УДК 346.548(497.11)

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THE STRATEGIC AND LEGAL FRAMEWORK FOR MOTHER AND CHILD HEALTH IN AN ACCESSION COUNTRY, THE REPUBLIC OF SERBIA

The Constitution specifies that children, pregnant women and mothers on maternity leave, single parents with children under 7 years of age and the elderly population are to be provided with publicly funded health care. Since 2000, significant progress has been made in developing overall health policy in Serbia. The present review attempts to describe the strategic and legal framework for mother and child health as an exemplary field of health care, developed in the Republic of Serbia since the democratic change of the national government at the beginning of this century and the increasing orientation towards accession to the European Union. First an overview of the multi-sectorial and sectorial strategies, health policies, laws, decrees, programmes is provided. Secondly the health services for mother and child and their accessibility as well as their outcomes in terms of mortality are described. And thirdly the national response with a focus on the legislation and the requirements of the accession to the European Union are presented. The Serbian government has made considerable progress which can serve as a blueprint for countries with similar orientation.

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Keywords: Maternal and child health, health legislation, Serbia, Acquis Communautaire.

Introduction

A comprehensive understanding of the children's and women's health as a state of complete physical, mental and social wellbeing*, is essential to the health of current and future generations. The prevention of disease requires overall investment in the social determinants of health and reduction of inequalities and unfairness in health, a task for the public health workforce. The right to health and health care is furthermore defined in article 68 of the Constitution of the Republic of Serbia, which provides for a health care system based on mandatory health insurance**. The Constitution specifies that children, pregnant women and mothers on maternity leave, single parents with children under 7 years of age and the elderly population are to be provided with publicly funded health care.

Since 2000, significant progress has been made in developing overall health policy in Serbia. The aim of an ambitious reform programme undertaken from 2004 to 2010 was to strengthen preventive health care and services, with a view to decreasing rates of preventable diseases and total health care costs. The reform also included the restructuring of hospitals to respond to patient needs more effectively and the development of a new basic package of health care services aligned with existing resources. The aim of the present health care management system is to work towards greater decentralization and delegation of powers and responsibilities to the local government level. This objective has also been emphasized in recent Government documents and strategies*** that call for uniform development of the health sector with a view to reducing regional differences in health. The Government's health policy aims at improving public health and increasing efficiency through an optimized network of health institutions.

The present review attempts to describe the strategic and legal framework for mother and child health as an exemplary field of health care, developed in the Republic of Serbia since the democratic change of the national government at the beginning of this century and the increasing orientation towards accession to the European Union.

1) The strategic framework

A number of multi-sectorial and sectorial strategies, health policies, laws, decrees, programmes and other regulations have been developed – with scientific support of leading public health professionals – and adopted providing the foundation for the implementation of services for promotion of health and health status of children and women in Serbia (table 1).

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* Available at: http://www.who.int/governance/eb/who_constitution_en.pdf.

** Ustav Republike Srbije. Beograd: Službeni glasnik RS 98/2006.

*** Government of RS. Fiscal Strategy for 2013 with projections for 2014 and 2015. Available at: http://mfp.gov.rs/UserFiles/File/dokumenti/2012/Nacrt%20fiskalne%20strategije%20za%202013_%20godinu%20sa%20projekcijama%20za%202014_%20i%202015.pdf.

Table 1: Examples of multi-sectorial and sectorial strategies that directly or indirectly support health and health status of children and women in Serbia

Multi-sectorial strategies	Sectorial strategies
Poverty Reduction Strategy RS, 2003.	National Strategy for the Fight against HIV/AIDS, 2005. HIV Infection and AIDS Strategy, 2001.
Action Plan for Children, 2004.	Strategy for Youth Development and Health, 2006.
Pro-natal Strategy, 2008.	Tobacco Control Strategy RS, 2007.
National Strategy for Youth, 2008.	Strategy for Mental Health Protection Development, 2007.
National Strategy on Protection of Children from Violence, 2008.	Strategy for Fight against Drugs for 2009-2013, 2009.
National Strategy for Promotion of Status of Women and Promotion of Gender Equality, 2009.	Strategy for Prevention and Control of Chronic Non-communicable Diseases, 2009.
Strategy for Improvement of the Status of Roma, 2009.	Public Health Strategy, 2009.
National Strategy for Preventing and Combating Domestic Violence and Violence in Intimate Partner Relationships, 2011.	Strategy for the Continuous Improvement of Health Care Quality and Patient Safety, 2009.

Source: Website of the Government of the RS, available at: www.srbija.gov.rs, and Ministry of Health of the RS available at: www.zdravlje.gov.rs.

However, while progress has been made in policy formulation this is only true to a lesser degree when it comes to policy implementation and evaluation, mostly due to insufficient reform capacities at the Ministry of Health and the economic restrictions the country is presently struggling with. In order to support the implementation of reforms, the Healthcare Development Plan of the Republic of Serbia* sets a number of specific goals to be met by 2015/6. These include the implementation, monitoring and evaluation of multi-sectorial and sectorial strategies and plans aimed at improving health among children and adolescents. An important objective is to enhance health care for women of reproductive age, school-aged children and adolescents, persons with disabilities, as well as socially marginalized groups. The plan highlights the importance of continuing the consistent implementation of the National Program of Health Care of Women, Children and Adolescents**. Detailed methodological instructions for the implementation of this Program were produced in 2010 by the Republic Commission for Women's, Children's and Youth's Health Care***.

* Decision on Healthcare Development Plan of the Republic of Serbia. Official Gazette of RS 88/2010.

** Bylaw on National Programme of Health Care of Women, Children and Adolescents. Official Gazette of RS 28/2009.

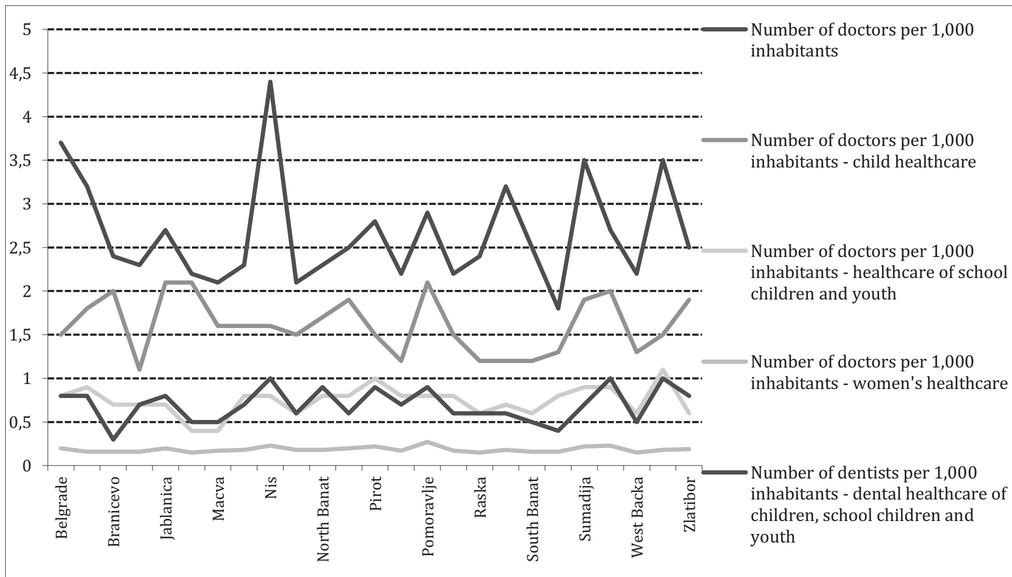
*** Republic Commission for Women's, Children's and Youth's Health Care. Professional-methodological instructions for implementation of the Bylaw on National Programme of Health Care of Women, Children and Adolescents. Belgrade: Institute of mother and child health care of Serbia «Dr Vukan Čupić» 2010.

2a) Health services

Primary healthcare for children and women is provided by teams of chosen physicians (pediatricians, gynecologists, and general practitioners) in primary healthcare centres with defined lists of activities and performance measures*. In 2011, primary health care for ages 0–6 years was provided by 752 physicians out of whom 85% were specialists**. A total of 753 physicians, 63% of whom were specialists provided health care services to children and adolescents aged 7 to 19 years.

Measured at the national level, the availability of such teams is good, but there are significant variations in availability at the district level. A Ministry of Health Decree from 2010*** calls for the optimization of the network of health care institutions in Serbia, including through increased decentralization, in order to address regional inequalities and disparities in the accessibility of healthcare services for children and women (figure 1).

Figure 1: Availability of healthcare for children and women at the primary level in **2010,** in districts of Serbia



Source: Institute of Public Health of Serbia – Health Resources and SORS – Vital Statistics 2010, available at: http://webrzs.stat.gov.rs/WebSite/Default.aspx.

In addition to basic primary health care also counselling services for child growth and development in municipalities with a minimum of 8,500 preschool children were set up. The standards established for this service envisage

* Book of rules about conditions to perform health care in health organizations and other forms of health services. Official gazette of RS 43/2006; 112/2009.

** Institute of Public Health of Serbia «Dr Milan Jovanović Batut». Health Statistical Yearbook of Republic of Serbia 2011. Belgrade: Institute of Public Health of Serbia 2012. p. 107.

*** Decision on Healthcare Development Plan of the Republic of Serbia. Official Gazette of RS 88/2010.

a multidisciplinary team composed of a pediatrician, nurse, psychologist, social worker and special pedagogue. Developing the health care of children with disabilities and developmental problems is recognized as one of the priorities in the health care development plans drawn up on the basis of the Article 16 of the Law on Health Care. Directives and programs regulating this area* attach great importance not only to treatment but also prevention, counselling services and education of health professionals and parents. The fact that there are only 14 municipalities in Serbia that have the required 8,500 preschool children suggests that the regulation needs to be revisited. It should also be noted that according to unpublished data collected by the Republic Institute of Public Health, units for developmental counselling exist in as many as 26 municipalities. It is possible that such services are provided in many municipalities by chosen paediatricians as an integral part of their work and not as a separate service, as primary health centres can also provide developmental counselling services without having a separate organizational unit. The coverage of these services should be further explored through a focused survey.

Secondary specialized healthcare for children and women is provided within the paediatric/gynaecological/obstetric, and other departments of general hospitals. At the tertiary level, highly specialized services are provided in institutions concentrated in Belgrade with a total of 1,227 beds, and with one located in Novi Sad**. Out of Serbia's total in-patient capacity (day hospitals excluded), paediatric departments account for 2,698 beds (6.8% of in-patient capacity), while gynaecological and obstetric departments account 3,527 beds (8.9%).

2b) Mortality indicators

Higher mortality of ***infants and children*** is still present in rural areas, among people living below the accepted poverty line and – as regards South Eastern Europe in particular among Roma subpopulations***. Child mortality due to preventable causes is further compounded by poverty, unfavourable living conditions, low educational level of mothers, social exclusion, neglect, violence against children, and insufficiently accessible antenatal and postnatal health care.

Child mortality and especially infant mortality (figure 2) is regarded as a basic indicator of population health and a measure of long-term consequences of peri-natal events. This parameter is particularly important for monitoring

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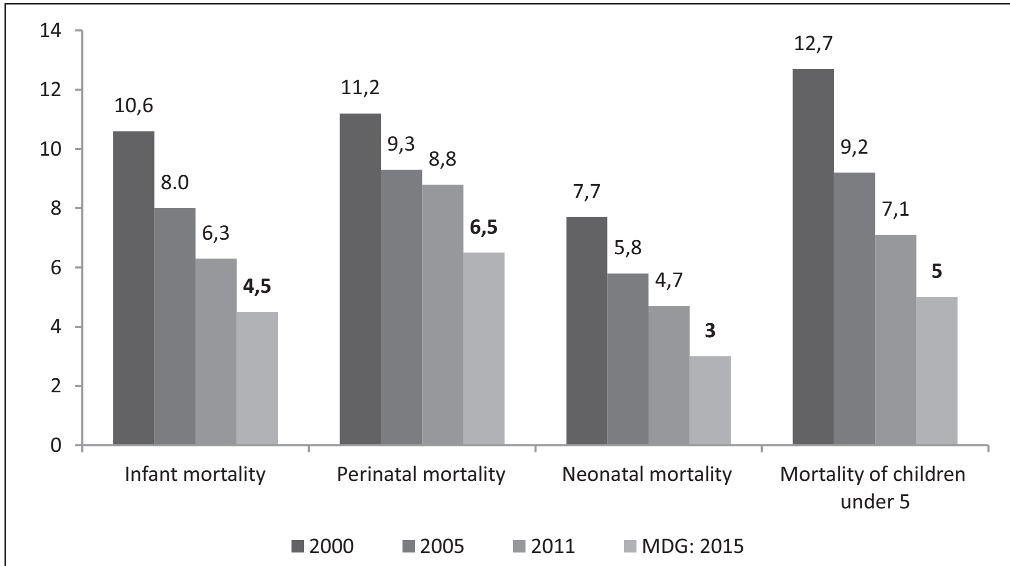
* Bylaw on National Program of Health Care of Women, Children and Adolescents (Official Gazette of RS 28/2009) and Bylaw on National Program of Preventive health care for children with psycho-physiological disorders and pathology of development. (Official Gazette of RS 15/2009).

** University Hospital for Neurology and Psychiatry of Children and Adolescents, Institute for Mother and Child Health Care of Serbia «Dr Vukan Čupić», University Children's Hospital, Institute of Neonatology, University Hospital for Gynaecology and Obstetrics, Institute for Health Care of Mother and Child in Novi Sad.

*** UNICEF 2012: UNICEF (UN Inter-agency Group for Child Mortality Estimation). Levels & Trends in Child Mortality. Report 2012. New York: UNICEF Headquarters 2012.

and assessing health outcomes in high risk groups such as pre-term children and children with developmental difficulties. Trends show that Serbia has made significant progress towards the Millennium Development Goal relating to infant mortality*, **.

Figure 2: Child mortality rates in Serbia in relation to Millennium Development Goals



Source: Statistical Office of the Republic of Serbia – Vital Statistics 2011, available at:

http://webrzs.stat.gov.rs/WebSite/Default.aspx;

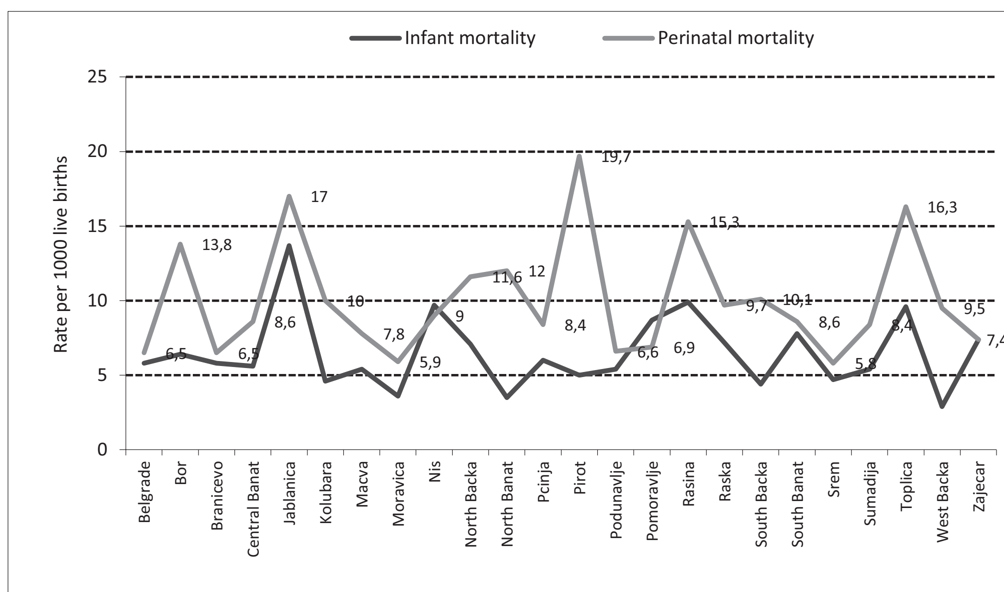
Institute of Public Health of Serbia «Dr Milan Jovanović Batut». Health Statistical Yearbook of Republic of Serbia 2011. Belgrade: Institute of Public Health of Serbia 2012.

While Serbia has recorded satisfactory progress at the national level, data derived from updated registration and reporting systems (DevInfo database), reveal marked regional variations in Serbia, particularly relating to peri-natal mortality (figure 3). The causes for this should be further investigated. For example, the districts of Pirot, Jablanica and Toplica have significantly higher perinatal mortality than the districts of Srem, Morava or Braničevo.

* Institut za javno zdravlje Srbije «Dr Milan Jovanović Batut». Zdravlje stanovnika Srbije. Analitička studija 1997–2007. Beograd: Institut za javno zdravlje Srbije 2008.

** Institut za javno zdravlje Srbije «dr Milan Jovanović Batut». RepublikaSrbija. Odabranizdravstvenipokazateljiza 2011. godinu. Beograd: IZJZS 2012.

Figure 3: Regional variations in perinatal and infant mortality in 2011



Source: Statistical Office of the Republic of Serbia – Vital Statistics 2011, available at: http://webrzs.stat.gov.rs/WebSite/Default.aspx

Maternal mortality* is generally considered a good indicator for a number of social determinants of health including the effectiveness of health services and the quality of health services provided. In the last decade, there have been considerable fluctuations in the maternal mortality rate in Serbia, and in order to capture this trend, the adjusted Millennium Development Goals for Serbia are now being monitored by 5-year averages. Calculated in this way, the five-year maternal mortality average in the period 2007 to 2011 amounted to 13.7, i.e. twice the figure recorded for European Union countries in the period 2006 to 2010. The small numbers of maternal deaths do not allow for significant analyses of subgroups. The major variations recorded over the last years, clearly indicate that additional factors other than maternal mortality need to be monitored for a comprehensive understanding of the reproductive health of women to emerge. This includes health strategies to remove barriers that prevent women from deciding on own health.

The life expectancy of women is rising but at a slower rate than life expectancy of men, with marked regional differences**. Accordingly, in addition to the recommended indicator of maternal mortality, it is necessary, to take into consideration other specific features of female health, bearing in mind that health issues specific to women significantly contribute to the total burden of diseases in the society as a whole. Relatively more women die from these diseases in Serbia than in the EU: the rate is e.g. up to three times as high for cervical cancer. Also non-fatal health outcomes affect women more in terms of quality adjusted life years (DALYs) – 20% for men vs. 25% for women –,

* Maternal mortality defined as: number of women who die due to complications during pregnancy, childbirth or immediately thereafter per 100,000 live births.

** Vlada Republike Srbije. Praćenje socijalne uključenosti u Srbiji. 2006–2012. Drugo dopunjeno izdanje. Beograd: RZS 2012.

suggesting a need to address preventable diseases and improve preventive health care services for this population, so as to ensure timely detection and treatment of the most common causes of death among women.

3a) National response

Following the political changes in 2000, the government identified the reform of the health sector as one of the national priorities and committed itself to carry out health reforms within the wider context of EU integration and public sector reform. Several steps have been taken so far. Among efforts made to establish order in the domain of health care, the most important was the adoption of the Health Policy Document* by the Serbian Government. In view of the fact that no similar document has ever been adopted in Serbia, the process of bringing health in Serbia closer to the relevant policy of the European Union was hereby initiated.

After adoption of the new system laws in 2005 ff., decentralisation played an important role in the portfolio of possible activities to improve governance and management of the health system in Serbia. Therefore, primary health centres and appointing the management team is now a responsibility at the municipality level. The local community is now obliged to prepare a local health care plan and to formulate specific programmes tailored to the needs of the local population**. However, lack of financial resources and economic crisis slowed down these processes. Nevertheless, key steps have been taken, e.g. that the Republic Fund of Health Insurance (RFHI) is led by the Board of Directors equally composed by representatives of the insured, namely proportional to type of insurance and number of insured according to the Health Insurance Law of 2005/art. 209***. Furthermore state based health institutions are founded on the basis of the Plan of the Network of Health Care Facilities, which is to be adopted by the Government. The Plan specifies: The number, structure, capacities, and spatial distribution of health care facilities and their organizational units by levels of health care, organization of the service of emergency medical care etc. Recent Government documents**** summarise these changes and stipulate uniform development aiming at reduction of regional differences in health.

The Ministry of Health of the Republic of Serbia, tried also to improve quality of health care for many years. The national strategy for health care quality and patient safety has been introduced in 2009***** and guidelines for good clinical practice in many areas of health care since

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* Serbian Government. The Health Policy of Serbia, available at: www.prsp.gov.rs/download/Zdravlje.doc.

** http://www.inkluzija.gov.rs/?page_id=2347&lang=en.

*** Health Insurance Law. Official Gazette of RS 107/2005.

**** Government of RS. Fiscal Strategy for 2013 with projections for 2014 and 2015. http://mfp.gov.rs/UserFiles/File/dokumenti/2012/Nacrt%20fiskalne%20strategije%20za%202013_%20godinu%20sa%20projekcijama%20za%202014_%20i%202015.pdf (accessed September 12, 2013).

***** Strategy for continuous quality improvement of health care and patient safety. Official Gazette RS 15/2009.

2004*. In recent years, the system for monitoring health care indicators has been significantly improved, which allows better insight into the work of health services**. The Agency for Accreditation of Health Care Institutions of Serbia (AZUS) was founded in October 2008*** by support of EU project funding, to perform professional, regulatory and development activities in the process of accreditation of healthcare institutions. It started its operations in July 2009, aiming to fulfill its designated duties that include establishment of health care accreditation standards, evaluation of quality of health care provided to the general population, decision making in health care accreditation management issues, awarding accreditation status and issuing public accreditation certificates, and keeping records of accreditation certificates issued. Funds for the establishment and functioning of the Agency for Accreditation are provided from the Budget of the Republic of Serbia. In 2012, the Agency has become the Regional Health Development Center of the South East Europe Health Network on Accreditation and Continuous Quality Improvement of Health Care.

The Law on Healthcare and Law on Health Insurance further regulate the right to better access to healthcare. A recent amendment to the Law on Health Insurance provides additional safeguards as regards the right to privacy and data confidentiality **** for children between 15 and 18 years of age. The amended law also provides improved health care for victims of domestic violence and victims of human trafficking. The amendments stipulate that a child who is 15 years of age and considered mentally competent and able to make own decisions, is entitled to see his/her medical records. The child is also entitled to confidentiality of all data contained in such medical records. Under the same amendment, health information cannot be shared with parents, guardians or legal representatives, without the child's express authorization. The only exception to this rule allows the attending health professional to communicate health information if this is deemed necessary for avoiding serious danger to the life and health of the patient. However, social norms and practice frequently make it hard to fully implement these legal provisions. Such problems have been recorded in reports prepared by civil society associations*****.

Numerous health specific and multi-sectorial measures and policies have been introduced in relation to adolescent health including strategies and amendments to the Law on Health Care with accompanying by-laws, as well as professional and methodological instructions and guidelines for good practice, which have already been mentioned. The Strategy for Development

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* Development of guidelines for good clinical practice started in 2004 with support of the European Union projects. See at: Ministry of Health, Working group for guidelines. http://www.zdravlje.gov.rs/showpage.php?id=145.

** Book of rule on quality of health care indicators. Official Gazette 49/2010.

*** Agency for Accreditation of Health Care Institutions of Serbia. http://www.azus.gov.rs/en/.

**** Zakon o izmenama i dopunama Zakona o zdravstvenoj zaštiti. Službeni glasnik Republike Srbije 57/2011.

***** Strategija za smanjenje siromaštva, Kontakt organizacija za decu. Ka smanjenu siromaštva dece. Resursi, zaključci i preporuke klastera organizacija za decu. Niš: Punta – Društvo za zaštitu i unapređenje mentalnog zdravlja dece i omladine 2008.

and Health of Young People defines a number of particularly vulnerable groups of young people, such as: young people without parental care, poor and street children, young people placed in residential institutions, young people excluded from the educational system, young people requiring special support, as well as refugees and internally displaced persons. However, a national response on impaired mental health, violence especially within family, and sexual health has not yet been fully implemented, though policy framework exists.

In an effort to address substance abuse among young people, a Multidisciplinary Commission for Controlled Psychoactive Substances has been established as envisaged under the 2010 Law on Psychoactive Substances. This Commission gathers experts and representatives of competent institutions to support coordination and cooperation in this area. The Department of Narcotic Drugs and Precursors in the Ministry of Health, together with partners from various sectors, supports the activities of the Commission. Since activities related to narcotics are within the purview of many different sectors, each sector has its own monitoring body. Currently, at the Ministry of Health there are special commissions for drugs (set up in 2008), alcohol and mental health. Key pieces of legislation have been enacted to combat illicit drug use.

- Law on Psychoactive Substances (Official Gazette RS 99/2010);
- Law on Substances Used in Illicit Manufacturing of Narcotic Drugs and Psychotropic Substances (Official Gazette RS 107/05);
- Law on Medicines and Medical Devices (Official Gazette RS 84/04); as well as
- Penal Code (Official Gazette RS 111/2009).

3b) Adoption of the Aquis Communautaire

The process of accessing Serbia to the European Union started end of the 1999 in the context of opening a perspective for the entire Western Balkan. An important concrete step was the decision of the Council of Foreign Ministers of European Union Member States on October 25, 2010 to forward Serbia's application for membership to the European Commission for consideration. On January 19, 2011 the European Parliament ratified the Stabilization and Association Agreement between the EU and Serbia and on October 12, 2011 the European Commission recommended that Serbia be given the status of candidate for membership in the EU. The European Commission recommended opening negotiations with Serbia as soon as Belgrade achieves further good progress in normalising the relations with Kosovo. Finally on March 1, 2012 the European Council granted Serbia membership candidate status. So far Serbia has signed the following agreements:

- Stabilisation and Association Agreement;
- Agreement on trade of textiles and textile products;
- Agreement on the energy community for South Eastern Europe;
- The open skies agreement;
- Agreement on free trade in the Balkans (CEFTA);
- Agreement on visa facilitation and the agreement on readmission.

The current as well as the previous Serbian governments are committed to the accession of Serbia to the European Union. The full adoption of the pre-existing legislative corpus of the European Union, the Acquis Communautaire

is a precondition. The transposition of the Aquis Communautaire is almost fully on track. The Serbian Parliament adopted the National Plan for the Adoption of the *Acquis* 2013-2016 (NPAA 2013–2016). Its implementation was completed by 85% for the period of January-June 2013 (111 regulations out of 131)*. Chapter 28 of the NPAA is related to public health legislation as relevant to consumer and health protection (biomedicine, public health, screening, communicable diseases).

The list of laws and bylaws adopted in 2013, according to the National Plan are related to pharmaceutical products, medical devices, medical devices for active implantation and in vitro medical devices for diagnostics and regulations on health protection referring to communicable diseases, laboratory testing, and immunisation etc. The National Plan refers directly or indirectly to the health sector in 4 sections:

1. Safety and Health at Work: The deadline for the enactment of the proposal of the Law amending the Law on Safety and Health at Work is set for December 2013, referring especially to the improving of the occupational health service.
2. Science and Research: The basic strategic document guiding the science policy is the Scientific and Technological Development Strategy of the Republic of Serbia for the period 2010-2015 (67). Priorities for 2013 are adoption and drawing up a road map for research infrastructure.
3. Education: Key documents are the Law on Higher Education which is adopted and fully implemented following the Bologna process** and the Strategy for Education Development in Serbia until 2020***. The deadline for amending the legislation accordingly is set for the third quarter 2013.
4. Health Protection: Regarding biomedicine, the main activity is the adoption and implementation of 11 laws (rulebooks) in various health fields; regarding public health the main focus is the implementation of the Health 2020 of WHO-Europe, adopted 2012 in Malta; regarding screening, a National Cancer Screening Office is established within the National Institute of Public Health of Serbia in 2013 supervising screening for breast cancer, cervical cancer, and colorectal cancer; in the area of Communicable Diseases harmonisation of the respective legislation with priority for the Law on Protection of the Population from Communicable Diseases is ongoing****.

For supporting projects (partly co-financed by the Serbian Government) of the Instrument for Pre-Accession Assistance (IPA), a total of approximately 28.3 million Euros has been invested or planned. The most important recent projects are the following:

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* The European Integration Office: National Plan for the Adoption of the Aquis 2013–2016. Belgrade, February 2013, available at: http://www.seio.gov.rs/home.50.html; accessed September 12, 2013.

** Law on Higher Education. Official Gazette of RS, 76/2005, 100/2007, 97/2008, 44/2010 and 93/2012.

*** Strategy for Education Development in Serbia. Official Gazette of RS, 107/2012.

**** Law on Protection of Population from Communicable Diseases. Official Gazette of RS 125/04.

– Treatment of Medical Waste (2008);
– Implementation of a Hospital Information System (2008);
– Implementation of the National screening programme for colorectal, cervical and breast cancer (2009);
– Development of Palliative Care Services in the Republic of Serbia (2010);
– Implementation of the Strategy for fight against drugs – supply reduction component (2010).

Remaining challenges

While there has been significant progress in the enactment of strategies and legal regulations in the area of health and health care of children, still challenges and problems remain when it comes to inter-sectorial coordination among national, regional and local levels of healthcare services. Initiatives to resolve these problems have been taken both at the national level (Ministry of Health and drafts of new laws on mental health and patients' rights*) and by activities combining local actions within the Standing Conference of Towns and Municipalities** (elaborated proposals for setting up multidisciplinary councils for health within municipalities). International organizations and international projects dealing with decentralization and improvement of health care services at the local level have also provided support to institutional adoption of proposed solutions and examples of good public health practice. One of these projects (*DILS*)*** provides the starting point for the development of IT support to chosen physicians' practices, continuing education for empowerment of local public health teams, and initial resources for launching multidisciplinary projects in local self-governments focusing on the health and health care of children. In the current adverse economic conditions this support is extremely valuable primarily in helping to change the mindset, general culture and develop competencies of responsible parenting and accountable, quality health care system. More extensive involvement of medical schools and nursing colleges in continuing education of chosen physicians and other health professionals will be extremely valuable. Currently, these initiatives are only sporadic, and often fail to include innovative pieces of knowledge into textbooks used for the education of future health professionals. The main challenge for the years to come will not be the adoption only of the *Aquis* but the full implementation of the European regulations. Some of them could create problems as e.g. the freedom of movement for professionals. Already now many health professionals work in EU countries especially in Germany and Switzerland. Accession could contribute to increasing the options and thus deplete the Serbian health system, especially from the best qualified professionals. On the other hand improvements in the delivery of high quality and user friendly health services may constitute a major argument to convince the electorate of the advantages

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* Ministarstvo zdravlja Republike Srbije. Radne verzije i nacrti zakona. http://www.zdravlje.gov.rs/showpage.php?id=185 (accessed January 30, 2013).

** Available at: UNICEF. http://www.unicef.rs/.

*** Ministarstvo zdravlja, Ministarstvo prosvete nauke i tehnološkog razvoja, Ministarstvo rada i socijalne politike. Projekat: Pružanje unapređenih usluga na lokalnom nivou. http://www.dils.gov.rs/.

of accession. In addition the Serbian experience may serve as a blueprint for other countries with similar orientation.

Бджековіч-Мікановіч В., Сантріч Й.

Стратегічні та правові межі здоров'я матері та дитини в країні – кандидаті на вступ до ЄС Республіці Сербія

Проаналізовано стратегічні та правові межі здоров'я матері і дитини, що сформувалися у системі охорони здоров'я Республіки Сербія з часу демократичної зміни національного уряду на початку XXI ст. Виокремлено низку мультигалузевих і галузевих стратегій політики у сфері охорони здоров'я, законодавчих актів, програм, наказів та інших нормативних документів, розроблених за участі провідних фахівців у сфері громадського здоров'я і спрямованих на зміцнення здоров'я дітей і жінок у Сербії.

Охарактеризовано систему надання медичних послуг дітям і жінкам на первинному, вторинному і третинному рівнях медичної допомоги. Первинну медичну допомогу дітям і жінкам надають бригади лікарів (педіатри, гінекологи та сімейні лікарі) у центрах надання первинної медичної допомоги з визначеним переліком заходів, до яких вони можуть вдаватись. Однак рівень забезпечення цих бригад у різних місцевостях різний. Одним із шляхів оптимізації цієї системи є посилення децентралізації. Спеціалізовану медичну допомогу жінки і діти отримують у дитячих та акушерсько-гінекологічних відділеннях загальних лікарень. На третинному рівні високоспеціалізовані медичні послуги надають установи, розташовані у містах Белград і Новий Сад. Охарактеризовано показники дитячої та материнської смертності. Виокремлено фактори, які впливають на збільшення рівня дитячої смертності, як-от: бідність, несприятливі житлові умови, низький рівень грамотності матерів, застосування насильства щодо дітей, брак антенатальних і постнатальних медичних послуг. У процесі реформування системи охорони здоров'я, зокрема децентралізації, вирішення питань, пов'язаних із функціонуванням центрів первинної медичної допомоги, було передано до компетенції органів місцевого самоврядування. Сьогодні місцеві громади повинні розробляти місцеві плани охорони здоров'я та формулювати програми, спрямовані на вирішення проблем населення конкретної території.

Охарактеризовано ключові законодавчі акти, спрямовані на поліпшення якості медичних послуг і забезпечення доступності медичної допомоги, зокрема Закон про охорону здоров'я, Закон про медичне страхування, а також заходи, яких було вжито з метою запобігання вживанню молоддю наркотичних речовин, зокрема створення мультидисциплінарних комісій з контролю за психоактивними речовинами. Проаналізовано процес нормативно-правового наближення правової системи Сербії до правової системи Європейського Союзу, наведено перелік уже підписаних міжнародних угод і перелік проблем, які постали перед Сербією на шляху до набуття членства в Європейському Союзі.

Ключові слова: дитяче та материнське здоров'я, законодавство про охорону здоров'я, Сербія, Acquis Communautaire.

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Стратегические и правовые рамки здоровья матери и ребенка в стране – кандидате на вступление в ЕС Республике Сербия

Проанализированы стратегические и правовые рамки здоровья матери и ребенка, сформировавшиеся в системе здравоохранения Республики Сербия с момента демократической смены национального правительства в начале XXI в. Выделен ряд мультиотраслевых и отраслевых стратегий политики в сфере здравоохранения, законодательных актов, программ, приказов и других нормативных документов, разработанных при участи ведущих специалистов в области общественного здоровья и направленных на улучшение состояния здоровья детей и женщин в Сербии.

Охарактеризована система предоставления медицинских услуг детям и женщинам на первичном, вторичном и третичном уровнях медицинской помощи. Первичная медицинская помощь оказывается детям и женщинам бригадами врачей (педиатры, гинекологи и семейные врачи) в центрах оказания первичной медицинской помощи с определенным перечнем мероприятий, к которым они могут прибегнуть. Однако уровень обеспечения таких бригад в разных местностях разный, что требует оптимизации системы, в том числе путем усиления децентрализации. Специализированная медицинская помощь оказывается женщинам и детям в детских и акушерско-гинекологических отделениях общих больниц. На третичном уровне высокоспециализированные медицинские услуги предоставляют учреждения, находящиеся в городах Белград и Новый Сад. Охарактеризованы показатели детской и материнской смертности. Выделены факторы, влияющие на повышение уровня детской смертности, например, бедность, неблагоприятные жилищные условия, низкий уровень грамотности матерей, применение насилия в отношении детей, недостаточное наличие антенатальных и постнатальных медицинских услуг. В процессе реформирования системы здравоохранения, в частности ее децентрализации, решение вопросов, связанных с функционированием центров первичной медицинской помощи, отнесено к компетенции органов местного самоуправления. Сегодня местные общины должны разрабатывать местные планы охраны здоровья, формулировать программы, направленные на решение проблем населения конкретной территории.

Охарактеризованы ключевые законодательные акты, направленные на улучшение качества медицинских услуг и обеспечение доступности медицинской помощи, в том числе Закон о здравоохранении, Закон о медицинском страховании, а также меры, принятые с целью предотвращения употребления молодежью наркотических веществ, в частности, создание мультидисциплинарных комиссий по контролю за психоактивными веществами. Проанализирован процесс нормативно-правовой гармонизации правовых систем Европейского Союза и Сербии, приведены перечень уже подписанных международных соглашений и перечень проблем, возникших перед Сербией на пути к членству в Европейском Союзе.

Ключевые слова: детское и материнское здоровье, законодательство о здравоохранении, Сербия, Acquis Communautaire.