European Network of Childbirth Associations (ENCA)

CROATIA

Annual Report 2016

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1. General Information

The information in this report is based on the Survey on Maternity Practices in Croatia 2015. The Survey was prepared by a group of six NGOs from the former Yugoslavia with the assistance of an expert in survey preparation, and the Survey on Routine Practices in Maternity Hospitals in Croatia, 2013, conducted among Croatia's 30 maternities with individual data available to the public at http://rodilista.roda.hr.

Women regularly contact Roda with reports on their experiences in maternity care, both to provide negative and positive experiences. The channels they use are Roda's social media (mostly Facebook) but also direct email requesting information on next steps they can take to get legal recourse. The number of women who reach out via social media is very hard to estimate (Roda's page is very active has over 50,000 followers) while about 100 direct emails arrive requesting information on recourse annually.

2. Informed Consent and Refusal

The vast majority of women (60-70%) reported that they did not give informed consent during antenatal and intrapartum care. There is no standardized printed information available about options and interventions in pregnancy and childbirth, save for consent forms given in hospital. The information is provided in short and although it is accurate, it also lacks detail, integral in making any informed decision / refusal.

Blanket Consent Forms

When being admitted to a healthcare facility women must sign something called a "blanket consent form" the meaning of which varies from facility to facility. In Roda's 2013/2014 survey of maternity hospitals, we asked what the blanket consent form covered exactly, and which procedures require separate, specific consent forms. Despite the fact that the legislative framework is the same for all hospitals in the country, the answers varied from facility to facility, with some considering the blanket consent form to cover everything save a caesarean and/or induction, while other facilities stated that the consent form was only for hospitalisation and routine procedures e.g. monitoring and drawing blood, while specific signed consent was required for all other procedures. No blanket consent form details exactly what the woman is consenting to when she is consenting to hospitalisation and the wording is very general. Women are not invited to question the consent form, and often the admitting midwife / nurse is either not interested in or not authorised to give any concrete information.

Birth Interventions

Intrapartum interventions are mostly presented as necessary and not open to discussion, although if a woman chooses to, she can ask for additional information and/or decline certain interventions (although informed refusal is not usually welcome, and consent is oftentimes granted after a woman is emotionally or psychologically coerced). Roda's 2013/2014 Hospital Survey showed that while some interventions are open for discussion in some hospitals if the woman herself instigates the conversation (e.g. she will not be asked or presented the idea in the manner that it is open for discussion) others are not open for discussion if a healthcare provider deems them "medically necessary". What is deemed necessary, and what is even presented to the woman before being done, is arbitrary and depends mostly on the team on duty at the time, their preferences and style of care.

Women regularly report having been promised certain kinds of support (labour companion, undisturbed access to their newborn) antenatally, which is then dependent on the team on duty when the woman is labouring who oftentimes refuses to uphold the original agreement. Interestingly, in situations where a woman has a recommendation from her antenatal obstetrician saying that she should have a medically indicated caesarean, when she comes into the hospital the obstetrician on duty oftentimes dismisses this insisting she should have a vaginal birth (quite often outright refusing to perform the caesarean the woman has prepared for and has the recommendation for). The converse is true if a woman comes in wanting a physiological birth, with the team on duty then saying that this woman is destined for a caesarean and working hard to make sure it happens. Birth plans are oftentimes treated the same way, with women who bring them in being especially picked on, with staff oftentimes purposefully performing in a way so as to contradict the birth plan, explaining that they are "medically necessary", using emotional and psychological tactics to bully the woman into believing they are right should she question them.

Informal Payments and Favours

It is usual in the Croatian health system to try and "pull strings" to find someone who knows someone who works in the maternity hospital (the Croatian word for this is *veza* or connection). This person can receive an informal payment but most often it is a form of a favour. In some hospitals it is common for women to give informal payments to obstetricians to personally be present at their labour and birth. Interestingly, the women who have a connection in the maternity hospital or who give an informal payment to an obstetrician are quite often those who are subjected to the most interventions, even if they did not want any interventions in the first place.

Labour Companions

Having a labour companion is a contentious issue, with many hospitals requiring that this person fulfil certain criteria. The criteria are sometimes written and known (companion must complete a course, must be dressed in a certain manner, must pay a fee), while others are informal (the companion must be male, must meet arbitrary criteria set by the maternity ward head, can only be present from the pushing phase onwards). The companion is allowed in the birthing room most often only in the pushing phase and for an hour after birth, and again this is arbitrary as the person is invited in by the team on duty and their restrictions and preferences apply. Visiting hours are usually one hour per day, interestingly most often this hour is during business hours (so not available for people who work during business hours), and only include one person. Older children are not allowed to visit.

Hospital policies are fairly rigid and vary from institution to institution. They are summarized on http://rodilista.roda.hr and oftentimes even though the hospital states that the woman can refuse certain interventions, in practice only women who know beforehand that they can refuse the intervention do so, and immense pressure is put on them to consent to the care the team on duty wants them to receive.

Private Maternity Care

There is one private maternity hospital in Croatia, where a vaginal birth costs about 2600 EUR (four-times the average monthly salary) and a caesarean costs about 4600 EUR (six-times the average monthly salary) plus the cost of antenatal care. Needless to say, the cost is prohibitive. The private hospital allows women to have their partner present throughout labour and birth (even at a caesarean, which is unheard of at state hospitals), provides her with one-to-one care from a midwife and a well-equipped room for her stay after the birth. Given the prohibitive cost and its 76% caesarean section rate this hospital is not an alternative to public-hospital care in any sense.

3. Informed Consent and Refusal for Common Birth Interventions

Common Interventions

Induction of labor (getting labor going) – Generally, women have to sign a separate consent form for an induction and it is planned ahead. Most often the induction is presented as lifesaving and is not put up for debate.

Breaking the amniotic sac (artificial rupture of membranes) – Women mostly report that they do not get any information about AROM, and it is done during a vaginal exam without them even knowing (66% of women reported having AROM).

Freedom of movement/ position – Women are not allowed freedom of movement for the most part, and most often labour alone in a pre-birth room (*predrađaonica*) where they are not allowed a companion. This room often has many different labouring women, who sometimes have a HCP check on them and sometimes not, depending on the hospital culture and staff on duty. Later on, when they are ready to push, a companion is called in and they are in a room referred to as a *box* which is essentially a three-walled room with no door (or no closed door) opened towards a common hallway. In some hospitals the dividing wall has a large window (sometimes with blinds), in some it is a short wall that does not reach all the way to the ceiling, in a few hospitals it is a full wall. (76% of women have to remain lying down throughout labour and birth).

Electronic foetal monitoring – Electronic foetal monitoring is presented as lifesaving and necessary and few women question it. Wireless CTG units are available in a few hospitals, but are very few in number. The consent is covered by the blanket consent form in most hospitals (81% of women were attached to a CTG machine for the duration of their labour and birth).

Pain Medication – Women must give special consent for an epidural, although not all hospitals have on-call anaesthetists available and women are as such not always guaranteed an epidural if they want one (23% of women had an epidural, 19% wanted one but couldn't get one). Other pain medication is given (trospium and pethidine being drugs of choice) if the woman is being given an IV, oftentimes without her knowing at all.

Augmentation of labour (speeding labour up) – Women are sometimes asked for consent regarding augmentation or *drip* however, this is presented as a necessity and lifesaving and few question it. Moreover, the women who do question or refuse it are almost always bullied or belittled until they accept it. Another common practice is that an IV is administered with the woman being informed that she is getting "fluids" while in reality the IV includes medication for augmenting labour (70% of women reported getting artificial oxytocin during labour / birth). Many hospitals require that an IV shunt be put in when the woman is admitted, and so this is very easy to do. Syntocinon (artificial oxytocin), administered for the birth of the placenta, is either administered by putting it in an already-placed IV or is administered by surprising a woman with an injection in the arm. She is not told in advance or even warned.

Planned caesarean section – Women are given special consent forms for planned caesarean section, although "planned" in the Croatian context means medically-indicated (whether or not the indication is evidence based is debatable). Interestingly, there are conditions (such as a high / low dioptre factor) that are cultural indications for planned caesarean that have no scientific basis but continue to persist.

Caesarean section during labour (emergency or otherwise) – In labour caesareans are always presented as medically indicated, with no questions allowed or posed, while women who wonder whether they need a caesarean (long, difficult labour) are "punished" by not being given one and berated just because they asked if they could have one. A special consent form is

required for in-labour caesarean, but the risks and benefits are most often not explained or considered important since the caesarean is always life-saving.

Among other interventions, pubic shaving and enema are routine in almost all maternity hospitals, and although in theory women can refuse them (and they oftentimes do), the majority of women continue to get this routine treatment because it is presented as normal and necessary. Risks and information about these interventions is almost never given.

One intervention that is specific for the region is fundal pressure or the Kristeller maneuver, which is never presented or explained to the woman (oftentimes after it is done the obstetrician explains to the companion on how it was helpful or important). Not only is consent not gained for this manoeuvre, it is only rarely written up in the patient notes (writing it up would open the HCPs to possible legal prosecution should something go awry – 9 of 30 hospitals admitted to this practice in the 2013/2014 survey).

What if Informed Consent is not Given?

Women who have had their right to informed consent violated in practice have no recourse, because the healthcare providers always deny the woman's story and the culture of the healthcare sector is such that colleagues do not speak out about negatively about the care provided by colleagues. The legal system provides little or no legal recourse, unless the woman or her child/ren have lasting physical consequences from the treatment received. Even then the legal system is slow, expensive and seemingly arbitrary and only rarely do parents choose to use it.

4. Midwifery/ Out-Of-Hospital Birth

Midwifery Education in Croatia

Midwives in the Croatian healthcare system only work in hospitals as doctor's assistants. Even those who have completed a university education and who have the competencies to work independently within the hospital system (e.g. they can be the primary caregiver to the labouring and birthing woman throughout the process) are not allowed this right. A recent survey conducted by the Croatian Chamber of Midwives showed that university-educated midwives continue to do the same job as their colleagues with a secondary school education.

All women receive care antenatally, intrapartum and postnatally from obstetrician-gynaecologists. The woman does not know who will be attending her birth beforehand, as she is cared for by the on-call team when she comes in. She cannot influence this (unless she is having a planned caesarean or induction).

Midwife Shortage

The ratio of midwives to births ranges from approximately 1:40 to 1:270 in some large hospitals. A new midwifery program has been opened in Croatia's second-largest city (Split) and a part-time program is available in the third-largest city (Rijeka). The capital, Zagreb, does not have a university-level program, nor does the one remaining regional centre, Osijek, meaning that the north and east of the country effectively have no higher education programs for midwives. Once midwives complete the program they are met with further bureaucratic barriers and issues in employment. The state continues to open secondary-school level programs for midwifery education (midwives' assistants) even though EU Directives clearly state that midwives need a university-level education. Finally, some university-level programs require that applicants have completed a secondary school midwifery education (e.g. they cannot have a diploma from a different secondary school diploma) which is not the case for other healthcare professions.

Home Birth

Out of hospital birth is present and women are mostly attended by foreign midwives. Although they have the education to attend out of hospital births, university-educated Croatian midwives do not have the experience or tradition in doing so. Attending an out of hospital birth could be considered illegal for healthcare providers, as a number of laws are in conflict and do not define the role and competencies of midwives outside of hospitals. No insurance (state or private) covers out of hospital birth.

No midwives are currently undergoing criminal proceedings for attending OOH births in Croatia, although should a midwife do so, it would only be a matter of time before she is brought before the authorities.

Emergency care providers have very limited training and equipment to assist with an OOH birth or transfer or to resuscitate a newborn. Women from rural areas and islands routinely give birth en-route to hospital, and there have been no moves on the part of the healthcare system to provide them local midwifery care or have a midwife accompany them to their closest maternity hospital.

The state and regulation of OOH birth means that many women who would choose it do not, even though a small number of women still choose it. The state has refused to note that their inaction is making birth unsafe for women within and outside of hospitals, and continues to repeat that as long as maternal and perinatal mortality remain low, they do not have the initiative to make any changes.

5. How would you say that the state of regulation and integration for out-of-hospital birth affects out of hospital birth safety?

A small number of women still choose out of hospital birth, and are then either unattended or attended by midwives who travel from other jurisdictions (other EU countries). The women must then keep the midwives' identity a secret when registering their child's birth.

Unattended Births

Unattended births, chosen by women because they cannot have anyone legally attend them out of hospital, are dangerous and no woman should be put in a position where a healthcare provider cannot attend her and provide care during her birth.

The problem of midwives attending out of hospital births from other jurisdictions is that they must keep their identity a secret and as such she must abandon care if a woman should she need a transfer to hospital, care is then not optimal and time is lost because of a lack of communication between healthcare providers. Furthermore, a perceived unfriendly environment at the hospital may make the midwife wait longer for a non-emergency transfer, making the situation potentially dangerous.

Vaginal Birth after Caesarean (VBAC)

It is also important to note that certain healthcare centres in Croatia have very low VBAC rates, and that VBAC after more than one caesarean section is unheard of. Women who want to plan a VBAC are then essentially left outside the system and must opt for a home birth. The situation for these women is even more perilous, because the chances for a transfer are higher for them. In essence, the system won't let them have a vaginal birth in hospital, but also refuses to provide them with a (safe) alternative.

Despite many colourful stories being circulated in hospital gossip circles, Roda is not aware of any adverse outcomes at home births in Croatia over the past five to ten years, nor have any parents and/or midwives been successfully convicted for choosing or attending an out of hospital birth, although some parents have been questioned and had minor bureaucratic issues regarding birth registration that were settled within a short period of time. Official statistics on these do not exist.