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ЕЖЕМЕСЯЧНЫЙ НАУЧНЫЙ ЖУРНАЛ

Медицинские новости Грузии
საქართველოს სამედიცინო სიახლენი

GEORGIAN MEDICAL NEWS

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GMN: Georgian Medical News is peer-reviewed, published monthly journal committed to promoting the science and art of medicine and the betterment of public health, published by the GMN Editorial Board since 1994. GMN carries original scientific articles on medicine, biology and pharmacy, which are of experimental, theoretical and practical character; publishes original research, reviews, commentaries, editorials, essays, medical news, and correspondence in English and Russian.

GMN is indexed in MEDLINE, SCOPUS, PubMed and VINITI Russian Academy of Sciences. The full text content is available through EBSCO databases.

GMN: Медицинские новости Грузии - ежемесячный рецензируемый научный журнал, издаётся Редакционной коллегией с 1994 года на русском и английском языках в целях поддержки медицинской науки и улучшения здравоохранения. В журнале публикуются оригинальные научные статьи в области медицины, биологии и фармации, статьи обзорного характера, научные сообщения, новости медицины и здравоохранения. Журнал индексируется в MEDLINE, отражён в базе данных SCOPUS, PubMed и ВИНТИ РАН. Полнотекстовые статьи журнала доступны через БД EBSCO.

GMN: Georgian Medical News – საქართველოს სამედიცინო სიახლენი – არის ყოველთვიური სამეცნიერო სამედიცინო რეცენზირებადი ჟურნალი, გამოიცემა 1994 წლიდან, წარმოადგენს სარედაქციო კოლეგიისა და აშშ-ის მეცნიერების, განათლების, ინდუსტრიის, ხელოვნებისა და ბუნებისმეტყველების საერთაშორისო აკადემიის ერთობლივ გამოცემას. GMN-ში რუსულ და ინგლისურ ენებზე ქვეყნდება ექსპერიმენტული, თეორიული და პრაქტიკული ხასიათის ორიგინალური სამეცნიერო სტატიები მედიცინის, ბიოლოგიისა და ფარმაციის სფეროში, მიმოხილვითი ხასიათის სტატიები.

ჟურნალი ინდექსირებულია MEDLINE-ის საერთაშორისო სისტემაში, ასახულია SCOPUS-ის, PubMed-ის და ВИНТИ РАН-ის მონაცემთა ბაზებში. სტატიების სრული ტექსტი ხელმისაწვდომია EBSCO-ს მონაცემთა ბაზებიდან.

WEBSITE

www.geomednews.com

К СВЕДЕНИЮ АВТОРОВ!

При направлении статьи в редакцию необходимо соблюдать следующие правила:

1. Статья должна быть представлена в двух экземплярах, на русском или английском языках, напечатанная через **полтора интервала на одной стороне стандартного листа с шириной левого поля в три сантиметра**. Используемый компьютерный шрифт для текста на русском и английском языках - **Times New Roman (Кириллица)**, для текста на грузинском языке следует использовать **AcadNusx**. Размер шрифта - **12**. К рукописи, напечатанной на компьютере, должен быть приложен CD со статьей.

2. Размер статьи должен быть не менее десяти и не более двадцати страниц машинописи, включая указатель литературы и резюме на английском, русском и грузинском языках.

3. В статье должны быть освещены актуальность данного материала, методы и результаты исследования и их обсуждение.

При представлении в печать научных экспериментальных работ авторы должны указывать вид и количество экспериментальных животных, применявшиеся методы обезболивания и усыпления (в ходе острых опытов).

4. К статье должны быть приложены краткое (на полстраницы) резюме на английском, русском и грузинском языках (включающее следующие разделы: цель исследования, материал и методы, результаты и заключение) и список ключевых слов (key words).

5. Таблицы необходимо представлять в печатной форме. Фотокопии не принимаются. **Все цифровые, итоговые и процентные данные в таблицах должны соответствовать таковым в тексте статьи**. Таблицы и графики должны быть озаглавлены.

6. Фотографии должны быть контрастными, фотокопии с рентгенограмм - в позитивном изображении. Рисунки, чертежи и диаграммы следует озаглавить, пронумеровать и вставить в соответствующее место текста **в tiff формате**.

В подписях к микрофотографиям следует указывать степень увеличения через окуляр или объектив и метод окраски или импрегнации срезов.

7. Фамилии отечественных авторов приводятся в оригинальной транскрипции.

8. При оформлении и направлении статей в журнал МНГ просим авторов соблюдать правила, изложенные в «Единых требованиях к рукописям, представляемым в биомедицинские журналы», принятых Международным комитетом редакторов медицинских журналов - <http://www.spinesurgery.ru/files/publish.pdf> и http://www.nlm.nih.gov/bsd/uniform_requirements.html В конце каждой оригинальной статьи приводится библиографический список. В список литературы включаются все материалы, на которые имеются ссылки в тексте. Список составляется в алфавитном порядке и нумеруется. Литературный источник приводится на языке оригинала. В списке литературы сначала приводятся работы, написанные знаками грузинского алфавита, затем кириллицей и латиницей. Ссылки на цитируемые работы в тексте статьи даются в квадратных скобках в виде номера, соответствующего номеру данной работы в списке литературы. Большинство цитированных источников должны быть за последние 5-7 лет.

9. Для получения права на публикацию статья должна иметь от руководителя работы или учреждения визу и сопроводительное отношение, написанные или напечатанные на бланке и заверенные подписью и печатью.

10. В конце статьи должны быть подписи всех авторов, полностью приведены их фамилии, имена и отчества, указаны служебный и домашний номера телефонов и адреса или иные координаты. Количество авторов (соавторов) не должно превышать пяти человек.

11. Редакция оставляет за собой право сокращать и исправлять статьи. Корректур авторам не высылаются, вся работа и сверка проводится по авторскому оригиналу.

12. Недопустимо направление в редакцию работ, представленных к печати в иных издательствах или опубликованных в других изданиях.

При нарушении указанных правил статьи не рассматриваются.

REQUIREMENTS

Please note, materials submitted to the Editorial Office Staff are supposed to meet the following requirements:

1. Articles must be provided with a double copy, in English or Russian languages and typed or computer-printed on a single side of standard typing paper, with the left margin of 3 centimeters width, and 1.5 spacing between the lines, typeface - **Times New Roman (Cyrillic)**, print size - 12 (referring to Georgian and Russian materials). With computer-printed texts please enclose a CD carrying the same file titled with Latin symbols.

2. Size of the article, including index and resume in English, Russian and Georgian languages must be at least 10 pages and not exceed the limit of 20 pages of typed or computer-printed text.

3. Submitted material must include a coverage of a topical subject, research methods, results, and review.

Authors of the scientific-research works must indicate the number of experimental biological species drawn in, list the employed methods of anesthetization and soporific means used during acute tests.

4. Articles must have a short (half page) abstract in English, Russian and Georgian (including the following sections: aim of study, material and methods, results and conclusions) and a list of key words.

5. Tables must be presented in an original typed or computer-printed form, instead of a photocopied version. **Numbers, totals, percentile data on the tables must coincide with those in the texts of the articles.** Tables and graphs must be headed.

6. Photographs are required to be contrasted and must be submitted with doubles. Please number each photograph with a pencil on its back, indicate author's name, title of the article (short version), and mark out its top and bottom parts. Drawings must be accurate, drafts and diagrams drawn in Indian ink (or black ink). Photocopies of the X-ray photographs must be presented in a positive image in **tiff format**.

Accurately numbered subtitles for each illustration must be listed on a separate sheet of paper. In the subtitles for the microphotographs please indicate the ocular and objective lens magnification power, method of coloring or impregnation of the microscopic sections (preparations).

7. Please indicate last names, first and middle initials of the native authors, present names and initials of the foreign authors in the transcription of the original language, enclose in parenthesis corresponding number under which the author is listed in the reference materials.

8. Please follow guidance offered to authors by The International Committee of Medical Journal Editors guidance in its Uniform Requirements for Manuscripts Submitted to Biomedical Journals publication available online at: http://www.nlm.nih.gov/bsd/uniform_requirements.html
http://www.icmje.org/urm_full.pdf

In GMN style for each work cited in the text, a bibliographic reference is given, and this is located at the end of the article under the title "References". All references cited in the text must be listed. The list of references should be arranged alphabetically and then numbered. References are numbered in the text [numbers in square brackets] and in the reference list and numbers are repeated throughout the text as needed. The bibliographic description is given in the language of publication (citations in Georgian script are followed by Cyrillic and Latin).

9. To obtain the rights of publication articles must be accompanied by a visa from the project instructor or the establishment, where the work has been performed, and a reference letter, both written or typed on a special signed form, certified by a stamp or a seal.

10. Articles must be signed by all of the authors at the end, and they must be provided with a list of full names, office and home phone numbers and addresses or other non-office locations where the authors could be reached. The number of the authors (co-authors) must not exceed the limit of 5 people.

11. Editorial Staff reserves the rights to cut down in size and correct the articles. Proof-sheets are not sent out to the authors. The entire editorial and collation work is performed according to the author's original text.

12. Sending in the works that have already been assigned to the press by other Editorial Staffs or have been printed by other publishers is not permissible.

**Articles that Fail to Meet the Aforementioned
Requirements are not Assigned to be Reviewed.**

ავტორთა საქურაღებოლ!

რედაქციაში სტატიის წარმოდგენისას საჭიროა დაიცვათ შემდეგი წესები:

1. სტატია უნდა წარმოადგინოთ 2 ცალად, რუსულ ან ინგლისურ ენებზე დაბეჭდილი სტანდარტული ფურცლის 1 გვერდზე, 3 სმ სიგანის მარცხენა ველისა და სტრიქონებს შორის 1,5 ინტერვალის დაცვით. გამოყენებული კომპიუტერული შრიფტი რუსულ და ინგლისურენოვან ტექსტებში - **Times New Roman (Кириллица)**, ხოლო ქართულენოვან ტექსტში საჭიროა გამოვიყენოთ **AcadNusx**. შრიფტის ზომა – 12. სტატიას თან უნდა ახლდეს CD სტატიით.

2. სტატიის მოცულობა არ უნდა შეადგენდეს 10 გვერდზე ნაკლებს და 20 გვერდზე მეტს ლიტერატურის სიის და რეზიუმეების (ინგლისურ, რუსულ და ქართულ ენებზე) ჩათვლით.

3. სტატიაში საჭიროა გაშუქდეს: საკითხის აქტუალობა; კვლევის მიზანი; საკვლევი მასალა და გამოყენებული მეთოდები; მიღებული შედეგები და მათი განსჯა. ექსპერიმენტული ხასიათის სტატიების წარმოდგენისას ავტორებმა უნდა მიუთითონ საექსპერიმენტო ცხოველების სახეობა და რაოდენობა; გაუტკივარებისა და დაძინების მეთოდები (მწვავე ცდების პირობებში).

4. სტატიას თან უნდა ახლდეს რეზიუმე ინგლისურ, რუსულ და ქართულ ენებზე არანაკლებ ნახევარი გვერდის მოცულობისა (სათაურის, ავტორების, დაწესებულების მითითებით და უნდა შეიცავდეს შემდეგ განყოფილებებს: მიზანი, მასალა და მეთოდები, შედეგები და დასკვნები; ტექსტუალური ნაწილი არ უნდა იყოს 15 სტრიქონზე ნაკლები) და საკვანძო სიტყვების ჩამონათვალი (key words).

5. ცხრილები საჭიროა წარმოადგინოთ ნაბეჭდი სახით. ყველა ციფრული, შემაჯამებელი და პროცენტული მონაცემები უნდა შეესაბამებოდეს ტექსტში მოყვანილს.

6. ფოტოსურათები უნდა იყოს კონტრასტული; სურათები, ნახაზები, დიაგრამები - დასათაურებული, დანომრილი და სათანადო ადგილას ჩასმული. რენტგენოგრამების ფოტოასლები წარმოადგინეთ პოზიტიური გამოსახულებით **tiff** ფორმატში. მიკროფოტოსურათების წარწერებში საჭიროა მიუთითოთ ოკულარის ან ობიექტივის საშუალებით გადიდების ხარისხი, ანათალებების შედეგების ან იმპრეგნაციის მეთოდი და აღნიშნოთ სურათის ზედა და ქვედა ნაწილები.

7. სამამულო ავტორების გვარები სტატიაში აღინიშნება ინიციალების თანდართვით, უცხოურისა – უცხოური ტრანსკრიპციით.

8. სტატიას თან უნდა ახლდეს ავტორის მიერ გამოყენებული სამამულო და უცხოური შრომების ბიბლიოგრაფიული სია (ბოლო 5-8 წლის სიღრმით). ანბანური წყობით წარმოდგენილ ბიბლიოგრაფიულ სიაში მიუთითეთ ჯერ სამამულო, შემდეგ უცხოელი ავტორები (გვარი, ინიციალები, სტატიის სათაური, ჟურნალის დასახელება, გამოცემის ადგილი, წელი, ჟურნალის №, პირველი და ბოლო გვერდები). მონოგრაფიის შემთხვევაში მიუთითეთ გამოცემის წელი, ადგილი და გვერდების საერთო რაოდენობა. ტექსტში კვადრატულ ფხიხლებში უნდა მიუთითოთ ავტორის შესაბამისი N ლიტერატურის სიის მიხედვით. მიზანშეწონილია, რომ ციტირებული წყაროების უმეტესი ნაწილი იყოს 5-6 წლის სიღრმის.

9. სტატიას თან უნდა ახლდეს: ა) დაწესებულების ან სამეცნიერო ხელმძღვანელის წარდგინება, დამოწმებული ხელმოწერითა და ბეჭდით; ბ) დარგის სპეციალისტის დამოწმებული რეცენზია, რომელშიც მითითებული იქნება საკითხის აქტუალობა, მასალის საკმაობა, მეთოდის სანდოობა, შედეგების სამეცნიერო-პრაქტიკული მნიშვნელობა.

10. სტატიის ბოლოს საჭიროა ყველა ავტორის ხელმოწერა, რომელთა რაოდენობა არ უნდა აღემატებოდეს 5-ს.

11. რედაქცია იტოვებს უფლებას შეასწოროს სტატია. ტექსტზე მუშაობა და შეჯერება ხდება საავტორო ორიგინალის მიხედვით.

12. დაუშვებელია რედაქციაში ისეთი სტატიის წარდგენა, რომელიც დასაბეჭდად წარდგენილი იყო სხვა რედაქციაში ან გამოქვეყნებული იყო სხვა გამოცემებში.

აღნიშნული წესების დარღვევის შემთხვევაში სტატიები არ განიხილება.

E. Didebulidze, L. Nadareishvili, S. Sturua, G. Berishvili, S. Tsertsvadze, N. Janelidze, N. Geliashvili, M. Kutateladze, P.M. Lydyard, M. Tediashvili. EARLY HUMORAL IMMUNE RESPONSES TO BACTERIOPHAGES AND SHORT-COURSE PHAGE THERAPY OUTCOMES IN PATIENTS WITH URINARY TRACT INFECTIONS.....	6-17
Iryna Yevchenko, Andrii Masliuk, Serhii Myronets, Inna Lapchenko, Nataliia Ortikova. CORRELATION OF EMOTIONAL EMPATHY WITH MENTAL HEALTH INDICATORS IN ADULTS TO DETECT PSYCHOLOGICAL WELL-BEING MARKERS.....	18-26
Maksat Seiitkhan, Altyn Saparbek, Aibergen Tleubergenov, Kurmanay Soltanbayeva, Sayazhan Stanova. ENDOSCOPIC ENDONASAL TREATMENT OF PRIMARY INVERTED PAPILLOMA OF THE SPHENOID SINUS: A CLINICAL CASE.....	27-34
Dae-Hwan Lee, Bong-Sik Woo, Jung-Ho Lee. RETROSPECTIVE EVALUATION OF A COMMUNITY-BASED ELASTIC BAND EXERCISE PROGRAM USING A BALANCE PAD IN RURAL OLDER WOMEN.....	35-42
Mohamed Abdelhadi, Muna HM Alhendi, Khalil AlShowaiker, Ahmad Almaimooni, Khaled Aljenae, Sulaiman Hajji, Ramadan Eldamarawy, Neveen Shalaby. A RARE PRESENTATION OF DIFFUSE LARGE B-CELL LYMPHOMA AS SEVERE ACUTE HEPATITIS AND SECONDARY HEMOPHAGOCYTIC LYMPHOHISTIOCYTOSIS IN A YOUNG ADULT: A CASE REPORT.....	43-46
Lian-Ping He, Ling-Ling Zhou, Jing-Jin Yang, Ying-Rui Huang, Guang Chen. ARTIFICIAL INTELLIGENCE-ASSISTED TEACHING MODEL AS A STRATEGY TO ENHANCE CORE COMPETENCIES OF CLINICAL MEDICINE UNDERGRADUATES: A SCIENTIFIC HYPOTHESIS.....	47-51
Diana Sargsyan, Arevhat Badalyan, Sona Harutyunyan, Siranush Hovhannisyan. THE STUDY OF CORRELATIONS OF PSYCHOLOGICAL FACTORS ENSURING THE FAMILY MENTAL HEALTH.....	52-60
Gani Uakkazy, Chingiz Shashkin, Natalya Slivkina, Viktor Tkachev, Mirbanu Aikhozhayeva, Gulbana Khussainova, Raushan Baigenzheyeva, Zilola Mavlyanova, Raikhan Burumbayeva, Mereke Alaidarova, Joseph Almazan, Amangali Akanov. CONTEXTUAL ANALYSIS OF ADAPTED BOXING AND KICK-/KNEE-STRIKE EXERCISE MODULES IN MULTIDISCIPLINARY NEUROREHABILITATION AND NURSING CARE: SECONDARY ANALYSIS OF TWO PROSPECTIVE STUDIES.....	61-70
Turkiyah Mohsin Elias, Anmar B. AL-Dewachi. DETERMINANTS OF DIABETIC FOOT AMONG PATIENTS WITH TYPE 2 DIABETES: A CASE-CONTROL STUDY.....	71-77
Khatuna Kudava. CLINICAL CHARACTERISTICS OF INFECTION-ASSOCIATED PALMOPLANTAR DERMATOSIS IN PREPUBERTAL CHILDREN: AN OBSERVATIONAL STUDY.....	78-81
Renta Sanxhaku, Ditila Doracaj, Delina Xhafaj, Stela Sanxhaku, Andi Gjini, Alban Xhafaj, Edi Grabocka. HOMOCYSTEINE TESTING IN PREVENTIVE HEALTHCARE: COMPARATIVE INSIGHTS AND POLICY IMPLICATIONS FOR ALBANIA.....	82-87
Sara Ali, Marwan Ismail, Praveen kumar, Salma Elnour Mohamed, Weam Alyoubi, Hiba Mohamed, Raghad Alamri, Fatima Mohamed Osman Yasin, Safa Mohamed Abdelrahman, Huda F. Alshaibi, Einas Awad Osman, Akhtamova Shahzoda Fozilovna, Matlyuba Badritdnova, Rihab Akasha, Mohamed Alfaki. PAN-CANCER ANALYSIS OF CHEMOKINE (C-C MOTIF) LIGAND 26 (Ccl26) AS A PROMISING PROGNOSTIC BIOMARKER AND IMMUNOMODULATORY MEDIATOR.....	88-115
Altin Sallahu, Ferat Sallahu. PROGNOSTIC AND PREDICTIVE VALUE OF TUMOR BUDDING, LYMPHOVASCULAR INVASION, AND PERINEURAL INVASION IN COLORECTAL CARCINOMA.....	116-119
Ghukasyan Norayr, Gharibyan Edita, Geokchyan Haykuhi, Vardanyan Ara, Gekchyan Gor, Sahakyan Lusine. SUCCESSFUL PREGNANCY AND TERM DELIVERY AFTER RADICAL SURGERY FOR COLON CANCER: A CASE REPORT.....	120-124
G.N.K. Ganesh, Clara Shertaeva, Galiya Umurzakhova, Malik Sapakbay, Sabina Seidaliyeva. DIGITALISATION OF THE PHARMACEUTICAL INDUSTRY IN KAZAKHSTAN: HOW IS THE SECTOR ADAPTING TO NEW REALITIES?	125-130
Klara Kaldygozova, Aigul Sergazina, Gulmira Datkayeva, Sulugaisha Kalen, Maya Maksut. METABOLIC DISORDERS IN CHILDREN SUFFERING FROM ACUTE RESPIRATORY VIRAL INFECTIONS (ARVI): COMPLICATIONS AND PREVENTIVE MEASURES.....	131-140
Anas Alhur, Sarah Ibrahim Al-Atif, Afrah Alhur, Fahad Saud Alshammari, Hozan Muslat Nasser Al-Taweel, Reeuof Abdullah Zarbah, Remas Abdullah Mohammed Al-Shahrani, Shaimaa Ahmed Yahya Al-Abdullah, Jana Jameel Salamah Allah, Dhay Hammad Al-Amer, Alhanouf Sulaiman Alharbi, Ali Ahmed Alzahrani, Sultan Saad Ali Alowaydi, Reema Al Shahrani, Abdulrahman A. Alsaqabi. GENERATIVE AI-ASSISTED DRUG-DRUG INTERACTION CASE SUPPORT AND PHARMACY STUDENTS' COMPETENCE: A MIXED-METHODS STUDY.....	141-151

Sara Abdelmehmoud Omer, Alaa Hanafi Makki Elkhalfifa, Abdelkarim Abobakr Abdrabo, Einas A Osman. ASSOCIATION BETWEEN THYROID HORMONE LEVELS AND ADVANCED LIVER FIBROSIS IN PATIENTS WITH TYPE 2 DIABETES MELLITUS AND NON-ALCOHOLIC FATTY LIVER DISEASE.....	152-157
Lingzhi Bao, Jie Ma. NAVIGATING AI IN MEDICAL EDUCATION: A NARRATIVE REVIEW OF APPLICATIONS, CHALLENGES, AND FUTURE STRATEGIES.....	158-166
Mukasheva Gulbarshyn, Seitmaganbetova Indira, Kurmangali Zhanar K. SOCIODEMOGRAPHIC DETERMINANTS OF PRENATAL CARE ACCESS AMONG PREGNANT WOMEN IN THE MANGYSTAU REGION: A CROSS-SECTIONAL STUDY.....	167-173
Sultan M. Siham, Ali L. Jasim, Amar K. Almajidy. INVESTIGATING THE PERSPECTIVES OF RESPIRATORY PHYSICIANS ON HOW SOCIAL DETERMINANTS OF HEALTH AND HEALTH LITERACY INFLUENCE ASTHMA OUTCOMES: A QUALITATIVE STUDY.....	174-178
Datumyan G.S, Sargsyan M.V, Shaboyan K.R, Hovhannisyan M.E, Sahakyan K.M, Muradyan A.A, Hakobyan A.I, Hovhannisyan H.V. SEVERE UPPER EXTREMITY CRUSH SYNDROME IN A NON-DISASTER SETTING: A CASE REPORT OF SUCCESSFUL MULTIMODAL MANAGEMENT WITH COMPLETE RENAL RECOVERY.....	179-184
Tea Chitadze. TEMPORAL DYNAMICS OF GLOBAL LONGITUDINAL STRAIN AND NT-PROBNP IN THE EARLY DETECTION OF ANTHRACYCLINE-INDUCED CARDIOTOXICITY: A 24-MONTH PROSPECTIVE STUDY IN POSTMENOPAUSAL WOMEN WITH BREASTCANCER.....	185-197
Bodnar-Petrovska O.B, Verenkiotova O.V, Petrovskiy A.V, Krykun V.V, Batryn O.V, Ivakhnenko O.A. COMPARATIVE ANALYSIS OF MATERNAL AND CHILD HEALTH CARE IN THE MEMBER STATES OF THE EUROPEAN UNI ON.....	198-208
Gulbarshyn Mukasheva, Tolkyun Bulegenov, Indira Seitmaganbetova, Aigul Tugelbayeva, Meruyert Malik. QUALITY OF LIFE AMONG YOUNG ADULT PATIENTS WITH CARDIOVASCULAR DISEASE.....	209-215
Marina Zhorobekova, Salima Nayzabekova, Dinara Alieva, Saikal Melisova. MEDICAL AND SOCIAL REHABILITATION OF ELDERLY PATIENTS WITH POST-COVID SYNDROME AND COPD: THE EXPERIENCE OF KYRGYZSTAN.....	216-224
Davit Chakvetadze, Otar Darjanian. PREVALENCE, RISK FACTORS, AND STRUCTURAL CHARACTERISTICS OF DENTOALVEOLAR ANOMALIES IN THE SCHOOL- AGED POPULATION OF KUTAISI.....	225-232
Kurmangaliyeva Klara, Shlymova Raikhan, Askarova Karashash, Darybayeva Aisha, Kazangapova Assem, Sagyndykova Gulnur, Yeshmagambetova Zhanna, Akhmedyarova Elmira. EFFECTIVENESS OF PLASMA EXCHANGE IN THE THERAPY OF DRUG-INDUCED HEPATITIS IN PATIENTS WITH PULMONARY TUBERCULOSIS AND CHRONIC VIRAL HEPATITIS B AND C.....	233-242
Matitaishvili T, Domianidze T, Burjanadze G, Shengelia M, Menteshashvili N. EFFECTS OF LONG-TERM SOCIAL ISOLATION ON MEMORY AND DEPRESSIVE-LIKE BEHAVIOR IN RATS OF DIFFERENT SOCIAL STATUS.....	243-248
Svetlana Trofimova, Aruzhan Mendybayeva, Irina Izbassarova, Aida Bokayeva, Aliya Aituganova. DIFFERENTIAL DIAGNOSIS CHALLENGES OF PULMONARY SARCOIDOSIS IN PRIMARY CARE PRACTICE: THE ROLE OF MULTIDISCIPLINARY AND PERSONALIZED APPROACHES.....	249-254
Farman K. Rafeeq, Zeina A. Al-Thanoon. THE POTENTIAL HEPATOPROTECTIVE EFFECT OF PALMITOLEIC ACID AGAINST KETAMINE-INDUCED LIVER INJURY IN RATS: OXIDATIVE, INFLAMMATORY, AND HISTOPATHOLOGICAL EVALUATION.....	255-261
Zakharov Oleg B, Vasileva Anastasiya A, Idiatullin Ravil M, Maslov Vladimir G, Malashikhina Alyona V, Solomonov Sergei A, Falicheva Anastasiia O, Ruchkina Kseniia A, Popov Vasilii V, Litiuk Daria V, Oshchipok Damir D, Tarusina Viktoriia M, Kulbyakova Maria L, Saryeva Albina R, Torba Danil G, Korotkova Sofia E, Sakharova Viktoriya S, Mamutova Zeyneb M, Yaksun Vasilisa S, Suvorova Sofia M. BEYOND CONTRACTILITY: PHENOTYPIC SWITCHING OF VASCULAR SMOOTH MUSCLE CELLS IN ATHEROSCLEROSIS.....	262-269
A.V. Podobed, V.P. Kurchyn, I. Kobidze. VIDEO-ASSISTED THORACOSCOPIC RESECTION OF THE LEFT BRACHIOCEPHALIC AND SUPERIOR VENA CAVA FOR PRIMARY AND RECURRENT THYMIC TUMORS.....	270-275
Fadia Thamir Ahmed. ASSESSMENT OF MELATONIN USE PATTERNS, SAFETY, AND ATTITUDES TOWARD ITS USE IN ADULT POPULATION.....	276-281
Daniel Godoy-Monzon, Patricio Telesca, Jose Manuel Pascual Espinosa. MID-TERM CLINICAL AND RADIOLOGICAL OUTCOMES OF SHORT-STEM VERSUS CONVENTIONAL-STEM TOTAL HIP ARTHROPLASTY IN PATIENTS WITH OSTEONECROSIS OF THE FEMORAL HEAD: A PROSPECTIVE CASE-CONTROL STU DY.....	282-287

COMPARATIVE ANALYSIS OF MATERNAL AND CHILD HEALTH CARE IN THE MEMBER STATES OF THE EUROPEAN UNION

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Abstract.

The article is devoted to a comparative analysis of the legal provision of maternal and child health care in the member states of the European Union (EU). The relevance of the study lies in the analysis of modern European approaches to the regulation of maternal and child health care, as well as in determining the possibilities of adapting positive experience for states that have embarked on the path of European integration. The methodological basis of the study is a complex of general scientific and special legal methods.

As a result of the study, it has been established that the legal regulation of maternal and child health care in the EU is based on a combination of unified standards of EU law and national models of their implementation. At the same time, it has been found that despite the presence of common European standards in the field of health care, there are differences in access to medical services, social protection systems for pregnant women and mothers, ensuring reproductive rights, as well as in indicators of maternal and perinatal mortality in EU countries. The problems of unequal access to medical care, especially for migrants, refugees and socially vulnerable groups of the population, have been identified.

It has been concluded that the effectiveness of maternal and child health care systems largely depends on the following factors: legal guarantees, a developed system of social protection for women, effective functioning of the health care system and access to medical services. The generalization of the experience of EU member states made it possible to identify the most effective models of legal regulation and organization of medical care, which can be used in the formation of state policy and improvement of legislation in states aspiring to EU membership.

Key words. Child, family, healthcare services, medical care, reproductive rights, legal safeguards, European standards.

Introduction.

Maternal and child health care is now a priority area of modern state policy, as it is a vital component of national security, directly linked to the development of a healthy generation and the preservation of the nation's gene pool [1]. However, in the EU member states there are significant differences in the practice of providing medical care, the level of accessibility of medical services, the degree of implementation of social and labor guarantees for pregnant women, mothers in labor, children, as well as women from vulnerable categories, in particular migrants.

Particularly acute in the EU member states are the issues of maternal and perinatal mortality, access to prenatal and postpartum care, reproductive and mental health of women, etc. A comparative analysis of legal regulation and existing models operating in the EU member states makes it possible to identify both common standards for organizing maternal and child health care, and national characteristics of individual states. The study of such experience is important for building an optimal model of the health care system.

It is these circumstances that determined the purpose of this article - to conduct a comparative analysis of maternal and child health care in individual EU member states, identify common approaches and national characteristics in this area, and identify positive experiences that can be used by states aspiring to EU membership.

The expected results of the study are to form a holistic picture of the current state of legal support for maternal and child health care in individual EU member states, as well as to identify the most effective models and problematic aspects of their functioning. The significance of this study is that its conclusions can be used in the formation of state policy in the field of health care, social protection of women and children, as well as in the process of adapting the national legislation of states aspiring to EU membership to European standards.

Literature review.

It should be noted that certain aspects of the issues outlined here have already been addressed in academic works. Thus, this study takes into account the series of scholarly works by Teremetskyi et al., in which: 1) the legal aspects of the realization of the right to health care have been revealed in the context of international and European standards [2]; 2) the interconnection between guarantees of social human rights, particularly the right to health care and the right to housing as well as their significance for ensuring adequate living conditions for families and children, has been identified [1]; 3) the issues of social protection of women and ensuring a balance between professional and family life as important elements of modern policy in the field of maternal and child health protection have been analyzed [3]; 4) certain aspects of the implementation of reproductive human rights and cross-border practices of providing medical services in the field of reproductive medicine [4]. These works provide a relevant basis for defining the general legal framework of the present research. At the same time, this article further develops and specifies that framework by relying on European studies concerning national models of maternity care, perinatal health

indicators, and access to healthcare services for women in vulnerable situations.

When writing this article, its authors relied on Tsybenko's dissertation, dedicated to the peculiarities of legal regulation of maternal and child health care in Ukraine [5]. This dissertation is relevant to the present study, since one of the practical objectives of the article is to identify European practices that may be useful for EU candidate countries, including Ukraine.

In addition, the study draws on works by European researchers addressing the accessibility and quality of maternity care. Particular attention is paid to studies examining barriers to adequate maternal care in Poland through the criteria of availability, appropriateness, affordability, approachability, and acceptability, as well as communication between healthcare professionals and patients [6]; research concerning standards of perinatal care and maternal mortality in Italy based on data from the Italian Obstetric Surveillance System [7]; and studies on organizational aspects of the functioning of healthcare systems in Italy [8]. These studies are relevant because they demonstrate that maternal and child health care should be assessed not only through legal guarantees, but also through the real functioning of medical institutions, quality assurance mechanisms and patient experiences.

A separate group of studies addresses the Dutch model of maternity care. Amelink-Verburg and Buitendijk examine the division of roles between independently practising midwives, who provide care in cases of physiological pregnancy and childbirth, and obstetricians, who are responsible for high-risk or pathological pregnancy and childbirth [9]. De Vries, Nieuwenhuijze and Buitendijk characterize the Netherlands as an example of a strong and independent midwifery profession, while emphasizing that this model depends on broader institutional, cultural and professional conditions [10]. Boesveld et al. analyze integrated maternity care in the Netherlands, focusing on maternity care networks and birth centers as elements of the transition from an autonomous midwife-led model to more coordinated and integrated perinatal care [11]. Taken together, these studies provide a basis for considering the Netherlands as a distinctive comparator within the European healthcare context.

Mattern, Lohmann and Ayerle examine women's experiences and expectations regarding systemic aspects of midwifery care in Germany, including access, availability, choice, continuity, and the place of midwifery within the healthcare system [12]. Lohmann, Mattern and Ayerle analyze midwives' perceptions of women's preferences in Germany and identify organizational challenges related to interprofessional cooperation, workforce capacity, and the practical realization of woman-centred care [13]. Lange et al. study antenatal care and health behaviour among pregnant women in Germany, emphasizing the importance of preventive check-ups and the influence of socioeconomic factors on the use of prenatal care [14]. These sources are particularly important for the present article because Germany represents a statutory health insurance-based model with regulated prenatal check-ups, preventive examinations, and a developed legal framework for maternity protection.

The authors of this article have also analysed and used studies focused on inequalities in access to maternity care among

migrant women, asylum seekers, Roma women, and other groups in vulnerable situations. Boerleider et al. show that women of non-Western origin in the Netherlands are more likely to make inadequate use of prenatal care, particularly because of late entry into care [15]. Verschuuren et al. analyse community midwives' perspectives on perinatal care for asylum seekers and refugees in the Netherlands, identifying barriers related to communication, continuity of care, psychosocial support, and interprofessional cooperation [16]. LeMasters et al. examine the pregnancy experiences of women in rural Romania and demonstrate that ethnic and socioeconomic disparities affect women's interaction with the healthcare system during pregnancy [17]. These studies confirm that formal entitlement to maternity care does not always guarantee effective access in practice, especially for women in socially vulnerable situations.

Finally, the comparative dimension of the study is supported by European reports and indicator-based research, in particular the Euro-Peristat report on core indicators of the health and care of pregnant women and babies in Europe [18]. Such sources are important because they make it possible to compare maternal, perinatal, neonatal, and infant health indicators across European countries and to assess how national legal and organizational models are reflected in actual health outcomes.

At the same time, there are no works in the scientific literature that would examine maternal and child health care in the EU member states through the prism of a combination of legal, organizational, social and comparative approaches. The issues of the correlation between unified EU standards and national models of their implementation, the features of access to medical care for vulnerable categories of women, as well as the possibilities of adapting individual European practices to modern socio-legal realities also remain insufficiently covered.

Materials and Methods.

The theoretical framework of this study is based on scholarly works addressing issues related to the right to maternal and child health care, reproductive rights, children's rights, and social protection for women. The legal framework of this article is grounded in primary and secondary EU law, specifically the Treaty on European Union, the Charter of Fundamental Rights of the EU, Council Directive 92/85/EEC on the safety and health at work of pregnant workers and workers who have recently given birth or are breastfeeding [19], Directive (EU) 2019/1158 on work-life balance for parents and carers [20], as well as specific national legislative acts of EU member states.

In writing the article, the authors employed general scientific and specialized legal methods. The dialectical method allowed for the examination of maternal and child health as a dynamic sphere that changes under the influence of social, economic, demographic, and legal factors. The formal-legal method was applied to analyze the content of EU legal acts and the national legislation of individual states. The comparative legal method is central to the study, as it enabled a comparison of the approaches of various EU member states to the organization of medical care, social and labor guarantees, as well as the protection of women's and children's rights. The statistical method was used in the analysis of maternal, infant, and perinatal mortality rates.

Results and Discussion.

Legal framework and current trends in maternal and child health care in the European Union:

In EU law, pregnancy and maternity are considered circumstances deserving special protection. Article 3(3) of the Treaty on EU establishes that one of the objectives of the EU is to promote the protection of the rights of the child, which includes the right to health [21]. The Charter of Fundamental Rights of the EU recognises the right of access to preventive health care and the right to receive health care under the conditions laid down by national law and practices [22]. The right to health is therefore not explicitly enshrined in the Charter, but is indirectly guaranteed by various articles, in particular the right to respect for physical and mental integrity (Article 3), the right to respect for private and family life (Article 7), the right to non-discrimination (Article 21), and the right to fair and just working conditions (Article 31) [2].

The most well-known piece of EU legislation governing the health of women as expectant mothers and the protection of their labor rights is Council Directive 92/85/EEC of October 19, 1992, on the introduction of measures to encourage improvements in the safety and health at work of pregnant workers, workers who have recently given birth, or are breastfeeding (hereinafter referred to as Council Directive 92/85/EEC) [19]. Council Directive 92/85/EEC established a minimum period of maternity leave of 14 weeks, including 2 weeks of compulsory leave before and/or after childbirth, with appropriate financial assistance depending on national legislation.

The right to 2 weeks of mandatory leave before and/or after childbirth in connection with the birth of a child was introduced in Directive (EU) 2019/1158 of the European Parliament and of the Council of 20 June 2019 on work-life balance for parents and carers and repealing Council Directive 2010/18/EU (hereinafter referred to as Directive (EU) 2019/1158) [23]. Furthermore, Directive (EU) 2019/1158 modernised some existing rights, namely the right to parental leave and the right to flexible working hours. It also aims to establish a new sharing of the risks associated with childcare. Its aim is to improve the situation of women in the labour market by promoting a better sharing of care responsibilities between women and men [3].

Directive (EU) 2019/1158 sets out two main areas of reform:

1) the introduction at the EU level of a specific right for parents to paid parental leave, as well as the creation of incentives for its use, in particular through a combination of non-transferable and adequately paid leave;

2) the application of a life-cycle approach aimed at ensuring a balance between work and personal life [5]. This approach involves taking into account the needs of employees in combining work and family responsibilities, in particular in connection with the presence of children or the need to care for sick or dependent family members, and is implemented through the provision of the right to appropriate types of leave [24].

On January 29, 2025, the «MEPs for Women's Health» group resumed its work in the European Parliament. This is a cross-party group dedicated to addressing women's health issues in the EU. The initiative brings together MEPs with a shared commitment to improving women's health policies, ensuring

access to quality healthcare and promoting gender-sensitive healthcare systems across the EU.

The “MEPs for Women's Health” group planned to focus on the following priorities: 1) increasing investment in women's health research and data collection; 2) raising awareness of how diseases affect women differently; 3) mainstreaming sex and gender issues in the professional education of healthcare professionals; 4) eliminating gender inequalities in access to healthcare and its outcomes; 5) focusing on disease prevention; 6) ensuring sexual and reproductive health rights; 7) advocating for improved maternal health standards; 8) implementing work-life balance policies in line with the European Pillar of Social Rights [25]; 9) combating gender-based violence and its impact on women's [26].

The EU is therefore concerned about the low birth rate and the problems with public health in general and women's health in particular. In the future, this may also have a positive impact on maternal and child health.

Despite the existence of numerous international and European legal instruments in the field of maternal health, certain obstacles still remain in the implementation of this right. Studies of universal health coverage systems in Europe indicate the presence of institutional and organizational barriers to access to health care for women during pregnancy, childbirth and the postpartum period, as well as for children. The greatest difficulties are experienced by residents of rural areas, the elderly, people with limited mobility, vulnerable categories of women, as well as migrants and refugees, who often avoid seeking health care due to fear of deportation or administrative, financial and social obstacles [27].

One of the key indicators of maternal health is the maternal mortality ratio, which the World Health Organization defines as the mortality of women due to complications of pregnancy and childbirth. In the European Region, this rate is among the lowest in the world, standing at approximately 11 cases per 100,000 live births [28]. Despite the general trend towards its decline, significant differences persist between the countries of Western and Eastern Europe, due to the level of their socio-economic development and the peculiarities of the functioning of their healthcare systems. In particular, the OECD records a significant increase in maternal mortality in Latvia compared to the previous decade, while countries such as Ireland, Poland and Italy show significantly lower rates [29].

In general, modern European Union policy is increasingly focused on a strategic approach to women's health at different stages of their lives, which is reflected in national strategies and specialized programs to support motherhood and childhood [29].

Perinatal mortality rates in Europe vary considerably between countries. Although the rate remains relatively low in most EU countries, there are still notable differences between them.

According to Eurostat, the total fertility rate in the EU in 2024 was around 1.34 children per woman, varying considerably between member states [30]. The most critical period of increased risk for the life of a newborn is childbirth and the first month of life. At the same time, stillbirth and neonatal mortality rates in the EU remain lower than in most other regions of the world [29].

The burden of perinatal mortality and morbidity remains a major public health problem in Europe. Perinatal complications have not only medical but also significant psychological, social and economic consequences for families and health systems. Favourable perinatal outcomes provide the basis for the lifelong physical and mental health of children and their parents. However, perinatal complications can have long-term negative consequences, including neurodevelopmental impairment, disability due to preterm birth, severe intrauterine growth retardation or hypoxic-ischemic encephalopathy [18].

Studies also confirm a link between adverse perinatal outcomes and an increased risk of chronic diseases later in life. At the same time, the negative consequences of perinatal complications are disproportionately more common among socially vulnerable groups, which contributes to the perpetuation of health inequalities across generations [18].

Current statistics show that the infant mortality rate in the EU remains one of the lowest in the world. In 2024, it was approximately 3.5 cases per 1,000 live births, demonstrating a general trend of gradual decline in this indicator over recent decades [31]. However, there are still significant differences in the respective indicators between EU member states. For example, in 2024, the highest infant mortality rates were recorded in Romania (at 6.6 deaths per 1 000 live births), while the lowest were recorded in Estonia (1.4 deaths per 1 000 live births) [31]. Overall, over the past decades, there has been a steady trend towards a decrease in child mortality in EU countries. At the same time, the persistence of differences between EU member states indicates the existence of different approaches to the organization of maternal and child health care.

Comparative Legal Analysis of National Models of Maternal and Child Health Care in Individual EU Member States:

To make the comparison between the selected countries more objective, it is necessary to present key demographic and health indicators in a uniform manner. Table 1 summarises the maternal mortality ratio, infant mortality rate, and total fertility rate in the countries examined in this study. These indicators do not exhaustively reflect the effectiveness of maternal and child health care systems, since they are influenced by a wide range of legal, organizational, social, economic, and demographic factors. However, they provide a common statistical basis for comparing national models and identifying differences in outcomes.

The data presented in Table 1 show that the selected countries differ not only in their legal and organizational models of maternal and child health care, but also in key demographic and health outcomes. This confirms the need for a comparative approach that combines legal analysis with the assessment of statistical indicators.

In Ireland, children have long been recognised as a special group in society, largely because of their vulnerability. Historically, children have been granted fewer rights and had fewer responsibilities than adults. Their primary responsibility has been that of their parents and guardians. However, over the past decade, Ireland has undergone constitutional changes aimed at strengthening the rights of children, which have led to changes in their rights, responsibilities and treatment [32].

Ireland was chosen for a more detailed analysis because the country's fertility rate remains relatively high at 1.8, which is above the EU average (1.5), and because it places significant emphasis on health and child care [33].

Amendment 42A to the Constitution of Ireland was approved in a referendum on 10 November 2012. As a result, for the first time, direct and independent protection of the rights of the child was ensured at the constitutional level [32]. In addition, the Children and Family Relationships Act 2015 enshrines the principle of the best interests of the child and the right of the child to be heard. Children under the age of six are entitled to free medical care [34]. To do this, the child must be registered with the Health and Social Care Service in [35].

Children in Ireland are dependents of their parents and have the same entitlement to healthcare as their parents. This means that if the child's parents have a health insurance card, the child is listed as a dependent and is entitled to the same range of services as their parents. Children aged 16 and over can consent to surgical, medical or dental procedures without the consent of their parents or guardians. This is provided for in the Non-Fatal Offences Against the Person Act 1997 [36].

The Irish child health program is similar to international models of child health programs – it includes child health checkups, vaccinations, and screenings. The service is free for all children in Ireland, and its universal nature promotes greater acceptance among families, as all children have equal access. The child health program provides a range of medical services from the prenatal period through the child's first year of school. Hospitals and family doctors provide prenatal and postnatal care (including two checkups at two and six weeks). Family doctors administer the primary immunization program (up to 13 months) and monitor growth at two and five years of age as part of the "Children Under 6" family doctor contract.

In 2024, Ireland began developing the Women's Health Action Plan for 2024–2025, which aims to introduce new services in the field of women's health. In particular, it is planned to expand screening services (diabetes retina screening and breast screening), expand abortion services, etc. [37]. In addition, it is planned to create the first state-run assisted reproductive technology treatment center. Work is currently underway to ensure the implementation of the first-ever Women's Mental Health Charter in the history of the state, with the aim of providing women with inclusive, supportive and effective mental health services.

Thus, a review of Ireland's experience in the field of women's and children's health shows that the state pays considerable attention to this area, considering it as one of the priorities of state policy. The country implements programs and plans aimed at preserving the health of the nation and maintaining a high (compared to the average European) birth rate.

Ireland's experience is useful and innovative in terms of creating a National Registry of Persons Conceived Through Donor Reproductive Technologies, developing and implementing a national Action Plan for Women's Health, including mental health, and establishing a national assisted reproductive technology treatment center. An important stage in the transformation of reproductive policy was also the reform of the abortion legislation: after the 2018 referendum,

Table 1. Comparative Indicators of Maternal and Child Health Care in Selected EU Member States.

Country	Maternal mortality ratio, 2023 / nearest year, per 100,000 live births	Infant mortality rate, 2023, per 1,000 live births	Total fertility rate, 2023, live births per woman	Relevance for comparison
Ireland	low / below 3 according to OECD 3-year average	low / from 2,1 to 3,0t	1.47	Constitutional recognition of children's rights; women's health strategy; relatively higher fertility than many EU states
Italy	low / below 3 according to OECD 3-year average; national surveillance study estimates 8.4	lowest / from 1,7 to 2,0t	1.21	Universal national health service; low fertility; regional disparities in maternal health care
Poland	low / below 3 according to OECD 3-year average	higher / from 3,1 to 5,0t	1.16	Restrictive reproductive rights context; problems of communication and quality of maternity care
Germany	4	low / from 2,1 to 3,0t	1.35	Social health insurance model; structured prenatal care; maternity record; strong labour-law protection
Netherlands	4	higher / from 3,1 to 5,0t	1.39	Compulsory insurance; primary midwife-led maternity care; structured referral and integrated perinatal care
Romania	17.2 according to OECD 3-year average	highest / from 5,1 to 6,0t	1.54	Higher inequalities; rural and Roma communities; formal guarantees combined with practical access barriers

Sources: Eurostat; OECD/European Commission, *Health at a Glance: Europe 2024*; World Bank Data; Italian Obstetric Surveillance System/

the constitutional ban on abortion was repealed and the Health (Regulation of Termination of Pregnancy) Act 2018 was adopted, which allowed for abortion under legally defined conditions, including in the case of a lethal fetal anomaly [38].

In Poland, despite positive indicators of maternal health, women's experiences regarding the quality of care are mixed. Access to adequate medical care in this country is assessed based on criteria such as availability, appropriateness, accessibility, and acceptability. The main barriers include insufficient communication by healthcare professionals, inappropriate treatment of patients, the existence of out-of-pocket (non-insurance) payments, informal quality assurance procedures for medical care, non-compliance with established standards of perinatal care, and shortages of healthcare personnel [5].

Taken together, these factors create a situation in which adequate care is the exception rather than the norm. The identified problems can be addressed, in particular, by effectively reallocating budget funds to specific maternal care services. Other priority measures include the introduction of mandatory training for health workers in accordance with the Standards of Perinatal Care, as well as increased control by state institutions over the quality of such services [6].

Since 2021, following the entry into force of the judgment of the Polish Constitutional Tribunal of 22 October 2020, active theoretical and legal discussions, as well as mass public protests, have continued in Poland regarding the restriction of access to abortion, including debates on the liberalisation of abortion law and the consequences of prohibiting termination of pregnancy in cases of severe foetal abnormalities. It should be noted that in Poland, as historically in Ireland, religion has played an important role in shaping public and normative discourse on reproductive choice. This issue remains complex and controversial, as it involves profound ethical, social, medical, and medico-legal aspects. The tightening of legislative restrictions on access to abortion in Poland and in some other

European countries may increase the risk that women will resort to unsafe or informal procedures, thereby creating risks to their life and health. Differences in the legal regulation of abortion across European countries have also contributed to the phenomenon sometimes referred to as "abortion tourism", whereby women seek such services in jurisdictions with more liberal legislation [39]. In this respect, the Polish experience illustrates how the formal regulation of reproductive health may directly affect women's effective access to healthcare services and the protection of their health rights.

The Polish case also makes it possible to move from the issue of abortion to the broader problem of fragmented regulation of reproductive rights and assisted reproductive technologies in Europe. A comparable legal uncertainty is observed in the field of surrogacy. Polish law does not provide a direct and comprehensive regulation of surrogacy, while surrogacy agreements are generally regarded as legally ineffective. At the same time, the situation in the European legal space remains highly differentiated: in some countries surrogacy is prohibited, in others it is permitted only under limited or altruistic conditions, while in a number of jurisdictions it remains insufficiently regulated. Such divergence does not eliminate the practice, but contributes to the development of cross-border reproductive arrangements and creates challenges for national legal systems, particularly with regard to the recognition of parenthood, the legal status of children born abroad, and the protection of the rights and interests of all parties involved. Therefore, the Polish example is important not only for understanding national restrictions in the field of reproductive health, but also for demonstrating the broader need for greater coordination of European approaches to cross-border reproductive medical practices [4].

The Italian experience in healthcare is noteworthy. The Italian National Health Service guarantees universal access to healthcare. The national government defines a standard package

of healthcare services and distributes public funds between regional healthcare systems. At the same time, the planning, administration and direct provision of healthcare services are carried out and controlled at the local level by the 19 Italian regions and 2 autonomous provinces.

Italy has a relatively low maternal mortality ratio in the European context. A national study published in 2024 by the Italian Obstetric Surveillance System estimated the maternal mortality ratio in Italy at 8.4 deaths per 100,000 live births for 2011–2019, using an integrated record-linkage approach [8]. This estimate demonstrates the importance of enhanced obstetric surveillance systems for more accurate monitoring of maternal mortality. However, significant regional disparities persist in Italy, particularly affecting the southern regions in terms of healthcare provision and health outcomes. For example, the maternal mortality ratio ranged from 3.6 in Tuscany to 13.1 in Sicily [8].

Italy represents an important example of the role of enhanced obstetric surveillance in the assessment of maternal mortality. A national study published in 2024 and based on data from the Italian Obstetric Surveillance System estimated the maternal mortality ratio in Italy at 8.4 deaths per 100,000 live births, which was significantly higher than the figure of 3.9 deaths per 100,000 live births calculated solely on the basis of the Death Registry [8]. At the same time, the study identified a notable declining trend in maternal mortality over the study period. The leading causes of maternal deaths within 42 days of the pregnancy outcome were obstetric haemorrhage, sepsis, and cardiovascular diseases, while late maternal deaths were mainly associated with suicide, malignancies, and cardiovascular diseases [8]. Therefore, the Italian experience is important because it demonstrates the value of integrated surveillance systems for identifying the actual magnitude, trends, and causes of maternal mortality. This approach may be useful for countries seeking to improve the monitoring and prevention of maternal deaths.

In response to the demographic challenges of recent years, the Italian government has implemented a number of measures aimed at supporting fertility and improving family life. One such initiative is the statutory parental leave [40], which provides for the possibility for both parents to take paid leave to care for newborn children. Such measures are aimed at creating a favorable social environment for families, stimulating fertility, and stabilizing the social protection system in the context of an aging population [8].

Legislative Decree No. 105 of 30 June 2022 provides for a series of provisions aimed at improving the work-life balance of parents and carers [23]. The main objective of the document is to achieve a fair distribution of care responsibilities between women and men, as well as to ensure gender equality in both employment and family life. These provisions apply to both private and public sector workers.

In furtherance of this legislative act, INPS Circular No. 122 of 27 October 2022 was adopted, providing the first operational instructions on the application of Legislative Decree No. 105 of 30 June 2022 [40]. The document concerns changes in the legal regulation of compulsory paternity leave, parental leave, and maternity allowance for self-employed women, as well as

the procedure for exercising the relevant rights by employees, persons enrolled in the Separate Social Security Scheme, self-employed persons, and freelance professionals.

The experience of Italy shows a uniform approach to the provision of parental leave for all officially employed persons, and a differentiated approach to establishing the number of months of such leave depending on the status of the person for the child.

The Dutch healthcare system is characterised by a combination of compulsory standard health insurance, regulated access to essential healthcare services, and a strong tradition of primary maternity care. Under the Dutch standard health insurance system, the government determines the scope of the standard health insurance package, while healthcare insurers are obliged to accept anyone who applies for this package, regardless of age or health status. The system is based on the principle of social solidarity, with healthcare costs financed through premiums and income-related contributions; maternity care is expressly included among the areas covered within this collective financing model. Children under the age of 18 must have health insurance but do not pay premiums for the standard package, which strengthens the family-oriented and child-protective character of the Dutch model [41].

A distinctive feature of maternity care in the Netherlands is the central role of midwives in low-risk pregnancy and childbirth. Expectant mothers normally receive care during pregnancy and childbirth from a midwife or, in some areas, from a general practitioner practising obstetrics. Where specialist care is required, the woman is referred to a gynaecologist or a hospital-based midwife [42]. Thus, the Dutch model is based on a differentiated organisation of care: physiological pregnancy and childbirth are primarily managed within community-based maternity care, while pathological or high-risk cases are referred to specialist obstetric care. This division of professional roles is supported by referral mechanisms, including the “List of Obstetric Indications”, which determines when midwife-led care remains sufficient and when referral to specialist obstetric care is required [9].

From a comparative legal perspective, the Dutch model is important because it combines the professional autonomy of midwives with mechanisms of clinical risk assessment and referral. De Vries, Nieuwenhuijze and Buitendijk describe the Netherlands as an example of a strong and independent midwifery profession, while emphasizing that this model depends on broader institutional, cultural, and professional conditions [10]. At the same time, the development of the Dutch system demonstrates a gradual transition from a relatively autonomous midwife-led model to more integrated perinatal care. Studies of Dutch maternity care networks and birth centers show that concerns about perinatal outcomes and the fragmentation of services have made coordination between community midwives, obstetricians, hospitals, maternity care assistants, and other professionals an important policy direction [11].

Another relevant feature of the Dutch experience is the attention paid to woman-centred quality improvement. Research on Dutch Maternity Care Collaborations shows that improving maternity care increasingly requires the integration of women’s

experiences into quality assurance processes. However, the practical use of women's voices remains difficult because of organizational limitations, lack of time, financial constraints, and insufficient expertise [43]. This is important for the present study because the effectiveness of maternal and child health care depends not only on formal access to services, but also on the ability of the healthcare system to respond to women's actual needs, expectations, and experiences.

At the same time, the Dutch model should not be idealised. Research on perinatal care for asylum seekers and refugees in the Netherlands demonstrates that even highly developed healthcare systems may face barriers related to communication, continuity of care, psychosocial support, and interprofessional cooperation [16]. Therefore, the Netherlands is a valuable comparator for this study because its model combines legal guarantees, compulsory health insurance, primary midwife-led care, risk-based referral to specialist obstetric care, and the development of integrated perinatal care. For EU candidate countries, including Ukraine, this experience is useful because it shows that the protection of maternal and child health requires not only formal legal guarantees, but also a well-organised system of referral, continuity of care, professional cooperation, quality assessment, and targeted support for women in vulnerable situations.

Germany represents a highly institutionalised model of maternal and child health care, based on statutory health insurance, preventive prenatal care, legally guaranteed midwifery assistance, and maternity protection in employment, training, and education. This makes Germany a relevant comparator for the present study, since its model demonstrates how maternal health may be protected through the interaction of health law, social insurance law, labour law, and medical guidelines and standards.

One of the central organisational instruments of German prenatal care is the system of regular preventive check-ups. Pregnant women with statutory health insurance are offered prenatal examinations generally every four weeks and, from the 32nd week of pregnancy, every two weeks; these examinations are voluntary. They include medical history-taking, physical examinations, laboratory tests, and ultrasound screening. Their results are recorded in the maternity record, known as the *Mutterpass*, which is usually issued at the first check-up and contains important information about the health of the woman and the development of the child [44]. From a legal and administrative perspective, this system creates a standardised mechanism for documenting pregnancy, monitoring risks, and ensuring continuity between different healthcare professionals.

German prenatal care also combines medical supervision with midwifery assistance. Women covered by statutory health insurance are entitled to midwife assistance during pregnancy, childbirth, and the postpartum period, in addition to medical care. Such assistance includes antenatal care, obstetric care, postpartum support up to twelve weeks after birth, breastfeeding counselling, and postnatal exercise classes. These services are generally provided as benefits in kind, meaning that midwives bill the statutory health insurance funds directly [45]. Thus, the German model combines legal entitlement, social insurance financing, and professional maternity support.

At the same time, studies show that the practical functioning of midwifery care in Germany is not without difficulties. Mattern, Lohmann and Ayerle demonstrate that women's expectations concern not only the availability of services, but also choice, continuity, information, and the position of midwifery within the wider healthcare system [12]. Lohmann, Mattern and Ayerle further identify organisational challenges related to shortages of midwives, insufficient interprofessional cooperation, and unclear delineation between the competencies of midwives and obstetricians, especially in hospital settings [13]. These findings indicate that formal legal entitlement to maternity care does not automatically ensure that women experience care as sufficiently accessible, continuous, and woman-centred.

The preventive orientation of the German system is also confirmed by empirical research on prenatal care and health behaviour. Lange et al. note that regular preventive medical check-ups during pregnancy are an important preventive measure, while socioeconomic factors may influence women's participation in prenatal care [14]. Recent research by Janke et al. also emphasises the need to strengthen personalised support, structured information, communication, and continuity of care during the preconception and pregnancy phases [46]. These findings are relevant for legal analysis because the effectiveness of maternal and child health protection depends not only on the formal existence of prenatal examinations, but also on whether different groups of pregnant women can effectively use these services in practice.

Germany is also important for this comparative study because of the challenges related to migrant and refugee women. Dopfer et al. show that pregnancy among refugee women in Northern Germany is associated with increased use of primary healthcare, while language barriers and cultural factors may impede access to adequate care for some pregnant refugee women [47]. This confirms that even in countries with developed statutory health insurance and formal legal guarantees, women in vulnerable situations may face practical barriers to maternal health services.

The German model also includes a developed system of maternity protection in labour law and social protection. The Maternity Protection Act protects the health of pregnant and breastfeeding women and their children at the place of work, training, and study. Its purpose is not only to prevent health risks, but also to counteract disadvantages connected with pregnancy, childbirth, and breastfeeding [48]. Therefore, Germany's approach to maternal health is broader than medical care alone: it combines preventive healthcare, insurance coverage, midwifery assistance, systematic documentation, occupational protection, and income protection safeguards. For EU candidate countries, including Ukraine, this experience is useful because it demonstrates the importance of integrating medical, social insurance, labour-law, and organisational mechanisms within a single maternal and child health policy.

Romania represents a specific model within the comparative framework of this study, as it demonstrates how formal legal guarantees may coexist with significant socio-economic, territorial, and ethnic disparities in access to maternal and child health care. Unlike countries with more evenly distributed healthcare provision, Romania continues to face considerable

differences between urban and rural areas, as well as between the general population and groups in vulnerable situations. Therefore, Romania is relevant not as an example of the most effective model, but as a case illustrating the risks of insufficient practical implementation of legal guarantees.

Romanian legislation provides special protection for pregnant women and women in the postpartum period within the social health insurance system. Pregnant women and women who have recently given birth who have no income, or whose income is below the national minimum wage, may be insured without paying social health insurance contributions. Pregnant women are also exempt from co-payment for pregnancy-related medical services, while women without income, or with income below the minimum wage, are exempt from co-payment for all medical services [49]. Children, as well as young people up to the age of 26 if they are enrolled in education, are entitled to the basic package of health services without paying social health insurance contributions, and uninsured pregnant women are entitled to a minimum package of health services [50]. These provisions create an important legal safety net for women and children who might otherwise remain outside the regular contribution-based health insurance system.

However, the effectiveness of these guarantees is limited by structural barriers. Romania still has a high level of unmet needs for medical care, especially among people at risk of poverty and those living in rural areas. Territorial disparities are particularly relevant to maternal and child health, since pregnancy, childbirth, and emergency obstetric and neonatal care require timely access to family doctors, maternity units, emergency transport, and specialised hospital services. These difficulties are also reflected in health indicators: although Romania has made progress over the last two decades, maternal and infant mortality remain higher than in many other European countries [51].

Particular attention should be paid to women in vulnerable situations, including women living in rural areas, women without employment, and Roma women. Empirical research on pregnancy experiences in rural Romania shows that Roma and non-Roma women face intersecting barriers during pregnancy, including transport difficulties, costs, limited information, different perceptions of prenatal care, socioeconomic vulnerability, and ethnic discrimination [17]. These findings demonstrate that access to maternity care in Romania is not merely a matter of legal entitlement or financial affordability, but also a social, cultural, and territorially conditioned challenge.

In response to these challenges, Romania has implemented social inclusion policies aimed at reducing poverty, combating discrimination, and improving access to public services, including through the National Roma Strategic Framework [52]. In the context of maternal and child health care, such policies are important because formal legal entitlement to healthcare services must be supplemented by practical mechanisms: outreach to rural communities, health mediation, transport support, stronger primary care coverage, and culturally sensitive services for Roma women and other groups in vulnerable situations. Thus, Romania illustrates the importance of distinguishing between formal legal entitlement and effective access in practice to maternal and child healthcare services. For EU candidate

countries, including Ukraine, Romania's experience is useful because it demonstrates the need to combine legal guarantees with targeted measures aimed at overcoming territorial, ethnic, and socio-economic barriers to maternal and child health care.

Legal regulation of migrant women's access to maternal health services in EU member states:

EU member states take different approaches to regulating access to maternal health services for specific categories of women, particularly undocumented migrant women. Broadly speaking, two main approaches can be identified. The first encompasses a group of member states that have implemented legislative and policy mechanisms ensuring undocumented migrant women full access to maternal health services, either free of charge or at a subsidized cost. These include countries such as Belgium, Estonia, France, Germany, Greece, Italy, Ireland, the Netherlands, Portugal, Romania, Spain, and Sweden.

In particular, in the Netherlands, irregular migrants are entitled to health insurance that covers emergency care and treatment, as well as access to primary and secondary medical care. In Germany, for individuals granted a residence permit, as well as for other foreigners with a temporary residence permit, the state covers the costs of medical care and treatment, obstetric care, medications, bandages, and medical supplies both during pregnancy and in the postpartum period, provided certain criteria are met.

However, despite these benefits, undocumented migrant women do not have access to maternity services, as current legislation prohibits them from participating in the health insurance system. The only alternative is to pay for health services out of their own pocket, which is usually impossible due to the lack of a stable source of income.

In contrast, in Spain, according to regional legislation, all migrants have the right to health care on an equal basis with nationals, provided that they register with the local civil registry to obtain an individual health card. However, this requirement does not apply to pregnant women, who face additional difficulties in accessing health care. In cases where migrants cannot register due to lack of permanent residence, they effectively lose access to health services. In response to this problem, some regions in Spain have implemented more humane approaches, providing health cards to undocumented migrants without requiring prior registration with the civil registry [27].

Thus, it can be concluded that there is a supportive and tolerant approach toward pregnant migrant women, provided certain requirements are met. At the same time, if such a woman is unwilling or unable to meet the aforementioned requirements, she may pay for the relevant maternity-related medical services.

A second group of member states has laws and policies that hinder easy and rapid access to maternal health services and require women to cover some or all of the costs themselves. These include countries such as Austria, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Finland, Hungary, Latvia, Lithuania, Luxembourg, Malta, Poland, Slovakia, and Slovenia. Although Europe is considered one of the safest regions in the world to give birth, differences persist among EU member states regarding free access to healthcare. The main barriers to accessing maternal health services include high

costs, language barriers, a lack of clear policies and information, fear of deportation, the remoteness of medical facilities, and prejudiced attitudes among healthcare workers. In addition, pregnant women face a range of additional challenges, including disrespectful treatment in healthcare facilities, such as physical violence, neglect, and disregard during childbirth. Maternal mortality is significantly more likely to occur among women living in the most disadvantaged socioeconomic conditions [27].

The above demonstrates the different approaches of EU member states to the health care of vulnerable women – from ensuring full and free access to maternity-related health services to establishing conditions that migrant women are often unable to meet.

Conclusion.

The comparative analysis of maternal and child health care in Ireland, Italy, Poland, Germany, the Netherlands, and Romania demonstrates that, despite the existence of common EU legal standards, national models differ significantly in terms of healthcare financing, the organisation of maternity services, the role of midwives and obstetricians, social and labour guarantees, reproductive health regulation, and effective access to healthcare services for women and children in vulnerable situations.

At the EU level, the protection of maternity, women's rights, and children's rights is based on a combination of primary and secondary EU law, including the Treaty on European Union, the Treaty on the Functioning of the European Union, the Charter of Fundamental Rights of the European Union, Council Directive 92/85/EEC, and Directive (EU) 2019/1158. These instruments establish a general legal framework for the protection of maternity, childhood, non-discrimination, access to preventive healthcare and healthcare, work-life balance, and safe and healthy working conditions. However, the practical realisation of these guarantees depends primarily on national legal mechanisms, the institutional capacity of healthcare systems, and the effectiveness of social protection policies.

The analysed national models show that a number of European practices may be relevant for EU candidate countries, including Ukraine. Ireland demonstrates the importance of constitutional recognition of children's rights, national women's health action plans, mental health support for women, and institutional mechanisms in the field of assisted reproductive technologies. Italy shows the value of combining a universal healthcare system with parental leave and work-life balance policies, while also confirming the need to reduce regional disparities in access to maternity care. Poland illustrates that relatively positive maternal health indicators do not always correspond to high-quality patient experience, especially when communication, respect for women's dignity, reproductive health regulation, and compliance with perinatal care standards remain problematic.

The Netherlands is particularly relevant as an example of a model combining compulsory health insurance, primary midwife-led care, risk-based referral to specialist obstetric care, postnatal support, and the development of integrated perinatal care. Germany demonstrates the effectiveness of a legally structured prenatal care system based on statutory health insurance, preventive examinations, the Mutterpass system, midwifery assistance, and labour-law protection of pregnant and

breastfeeding women. Romania, in turn, confirms that formal legal guarantees are insufficient without practical measures aimed at overcoming barriers linked to socio-economic status, place of residence, and ethnic discrimination, especially in rural areas and among Roma communities and other groups in vulnerable situations.

On this basis, Ukraine and other EU candidate countries should not mechanically copy individual European models, but should adapt their most effective elements to national institutional, financial, demographic, and social conditions. First, national legislation should establish a coherent legal framework for maternal and child health care, combining health law, social protection law, labour law, child protection law, and reproductive health regulation. Such a framework should cover prenatal care, childbirth, postnatal care, maternal mental health, early childhood health services, and targeted protection for groups in vulnerable situations.

Second, access to pregnancy-related and childbirth-related healthcare services should be guaranteed regardless of a woman's place of residence, income level, displacement status, or other circumstances of vulnerability. Legal entitlement to such services should be supported by insurance-based or public funding mechanisms that remove financial barriers to prenatal examinations, childbirth, emergency obstetric and neonatal care, postnatal support, and basic child health services.

Third, candidate countries should develop an integrated model of perinatal care based on clear referral pathways among primary care providers, midwives, obstetricians, maternity units, emergency services, and specialised neonatal care. The Dutch and German experiences show that maternal and child health care should not be limited to hospital-based services, but should include continuity of care, timely risk assessment, professional cooperation, and effective postnatal support.

Fourth, maternal and child health policy should include targeted measures for women and children in vulnerable situations, including internally displaced persons, refugees, migrants, women living in rural areas, low-income women, Roma women, and women belonging to other ethnic minorities. Such measures should include transport support, health mediation, translation and interpretation services, culturally sensitive counselling, outreach programmes, and simplified access to prenatal and postnatal services.

Finally, reforms should be based on reliable data and measurable indicators, including maternal mortality, perinatal mortality, infant mortality, access to prenatal care, coverage of postnatal services, regional disparities, quality of care, and patients' experiences. For Ukraine, the most relevant direction is the creation of an integrated maternal and child health care model that combines European legal standards, guaranteed access to pregnancy-related and childbirth-related services, strengthened midwifery care, systematic prenatal monitoring, maternal mental health support, targeted protection for women and children in vulnerable situations, and evidence-based evaluation of outcomes. Such an approach would allow Ukraine to align national legislation and healthcare practice with European standards while responding to the consequences of war, internal displacement, regional disparities, and the needs of post-war recovery.

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