronic source]. – URL: https://www.unodc.org/pdf/convention_1961_en.pdf

[38] The Convention on Psychotropic Substances of 1971 [Electronic source]. URL: https://www.unodc.org/pdf/convention_1971_en.pdf

[39] What You Need to Know About Marijuana Use and Pregnancy [Electronic source]: Centers for Disease Control and Prevention. – URL: https://www.cdc.gov/marijuana/factsheets/pregnancy.htm

[40] *Чернов Д. Н.* Социокультурная обусловленность языковой компетенции ребенка: проблемы и перспективы решения: Монография. – М.: ТЕЗАУРУС, 2013. – С. 49.

[41] Cocaine Use During Pregnancy (2002) [Electronic source]. URL: http://www.tgorski.com/Prevention/cocaine_use_during_pregnancy.htm

[42] *Pappas S.* Ecstasy in Pregnancy Is Bad for Baby, Study Finds (2012) [Electronic source]. – URL: https://www.livescience.com/18943-ecstasy-pregnancy-development.html

[43] Hallucinogens: What are they? [Electronic source]. URL: https://www.unodc.org/drugs/en/get-the-facts/hallucinogens.html

[44] Hallucinogens [Electronic source]: Centre for Addiction and Mental Health. – URL: http://www.camh.ca/en/hospital/health_information/a_z_mental_health_and_addiction_information/hallucinogens/Pages/default.aspx

[45] *Namboodiri V., George S., Boulay S., Fair M.* Pregnant heroin addict: what about the baby? BMJ Cse Rep. (2010). URL: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3029977/

[46] *Wright T. E., Schuetter R., Tellei J., Sauvage L.* Methamphetamines and Pregnancy Outcomes // J. Addict Med. – 2015. – Mar-Apr; 9 (2):111–117.

[47] ICD-10 Version: 2010 [Electronic source]. URL: http://apps.who.int/classifications/icd10/browse/2010/en#/P04.4

[48] ICD-10 Version: 2010 [Electronic source]. URL: http://apps.who.int/classifications/icd10/browse/2010/en#/P96.1

[49] ICD-10 Version: 2010 [Electronic source]. URL: http://apps.who.int/classifications/icd10/browse/2010/en#/P04.5

[50] ICD-10 Version: 2010 [Electronic source]. URL: http://apps.who.int/classifications/icd10/browse/2010/en#/P04.6

[51] ICD-10 Version: 2010 [Electronic source]. URL: http://apps.who.int/classifications/icd10/browse/2010/en#/P04.8

[52] ICD-10 Version: 2010 [Electronic source]. URL: http://apps.who.int/classifications/icd10/browse/2010/en#/P04.9

[53] American Convention on Human Rights, "Pact of San Jose", Costa Rica (1969) [Electronic source]. – URL: http://www.refworld.org/docid/3ae6b36510.html

[54] Keeping Children and Families Safe Act of 2003 [Electronic source]. URL: https://www.congress.gov/108/plaws/publ36/PLAW-108publ36.pdf

[55] *Coleman E. E., Miller M. K.* Assessing legal responses to prenatal drug use: can therapeutic responses produce more positive outcomes than punitive responses? // 20 J.L. & Health 35 (2006–2007). – P. 45.

[56] *Boudreaux J. M., Thompson Jr.* Maternal-Fetal Rights and Substance Abuse: Gestation Without Representation // The Journal of the American Academy of Psychiatry and the Law. – 2015. – Vol. 43. № 2. – P. 139.

[57] Pregnant women and substance use. Jacobs Institute of Women's Health (2017). – P. 51.

[58] *Dorothy E. Roberts*, KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY 162-63 (1997).

[59] *Coleman E. E., Miller M. K.* Assessing legal responses to prenatal drug use: can therapeutic responses produce more positive outcomes than punitive responses? // 20 J.L. & Health 35 (2006–2007). – P. 43.

[60] *Khazan O.* States are jailing mothers for drug addiction and taking their children away [Electronic resource]: The Atlantic. – 2015. – May, 8. – Access from: http://www.theatlantic.com/health/archive/2015/05/intothebodyofanother/392522/

[61] *Boudreaux J. M., Thompson Jr.* Maternal-Fetal Rights and Substance Abuse: Gestation Without Representation // The Journal of the American Academy of Psychiatry and the Law. – 2015. – Vol. 43. № 2. – P. 140.

[62] ACOG Committee Opinion No. 473: Substance abuse reporting and pregnancy: the role of the obstetrician-gynecologist. Obstet Gynecol 117:200. – 1, 2011.

[63] *Palmer C. S.* The Risk of State Intervention in Preventing Prenatal Alcohol Abuse and the Viability of an Inclusive Approach: Arguments for Limiting Punitive and Coercive Prenatal Alcohol Abuse Legislation in Minnesota // 10 Hastings Women's L.J. (1999). – P. 44.

[64] McKnight v. State, 661 S.E.2d 354, 358 n.10 (S.C. 2008).

[65] *Khazan O.* Into the Body of Another // The Atlantic (May 2015). – P. 3.

[66] *Coleman E. E., Miller M. K.* Assessing legal responses to prenatal drug use: can therapeutic responses produce more positive outcomes than punitive responses? // 20 J.L. & Health 35 (2006–2007). – P. 50.

[67] *Coleman E. E., Miller M. K.* Assessing legal responses to prenatal drug use: can therapeutic responses produce more positive outcomes than punitive responses? // 20 J.L. & Health 35 (2006–2007). – P. 57.

[68] *Coleman E. E., Miller M. K.* Assessing legal responses to prenatal drug use: can therapeutic responses produce more positive outcomes than punitive responses? // 20 J.L. & Health 35 (2006–2007). – P. 57.

[69] *Coleman E. E., Miller M. K.* Assessing legal responses to prenatal drug use: can therapeutic responses produce more positive outcomes than punitive responses? // 20 J.L. & Health 35 (2006–2007). – P. 59.

[70] Law No. 286 of July 2009 of the Criminal Code [Electronic source]. URL: http://www.legislationline.org/download/action/download/id/5895/file/Romania_Criminal_Code_am2012_EN.pdf

[71] Greek Penal Code [Electronic source]. – URL: http://www.c00.org/p/greek-penal-code.html

[72] Para. 2 of the Article 8 of the European Convention on Human Rights [Electronic source]. – URL: http://www.echr.coe.int/Documents/Convention_ENG.pdf

[73] Guide on Article 5 of the Convention: Right to Liberty and Security [Electronic source]: Council of Europe/ European Court of Human Rights, 2014, p. 13. – URL: http://www.echr.coe.int/Documents/Guide_Art_5_ENG.pdf

[74] Kharin v. Russia, app. no. 37345/03 (2011), para. 34.

[75] Vo v. France, app. no. 53924/00 (2004).

[76] Aydoðdu c. Turquie, req. no. 40448/06 (2016).

[77] Decision of Judicial Chamber on Criminal Cases of the Supreme Court of Ukraine (extract) dated 01.11.2001 [Electronic source]. – URL: http://www.scourt.gov.ua/clients/vsen.nsf/0/C8C38F5F5B6CBA2DC2256D2500436EB9?OpenDocument

[78] Вирок Саратського районного суду Одеської області від 18 травня 2016 року [Електронний ресурс]: Єдиний державний реєстр судових рішень. – URL: http://www.reyestr.court.gov.ua/Review/57807726

[79] Вирок Овідіопольського районного суду Одеської області від 11.08.2015 р. [Електронний ресурс]: Єдиний державний реєстр судових рішень. – URL: http://www.reyestr.court.gov.ua/Review/48674428

[80] *Эртель Л. А.* Автономия ребенка как пациента в педиатрии и неонатологии // Автореф. дисс. … докт. юрид. наук (14.00.52). – Волгоград, 2006. – С. 278.

Резюме

Шрамова О. С. **Право на здоров'я дитини на пренатальній стадії розвитку.**

Право на здоров'я дитини у пренатальний період на сьогодні не є визнаним. У статті досліджується право на здоров'я та його складові, зв'язки права на здоров'я та життя вагітної жінки з правами на здоров'я та життя її дитини в утробі. Розглянуто вплив шкідливих факторів на здоров'я дитини, що перебуває на пренатальній стадії розвитку: тютюнопаління, вжиття алкоголю, наркотичних речовин та ін. Досліджено досвід зарубіжних держав, зокрема США, Румунії та Греції у протидії порушенням права дитини на здоров'я у пренатальний період, практику Європейського суду з прав людини з даного питання. Аналізуються підходи до вирішення судових справ про медичну недбалість щодо дитини на пренатальній стадії розвитку. Пропонується визнання правоздатності дитини на пренатальній стадії розвитку як передумова захисту її суб'єктивного права на здоров'я.

Ключові слова: дитина на пренатальній стадії розвитку, ненароджена дитина, плід, права дитини, пренатальні права, право на здоров'я, медична недбалість.

Резюме

Шрамова А. С. **Право на здоровье ребенка на пренатальной стадии развития.**

Право на здоровье ребенка в пренатальный период на сегодняшний день не является признанным. В статье исследуется право на здоровье и его составляющие, связи права на здоровье и жизнь беременной женщины с правами на здоровье и жизнь ее ребенка в утробе. Рассмотрено влияние вредных факторов на здоровье ребенка, находящегося на пренатальной стадии развития: курения, употребления алкоголя, наркотических веществ и др. Исследован опыт зарубежных государств, в частности США, Румынии и Греции в противодействии нарушениям права ребенка на здоровье в пренатальный период, практика Европейского суда по правам человека по данному вопросу. Анализируются подходы к решению судебных дел о медицинской халатности в отношении ребенка на пренатальной стадии развития. Предлагается признание правоспособности ребенка на пренатальной стадии развития как предпосылка защиты ее субъективного права на здоровье.

Ключевые слова: ребенок на пренатальной стадии развития, нерожденный ребенок, плод, права ребенка, пренатальные права, право на здоровье, медицинская халатность.

Summary

Shramova O. **The right to health of the child in prenatal stage.**

The right to health of the child in prenatal stage to date is not recognized. In this article there are considered such issues as the right to health and its elements, links between maternal and prenatal rights to health and life. Such harmful factors, as cigarette smoking, alcohol use, drugs abuse, and other maternal harmful lifestyles and their impact on the child in prenatal stage are also considered in this article. Foreign countries' experience, such as the USA, Greece and Romania, in resisting violations of the right to health of the child in prenatal stage, as well as the ECHR case law on this issue. The approaches of courts when resolving the cases on medical negligence, which have caused harm to health of the child in prenatal stage, were also analyzed in this article. The recognition of the child's in prenatal stage legal personhood is offered as a prerequisite of protection of its subjective right to health.

Key words: the child in prenatal stage, unborn child, fetus, rights of the child, prenatal rights, right to health, medical negligence.