MEDICINE, LAW & SOCIETY
Vol. 17, No. 2, pp. 203–226, October 2024

REPRODUCTIVE RIGHTS IN THE CONTEXT OF MEDICAL LAW AND DEMOGRAPIC TRENDS

Accepted
1. 9. 2024

Revised
20. 9. 2024

Published
23. 10. 2024

HAJRIJA MUJOVIĆ, ANKICA ŠOBOT
Institute of Social Sciences, Belgrade, Serbia
hajrija.mujovic@gmail.com, asobot@idn.org.rs

CORRESPONDING AUTHOR
hajrija.mujovic@gmail.com

Abstract Medical Law examines reproductive rights through the prism of reproductive health. It encompasses all aspects from the perspective of human rights. The focus is on sources of law. The medical context of issues is very important. It is considered a serious violation if basic rules such as informed consent and patients' rights are neglected. Considering demographic trends leads to a connection between birth rates and restrictive legislation which has not been confirmed as a good solution. The conclusion emphasizes that medical law should have a more contributing role in improvement of reproductive health services, quality standards, and better legal perception and protection for all.

Keywords
health,
human reproduction,
medical law approach,
human rights,
birth rates and policies

https://doi.org/10.18690/mls.17.2.203-226.2024
CC-BY, text © Mujović, Šobot, 2024
This work is licensed under the Creative Commons Attribution 4.0 International License.
This license allows reusers to distribute, remix, adapt, and build upon the material in any medium or format, so long as attribution is given to the creator. The license allows for commercial use.
https://creativecommons.org/licenses/by/4.0

1 Introduction

Human reproduction raises numerous questions, particularly regarding the creation of conditions and the encouragement of childbirth. The consideration of social roles and fundamental relations becomes extremely important. In every community, reproduction is essential for the survival of the human species, and the characteristic of all living beings is to produce offspring.[1] If we start from the legal regulation of human childbirth, we can say that many questions have undergone certain changes through a development that has not always gone in the same direction. Initially, the legal interest was solely in the issue of abortion as it impacts the emerging human life. The assessment of abortion was traditionally a matter for criminal law, more precisely the prohibition of abortion. In a part of civil law, the only rule was that a doctor who undertakes a prohibited abortion should be held liable for harmful consequences (Medicus, 1985). Over time, discussions began to open up questions of civil law related to the beginning of life, primarily in the sphere of individual rights. This also aimed to show the close connection between reproductive health, reproductive rights, and patients' rights. This includes the right to health care and attention to all aspects of health, including reproductive health. The expansion of knowledge about relevant causal relationships and new treatment possibilities has gained significance. For example, in certain forms of pregnancy control and prenatal diagnosis, development has advanced rapidly. The same is true for techniques of in-vitro fertilization and medical genetics.

Human reproduction is a vital determinant in the field of research and social development. It also emphasizes the connection with population studies (Laisk et al., 2018). Indeed, every individual should enjoy reproductive autonomy regardless of their social status. In adverse conditions and difficult situations, the solution should not be to deprive individuals of their right to reproduce but to change the conditions in which they live. It is precisely the case that fundamental human rights often cannot be realized without the support of state measures and the social community, including in the sphere of reproductive behavior.

[1] https://www.encyclopedia.com/social-sciences/applied-and-social-sciences-magazines/human-reproduction (March 10, 2024).

2 Defining the Context

Engaging with this topic begins with one of the shortest definitions of reproductive rights, stating that it is a woman's right to choose whether or not she will have a baby. [2] However, discussions invariably highlight the complex nature and multiple present meanings that indicate an integrative definition (Starrs et al., 2018). Namely, reproductive rights in a broader sense consist of a series of individual human rights concerning childbirth, such as the right to family planning, the right to establish a family, the right to be free from gender discrimination, and the right to be free from sexual abuse (Elias & Annas, 1987). The literature also suggests that reproductive rights reflect the broader civil rights debate.[3] At the center of reproductive rights is the legal concept of self-determination. This term refers to the legal ability of an individual to manage their private life. Additionally, the concept of autonomy is part of the explanation for self-determination. Fundamental laws protect the ability to make decisions by invoking citizens' constitutional rights. This implies protection of the private sphere from potential state interventions. One question is how far regulations and state policies should enter the private sphere of reproduction.

In most developed democracies, it is considered that people morally and legally enjoy reproductive freedom or reproductive autonomy (Elias & Annas, 1987). This includes both the right to reproduce and the right to prevent reproduction. It is the right to have offspring. Legally speaking, one cannot have a right to offspring, as no one can guarantee offspring. Hence, the right to reproduce is best understood as the right to choose, i.e., to decide on activities that have the expected goal of giving birth to a child. The right to reproduce, understood as the right to decide about childbirth, is generally recognized as a fundamental human right. Defining the legal nature and scope of reproductive rights entails clarifying the meaning of reproduction. Conceptually, the right focuses on protecting the act of giving birth and all activities leading to that goal. Procreation is highly valued socially as the customary way to have and raise children. The right to reproduce protects individuals' interests in establishing a family. Interference in individual reproductive autonomy represents a violation of the individual's right to self-determination, physically, emotionally, and

[2] Reproductive rights. Merriam-Webster.com Dictionary, Merriam-Webster, https://www.merriam-webster.com/dictionary/reproductive%20rights (July 21, 2024).
[3] https://www.findlaw.com/family/reproductive-rights/what-are-reproductive-rights-.html#Men (March 12, 2024).

even spiritually. The decision-making of the individual, primarily the woman, about herself regarding whether, when, and how often she wants to give birth is emphasized.

The quality of services and the protection of reproductive health are of great importance for childbirth. At the International Conference on Population and Development in Cairo in 1994, this aspect of reproductive rights was particularly discussed (Diduck, 2011). Reproductive health was marked as an integral part of these rights.[4] Sometimes, the decision about childbirth can have various health outcomes, such as in situations where a hysterectomy or vasectomy is desired. In that sense, the right to reproduce can be expressed as both a positive and a negative right. As a positive right, it is the right to achieve reproduction, i.e., the desired birth of a child, for example, the planned fertility treatment for sterile individuals. As a negative right, it is the right to prevent reproduction, i.e., the unwanted birth of a child, such as sterilization, abortion, and contraception (Steinbock, 1998).[5] The medical procedures taken have significant health consequences for the individual involved. Therefore, it is said that reproductive rights are a type of human rights closely related to reproductive health (Bonnet & Guillaume, 2004).

3 Sources of Law

Reproductive rights are realized and protected by referencing health legislation, professional standards, guidelines, and codes of practice. There is a substantial body of international documents related to reproductive rights that outline and affirm modern standards of health care worldwide. The leading role in the field of health is held by the recommendations of the World Health Organization, which are

[4]Convention on the Elimination of All Forms of Discrimination Against Women, https://www.un.org/womenwatch/ daw/csw/shalev.htm (March 18, 2024).

[5] See: There are still many controversial issues in legal theory and practice regarding the concept and characteristics of reproductive rights. For example, do individuals or only married couples have the right to reproduce? Is this right limited only to heterosexual couples? Is it limited by the age limit, as in minors or in older postmenopausal women? Does this right belong only to fertile people who can give birth naturally, via coitus, or also to sterile people? These and similar questions cannot be answered without a coherent conception of the right to reproduction, which is the primary task of legal experts.

implemented by national states.[6] Human rights standards are contained in the documents of the UN[7] and the World Medical Association.[8]

When viewed comparatively, national legislations strive to normatively round out the area of reproductive health, with developed countries in Europe and the USA being the furthest along in this regard. For instance, Germany has repeatedly adopted amendments to criminal law concerning penalized abortion.[9] A special Law on Assistance to Pregnant Women and Families was adopted to protect women who conceal or suppress their pregnancies and are not covered by the regular support system for pregnant women. The law aims to prevent secret births outside medical institutions while also preventing newborns from being sold, abandoned, or killed anonymously.[10] A significant number of issues related to reproductive freedoms and rights have been subject to long-term reform, seeking to partially address prenatal diagnosis issues, deadlines, and indications for termination of pregnancy through new regulations. Developed judicial practices also played and continue to play an important role in medical cases in this area.[11] In the domain of liability for medical errors related to childbirth procedures, Great Britain has adopted distinct solutions, including the Law on Congenital Defects and Liability for Damage.[12] Concerning Comparative Law approuch, notable legal solutions have been achieved by France, which was among the first to enact so-called Bioethics Laws and incorporate them into its Civil Code.

Furthermore, it adopted regulations on covering health risks titled - The Law on Patient Rights and Quality of the Health System.[13] Regarding the right to abortion, the law regulating it dates back to 1975. Abortion was decriminalized, which was

[6] WHO recommendations on self-care interventions: self-management of medical abortion, 2022 update, WHO guideline on self-care interventions for health and well-being, 2022 revision (February 6, 2024); Family Planning: Global Handbook for Health Care Providers, World Health Organization (WHO), translation, IMD, Belgrade, www.imd.org.rs/pdf/republicki-centar/planiranje_porodice_za_zdravstvene_radnike.pdf (March 22, 2024).
[7] UN OHCHR, https://www.ohchr.org/en/women/sexual-and-reproductive-health-and-rights (August 29, 2024).
[8] WMA Statement on Medically-Indicated Termination of Pregnancy, Adopted by the 24th World Medical Assembly, Oslo, Norway, August 1970, and revised by the 35th World Medical Assembly, Venice, Italy, October 1983, the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006, and the 69th WMA General Assembly, Reykjavik, Iceland, October 2018; ACOG's *Guidelines for Women's Health Care, A Resource Manual, 4th Edition.*
9 218 - 219d StGB – Strafgesetzbuch, https://www.gesetze-im-internet.de/englisch_stgb/ (August 11, 2024).
[10] Gesetz zum Ausbau der Hilfen für Schwangere und zur Regelung der vertraulichen Geburt, 2014.
[11] German Constitutional Court Abortion decision, BVerfGE 39, 1, First Senate of the 25th of February, 1975.
[12] Congenital Disabilities (Civil Liability) Act 1976. Retrieved from: https://www.legislation.gov.uk/ukpga/1976/28/england/ enacted/data.html (July 3, 2024).
[13] Loi n° 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé. Retrieved from: https://www.legifrance.gouv.fr/jorf/id/JORFTEXT000000227015/ (August 10, 2024).

presented as a significant advancement in favor of women's rights to decide about their bodies and control their fertility.[14] This also meant progress in public health, as women were granted access to abortion in safe and supervised conditions. The right to abortion allows women wanting to terminate a pregnancy to do so without the risk of sanctions. This right has been taken a step further. In March 2024, the French Parliament voted on a Constitutional provision,[15] that guarantees women the freedom to opt for voluntary termination of pregnancy, making France the first country in the world to enshrine this in its highest legal act. Amendments to the Bioethics Law have also been made, defining access to medically assisted reproduction,[16] with permitted techniques aiming better to meet the needs of French men and women so they do not seek reproductive care in foreign centers outside the French healthcare system. Through a special decree, medically assisted reproduction has been approved for all women in France (Rozée Rochebrochard, 2021).

As an example of relevant solutions in this area, one can look at the laws of Serbia. The sources in this matter are primarily found in constitutional guarantees.[17] A part of basic freedoms and rights represents the freedom to decide about childbirth. Everyone has the right to decide freely about having children. The state encourages parents to choose to have children and assists them in this (Article 63). The inviolability of physical and mental integrity is guaranteed. No one shall be subjected to torture, inhuman or degrading treatment or punishment, nor be subjected to medical or scientific experiments without their freely given consent (Article 25). In this regard, everyone has the right to protect their physical and mental health. The Constitution also proclaims that children, pregnant women, mothers during maternity leave, single parents with children up to seven years old, and elderly individuals have the right to healthcare funded from public revenues if they do not receive it in another way, in accordance with the law. Health insurance, healthcare, and the establishment of health funds are regulated by law (Article 68).[18] Termination of pregnancy can only be carried out at the request of the pregnant woman (Article 2) and in accordance with the conditions prescribed by the Act on

---

[14] Loi n° 75-17 Veil du 17 janvier 1975 Retrieved from: https://ivg.gouv.fr/le-droit-lavortement (June 20, 2024).
[15] Le 4 mars 2024, La Constitution de France.
[16] Loi n° 2021-1017 du 2 août 2021 relative à la bioéthique.
[17] Constitution of Serbia, *Official Gazette of RS*, no. 98/2006 and 115/2021
[18] See: Health Care Act, Health Insurance Act, *Official Gazette of RS*, no. 25/2019 and 92/2023 - authentic interpretation.

Termination of Pregnancy Procedure.[19] The law that regulates the rights and obligations in providing health services is the Patient Rights Act.[20]

The source of medical law also includes rules related to the profession, that is, the medical profession, which are complementary to legal provisions and accepted by judicial practice. The most important rules are contained in the Code of Medical Ethics of the Medical Chamber of Serbia, supporting family planning (Article 59).[21] A physician advises and thoroughly informs partners about the most favorable methods for family planning, as well as the possibilities for regulating conception in accordance with the current medical doctrine. Rules regarding contraception and the attitude towards abortion are adopted (Article 60). A physician advocates for family planning to be conducted using modern contraceptive methods, with abortion being a last resort. A physician is obliged to inform the patient about the effects of contraceptives, the dynamics of their use, and any possible undesirable side effects.

4 Medical Law Approach

4.1 General View

Medical law considers reproductive rights through the lens of reproductive health (Starrs et al., 2018). The fact is that the issue of reproductive rights today far exceeds the realm of health. However, within a general legal framework, this does not mean ignoring the medical context. It remains crucial for certain legal relationships, outcomes, and the protection of rights. Reproductive rights mainly, and sometimes exclusively, arise through medical procedures and health services. The realization of these rights is accompanied by technological improvements, the development of medical methodologies, and procedures that have greatly advanced. To understand this development, significant characteristics of individuals who are holders of reproductive rights are important, especially when defined by a certain age or vulnerability, such as adolescents, postpartum women, or older women (Jablan & Sjeničić, 2021). In addition to specifics regarding healthcare, there is also a uniqueness to legal protection (Xing et al., 2023). Moreover, in the context of

[19] Act on the Procedure for Termination of Pregnancy in Health Institutions, *Official Gazette of RS*, no. 16/95 and 101/2005 - dr. the law.

[20] Patients rights Act, *Official Gazette of RS*, no. 45/2013 and 25/2019 - dr. the law.

[21] Code of Medical Ethics of the Medical Chamber of Serbia, *Official Gazette of RS*, no. 104/2016.

reproductive rights, attention is also given to the interests of a third party, namely the unborn child, who is not the immediate subject of treatment but whose moral status is protected by law (Radišić, 1995).

Reproductive health implies that people have a satisfying and safe sexual life and have the ability to reproduce and the freedom to decide whether, when, and how often to do so (Steinbock, 2009). Indirectly, this also implies the right of both men and women to be informed and to have access to safe, effective, and acceptable family planning methods of their choice, as well as other fertility regulation methods that are legally permissible, and the right to access healthcare services capable of guiding a woman through a safe pregnancy and childbirth, and to care for couples with the best chances of having healthy offspring.

Legal analysis encompasses all aspects of specific medical procedures and various diagnostic procedures from the perspective of human rights in the area of health (Starrs et al., 2018). Previously, the primary concerns were more about the relationship between the doctor and patient, the legal qualifications of gynecological examinations, interventions, and obstetric procedures. Today, legal relevance extends to issues regarding the status of actors and reproductive behavior, the development of counseling for health services, as well as the reduction of invasive methods. In this regard, reproductive health policy simultaneously covers the realm of maternal and child health, as well as the regulation of fertility and sexual health.[22] Areas of care now include contraception, unintended pregnancies, complications of pregnancy, childbirth and abortion, infertility, genital infections, sexually transmitted diseases, cancer and the genital tract, maternal morbidities and mortality, as well as disability and sexual violence. In addition to the focus on a woman's reproductive period (conception, childbirth, diagnosis), medical treatment is now provided for various conditions affecting women through different life cycles from the beginning to the end of their lives (prevention, hormonal status, menopause, etc.). There has also been improved treatment and monitoring of related health conditions in women. For example, this involves identifying conditions that complicate childbirth, such as infections, malignancies, rare diseases, and various surgical interventions related to gender or surrogacy. This previously was not sufficiently recognized

[22] UNFPA (2018) International Technical Guidance on Sexuality Education. Tracking women's decision-making for sexual and reproductive health and reproductive rights https://www.unfpa.org/sites/default/files/pub-pdf/ITGSE.pdf. (August 6, 2024).

through the healthcare system, and has now been achieved by raising standards of health care (Laisk et al., 2018).

4.2 Reproductive Practice and Respect for Rights

Medical law in this matter aims to bring about legal determination and qualification of the arising relationships, as well as the status of holders of rights and obligations. Medical law endeavors to enable the effective and full application of laws through the implementation of national and supranational regulations (Jabbari, 1990; López et al., 2021). How and under what conditions reproductive rights are realized is more closely determined by specific healthcare laws, as well as regulated relationships between providers and users of reproductive health services. In that sense, any violation of due diligence by health professionals is not permitted. Poor outcomes exist, for example, if basic institutes of medical law are ignored, such as the principle of consent (informed consent) and respect for the basic rights of patients (Xing et al., 2023).

Numerous questions have arisen in legal theory and practice that impose high-level professional and sophisticated tasks in the field of health. A common problem is the gap between legal and medical terminology and the different understandings of disputed situations during treatment. Prevailing legal theory and judicial practice qualify any intervention by a physician on a patient's bodily integrity, thus also diagnosing treatment or childbirth, as a violation of the body (Đurđević, 2002). The legal basis for a physician's actions is the consent of the pregnant woman (postpartum woman), and only in this way is the intervention not contrary to law. As consent is a legal basis, the physician must obtain valid consent, and the prerequisite for valid consent is informing the patient receiving medical treatment. Generally, consent is valid and enforceable when all decisive circumstances have been communicated to the patient so that she is aware and understands what she is consenting to. When it comes to Serbian law, the relevant provision of the Law on Patient Rights speaks more closely about the content of information in relation to a larger number of possible situations.[23]

[23] See Article 11: The patient has the right to receive timely notification from the competent health worker, which he needs in order to make a decision to agree or not to agree to the proposed medical measure. The notification from paragraph 1 of this article includes: 1) diagnosis and prognosis of the disease; 2) brief description, goal and benefit of the proposed medical measure, duration and possible consequences of taking or not taking the proposed medical measure; 3) the type and probability of possible risks, painful and other secondary or permanent

Professional duties and ethical behavior of physicians are prominently highlighted in medical ethics codes, especially concerning the maintenance of unborn life, pregnancy management, and childbirth (Radišić, 2008). In the spirit of these acts, a physician who undertakes medical care for a pregnant woman simultaneously assumes responsibility for the health and life of the child, until its birth. In the case of high-risk pregnancies, the physician must present all diagnostic and therapeutic options of modern medical genetics and prenatal diagnostics. By providing this information, the physician is obliged to warn interested parties of the risks associated with the implementation of prenatal testing.

Translated into legal terms, in these situations, the pregnant woman enters into a legal relationship with the gynecologist aiming for him to undertake the necessary diagnostic and therapeutic procedures and lead to delivery. The woman is not alone in her pregnancy since it is not solely about her health; rather, the relationship is established also for the benefit of a third, i.e., the child, so that it can be born alive and healthy. Thus, the protective scope of the contract for the provision of medical services also includes the protection of the fetus. From a legal standpoint, this represents a schematic view that takes on a new quality once mutual rights and obligations, legal effects, and the intermingling with ethical and professional medical questions are incorporated. The possibility of applying prenatal diagnostic procedures places the physician before numerous ethical and legal dilemmas concerning the different interests of the unborn child, prospective parents, and the social community (Cramer, 1992). Unlike most other diagnostic procedures, which regularly lead to therapy and qualitatively new conditions, the outcome of prenatal diagnostics can sometimes be the termination of pregnancy, ending the reason for further diagnostics.

In determining the legal position of subjects and generally participants in the management of pregnancy and childbirth, it begins with the question of who possesses the status of a patient during diagnostics on the pregnant woman, that is, whether there is one or two patients. The pregnant woman, as a future mother, undoubtedly holds the status of a patient. In contrast, the status of the fetus is often debatable (Mujović Zornić, 2002). Medicine clearly perceives the fetus as an

consequences; 4) alternative methods of treatment; 5) possible changes in the patient's condition after undertaking the proposed medical measure, as well as possible necessary changes in the patient's lifestyle; 6) effect of drugs and possible side effects of that effect.

independent patient on whom not only a diagnosis is made but also fetal therapy is practiced, given that in highly developed countries, a respectable degree of fetal medicine development has been achieved (Laufs, 1990; Nagamizu, 2024). The fetus in the womb of the pregnant woman can be observed with great precision and clear detection of heart activity. In this sense, the fetus is considered a patient, whereby the attending physician conducts an early diagnosis of malformations or other developmental irregularities of the fetus. In certain cases, fetal therapy may be applied for the medical treatment of identified anomalies. When it is determined that an anomaly at the time of diagnosis discourages further maintenance of pregnancy, a therapeutic termination of the pregnancy is performed. A different conclusion is reached if civil law rules regarding status are consistently applied, which do not grant legal subjectivity to the fetus. It is morally valued as a legally protected good, with the concept of fictitious rights depending on its subsequent live birth (Gams, 1979). From this perspective, it cannot be said that the fetus serves as a patient (potentially a sui generis patient), given that the status of a patient essentially means the existence of effective rights and obligations on the part of the holder. A patient is someone with rights, and therefore, a patient must be a person (Mujović Zornić, 2002). According to the majority opinion of lawyers, the fetus can be understood as possessing subjective interests (Steinbock, 2009). Due to the underdevelopment of its central nervous system, the fetus lacks the valuation and beliefs that constitute the basis of such interests. It enjoys full moral status. There cannot be an autonomous obligation on the part of the fetus, nor full significance of the rights of the fetus, especially its right to life, in the sense that the fetus generates rights itself. The fetus can manifest symptoms subject to diagnosis and treatment that the physician addresses or applies, but the patient is the pregnant woman (McLean & Petersen, 1996). Only through her is treatment provided in such a way that it authorizes the physician to intervene. The decision is hers, and she is not obliged to accept all that is presented to her by the physician as a risk of morbidity and mortality, including the protection and promotion of fetal interests. The assumption is made that the woman represents the interests of the unborn child in her body in the best way. However, even though the fetus is perceived as part of the mother's body and lacks legal capacity, this fact does not undermine its eventual claim as a newborn child for damages sustained while it was in utero, even against the mother, since during that time it enjoyed full legal protection. Damages are compensated only in the case of the live birth of the impaired child, while such a claim cannot be made prior to birth (Radišić, 2000; Vodinelić, 1995).

If we look at practical examples of disputes related to reproductive rights issues, they mostly testify to insufficient knowledge of law. There is a tendency to resort to general legal assessments rather than utilizing specialized knowledge in the field of medical law. For example, in cases of denial of right to a free, it is often stated that terminating a pregnancy does not represent a therapeutic measure, overlooking the medical law principle that therapeutic and non-therapeutic acts are equated in legal terms (Renaut, 1999; Radišić, 2008).[24] Thus, such a stance constitutes a violation of the patient's rights to exercise her reproductive rights. A similar legal assessment occurs in highlighting fetal pain arguments, where the autonomous rights of the woman, or the couple in the fertilization process, to decide on their medical procedure are completely disregarded. Likewise, a conscientious objection on the part of healthcare professionals, according to medical law, should never mean the denial of reproductive rights, the fulfillment of which must be ensured in the existing healthcare system, regardless of different conditions and circumstances. Anything else resembles negligence regarding reproductive rights, which is unacceptable. It also happens that family law favors aspects of childbirth and child protection when evaluating reproductive behavior, while neglecting other rights in the areas of health and social protection. Two recent cases demonstrate the insufficient knowledge of medical law in Serbia: i) Denial of genetic counseling services for women at risk of rare diseases who were undergoing in vitro fertilization, being rejected by a reference center and referred to pay for services in private practice (Mujović, 2023). The response of medical law lies in the rights to access and continuity in treatment; ii) Disputed handling of frozen embryos when one partner who had previously given consent dies during the assisted reproduction process, where it was considered that the procedure could not be validly completed and that the frozen embryos should be destroyed (Marčetić & Sjeničić, 2024). The response of medical law is found in presumed consent and potentially elements of the patient's advance directive.

Critical views of legal theorists in Serbia believe that there has been a long delay in reforming the appropriate legal regulations, which would significantly define and advance the entire area of reproductive health. Regarding abortion, the law in force is from 1975 (Konstantinović-Vilić & Petrušić, 2010), although it has undergone

[24] See The definition of the medical operation itself has been changed. According to the earliest understandings, only the surgical intervention was such an act, while neither the examination nor the diagnosis had that character. Later, only therapeutic reasons were taken into account as a criterion. Today, however, the definition of medical treatment also includes actions that are not of a therapeutic nature, thus leaving the previous framework. The rule *Voluntas aegroti suprema lex est* applies.

minimal changes in the current version. Numerous questions regarding the boundaries of permissibility or differences in medical practice related to childbirth are resolved by applying civil and criminal law regulations. In situations where there is a legal vacuum, customary law applies, which is largely based on the principles of the medical profession and ethics. It is undisputed that according to the law, women of reproductive age enjoy special protection and are considered a vulnerable category of health service users, whose expenses are covered by mandatory insurance. However, the downside of the legislative approach to this issue is still the lack of systematicity and the absence of a comprehensive understanding due to insufficient knowledge of medical law. In practice, exercising rights encounters obstacles, leaving them declarative. The situation with reproductive health and family planning in Serbia indicates that the existing legal framework has its shortcomings regarding the consistency and functionality of regulations and other acts. The practice of abortion is viewed negatively in the community. This has also influenced the long-held belief among healthcare professionals that family planning signifies a process that leads to a low birth rate in Serbia, that is, to increasingly fewer births (Horga & Mujović Zornić, 2013).[25] It could be stated in legal analysis that the crisis and transition have long kept this area of health care neglected and that only recently have newer issues started to emerge. What the law means for Serbia in terms of development into greater rights are regulations in the field of in vitro fertilization and new reproductive technologies. This has brought a noticeable change in practice, which is also the subject of analysis (Kovaček Stanić, 2020). The first codification in this matter was carried out in 2009, and the currently valid Law on Biomedically Assisted Reproduction[26] was adopted in 2017 with significantly improved solutions (Mujović Zornić, 2017).

5 Reproductive Rights, Low Birth Rates and Policies

The decline in birth rates during the second half of the 20th century is associated with changes in the value system, individualization, changes in lifestyles, and an increase in the individual's awareness of the need to control and rationalize reproductive behaviour (Lesthaeghe & Neels, 2002; Van de Kaa, 2003; Surkyn &

[25] See the research results. *Assessment of the Family Planning Services in the Republic of Serbia.* UNFPA; Report of a mission conducted by Dr. Horga, Mihai 2013. East European Institute for Reproductive Health, p. 76. Retrieved from: https://serbia.unfpa.org/sites/default/files/pubpdf/FINAL_REPORT_Family_Planning_Assessment_SerbiaReport.pdf (July 20, 2024).
[26] Act on Biomedically Assisted Fertilization, *Official Gazette of RS,* no. 40/2017 and 113/2017 - dr. the law.

Lesthaeghe, 2004; Sobotka, 2008; Lesthaeghe, 2010). Decisions about parenthood and childbirth are understood as personal choices. Reproductive behaviour in modern societies is influenced by a number of different factors, and these influences are conditioned by both micro and macro environmental factors. Within these environments, there are factors that encourage and limit, depending on socio-economic conditions as well as the course of life and events in certain periods of life (Philipov, Liefbroer & Klobas, 2015).

In the countries with the highest birth rates in Europe, which had long maintained relatively high birth rates, a trend of declining fertility was recorded in the middle of the second decade of the 21st century (Eurostat, 2023). The most significant drop occurred in Finland, where in 2021, the rates were 20 percent lower compared to 2011 (1.46 compared to 1.83[27]). In Denmark, during 2011-2021, the rate increased until 2016 (reaching a value of 1.79), after which there was a slight decline, and in 2021 it was 1.72. The drop in the birth rate in Sweden is about 12 percent (from 1.90 to 1.67). The highest birth rates in this period were in France, where fertility has decreased by less than 10 percent, with a rate of 1.84 in 2021 compared to 2.01 in 2011.

In the European framework, fertility is the lowest in the countries of Southern Europe. The highest total fertility rate (TFR) is 1.4, recorded in Greece in 2021 and in Portugal from 2018 to 2021. Compared to France, these values are more than 20 percent lower. The rates are even lower in Italy, where fertility fell to 1.25 in 2021, and even lower in Spain, at 1.19.

Examining reproductive rights in the context of demographic trends leads us to policies addressing low fertility. The drop in birth rates to a level below the needs of simple reproduction caused European governments in the early 2000s to recognize the need to respond to the phenomenon of insufficient births (Gauthier & Philipov, 2008; Sobotka, Matysiak & Brzozowska 2019). Political responses were intensified towards defining measures based on empirical research into the reasons behind changes in the intention to have children, while highlighting the significant

[27] Total fertility rate (TFR) shows the average number of live births by women in the reproductive period (15 - 49 years), in the year of observation.

importance of gender roles (Bernardi, Mynarska, & Rossier, 2015; Klobas & Ajzen, 2015; Spéder & Kapitány, 2015; Liefbroer, Merz & Testa, 2015).

Policies addressing low fertility have a significant impact on fertility levels in European countries and are "responsible" for differences in birth rates (Neyer, 2006; Sobotka, 2008). While individual countries respond differently to low fertility, their common feature from a human rights perspective is that these responses are not repressive (Szalma et al., 2022). Measures to address low birth rates are part of family policies, which aim to improve the functioning of families with young children, provide support to parents, and facilitate a balance between work and family obligations. Family policies in developed countries focus on creating favorable conditions and respecting individuals' freedom to decide whether to become parents, as well as their right to realize that decision in accordance with their intentions and personal life organization (Philipov, Liefbroer & Klobas, 2015). Efforts to encourage childbirth are based on the discrepancy between the achieved and desired number of children (Sobotka & Beaujouan, 2014; Liefbroer, Klobas, Philipov & Ajzen, 2015), and do not encroach on the right to abortion."

The promotion and availability of modern contraceptives are key strategies to address the problem of a high prevalence of induced abortions, which has negative consequences for both the individual and society (Rašević & Sedlecki, 2011). Welti (1993) notes that by the end of the 20th century, effective contraceptives were the primary factor in birth control. It has been emphasized that the impact of abortion on fertility levels is related to the failure of contraception and that it is necessary to promote modern methods of birth control, making them accessible to all social classes and improving their effectiveness. Although this perspective is reflected in research that addresses the need for family planning policies associated with high birth rates, it also applies to the promotion of modern birth control methods in any context, regardless of fertility levels.

Abortion indicators reveal that abortion is part of reproductive behaviour in developed European countries, which are expected to have widespread use of modern contraceptives (Eurostat, 2024). In France, the abortion rate during 2013-2022 ranged between 13.0 and 14.0. In contrast, in Spain, the abortion rate in 2022 is nearly half that of France, and in Italy, it is almost one-third lower (8.4 and 5.0, respectively). Abortion is more prevalent in France, the country with the highest

fertility in Europe, whereas Italy and Spain have very low birth rates and less widespread abortion.

The impact of abortion liberalization on fertility trends attracted researchers' attention in the mid-20th century, at the beginning of this process. For example, in Australia, it was observed that access to abortion did not cause a decline in fertility. Instead, the spread of contraceptives contributed to a reduction in legal abortions, while illegal abortions remained a significant social problem (Browne, 1981). In this context, the decline in birth rates is seen as a result of individual attitudes and decisions regarding reproductive behavior, with abortion being one of the methods used.

In the absence of modern contraceptive use, there is a significant risk of widespread illegal abortions. Therefore, liberalization is viewed as a preventive measure against the negative effects of illegal abortions, which is accompanied by an increase in recorded abortion rates due to easier access to abortion services (Frederiksen & Brackett, 1968). By analyzing fertility trends and abortion rates, Frederiksen and Brackett concluded that the liberalization of abortion would not lead to a significant decline in fertility when modern contraceptives are used. However, they noted a potential negative impact, which could be a decrease in the use of more effective birth control methods. They also found that an increase in contraceptive use results in a decrease in abortion rates, which is linked to a reduction in the number of pregnancies and fertility rates. Given that the legalization of abortion has led to a significant decrease in mortality from unsafe abortions, this positive impact is considered more significant than the effect on fertility (Tietze, 1975).

Empirical research has disproven claims that in Australia, individuals who have become parents hold less liberal attitudes towards abortion compared to non-parents, indicating that efforts to achieve gender equality have increased support for abortion as a method of birth control (Clarke, Sibley & Osborne, 2023). However, the experience of other countries shows that a more egalitarian gender regime alone is not sufficient to improve women's reproductive rights; it is also necessary to address gender stereotypes to change traditional norms of reproductive behavior (ShiJing, 2023). Conversely, the rise of anti-gender movements has negative implications for reproductive rights and freedoms, including the discrediting of the right to legal abortion (Petričušić & Delić, 2023). Additionally, the impact of

abortion on the decline in fertility is less significant compared to its impact on the disruption of the sex ratio of live-born children, due to the prevalence of sex-selective abortions (Chen, 2007).

Most of the criticism of policies aimed at addressing low fertility is directed at the negative implications related to reproductive rights. The central issue arises when, due to a focus on increasing birth rates, the options for personal choice are limited. This includes restrictions on an individual's freedom to decide whether to become a parent, when to have children, how many children to have, and the intervals between births, while neglecting the structural factors underlying low reproductive norms (Đorić & Gavrilović, 2006; Drezgić, 2008; Stevanović, 2008; Bilanović, 2015). From a feminist perspective, women's reproductive rights are considered inalienable individual rights, which include the right not to give birth, and the right to access all necessary information and resources provided by the state, while maintaining high standards of sexual and reproductive health (Đorić & Gavrilović, 2006). Feminist discourse views pronatalist policies as mechanisms that restrict and undermine women's reproductive rights and freedoms to make autonomous decisions about childbirth, including the use of abortion as a method of birth control. Đorić and Gavrilović (2006) argue that from a feminist perspective, acceptable policies are those that respect the integrity of a woman's body and her sexual and reproductive rights, that do not subordinate a woman's individual rights to childbirth to any higher authority (such as family, nation, state, or church), and that respect women's reproductive rights regardless of their marital and family status. Such policies should not confine women to the role of mother within a marital union. This approach aligns with modern family policies, which, even if pronatalist in nature, do not limit the right to choice, freedom, and autonomy in decisions about childbirth.

Considering the health risks associated with abortion, the World Health Organization emphasizes a standard that encompasses comprehensive abortion care, which includes the provision of information, abortion services, and implementation of post-abortion care (WHO, 2024). This approach not only protects reproductive rights but also supports the right to reproductive health and advocates for the availability of medically safe induced abortions, which require expertise and necessary medical skills. A decline in the prevalence of abortion is considered positive and desirable, but only when it results from the use of modern contraceptives, rather than from restrictions and prohibitions.

A liberal attitude towards abortion does not equate to its promotion or endorsement but rather signifies a refusal to deny the right to use abortion as a method of birth control. Conversely, respect for reproductive rights is compatible with modern family policies, provided that their focus is on the conditions under which childbirth and parenthood occur. This approach addresses the barriers that hinder intentions to have children. Declining fertility trends and very low birth rates are the result of structural and individual factors, not the liberalization of abortion. While a birth rate below the level needed for simple reproduction is not ideal from a demographic perspective and thus justifies the development of policies, modern approaches to this issue do not entail limiting reproductive rights. The promotion and support of reproductive health and modern contraceptives are essential elements, not threats, to efforts aimed at addressing low fertility. A liberal attitude towards abortion does not impede the implementation of policies aimed at increasing birth rates but rather ensures higher health security when abortion is used as a method of birth control. Restricting or banning abortion does not lead to increased birth rates but poses a risk of illegal abortions, which endangers health and increases the risk of unsafe pregnancy terminations.

Reproductive rights can also be examined from the perspective of infertility. The current level of development in reproductive technologies allows for the fulfillment of parenthood desires even when there are medical and biological limitations. However, these technologies have not had a significant impact on overall fertility rates, and assisted reproductive technology (ART) cannot induce a substantial increase in very low birth rates (Yun, Cha, Nam, et al., 2023). As part of its pronatalist policy, Serbia finances an unlimited number of ART attempts (Barać, 2021). In 2013, 1,688 ART procedures were provided in public and private institutions, whereas in 2024, that number has increased to 4,918 (NHIF, 2013; NHIF, 2024). This nearly threefold increase reflects the state's commitment to addressing infertility issues and supporting affected individuals.However, it also highlights the need for promoting reproductive health to prevent potential infertility risks. Regarding demographic effects in Serbia, it is important to note that the fertility rate in 2021 was 17 percent lower than in France (1.52 compared to 1.86), and achieving the target set by the 2018 Strategy will not be feasible without a significant increase in birth rates beyond what can be achieved through ART alone.

Although the use of ART does not significantly impact demographic trends or result in a notable recovery of birth rates, it remains crucial for fulfilling the desire for offspring. Thus, its significance is more pronounced from the perspective of reproductive rights. In this context, it is important to recognize that the implementation and expansion of ART in any given country depend not only on economic development but also on non-economic factors such as educational levels, religious affiliations, and the extent to which existing conditions and norms in a particular social community facilitate the practical realization of the right to use ART (Präg & Mills, 2017). A key socio-cultural predictor of negative and ambivalent attitudes towards ART is the polarization between traditional and modern family values, as well as a lack of adequate information about these technologies (Bilinović Rajačić, Zotović, Škorić, & Kričković Pele, 2017).

6 Concluding Remarks

A characteristic of global and national trends is that a great deal of attention is paid to reproductive health and all actors and results achieved in this area. The contribution of legal theory and practice of medical law is essential, as regulations have proliferated, and the administration and judicial practice are abundant in case diversity and the number and quality of health decisions. Progress in medical terms in the field of human reproduction, which is constant, is accompanied by corresponding legal solutions. This is evidenced by examples from comparative law. Certainly, the issues of reproductive rights and measures for their realization in society depend on the level of freedom and the degree of guaranteed rights. It can be said that practices and disputes that were once subjects of national and international legal instances have contributed to establishing certain legal standards. There has also been a phenomenon of cross-border health care and health tourism in this area. In contrast to the very narrow specialist knowledge in medicine, corresponding legal expertise has developed. These are characteristic of the work of health lawyers and the field of medical law worldwide. In this sense, many positions regarding reproductive techniques and procedures have been defined, ranging from public health to operational work. The principles of informed consent, respect for privacy and confidentiality, as well as family planning and good practices in the work of health services are promoted throughout.

When it comes to less regulated legal systems, such as Serbian law, further work is needed to define a more contemporary and substantive legal framework for reproductive health and family planning. The position of family planning should be strengthened through education, prevention, and better treatment. Counseling centers and networking can certainly contribute to this. Continuous medical education in the area of reproductive health and reproductive rights should also be pursued. A comprehensive and intersectoral approach can yield new quality. The aspect of human rights cannot be neglected in relation to family planning. What is lacking is a unified perspective on reproductive rights: deciding on childbirth, contraception, and free parenting. Only such a comprehensive approach can lead to fully respected human rights.

Note

This article is based on authors' presentation, "Reproductive rights in the context of medical law and demographic trends" given at the Webinar "Zdravstvo med javnim in zasebnim sektorjem / Pravica do življenja in reproduktivne pravice", on March 21, 2024., University of Maribor.

References

Barać, I. (2021). Biomedicinski potpomognuto oplođenje i demografska politika, *Poltička revija,* 70(4), 173-195. https://doi.org/10.22182/pr.7042021.9

Berer, M (2017). Abortion Law and Policy Around the World: In Search of Decriminalization, *Health and Human Rights Journal*, 19(1), 13-27

Bernardi, L., Mynarska, M. & Rossier, C. (2015). Uncertain, Changing and Situated Fertility Intentions. In: Philipov, D. et al. (eds.) *Reproductive decision-making in a macro-micro perspective* (pp. 113-139). New York, London: Springer. https://doi.org/10.1007/978-94-017-9401-5

Bilanović, A. (2015). Konceptualni okvir analize reproduktivnih prava i sloboda, IN: Vujević, V. (ed.), *Nauka i sloboda, knjiga* 9, pp. 359-374. https://doi.org/10.7251/ZRNSFFP0915359B

Bilanović Rajačić, A., Zotović, M., Škorić, M. & Kričković Pele, K. (2018). Attitudes of Infertilie Women in Serbia Towards Third-Party Reproduction, *Teme*, 42(4), 1107-1122. https://doi.org/10.22190/TEME1804107B.

Bonnet, D. & Guillaume, A. (2004). La santé de la reproduction: une émergence des droits individuels, *Santé de la reproduction au temps du Sida en Afrique*, IN: Guillaume,A. & Khlat, M. (eds.) L'INED, l'IRD et les Universités de Paris, Centre Population et Développement, pp. 12-32.

Browne, E. (1981). Demography and abortion: a perspective. *Family planning information service*, 1(6), 1–8, https://pubmed.ncbi.nlm.nih.gov/12263448/.

Chen, W. (2007). Induced Abortion and its Demographic Consequences, IN: Zhongwei, Z. & Fei,G. (eds), *Transition and Challenge: China's Population at the Beginning of the 21st Century* (online edn, Oxford Academic, 1 May 2007), https://doi.org/10.1093/acprof:oso/9780199299294.003.0006 (February 5, 2024).

Clarke, E.V., Sibley, C.G. & Osborne, D. (2023) Examining Changes in Abortion Attitudes Following the Transition to Parenthood, *Sex Roles*, 89, 505–516. https://doi.org/10.1007/s11199-023-01408-3.

Cramer, E. (1992). Pränatale diagnostik und Fetaltherapie, Auswirkungen auf die Rechtsprechung des Bundesgerichtstofes zür Zeugung oder Geburt eines genetisch geschadigten Kindes als Schadensfall (wrongful birth action), *Medizinrecht*, 1, p. 14.

Diduck, A. (2011). Reproduction and the Equality Problem, *Human rights of women: 30 years after CEDAW*, IN: Radačić, I. (ed.), University College London / Institute of Social Sciences Ivo Pilar, pp. 283-296.

Đorić, G. & Gavrilović, D. (2006). Betweem Pronatalist Population Policy and Women`s Reproductive Rights: The Analysis of Exposure of the Two Discourses in Press Media After 2000, *Sociologija*, 48(1), 73-95, https://10.2298/SOC0601073D.

Drezgić, R. (2008). From Family to Population Policy: A Paradigm Shift in Serbian Demography at the end of the 20th Century, *Filozofija i društvo*, 19(3), 181-215, https://doi.org/10.2298/FID0803181D.

Đurđević, N .(2002). *Pristanak pacijenta na lečenje*, Pravni fakultet Univerziteta u Kragujevcu.

Elias, S. & Annas, G. (1987). *Reproductive genetics and the law*, Year Book Medical Publishers. INC, Chicago/London/Roca Baton, pp. 143-162.

Eurostat (2023). *Fertility rates by age,* retrieved from Statistics | Eurostat (europa.eu) (February 5, 2024).

Eurostat (2024). *Abortion indicators,* retrieved from Statistics | Eurostat (europa.eu) (June 11, 2024).

Frederiksen, H., & Brackett, J. W. (1968). Demographic Effects of Abortion. *Public Health Reports* (1896-1970), 83(12), 999–1010, https://doi.org/10.2307/4593469.

Gams, A. (1979). *Uvod u gradjansko pravo*, Beograd.

Gauthier, A.H., & Philipov, D. (2008). Can Policies Enhance Fertility in Europe?, *Vienna Yearbook of Population Research*, 6(2008), 1–16.

Horga, M. & Mujović Zornić, H. (2013). *Assessment of the Family Planning Services in the Republic of Serbia.* UNFPA; East European Institute for Reproductive Health, p. 76 https://serbia.unfpa.org/sites/default/files/pubpdf/FINAL_REPORT_Family_Planning_Assessment_Serbia-Report.pdf (June 11, 2024).

Jabbari, D. (1990). The role of law in reproductive medicine: a new approach. *Journal of medical ethics*, University of Reading, Mar; 16(1), 35–40. https://doi:10.1136/jme.16.1.35.

Jablan, B. & Sjeničić, M. (2021). Reproductive health of visually impaired women. *Teme*, 45(1), 265-279.

Klobas, J.E. & Ajzen, I. (2015). Making the Decision to Have a Child. In Philipov, D. et al. (eds.), *Reproductive decision-making in a macro-micro perspective* (pp. 41-78). New York, London: Springer. https://doi.org/10.1007/978-94-017-9401-5

Konstantinović-Vilić, S. & Petrušić, N. (2010). *Žene, zakoni i društvena stvarnost*, Ženski istraživački centar za edukaciju i komunikaciju, Niš, 435.

Kovaček Stanić, G. (2020). Reproduktivna autonomija žene kao ljudsko pravo, IN: Varadi, T. & Pajvančić, M. (eds.) *Rodna ravnopravnost – od jednakih prava do jednakih mogućnosti*, Beograd, SANU, pp. 121-135.

Laisk, T., Tšuiko, O., Jatsenko, T., Hõrak, P., Otala, M., Lahdenperä, M., Lummaa, V., Tuuri, T., Salumets, A., & Tapanainen, J.S. (2019). Demographic and evolutionary trends in ovarian function and aging, *Human Reproduction Update*, 25(1), 34–50 doi:10.1093/humupd/dmy031

Laufs, A (1990). Pränatale Diagnostik und Lebenschutz aus arztrechtlicher Sicht, *Medizinrecht*, 5, 231.

Lesthaeghe, R. (2010). The Unfolding Story of the Second Demographic Transition, *Population and Development Review,* 36(2), 211-251. https://doi.org/10.2307/25699059.

Liefbroer, A,C., Klobas, J.E., Philipov, D. & Ajzen, I. (2015). Reproductive Decision-Making in a Macro-Micro Perspective: A Conceptual Framework. In Philipov, D. et al. (eds.), *Reproductive decision-making in a macro-micro perspective* (pp. 1-15), New York, London: Springer, https://doi.org/10. 1007/978-94-017-9401-5.

Liefbroer, A.C., Merz, E.M. & Testa, M.R. (2015). Fertility-Related Norms Across Europe: A Multi-level Analysis. In Philipov, D. et al. (eds.), *Reproductive decision-making in a macro-micro perspective* (pp. 141-163), New York, London: Springer, https://doi.org/10.1007/978-94-017-9401-5.

López, A., Betancourt, M., Casas, E., Retana-Márquez, S., Juárez-Rojas, L., & Casillas, F. (2021). The need for regulation in the practice of human assisted reproduction in Mexico. An overview of the regulations in the rest of the world, *Reproductive Health*, 18(1), 241. https://doi.org/10.1186/s12978-021-01293-7.

Marčetić, D. & Sjeničić, M. (2024). Zakon o biomedicinski potpomognutoj oplodnji – postoji li pravna praznina ili ne?, *Aktuelnosti medicinskog prava - Teorija, praksa i zakonodavstvo 5*. Beograd, pp. 20-23.

McLean, S. & Petersen, K. (1996). Patient Status: The Foetus and the Pregnant Woman, *Australian Journal of Human Rights*, AU JlHRights 6; 2(2), 229.

Medicus, D. (1985). *Zivilrecht und werdendes Leben*, Bayerische Akademie der Wissenschaften München, C.H. Beck, Nördlingen, p. 5.

Mujović Zornić, H. (2002). Legal status of handicapped newborn child and civil liability, *Book of proceedings II*, 14th World Congress on Medical Law, Maastricht, Netherlands, pp. 453-457.

Mujović Zornić, H. (2017). Vantelesna oplodnja sa stanovišta medicinskog prava – Zakonodavne promene u Srbiji, *Aktualnosti građanskog i trgovačkog zakonodavstva i pravne prakse*, Pravni fakultet u Mostaru, Mostar, pp.432-445.

Mujović, H. (2023). Pitanja odgovornog postupanja kod preimplantacione genetičke dijagnostike.n*Srbija i reformisanje instituta odgovornosti 6*, Institut društvenih nauka, Beograd, pp. 36-38.

Nagamizu, Y. (2024). Legal Protections of the Fetus and the Mother in the Context of the Development of Fetal Therapy in Japan, *St. Andrew's University Law Review*, 40, 49-60.

Neyer, G. (2006). Family Polices and fertility in Europe: Fertility polices at the intersection of gender polices, employment polices and care polices, Working paper, 2006-010, Max Planck Institute for Demographic Research.

NHIF – National Health Insurance Fund of Republic Serbia (2013). *Treatment of infertility by biomedically assisted fertilization procedures, Preliminary report*, Retrieved from https://www.rfzo.rs/download/vto/Preliminarni%20Izvestaj%20o%20lecenju%20neplodnosti%20postupcima%20BMPO,010414.pdf (February 2, 2024).

NHIF – National Health Insurance Fund of Republic Serbia (2024). *Treatment of infertility by biomedically assisted fertilization procedures, Preliminary report*, Retrieved from https://rfzo.rs/download/vto/Preliminarni%20Izvestaj%20o%20lecenju%20neplodnosti%20postupcima%20BMPO,01.07.2024.pdf (July 22, 2024).

Petričušić, A. & Delić, D. (2024). Osporavanje reproduktivnih prava žena pravnom mobilizacijom antirodnog pokreta u Republici Hrvatskoj. *Revija za sociologiju*, 54(1), 35-62. https://doi.org/10.5613/rzs.54.1.2

Philipov, D., Liefbroer, A.C. & Klobas, J.E. (eds.) (2015). *Reproductive decision-making in a macro-micro perspective* (New York, London: Springer) https://doi.org/10.1007/978-94-017-9401-5.

Präg, P. & Mills, C.M. (2017). Cultural determinants influence assisted reproduction usage in Europe more than economic and demographic factors, *Human Reproduction*, 32(11), 2305–2314, https://doi.org/10.1093/humrep/dex298.

Radišić, J (2000). Pravna zaštita embriona u Saveznoj republici Nemačkoj, *Pravni život*, 9, 140-141.

Radišić, J (2008). *Medicinsko pravo*, Nomos, Beograd.

Rašević, M & Sedlecki, K. (2011). Pitanje postojanja abortusne kulture u Srbiji, *Stanovništvo*, 49(1), 1–13. https://doi.org/ 10.2298/STNV1101001R.

Renaut, M.H. (1999). Lévolution de l'acte medical, *Revue de droit sanitaire et social*, 35(1), 01-03.

Rozée, V. & de La Rochebrochard, E. (2021). Assisted human reproduction outside the French legal and medical framework: issues and challenges, *Population & Societies*, 593, October, 1-4.

ShiJing, Z. (2023). Body Rights and Autonomy: Gender equality and women's reproductive decision-making, In: S. Yacob et al. (eds.), Proceedings of the 2023 7th International Seminar on Education, Management and Social Sciences (ISEMSS 2023), Advances in Social Science, Education and Humanities Research 779, pp. 1981-1991, https://doi.org/10.2991/978-2-38476-126-5_226.

Sobotka, T. (2008). The diverse faces of the Second Demographic Transition in Europe, *Demographic research*, 19, article 8, 171-224, https://doi.org/10.4054/DemRes.2008.19.8.

Sobotka, T., Matysiak, A., & Brzozowska, Z. (2019). *Policy responses to low fertility: How effective are they?* Working Paper No. 1. (New York: UNFPA) Retrieved from https://www.unfpa.org/publications/policy-responses-low-fertility-how-effective-are-they (July 25, 2024).

Sobotka, T. & Beaujouan, E. (2014). Two is the best? The Persistence of a Two-Child Family Ideal in Europe, *Population and Development Review*, 40(3), 391-419.

Spéder, Z. & Kapitány, B. (2015). Influences on the Link Between Fertility Intentions and Behavioural Outcomes: Lessons from a European Comparative Study, In Philipov, D. et al. (eds.), *Reproductive decision-making in a macro-micro perspective*, pp. 79-112 (New York, London: Springer). htpps://doi.org/10.1007/978-94-017-9401-5.

Starrs, A.M., Ezeh, A.C., Barker, G., Basu, A., Bertrand, J.T, Blum, R., Coll-Seck, A.M., Grover, A. Laski, L., Roa, M., Sathar, Z.A., Say, L., Serour, G.I., Singh, S., Stenberg, K., Temmerman, M., Biddlecom, A., Popinchalk, A., Summers & C. Ashford, N. (2018). Accelerate progress—sexual and reproductive health and rights for all, *African Population and Health Research*, L.S Guttmacher Institute, New York, Vol 391 June 30, 1642 – 2692.

Steinbock, B. (1998). Rethinking the Right to Reproduce, 23 *Harvard Ctr. for Population & Dev. Studies*, Working Paper Series No. 98.05, 114.

Steinbock, B. (2009). Wrongful Life and Procreative Decisions, University at Albany, *State University of New York Scholars Archive Philosophy*, p. 156. Retrieved from: https://scholarsarchive.library.albany. edu/cas_philosophy_scholar/5 (June 30, 2024).

Stevanović, J. (2008). Reproduktivna prava u Srbiji, IN: Zaharijević, A. (ed.) *Neko je rekao feminizam,* pp. 83-90. https://pescanik.net/wp-content/PDF/3jasmina.pdf

Surkyn, J. & Lesthaeghe, R. (2004). Value Orientations and the Second Demographic Transition (SDT) in Northern, Western and Southern Europe: An Update, *Demographic research*, Special Collection 3, 45-86. Retrieved from: www.demographic-research.org/special/3/3/ (March 2, 2024).

Szalma, I., Hašková, H., Oláh, L. & Takács, J. (2022). Fragile Pronatalism and Reproductive Futures in European Post-Socialist Contexts. *Social Inclusion*, 10(3), 82–86. https://doi.org/10.17645/si.v10i3.6128.

Tietze, C. (1975). The Effect of Legalization of Abortion on Population Growth and Public Health. *Family Planning Perspectives*, 7(3), 123–127. https://doi.org/10.2307/2133730.

Van de Kaa, D.J. (2003). *The Idea of a Second Demographic Transition in Industrialized Countries*, Paper presented at the Sixth Welfare Policy Seminar of the National Institute of Population and Social Security, Tokyo, Japan, 29 January 2002. Retrieved from: http://www.ipss.go.jp/webj-ad/webjournal.files/population/2003_4/kaa.pdf (July 25, 2024).

Vodinelić, V. (1995). Moderni okviri prava na život, *Pravni život*, 35(9), 20-25.

Welti, C. (1993). The demographic impact of abortion. Estimated to be one fifth of total fertility, *Demos*, (6), 25-6, Spanish [The demographic impact of abortion. Estimated to be one fifth of total fertility] - PubMed (nih.gov).

WHO – World Health Organization (2024). *Abortion – Key Fact*, Retrieved from: https://www.who.int/news-room/fact-sheets/detail/abortion (June 11, 2024).

Xing, E., Owda, R., Loder, C. & Collins, K. (2023). Abortion rights are health care rights, *JCI Insight*, 8(11), e171798. https://doi.org/10.1172/jci. insight.17179.

Yun, I., Cha, W., Nam, C.M. et al. (2023) The impact of assisted reproductive technology treatment coverage on marriage, pregnancy, and childbirth in women of childbearing age: an interrupted time-series analysis. *BMC Public Health*, 23, 1379, Open Access. https://doi.org/10.1186/s12889-023-16286-3 (July 15, 2024).

Povzetek v slovenskem jeziku

Medicinsko pravo preučuje reproduktivne pravice skozi prizmo reproduktivnega zdravja. Obsega vse vidike z zornega kota človekovih pravic. Poudarek je na pravnih virih. Medicinski kontekst vprašanj je zelo pomemben. Šteje se, da gre za resno kršitev, če se zanemarijo osnovna pravila, kot so informirana privolitev in pravice bolnikov. Upoštevanje demografskih trendov vodi do povezave med rodnostjo in omejevalno zakonodajo, ki ni bila potrjena kot dobra rešitev. V zaključku je poudarjeno, da bi moralo medicinsko pravo bolj prispevati k izboljšanju storitev reproduktivnega zdravja, standardov kakovosti ter boljši pravni zaznavi in zaščiti za vse.