

CROATIA

Annual Country Report

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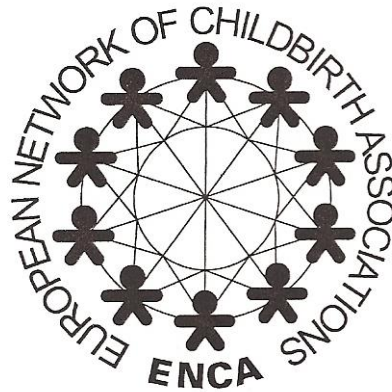
EUROPEAN NETWORK OF CHILDBIRTH ORGANISATIONS

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PRVI HRVATSKI PORTAL ZA PORODE I PRAVA TRUDNICA I RODILJA



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About Roda

Since its foundation in 2001 Roda has been an important stakeholder in the areas of respect and access to reproductive healthcare, specialising in maternity care. We are a **pro-choice organisation** that advocates for changes in two main areas in the realm of reproductive rights: **Medically Assisted Reproduction and Respectful Maternity Care.**

Roda has representatives on the Ministry of Health's Working Group for the Mother and Baby Friendly Initiative, currently running a pilot program in four of thirty Croatian maternity hospitals. In 2018 Roda updated its website on maternity hospital statistics in Croatia, including most recent available information (2016 data), available at <http://rodilista.roda.hr>. The information includes statistics for all of Croatia's maternity hospitals (caesarean, episiotomy, mortality rates etc.) for all Croatian maternities, public and private. This is the only place where the statistics are available to the public. Statistics were sourced from surveys sent to maternity facilities directly, from professional journals and the Croatian Institute for Public Health (via access to information request).

About Croatia

Croatia is a boomerang-shaped country in southern Europe that boasts a long coastline and deep continental regions. Croatia shares borders with Italy (at sea), Slovenia, Hungary, Serbia, Bosnia-Herzegovina and Montenegro and joined the European Union in 2013. The healthcare system is publically funded with a relatively small number of private clinics and hospitals. The population is homogenous with few immigrants and foreigners living in-country. In 2016, Croatia had a population of 4.2 million people, with just over 37.500 births; the population and birth rate have been steadily declining since 1998.¹ Economically, Croatia is classified as an upper-middle income country.² Poverty is a problem, with data from 2011-2012 showing that one in five children live in poverty.³

Croatia's constitution defines Croatia as a secular country; however the Catholic Church, institutions and organisations affiliated with it have a strong political influence. This has been evident in the increasing neo-conservative movement seeking to restrict minority rights as well as sexual and reproductive health rights. These organisations are well-funded and well-networked and have succeeded in preventing the introduction of sexual, health and civic education in Croatian schools. They also had a successful referendum restricting the right to marriage for same-sex couples and have been working to restrict access to abortion services. Their activities have also stretched towards decreasing quality and access to medically-assisted reproduction services and reproduction.

Reproductive rights, including the right to choose during pregnancy, birth and postpartum have been under attack in Croatia for many years, and Roda has been at the forefront of advocacy activities to maintain and improve the status of these rights since 2001.

¹ Croatian Bureau of Statistics, (2017) *Statistical Yearbook of the Republic of Croatia 2017*. Zagreb: Croatian Bureau of Statistics.

² World Bank, (2016) *Croatia | Data*. World Bank. Available at: <https://data.worldbank.org/country/croatia> (Accessed: 6 April 2018).

³ Šućur, Z., Kletečki Radović, M., Družić Ljubotina, O. and Babić, Z. (2015) *Poverty and well-being of preschool children in Croatia*. Zagreb: UNICEF Croatia, 2015.

Maternity and Parental Leave Benefits

Croatian maternity leave benefits facilitate breastfeeding with the majority of infants having a caregiver with them for twelve months. Despite a capped benefit for the second-half of the twelve-month period, over 85% of mothers use the full 12-months of maternity leave.⁴

Women who return to work or share their parental leave benefit with their partner before their child's first birthday can use a breastfeeding break benefit whereby they can two hours (paid) for breastfeeding breaks in a given work day up to twelve months postpartum.⁵ The flexibility and uptake of leave benefits make it clear maternity benefits in Croatia do not constrict breastfeeding exclusivity or duration, even in the minority of cases where a woman returns to work before twelve months postpartum.

Antenatal, Intrapartum and Postnatal Care

Antenatal care is provided by primary care gynaecologists every four weeks. After 36 weeks, care is transferred to a maternity hospital and check-ups continue with the on-call obstetrician. Midwives work under the supervision of gynaecologist-obstetricians and are only involved in a woman's care during labour and birth in hospital; there is no continuity of care and women see whomever is on shift. The perinatal mortality rate is low, at 6.6‰ and the caesarean section rate is growing steadily, at 22.97% in 2016⁶ which reflects a doubling over the rate in 2001.

Public and private hospitals

Of Croatia's 31 maternity facilities, 30 are public and one is a private facility, located in Zagreb. The private facility is a small one, accounting for about 300 births per year, or less than 1% of the country's total births. All of Croatia's public maternity facilities are certified Baby-Friendly Hospitals, while the private maternity is not. As is the case in other countries, the caesarean section rate at the private maternity facility is much higher than the national average, and was 71% in 2016.⁷

Closure of small out of hospital maternity units

Since 2010 Croatia has moved towards centralizing birth and postpartum care in 30 maternity hospitals throughout the country. Small out-of-hospital (ambulatory) units have been closed.⁸ Although there is no official data on the number of women of reproductive age who live more than 50 km away from a maternity hospital,⁹ on the basis of 2011 census data it is estimated that 361,100 women of fertile age, representing 52% of women in Croatia (out of 698,675 in total), live outside of cities with maternity hospitals.¹⁰

⁴ Dobrotić, I., Matković, T. and Zrinščak, S. (2012) "Gender Equality Policies and Practices in Croatia - The Interplay of Transition and Late Europeanization", *Social Policy & Administration*. Social Policy & Administration, 47(2), pp. 218-240. doi: 10.1111/spol.12016.

⁵ Maternity and Parental Leave Support Act 2017. Available at: <https://www.zakon.hr/z/214/Zakon-o-rodiljinim-i-roditeljskim-potporama>

⁶ Rodin, U., Draušnik, Ž. and Cerovečki, I. (2017) *Childbirths in healthcare institutions in Croatia in 2016*. Zagreb: Croatian Institute for Public Health, 2017.

⁷ Đelmiš J. et al., *Gynaecologia et perinatologia* v. 26, supl 1, table 11, page 11 (2016).

⁸ Comment by the Croatian Chamber of Midwives Regarding the Closure of Ambulatory Birthing Units (2010) (last visited Jun. 11, 2015) available at <http://www.komora-primalja.hr/sluzbeni-dopisi/279-priopcenje-hrvatske-komore-primalja-vezano-za-zatvaranje-manjih-rodilista>.

⁹ Roda contacted the Croatian Institute for Public Health and the Croatian Institute for Health Insurance (that refunds travel expenses for all healthcare users who travel more than 50 km to obtain care), and neither body collects statistics on the number of women who travelled more than 50 km to receive care during birth.

¹⁰ Calculated using data from the 2011 census, available at

http://www.dzs.hr/Hrv/censuses/census2011/results/htm/h01_01_13/h01_01_13_RH.html

The lack of available data and research impedes assessment of the impact and effectiveness of this process of centralization. However, there are regular media reports of births taking place at roadsides and in military helicopters. Not least as women living on the Croatian islands need to be transported to mainland hospitals to give birth. These reports are indicative of the challenges many rural women face in accessing maternal health care in Croatia.¹¹

The majority of births in Croatia (99%) take place in maternity hospitals and are most often attended by doctors with midwives assisting. Ambulatory birth services (in maternity units that are not attached to hospitals) were available in rural and hard-to-reach areas (e.g. islands and mountain areas) from the end of World War II until the early 2000s; in 1995 for example 4% of babies were born in this type of institution.¹² The safety of these hospitals is demonstrated by the fact that in 1995, there was only one foetal death in one of these units, accounting for a perinatal mortality rate of 0.6‰. Political changes in the early 2000s had the goal of restricting women's sexual, reproductive and health rights across the board, including restricting access to abortion and medically assisted fertility services. Changes did not end there, and the majority of Croatia's ambulatory maternity units were closed in 2010.¹³ The reason cited for this was the fact that these units did not have surgical theatres to perform caesarean sections; this was despite the fact that the maternal and perinatal mortality rates for the out of hospital maternity units was lower than the country average for the period 2000-2009 (the difference being statistically significant).¹⁴ For political reasons, one maternity unit was reopened in 2011 (ironically, the one closest to a large hospital maternity unit).¹⁵

Out of hospital birth with a skilled attendant

Croatian legislation does not recognize the possibility for midwives to work independently outside of hospital settings and as a result does not enable women to choose home birth with a skilled attendant.¹⁶ There are home births, but there are no statistical data on their number;¹⁷ the majority of women who have a planned home birth do so with the assistance of a foreign midwife licensed to work in one of the countries around Croatia.¹⁸

Postnatal care

Upon being discharged from hospital a family receives visits from a community nurse whose role is to provide postpartum care for mother and infant, including monitoring breastfeeding. Grgurić and Pećnik

¹¹ See for example, Tri muškarca, mama i beba: U helikopteru iznad Splita rođena djevojčica: "Sve se odvijalo brzo..." available at <https://dnevnik.hr/vijesti/hrvatska/u-helikopteru-hrz-a-rodjena-beba---513424.html>; U helikopteru HRZ i PZO još jedna Korčulanica rodila bebu, <http://www.morh.hr/hr/vijesti-najave-i-priopcenja/priopcenja/11279-u-helikopteru-hrz-i-pzo-jo%C5%A1-jedna-kor%C4%8Dulanica-rodila-bebu.html>; Korčulanica rodila u helikopteru HV-a iznad bračkog kanala, available at <http://bljesak.info/rubrika/vijesti/clanak/korculanica-rodila-u-helikopteru-hva-iznad-brackog-kanala/4371>; Uranila na ovaj svijet: Rodila na cesti u Zadru!; available at <http://www.vijesti.rtl.hr/novosti/1287995/uranila-na-ovaj-svijet-rodila-na-cesti-u-zadru/>; 24 SATA TV, Žena rađala curicu dok ju je suprug vozio kroz Učku, available at <http://www.24sata.hr/dobre-vijesti/zena-raala-curicu-dok-ju-je-suprug-vozio-kroz-ucku-155284>.

¹² Rodin and Dražančić. OUT-OF-HOSPITAL MATERNITIES: Medically survived or useful? *Gynaecol Perinatol* 2011;20(1):6–15.

¹³ Croatian Chamber of Midwives Statement on the Closure of Small Out of Hospital Maternity Units (2010). Available at: <https://www.komora-primalja.hr/sluzbeni-dopisi/279-priopcenje-hrvatske-komore-primalja-vezano-za-zatvaranje-manjih-rodilista>

¹⁴ Rodin and Dražančić. OUT-OF-HOSPITAL MATERNITIES: Medically survived or useful? *Gynaecol Perinatol* 2011;20(1):6–15.

¹⁵ Out of Hospital Maternity Unit in Sinj Re-Opened (2010). Available at: <https://dnevnik.hr/vijesti/hrvatska/ponovno-otvoreno-sinjsko-rodiliste.html>

¹⁶ See Roda and the Croatian Association for the Promotion of Midwifery, *Petition to the European Parliament on Access to Midwifery (2014)*.

Available at: http://www.roda.hr/media/attachments/english_roda/Petition_EU_Parliament_Orig.pdf

¹⁷ Despite numerous requests for information to the Ministry of Administration, Ministry of Health and Croatian Health Insurance Institute, no data are collected or available (Roda, 2018).

¹⁸ Drandić, Daniela. Home Birth in Croatia (2017). Available at: <http://www.roda.hr/portal/porod/kako-radamo/porod-kod-kuce-u-hrvatskoj.html>

showed that 96% of families were visited by community nurse postpartum; 84% had three or more visits, mostly concentrated in the first month postpartum, with fewer visits in the second month.¹⁹ Community nurses provide care to the community at large, hold a general nursing degree, and some have specialised training on breastfeeding (although this is not obligatory). Most infants have a primary care paediatrician, and their first appointment is at four weeks postpartum.

Breastfeeding

Croatia is one of the few countries in the world where all public maternity services are certified as Baby-Friendly, accounting for 99% of the births in Croatia in 2016 (Roda, 2018). Over 80% of infants and mothers have skin-to-skin contact within one hour of birth, when breastfeeding is likely to be initiated (WBTi Croatia, 2015) and over 90% of women report breastfeeding their infant while in hospital (Grgurić and Pećnik, 2013a). However, once discharged, breastfeeding rates begin to fall tremendously, with national rates dropping to just 51% at four months (Grgurić and Pećnik, 2013a). Inconsistency in data collection (Grgurić and Pećnik, 2013a) means this figure likely refers to any breastfeeding as opposed to exclusive breastfeeding.

Disrespect and harmful practices during facility-based childbirth

Since 2001, Roda has monitored the treatment of pregnant women in hospitals. Women's stories reflect concerns about the treatment of pregnant women during childbirth in hospitals and indicate that there may be serious deficits in ensuring women give their full and informed consent to medical interventions during childbirth and contain reports of frequent disrespectful and abusive, and even violent, treatment of women by medical professionals. The caesarean rate has also been rising, and the vaginal birth after caesarean (VBAC) rate has remained low.

Roda's 2015 Survey on Experiences in Maternity Services found that large numbers of women report being subjected to procedures that may not always be supported by medical evidence and may be harmful to women's physical and mental health.²⁰ These included the Kristeller Manoeuvre (fundal pressure), extensive use of episiotomy, and routine use of enemas often accompanied by obligatory shaving of pubic hair.

Rising Caesarean Section Rate

Since 2001 the caesarean section rate in Croatia has doubled, from 11.9% reaching a high of 22.97% in 2016 – currently one in five women give birth surgically (vacuum extractions have been stable over the past ten years, about 1.2% of all births; forceps are very rare, 0.05% of all births)²¹. The reasons for this are many-fold, but include the low vaginal birth after caesarean (VBAC) rate, which was only 26% in 2016.²² The overuse of

¹⁹ Grgurić, J. and Pećnik, N. "The Availability and Use of Services to Support Parents and Early Child Development", in Pećnik, N. (ed.) *How Parents and Communities Care for the Youngest Children in Croatia*. Zagreb: UNICEF Croatia, 2013, pp. 148-165.

²⁰ Roda, *Survey on Maternity Practices in Croatia* (2015), available at <http://roda.hr/article/read/roda-survey-on-maternity-practices-in-croatia-march-2015>.

²¹ Rodin et al., *Childbirths in healthcare institutions in Croatia in 2016*. Croatian Institute for Public Health. Zagreb, 2017. Available at: https://www.hzjz.hr/wp-content/uploads/2017/08/Porodi_2016.pdf

²² Đelmiš J. et al., *Gynaecologia et perinatologia* v. 26, suppl 1 (2017).

interventions and hospital culture have contributed to the increased caesarean section rate, which continues to rise steadily.²³

The Kristeller Manoeuvre

The Kristeller Manoeuvre involves applying heavy pressure on a pregnant woman's abdomen supposedly with the purpose of speeding up the delivery.²⁴ There is no evidence of the procedure's usefulness²⁵ and emerging evidence indicates that it can cause severe pain and side effects.²⁶ Roda's 2015 Survey found that 54% of women report being subjected to the Kristeller Manoeuvre in one form or another.²⁷

Episiotomy

Prior to 2008, episiotomy was performed at nearly 70% of vaginal births, and although this has been decreasing it is still very high. Roda's 2015 survey revealed that episiotomy rates may be severely underreported (the Croatian Institute for Public Health reports a rate of 36 percent of vaginal births for 2016²⁸, while women's reports to Roda in 2015 indicated a rate of 56 percent).²⁹ Furthermore, episiotomy rates vary drastically from hospital to hospital, from rates of over 56% to rates of only 8%.³⁰ There is no medical evidence that the liberal or routine use of episiotomy is beneficial, but there is clear evidence that it may cause harm to women's health.³¹

Other Harmful Routine Practices

Roda's Survey on Maternity Practices (2015) also showed the large numbers of women being subjected to other harmful practices; for example 76% of women had to remain laying down throughout the duration of their labour and birth; 81% were attached to a CTG monitor for the full duration of their labour and birth; 66% had their membranes artificially ruptured (AROM). Finally, 78 percent of women surveyed reported having been given an enema; and although the survey did not include a question about routine pubic hair shaving, many women report that this is usually conducted just before an enema is administered.³²

²³ Drandic, D. Why is the Caesarean Section Rate Rising in Croatia? <http://www.roda.hr/portal/porod/kako-radamo/zasto-je-stopa-carskih-rezova-u-stalnom-poratu-u-hrvatskoj.html>

²⁴ Habek, Bobić, Hrgović, *Possible Feto-Maternal Risk of Kristeller Expression*, Journal of Central European Medicine, Volume 3, Issue 2 (2008), pp. 183-186, available at <http://link.springer.com/article/10.2478%2Fs11536-008-0008-z#page-1>.

²⁵ WORLD HEALTH ORGANIZATION: Care in Normal Birth: a practical guide. Geneva: Department of Reproductive Health & Research, 1996, s. 25 – 26, available at http://whqlibdoc.who.int/hq/1996/WHO_FRH_MSM_96.24.pdf?ua=1.

²⁶ *Id.* See also Sartore A1, De Seta F, Maso G, Ricci G, Alberico S, Borelli M, Guaschino S, The effects of uterine fundal pressure (Kristeller maneuver) on pelvic floor function after vaginal delivery.

²⁷ Roda, *Survey on Maternity Practices in Croatia*, 6 (2015), available at <http://roda.hr/article/read/roda-survey-on-maternity-practices-in-croatia-march-2015>.

²⁸ Information from the Croatian Public Health Authority, compiled by Roda, available at <http://rodilista.roda.hr>

A further problem is that data cited by the Croatian Public Health Authority is calculated as a percentage of all births, while episiotomy rates should be calculated as a percentage of vaginal births; this makes the rate seem lower than it actually is. More at: Croatian Public Health Authority, *Health Statistics Yearbook 2016*, available at https://www.hzjz.hr/wp-content/uploads/2018/01/Ljetopis_2016_IX.pdf

²⁹ Roda, *Survey on Maternity Practices in Croatia*, (2015), available at <http://roda.hr/article/read/roda-survey-on-maternity-practices-in-croatia-march-2015>.

³⁰ CEDAW Committee, *Concluding observations: Croatia*, para 31 d), U.N. Doc. CEDAW/C/HRV/CO/4-5

³¹ See *Intrapartum Care: Care of healthy women and their babies during childbirth. Clinical Guideline 190: Methods, evidence and recommendations*. London: National Collaborating Centre for Women's and Children's Health, 2014, s. 611, available at <http://www.nice.org.uk/guidance/cg190/evidence/cg190-intrapartum-care-full-guideline3>; WORLD HEALTH ORGANIZATION: Care in Normal Birth: a practical guide. Geneva: Department of Reproductive Health & Research, 1996, s. 29; FIGO Safe Motherhood and Newborn Health (SMNH) Committee: Management of the second stage of labour. In: vol. 119, 2012, s. 111 – 116, available at www.odondevice.org/press/FIGO-second-stage.pdf.

³² Roda, *Survey on Maternity Practices in Croatia*, (2015), available at <http://roda.hr/article/read/roda-survey-on-maternity-practices-in-croatia-march-2015>.

Roda's 2015 report showed that 70% had their labour augmented with artificial oxytocin (colloquially known as drip); during Mother Friendly Hospital Pilot evaluations conducted in 2017, all four pilot sites cited an approximate number of 90% of women augmented with artificial oxytocin; unfortunately, there are no official statistics on this practice.

All of the above-named practices are explicitly named as harmful in World Health Organisation documents, especially in the 2018 WHO recommendations: intrapartum care for a positive childbirth experience³³ which reiterates the need to provide women with supportive care and time to labour and birth at her own pace.

Informed Consent

Roda's survey also raises concern as to whether medical professionals are sometimes failing to adhere to the principle of full and informed consent when treating pregnant women. Many women reported that they were asked to sign informed consent forms upon arriving at maternity hospitals without being provided with information about what they were signing and what procedures the forms covered. They reported that medical interventions were sometimes carried out contrary to their wishes. Roda's survey found that in 68 percent of cases women believed they were not provided with sufficient information to meet informed consent requirements, calling into question compliance with the Patients' Rights Act.³⁴

Pregnant women also reported facing forms of persuasion, manipulation and coercion from health professionals and a lack of respect for their preferences and wishes. For example, Roda's 2015 survey found that 62 percent of women did not participate in decisions about how they would give birth and 40 percent of women did not have privacy during birth. Roda's survey found that 70 percent of women were not allowed to move around during labour and birth, and 76 percent of women were made to lie down for the duration of their labour and birth.

Women have reported being given pharmaceuticals for pain in labour that they were not aware of and did not consent to. Other women have been denied epidural analgesia despite expressly seeking it out repeatedly. Women are not routinely offered or given anaesthesia when being sutured for perineal tears after vaginal birth, and the same is true for women who are undergoing *dilatation and cutterage* procedures after miscarriage.³⁵

The experiences described above raise serious concern's regarding respect for women's human rights during childbirth in Croatia. Often women may suffer physical and mental trauma and harm as a result of such practices and their autonomy and decision-making capacity is heavily undermined.

³³ WHO, WHO recommendations: intrapartum care for a positive childbirth experience (2018). Available at: <http://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/>

³⁴ Protection of Patients' Rights Act, NN 169/04, available at <http://www.zakon.hr/z/255/Zakon-o-za%C5%A1titi-prava-pacijenata>.

³⁵ *Ibid.*

Barriers to a Positive Pregnancy, Birth and Postpartum Experience

Companions during labour and birth

Having a companion while giving birth is proven to improve birth outcomes.³⁶ Croatian hospitals often place undue restrictions on who can be with the woman (including requiring payments and/or the companion taking a special orientation course), creating an undue barrier that often targets parents with lower socio-economic status and education.³⁷ This practice especially discriminates minorities such as Roma and refugees / those seeking international protection. Furthermore, companions are often only allowed at the birth when the baby is crowning, meaning that the woman has no companion for the majority of her labour.³⁸

Lack of Mental Health Support

Recent data from the UK has shown that the leading cause of death in the year following pregnancy and childbirth is mental health.³⁹ Unfortunately, Croatia does not offer perinatal mental health screening, nor does it have a robust system of professional support for women's mental health in pregnancy and after giving birth. There is only one team in Zagreb with long waiting periods, and other parts of the country do not offer any support to women suffering from ante- and post-partum mental health issues.

Access to infants immediately after birth

In many hospitals, there have been problems with facilitating immediate skin to skin contact with mothers and their infants immediately after birth; skin to skin contact has proven benefits for the mother's immediate postpartum health by decreasing bleeding and encouraging the birth of the placenta, but also has proven benefits for the health and wellbeing of infants.^{40,41} Skin to skin care is especially restricted for mothers who are giving birth by caesarean section, who are often separated from their children for a number of hours, and for mothers whose infants need care in the neo-natal intensive care unit (NICU).⁴²

The Mother-Friendly Hospital Initiative

In response to growing public pressure to improve maternity services and growing on the success of the Baby Friendly Hospital Initiative, the Ministry of Health, UNICEF and other stakeholders including professional organisations civil society came together in 2016 to begin adapting and implementing the

³⁶ Cochrane Library. *Continuous Support for Women during Labour* (2017), available at: http://www.cochrane.org/CD003766/PREG_continuous-support-women-during-childbirth

³⁷ Roda, *Survey on Maternity Practices in Croatia*, 6 (2015), available at <http://roda.hr/article/read/roda-survey-on-maternity--practices-in-croatia-march-2015>.

³⁸ *Ibid.*

³⁹ MBRRACE-UK, *Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15* (2017), available at:

<https://www.npeu.ox.ac.uk/downloads/files/mbrance-uk/reports/MBRRACE-UK%20Maternal%20Report%202017%20-%20Web.pdf>

⁴⁰ Cochrane Library. *Early Skin to Skin Contact with Mothers and Healthy Newborn Infants* (2016), available at:

http://www.cochrane.org/CD003519/PREG_early-skin-skin-contact-mothers-and-their-healthy-newborn-infants

⁴¹ Cochrane Library. *Kangaroo mother care to reduce morbidity and mortality in low birthweight infants* (2016) available at

http://www.cochrane.org/CD002771/NEONATAL_kangaroo-mother-care-reduce-morbidity-and-mortality-low-birthweight-infants

⁴² Pavičić Bošnjak, A. et. al., *Breastfeeding support in neonatal intensive care units in Croatia: a national survey* (2015), available at <http://bib.irb.hr/prikazi-rad?rad=886285>

FIGO/ICM Ten Steps to a Mother and Baby Friendly Hospital.⁴³ In 2016-7 the first training session was held for healthcare providers from four hospitals that are piloting the program,⁴⁴ and the two facility evaluations (before and after training) were held in the same period. Currently, the working group is evaluating the piloting process and deciding on next steps.

Barriers to allowing midwives to practice their profession

There is a severe shortage of healthcare personnel in some maternities, in Split for example the ratio of midwives to births annually was 1:278 in 2015⁴⁵ where the golden standard should be 1:29.⁴⁶ The moves to employ new midwives are slow and cumbersome, even though there are midwives on the labour market. The official statistics are hidden by the Ministry of Health, even though they were supposed to be public at the end of 2015.

Once Croatia entered the EU, it adopted the EU requirements for midwifery education, which include university-level training⁴⁷. In this process however, Croatia did not abolish secondary-school training for midwives, instead choosing to offer a midwives' assistant training program at vocational secondary schools. Despite an increasing number of midwives graduating from university midwifery programs and a deficit of qualified midwives, job notices for new midwives favour midwives assistants with secondary-school education and often purposely exclude midwives with a university education.⁴⁸ No master's level and above programs are available in midwifery, and as a result professors at midwifery programs are mostly obstetricians and nurses.⁴⁹ Furthermore, midwives' scope of practice does not offer them autonomy within or outside of hospitals, despite the fact that in 2010 the European Court of Human Rights made it clear that "private life" includes a woman's right to choose the circumstances of childbirth⁵⁰, meaning a woman has the right to care if she chooses to birth outside of a hospital.

Not allowing midwives to practice autonomously breaches a woman's right to quality care and a midwife's right to practice her profession.

⁴³ International Federation of Gynecology and Obstetrics, International Confederation of Midwives, White Ribbon Alliance, International Pediatric Association, World Health Organization. Mother-baby friendly birthing facilities. *International Journal of Gynecology and Obstetrics* 128 (2015) 95–99.

⁴⁴ Roda. The Mother and Baby Friendly Hospital Pilot Program in Croatia. Available: <http://rodilista.roda.hr/rodilista-prijateljji-majki/pilot-program-rodilista-prijateljji-majki-i-djece-u-rh.html>

⁴⁵ Dana given at meeting between Roda and the Ministry of Health; official report findings still unpublished. See more information at Roda, *One Year after #BreakTheSilence* (2016), available at: <http://www.roda.hr/udruga/programi/trudnoca-i-porod/godinu-dana-nakon-akcije-prekinimo-sutnju.html>

⁴⁶ National Audit Office (UK), *Maternity services in England* (2013), available at: <https://www.nao.org.uk/wp-content/uploads/2013/11/10259-001-Executive-Summary.pdf>

⁴⁷ European Midwives' Association. *EU Directives*, available at: <http://www.europeanmidwives.com/eu>

⁴⁸ Croatian Chamber of Midwives, *Does Croatia Really Need University-Educated Midwives?* (2016) available at: <https://www.komora-primalja.hr/datoteke/Status%20prvostupnica%20primaljstva%20u%20Hrvatskoj%20-%20primaljski%201.pdf>

⁴⁹ Mivšek, P. et. al., *Midwifery education in Central-Eastern Europe* (2016), available at https://www.sciencedirect.com/science/article/pii/S0266613815003095?_rdoc=1

⁵⁰ European Court of Human Rights Decision in *Ternovsky v. Hungary* (2010), available at <http://hudoc.echr.coe.int/fre-press?i=003-3372071-3778873>

Problems with data collection and statistics

Although Croatia has a robust system of perinatal mortality statistics, data collection for other key quality indicators is sporadic or missing. These include information on the number of inductions, augmentation of labour, epidural use, number of women who have birth companions, etc. There are no available statistics on maternal mortality between 43 days and one year after giving birth, having access to such data would do much to identify reasons for maternal deaths in the year following childbirth and to address them.

Finally, there is no confidential review of cases of maternal mortalities that involves all stakeholders, which would also do much to improve maternal mortality by addressing key reasons for deaths in the year following childbirth.

Reporting by International Bodies

In its report to Croatia in 2015, the CEDAW Committee urged that the state party „ensure the existence of adequate safeguards so that medical procedures for childbirth are subject to objective assessments of necessity and conducted with adequate standards of care and respect for women’s autonomy and the requirements for informed consent, and to introduce options for home births for women who wish to avail themselves of that possibility.“

More generally, the Committee has emphasized that states have an obligation to ensure that health services are, “delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.”⁵¹ The WHO considers that, “[a]buse, neglect or disrespect during childbirth can amount to violation of a woman’s fundamental human rights,”⁵² and that such treatment includes “outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures,... lack of confidentiality, failure to get fully informed consent.”⁵³

This was further reiterated by the Council of Europe's Commissioner for Human Rights who stated: „States should ensure that sexual and reproductive health services, goods and facilities are available to all women throughout the country, physically and economically accessible, culturally appropriate, and of good quality in line with the Committee on Economic, Social and Cultural Rights [General Comment](#) No. 22 (2016) on the Right to sexual and reproductive health... States should put in place adequate safeguards, including oversight procedures and mechanisms, to ensure that women have access to appropriate and safe child birth procedures which are in line with adequate standards of care, respect women’s autonomy and the requirement of free, prior and informed consent.”⁵⁴

⁵¹ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 11, para. 22.

⁵² See WHO, *The prevention and elimination of disrespect and abuse during facility-based childbirth* (2014), available at http://apps.who.int/iris/bitstream/10665/134588/1/WHO_RHR_14.23_eng.pdf?ua=1&ua=1.

⁵³ *Id.*

⁵⁴ Council of Europe Commissioner for Human Rights. Commissioner’s Human Rights Comments, *Protect women’s sexual and reproductive health and rights* (2016), available at: <https://www.coe.int/en/web/commissioner/-/protect-women-s-sexual-and-reproductive-health-and-rights>