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**Promotion and protection of all human rights, civil,
political, economic, social and cultural rights,
including the right to development**

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Croatia

Note by the Secretariat

Pursuant to resolution 33/09, the Secretariat has the honour to transmit to the Human Rights Council the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Croatia, which took place from 28 November to 6 December 2016.

As the newest member of the European Union, Croatia has made progress regarding the realization of the right to health, particularly by strengthening primary and specialized healthcare and investing initial efforts in necessary mental health reforms. The Special Rapporteur encourages the Government to further advance by developing policies guided by a human rights-based approach, in line with the Agenda 2030, avoiding retrogressive measures and paying particular attention to groups in most vulnerable situations, including women, children, people on the move, national minorities, persons with intellectual, cognitive and psychosocial disabilities, and older persons. The report addresses challenges and opportunities and makes a number of recommendations recalling the need to use financial resources, in a transparent manner and in full compliance with international human rights.

Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Croatia

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I. Introduction

1. The Special Rapporteur visited Croatia from 28 November to 6 December 2016 at the invitation of the Government. The purpose of the mission was to ascertain, in a spirit of cooperation and dialogue, national endeavours to implement the right to health, measures taken for its successful realization, and the obstacles encountered.

2. During his visit, the Special Rapporteur met with high-ranking Government officials from the Ministries of Foreign and European Affairs; Health; Demographics, Family, Youth and Social Policy; Finance; Science and Education; Labour, and from the Offices for Gender Equality, Human Rights and Rights of National Minorities and the Office of the Agent of the Republic of Croatia before the European Court for Human Rights. He also met with members of the Parliament and the Constitutional Court, as well as with the Ombudswomen and the Ombudspersons for children, persons with disabilities and for Gender Equality. Meetings were additionally held with representatives of civil society, international organizations, and United Nations entities.

3. The Special Rapporteur visited different health facilities, one secondary school and a community-based facility for persons with psychosocial disabilities, a reception centre for Asylum Seekers, one Roma Settlement and a drug dependence centre, in Zagreb, Osijek, Vukovar and Split.

4. The Special Rapporteur is grateful to the Government of Croatia for its invitation and outstanding cooperation prior and during the visit. He appreciates the important support provided by the United Nations in the country, including the United Nations Development Programme (UNDP), the World Health Organization (WHO), the Office of the United Nations High Commissioner for Refugees (UNHCR), the United Nations International Children's Emergency Fund (UNICEF) and the International Organization for Migrants (IOM).

II. Framework of the right to health in Croatia

A. Background

5. After reaching independence from the Socialist Federal Republic of Yugoslavia in 1991, Croatia successfully joined the European Union (EU) in July 2013. This process involved the overall revision of, and amendments to, around 680 pieces of legislation, which inter alia brought improvements in terms of the human rights framework, including a strengthened role of the Ombudsperson.

6. In the healthcare sector, accessing the EU required harmonizing the normative and institutional framework and EU relevant regional strategies (i.e. the European Health Strategy) became immediately applicable.¹

7. The current healthcare system maintains the principles of universality and solidarity pre-1991 with elements from the various reforms that the sector has undergone due to, inter alia, the process of independence and the global financial crisis of 2008. As a result, one public entity, the Croatian Institute for Health Insurance (CIHI), now consolidates previous separate insurance schemes (for employees, farmers and artisans, and the self-employed)

¹ European Observatory on Health Systems and Policies 2014, Health Systems in transition- Croatia Health System Review, Vol. 16 No. 3, available at http://www.euro.who.int/__data/assets/pdf_file/0020/252533/HiT-Croatia.pdf?ua=1, p. 21.

absorbing most of the healthcare budget. Some private providers are also active in certain areas.

8. The share of the gross domestic product (GDP) allocated to the health sector has gradually increased since the 2000s reaching 6.7% of GDP in 2015; however, it has not yet reached the levels of most EU countries (in average 9.5%).² When looking at expenditure in the health sector, the proportion of public spending decreased between 1995 and 2012, but continues to be high compared to most countries in the EU,³ showing the continuous priority of the health sector in the national agenda.

9. In the context of the Agenda 2030, Croatia made good progress regarding all indicators linked to child mortality (MDG4), notably under-five mortality rate decreased from 12.8 deaths per 1,000 in 1990 to 4.5 in 2013. Advances are also reported in some indicators linked to maternal health improvement (MDG5), particularly maternal mortality rates decreased from 10 in 1990 to 8 in 2015. The Special Rapporteur regrets, however, that information on other indicators of MDG5 is not available, remarkably regarding contraceptive prevalence rates and unmet needs for family planning. Finally, progress has also been achieved on indicators linked to goal MDG6, in terms of tuberculosis' incidence, prevalence, death rate per year, detection and treatment.⁴

10. Future endeavours should involve investment in human rights-based approach policies, in line with the SDGs. Croatia should use the historic opportunity presented by the juncture of becoming an EU member and the global adoption of the Agenda 2030 to further advance the right to health. Additional progress could be achieved on MDG-related issues that remained underreported and are now linked to the new global goal SDG 3.7 on universal access to sexual and reproductive healthcare services. Actions in this direction will be strengthened by the effective implementation of the Global Strategy on Women's, Children's and Adolescents' Health (2016-2030). Further MDG-related issues that could be continuously advanced in the new global agenda relate to certain indicators of universal health coverage (SDG 3.8) and to mental health (SDG 3.4).

11. Structural EU funds should be devoted to develop rights-based healthcare policies and services and should be used in a transparent manner with full compliance with universal human rights principles.

B. Normative and institutional framework

12. Croatia has ratified most of the international human rights treaties.⁵ Between 2014 and 2015, it underwent reviews by the Human Rights Committee, the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW), the Committee on the Rights of the Child (CRC) and the Committee against Torture (CAT). While Croatia is party to the Covenant on Economic, Social and Cultural Rights (CESCR) since 1992, its second report is currently overdue. In October 2016, Croatia was elected member of the United Nations Human Rights Council (HRC) for 2017 to 2019, with the possibility of re-election for a second consecutive term.

² Ibid p. 51-59, and European Commission 2017, Country Report Croatia, Commission Staff Working Document, Brussels, 22.2.2017 SWD(2017) 76 final, at https://ec.europa.eu/info/file/96682/download_en?token=k-4wwF_K, p. 53

³ In 2013, 17.6% of the total State budget was allocated to healthcare, see the European Observatory op. cit. p. 51-59.

⁴ MDG data available at <http://mdgs.un.org/unsd/mdg/Data.aspx>

⁵ With the exception of the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (CMW) and pending ratification of the Convention for the Protection of All Persons from Enforced Disappearance (CED), signed on 7 February 2007.

13. In 2003, Croatia extended a standing invitation to the Special Procedures of the HRC, and the Special Rapporteur on the right to health is the fifth mandate to visit the country since then. Croatia has gone through the Universal Periodic Review process in 2013 and 2015; the country's next review is scheduled for May 2020.

14. At the regional level, Croatia is State party to the European Convention on Human Rights, the European Social Charter and its Additional Protocol as well as the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. The European Committee for this Convention (CPT) has visited the country in four occasions, the last in 2012, and has issued recommendations regarding the right to health, notably in relation to healthcare in prisons and in psychiatric institutions. The European Court of Human Rights has also dealt with cases regarding, inter alia, inhuman or degrading treatment towards persons with psychosocial disabilities and (in)adequate support to, or deprivation of, legal capacity of persons with intellectual, cognitive or psychosocial disability resulting in human rights violations.⁶

15. Nationally, the right to health has been enshrined in the Constitution (current art. 59) since its promulgation in 1990, together with relevant rights, including informed consent (art. 23), rights to life (art. 21), to suitable life (current art. 63, previously referred to as *decent* life), healthy life (current art 70) and the rights to equality and non-discrimination (art. 1, 3, 14, 15, 17). Pursuant to current Constitutional article 59 “[e]veryone shall be guaranteed the right to health care in conformity with law.”⁷

16. The most important legal acts governing the right to health are the Health Care Act (2008) and the Mandatory Health Insurance Act, MHI (2013).⁸ The first regulates the organization and provision of healthcare, rights and obligations of users, as well as responsibilities of healthcare institutions at different levels; establishing the principles to monitor them. The MHI is explained in the next section.

17. Additional acts regulate specific areas, including the Patients' Rights Protection Act, the Medical Practice Act, the Pharmacy Act, the Nursing Act and the Dental Care Act; the Midwifery Act; the Physical Therapy Activities Act, and the Act on the Health Care Technical Services. The quality of health care services is regulated in the Act on Quality of Health and Social Care and the provision of voluntary health insurance is governed by the Voluntary Health Insurance Act.

18. Croatia's national human rights institution (NHRI) is the Office of the Croatian People's Ombudsman. It was established in 1992 and over the years, was progressively assigned additional responsibilities. At present, it functions as a NHRI, Central Equality Body and National Preventive Mechanism.⁹ In 2008 and 2013, the Ombudsman was accredited “A” status by the then International Coordinating Committee (ICC) Sub-Committee¹⁰ in compliance with the Paris Principles. The Office, governed by the Ombudsman Act of 2012, examines human rights complaints and submits annual reports to the Parliament.

6 European Court of Human Rights 2017, Press Country Profile, Croatia, January 2017, available at www.echr.coe.int/documents/cp_croatia_eng.pdf

7 Constitution of the Republic of Croatia 2010 (consolidated text), Class: 012-02/10-01/01, Zagreb, 6 July 2010, available at www.sabor.hr/fgs.axd?id=17074

8 European Observatory 2014, op. cit. p. 15 and 17-18.

9 Equinet, Office of the Ombudsman Croatia, available at <http://adsdatabase.ohchr.org/IssueLibrary/Office%20of%20the%20Ombudsman%20-%20Croatia.pdf>

10 In 2016, the ICC changed its name into Global Alliance of National Human Rights Institutions (GANHRI). The chart of NHRI status is available at http://www.ohchr.org/Documents/Countries/NHRI/Chart_Status_NIs.pdf

19. Complaints currently dealt with by the Ombudswoman comprise 17 discriminatory grounds as listed in the Anti-discrimination Act (art 1, (1)),¹¹ exempting gender, gender identity and expression and sexual orientation; discrimination against children, and disabilities, as these are dealt with by specialized Ombudspersons for Gender Equality and for Children (both introduced in 2003) and for persons with disabilities (established in 2008), respectively.

20. Since 2011, the Croatian Government is obliged to monitor and report on the fulfilment of recommendations issued by the Ombudsperson.¹²

C. The National Healthcare system¹³

21. With a population of about 4.3 million, life expectancy at birth in Croatia has progressively increased (81 years in 2014); although remains slightly below the EU average (83.6 years).¹⁴ As in many European countries, population in Croatia is ageing and demanding adjustments in the healthcare system. Furthermore, new public health concerns have emerged, including overweight and obesity along with concerning trends of low physical inactivity which rates continue to decrease. More than half men and women are overweight and one fifth of the population is obese.¹⁵

22. While alcohol consumption, smoking and unhealthy diet show some positive trends,¹⁶ official information show that drug dependence has steadily increased,¹⁷ and public mental health continues to be an area requiring attention. In 2015, mental and behavioural conditions were one of the most common reasons for users to seek hospital treatment.¹⁸

The sector in transition

23. Since the process of independence, the healthcare sector has faced financial difficulties which have been tackled since the 1990s with various austerity measures. Between 2008 and 2011, healthcare reforms mainly to seek financial stability were neither properly consulted nor always combined with thorough implementation plans, resulting in partial implementation.¹⁹ Reforms in the next years have focused on achieving cost-effectiveness in the hospital sector.

24. According to the European Commission,²⁰ arrears in the health sector joined by inadequate administrative capacity and strategic planning have hindered the absorption of EU funds. Health-related current arrears are largely linked to the organization and structure

11 Anti-discrimination Act, July 2008, Class: 011-01/08-01/89 Reg. No.: 71-05-03/1-08-2, at http://www.minoritycentre.org/sites/default/files/antidiscrimination_law_croatia.pdf

12 Universal Periodic Review on Human Rights in the Republic of Croatia - NHRI Joint Coalition Report, 2nd cycle, September 2014, at www.ohchr.org/Documents/Issues/OlderPersons/MIPAA/NHRI_Croatia.docx

13 See the European Observatory 2014, op. cit.

14 Eurostat, Life expectancy at birth, 1980–2014 (years) YB16.png, available at: [http://ec.europa.eu/eurostat/statistics-explained/index.php/File:Life_expectancy_at_birth,_1980%E2%80%932014_\(years\)_YB16.png](http://ec.europa.eu/eurostat/statistics-explained/index.php/File:Life_expectancy_at_birth,_1980%E2%80%932014_(years)_YB16.png)

15 European Observatory 2014, op. cit., p. 10

16 Ibid, p. 10-13.

17 Office for Combating Narcotic Drug Abuse, “National Strategy on Combating Drug Abuse in the Republic of Croatia for the period 2012-2017), at: http://www.emcdda.europa.eu/system/files/HR_National%20strategy_en.pdf, p. 7.

18 Croatian National Institute of Public Health (2016), Croatian Health Service Yearbook 2015, at http://www.hzjz.hr/wp-content/uploads/2017/02/Ljetopis_2015_IX.pdf, p. 21

19 European Observatory 2014, op. cit. p. 123-129.

20 European Commission 2017, op. cit. p. 54

of hospitals, which are concentrated in metropolitan areas and mainly managed through a model of funding and reimbursement, on the basis of advance payments. In addition to the needed hospital reform, the European Commission has stressed the need to reduce pharmaceutical expenditure and elaborate concrete plans to address arrears' accumulation.

25. In 2015, public consultations to reform the Health Care and MHI Acts to introduce cost-reduction measures triggered a debate about its impact on the quality of healthcare services which could be diminished, disproportionately affecting people in most vulnerable situations. Additional issues raised include the potential disparities that could result from medical doctors' simultaneous work in the public and private sectors. Due to lack of compliance of the consultations process with the Regulatory Impact Assessment Act and the Act on the Right to Access to Information, the 2015 reform was partly interrupted.²¹

26. The Special Rapporteur recalls that any reform in the healthcare system should include meaningful participation of all major stakeholders in policy decision-making, as well as independent monitoring and review of outcomes based on indicators of the population's health status and the performance of the health system. Implementing the principles of accountability, participation and transparency allow healthcare systems to be self-critical and prevents the ineffective use of resources and corruption within the system.

Universal coverage and affordability

27. The Ministry of Health is the main authority responsible for health policy, planning and evaluation; public health programmes, and the regulation of investments. Healthcare services in Croatia are organized in a network of public health institutes with one national, managed by the Ministry of Health and 21 in each county, managed by counties. The national institute coordinates and supervises country institutions and is responsible to gather, analyse and publish statistics. Counties develop local plans, collect local statistics and participate in the formulation and implementation of local plans.

28. Healthcare institutions (university hospitals, national institutes, specialist clinical hospitals) may only be established by the Ministry of Health. Four University Hospital Centres in Zagreb, Split, Rijeka and Osijek provide training and education for future medical doctors and conduct scientific-research. Other facilities, including general and specialized hospitals; primary health centres; county institutes of emergency medicine and public health; outpatient clinics; spas; facilities providing home and palliative care, and pharmacies, may be established by each county.

29. Long-term healthcare in Croatia mainly involve older persons and persons with intellectual, cognitive or psychosocial disabilities and is mostly organized through the social welfare system and provided in institutional settings. Since 2013, the Social Welfare Act has sought to reverse institutional long-term care for older persons by keeping them at home with their family; promoting their social inclusion and improving their quality of life through non-institutional services and volunteering.

30. Through the Mandatory Health Insurance (MHI) all Croatian citizens and residents have the right to health. The single insurer in this scheme is the Croatian Institute for Health Insurance (CIHI), established in 1993 to provide universal health insurance coverage to the whole population, based on a benefits' package defined under the MHI scheme. Basic healthcare services are provided according to the users' needs.

31. The CIHI has an important role in defining basic health services, performance standards, and prices of services covered within the MHI scheme. It is also responsible for relevant social security allowances and benefits, including sick leave compensation and

21 Annual Report of the Ombudswoman 2016, op. cit., p. 78.

maternity-related benefits, and is the main provider of the supplemental health insurance explained later.

32. In 2013, most of the Government's healthcare budget (91%) was allocated to the CIHI which is also funded by contributions from employees, self-employed and farmers. *Full* contributions are only paid by about a third of the population and certain groups are completely exempted, including under 18-year old, students, the military, war invalids, unemployed persons, persons with disabilities and blood donors when reaching a determined donations' amount. These groups are financed from the payroll of contributing users and from transfers by both the Government's and counties' budgets. Contributions represent 76% of the CIHI total income.

33. Some healthcare services under the MHI are subjected to co-payments and relevant amounts are defined according to the users' ability to pay. In addition, supplemental health insurance is available and purchased individually and on a voluntary basis, from either the CIHI or private insurers and mostly to cover for user charges in the MHI system. Persons with disabilities, human organ and blood donors, students, and low-income persons have the right to free supplemental health insurance in the CIHI.

34. In Croatia, the right to health's affordability has been impacted since 2003 with increases in co-payments in practically all services and the introduction of the rationing of services. However, groups in vulnerable situation have been financially protected through full coverage and free supplemental health insurance. In addition, co-payments, usually paid through the supplemental insurance, cannot exceed a fixed-amount limit.

Access to healthcare services

35. Users' regular first point of contact with the healthcare system is the General Practitioner (GP) at the primary care level. Users may choose their own GP and dentist, as well as gynaecologist and paediatrician, as applicable. All of them perform as GPs in Croatia. There must be at least one primary healthcare centre in each county and three in Zagreb. Users' may also choose their specialist and hospital, a decision that is not restricted to their place of residence.

36. As noted by WHO²² and observed by the Special Rapporteur during the visit, there is a tendency to skip the primary level to search for specialized care, under an overall misconception that primary care may not provide the needed attention and quality of care. The Special Rapporteur stresses that primary healthcare is the cornerstone and the means of sustainability of any healthcare system, which functions more effectively and rationally when the majority of cases (up to 80 per cent) are dealt with at the primary level. This allows for the accumulation of resources to finance expensive treatments of severe and complicated medical cases at the specialized level.

37. Solid primary healthcare services, which are trusted by the people, are crucial in rationalizing the resources allocated to specialized medicine and to costly inpatient healthcare. A number of studies show that health systems can improve equity, efficiency, effectiveness and responsiveness by strengthening primary care while decreasing the unnecessary use of specialists and hospital care.²³

38. Croatia needs to strengthen primary healthcare, both in quantity and quality for the early detection and treatment of mild forms of illnesses, before they reach the level where they need specialized care. An optimal balance between GPs and specialists should be sought by providing outpatient specialist care which backs-up GPs. Specialists should

22 European Observatory 2014, op. cit. p. 97

23 See Public M. Seychell and B. Hackbart "The EU Health Strategy – Investing in Health" in Health Reviews, Vol. 35, No 1, p. 7.

receive patients from the GPs and consult them on the cases, notably regarding treatment for non-complicated cases. Otherwise, specialized care risk saturation. In terms of physical health, the largest part of health conditions is mild cases that should be managed by GPs.

39. To achieve balance between GPs and specialists, the capacities and competencies of GPs and their teams (nurses, social workers, and assistants) should be improved, through continuous learning programmes and incentives to consolidate their position as “gatekeepers” of the system.

40. As noted by the European Commission, strengthening the Croatian primary healthcare would bring along reductions, not only in the number of referrals to specialists, but in the cost of specialist and hospital treatments. The Commission has stressed the over-reliance on hospital services, due to the partial development of primary care in Croatia, recommending a reorganization of the current unequal distribution of hospitals to promote fiscally responsible hospital management and gain sustainability.²⁴ WHO has further noted the lack of care pathways for users which would help to change the practice of skipping the primary level to look for specialists.²⁵

Challenges around access to healthcare and informed consent

41. While unmet needs for medical examination in Croatia are below the EU average, inequalities in accessing healthcare have increased since 2012, notably due to distance-related challenges linked to Croatia’s geography and high number of islands (over a thousand). During his visit, the Special Rapporteur was briefed about the unequal access to healthcare particularly faced by older persons, children and pregnant women in rural areas, smaller towns and islands with poor traffic connections with large cities. The Special Rapporteur was also briefed about promising initiatives to address these challenges with a strategic framework for islands that improve connections through speedy boats, in addition to helicopters, for medical doctors in large cities to increase the frequency of consultations in remote locations. He trusts these initiatives will be implemented.

42. Regarding healthcare complaints dealt with by the Ombudsperson, these have increased from 64 in 2012 to 178 in 2015.²⁶ Complaints in 2015 include issues linked to accessing certain healthcare services such as therapies for rare diseases, problems in making doctor’s or treatment’s appointments, long waiting lists, and the overall quality of healthcare services, treatments and facilities.²⁷

43. During the visit, the Special Rapporteur was consistently informed that one of the most pressing challenges to access the right to health in Croatia is the long waiting lists for medical procedures and the limited access to good quality medical treatments. Both issues seem to ultimately compel users who can afford it to turn to private providers albeit, usually, the same doctors simultaneously work in the public and private sectors. Private services seem to also dedicate more time for users and to provide more information on treatments, their effects and options. All these elements, lead to discrimination towards users who cannot afford private services and/or are less educated and do not get adequate information on their health and treatments due to the lack of time allocated in public services to inform about them.

24 European Commission 2017, op. cit. p. 54

25 European Observatory 2014, op. cit. p. 97.

26 Annual Report of the Ombudswoman of the Republic of Croatia, March 31st 2016, at <http://ombudsman.hr/attachments/article/1016/Annual%20Report%20of%20the%20Ombudswoman%20of%20Croatia%20for%202015.pdf>, p. 8.

27 Ibid p. 126

44. The issue of long waiting lists was partially dealt with in 2015 through some programmes for specific medical procedures, which were successful in certain cases.²⁸ However, the overall issue of long waiting lists seems to be far from being sufficiently addressed as illustrated by cases of rehabilitation treatments linked to surgeries which can take several years to be approved and actually provided.

45. Finally, while the rights to be informed on alternative treatments and to consent to or refuse treatment are protected by the national framework,²⁹ the Special Rapporteur ascertained that informed consent seems to be not-well understood by healthcare personnel. In practice, informed consent has become a simple formality, whereby users are often requested to sign the relevant consent form in the waiting room before meeting the doctor. In addition, it was reported that 3 out of 5 women in Croatia do not participate meaningfully in decisions concerning labour and birth.

46. To appropriately address these issues, official statistics on waiting lists and proper assurances of users' consent should be produced, together with result-assessments of 2015 programmes. All measures aimed at addressing these issues should not only consider the elements of accessibility and availability, but also the good quality of services.

III. Healthcare in institutions and the way forward

A. Mental health framework

47. At the international level, mental health is increasingly taken priority as reflected by recent discussions at the Human Rights Council³⁰ and at WHO where the issue has recently been addressed as a priority. The Convention of the Rights of Persons with Disabilities (CRPD) has brought forward the need to thoroughly apply all human rights, including the right to health, to persons with disabilities and especially those with intellectual, cognitive and psychosocial disabilities.

48. Croatia was among the first countries to ratify the CRPD in August 2007 and during the visit, the Special Rapporteur was encouraged about the new legal framework and measures aimed at addressing many of the CRPD recommendations. Already in 2012, amendments to the electoral law granted the right to vote to 18,000 people with intellectual, cognitive or psychosocial disabilities who had been deprived of their legal capacity for decades. Further steps include reforms to the Social Welfare Act in terms of de-institutionalization as explained in the next section and the new Family Act which, inter alia, abolishes full guardianship and establishes a five-year deadline for reviews of all court decisions on deprivation of legal capacity, combining the concepts of mental and legal capacity, and introducing the concept of supported decision making.

49. The Law on the Protection of Persons with Mental Disorders of 2015, which replaces an earlier law on mental health, now provides stronger mechanisms and guarantees to progressively reduce involuntary institutionalization, including the requirement to return under judicial control, non-consensual hospitalization (of persons with intellectual, cognitive and psychosocial disabilities "unable" to give consent) for the written consent of their legal guardian or trusted person. The law also introduces the possibility of independent supervision over the decisions of the legal guardian.

28 Ibid p. 125

29 European Observatory 2014, op. cit. p. 45.

30 HRC Resolution A/HRC/32/L.26, June 2016 requested the UN High Commissioner for Human Rights to prepare a report on human rights and mental health (A/HRC/34/32), which was presented at its 34th session.

50. The Ministry of Health is the main responsible for mental healthcare services, through national strategies. The Strategic Plan for the Development of Public Health includes goals of mental health promotion, prevention, social inclusion and rights' protection. Other policies with elements of mental health include Deinstitutionalization Plans in the social welfare system and the provisions to include mental health themes at preschool, primary, and secondary school levels.

51. While mental healthcare is provided in Croatia at primary level (GPs, school medical specialists, psychiatrists and professionals in mental health centres and public health institutes), secondary level (mental health professionals, mainly psychiatrists) and tertiary care level, the mental health system is still too much focused on psychiatric hospitals. Since 1991, there has been inadequate attention to the development of outpatient mental health services at the community level, which has led to an overreliance of the system on inpatient services, mainly provided in psychiatric hospitals. To illustrate: mental health conditions are one of the most common reasons for hospital treatment and nearly every fourth day of hospital treatment is used to treat a mental condition.³¹

B. Deinstitutionalization

52. Deinstitutionalization has been a key policy priority for the Croatian Government for years, but within the social welfare sector mainly, with scarce actual participation of the health sector. In 2011, the Ministry of Social Policy formulated the National Plan for Deinstitutionalization and Transformation of Social Welfare Homes 2011-2018. Two years later, several institutions began the process of finding homes for persons previously institutionalized. In 2014, the Plan was revisited to, inter alia, integrate and operationalize funds from the EU. The plan seeks to, inter alia, transform previous homes into community services, develop community support and include users in the community.

53. With de-institutionalization efforts, the Special Rapporteur learnt that by 2016, around 600 persons had been moved out of institutions to community-based services. However, he also learnt that the same amount of people have since been institutionalized in hospitals through the healthcare system. While good efforts by the social welfare system are directed at reducing reliance on institutional care, stigma and discrimination to ultimately reduce the number of people living in institutions; the healthcare system, largely based on treatment in psychiatric hospitals with mainly biomedical interventions, continues to "feed" the institutional care system. This shows the lack of an effective "gatekeeping" policy in the healthcare sector and above all, the urgent need for coordination between the social welfare and health sectors.

54. The capacity in Croatian psychiatric institutions continues to escalate, as shown by the increasing number of psychiatric beds³² and of financial resources directed at enhancing hospital infrastructure, a situation that could be observed by the Special Rapporteur's visit to a psychiatric hospital in Zagreb which was in the process of expanding with the construction of a new building for forensic patients.

55. On the other hand, Croatia is one of the first countries to have invested in community-based pilot projects to end institutionalization. A good practice is the experience developed at the Centre "I am just like you" in Osijek. The Special Rapporteur visited the Centre and assessed the full inclusion of people with psychosocial disabilities in society, living in regular apartments, in small groups, and minimal regular support from Centre's staff. The Special Rapporteur strongly recommends this good-practice to be replicated in Croatia and in other countries. The experience shows that transforming

31 Croatian National Institute of Public Health (2016), op.cit. p. 22
32 European Observatory 2014, op. cit. p. 83-84

services from institutions to community-based is beneficial for persons with psychosocial disabilities and for the society at large. It also illustrates that it is possible to end the sad legacy of institutional care if there is will.

56. Successful pilot projects to integrate persons with psychosocial disabilities into community, such as the one in Osijek, have not been taken seriously to make a real difference in the Croatian mental health system, its funding or decision-making, which remain focused on large inpatient and residential psychiatric institutions. The Croatian Ombudswoman for persons with disabilities has consistently stressed the need to reorganize mental health services and to move away from the model of recurrent hospitalisation towards more outpatient support and treatment as well as community-based services.

57. Persons with psychosocial disabilities are the largest group of persons with disabilities who are institutionalised in Croatia. Overall, the Special Rapporteur was informed that around 4,200 people with intellectual, cognitive and psychosocial disabilities still live in institutional care, deprived of their liberty and not able to fully enjoy their rights in an equal manner with other members of the society.

58. Croatia should develop policies strongly oriented to address the needs and rights of the users of services at large, as opposed to the needs of the existing infrastructure of services. In this respect, Croatia could use the unique opportunity to continue transforming the mental healthcare system in an improved manner, now that EU structural support funds are available. Any healthcare reform demands additional resources due to the time needed for the new system to be operational. There is a period when the old ineffective system and the rights-compliant reformed system should be running simultaneously, as it is not possible to radically close residential institutions and psychiatric hospitals before alternative services are well developed and integrated into primary care, community care and general hospitals.

59. EU structural funds need to focalize in building-up a modern rights-compliant system throughout Croatia, with services that stop referrals to both psychiatric hospitals and large residential institutions. Rights-compliant and cost-effective mental healthcare systems require the relevant services to be integrated in community-based health and social services.³³ Segregated institutions and large psychiatric hospitals aimed at long-term healthcare should no longer be supported nor expanded in Croatia. Instead, rights-compliant services should be developed at the community level based on a combination of necessary psychotropic medications, psychosocial rehabilitation, psychotherapy, professional and vocational rehabilitation as well as supported housing.

60. While this shift in policy and practice is yet to thoroughly happen, the country has invested good efforts on this. Croatia has an incredible opportunity to replicate throughout the country the laudable experiences that have already proven be rights-compliant and effective. Each county in Croatia should develop a health and social care plan to implement the transformation towards outpatient mental health primary care and community-based services, so that there is no longer a need to rely on large psychiatric institutions.

61. Croatia's ambitious plan to become an inclusive society, as was informed to the Special Rapporteur during his visit, should fully consider a mental health reform that fully integrate people with intellectual, cognitive and psychosocial disabilities, as well as older persons, into the society.

IV. Sexual and Reproductive Health Rights

62. Progress on the right to health of women in Croatia includes advances in certain health indicators such as maternal mortality. A welcomed development before the Special

33 WHO, The World health report: 2001 : Mental health : new understanding, new hope.

Rapporteur's visit was the announcement of Croatia's intention to ratify the Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention), which Croatia had signed in January 2013. He trusts that this ratification will become a reality soon.

63. Various challenges of women's realisation of their right to health remain insufficiently addressed. The Special Rapporteur could observe that CEDAW's concerns (CEDAW/C/HRV/CO/4-5) remain valid to date and have, furthermore, been exacerbated by attempts to implement retrogressive measures, including the redefinition of "marriage" in the Constitution, which may limit women's right to access healthcare based on their marital status, and a pending revision of the 1978 Act on Abortion.

A. Maternal healthcare and women's rights during childbirth

64. Since 2010, Croatia has centralized birth and postpartum care in 31 maternity hospitals, closing down small maternity units which were reportedly working well. As a result, the distance between place of residency and maternity hospitals has increased, disproportionately affecting women in islands and remote locations. Reports indicate that 52% of fertile-age women live outside cities with maternity hospitals and, in 2014, 2% of births took place with emergency teams' assistance on the way to the hospitals. However, there is a lack of more detailed official statistics on women living more than 30km or 50 km from a maternity hospital and their access to healthcare services.

65. Considering that home birth is not regulated in Croatia,³⁴ the great majority of births take place in hospitals, attended by doctors with midwives' assistance. Neither doctors nor midwives may attend home births, except for accidental or emergency cases. This hinders women's choice on where to give birth. Consideration should be given to planned out-of-hospital births as an affordable and accessible option available to women so that they can make informed choices on their delivery preferences. Women should not be deprived from medical assistance should they choose to give birth at home and healthcare personnel should be allowed to provide such assistance.

66. The Special Rapporteur was briefed about certain practices during labour and birth, very often applied without women's consent, sometimes even against their wishes and in most cases remained underreported. This include mandatorily laying down during the entire duration of labour and birth; labours augmented with artificial oxytocin; routine enemas before birth; extensive use of episiotomy; and the Kristeller Maneuver: full-body pressure on abdomen to attempt to speed up the delivery and at times associated with broken ribs amongst other undesirable side-effects. Women's privacy is not fully guaranteed, as hospitals' birthing rooms rarely have doors and when they have, doors tend to remain opened.

67. Regarding Medically Assisted Reproduction, while the new Act of 2012 brought along improvements in the area, the procedure is only available to heterosexual women and couples, while same-sex couples are explicitly excluded in the Law; single women may only access with proof of infertility, which is difficult to obtain in practice; and women 42-year-old and above can only access private procedures. Women who cannot afford related costs are also left behind as only certain treatments are reimbursed within the CIHI and additional payments are required for the public notary who must certify the relevant

34 European Parliament 2016, "Petition No 1400/2014 by D. D. (Croatian) on an alleged breach of provisions on professional qualifications of midwives of Directive 2005/36/EC in Croatia", 29.06.2016, at <http://www.europarl.europa.eu/sides/getDoc.do?type=COMPARL&reference=PE-567.561&format=PDF&language=EN&secondRef=03>.

informed consent form. Medically-assisted reproduction is reportedly the single healthcare treatment in Croatia where the consent form is not signed in a healthcare facility.

68. The lack of official data regarding the issues before mentioned hampers their adequate assessment and identification of appropriate measures.

B. Access to modern and emergency contraception

69. The use, availability and accessibility of modern contraception and reproductive services continue to be low in Croatia and excluded from the CIHI coverage. In addition, as mentioned previously, available updated data on this area is insufficient. This hinders access and fosters misperceptions and lack of knowledge about these methods. Additional barriers refer to the relatively high price and inadequate availability of different types of contraceptives in the country.

70. Regarding emergency contraception, the Ombudswoman for Gender Equality has noted³⁵ that women who wish to purchase the brand authorized by the European Commission for sale without prescription, are requested to answer a questionnaire, disclosing private information about their sexual behaviour and reproductive health which should be protected according to their right to privacy (CCPR/C/21/Rev.1/Add.10, para 20). In Croatia, pharmacists can refuse to sell the pill if they consider answers are unsatisfactory and must report the transaction to the woman's gynaecologist. Under-18-year old girls are not allowed to buy the pill without third party authorization in the way of the required presence of the parent or legal guardian.

C. The right to safe abortion

71. The 1978 Act on Health Care Measures for Exercising the Right to a Free Decision on Giving Birth establishes Croatian women's legal access to abortion up to the 10th week of pregnancy and with the approval of a commission for more advanced pregnancies in three cases of i) pregnancy resulting from a crime, ii) prevent damage to the woman's health or save her life, and iii) the foetus' serious congenital impairments.³⁶ The Act also establishes that under 16-year-old girls require their parent's or legal guardian's consent, although, in practice, parental consent is reportedly requested also for under 18-year-old girls.

72. In addition to the issue of third party authorization, for years the implementation of the Act has faced various challenges, including its increasing cost which is included into the CIHI only in cases where abortion is necessary for medical reasons.³⁷ The Special Rapporteur was informed that the cost of abortion in five hospitals is above the country's net minimum salary per month.

73. In practice, access to safe abortion has been obstructed by the overuse of the legal provisions to deny it on the grounds of conscientious objection. Individual doctors' are legally allowed to refuse diagnosis, treatment and rehabilitation based on personal ethical, religious or moral beliefs and are required to promptly inform the user and make a referral

35 Referred to in the European network of legal experts in gender quality and non-discrimination, 2016. "Country report on Gender Equality. Croatia 2016", p. 42, at: <http://www.equalitylaw.eu/downloads/3767-2016-hr-country-report-gender>

36 Act on Health Care Measures for Exercising the Right to a Free Decision on Giving Birth, Act No. 1252-1978 of 21 April 1978, art. 22

37 European network of legal experts in gender quality and non-discrimination, 2016, op.cit, p. 42

to another appropriate medical professional.³⁸ The Special Rapporteur was further informed that while half of gynaecologists refuse in their public practice to provide legal abortion on conscientious-grounds, many of them offer the same service in their private practice in exchange of a fee. This questions the real grounds for the denial in their public practice. Moreover, while legally only individual refusals are allowed, in practice refusals are exercised at the institutional level and, in some cases, as a part of hospitals' policy.

74. Barriers to access public safe legal abortion services lead women to look for clandestine options, which put their integrity and health at risk and disproportionately affect women in situations of social exclusion and in remote areas who cannot afford other services or even access them. Failure to implement the law should be combined with appropriate sanctions and mechanisms to monitor its implementation. At present, there is no official data about the prevalence of conscience-based refusals which prevents the development of effective measures to address these challenges.

75. The Special Rapporteur is concerned about announcements in October 2016 on the assessment and possible reversion of the Act on abortion of 1978. Any legal measures that restrict existing core provisions in the protection of human rights constitute retrogressive measures in contravention with relevant international framework.

D. Sexuality education

76. While sexuality education was introduced as part of the curriculum for Health Education in elementary and secondary schools, only two hours per year were allocated to it. Moreover, the delivery of the relevant module actually depends on each teacher, as ascertained by the Special Rapporteur during his visit to a secondary school. Teachers often refuse to deliver sexuality education on the basis on misleading arguments that prevent children and adolescents from learning about gender equality and from making informed decisions about their bodies and sexuality, including about healthy sexual behaviours and the use of contraceptives. Adolescent students who met with the Special Rapporteur expressed their need for more and better age-sensitive comprehensive sexuality education.

77. The Ombudswomen for children has further noted the overall absence of systematic health education, such as education on sexually transmitted diseases, including HIV-AIDS, which should be provided through an increased number of lessons delivered by competent experts. Overall, teachers should be trained on health and sexuality education so as to deliver quality information to students and based on good quality teaching materials.

E. Other challenges

78. Remaining challenges in Croatia regarding women's right to health include issues at work, assistance to victims of domestic violence and the current socio-political environment vis-a-vis women's rights.

79. While Croatia's Labour Act prohibits employers to ask questions about women's pregnancy plans and to deny, terminate or reassign employment due to pregnancy, available data indicate that many have been asked about their plans to have children at job interviews; overlooked for promotions as a result of being mothers; have not had their contracts extended due to pregnancy or other parental obligations or have been discriminated at some point in their career or job search due to their parental obligations.

38 Conscientious objections may be applied by doctors as long as the doctor's refusal does not conflict with the medical profession's rules and it does not cause permanent damage to the users' health or life, Medical Practice Act, art 20.

80. Additionally, maternity benefits are subject to employment status, putting women on part-time contracts at a disadvantage. After sick leave linked to pregnancy, maternity leave or parental leave, women on part-time contracts are considered unemployed and receive lower maternity or parental benefits, despite having worked before her maternity leave.

81. The Ombudswoman for Gender Equality has warned that women's participation in the workplace is undermined by the lack of adequate day-care for preschool and school aged children. Costs, which vary considerably by region and parents' income, are another significant barrier.

82. In despite of remaining challenges, the Special Rapporteur was also appraised that Croatia provides one of the most generous sick leave and maternity compensation packages by international standards which, according to some could make the system subject to abuse.³⁹ All these elements support the need for monitoring mechanisms that oversee the correct application of work compensation packages with special attention to the implementation of legal provisions that protect women at work.

83. A different set of barriers regarding women's right to health refer to shelters and counselling centres for victims of domestic violence which lack consistent and adequate funding. Legal reforms are necessary to effectively protect women from domestic violence, and to address remaining gaps in the implementation of the hate crime provisions of the Criminal Code, involving violence against LGBT people. The Special Rapporteur was informed about alleged violent and abusive acts by law enforcement officials, including insults, physical aggression, violations to victims' rights, rejection of complaints on insufficient grounds and courts' negative decisions.

84. During his visit, the Special Rapporteur could observe in practice what CEDAW's has consistently cautioned about, regarding church-related organizations which appear to adversely influence policies concerning women's rights and thereby impeding the full implementation of human rights international treaties. Sexual and reproductive health services that are most needed by women, in particular young women, include access to safe, reliable and good quality contraception, comprehensive maternal health services, safe abortion and treatment for complications from unsafe abortion, and prevention and treatment of sexually transmitted infections and HIV/AIDS (see E/CN.9/2014/4, paras. 68-77). Poverty, low education, insufficient access to health services, gender discrimination and lack of empowerment are barriers for women to make the best informed choices about their sexual and reproductive health and the health of their children resulting in poorer health outcomes and higher risks (A/HRC/27/31, para. 74).

85. Sexual and reproductive health rights are human rights. Retrogressive measures preventing access to safe abortion and contraceptives, and hindering access to age-appropriate comprehensive sexuality education, may amount to human rights violations (E/C.12/2000/4, para.48, E/C.12/GC/22 para 38). Sexual and reproductive health rights also indicate that primacy should be given to women's and children's rights and not to the family unit. In this respect, the Special Rapporteur is concerned about the Constitutional Court's potential redefinition of marriage as the union between a man and a woman, provided this could hinder proper access to sexual and reproductive health rights on the basis of marital status.

86. The Special Rapporteur further noted a strong opposition among policy makers and within the society at large towards well-established standards, instruments and mechanisms for the promotion and protection of women's sexual and reproductive health rights. He urges all stakeholders to support policies, based on universal human rights principles, including sexual and reproductive health, and to reject "conspiracy" theories which promote patriarchal gender stereotypes and undermine the role of women and girls in

39 European Observatory 2014, op. cit. p. 52

society. These theories are detrimental to the enjoyment of all rights, including the right to health, in particular of women and children. Croatian authorities must ensure full adherence to universal and regional human rights principles and standards which, if applied in a consistent manner, constitute the basis for the realisation of the right to health and other rights.

V. Right to health of key population groups

A. Children

87. While there have been advances in some health indicators, notably child mortality, Croatia still faces challenges regarding children's health, including easy access to alcohol and tobacco, linked to a lack of compliance with relevant law⁴⁰.

88. Additional well-documented challenges include the lack, of and non-accessibility to, certain healthcare experts, including paediatricians, school and university medicine specialists, speech therapists, psychologists, occupational therapists, nurses and social workers. For example, many paediatricians are in an age close to retirement but enrolment into paediatric training programs is decreasing. This is leading to an increased number of infant users per primary care team, leaving insufficient quality time for preventive care, including for the screening and identification of children with developmental difficulties, which appears to be increasing.

89. A common concern for the Ombudspersons for children and persons with disabilities refers to children's mental health and particularly children with autism. The Croatian system seems to lack adequate capacity with insufficient healthcare personnel and facilities. A large number of children with mild to moderate autism are not identified until they reach school age, showing the need for a coordinated and systemic network of early childhood interventions in, or close to, the area where they live.

90. While an important step was taken by including early childhood interventions as a service defined in the Social Welfare Act in 2011, the State has yet to create the conditions for the implementation of such provision. According to official data, in 2013 there were 4,800 children who required these services, but only 641 had access (13%). Early childhood interventions are provided through few facilities located in or around the capital and at a high cost for the average parents. Only one institution in Croatia specializes in early childhood interventions, which is furthermore understaffed and the therapy often discontinued after the age of 3.

91. A more systemic approach that integrates health, education and social services, is needed for the early screening and detection of developmental challenges in young children at the primary health care level. This requires introducing appropriate, standardized, scientifically reliable and valid instruments and a family-centred approach to monitor child development with the family as an active partner. Primary healthcare workers should have access to professional educational development and protocols and guidelines should be developed for the cross-sectoral collaboration of health, education and social services in the assessment, diagnostic and early intervention services of children with developmental challenges and risks.

92. In terms of breastfeeding, relevant advances include the adoption of the National Program for Protecting and Supporting Breastfeeding in May 2015 and "Baby-Friendly" designation to all 31 maternity hospitals. However, while the rate of early initiation of

40 Croatian Ombudsperson for Children 2014, Report on her Work, March 2015, at file:///D:/downloads/Summary_Report2014.pdf, p. 17.

breastfeeding is high (80%), its duration has not significantly increased, in part due to the lack of awareness of the benefits of exclusive breastfeeding and lack of adequate support services to women.

93. The Special Rapporteur gathered information about the strong support by most paediatricians in Croatia towards introducing solids to babies as early as 17 weeks. He also learned about the counterproductive influence of companies that commercialise breast milk substitutes. The latter is evident in their regular sponsorship of paediatric and nurses conferences, which is not perceived as a conflict of interest in the country.

94. Breastfeeding is a human right that should be protected and promoted. Women should be supported in their choice and ability to breastfeed their infants optimally, with adequate information and services and without being condemned or judged if they do not want or cannot. However, breast milk marketing negatively affects women's choices and can impede both babies and mothers from enjoying the many health benefits of breastfeeding. Croatia should fully align with the International Code of Marketing of Breastmilk Substitutes, including the sanctioning of Code violators and subsequent relevant World Health Assembly resolutions.

95. Additional challenges in the same area include the monitoring of breastfeeding practices, which is currently insufficient and not uniform throughout the country as well as feeding of children whose mothers are HIV positive, which guidelines are yet to be developed, and infant feeding in emergency situations which still lacks policy measures to protect breastfeeding.

B. People on the move

96. Croatia is still perceived as a transit country with some 70% of asylum-seekers absconding from the country to continue their onward movement. Between September 2015 and March 2016, a total of 658,068 refugees and migrants transited Croatia during the refugee emergency response. Subsequent to the closure of the "Western-Balkans" route in March 2016, the number of asylum-seekers raised in Croatia, including individuals transferred to Croatia under the Dublin Regulation. By the end of September 2016, the Government recorded 1,584 asylum-seekers, which compared to the annual statistics of 2015 (211) indicates a considerable increase. Reception capacity in Croatia is of 700 persons with Centres in Porin, Zagreb and Kutina about 80km from Zagreb.

97. Croatia is a signatory to the main international and regional instruments protecting the rights of Refugees and Stateless Persons. Notably, the Croatian International and Temporary Protection Act adopted in July 2015 harmonize national asylum legislation with the EU Acquis Communautaire regulating protection of third country nationals.

98. Asylum-seekers in Croatia are entitled to healthcare through the Acts on MHI and Health Care for Foreigners. However, with the last amendments to the Law on Asylum, healthcare in Croatia was restricted to emergency care and most necessary treatment of illnesses and serious mental conditions, restricting effective access to healthcare. This has particularly affected children and pregnant women who are both asylum-seekers and migrants. An additional barrier is language, as free interpreting services are not provided by the Government and most of the asylum-seekers are not able to pay for such assistance.

99. As ascertained by the Special Rapporteur, many children arriving in Croatia have not been vaccinated against preventable diseases. In this connection, urgent efforts are needed to vaccinate all children without relevant health records that arrive or are born in Croatia and to provide all pregnant women with regular medical care, irrespective of her

nationality or legal status. Likewise, medical check-ups upon arrival should be immediately reinstated.

100. The Special rapporteur observed that, since September 2016, the provision of services improved in the Reception Centre of Porin through the regular attendance of a GP and support of the non-governmental organization Médecins du Monde (MdM). However, he also noted the need for national authorities to promptly undertake the work carried out by MdM to ensure continuity, ownership and compliance with Croatia's international obligations. Similarly, the regular presence of a GP in Kutina should be ensured, as by the time of the visit this was still lacking.

101. The Special Rapporteur was informed about the outstanding work done by humanitarian organizations vis-à-vis the refugee emergency response. These organizations should have access to all migrants in need irrespective of their legal status. Migrants should always be treated in a way that respects their dignity and upholds their fundamental rights. Notwithstanding the valuable work humanitarian organizations, the State remains the main duty-bearer responsible to ensure the protection and full realisation of the rights of people on the move.

C. Roma

102. Croatia has invested relevant efforts to improve the inclusion of Roma, including the National Roma Inclusion Strategy 2013-2020 and its related Action Plans. A significant element is the introduction of "health mediators", recruited from Roma communities to provide direct support in accessing healthcare services. The Special Rapporteur noted the Government's awareness about the continuous challenging situation faced by Roma in Croatia, who remain the most marginalized minority, and the will to address challenges.

103. Ongoing and upcoming measures specifically targeting the Roma population are welcomed, but there is a need to further strengthen the existing framework.

104. Available data indicate that one-fifth of Roma children in Croatia may not have access to health care and that infant mortality rates of Roma children are significantly above the national average, in particularly mortality associated with sudden infant death syndrome and respiratory diseases.

105. Roma women face various constraints to access healthcare, as a result of multiple discrimination and social exclusion based on ethnicity affiliation, gender and social status. Available data indicate that 21% of Roma women never had any health insurance, with the exception of pregnant women who access public support for expectant mothers.

106. Main barriers for Roma to access healthcare related to challenges in obtaining identity documents. By 2016, about 2,800 Roma were still without permanent or temporary residence⁴¹ and at risk of statelessness. While Roma in Croatia are insured, a serious gap refers to the fact that they pay for their own insurance.

107. In his visit to a Roma settlement, the Special Rapporteur noted that environmental conditions may be a threat to their health and worsened by climate and other factors, including the insufficient collection of waste by the relevant authorities. He also observed that their diet is nutritionally deficient and is particularly affecting children with direct impact on school drop-out rates. Deficient diets also largely contribute to worsening chronic diseases in adulthood.

41 UNHCR data quoted in Amnesty International Report on Croatia 2016-2017, available at: <https://www.amnesty.org/en/countries/europe-and-central-asia/croatia/report-croatia/>

E. People who use drugs

108. In 2015, healthcare facilities treated 7,533 persons for psychoactive substance dependence and nearly every tenth person was under 20. Most of the treated patients were from the 30-39 group age and opiate dependence was the predominant type.⁴²

109. While the Ministry of Health is the main responsible for drug-related treatment, certain treatments, including programmes for young drug users, rehabilitation and re-socialisation of drug dependence are under the responsibility of the Ministry of Social Policy. The Ministry of Justice is responsible for drug treatment in prisons and during probation period and the Office for Combating Drug Abuse, counties and other donors also participate in therapeutic communities.

110. The National Strategy on Combating Drug Abuse (2012–2017) include a public health approach with the purpose of reducing both the demand for, and the supply of, drugs in society, protecting the health of individuals, families and communities. County Committees for Combating Drug Abuse composed with experts and members of local administrations were established in 2014 and 2015 to coordinate the implementation of this strategy at the local level.

111. Accordingly, while some hospital-based inpatient treatment and therapeutic communities remain, drug treatment in Croatia is centred on the provision of outpatient care, through county services for mental health promotion and dependence prevention. Services include individual and group psychotherapy, prescription and continuation of Opioid Substitution Therapy (OST) and other pharmacological treatments, and testing and counselling on a wide-range of issues, with a prevalence of medication-based treatments and harm reduction programmes, including different substitution therapies and syringe programmes.

112. In his visit to the Split Counselling Centre for the Prevention and Treatment of Addiction, the Special Rapporteur welcomed the interdisciplinary approach applied in the prevention and treatment of drug dependence and associated mental health conditions, with services provided on voluntary basis. This approach paves the way for the positive outcome of therapeutic interventions.

113. In addition to these centres, outpatient drug treatment is provided by some associations, GPs, and some outpatient units in general hospitals, with psychosocial treatment for enhancing interpersonal relationships and user's life situation that complement OST and other treatments. Guidelines for the psychosocial treatment of drug users in the healthcare, social and prison system were adopted in 2014 to standardise the delivery of psychosocial treatment in this area.

V. Conclusions and recommendations

114. **Croatia has made good progress towards the progressive realization of the right to health. Despite different challenges, the State has strived to make the healthcare system sustainable and accessible.**

115. **Measures have been taken to develop and strengthen primary and specialized healthcare, investing innovative efforts in mental health reforms and interdisciplinary approaches to address drug use and dependence.**

116. **The right to health should be promoted and protected not only through access to health services, supplies and facilities, which should be available, affordable,**

42 Croatian National Institute of Public Health (2016), op.cit. p. 23

appropriate and of good quality. The right to health is also realized through the enjoyment of the underlying and social determinants of health, and it requires the design and implementation of cross-sectoral policies and programmes that focus not only on life-saving interventions but also on broader socioeconomic, cultural and environmental factors.

117. Health policies and programmes in Croatia should be guided by a human rights-based approach with strong emphasis on the principles of equality and non-discrimination, transparency, participation, and accountability. Right to health-related issues are inter-sectorial and should be addressed with horizontal approaches that promote the effective use of primary care and incorporate the concerted efforts of all stakeholders.

The Special Rapporteur recommends that the State:

118. Further advance the right to health with rights-based policies, in line with the Agenda 2030, avoiding any retrogressive measures and paying particular attention to groups in most vulnerable situations, including women, children, people on the move, minorities, persons with intellectual, cognitive and psychosocial disabilities, and older persons.

119. Continue to promote and strengthening primary healthcare looking for an optimal balance between General Practitioners (GPs) and Specialists, while providing outpatient specialist care, ensuring coordination between specialists and GPs, and improving the capacities and competencies of GPs and their teams.

120. Strengthen primary level capacity for early intervention services for children with a family-centred and interdisciplinary approach and clear guidelines for cross-sectoral collaboration of the health, education and social services sectors.

121. Fully align to the International Code of Marketing of Breastmilk Substitutes by further developing mechanisms to monitor breastfeeding practices and produce guidelines and protocols for children whose mothers are HIV positive and for infant feeding in emergency situations.

122. Produce official reliable statistics on remaining challenges for the health system, including long waiting lists; access to maternity hospitals, information on medically-assisted reproduction; contraceptive prevalence; unmet needs for family planning, and prevalence of conscience-based refusals to abortion in order to assist in the development of concrete measures to address these issues.

123. Give priority to women's and children's rights in the area of sexual and reproductive health rights, with appropriate access to safe, reliable and good quality contraception, comprehensive maternal health services, safe abortion and treatment for complications from unsafe abortion.

124. Develop comprehensive sexuality education in schools, build capacities of teachers in this area, and monitor performance of programmes.

125. Ensure that informed consent is respected by allocating adequate time to inform users about treatments, their effects and options, on the basis of services that are sensitive to all rights of all users and through improved training of medical doctors and other healthcare personnel in human rights and medical ethics.

126. Invest resources, including EU structural funds, based on a modern rights-compliant mental healthcare system throughout the country, with the aim of strengthening community-based outpatient services that can stop excessive referrals to long-term care institutions.

127. Stop directing funds/investments, either national or international, at reinforcing the inefficient system of segregated large psychiatric hospitals and residential institutions, and redirect them to the development of community-based services which focus on the needs and rights of the users and not on needs of existing infrastructure of services.

128. Replicate throughout the country the good practices of de-institutionalization with local plans at each county and the meaningful participation of relevant stakeholders.

129. Immediately reinstate mandatory initial medical check-ups upon arrival for people on the move, and build capacity to assume responsibility for the services provided by NGOs in Reception Centres, in close collaboration with the latter.

130. Urgently develop measures to vaccinate all children without relevant health records that arrive or are born in Croatia and provide all pregnant women with regular medical care, irrespective of her nationality or legal status.

131. In the context of the refugee emergency response, ensure access by humanitarian organizations to all migrants in need irrespective of their legal status.

132. Expand healthcare insurance and services for Roma with outreach programs for Roma children and mothers.

133. The Special Rapporteur recommends all stakeholders in Croatia to support policies based on universal human rights principles, including sexual and reproductive health rights and to reject patriarchal approaches and gender stereotypes detrimental to the enjoyment of all human rights, in particular the right to health of women and children.
