

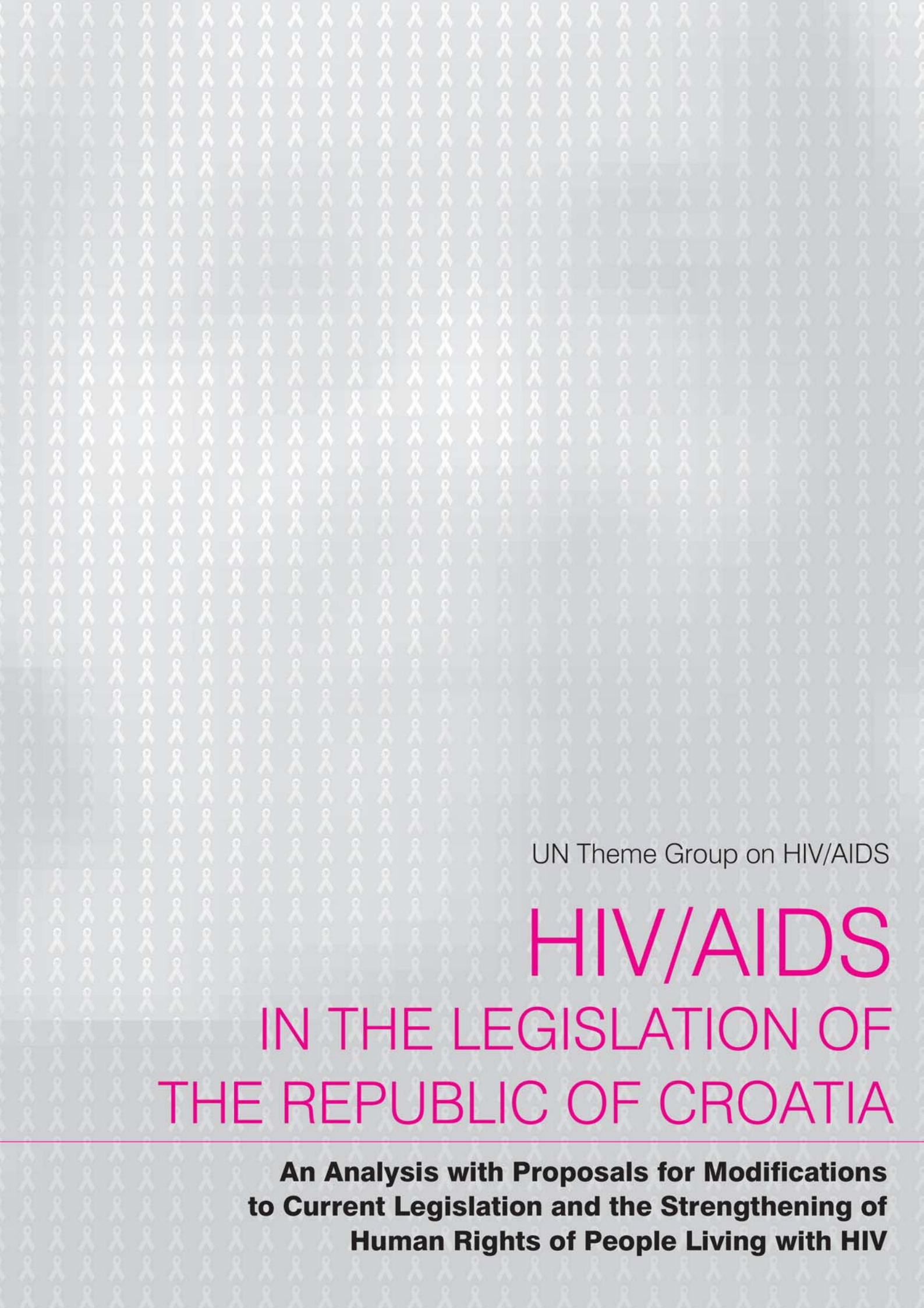


UN Theme Group on HIV/AIDS

# HIV/AIDS IN THE LEGISLATION OF THE REPUBLIC OF CROATIA

**An Analysis with Proposals for Modifications  
to Current Legislation and the Strengthening of  
Human Rights of People Living with HIV**





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The UN Theme Group on HIV/AIDS, as the main instrument of United Nations co-ordination on HIV/AIDS in Croatia, supports national institutions, develops monitoring and evaluation systems and reinforces UNAIDS co-sponsors' activities. Its main objective is to strengthen the national HIV/AIDS response. Members of the UN Theme Group are representatives of: UNHCR, UNICEF, WB, WHO, IOM, UNFPA and UNDP.

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The Analysis with Propositions of Modifications of Current Legislation and Strengthening of Human Rights of People Living with HIV

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**HIV/AIDS** has claimed 25 million lives and estimated 40 million persons got infected with HIV since it was first recognized in 1981. Its destruction is fuelled by a wide range of human rights violations, including sexual violence and coercion faced by women and girls, stigmatization of men who have sex with men, abuses against sex workers and injecting drug users, and violations of right of young persons to information on HIV transmission. Human rights violations only add to the stigmatization and marginalization of persons at highest risk of infection and drive underground those who need information, preventive services, and treatment.

The Analysis with Propositions of Modifications of Current Legislation and Strengthening of Human Rights of People Living with HIV provides us with answers to following questions;

- is the current legislation sufficient to protect people living with HIV from any form of discrimination in all areas of life, ranging from access to labour market to access to services,
- are the particular legal provisions in accordance with international recommendations, and to which extend they foster human rights based approaches,
- how does the current legislation address confidentiality of medical information, and are there provisions that ensure it,
- are the existing social welfare/support provisions sufficient to ensure support and protection of people living with HIV,
- to what extent the legal provisions regarding groups particularly vulnerable to HIV are human rights based, and facilitative of targeted HIV/AIDS prevention services etc.

The text also provides us with examples of discrimination that occurred and with concrete recommendations and models for the legislation reform.

It is of the most importance to emphasize that the members of the National AIDS Commission, a multisectoral national AIDS authority, gave very constructive suggestions and comments that are incorporated in the final text and therefore making its recommendations a national priority in scaling up HIV/AIDS response in Croatia.

UN Theme Group on HIV/AIDS, as a coordination mechanism of United Nations activities at the country level, will use this document to advocate for changes in laws and by-laws that are currently discriminatory towards people living with HIV or where such persons are not guaranteed sufficient protection.

We will base our work and annual activities on implementing recommendations and starting with developing a handbook on rights of people living with HIV.

I would like to thank prof. dr sc. Ksenija Turković and her team for doing a marvellous job and thoroughly analysing 13 international documents, 25 acts as well as many ordinances, regulations and decisions.

Yuri Afanasiev  
UNDP Resident Representative and  
Chairperson of UN Theme Group on HIV/AIDS






# 1. FOREWORD



According to the epidemiological report by the Croatian National Institute of Public Health (CNIPH), in the period from 1985 to December 2005, 537 people were registered as HIV positive, of whom 234 developed AIDS. 127 people died in the same period. 60% of patients are considered to have been infected outside Croatia. In 2005, 11 people developed AIDS. The average yearly occurrence of AIDS in the Republic of Croatia is 4 patients per million inhabitants. This fact puts Croatia in the group of countries with a low AIDS incidence. People living with HIV are almost exclusively members of high-risk groups, and primarily homo/bisexual men (MSM - men having sex with men). High-risk heterosexual transmission is registered in men who have frequent contacts with commercial sex workers outside Croatia. Partners of people living with HIV are most frequently women, usually the permanent partners of people living with HIV, most often their wives. 3 children, out of 9 infected by mother-to-child transmission, have actually developed AIDS. Drug users comprise 8.3% of all HIV patients, but 9.7% of people living with HIV. The number of newly-infected among injecting drug users in Croatia is also monitored on an annual basis (around 700-800 people are tested). The percentage of infected people among injecting drug users is around 1%. However, the number of infected people has not increased in the past 10 years. According to lab data, 194,292 people were tested in 2003, and 81 of them, or 0.04%, were HIV positive. However, it should be pointed out that lab data might include multiple testing of one and the same person, or testing of people previously known to the epidemiology unit as HIV positive. In addition, 4 HIV positive people were registered among blood donors, which accounts for 0.002% of people living with HIV. 9, or 1.03%, out of 869 drug users are also HIV positive. Unless this problem is given full attention, the number of infected people in the Republic of Croatia is expected to increase rapidly in the next few years.

In the battle against HIV/AIDS, the protection of human rights is as important as the protection of public health. The correlation and interdependence between human rights and public health influence our approach to the fight against the epidemic. A person living with HIV can lead a fulfilled life provided there are no restrictions imposed by the government, or discrimination or stigmatisation, and as long as respect for his/her rights is guaranteed. Respect for human rights is required in order to encourage people to submit to voluntary testing, coun-





selling, education and timely treatment, and to inform their partner. It is simply impossible to impose changes in behaviour by force in order to reduce unsafe sex and needle-sharing. If human rights are not respected, the efficiency of public health is lower.

Even the headlines in the newspapers in the past two years (e.g. the case of the little girl called Ela or the case in Split) show that there is discrimination, at all levels of Croatian society, against people living with HIV, members of their families, friends, and even people who care for their health. This type of discrimination is based on the person's status and is prohibited by international documents protecting human rights. Discrimination and stigmatisation may often be the result of certain legislative solutions. Therefore, it was with great pleasure that we, at the request of UN Theme Group on HIV/AIDS, undertook an analysis of Croatian legislation in order to observe the solutions that already exist in the Republic of Croatia regarding people living with HIV, to find out if there are regulations of a discriminatory and/or stigmatising character, and to determine what kinds of regulations are missing when it comes to the protection of people living with HIV. Alongside the analysis of regulations regarding testing, protection of confidential information, keeping of medical records and files, health insurance, medical assistance, criminal liability for transmission of the disease, social welfare, compensation, education, work, status of children living with HIV, asylum seekers and prisoners, etc., we have recommended new or different legal solutions that we consider to be necessary.

This analysis of Croatian legislation from the perspective of protecting the human rights of people living with HIV, is intended for ministries (particularly the Ministry of Health and Social Welfare and the Ministry of Justice), non-governmental organisations and legislators, as well as for people living with HIV.





2.  
RIGHT TO  
PRIVACY  
AND HIV  
STATUS

The right to privacy is guaranteed by a number of international documents: Article 9 of The Universal Declaration of Human Rights, Article 17 of The International Pact On Civil and Political Rights, Article 8 Paragraph 1 of The European Convention for the Protection of Human Rights and Fundamental Freedoms of 1950 (EConventionHR), and The Convention for the Protection of Individuals with Regard to the Automatic Processing of Personal Data. According to the latter Convention (Art 6), personal data concerning health<sup>1</sup> belong to special categories of data that may not be processed automatically unless domestic law provides appropriate safeguards. The Convention on Human Rights and Biomedicine (hereafter referred to as the Bioethical Convention), following on from the previously mentioned documents, establishes the right to the privacy of data concerning health (Art 15 Para 1). This right is not absolute, and the Convention itself anticipates the possibility of restrictions by law to the extent necessary in a democratic society and for the general interest (the interest of public safety, the prevention of crime, the protection of public health) and in the interest of the protection of the rights and freedoms of others (Art 26 Para 1). These restrictions should be necessary, proportional and subsidiary, taking into account the social and cultural context of the country they have been introduced in. The right to privacy is accentuated in the Declaration of Commitment on HIV/AIDS adopted by UN General Assembly in 2001.

The right to privacy is guaranteed by the Croatian Constitution. The provisions of Article 35 of the Constitution of the Republic of Croatia guarantee respect for and the legal protection of personal and family life to all citizens. This right is not absolute. In accordance with Article 16, Paragraphs 1 and 2 of the Constitution, freedom and rights may only be restricted by the law in order to protect the freedom and rights of other people and public order, morality and health. All restrictions on freedoms or rights must be proportional to the nature of the need for restriction in any particular case. In other words, the means of restriction must be proportional to the objective intended to be achieved by the restriction.<sup>2</sup>

Article 37 of the Constitution guarantees the safety and secrecy of personal data to everyone. According to this provision of the Constitution, personal data may be collected, processed and used without the consent of the person concerned only under conditions specified

1. Personal health data include data concerning the past, present, future, physical and mental health of a person. They apply to the data of ill, healthy and deceased persons. They also include data on alcohol and drug abuse.

2. See in this respect the ruling by the Constitutional Court of the Republic of Croatia U-1/3824/2003 of April 28, 2004. In the ruling of the Supreme Court, this requirement is more precise. The ruling says that legal objectives must be necessary and distinctive, and the measures adopted to achieve the objective in question must be rationally connected to the objective, the effects of the measures must be proportional to the objective and the restriction should impair "as little as possible" the right or freedom in question - the so-called Oakes test. See *R v Oakes* Š1986Č 1 S.C.R. 103, 1986 SCC 7.



by law, and as long as they are used only for the purpose of their collection. The protection of data and the supervision of the work of information systems in the state must be regulated by law.

The right to privacy on the one hand refers to the protection of the autonomy and independence of an individual, and on the other hand, to the protection of the privacy of data on personal and family life. Protection of autonomy includes respect for physical privacy, which means that HIV testing, as an invasive procedure, cannot be performed unless a person gives his/her consent. The request for the respect of privacy of data concerning a person's HIV positive status derives from the protection of the privacy of data on personal and family life.

## 2.1. HIV TESTING

HIV testing is extremely important for planning and carrying out efficient and quality prevention, and for following trends in the spread of the infection, as well as for diagnosis and treatment. HIV testing must be performed in such a way that it protects human rights and ethical principles. While performing HIV testing, the following must be ensured according to UNAIDS/WHO recommendations: 1) a setting of privacy; 2) appropriate counselling before and after performing the test; 3) defining the purpose and benefits of testing; 4) a connection between the places of testing, counselling and treatment; 5) defining the way of treating people whose test results are positive; 6) protection from stigmatisation and discrimination; 7) health-care infrastructure that will provide the necessary services in an adequate manner.

UNAIDS/WHO recommends distinguishing between 4 types of testing: 1) testing at one's own request; 2) diagnostic testing (performed whenever a person shows signs or symptoms of HIV/AIDS); 3) routine testing that should be offered to persons being treated for sexually transmitted diseases, pregnant women and members of communities in which HIV is prevalent; 4) mandatory testing (for blood, blood component, organ, tissue or bodily fluid donation).<sup>3</sup>

According to UNAIDS and WHO joint recommendations, all types of testing, including mandatory testing, must be performed with informed consent. Informed consent to testing implies that a person is informed about testing and that it is voluntary (exclusive of exceptional cases).<sup>4</sup> In addition, informed consent must include information on the clinical benefits and preventive benefits of testing, on patients' rights to refuse testing, on attendant services that will be offered, and in the case of positive test results, on the importance of acknowledging the need to inform all those who are at risk, and who cannot find out in any other way that they are at risk. HIV testing may be performed without consent in exceptional cases when a patient is unconscious, his/her legal representative or guardian is not present, and HIV status information is indispensable for optimal care.

### 2.1.1. Non-mandatory testing in the Republic of Croatia (testing at one's own request, routine and diagnostic)

In accordance with The Protection of Patient's Rights Act (hereafter referred to as PPRA) persons who are capable of giving consent, have the right to allow or refuse particular diagnostic or therapeutic procedures (Art 16 Para 1 of PPRA). If a patient is not capable of giving consent (persons who are unconscious, patients with serious mental illnesses, persons who are unable to work and minors<sup>5</sup>), their legal representative or guardian should give consent (Art 17 Para 1 of PPRA). Consent/refusal must be in written form (Art 17 Para 1 of PPRA). Without the patient's consent, or the consent of his/her legal representative or guardian, only emergency procedures may be performed - where the postponing or failure to act on the doctors' part would directly endanger the patient's life or there would be serious and imminent danger of the severe deterioration of his/her health (Art 18 of PPRA). In an emergency, only those medical procedures that are nec-

3. See the UNAIDS/WHO Policy Statement on HIV Testing, <http://www.who.int/hiv/pub/vct/statement/en/>.

4. Ibid.

5. See 9.1 for observations regarding parents' consent for HIV testing of a juvenile patient.



6. Since the Republic of Croatia has ratified the Bioethical Convention, it is directly applied in our legal system and has the power of "supra" law (Art 140 of the Constitution).

7. Testing at one's own request is not free if persons tested in health institutions want to remain anonymous. Testing at one's own request in health institutions is free if the person has health insurance, hence it is not anonymous. Consequently, there is, in fact, no free anonymous testing in Croatia.

8. Apart from the above-mentioned testing in counselling centres and diagnostic testing, a study of sero-prevalence of HIV infection in high-risk groups is being conducted in Croatia at the moment. First, the purpose of testing is verbally explained to the testees, together with the benefits and risks, the meaning and value of the test, and also the fact that they are not forced to take part in testing, i.e. they can change their mind at any moment. Each testee is then asked to fill in a short questionnaire and carefully read the introduction to the questionnaire. In the introduction to the questionnaire, there is a description of the purpose, benefits and risks of the research, the person's right to change their mind about testing at any moment, and the name of the head researcher. Only after they have read the introduction and verbally agreed to testing (according to the PPRA written consent should be obtained), blood is taken. Since the testing is anonymous, testees' signatures are not requested. Testees may find out the test results, if they want to, based on a code that they are given if they agree to be tested. This research is being conducted by CNIPH.

The "Dr. Fran Mihaljević" Infectious Diseases Clinic is conducting a study of the sero-prevalence of HIV infection in the (tentatively speaking) general population, by collecting the remains of serum from hospitals throughout Croatia in order to test them for HIV. This would be done along the lines of so-called "unlinked anonymous" testing. This means that the researchers do not know whose serums they are testing, nor can test results be connected to persons whose serums were taken, and therefore, test results cannot be issued.

9. See supra footnote 4

essary to avert the threat of death and lasting consequences to the patient's health may be performed (if it is possible to postpone the procedure, it should not belong to this category - Art 18 of PPRA). Procedures may be performed only while the above-mentioned threat is present (Art 18 of PPRA) and only procedures that the patient directly benefits from may be performed (Art 9 of the Bioethical Convention).<sup>6</sup>

In accordance with the PPRA, patients (capable and partly capable of using their judgement) have the right to refuse, in a written and signed statement, information on the status of their health and the expected results of proposed and/or performed medical procedures and measures (Art 14 of PPRA). A doctor must respect such a wish of a patient. By refusing information, the patient does not renounce the right to consent, nor does it affect his/her competence to give consent (Art 10 Para 2 of the Bioethical Convention). The PPRA limits the right to refuse information in cases where a patient must be aware of the nature of his/her illness in order not to jeopardise other people's health (Art 15 Para 1 of PPRA).

In accordance with this, after the PPRA became effective, written consent must be requested for every HIV test in the Republic of Croatia. For persons who are unconscious, patients with serious mental illnesses, persons who are unable to work and minors, written consent for testing must be requested from their legal representative or guardian. Testing without consent is possible only in an emergency. According to the provisions of the PPRA, a person living with HIV does not have the right to refuse information on test results.

There is no separate legislation in the Republic of Croatia to regulate the carrying out of HIV testing (distinguishing between anonymous and confidential testing), methods of obtaining consent, methods of counselling, information that should be given to patients in connection with testing, means of communicating test results (in person, not by telephone), and so on. General regulations are insufficient in this sense, and also sometimes inapplicable.

Testing at one's own request in facilities for voluntary, free and anonymous testing is carried out after counselling.<sup>7</sup> If the beneficiary of counselling decides to do the test after counselling, he/she gives spoken consent and blood is obtained for the purpose of testing. Counselling informs each person of the benefits and risks of testing, the meaning and value of the test, and offers the possibility of changing his/her mind about testing. Since testing is anonymous, the signature of the beneficiary of counselling is not required. The beneficiary of counselling receives the test results based on a code that he/she is given after pre-test counselling.

Routine testing, in the sense that a certain sub-population is routinely offered HIV testing, does not exist in Croatia. The necessity of introducing routine testing for people who come to the doctor because of sexually transmitted infections, and for tuberculosis should be considered. The WHO recommends routine testing for such persons, based on informed consent and the right to refuse testing and counselling.

Diagnostic testing is carried out when HIV infection is suspected. Of course, it is also necessary with diagnostic testing to inform the patient of the intention of testing and to obtain informed consent.<sup>8</sup>

We believe that in all cases of non-mandatory testing, spoken consent, which is contrary to the provisions of the PPRA, is sufficient. Consequently, this law should be changed in this respect.

### 2.1.2. Mandatory testing in the Republic of Croatia

UNAIDS/WHO advocates mandatory HIV testing only for blood, organ, tissue or bodily fluid donations. UNAIDS/WHO opposes testing for reasons of public health, since it is considered that voluntary testing shows much better results in terms of prevention. Testing in connection with employment, immigration or the testing of military personnel is considered undesirable.<sup>9</sup>



### 2.1.2.1. Testing of blood of voluntary blood donors

The international recommendations of UNAIDS and the INTER-PARLIAMENTARY UNION (IPU) Resolution of 1998 request mandatory testing for all donated blood, and a statement from blood donors in which they confirm not being involved in behaviour that would put them in a situation in which there is a risk of being infected with HIV. The latter is requested because of the "window period" in which it is impossible to detect infection by testing. Following this procedure should exclude responsibility for indemnities if there is transmission of infection by infected blood. This position is taken since blood donation is indispensable for saving lives, and the risk of transmission of infection by infected blood, if blood is tested and high-risk behaviour checked upon, is very small, so the benefit highly exceeds the risk and these are cases of acceptable risk for which there is no civil legal responsibility.

As far as the testing of the blood of voluntary blood donors in the Republic of Croatia is concerned, The Ordinance on Blood and Blood Components (OBBC),<sup>10</sup> is in effect at the moment, and the Blood Supply Act is in being enacted and should be effective in the fourth quarter of 2005. This should adjust blood obtaining procedures in the Republic of Croatia to the EU Directive on blood and blood components that sets standards of quality and safety for the collection, testing, processing, storage and distribution of human blood and blood components.

Art 26 Para 1 of the OBBC stipulates mandatory testing of blood donor samples for HIV antibodies, type 1 and 2, including subtype (0) (which is not mandatory according to the EU Directive). A person whose blood is anti-HIV 1/2, reactive or positive<sup>11</sup> cannot be a blood or blood component donor, and blood or blood components already obtained from that particular donor, as well as prepared blood components, are destroyed by incineration (Art 28 Para 1 OBBC). Blood control procedures in the Republic of Croatia meet the standards set by the EU Directive, and are even stronger than the Directive itself.

According to the OBBC, the procedure, the risks of donating and the testing that will be carried out on his/her blood sample should be explained to a donor before blood or a blood component is obtained. In addition, he/she should be informed of the ways in which HIV infection spreads, so that a person with high-risk behaviour can change their mind about donating blood (Art 12 OBBC). An HIV positive donor is informed, in spoken or written form, of positive test results and referred to the appropriate health service. The appropriate public health institute is informed in accordance with the Protection of the Population from Infectious Diseases Act (Art 28 Para 3 OBBC). The possibility of being informed in writing should be excluded from the law, since it is necessary to counsel a patient living with HIV. Being informed in writing might possibly be considered only after the patient has previously given his/her consent, and if it also invited the patient to counselling. Voluntary blood donors sometimes live far from the location where testing is carried out, so it is not easy for them to come and hear the information in person.

In accordance with Art 16 of the OBBC, the following persons are permanently excluded from being blood donors: people living with AIDS; people for whom it is clinically or laboratorially proven that they are infected with the HIV virus; people who used to be or still are intravenous drug users; persons with homosexual behaviour, as well as all persons who can, in accordance with medical proof, be considered to have or who might have agents of infectious diseases transmittable by blood transfusion in their blood. In order to comply with the principle of interdiction of discrimination on the basis of sexual orientation (Art 6 Para 2 of the Equality of the Sexes Act and Art 21 Para 1 of the Same-sex Unions Act), the term "persons with homosexual behaviour" should be replaced by the term "all persons with high-risk sexual behaviour". This extending of the term to all high-risk groups would also mean better prevention.

10. In accordance with the Medicines and Pharmaceutical Products Act, the Health Minister should have approved the new Ordinance by August 6th 2004. Since he did not, the Ordinance from 1999 is still in effect.

11. Blood is considered to be positive if it is confirmed that it is positive. Reactive blood is blood which is not yet confirmed to be positive, so the person may be healthy (99% of blood donors). These donors are subject to further survey and medical examination until the final evaluation of donated blood.



### 2.1.2.2. Testing of organs and tissue for transplants

In the Republic of Croatia, all persons involved in the procedure of organ or tissue removal and transplantation must undertake all justifiable measures in order to reduce the risk of transmission of any disease to recipients, and avoid all practices that could influence the health of the organ or tissue to be transplanted (Art 8 CRTHOA). On the basis of Art 37 Para 3 and 11, the Minister of Health and Social Welfare has approved the Ordinances on Measures that Insure the Safety and Quality of Human Body Parts for Medical Use, which specifically regulates, among other things, the testing of donors for diseases that can be transmitted by transplantation, and this includes HIV sero-positivity and AIDS.<sup>12</sup> Each human body part taken for the purpose of transplantation has to be of acceptable quality and must not expose the recipient to unacceptable risk. HIV sero-positivity or illness or HIV infection-risk behaviour in the previous 12 months is considered to be an unacceptable risk (Art 3 of the Regulations). Anti-HIV-1 and 2 testing is obligatory for each potential human body-part donor. In addition, standard questionnaires of family and personal medical history and habits should, among other things, comprise information concerning risk behaviour in the previous 12 months (men having sex with men; people using medication taken subcutaneously, intramuscularly or intravenously for non-medical purposes; people suffering from haemophilia or other blood coagulation system disorders that have been treated with concentrates made from human blood; persons that have had sexual intercourse that was paid for with money or drugs; persons that have had sexual intercourse with the previously-mentioned persons or persons that are suspected of being HIV positive; persons that have been exposed to blood that is known to be or suspected of being infected with HIV (pricking incidents) or that have been exposed to similar open wounds or mucous; persons who have had a tattoo or piercing, or who have had acupuncture treatment if it is not undoubtedly certain that the instruments used were disposable). There are special requirements for child donors: a child whose mother was infected with HIV or participated in HIV risk behaviour (except in cases where HIV infection of the child may be excluded with absolute certainty). Such a child, up to the age of 18 months, or a child that has been breastfed in the previous 12 months should not be accepted as a donor, regardless of HIV tests results. If family or personal medical history shows an increased risk of HIV infection, it is necessary to prove the donor's suitability by molecular biology tests that reduce the time frame to the shortest possible. If it is not possible to perform the above-mentioned tests, such donor body parts may only be transplanted in an emergency or cases of exceptional pathology in a recipient who has given his/her informed consent.

The Regulations neglect to do so, but should require verbal informing and mandatory counselling for living donors if they turn out to be HIV positive. There is also the question of whether transplantation of organs between patients living with HIV should be allowed - in which case it should be taken into account whether the patients have the same subtypes of HIV. It should be accentuated that a positive HIV test is not contraindicated for organ recipients, only for donors.<sup>13</sup>

### 2.1.2.3. HIV testing of prisoners

On admitting prisoners for serving terms of imprisonment, as well as on release, medical examination is mandatory (art 104 para 1 spsa). The medical examination does not include hiv testing. The spsa stipulates that testing for infectious diseases may be ordered as a special measure for maintaining order and safety if there is a threat to maintaining that order and safety (art 135 para 2 item 7 spsa). This involuntary testing, when it comes to hiv testing is not justifiable, and this possibility should be omitted from the spsa. For more details on hiv testing of prisoners see ad. 3.

### 2.1.2.4. Testing of pregnant women

Mandatory HIV testing is not performed on pregnant women in the Republic of Croatia.

12. This means that the Instructions for Implementation of the Programme of Organ Removal (Instructions), according to which an HIV positive result is contraindicated for organ donation (Art XXIX) are no longer valid.

13. Accordingly, the doctor who refused to put two patients living with HIV on the list of patient-candidates for transplantation, with the explanation that HIV positive status is contraindicated for transplantation, was wrong.





### 2.1.2.5. Testing in connection with employment and work

As far as aircrews are concerned, there is no requirement for general testing, but testing may be performed on the basis of clinical indication (see the Ordinance on the Definition of Health Conditions Required of Aircrews and Conditions to be Fulfilled by Medical Institutions Performing Medical Examinations of Aircrews, Art 8.1.2.). When positive results of sexually transmitted disease (this includes HIV/AIDS) testing are confirmed, a process of rigorous testing and additional procedures should commence in order to enable individuals to continue working, provided that their competence to perform their duties to the prescribed standards is not jeopardised. Treatment must be evaluated by a specialist accepted by the Ministry, and must be individual and suitable for all individuals with regard to side effects. The acceptable testing regime is described in Item 2 "Appendix to Items 3.2(i), 3.2.5, 8.1. and Requirement EMCR(ATC) 18" (at the end of Appendix 4). The Croatian Ordinance was drawn up on the basis of the Requirements for European Class 3 Medical Certification of Air Traffic Controllers of the European Organisation for the Safety of Air Navigation and in accordance with the Manual of Civil Aviation Medicine, which refers to three-month and six-month rigorous testing, which does not include HIV testing, but medical examinations (particularly neurological testing, cognitive functions testing, and so on.) after the person's HIV positive status has been established. It would be good if the Ordinance explicitly stipulated that HIV positive status is not a reason for a person not to get a job if he/she is able to perform the duties despite his/her medical condition.

Mandatory HIV testing based on special Ordinances (the Ordinance on the Definition of Health Conditions Required of Maritime Vessel and Inland Navigation Vessel Crew Members; the Ordinance on the Means of Definition of General and Specific Health Conditions Required of Guards and Security Guards in Private Security Services; the Ordinance on Standards and Means of Definition of the Mental, Physical and Health Capacity of Mine-Clearing Experts) is performed on persons that are employed on maritime and inland navigation vessels, or as security guards or mine-clearing experts. Mandatory testing in these cases is contrary to the recommendations of UNAIDS and WHO. Mandatory testing is also performed on members of the armed forces of the Republic of Croatia who leave on peacekeeping missions or actions, allegedly on the basis of a UN request, although the UN Department of Peacekeeping Operations recommended in 2001 that such testing should be done on an exclusively voluntary basis. HIV testing in connection with employment is performed in some medical facilities without any legal grounds. Such a procedure represents employment discrimination. See more on this issue in Ad. 10.2.1.

### 2.1.3. Testing for the purposes of research

The Protection of Patients' Rights Act (PPRA) stipulates that scientific research on patients can be done only with their explicit written informed consent (Art 19/1 PPRA). The law does not regulate the testing of blood samples taken for other purposes, nor that of HIV testing itself for the purposes of research or education. Since, in this case, the experiment is not carried out on the patient, it could be interpreted that HIV testing of blood is possible even without special, explicit consent if its origin is not known, for this kind of testing is not harmful for that particular person, and is of some use to society. Of course, in such cases the person should have given their consent for blood donation. It would be desirable to give the person the option to prevent such a form of testing on his/her blood sample (such a regulation exists in the Netherlands). With this type of testing, additional blood samples should not be taken for HIV testing, and nor should there be additional information on the person (apart from demographic and clinical). All identifying information on the person should be removed before testing in such a way that the test results cannot be in any way connected to a particular person. People should also be informed of the possibility of HIV/AIDS counselling. It is advisable that similar situations are specifically regulated by law.<sup>14</sup>

14. In this context it would be useful to consider the Guidelines for Second Generation HIV Surveillance (UNAIDS/00.03) and WHO/CDS/CSR/EDC/2000,5.



#### 2.1.4. Testing for the purpose of protection of a third party (e.g. doctors)

Croatian legislation does not have explicit regulations on this matter. There have been cases when certain doctors have asked that some patients be tested for HIV before they have administered medical aid. In most countries, even in a case such as this, testing can be done only with the patient's consent, and if the patient does not give his/her consent, the method, though not the matter, of administering medical aid to him/her is the same as it would be for a person living with HIV. This procedure should be followed in Croatia, too. After the PPRA was passed, testing without the explicit informed consent of the patient or his/her legal representative or guardian, except in an emergency, is illegal.

#### 2.1.5. Proposals for legislative modifications regarding the performance of HIV testing

1. Existing legislation insufficiently distinguishes between different types of HIV testing: the conditions for performing non-mandatory and mandatory testing, and anonymous and confidential testing should be distinguished and listed precisely.
2. Mandatory testing is stated too broadly and should be limited to the testing of donated blood, organs, tissues and bodily fluids. Mandatory testing of persons under medical observation, persons seeking employment, and prisoners should be excluded.
3. Methods of performing testing should be laid down precisely: mandatory counselling; methods of informing patients of HIV positive status; what facts a person should know in order for his/her consent to be considered informed; whether spoken consent is enough, or whether written consent should be requested in order to perform testing, etc. A protocol on HIV testing should be enacted.
4. Instructions which deal precisely with the testing of organ donors should be approved. The regulations for testing blood donors should be followed here. In addition, the possibility of organ donation between people living with HIV should be considered.
5. Conditions under which blood given for some other purpose ("sentinel testing") may be used for the purpose of research or education should be stipulated.
6. We should consider the position that should be taken on the possibility of self-testing - whether the sale of home tests be banned because of lack of counselling.
7. The number of persons who have access to test results should be limited. It should be stated precisely who has access to this information and under what circumstances (the person who was tested, the person designated by the person who was tested, the CNIPH for the purpose of statistics, courts, spouses or partners, another doctor, etc.) The need and possibility of coding information on the person tested should be considered.

## 2.2. RIGHT TO CONFIDENTIALITY OF INFORMATION ON THE HEALTH OF PEOPLE LIVING WITH HIV

Because of the possibility of discrimination and stigmatisation, information concerning a person's HIV status<sup>15</sup> is more sensitive than some other medical information. It is therefore very important to approve regulations that protect the confidentiality of this kind of information. In some countries, separate regulations on the protection of medical information have been

15. Information on a person's HIV status should include: information on the fact that a person might be living with HIV; that he/she has been tested for HIV; that he/she has received therapy that would lead to the conclusion that he/she is living with HIV; that he/she was asked to undergo an HIV test or has undergone counselling about HIV; that he/she has a history of high-risk behaviour that puts him/her at risk of infection; or that he/she has been in contact with another person living with HIV.



approved (Hungary, Australia, New Zealand and Western European countries), and some have specific regulations concerning the protection of HIV positive status information (Canada, Australia - Tasmania). These regulations stipulate conditions under which personal data may be collected; in what way these data are protected (particularly if they are in electronic form); a person's right to access their personal data; ways of ensuring that data are relevant and comprehensive; the uses of data for the purpose of research; and for what purpose, except the one they were collected for, data may be disclosed (e.g. with informed consent, at a court's request, informing of partners, and so on). The ECourtHR has ruled that disclosing personal data of somebody's HIV status may represent a violation of that person's right to privacy.<sup>16</sup>

General protection of personal data in the Republic of Croatia is stipulated by the Personal Data Protection Act (PDPA), and methods of managing the collection of personal data by the Decree on Management Methods and Form of Register for the Collection of Personal Data. Croatian legislation lacks regulations that are specifically concerned with the problems of protection of confidentiality of medical information. In the PDPA, only one provision refers to the collection of health information, and this is not enough in order to regulate this subject. The PDPA prohibits the collection and processing of personal data concerning health or sex life, except with the respondent's consent and only for the purpose that the consent was given for. Without the respondent's consent, personal data may only be collected and processed: a) for the purpose of meeting the legal obligations of the supervisor of the collecting of the personal data; b) for the purpose of the protection of life or the physical integrity of the respondent or other persons in cases when the respondent is physically or legally unable to give his/her consent; c) if information is disclosed by the respondent himself/herself; d) if processing is done within the scope of activities of an institution, society or any non-profit-making organisation for political, religious or some other purpose, under the condition that the processing concerns their members exclusively and that the information is not disclosed to a third party without the respondent's consent; processing of this data must be marked and protected in a particular manner (Art 7 PDPA). The respondent has a right of access to his/her data in the collection and the right to request their updating or correction (Art 19 PDPA). The Agency for the Protection of Personal Data decides, in the form of a formal decision, on violations of the right to privacy. It is not possible to file an appeal against such a decision, but an administrative litigation may be instituted (Art 24 PDPA).

The Health Care Act (HCA) guarantees everybody's right to protection of confidentiality of all information concerning the status of their health in a very general manner (Art 21 Para 1 Item 9 HCA). The PDPA has only one provision on this issue, which stipulates the right to confidentiality of information that concerns the status of a patient's health is effectuated in accordance with regulations on keeping professional secrets and the protection of personal data (Art 25 Para 1).

In addition, a number of regulations guarantee and protect the keeping of medical secrets.<sup>17</sup> The Medical Practices Act guarantees every patient's right to protect his/her privacy and the protection of the confidentiality of his/her communication with doctors until he/she (or his/her representatives)<sup>18</sup> permits disclosure of the content of the communication, or until the law requests disclosure of certain information from medical records (Art 21 MPA).

A medical secret is a subtype of professional secret. According to Art 27 of the Protection of Data Secrecy Act (PDSA), professional secrets in medicine cover information on the personal<sup>19</sup> or family life of patients that become known to medical personnel and authorised personnel in their line of duty. The term "professional secret" is defined in a similar way in Art 89 Para 1 Item 16 of the CC. The term "medical secret" is defined, to some degree in a broader sense, and to some extent in more detail, by the Medical Practices Act (Art 21), according to which medical secrets include everything a doctor learns about a patient who seeks medical aid, and which is related to his/her medical status. The HCA, on the other hand, defines as a "medical secret" anything that medical personnel learn about the status of patient's health (Art 122 Para 1 HPA). The term is defined in the broadest sense in Article 17 Paragraph 1 of the Mentally Ill

16. *Z v. Finland*, February 25 1997, Appl. No 22009/93.

17. The right to confidentiality of medical information is ethically based on utilitarian and deontological principles. Confidentiality is based on the belief that the disclosing of patients' personal data and information on their illness on the part of the doctor would discourage patients from seeking medical aid. The damage to society would, in that case, exceed the benefits of the disclosure of the secret. This argument is based on the utilitarian concept that requires the following of the rule that gives the most benefit for the greatest number of people. In addition, doctors encourage their patients to disclose personal data by creating situations in which confidentiality is implicitly or explicitly promised. The deontology of the profession requires that doctors keep their promises.

18. According to the Medical Practices Act (MAP), consent in the name of the patient, if he/she is a minor, may be given by a parent or guardian, and if the patient is mentally incapable or dead, immediate family, guardian or a legal representative. According to the Mentally Ill Persons Protection Act (MIPPA), consent in the name of a person suffering from a mental illness who is not capable of giving consent may only be given by their legal representative. We can see that there is a discrepancy between the MPA and MIPPA in this matter, so these laws should be adjusted on the subject of consent given by a mentally incapable person (inadequate terminology) or a person suffering from a mental illness, who is not capable of giving consent. It seems to me that the MIPPA, as a special law, should be given precedence over the MPA. Or maybe the MPA should refer to a person incapable of giving consent in general terms, and not only to a person who is mentally incapable of giving consent.

19. Personal data is all information that refers to an identified physical person or a physical person that may be identified; a person that may be identified is a person whose identity may be established directly or indirectly, particularly on the basis of one or more indications specific to his/her physical, psychological, mental, economic, cultural or social identity. (Art 2 Para 1 Item 1 PDPA).



20. In the theory of criminal law, there is a prevalent opinion that authorisation has the character of a reason for excluding unlawfulness. Disclosure of a secret is authorised if: a) the secret was disclosed with consent given by the patient or his/her surrogate, or the third party that the secret refers to; b) the court considers that the secret was disclosed in the public interest or in the interest of another person that prevails over the interest of keeping the secret (that the interest will prevail if the benefit gained by disclosing the secret is greater than the damage suffered by the person whose secret is being disclosed - in the framework of this weighing of benefits, courts would, for example, deal with questions of disclosing the HIV positive status of one spouse to the other in spite of the opposition of the HIV positive spouse); c) there are general reasons to exclude unlawfulness, like extreme necessity or assumed consent, and so on the patient's consent is assumed in an emergency (Art 18 PPRA); d) certain acts include regulations on the obligation to keep a secret and the duty of communicating certain information in spite of it being a secret (specific regulations, for example, oblige doctors to report certain cases of pregnancy termination or certain sexually transmitted disease (e.g. HIV/AIDS) or other diseases).

21. The perpetrator of this criminal offence is anybody (persons stated in Art 132 of the PL are only examples) who discloses a secret that they found out about in the line of duty, without authorisation. The Act explicitly states that a doctor of medicine, a dentist, a midwife or other medical personnel may be a perpetrator. Persons who are assistants to these professions may also be perpetrators, as well as persons in training for certain professions (for example, medical students and interns).

22. Only doctors are held accountable for this offence, while the responsibility is much broader according to the PL.

23. According to the MIPPA, the person who discloses the secret, as well as the person in charge of the psychiatric institution, is held responsible for disclosing medical secrets; while according to the PL, only a doctor is held accountable for this misdemeanour. According to the HCA, all medical personnel who find out such information in the line of duty, together with medical students and nursing schools students, and all persons who have access to information on patients' health status in the line of duty, are obliged to keep professional secrets.

Persons Protection Act (MIPPA), according to which a 'medical secret' includes everything that people who work in healthcare or who treat people suffering from mental illnesses find out or observe while they are performing their duty, and in the Code of Medical Ethics and Deontology which defines a "medical secret" as anything doctors find out while they are performing their duty (Art 2 Para 13). Of course, in order for something to be considered a secret, the information that is being told to the other person should be unknown to them or their knowledge of it, until that moment, should be uncertain.

Nurses are also obliged to keep as a professional secret all information on a patient's health status (Art 3 Para 1 Nursing Act - NA).

Everyone has the obligation to keep a professional secret, no matter how they found out the secret information or acquired possible access to the secret information, when there is no doubt that it really is a secret (Art 28 Para 1 PDSA). Protective measures, as well as procedures for the protection of secret information, are obligatory to all that use such information or have access to it.

Unauthorised<sup>20</sup> disclosure of a professional secret a person has found out in the line of duty<sup>21</sup> (in this case, a medical or health secret) represents an offence under Art 132 of the PL, punishable by a fine not exceeding 150 daily incomes or confinement in jail for a term not exceeding 6 months, an offence under Art 59 of the MPA, punishable by a fine of HRK 5,000.00 to 10,000.00,<sup>22</sup> and under Art 192 Para 1 Item 1, Para 2 and Para 3 of the HPA punishable by a fine of HRK 10,000.00 to 50,000.00 for medical institutions and HRK 5,000.00 to 10,000.00 for medical personnel, and under Art 17 Para 1 Item 5 of the MIPPA, punishable by a fine of HRK 1,000.00 to 10,000.00.<sup>23</sup> Criminal proceedings are instituted after the motion. If criminal proceedings have started against such a person, minor offence proceedings cannot be instituted (*ne bis in idem*). If a person has been punished for a minor offence, criminal proceedings can be instituted against them, and the penalty from minor offence proceedings is included in the sentence pronounced in criminal proceedings.

As far as persons living with HIV are concerned, the right to confidentiality of data on their health is of particular relevance with regard to testing and confidentiality of data on testing, maintenance of the register of persons living with HIV, the keeping and availability of medical records of persons living with HIV, disclosing HIV positive status to a sexual partner, disclosing of HIV status in judicial proceedings, and disclosing of HIV status to another doctor.

### 2.2.1. Confidentiality of testing

When a medical institution, based on a medical examination, determines that a person is a carrier, it is obliged to report it to the public administration body responsible for managing sanitary inspections and to the county or City of Zagreb public health institute, according to the place of residence or abode of the carrier (Art 8 Ordinance on the Performance of Medical Examinations on Carriers of Infectious Diseases- OPMECID). A person who is detected as an HIV-carrier in a medical examination, is considered a chronic infectious disease carrier, i.e. a lifelong infectious disease carrier (Art 18 OPMECID). Medical examination of infectious disease carriers is performed in a medical institution that has an organised hygienic-epidemiological unit, and which is situated in the area where the infectious disease carrier has residence or place of abode (Art 17 of the Ordinance). The institution in question is required to keep records on infectious disease carriers, using special forms. If an infectious disease carrier moves from one place of residence to another, the medical institution that had carried out the medical observation of this particular infectious disease carrier is required to inform the medical institution in the infectious disease carrier's new place of residence or abode via the authorised sanitary inspection body (Art 18 OPMECID). We should think about whether this notification is necessary or whether it should be left to the patient to decide.



According to the Ordinance on the Methods of Reporting Infectious Diseases (OMRID), antibodies to the Acquired Immune Deficiency Syndrome (AIDS) virus must be reported. A medical institution, or private medical practice that establishes the presence of HIV antibodies, contraction of the disease or death from AIDS, informs the appropriate hygienic-epidemiological unit office that registers such data with the date when the data was entered into the contagious diseases register. The registration form is immediately and without delay forwarded to the appropriate county or City of Zagreb public health institute, and to the Croatian National Institute of Public Health. The medical institution or practice registers the data, with the date when the report was sent, in the contagious diseases register that is kept in the office of that medical institution or private medical practice. Reports are delivered in a sealed envelope and the envelope is labelled "confidential". A better method of confidentiality protection should be considered, since sending personal data creates an increased possibility of a violation of the privacy of people living with HIV. In order to raise the level of a person's protection of privacy, UNAIDS recommends sending coded data to the epidemiological unit for the purpose of keeping statistics. Of course, protection mechanisms should be used so that the codes cannot be disclosed.<sup>24</sup>

It is not clear why this subject is regulated by two different ordinances. It should be regulated by only one ordinance (the Ordinance on Methods of Reporting Infectious Diseases), while other regulations (e.g. the Ordinance on the Performance of Medical Examinations on Infectious Disease Carriers) should refer to it.

### 2.2.2. Maintenance of the register of people living with HIV

The Croatian National Institute of Public Health (CNIPH) maintains state public health registers, supervises data collection and co-ordinates other health registers (Art 98 Para 1 HCA). Public health institutes of local (regional) government units collect, control and analyse statistical reports on health in local (regional) government units for the CNIPH (Art 100 Para 1 Item 3 HCA). We have seen that, in accordance with the Ordinance on Methods of Reporting Infectious Diseases, a medical institution in which a person's HIV status has been established delivers the data to the relevant hygienic-epidemiological unit office. This then forwards it to the appropriate county or City of Zagreb public health institute and to the Croatian National Institute of Public Health. This means that registers of people living with HIV are kept at several levels. A person's name, surname and address are delivered for the purpose of keeping statistics. Confidentiality is protected by delivering data in a sealed envelope that is labelled "confidential"<sup>25</sup>. This type of protection is insufficient. Patients are usually reported to the register via the Dr. Fran Mihaljević Infectious Diseases Clinic to the CNIPH. The data is then forwarded to local epidemiologists. There have been cases in which local epidemiologists have tried to intervene in an inappropriate manner after finding out the identity of a person living with HIV. This shows the need to encode data stored in registers, at least at the local level.

The Croatian National Institute for Transfusion Medicine collects data for a yearly analysis of transfusion activities, analyses them and forwards them to the Ministry of Health and Social Welfare (Art 103 Para 1 Item 4 HCA). Only statistical data are delivered to the Ministry. The data contain, among other things, data on blood that has tested positive for HIV. The data is also reported to the register of people living with HIV at the CNIPH, but only initials are indicated, not full names.

All voluntary blood donors must fill in a form consisting of two parts. The first part is a form where the donor has to fill in his/her personal details. Other kinds of information on the blood donation itself and specifications connected to the blood are filled in by a doctor. The second part is a questionnaire containing a note that states that all the responses of the donor are a medical secret. People are asked whether they belong to one of the categories that are permanently excluded as donors: alcohol and drug addicts; intravenous drug users; persons who change partners frequently (more than 4 partners a year); persons who have had sexual relations with a prostitute; men who have had sex with

24. It is questionable whether information on HIV testing should be available to sanitary inspectors and doctors at the county institute for public health or a doctor who treats the patient in hospital. If we really want to narrow the circle of people who are familiar with the patient's identity only to the doctor who immediately treats the patient, all others should just have the code under which the patient is registered. This is the comment of Dr. Jureša of CMA. On the other hand, the CNIPH emphasises that the CIPH is under the authority of the CNIPH and that it is all one epidemiological service at the national level, which means that the data is not shared with other institutions, but remain within one service. The authors stress that the whole point of the protection of privacy of persons living with HIV is that the fewest possible number of persons know about their status, regardless of the fact whether these persons are part of the same service or of different services.

25. The CNITM used to send to the CNIPH only the initials of persons that were confirmed to be HIV positive, but lately the data is registered with a full name and surname so that the data is not duplicated. The CNITM provides medical examinationa at the Dr. Fran Mihaljević Infectious Diseases Clinic to all persons whose HIV positive status has been confirmed. The Clinic reports to the CNIPH on these examinations, which leads to the duplication of data.



men; people living with HIV or persons who have had sexual relations with another person living with HIV; persons who have had syphilis; sexual partners of persons with high-risk behaviour; and persons who were in the UK from 1986 to 1997 for a period of more than 6 months. In the transfusion unit, there is a register of donors who, according to the questionnaire, belong to one of the categories that are permanently excluded as donors, or who are temporarily or permanently refused as donors because they have had infectious diseases, or testing has proved the presence of infectious disease agents in their blood, or because the transfusion of blood component prepared from the blood or blood component of that particular donor has caused a disease (Art 21 OBBC).

The Croatian National Institute of Occupational Medicine keeps a register of occupational diseases, and observes and studies injuries and cases of occupational disablement in the Republic of Croatia. The register contains personal data. Data on people living with HIV are considered to be confidential, but, in accordance with the obligations with regard to reporting in the Protection of the Population from Infectious Diseases Act (PPIDA) and the Ordinance on the Methods of Reporting Infectious Diseases (OMRID), are delivered to the CNIPH in a sealed envelope with the name, surname and address of the person living with HIV.

In accordance with the Protection of Data Secrecy Act (PDSA), before collecting any personal data, the supervisor of the personal data collection or the person who processes the data is obliged to inform the respondent whose data is being collected of the identity of the supervisor of the personal data collection; of the purpose of processing the data; of the users and categories of users of the personal data; whether this sharing of information is voluntary or mandatory, and what the possible consequences of withholding information are. In the case of mandatory sharing of personal data, the legal basis of the processing of personal data is stated. It is questionable whether this is really done on an everyday basis. This provision should be further elaborated in the regulation concerning the confidentiality of information on persons living with HIV.

Unauthorised use of personal data is an offence punishable by a fine not exceeding 150 daily incomes or confinement in jail for a term not exceeding 6 months (Art 133 CC).

Keeping statistics on people living with HIV is necessary in order to prevent further infection, to establish the trends of infection and means of an epidemic spreading, to work out various prevention programmes, and to rationally allocate funds for epidemic control. The question here is whether it is better to have personal data that enable easy identification and more accurate statistics, or whether it is better to encode data and thus provide superior protection of privacy of people living with HIV, but at the risk of less accurate data. The degree to which a certain method of keeping the register influences people's willingness to undergo testing should be considered when making this decision. From the aspect of human rights protection, the encoding, or even double encoding, of data is recommended.

At any rate, we lack a separate regulation that would precisely regulate the protection of confidentiality of data in registers of people living with HIV, and in which cases and to whom such data is available.

In addition, possibilities of collecting statistical data at anonymous testing should be considered (usually, this information is reported only after the diagnosis established at anonymous testing has been verified at confidential testing).

### 2.2.3. Medical records

Doctors and medical personnel are obliged to keep detailed and dated health, i.e. medical, records and other files on persons they administer medical aid to (Art 149 Item 3 HCA and Art 23 Para 1 MPA). Private medical practitioners are also obliged to report this to the appropriate health institutions in accordance with regulations on medical sector records (Art 149 Item 3 HCA). When performing inspections, inspectors check methods for keeping and using appropriate medical records and files (Art 173 Item 5, Art 170 Para 2 and 3 HCA).



### 2.2.3.1. Electronic databases

Doctors or other medical personnel that are held responsible in a medical institution, trading company or other corporate bodies that administer medical aid are obliged to secure records that are saved in electronic media from change, premature deletion or unauthorised use (Art 23 Para 2 MPA). The keeping of medical secrets includes data storage systems (Art 2 Para 13 of the Medical Ethics and Deontology Code). These provisions are insufficient. This whole area should be regulated more precisely.

### 2.2.3.2. Access to medical records

Patients have the right to access all medical records regarding the diagnosis and treatment of their illness (Art 23 Para 4 MPA and Art 23 Para 1 PPRA), and may ask for copies at their own expense (Art 23 Para 2 PPRA). Patients also have the right to give spoken or written statements regarding people who can be informed of their admission to inpatient medical institutions, as well as of their health status. In addition, patients may specify people to whom this information cannot be given (Art 25 Para 2 PPRA). In the case of a patient's death, if the patient has not explicitly forbidden so while alive, the patient's spouse, partner, children who are not minors, parents, brothers or sisters who are not minors, and the patient's legal representative or guardian have right of access to the patient's medical records, unless the patient had opposed this in written form, attested by notary public (Art 24 Para 1 and 3 CPA). As far as people living with HIV are concerned, it would be better to stipulate that information is not available to other persons unless the patient has explicitly agreed to it (informing sexual partners should, of course, be regulated separately).

A doctor is obliged to show, upon request, medical records without the need for the patient's consent, to the ministry in charge of health, to public administrative bodies (in accordance with particular ordinances<sup>26</sup>), to the Croatian Medical Chamber (CMC)<sup>27</sup> and to the judicial authorities (Art 23 Para 2 MPA). According to the HCA, medical personnel are obliged to disclose information on patients' health status upon the request of the ministry in charge of health, to public administrative bodies in accordance with particular regulations, and the appropriate chamber of the judicial authorities (Art 122 Para 3 HCA). According to the MIPPA, medical records on the treatment of persons with mental illnesses may be disclosed without consent only to courts and for the purpose of ongoing judicial proceedings. The following should be stipulated more precisely: the purposes for which the records may be requested; what an argument requesting insight into medical records should contain; that it cannot be used for purposes other than those it was requested for; that the person who requested the records is obliged to keep findings from the records as a medical secret, and so on.

#### 2.2.3.2.1. Protection of confidentiality of information on people living with HIV in judicial proceedings

##### 2.2.3.2.1.1. Presenting medical records for the purpose of judicial proceedings

Presenting medical records for the purpose of judicial proceedings is a particularly sensitive question. The search of a doctor's office may be ordered only by the competent court in the form of a written warrant if the conditions prescribed by law are met (Art 228 Para 1 Criminal PA and Art 26 MPA).<sup>28</sup> Neither the MPA nor Criminal PA stipulate the details that a search-warrant must contain, but Art 26 Para 5 of the MPA states that the search must apply only to the records and objects that have a direct bearing on the criminal offence that is being investigated. When the search of a doctor's office is ordered, the court will immediately inform the CMC or its commission in the district where the office in which the search is to be conducted is situated. It is a doctor's right that he/she or his/her representative and an obligatory two witnesses, one of whom may be a CMC representative, are present while the doctor's office is being searched. The secrecy of medical records and objects must not be violated during the search of a doctor's office. Consequently, medical records cannot be taken away during a search as they are protected as a medical secret.<sup>29</sup>

26. For example, in order to realise social welfare rights. Certain provisions of the Social Welfare Act (SWA) imply the need for medical expert evaluation in order to determine the degree of physical or mental impairment, as can be seen from Art 10 Para 2. The Ordinance on the Structure and Methods of Work of Expert Evaluation Bodies with Regard to Social Welfare and Other Rights, in accordance with special regulations, applies here. According to Art 15 Item 4, the diagnosis stated in the report of the appropriate primary health care physician is required. Other medical reports are needed, too. Consequently, access to medical records is needed during the whole process of expert evaluation. In ordinances regulating the powers of the Ministry of Defence and Ministry of Foreign Affairs, we did not find particular powers which would result in the obligation to deliver medical records to these public administrative bodies.

27. In cases of disciplinary action against a doctor, the Code of Medical Ethics and Deontology defines a breach of the Code as an infringement of discipline (Art 10 Para 1.) Procedures for determining breaches and pronouncing sentences are stipulated by the ordinance on disciplinary action of the CMC.

28. Art 231 of Criminal PA cites cases in which it is possible to conduct a search without a warrant.

29. Because of the differences between regulations that define the expression 'medical secret', it is not clear which of the regulations would be considered relevant by the Criminal PA. See footnote no. 15 for cases in which it is possible to disclose a medical secret.



The Criminal PA stipulates that written statements to a doctor, unless the accused hands them over voluntarily upon request (Art 233 Para 3 Item 2 Criminal PA), as well as notes, excerpts from registers and similar documents that are kept in a doctor's office, and that he/she has made on facts that he/she has found out about from the accused in the line of duty (Art 233 Para 4 Criminal PA), are not subject to seizure. This is because the benefit of choice whether to testify or not that is given to doctors would be pointless. Consequently, according to Art 244 Para 1 Item 4, doctors are exempt from the obligation to testify. Neither do they have to hand over medical records concerning the accused to the police, State Attorney's Office or the courts, unless there is a legal basis that exempts them from keeping a medical secret (Art 244 Para 2 Criminal PA). In addition, the Criminal PA stipulates that government bodies, organisations, banks and other corporate bodies are not obliged to surrender to the State Attorney, upon his/her request, data representing a secret protected by law (Art 183 Para 3 Criminal PA). The police may seize written statements of the accused to his/her doctor in cases of investigations of criminal offences (Art 186 Criminal PA) and urgent investigative procedures (Art 196 Para 1 Criminal PA) or by court order. Evidence obtained in violation of the stated provisions cannot be used as evidence in criminal proceedings (Art 232, 233 Para 11 Criminal PA and Art 26 Para 5 MPA).

Several questions are raised regarding these provisions, such as whether the right not to hand over medical records is too narrowly understood when it is given only to doctors, and not to persons to whom doctors, for example in cases of patients living with HIV, are obliged to deliver their information (e.g. the CNIPH for the purpose of keeping the register), or when it does not refer to other persons in a medical institution who may be in contact with the accused or his/her medical records. In such cases, we may proceed from the interpretation that these persons are not obliged to hand over medical records if it would do more harm than good. They would all have the benefit of choice whether to testify or not, and they should all be exempt from the obligation to deliver records.<sup>30</sup> Moreover, it is not clear why the police have the right to seize written statements of the accused to his/her doctor in cases of investigations of criminal offences and urgent investigative procedures (Art 233 Para 8 Criminal PA). It is also not clear why the Criminal PA protects only the medical records of the accused and not those of other persons (see Art 233 Para 4 Criminal PA), or why there should be one standard for the protection of the medical records of the accused and another standard for everybody else (e.g. witnesses).

#### 2.2.3.2.1.2. Obligation to testify

In accordance with Art 244 Para 1 Item 4 of the Criminal PA, doctors of medicine, dentists, pharmacists and midwives are exempt from the obligation to testify about what they have learned from the accused in the line of duty. Nevertheless, they cannot deny their testimony if there is a legal basis which releases them from the duty to keep a secret. With regard to the obligation to testify of other medical personnel, Art 132 Para 2 of the CC is applicable, which means that these persons will be obliged to testify if their testimony is necessary for the public interest, or if the interest of another person prevails over the interest of keeping the secret. The question remains open as to who should decide on these things. The court holding the judicial proceedings is required to notify persons exempt from the obligation to testify, before they are questioned or as soon as their relation to the accused is discovered, that they are not obliged to testify. Both the notification and the answer are minuted. A verdict cannot be based on the testimony of a witness who is exempt from the obligation to testify if he/she was not notified of his/her right, or if he/she did not explicitly renounce this right, or if the notification and renunciation were not minuted (Art 245 Criminal PA). If the verdict is based on the testimony of such a witness, it would be a serious violation of criminal proceedings provisions.

#### 2.2.3.2.1.2. Expert evaluation

A person who is exempt from the obligation to testify cannot be an expert. This means an expert cannot be a doctor who learned something from the accused in the line of duty, which would mean he/she took part in the treatment of the accused (Art 267 Para 1 Criminal PA).

30. In assessing the obligation of other medical personnel to testify, Art 132 Para 2 of the PA is applied. This means these persons will be obliged to testify if their testimony is necessary for the public interest or if the interest of another person prevails over the interest of keeping the secret. The question remains open as to who should decide on these issues. The court holding the judicial proceedings is required to notify persons exempt from the obligation to testify, before they are questioned or as soon as their relation to the accused is discovered, that they are not obliged to testify. Both the notification and the answer are minuted.





### 2.2.3.2.1.3. The protection of privacy of a person living with HIV during proceedings

When a person's HIV status is discussed or mentioned, the public should be excluded from the judicial proceedings (Art 310 Para 1 Item 4, Art 316 Para 3 and 4 Criminal PA; Art 307 Civil PA). Persons present when the public has been excluded are obliged to keep whatever they learn in proceedings a secret (Art 311 Para 3 Criminal PA; Art 308 Para 4 Civil PA).

In order to protect their privacy, people living with HIV should be enabled to testify via technical devices so that their identity may be hidden or that they do not have to be present in the courtroom (Art 254 Para 3 Criminal PA).

The identity of a person living with HIV should be protected in case records (a person should be given a pseudonym). Protection given to endangered witnesses should extend to other categories of witnesses or the term "endangered witness" should be extended (249 - 253 Criminal PA).

### 2.2.3.2.2. Protection of the privacy of a person living with HIV in the media

A journalist has an obligation to report truthful, balanced and verified information (Croatian Journalists' Code of Honour, Item 4). Publication of information that violates someone's privacy, without the person's consent, must be justified by the public interest (Item 16). This also applies to publication of details or pejorative qualifications on any physical or mental impairment or illness (Item 19).

A journalist, who discloses without authorisation a medical secret that he/she has found out about in the line of duty, may be prosecuted under Art 132 of the CC. They may also be prosecuted for unauthorised disclosure of personal data under Art 133 of the CC. For reporting on personal and family circumstances (Art 201 Para 2, CC), a journalist will be prosecuted if the manner of expression and other circumstances clearly indicate that it is a case of conduct intended to only damage somebody's honour and reputation. If, on the other hand, a journalist purposefully spreads rumours he/she knows to be false, with the intention to cause disturbance to a great number of citizens, and such a disturbance develops, he/she may be prosecuted for spreading false and disturbing rumours under Art 322 of the CC, and victims are entitled to indemnity under the Civil Obligations Act (Art 1098 COA).<sup>31</sup> A journalist, therefore, may only disclose information on a person's HIV status if it is in the public interest or with the consent of that person living with HIV.

### 2.2.3.2.3. Disclosure of information on HIV status to another doctor

The question here is whether the information of a patient's HIV status may be disclosed to another doctor: a) when a doctor refers a patient living with HIV to another doctor, as a patient could, because of his/her HIV positive condition, be a threat to the health or the life, of the doctor, other medical personnel and other patients (this obligation is stipulated by Art 28 of the MPA), or b) when disclosing HIV status is necessary in order to undertake medical procedures for the patient's benefit (a similar provision regarding the treatment of persons with mental illnesses is stipulated in the MIPPA, Art 17 Para 3 Item (a)).

The question is whether it is justifiable to disclose a patient's HIV status to another doctor for his personal protection. The assumption is that doctors should always be careful and use protective equipment, so this information should not be disclosed without a patient's consent. If the legislature wanted to depart from this, such cases should be regulated more precisely and restrictively. In addition, information should not be disclosed to another doctor without the patient's consent even when it is crucial for administering medical aid for the patient's benefit. The dilemmas that appear here should be

31. Art 198 of the old COA



dealt with in accordance with the provisions on informed consent and provisions on proceedings in emergency cases.<sup>32</sup> Caution is required so that restrictions do not lead to unnecessary censorship. Special instructions should be issued on methods which promote responsible and non-sensationalist coverage and the use of appropriate and non-stigmatising language when reporting on HIV in the media.

#### 2.2.3.2.4. Disclosure of information on HIV status to a sexual partner of a person living with HIV

The law should prescribe exceptional circumstances in which doctors could, but would not be obliged to, disclose their patient's HIV status to a sexual partner who is at risk. A doctor should first convince his/her patient to tell his/her partner on their own. If a doctor suspects that a patient has not done so, and that he/she does not practise safe sex, the doctor could disclose the information to the partner of a person living with HIV. This solution is provided for by law, since the doctor is given the opportunity to disclose a medical secret if it is in the interest of another person, and this prevails over the interest of keeping the secret.

There is the question here of the civil and criminal liability of a doctor who does not inform a sexual partner of a person living with HIV of his/her status. This liability could be excluded by an Act, as is often done in US legislation.

### 2.2.4. Proposals for legislative modifications regarding the protection of confidentiality of information on people living with HIV

1. A separate law should be passed regulating the protection of confidentiality of medical records, the keeping of medical records including electronic maintenance of such records (passage of this law is anticipated by Art 122 Para 5 of the HCA and Art 23 Para 3 of the APPR), the keeping of registers, and other issues regarding medical secrets. Because there is a danger of discrimination and stigmatisation regarding the protection of information on the testing of people living with HIV, a separate regulation should be passed or special attention should be paid to its protection within the boundaries of the law regulating the protection of medical records.
2. Art 8 Para 2 of the Personal Data Protection Act (PDPA) does not allow for medical information to be collected and processed without the testees' consent if it is in the public interest. Consequently, all the data in the register of persons living with HIV would be illegal if there is no consent from them. Art 8 Para 2 of the PDPA should therefore be modified.
3. With regard to the keeping of medical records, the following should be stipulated separately:
  - a protection of confidentiality of medical records of people living with HIV (data should be available to others only with the consent of the person living with HIV; exceptions to the rule should be stipulated)
  - b how long the data should stay secret
  - c data may be given only for a specific purpose and are not to be used for other purposes
  - d data are not available to other persons, except with the explicit consent of a person living with HIV (informing of sexual partners, availability of data for judicial proceedings, and so on, should be regulated separately) persons requesting records are obliged to keep what they have learned from the records as a medical secret.

32. See, Ksenija Turković, The Patient's Right to Co-decide According to the Protection of Patients' Rights Act, p. 109.



4. With regard to the register of people living with HIV, the following should be stipulated:

- a. a encoding of information delivered to the registers and methods for their encoding - according to existing regulations, information sent to various institutions for the purpose of keeping statistics contains names, surnames, addresses, and so on; information should be encoded so that a person's identity cannot be revealed; data in the central register could contain personal information (name and surname) in order not to count one person several times, but further distribution to local institutes and local epidemiologists should contain encoded data
- b informing persons living with HIV about collection of data, its purpose and methods of keeping it

to whom, under what conditions and for what purpose data from the register may be available.

5. With regard to information on HIV testing, the following should be carried out:

- a if it is confidential testing, limiting the number of persons who have access to the information of test results and determining precisely to whom, and under what conditions this information is available (to the person who was tested, to a person he/she designates, to the CNIPH for the purpose of keeping statistics<sup>33</sup>, to courts, to spouses or partners, to another doctor, etc.);
- b considering whether it is necessary, if a person moves from one place of residence (place of abode) to another, for the medical institution in which the person was treated until that moment to inform the medical institution in the new place of residence or abode, or whether this decision should be left to the patient himself/herself;
- c regulating methods of reporting infectious diseases in just one ordinance (the Ordinance on Methods of Reporting Infectious Diseases), while other ordinances (e.g. the Ordinance on the Performance of Medical Examinations of Carriers of Infectious Diseases) should refer to it.

6. Proposals for modifications regarding the regulation of keeping medical secrets:

- a. differentiation between a criminal offence and a minor offence - the question here is whether it is justified to talk about both criminal liability and minor offences when disclosing a medical secret. Responsibility for a minor offence would make sense if it punished something different from what is punished as a criminal offence when a medical secret is disclosed. Such differentiation might be achieved through a different definition of a medical secret. For example, the HCA and MPA define a medical secret as anything medical personnel or a doctor learn on the status of a patient's health, or anything a doctor learns about a patient who asks for his/her medical aid, and which is connected to the patient's health. On the other hand, the MIPPA defines a medical secret as anything a person providing medical aid and treating people with medical illnesses learns or notices in the line of duty. Since criminal liability refers to disclosing information on a person's personal or family life that medical personnel, psychologists, people acting as guardians, or other persons learn in the line of duty, a minor offence should thus refer to disclosure of other information that medical personnel, psychologists, people acting as guardians, or other persons learn in the line of duty. We should determine how far we want to go in the protection of patient-doctor communication. The MPA (which protects information on health status and only with respect to doctors and not other medical personnel), the MIPPA (which protects all information

33. The CNIPH has remarked that epidemiology units have a broader spectrum of activities than just keeping statistics and that it is necessary that epidemiologists know the name and surname of the patient in order to be able to carry out anti-epidemic intervention. The authors of this text warn that it is necessary to consider international practices carefully in order to achieve optimum protection of privacy of people living with HIV.



learned in the line of duty of medical care for people with mental illnesses) and the Code of Medical Ethics and Deontology should be better co-ordinated in this sense.

- b plurality of responsibility for minor offences - a doctor's responsibility for the minor offence of disclosing a medical secret is stipulated in the HCA, MPA and MIPPA. We may say that the MPA is a *lex specialis* in relation to the HCA, and the MIPPA is a *lex specialis* in relation to both the HCA and MPA. The discrepancy in sanctions between these acts is disturbing. The question is whether we need so many minor offences for unauthorised disclosure of medical secrets.
  - c definition of medical secret - in relation to the above, the definitions of medical secret in the Protection of Data Secrecy Act, Criminal Code, MPA and MIPPA should be harmonised and differentiated.<sup>34</sup>
  - d. Definition of perpetrate - this minor or criminal offence should apply to all medical personnel. Laws should be harmonised in this sense.
  - e Institution of judicial proceedings - institution of judicial proceedings should be enabled *ex officio* because this criminal offence not only protects a person's right to personal secrets and to privacy, but also creates trust that people who provide medical care will keep as a secret anything they learn about in their line of duty. Without this trust, medical care cannot be properly provided.
  - f Defining public interest or the interest of another person that prevails over the interest of keeping the secret - the MIPPA defines public interest. These definitions should always be stated as examples, so that there is room for judicial practice to develop them further.
7. Provisions regarding treatment of people living with HIV in judicial proceedings should be reconsidered.
- a. Certain provisions of the Criminal PA should be reconsidered:
    - i the Criminal PA should stipulate what a search-warrant or a warrant for the temporary seizure of an object should contain and to what extent it should be specific
    - ii if the benefit of the choice whether to testify or not should apply to other medical personnel, not only to doctors (Art 144 Para 1 Item 4 Criminal PA)
    - iii how broad the exemption of medical records should be according to Art 233 Para 3 Items 2 and 4 of the Criminal PA
    - iv justification of protection of medical records of the accused only, and not those of other persons, for example, witnesses (Art 233 Para 4 Criminal PA)
    - v justification of authorisation for the police to seize written statements of the accused to his/her doctor in cases of investigations of criminal offences and urgent investigative proceedings (Art 233 Para 8 Criminal PA).
  - b. Provisions of the Civil PA should be reconsidered:
    - i. the possibility of questioning witnesses and parties via technical devices in order to protect a witness' or party's identity should be introduced
    - ii. the possibility of introducing a pseudonym into case records in order to protect a witness' or party's identity should be provided for.
  - c instructions for the state attorney's office in cases when an accused person is living with HIV (particularly the protection of data secrecy with regard to this person).

34. The NGO CAHIV suggests that the definition of medical secret in the PDPA and MIPPA should be adopted, since these acts define the term in the most comprehensive manner.





3.  
ADMINISTERING  
MEDICAL  
AID

### **3.1. THE OBLIGATION TO ADMINISTER MEDICAL AID**

According to the NGO CHIVA, there have been a few cases in the Republic of Croatia in recent years when doctors have refused to administer medical aid to people living with HIV because of their HIV status.<sup>35</sup>

35. In 1999, University Hospital Zagreb-Rebro refused to admit a patient living with HIV injured in a traffic accident. After a discussion that lasted for several hours, the patient was transported to the Traumatology Clinic. In 2000, a person living with HIV had cytomegalovirus (CMV) on both eyes and needed an operation. After consultation with a leading ophthalmologist, it was decided that the operation was unnecessary because the patient would die soon anyway because of his HIV status, and they would have to throw away all the equipment used during the procedure. At the beginning of 2004, a patient living with HIV sought medical help in a local community health centre, but the doctor prevented her from entering the facility, while a visiting nurse refused to go to her house to give her extra care. CAHIV submitted a petition to the superintendent, and after this the patient started receiving the level of health care that she was entitled to. In addition, a doctor refused to put two patients living with HIV on the list of patient-candidates for transplantation, with the explanation that HIV status is contraindicated for transplantation.

36. Circumstances that might result in lasting consequences for the patient's health (disability) or the patient's death because he/she was not given proper medical care (Art 18 Para 3 MPA).

Each and every person has the right to equality in the health insurance process, and the right to first aid and emergency medical aid when it is needed (Art 21 Para 1 Items 1 and 4 HCA). The PPRA guarantees every patient's general and equal right to quality and continuous healthcare appropriate to his/her health status, in accordance with universally accepted professional standards and ethical principles in the patient's best interest with respect for his/her personal beliefs (Art 2). According to the MPA, a doctor is obliged to administer necessary preventive measures, diagnoses, treatment, or rehabilitation to all persons for whom he/she is the chosen doctor, or who are referred to him/her by another doctor for medical care (Art 18 Para 1). In an emergency<sup>36</sup>, a doctor is obliged to help any patient without delay, and assist other patients according to the degree of medical priority, or according to a waiting list (Art 18 Para 2 MPA). A doctor is entitled to conscientiously object if he/she cannot perform a diagnosis, therapy or rehabilitative procedure because of his/her religious, ethical or moral views or convictions, but then has to refer the patient to another doctor specialised in the same area (Art 20 Para 1 MPA). HIV status on its own does not amount to conditions for conscientious objection. The Code of Medical Ethics and Deontology obliges doctors to respect human life from its beginning until death, to promote health, prevent and treat diseases, respect the human body and personality even after death, administer medical aid to all alike, regardless of their age, sex, race, nationality, religious or political beliefs and social position, while respecting human rights and personal dignity (Art 1 Paras 2 and 3). Administering medical aid is limited to administering emergency medical aid only for certain categories of persons who are not insured (Art 5 and Art 66 Para 1 HIA, and Art 17 of the Modifications and Additions Act to the HIA).



Non-administration of medical aid may be either a criminal or minor offence. Non-administration of medical aid is an offence punishable by a fine of HRK 10,000.00 to 50,000.00 for medical institutions, HRK 5,000.00 to 10,000.00 for medical personnel (Art 192 Para 1 Item 1, Para 2 and Para 3 HCA) and HRK 5,000.00 to 10,000.00 for doctors (Art 59 Para 1 Item 2 MPA).

Art 243 of the CC punishes non-administration of medical aid with a fine or jail sentence of a term not exceeding 2 years. This criminal offence is an omission violation, i.e. a violation by omission which is *lex specialis* to the criminal offence of not administering medical aid in Art 104 of the CC. The perpetrator may be a doctor of medicine, dentist, or any other member of medical personnel. The aid has to be urgent and necessary. The aid does not have to be requested - a doctor of medicine, dentist or any other member of medical personnel is liable for non-administration of medical aid regardless of the fact where he/she encounters the situation (at work or somewhere else). We are talking about a deliberate offence - the intention must involve the awareness of urgent aid because of a person's life being in imminent danger. We are talking here about a person's life being in abstract danger - it is not required that consequences have developed. In the case of grievous bodily harm, serious damage to health, a prior disease, or the person's death, it will be considered as a qualified form of basic act (Art 249 CC). An attempt is not punishable. Criminal proceedings are instituted by the state attorney *ex officio*. In available records of the Constitutional and Supreme Courts, we did not find any cases of non-administration of medical aid.

## 3.2. ADMINISTERING OF MEDICAL AID BY A DOCTOR LIVING WITH HIV

This issue is not regulated by Croatian legislation. The question here is whether it is safe for doctors living with HIV to perform invasive procedures during which the infection may be transmitted, and if they perform such procedures, under what circumstances they are allowed to do so. If this issue is regulated separately, it is usually in the following manner: a) the medical procedures that such a doctor is allowed to perform are limited and/or b) the doctor is obliged to inform the patient of his/her seropositive status before performing an invasive procedure, and is only allowed to do so if there is informed consent by the patient.

In regulating this issue, the following principles should be used as a starting point:

- a) the patient's health and well-being are more important than the infected doctor's right to perform invasive procedures;
- b) there is no minimal risk of transmission that is tolerable with diseases which might cause great damage or where there is a high risk of transmitting the infection;
- c) a patient's right to self-determination should be respected and their informed consent should be asked for before any invasive procedure is performed by an infected doctor.

## 3.3. SUGGESTIONS FOR MODIFICATIONS TO LEGISLATION REGARDING THE ADMINISTERING OF MEDICAL AID

1. The cases stated at the beginning of this chapter indicate the need to train doctors and other medical personnel in facts connected with HIV, as well as on their rights and responsibilities.





2. It would be good to create special rules of conduct for dealing with patients living with HIV - a patient living with HIV should be treated in the same way as any other patient suffering from a fatal disease.
3. Questions regarding discrimination, informed consent, confidentiality of information, settling of disputes, and so on, in connection with people living with HIV should be elaborated upon in more detail.
4. Employers' obligation to provide the necessary equipment should be regulated by legislation, as well as the obligation of medical personnel to follow standard work safety measures.
5. Specific medical care should be offered and provided for patients in terminal stages of illness in their homes (nurses specialised in AIDS).
6. The administering of medical aid by medical personnel living with HIV should be regulated by law.






4. MEDICAL  
RESEARCH  
ON PEOPLE  
LIVING  
WITH HIV

# HIV/AIDS IN THE LEGISLATION OF THE REPUBLIC OF CROATIA

The Republic of Croatia has ratified the Bioethical Convention, so the provisions of the Convention that are directly applicable have the force of 'supra' law in the Republic of Croatia. This refers to provisions of the Convention that stipulate methods of conduct for biomedical research. This research is determined by the Convention (Art 15-16) in the same way it is stipulated in the PPRA (Art 19-21). In connection with the conduct of biomedical research related to AIDS on people living with HIV, mandatory counselling should be stipulated before, during and after conducting the research, and there should be a guarantee and protection of confidentiality of all personal data as well as information resulting from the research.



A large, stylized pink awareness ribbon is positioned on the left side of the page. The ribbon is rendered with a gradient from light pink to a darker magenta, giving it a three-dimensional appearance. It is set against a background that is white on top and black on the bottom, separated by a horizontal line. A vertical dashed line, which is red on the white background and white on the black background, runs down the center of the page, passing through the ribbon.

# 5. HEALTH INSURANCE AND PEOPLE LIVING WITH HIV

The Health Insurance Act (HIA) determines three types of health insurance in the Republic of Croatia: basic, additional and private (Art 2 Para 1). Basic health insurance is compulsory (Art 2 Para 4) and is managed by the Croatian Institute for Health Insurance (CIHI) (Art 2 Para 5). Additional health insurance covers the difference in the cost of health care services that are not covered by basic health insurance, but only for persons who already have basic health insurance through the CIHI (Art 2 Para 6.). As far as private health insurance is concerned, persons may be insured for services not covered by the CIHI. The difference between additional and private health insurance is defined in Art 2 Paras 8 and 9, because additional health insurance is managed by the CIHI and insurance companies and private health insurance is managed by insurers. Both types of insurance are voluntary (Art 2 Para 10).

For persons insured with the CIHI, the cost of prevention and treatment with regard to HIV infection and other infectious diseases for which the law stipulates the implementation of measures preventing their spread, is completely covered (Art 17 Para 2 Item 1 Subparagraph 7 COA). A problem may appear in healthcare for people living with HIV, because their right under basic health insurance is limited to the right to use medications from the list of medications of the CIHI (Art 15 Para 1 Item 4 HIA). The decision on defining the CIHI List of Medications, in force from January 17th 2005, put three medications on the List (Zidovudin, Didanozin and Zalcitabin). As far as other medications used for HIV infection are concerned, like Indinavir, Ritonavir, Nelfinavir, Lopinavirpositive Ritonavir, Zalcitabin, Stavudin, Lamivudin, Lamivudinpositive Zidovudin and Nevirapin and Efavirenz, authorisation from the CIHI must be asked for. The CIHI generally approves the use of medications that are not on the List, because it is not up-to-date and does not keep up with the arrival of new medications.





6.  
TRANSMISSION  
OF HIV AS A  
CRIMINAL  
OFFENCE

There have not been any criminal proceedings in the Republic of Croatia regarding transmission of HIV. At the end of 2004, a question of the criminal liability of a man who allegedly infected two women through voluntary, but unprotected sexual relations appeared in the media. These articles, however, did not lead to institution of criminal proceedings.

The Croatian CC does not speak of a specific criminal offence of transmitting HIV, nor is transmission of HIV specified as qualifying circumstances in a criminal offence. Transmission of HIV may occur through sexual relations, but also in other manners (e.g. the sharing of needles between drug users, transfusion of infected blood, or transplantation of an infected organ, etc.) Regarding the manner of transmission, the transmission of HIV may fall into different categories of criminal offence.

If HIV was transmitted through sexual relations or an equivalent sexual act or in any other way (e.g. drug users sharing a needle), it could be regarded as the criminal offence of transmitting a sexually transmitted disease (Art 239 CC). If transmission occurs via infected blood or organs, it could be regarded as the criminal offence of transmitting an infectious disease (Art 238 CC).

## **6.1. TRANSMISSION OF SEXUALLY TRANSMITTED DISEASES**

This criminal offence is committed by a person who knows he/she is infected with a sexually transmitted disease and infects another person with that sexually transmitted disease through sexual relations or an equivalent sexual act, or in another manner, if this does not include the committing of the criminal offence of grievous bodily harm.

This is a criminal offence of injuring, so it has to involve the transmission of an infectious disease where the other person develops the disease. The offence can be committed against a spouse. The perpetrator has to know he/she is infected and that it is a sexually transmitted disease. It is not clear, however, how the courts will determine whether a person knew his/her HIV status. Does this only include persons who have had test results confirming they are HIV posi-



tive, or also persons that should know they are HIV positive (because of high-risk behaviour or certain symptoms), but who have not been tested. The Austrian theory proceeds from the fact that the latter case is a case of negligent transmission of infectious disease. If we accept this interpretation, there would be no possibility of punishment for transmission of sexually transmitted diseases according to the Croatian CC, since it is only possible to commit this act intentionally. However, this case may be interpreted as acting with indirect intention, as there is awareness of the possibility of infection and the person agrees to sex in spite of this.

There is also the question of whether the use of a condom eliminates the existence of the intention to transmit a sexually transmitted disease. UNAIDS recommends not making transmission of HIV in situations when the person living with HIV has undertaken safety measures (use of a condom) a crime. This is in order to lower the risk of transmitting the infection, regardless of the fact whether he/she has disclosed his/her status to the person he/she has sex with. The Austrian theory takes the position that in these situations there is no socially inadequate behaviour that would require punishment. In addition, there is no actual danger of transmitting the disease in these situations, which is another reason to rule out punishment.

The legislature has also left open the question of what happens if a person informs his/her sexual partner of his/her disease, and the latter still agrees to have sexual relations or an equivalent sexual act during which transmission of the infection occurs. Judicial practice could solve these cases in two ways. Firstly, if we start from the fact that "informed" consent is a reason to exclude unlawfulness, in such a case a criminal offence does not exist. A large part of the law stipulates that there is no criminal liability for the transmission of HIV after the partner has been informed of the disease and has, with the knowledge of the disease, consented to sexual relations. Secondly, as Bačić and Pavlović advocate in their Commentary on the CC, it is not important whether a perpetrator hides his/her illness before the other party. Consequently, the consent of the other party is not relevant in considering if a criminal offence has been committed. This conclusion arises from the belief that transmission of HIV is contrary to the public interest, so a person's consent does not exclude unlawfulness.<sup>37</sup> Since the CC stipulates that proceedings for this kind of criminal offence are instituted after the motion, except if the criminal offence was committed to the detriment of a minor, I believe that the interpretation saying that the informed consent of a person who is of age excludes unlawfulness is more accurate, while the consent of a minor would not have the same effect.

If a perpetrator infects more than one person, it would be a case of concurrence, i.e. more than one criminal offence for which a single sentence is pronounced. There is the possibility of concurrence of this criminal offence with certain sexual crimes (we are talking about ideal concurrence where a single sentence is pronounced). Since transmission of a sexually transmitted disease is a special form of transmission of an infectious disease, it excludes this criminal offence (apparent concurrence). If this criminal offence has caused grievous bodily harm, it will be considered as a criminal offence causing grievous bodily harm, and there will be no liability for the transmission of a sexually transmitted disease because the law explicitly specifies the apparent concurrence between the two criminal offences through the clause of subsidiarity. The question arises of whether transmission of HIV is grievous bodily harm at all, since it will not lead to serious impairment of health if a person takes medication regularly.

Criminal proceedings regarding the transmission of a sexually transmitted disease are instituted after the motion, unless the criminal offence was committed to the detriment of a minor. The suit has to be submitted within 3 months of the authorised natural person finding out about the criminal offence and the perpetrator. If the damaged party dies in the period of time limited for submitting suits, his/her spouse, children, parents, brothers, sisters, adoptive parents or adopted child may file a suit for prosecution within 3 months of his/her death (Art 47 Criminal PA). Consequently, the initiative is with the damaged party, but when the damaged party decides to institute criminal proceedings, he/she surrenders it to the state attorney's office, because the disease may be very dangerous and a criminal prosecution may be in the public interest.

37. This results from the ECourtHR case, *Laskey, Jaggard & Brown v. the United Kingdom* on January 20th 1997, No. 109/1995/615/703-705. Countries have a great margin of appreciation when deciding on whether a limitation of the right to privacy is necessary in democratic societies in order to protect the rights in Art 8 (2) of the EConventionHR. The case discussed whether the United Kingdom had violated the right to privacy by punishing people for voluntary participation in sadomasochist activities. The Court concluded that the United Kingdom had not acted against Art 8 (2) of the EConventionHR.



## 6.2. TRANSMISSION OF AN INFECTIOUS DISEASE

This criminal offence is committed by a person who does not act in accordance with the regulations or decrees by which the relevant government body regulates the examination, disinfecting and separation of patients or other measures for the suppression or prevention of infectious diseases, and this leads to the danger of spreading an infectious disease (Art 238 CC). This is punishable by a fine or term in jail not exceeding 1 year. Proceedings are instituted ex officio.

This is a criminal offence involving a material threat, which means the infection does not have to be transmitted, as it is sufficient that there is a real and direct possibility of spreading an infectious disease. A person is liable if there is intent (there has to be consciousness of not acting in accordance with a regulation or a decree, and awareness that it is an infectious disease and that his/her actions have led to the danger of spreading an infectious disease) or negligence. This criminal offence is committed by anyone who does not act in accordance with the regulations or decrees of government bodies, and may even be committed by an infected person, by doctors or other medical personnel, or by an infected person's family members, etc. For example, this criminal offence is committed by a person who, while taking blood, or removing organs or tissue, does not carry out the appropriate testing and puts into circulation blood, an organ or tissue that is HIV positive and thus leads to the actual danger of spreading the infection; or a blood donor who does not admit being a member of one of the high-risk groups that are excluded from being blood donors.

The Conditions for Removal and Transplantation of Human Organs Act (CRTHOA) stipulates that persons who participate in procedures of removing and transplanting organs and tissue, and who do not undertake all necessary measures to reduce the risk of transmission of any disease to the recipient or avoid activities that might adversely influence the quality of the organ or tissue to be transplanted, will be punished with a fine of HRK 5,000.00 to 10,000.00 (Art 36 Para 1 Item 3, in connection to Art 8). In cases when a person does not perform the appropriate test on organs and tissue that are HIV positive, and this results in further consequences, this will be considered as an offence under the CRTHOA. In cases where failure to perform the appropriate test on organs and tissue that are HIV positive results in the imminent possibility of spreading infection, it will be considered as a criminal offence under Art 238 of the CC.

Since it is not explicitly excluded, as with the criminal offence of transmission of an infectious disease, a concurrence of the criminal offence of transmission of an infectious disease and of inflicting grievous bodily harm is possible.

## 6.3. OTHER CRIMINAL OFFENCES THAT MAY BE APPLICABLE

Upon transmission of HIV, the following criminal offences may also be applicable: actual bodily harm, grievous bodily harm, unpremeditated bodily harm, murder, manslaughter and various sexual offences.

Voluntary sexual intercourse between same-sex partners does not represent a criminal offence in the Republic of Croatia.

With regard to the prevention of the spread of HIV, there is the question of legalisation, i.e. decriminalisation of soft drugs because of easier prevention and avoidance of soft drug users becoming intravenous addicts. There is also the question of the role of decriminalisation of prostitution in the prevention of HIV.





## 6.4. PROPOSALS REGARDING CRIMINAL LIABILITY

### 1. Do we need a separate criminal offence of transmission of HIV or is existing legislation sufficient?

The question is whether the transmission of HIV is a public health problem or a criminal law problem. There is no consensus on this question. The legislature has taken a position that the transmission of diseases is not only a public health problem, but also a criminal law problem. Furthermore, the legislature does not distinguish transmission of HIV from the transmission of other infectious or sexually transmitted diseases, and thus follows opinions prevailing in the rest of the world regarding the criminalisation of transmitting HIV.<sup>38</sup> A different attitude would result in discrimination against people living with HIV with respect to persons who suffer from other serious infectious diseases (e.g. hepatitis C). I therefore conclude that there is no need to write into Croatian criminal law a separate criminal offence of transmission of HIV. Criminal law is, generally speaking, not appropriate for fighting HIV epidemics. Coercive criminal law measures may create a dangerous illusion that something is being done, but they are not an effective answer to practices of high-risk sexual behaviour or sharing of needles between injecting drug users. They may also divert attention from more important action like education, voluntary testing, counselling and rehabilitation. In addition, criminalisation of HIV transmission would contribute to further stigmatisation of marginal and vulnerable groups, and might result in a decrease in voluntary testing. Criminalisation is justified, if it is justified at all, within a set of very narrow boundaries.

### 2. Should the transmission of sexually transmitted or infectious diseases be classified as a criminal offence with consequences or as a criminal offence of imperilling?

The prevailing opinion is that the transmission of sexually transmitted diseases, if punishable at all, should be penalised only in cases where the disease has actually been transmitted. As far as punishing the transmission of sexually transmitted diseases is concerned, it is believed that a theoretical danger should not be penalised. Punishment of a concrete danger may be considered if deterrence (general prevention) is believed to be the most important goal of criminalising this offence.<sup>39</sup>

### 3. Should only an intention be penalised or negligence too?

When we are talking about the spreading of infection on the part of a person living with HIV, it is believed that only the intention should be penalised, or there might be discrimination against drug users, commercial sexual workers and sexual minorities. Therefore, a person should be punished only if it can be proved that at the moment of activity, the person knew he/she was HIV positive and that he/she knew his/her behaviour presented a significant risk (actual danger) of transmitting the disease.<sup>40</sup> This is partly covered in the Croatian CC, as transmission of a sexually transmitted disease is penalised only if it is intentional. We should reconsider whether it is necessary to limit punishment for the transmission of infectious diseases to intention when the infected person transmits an infection.

### 4. Should consent to sexual relations or sharing a needle exclude unlawfulness?

The prevailing opinion is that a person's consent to sexual relations or an equivalent sexual act when they are aware of their partner's HIV status (this should refer to both married couples and partners that are not married), or consent to sharing a needle with a person that the other person knows is HIV positive, regardless of the degree of risk in such behaviour, should be a reason for excluding unlawfulness.<sup>41</sup> It would be good if

38. The question is whether the transmission of HIV is a public health problem or a criminal law problem. There is no consensus on this question. The legislature has taken a position that the transmission of diseases is not only a public health problem, but also a criminal law problem. Furthermore, the legislature does not distinguish transmission of HIV from the transmission of other infectious or sexually transmitted diseases, and thus follows opinions prevailing in the rest of the world regarding the criminalisation of transmitting HIV

See, Criminal Law, Public Health and HIV Transmission, A Policy Option Paper, UNAIDS/02.12E, June 2002, available at [www.unaids.org](http://www.unaids.org) .

39. Ibid.

40. Ibid.

41. Ibid.



Croatian legislation stipulated this explicitly, and did not to leave it to judicial practice to decide freely. An exception might be stipulated in cases when the sexual partner or person sharing a needle is a minor.

There is, however, the opinion that consent to sex, regardless of whether the person knew he/she was engaging in sexual intercourse with a person living with HIV, should exclude the unlawfulness of transmission of HIV through sexual intercourse, because by consenting, the person consents not only to sexual relations, but also to all risks in connection with sexual intercourse (except, of course, if the person living with HIV has lied about his/her status after being asked explicitly - this would be intentionally misleading, so the consent would not be valid). In addition, it should be taken into account how difficult it is for a person to disclose his/her HIV status to another person, because of discrimination and stigmatisation resulting from such a status, and fear that their partner will find out about his/her infidelity.<sup>42</sup>

#### 5. Should use of protection exclude unlawfulness?

Use of protection should be a reason to exclude unlawfulness in cases when a partner was not informed of a person's HIV status and his/her consent to sexual intercourse was not asked for, since there was no intention to infect a person.<sup>43</sup> Cases in which protection was used but was not efficient are dubious. If these circumstances do not exclude unlawfulness, they should definitely be taken into consideration as extenuating circumstances when sentence is pronounced.

#### 6. Should the proceedings in cases of transmission of sexually transmitted diseases be instituted ex officio?

The answer to this question depends on the degree to which public health is protected if this is considered a criminal offence. If protection of public health is given priority, these proceedings should be instituted ex officio. But institution of these proceedings should not be enabled ex officio if a person's consent is not recognised as a reason to exclude unlawfulness.

#### 7. Offence liability

In the same way that the CRTHOA classifies the omission of controls on organs and tissue that are transplanted as an offence, the Blood Supply Act should stipulate cases of omission of blood controls as an offence.

#### 8. Misconceptions

It is recommended that the conviction of a person living with HIV that his/her partner knows about his/her condition and consents to sexual intercourse in this knowledge, as well as lack of knowledge on ways of transmitting the disease, represent a misconception that excludes criminal liability.

#### 9. Decriminalisation of possession of soft drugs for personal use

The question here is whether decriminalisation, i.e. legalisation of possession of soft drugs for personal use, is desirable from the point of view of preventing the spread of HIV.

#### 10. Decriminalisation of prostitution

We should reconsider whether decriminalisation of prostitution is desirable as a means of preventing the spread of HIV.

42. See National AIDS Trust (NAT), criminalisation of HIV Transmission - NAT Policy Update, June 2005.

43. Supra note 37





7.  
HIV,  
PRISONS AND  
PRISONERS'  
RIGHTS

Prisoners have a high risk of being infected with HIV, either as intravenous drug users or by participating in high-risk sexual relations. Nevertheless, the number of prisoners living with HIV in the Republic of Croatia is still very small.

In prison conditions, it is difficult to maintain quality healthcare, quality of life (quality diet, sport activities, and so on), and confidentiality of information, and there is increased danger of stigmatisation. Therefore, special attention should be paid to the protection of prisoners living with HIV.

When a prisoner is admitted into prison to serve a term, as well as when he/she is released, a medical examination is necessary (Art 104 Para 1 SPSA). This examination does not include HIV testing. The Serving of Prison Sentences Act (SPSA) does not forbid testing on entering prison, so it would be possible, though there are probably no financial means to carry it out. Most countries do not perform mandatory testing of prisoners (e.g. in the USA only 14 states perform mandatory testing of prisoners, and 6 of them segregate prisoners living with HIV; Great Britain introduced mandatory testing of prisoners and later banned it). Mandatory testing of prisoners is questionable from the aspect of protection of privacy and freedom. Even though there has not yet been such a case at the ECourtHR, a great number of leading figures consider this practice to be contrary to Art 8 of the EConventionHR. In addition, the effectiveness of this kind of testing is also questionable, because of the period during which it is practically impossible to prove the existence of infection.

The SPSA stipulates that testing for infectious diseases, as a special measure for maintaining order and security, may be ordered if there is a threat to the maintenance of order and security (Art 135 Para 2 Item 7 SPSA). This mandatory testing is not justified, and this possibility should be left out of the SPSA.

Confidentiality of information in medical record files and personal files concerning a prisoner's HIV status should be regulated more precisely. This information should be available to other persons, except medical personnel, only with the consent of the person living with HIV. The provision on confidentiality of information in personal files is too broad in this sense (Art 72 SPSA), and a provision on confidentiality of information in medical record files is missing.



According to figures from the NGO CAHIV, only one prisoner has, so far, complained about treatment in prison. He was, allegedly, put into solitary confinement in the prison in Remetinec for a month because of his HIV status. The question is raised whether isolation or segregation of prisoners living with HIV may represent inhumane or humiliating treatment. The ECourtHR has not had such a case yet. Inhumane treatment means intentional infliction of grievous mental or bodily suffering. It has to be considered in terms of its relevant gravity.<sup>44</sup> Humiliating treatment means any act that diminishes the position, reputation or character of a person, if it reaches a certain gravity.<sup>45</sup> Coercive segregation or isolation of prisoners living with hiv would probably be considered inhumane treatment, but it could also, depending on the circumstances, be characterised as humiliating treatment, particularly because public health experts do not consider such a measure as necessary.

## 7.1. PROPOSALS FOR TREATMENT OF PRISONERS LIVING WITH HIV

1. Practice of non-mandatory HIV testing upon prisoners' admission should be maintained.
2. Testing under Art 135 Para 2 Item 7 of the SPSA should be abolished.
3. The SPSA should regulate the confidentiality of medical records more precisely.
4. Putting prisoners into solitary confinement due to their HIV status should be avoided because it can be interpreted as humiliating treatment in contravention of Art 3 of the EConventionHR.
5. Special courses should be organised for correctional facilities' health personnel on how to diagnose hiv and how to treat people living with hiv. This is the task of local public health institutes, but unfortunately such training is not available.

44. Denmark et al. V. Greece (1969) Yearbook of the European Court of Human Rights 12, Ireland v. United Kingdom, European Court of Human Rights, Series A, Judgement of 18 January 1978).

45. East African Asians case (3 European Human Rights Reports 1976).





8.  
COMPENSATION  
FOR  
DAMAGE

The institution of compensation for damage is a mechanism used by society in order to divert a person from exposing another person to an unreasonable risk as well as to compensate those who have suffered damage caused by unreasonable behaviour. In relation to HIV, compensation claims in most cases are triggered by the transmission of HIV by infected blood, which implies the question of liability of hospitals, blood banks and others who have participated in blood transfusions with infected blood. In addition, there are compensation claims in cases of HIV-transmission via sexual intercourse or by needle sharing. There might also be claims for compensation by children of infected parents against doctors, and claims by parents or patients themselves against infected doctors if the patients were not informed of the doctor's infectious condition, as well as claims for damages for unauthorised disclosure of a person's HIV status. Finally, there is also the question of the possibility of compensation for fear resulting from the possibility of transmission of the disease even though infection did not occur.

There have been no compensation claims related to transmission of HIV or unauthorised disclosure of HIV status in Croatia. If they appeared, they would be subject to the application of general regulations on compensation for damages stated in the Civil Obligations Act (COA) (The PRPA prescribes in Art 29 that patients are entitled to compensation for damages in accordance with the general regulations of the law on obligations.) As of January 1, 2006, the new COA will come into force. In this text, we will analyse the provisions of the new COA, while references to corresponding provisions of the old COA that are still in force will be quoted in footnotes and commented on where they differ from the new COA.

## **8.1. COMPENSATION FOR TRANSMISSION OF INFECTION**

In cases of deteriorating health due to the transmission of infection, the infected person is entitled to claim compensation for medical treatment and other related costs and for salaries



withheld due to inability to work during his/her medical treatment (Art 1095 Para 1 of the COA)<sup>46</sup> as well as for non-material damages (violation of personal rights - e.g. physical pain, mental anguish and fear sustained - Art 1046 of the COA in relation to Art 1100 Para 2 of the COA).<sup>47</sup> If the afflicted person loses his/her pay due to complete or partial inability to work, or if his/her needs are permanently augmented, or if possibilities for his/her further development and promotion are destroyed or reduced, the responsible person must pay to the afflicted person a certain sum as compensation for the damage (Art 1095 of the COA).<sup>48</sup>

In the case of a person's death, the one who caused the death by transmitting the infection must pay the indemnity for: a) regular funeral costs, medical treatment costs for injuries sustained and other necessary costs related to medical treatment; b) salaries that were not paid due to the inability to work (Art 1093 of the COA)<sup>49</sup>, c) subsistence costs or costs for supporting the person supported or regularly taken care of by the deceased as well as for persons who would have the right to request subsistence from the deceased by law (Art 1094 Para 1 of the COA)<sup>50</sup> and d) non-material damage to the spouse, children, and parents as well as to partners, brothers, sisters, grandparents and grandchildren in cases where they were living in a common household with the deceased (Art 1101 of the COA).<sup>51</sup>

In cases of death, bodily harm or damaged health the compensation is, as a rule, determined as an annuity to be paid for life or for a certain period of time, in which case it is paid monthly and in advance (Art 1088 Paras 1 and 2 of the COA).<sup>52</sup> Loss of subsistence is also compensated for by payment of an annuity the amount of which is established by taking into account all the circumstances of each case and cannot exceed the amount which the injured party would be entitled to receive from the deceased if he/she were alive (Art 1094 Para 2 of the COA).<sup>53</sup> A court may increase the annuity in the future if requested by the injured party, but can also reduce it or cancel it when requested by the damaging party in cases of a substantial change in circumstances taken into consideration in the previous decision by the court (Art 1096 of the COA).<sup>54</sup> The right to compensation for damages paid as an annuity due to the death of a close person or for bodily harm or deterioration of health is not transferable to another person except for due amounts of compensation if the amount to be compensated is agreed upon in a written agreement between the parties or by a valid court decision (Art 1097 of the COA).<sup>55</sup> Compensation claims for non-material damage is transferable to a successor if the injured party submits a written claim or a complaint.<sup>56</sup>

Persons are liable for damage caused by death or deterioration of health under the principle of guilt i.e. if the damaging party caused the damage on purpose or due to neglect (Art 1045 and Art 1049 of the COA).<sup>57</sup>

### 8.1.1. Compensation for transmission of HIV infection by blood transfusion

Hospitals and blood banks are liable in their capacity as employers for the damage caused by their employees to a third person. They are also liable as legal persons for damage caused to a third party by hospital bodies in relation to the performance of their functions. An injured party is also entitled to directly request the employee to repair the damage if he/she caused the damage intentionally. Hospitals and blood banks, as employers, are entitled to request from their employees compensation for costs for repairing the damage if the damage was caused on purpose or due to neglect. This right is limited to six months starting from the day when the damage was established (Art 1061 and Art 1062 of the COA).<sup>58</sup> The hospital or the blood-bank will be considered negligent if infection is transmitted by blood transfusion if they did not pay the attention that is considered standard for hospitals and blood-banks in similar situations and circumstances (liability on the principle of presumed subjective guilt - the damaging party needs to prove that he/she is not guilty or that the procedure was performed with

46. Art 195 Para 1 of the old COA

47. The law that is still in force draws a distinction between compensation for material (medical treatment and other related costs, non-paid salaries due to inability to work - Art 195 Para 1 of the COA) and non-material damage (physical pain endured, mental pain endured due to reduced activities, disfigurement, fear - Art 202 Para 2 of the COA)

48. Art 195 Para 2 of the old COA

49. Art 193 of the old COA

50. Art 194 Para 1 of the old COA

51. Art 201 of the old COA includes only brothers, sisters and partners if they were living in a common household with the deceased

52. Art 188 of the old COA

53. Art 194 Para 2 of the old COA

54. Art 196 of the old COA

55. Art 197 of the old COA

56. According to the old COA, compensation claims for non-material damage is transferable to a successor only if it is recognized by a valid court decision or a written agreement (Art 204 Para 1 of the old COA)

57. Art 154 Para 1 and Art 158 of the old COA

58. Art 171 and Art 172 of the old COA





an increased level of consideration, and the consideration of a good employer).

This kind of transmission of infection raises the following questions:

1. 1. Could courts set lower compensation in cases of transmission of infection by blood transfusion or organ transplantation, since the damaging party caused the damage while doing something useful for the injured party?

Could the one who produced the infected blood and put it into circulation be liable in accordance with the principle of objective responsibility (liable for damage caused by a deficiency he/she did not know of)? In other words, could blood and blood preparations be treated as products or could blood transfusions be treated as a dangerous activity (Ref. Art 1073-1080 of the COA).<sup>59</sup>

In Slovenia, a separate law was passed on indemnification of persons infected by HIV via blood infusion (IPHIVA).<sup>60</sup> According to Art 1 of this Act, the right to compensation for damage is guaranteed to all persons who contracted infection prior to January 6, 1986 because at the time the method of blood warming was not used. Under the pressure of the European Court of Human Rights, a similar law was passed in France in relation to the period between March 12 and October 1, 1985. A similar law should be passed in the Republic of Croatia, too.

### 8.1.2. Compensation for transmission of infection via sexual intercourse or needle sharing

If a person has consensual sexual intercourse or an equivalent sexual act or agrees to sharing a needle with a person who has informed him/her that they are HIV positive, or if the person knew otherwise that the person was HIV positive, he/she is not entitled to compensation for damaged health or death (Art 1054 of the COA).<sup>61</sup> Could the provision on divided liability be applied in such cases (Art 1107 of the COA)?<sup>62</sup> There is also a question whether the person was aware of the consequences of needle sharing or having sex with an HIV positive person. Is there an obligation for compensation for damage to the spouse in such cases?

According to Art 1102 of the COA, the right to fair indemnification for non-material damage belongs to a person who has suffered a criminal act against sexual freedom and sexual morals committed by deceit or force or by abuse of a relationship of subordination or dependence. It seems to me that it would be relevant to define compensation for transmission of HIV through such a criminal offence.<sup>63</sup>

## 8.2. COMPENSATION IN CASES OF DEFAMATION OF CHARACTER OR UNAUTHORISED DISCLOSURE OF HIV STATUS

Every person insulting or giving or diffusing untrue information about another person which he/she knows or should know to be false, thus causing material damage to that person, must provide compensation for his/her act. A person communicating an untrue statement is not liable for the damage caused if he/she is not aware of its false nature and when that person or the person to whom the statement was communicated has a serious interest in it (Art 1098 of the COA).<sup>64</sup>

Unauthorised disclosure of HIV status (meaning breach of doctor-patient confidentiality) implies liability for damages in accordance with general regulations.

59. In this sense refer to Art 179 of the old COA

60. The Indemnification for Persons Infected with HIV through the Transfusion of Blood or Blood Preparations Act (PIHIVA), Official Gazette of the Republic of Slovenia RS 36/1997

61. Art 163 of the old COA

62. Art 192 Para 1 and Art 205 of the old COA

63. Such provision is unknown in the old COA

64. Art 198 of the old COA





### **8.3. COMPENSATION FOR FEAR RESULTING FROM THE POSSIBILITY OF TRANSMISSION OF THE DISEASE EVEN THOUGH INFECTION DID NOT OCCUR**

In cases of violations of personal rights, the court's ruling will include fair financial compensation, independent of compensation for material damage even when there isn't any, if they find that the gravity of the violation, as well as the circumstances of the case, justify it (Art 1100 Para 1 of the COA).<sup>65</sup> This means that, according to Croatian law, indemnification for fear sustained because of the possibility of transmission of the disease would be possible even though the infection did not occur.

### **8.4. PROPOSALS RELATED TO COMPENSATION FOR DAMAGE**

A separate act on compensation for persons infected with HIV by blood transfusion needs to be passed. Even if all patients infected in this way have died by now, the passage of such a law is necessary in order to regulate the rights of their successors. We should also think of the need for compensation from the hospital (state) and reflect on conditions in which the hospital (state) undertakes all standard measures of protection, in other words the possibility of imposing objective liability, as well as foreseeing reasons for discharge from liability.

65. Art 200 Para 1 of the old COA





9.  
CHILDREN  
AND HIV

It should be noted that in the Republic of Croatia there is a lack of provisions protecting the rights of children living with HIV as well as a lack of instructions related to dealing with and the treatment of such children. The Republic of Croatia has ratified the Convention on the Rights of the Child. The main articles of this Convention concerning children and HIV are: Art 3, according to which any activity towards a child needs to take into consideration his/her best interest; Art 12 in which children are entitled to express their opinion and have the right to have this opinion taken into account; Art 16 guaranteeing the right to privacy and Art 24 guaranteeing to children the right to the highest possible level of health and access to health services.

## 9.1. CHILDREN'S RIGHT TO CONSENT

According to the PPRA, consent for a juvenile patient is signed by a legal representative or foster-parent, except for cases of urgent medical intervention. Legal representatives or foster-parents may withdraw their consent at any time by signing a declaration of refusal of a certain diagnostic or therapeutic procedure. If the interests of a juvenile patient and his/her legal representative or foster-parent are opposed, a health professional must immediately inform the competent social welfare centre of this (Art 17 of the PPRA). In cases of emergency, diagnostic or therapeutic procedures may be carried out without the consent of the legal representative or foster-parent, but only for as long as the danger exists (Art 18 of the PPRA).

Consequently, the consent for HIV testing of a juvenile patient (it would be better to say a child patient) is given by his/her legal representative or foster-parent. Such a provision is not in conformity with Art 12 Item 4 of the Convention on the Rights of the Child, which obliges states that are signatories to the Convention to ensure that a child's opinion is taken into consideration in accordance with his/her age and maturity when he/she is able to reach independently his/her own judgments and express his/her opinions on matters that concern him/her. Similarly, the Croatian Family Act states that a child is entitled to express his/her opinion, which is taken into consideration according to his/her age and maturity, when it concerns procedures involving decisions on the child's rights or interest (Art 89 Para 5 of the FA). This also presumes, when possible and taking into considera-



tion the child's abilities, to give the child the right to accept or refuse HIV testing, naturally in accordance with his/her age and abilities.<sup>66</sup>

In this context, another issue becomes evident, the one on when and to what extent children should be told about their HIV status and who should decide about it. Some guidelines should be made in this regard.

## 9.2. CHILDREN'S RIGHT TO PRIVACY

Art 16 of the Convention on the Rights of the Child guarantees children's right to privacy. In Croatia, we do not have separate regulations on the protection of data confidentiality concerning children with HIV status. If children were entitled to agree upon diagnostic or therapeutic treatment in accordance with their capacities, thus including the right to decide on HIV testing, a particular regulation on the confidentiality of a child's medical data would be required. For example, in England, a child over 16 years of age must consent to disclosing information on his/her HIV status to his/her parents.

Special attention should be paid to regulation of information on the state of a child's health in adoption procedures, as well as on the availability of such information. According to the Family Act and the Ordinance on Keeping Personal Records and Files on Adoption (KPRFAO), an adoption dossier is an official secret and is kept separately from other files in such a way as to ensure protection of the official secret as well as protection against abuse, destruction and damage. This is archival material of permanent value. Experts in social welfare centres are obliged to keep official secrets related to adoptions even after they cease to work on such cases or in a particular social welfare centre. The Minister of Health and Social Welfare or other officials from the ministry authorised by the Minister may absolve an expert from keeping an official secret in judicial or administrative proceedings if it concerns data indispensable to establishing the state of facts and reaching a lawful decision (Arts 135-142 of FA and Arts 12-14 of the KPRFAO). In the KPRFAO there is no mention of a child's medical record. This should be regulated separately. In adoption proceedings, as well as in other matters where social services keep files about a child, data on his/her HIV status should be particularly well protected and available only to a very limited number of persons.

The Primary Education Act, Secondary Education Act and Science and Higher Education Act neither contain special provisions on data confidentiality concerning children or persons attending primary, secondary or higher education institutions, and nor do they regulate whether such information should be disclosed, and to whom, when children are enrolled in school. The danger of transmission of HIV infection is considered minimal in normal hygienic conditions in schools, so there should be a regulation limiting the number of persons to whom information on the HIV status of an enrolled child should be available. The persons who should know about it should be determined precisely and should assume the obligation to keep such information as an official secret.

Special attention should be paid to the protection of privacy in the media of children living with HIV. According to the Croatian Journalists' Code of Honour "a journalist may not interview a child (younger than 14 years of age) about his life or the life of other children, nor can he/she take his/her picture in the absence of parents or another adult responsible for the child". In its report for 2003, the Office of the Ombudsman for Children condemned the disgraceful work of journalists in the case of "girl E" (as mentioned in the report). Consequently, at the beginning of 2004 an initiative was raised with the aim of improving the Croatian Journalists' Code of Honour in order to achieve better protection of children with regard to their privacy.

Everything mentioned with regard to the protection of privacy in Section 2 of this text also applies to children.

66. According to the opinion of The Centre for Reproductive Health at the Zagreb Clinic for Children's Diseases, request for parents' consent will discourage many sexually active adolescents (minors), and particularly those from high-risk groups, from counselling and voluntary testing. Dr. V. Jureša of CMC shares this opinion and thinks that the legislature should regulate at what age (15 or 16) minors themselves could give their consent to testing.



### 9.3. TAKING CARE OF CHILDREN LIVING WITH HIV

The state does not have a regular model for taking care of children living with HIV. There are no separate regulations regarding their adoption or placement in a foster-home. There is, however, a Decision regulating a monthly allowance rate for accommodation for children living with HIV with foster-families, which amounts to 1,250% of the basic rate (Art 1 Para 1 Item 3). This allowance can be further increased by a maximum 20% if the needs of a child living with HIV have been augmented (and/or become specific) due to his/her health condition, disability, personality or other reasons, thus requiring more extensive services of a better quality from the foster-family (Art 1 Para 2 of the Decision).

There is also the question of whether, and to what extent, the HIV status of a parent is relevant in making custody decisions in divorce cases and in determining what kind of contact a child can have with a parent living with HIV when they live separately. In their observations on this text, the Ministry of Health and Social Welfare emphasised that parental capacities and childcare decisions in different proceedings instituted in accordance with the FA are assessed in the same way as other cases, and are guided primarily by the child's best interests. Consequently, the Ministry feels that there is no need for any special directives. The author of the text, however, feels that such directives would be useful in a society that stigmatises and discriminates against people living with HIV and is prejudiced against them.

### 9.4. EDUCATION

With regard to the right to education of children living with HIV, special attention needs to be paid to the following: 1) the right of children to freely attend school and to be treated in the same way as other students (prohibition of discrimination); 2) the right to privacy of information on their HIV status and the availability of such information only to those persons for whom this is indispensable, and who consequently need to keep it as an official secret; 3) increased hygiene conditions in schools, which contributes to limiting the number of persons who need to be aware of the HIV status of a child; 4) anticipation of special needs in education of children living with HIV.

The Primary Education Act, Secondary Education Act and Science and Higher Education Act are at no point discriminatory towards children living with HIV, but on the other hand they do not guarantee these children equal rights to education, either. The Ela and Nina cases revealed the unwillingness of our society to accept children living with HIV as equal and normal participants in the education process. Such examples of rejection of children living with HIV at school or the withdrawal of healthy children from school have been noted in other legal systems, too. Great Britain has tried to solve the problem through systematic education of the population. In America, the solution has been sought in courts.

A broad educational campaign about HIV transmission should be organised in the Republic of Croatia in order to fight prejudice. When drawing up the yearly report for 2003, the Ombudsman for Children concluded that the integration of girl "E" with other children was at a very minimal level.

Information on transmission of HIV, as well as on the consequences of this disease, should be included in the framework of sex education in schools. The Ministry of Health and Social Welfare has produced a programme called MEMOAIDS, but it is not compulsory. The Ministry of Science, Education and Sport plans the introduction of healthcare education that



should be mandatory in schools, but the approach towards sexually transmitted diseases is not yet known. Children should be taught about adequate and non-exclusive measures of protection. We should think about whether to give parents the right to decide if their child will attend sex education and what the contents of such a programme would be. The sex education programme must include aspects of human rights, as well (the protection of rights of people living with HIV).

It must be taken into account that children living with HIV might have special educational needs and that their HIV status should be considered when assessing whether the conditions for special educational needs exist.

## **9.5. PROPOSALS REGARDING IMPROVEMENT OF THE STATUS OF CHILDREN LIVING WITH HIV**

1. The right of a child to give his/her consent for medical treatment (particularly in connection with HIV testing) should be introduced into legislation in accordance with the Convention on the Rights of the Child and Family Act.
2. Instructions on how to treat children living with HIV should be drawn up (who should tell them about their HIV status and when, who can decide on it, how to manage various situations that involve children living with HIV, e.g. who should be informed about the child's health condition in adoption proceedings and when).
3. The confidentiality of data concerning the HIV status of a child must be ensured at all levels - in medical documentation, in school records, in medical records in adoption proceedings, as well as in the media.
4. Sex education should include information on the transmission of HIV and the consequences of infection, but also on all effective means of prevention.
5. The special educational needs of children living with HIV should be met as they occur.
6. A data base of foster parents willing to accept children living with HIV should be created.





10.  
HIV AND  
EMPLOYMENT



People living with HIV are often discriminated against at work by employers as well as by other employees. Quite often these persons get fired or demoted to a less well-paid post when their HIV status is disclosed. For example, in 1998/99 the employer of a 34-year-old mother with three children living in a rural area would not let her come back to work after he found out she was HIV positive, and demanded she stayed on sick leave despite her doctor's view that she was able to work. In 2004, a chef who informed his employer of his HIV status was demoted to the position of chef's assistant. His qualifications were not taken into account and his salary was reduced. When he complained about it, he was told he could leave if he was not happy.<sup>67</sup>

Discrimination at work and in connection with work may take various forms: requests for mandatory testing as a precondition for employment, withholding of employment and dismissal due to HIV status, impeding of promotion at work, or employment of people living with HIV in badly paid positions, etc.

## **10.1. INTERNATIONAL GUIDELINES ON HIV/AIDS WORKPLACE POLICIES**

International Guidelines on HIV/AIDS and Human Rights (1998) quote the following rights of people living with HIV at work (a number of measures that should be implemented within legal and work agreements):

- 1) 1) freedom from HIV testing for the purpose of recruitment or promotion, the right to health insurance, and support in voluntary HIV testing and counselling activities;
- 2) confidentiality of all medical information, including HIV status, and the possibility of their disclosure only when this is consensual;
- 3) security of employment for an employee living with HIV as long as he/she is able to do the job with some reasonable minor adjustments in the workplace and tasks;

67. Information source - NGO CAHIV



- 4) definition of first aid procedures and the existence of adequate first aid kits in the workplace; employees should be given advice, support, and medical services; when the costs of the above benefits are too high, employers may ask the relevant government and non-governmental organisations for assistance;
- 5) protection of all benefits that employees living with HIV are entitled to (life insurance, pensions, health insurance, etc.);
- 6) adequate healthcare facilities at work or near the place of work;
- 7) inclusion of employees living with HIV in the decision-making process concerning issues such as the policy of the employer towards HIV, the prevention of further transmission of infection, and protection of all employees against discrimination related to HIV;
- 8) access to information and education programmes concerning HIV for all employees;
- 9) protection against discrimination by colleagues, organisations, employers or clients. In this sense there should be inspections of the working environment and a legal framework should be established allowing for disciplinary measures against those employees who, in one way or another, discriminate against people living with HIV at work.

The International Labour Organisation (ILO) suggests a number of measures to be implemented by government bodies as well as employers and their organisations with the purpose of raising awareness and prevention of HIV in the labour and employment sectors. Among others, there is a suggestion to found national HIV councils that would involve representatives of employers, trade unions, persons living with HIV, and ministries responsible for labour and social issues. There is also a proposal to create a system of prevention programmes, especially at work. Benefits for employees living with HIV should be made equal (through legal acts passed by the responsible bodies) to benefits of those employees who have other serious illnesses. State bodies should insist on setting up a legal framework and, as necessary, review labour legislation with the aim of eliminating discrimination at work and defining the social status of people living with HIV. The implementation of such legislation should be ensured through the education of labour inspectors and specialised courts. Particular attention should be given to those employee groups who are exposed to an increased risk of HIV infection at work in order to diminish the risk factors.

## 10.2. DISCRIMINATION AT WORK OR IN CONNECTION WITH WORK

The Labour Act (LA) prohibits direct<sup>68</sup> and indirect<sup>69</sup> discrimination against a person seeking employment or against an employed person on grounds of, among other things, sex, sexual orientation or physical or mental difficulties (Art 2 Para 1). Discrimination is prohibited with regard to: a) recruitment conditions (including criteria and conditions for selection of candidates); b) promotion at work; c) access to upgrading and training; d) employment and work conditions; e) the right to membership and participation in various labour organisations (Art 2 Para 4 of the LA); f) dismissal. However, so-called positive discrimination is allowed, which means measures aimed at special protection and help for certain categories of workers (the disabled, pregnant women, mothers, and so on) (Art 3 Para 2 of the LA).

Harassment and sexual harassment also represent a form of discrimination. Harassment means any unwanted behaviour based on any of the grounds enumerated in Art 2 Para 1 of the LA, aimed at or resulting in the violation of the dignity of a person seeking employment or of a worker, and which is caused by fear or by an unfriendly, humiliating or offensive environment.

68. Direct discrimination takes place if a person is put or might be put in a less favourable position due to his/her sex, sexual orientation, physical or mental difficulties or any other reason quoted in the Labour Act (Art 2 Para 2 of the LA).

69. Indirect discrimination takes place when a certain regulation, criterion or practice that seem neutral puts or might put a person in a less favourable position in comparison with other persons due to any of the reasons quoted in the Labour Act (Art 2 Para 3 of the LA).



Thus, stigmatisation related to HIV status might represent harassment, and therefore, discrimination. Sexual harassment means any verbal, non-verbal or physical behaviour aimed at or resulting in the violation of the dignity of a person seeking employment or of a worker, and which is caused by fear or by an unfriendly, humiliating or offensive environment. The stigmatisation of homosexual men living with HIV or of homosexual men who are believed to be HIV positive might represent sexual harassment.<sup>70</sup>

Prohibition of discrimination, the right to privacy and the right to work are not absolute rights. In other words, there might be exceptions. According to the practice of the ECourtHR, a procedure will be considered discriminatory if there is no objective and reasonable justification with regard to the purpose and consequences of such an act, as well as if there is a disproportion between the means and goals.<sup>71</sup> Taking this into account, the LA does not regard as discrimination any act of differentiation, exclusion or giving priority to someone to perform a certain job, as long as the nature of the work itself or the working conditions are such that the reasons quoted as possible grounds for discrimination in the LA represent genuine and decisive conditions for performing the work in this way. This is under the condition that the goal to be achieved is justified and the restriction proportionate (Art 3 Para 1 of the LA). In the Republic of Croatia, there is still no jurisprudence that can define more precisely in which cases a hypothetical exclusion of a person living with HIV from work might not be considered discriminatory.

In foreign jurisprudence, on the other hand, it has become clear that it is up to the employer to prove that the requirement for HIV negative status is bona fide and represents a necessary prerequisite for the job, as well as there being an increased and genuine risk of transmission of infection in the workplace. So, for example in Canada, it was concluded that a fire-fighter living with HIV can do the job without representing a danger to himself/herself or others,<sup>72</sup> that a soldier does not have the obligation to "bleed safely",<sup>73</sup> that a doctor may do his/her job if the patient is informed of the doctor's HIV status<sup>74</sup> and that a flight attendant living with HIV only theoretically but not genuinely represents an increased risk of transmission of HIV infection.<sup>75</sup>

### 10.2.1. Examples of discrimination based on HIV status in Croatian legislation

Several employment regulations specifying health requirements for performing work find HIV infection a permanent obstacle for employment or continuation of work.

According to the Ordinance on the Definition of Health Conditions Required of Aircrews and Conditions to be Fulfilled by Medical Institutions Performing Medical Examinations of Aircrews, a license cannot be reissued to a person living with HIV. The Ministry of Health and Social Welfare may reconsider issuing licenses to persons living with HIV for flying in multi-member crews or flying with a safety pilot depending on the interval between examinations. The manifestation of AIDS or a group of symptoms related to AIDS are disqualifying (Chapter 7 of the Ordinance). This Ordinance was created in accordance with the Manual of Civil Aviation Medicine, but fails to regulate, unlike the Manual, that all people living with HIV who are in good health and asymptomatic should keep their license (see Chapter 9, Para 3 of the Manual) with the restriction of flying in multi-member crews.

The Ordinance on the Definition of Health Conditions Required of Maritime Vessel and Inland Navigation Vessel Crew Members considers HIV a permanent obstacle for working on a vessel at medical examinations before they are employed, as well as for the continuation of employment on a vessel, no matter the post or workplace.

The Ordinance on Methods of Definition of General and Specific Health Conditions Required of Guards and Security Guards in Private Security Services sees HIV positive serum results as a contraindication for performing guards' tasks.

70. *Smith and Grady v. UK*, No. 33985/96, 33986/96 (July 25, 2000) and *Perkins and R. v. UK*, No. 43208/98 and 44875/98 (October 22, 2002). The persons were interviewed by the employer (the army) and asked about their sexual orientation and HIV status. The ECourtHR found these questions discriminatory.

According to the Croatian LA, it is also prohibited for the employer to ask the employee about data that is not directly connected to his/her job (Art 27 LA).

71. *Belgium Linguistic Judgement*, judgements of February 9, 1967 and July 23, 1968

72. *Doe v. District of Columbia*, refer to [www.iaff.org/safe/content/infdis/John\\_Doe\\_v\\_District\\_of\\_Columbia\\_et\\_al.htm](http://www.iaff.org/safe/content/infdis/John_Doe_v_District_of_Columbia_et_al.htm).

Last checked on July 19, 2005

73. *Canada (Attorney General) v Thwaites* (1994), 94 CLLC 17040, Federal Court of Canada, Gibson J. For more information refer to R Ellis, P Engelmann. *HIV/AIDS and the Military in Canada*. *Canadian HIV/AIDS Policy & Law Newsletter* 1995; 1(3): 1, 14-15.

74. *Scoles v. Mercy Health Corp.*, 1994 WL 686623 (E.D. Pa. Dec. 8, 1994).

75. *Pacific Western Airlines Ltd v Canadian Air Line Flight Attendants Association* (1987), 28 L.A.C. (3d) 291 (Can. Arb. Bd.)



The Ordinance on Standards and Methods of Definition of the Mental, Physical and Health Capacity of Mine-Clearing Experts sees HIV positive serum results as a contraindication for gaining employment or performing mine-clearing experts' tasks.

The last three Ordinances define limitations on the employment of people living with HIV in a very broad way in comparison with the exceptions to prohibition of discrimination described in Art 3 Para 1 of the LA, as well as in relation to the definition of the ECourtHR regarding possible definitions of exceptions. Therefore, the above-mentioned provisions should be abolished, and exceptions, where considered necessary, should be defined less extensively and with more precision. For example, according to the Disability Act in the USA, HIV testing is possible in the recruitment phase only if the person has been offered a job and if testing applies to all the people to whom the job has been offered. Furthermore, test results are to be kept secret and may not be a reason for discrimination, which means that a person must be employed if he/she is capable of doing the job (HIV status in most cases does not affect a person's capabilities to perform requested tasks).

The Ordinance on Tasks that Must not be Performed by Women prohibits pregnant women from working in an environment where they are exposed to HIV (Art 4 Para 1 Item 14). If a woman works in an environment where she is exposed to HIV and then gets pregnant, in the case of her transfer to another post she is guaranteed the same rights as in her previous post (Art 65, Para 7, LA). In spite of that fact that this Ordinance is meant to protect women, it has a discriminatory character in its present form. Women should be able to decide freely whether they will or will not perform certain tasks instead of being a priori prohibited from doing so.

Regulations that are in effect do not require HIV testing of members of the armed forces on applying for a job in the Ministry of Defence (MD) or Croatian Armed Forces (CAF). However, according to information obtained from the MD, because of the specific work conditions of members of the CAF in peacekeeping missions and peacekeeping operations, before leaving and on returning from missions, tuberculosis and HIV testing are carried out on a voluntary basis. This is, according to the interpretation of the MD, stipulated in UN Regulations. It is true that the UN Regulations on Peacekeeping Forces recommend that people living with HIV are not sent on peacekeeping missions. But in 2001, UNAIDS and the UN Department of Peacekeeping Operations appointed a panel of experts with the task of formulating policies regarding the HIV testing of people being sent on peacekeeping missions. This panel reached a unanimous decision that HIV testing is not necessary for establishing a person's physical capability to act as part of a peacekeeping mission and that HIV status must not be considered an obstacle for a person otherwise physically capable of taking part in peacekeeping missions. The panel, however, recommended voluntary and informed HIV testing among members of peacekeeping forces.<sup>76</sup> These recommendations are not yet binding upon member states, but have been sent to all member states of peacekeeping missions with instructions to bring their policies into line with the recommendations.

All of the above lead to the conclusion that the mandatory testing of doctors upon employment or during employment is unacceptable, but that their voluntary testing should be encouraged.<sup>77</sup>

According to the Protection of the Population from Infectious Diseases Act (PPIDA), people who are carriers of antibodies to the virus causing Acquired Immune Deficiency Syndrome are placed under medical observation (Art 29 Para 1 Item 7). Persons under medical observation have to undergo a medical examination prior to being employed, a medical examination on entering the Republic of Croatia, and two medical check-ups a year during employment (Art 30 Para 1 Items 1, 3, and 4, PPIDA). Medical examinations (testing) of employed people living with HIV twice a year is completely unnecessary and should be eliminated from this Act. Mandatory testing of all people living with HIV (since they are all placed under medical observation) prior to being employed is discrimination. It is not clear what doctors are supposed to do with this information since reporting it to employers would represent a violation of the privacy of people living with HIV. These provisions should be amended.<sup>78</sup>

76. Report of the UNAIDS Expert Panel on HIV Testing in UN Peacekeeping Operations, 28-30 November, 2001, Bangkok, Thailand. See also, *On the Front Line - A review of policies and programmes addressing AIDS among peacekeepers and uniformed services*, July 18, 2005.

77. For example Centres for Disease Control and Prevention (CDC) refuse mandatory testing of doctors. See more in P. MILLER TERESKEREZ, R.D. PEARSON, J. JAGGER, *Infected Physicians and Invasive Procedures: National Policy and Legal Reality*, 77 THE MILBANK QUARTERLY 511 (1999.)

78. The CNIPH says that this is not done in practice, which is all the more reason to amend this legislative solution.



### 10.2.2. Compensation for discrimination

In cases of discrimination prohibited by the LA (Articles 2 and 4 of the LA) a person seeking employment may claim compensation in accordance with the general provisions of the Civil Obligations Act (Art 5 of the LA). If a worker suffers damage at work or in relation to their work, the employer must compensate the worker for the damage in accordance with the general provisions of the Civil Obligations Act. The right to compensation for damages is also applicable to any damage caused by the employer when he/she violated the rights that the worker enjoyed in his/her capacity of employed person. The salary belonging to a worker in the event of unlawful dismissal is not regarded as indemnification (Art 109 of the LA). It is up to the employer to prove that there was no discrimination, i.e. that he/she acted in accordance with provisions defining exceptions from prohibition of discrimination (Art 6 of the LA), in cases when a person who thinks he/she has been discriminated against presents facts that provide reasonable doubt as to whether the employer acted contrary to the prohibition of discrimination anticipated in Art 2 of the LA.

### 10.2.3. Criminal liability for discrimination

According to the Criminal Code, discrimination is punishable either as a violation of the equality of citizens (Art 106 Para 1 of the PA) or as racial or other discrimination (Art 174 Para 1 of the PA). These two criminal offences coincide for the most part and it is very difficult to separate them. There may be a difference in the area where the Croatian Constitution, laws and other acts establish certain rights related to equality that are not recognised by the international community or in areas where the international community protects certain rights not established in the Croatian internal legal system. In the first case, the only possible application would be that of Art 106 Para 1, whereas for the second case it would be Art 174 Para 1. There is a difference as well in the sense that Art 106 Para 1 refers to the protection of citizens (which means citizens of the Republic of Croatia, according to Bačić/Pavlović, but could also be interpreted in a more extensive way like in the French Declaration of Human Rights and Rights of the Citizen) while Art 174 Para 1 refers to all people. If the term citizen is interpreted in a broader sense, then there is no difference between the two. In cases where there is an overlapping of these two articles, in fact it would be all the same which one of them is applied because they both foresee the same sanction - confinement in jail for a term from 6 months to 5 years. It may be simpler to apply Art 106 Para 1 because it is easier to prove the existence of a certain right when it is explicitly determined by an act. In the case of overlapping, the two criminal offences could not be merged because it would mean a double punishment for the same offence which is contrary to the *ne bis in idem* principle.

The Slovenian CC, for example, contains an article that includes both of these offences. Such a solution seems better in Croatian criminal law, too.

Therefore, in cases of violation of Art 2 of the LA, which forbids discrimination, we need to apply Art 106 Para 1 of the CC with the exception of cases concerning certain rights not known to the Croatian legal system but protected by the international community relative to the prohibition of discrimination. In the case of the latter, Art 174 Para 1 of the PA would be applied.

There is also the question of the relationship between violations of the equality of citizens under Art 106 Para 1 of the CC and the criminal offence of the abuse of position and authority quoted in Art 337 Paras 1 and 2 of the CC, as well as of the relationship between the criminal offence of the violation of the equality of citizens (Art 106 Para 1 CC) and the criminal offence of violation of the right to work and of other rights related to work (Art 114 CC). If a violation defined under Art 114 (the right to work, freedom of labour, the free choice of profession, job availability, legally determined working hours, the right to a break, rights related to maternity, rights related to disability and social security or other rights determined by law, court decisions or work agreements) is the result of discrimination, Art 106 Para 1 is applicable instead of Art 114 of the CC.

It is interesting to observe the question of liability with regard to indirect discrimination in the application of these articles. That is to say that liability for the violation of the equality of citizens or for racial and other discrimination exists only if they are committed on purpose, i.e. when the person committing the act is



aware of his/her act and wants to act accordingly (direct intention) or when he/she is aware of the possibility of committing a criminal offence and accepts it (indirect intention). Indirect discrimination occurs when a certain seemingly neutral provision, criterion or practice puts or might put a person in a less favourable position in comparison with other persons due to a certain trait of his/hers or due to his/her status, orientation, convictions or system of values. If a person is aware that the provision only seems neutral and still wants to apply it or accepts its application despite being conscious of its discriminatory character, it will be interpreted as an intentional criminal offence. However, if a person is not aware of the falsely neutral nature of the provision he/she will be considered as being under a misapprehension as to the nature of the essence of the offence. As existence of intention is always excluded with regard to misapprehension about the nature of the act, it means that in the case of such misapprehension, the criminal act described in Art 106 Para 1 or Art 174 Para 1 of the CC (Art 46 Para 1 CC) would not exist. On the other hand, if the person committing the offence is simply not certain as to whether the provision only seems neutral, he/she will not be under a misapprehension about the nature of the act but will be regarded as having the indirect intention to act accordingly.<sup>79</sup> However, if the person is unaware that even indirect discrimination represents a form of discrimination, such a situation will be interpreted as legal misapprehension (Art 47 Para 1 CC). When such misapprehension occurs as a result of justified reasons, it will be regarded as unavoidable misapprehension, thus excluding guilt. However, if the misapprehension is avoidable i.e. if the person was unaware of the unlawfulness of indirect discrimination, but at the same time ought to have been and could have been aware that indirect discrimination is a criminal offence, there is the possibility of extenuating the punishment (Art 47 Para 2 CC). However, misapprehension will be considered avoidable when it concerns a person who should be familiar with the relevant legislation bearing in mind his/her vocation, profession or post (it is presumed that all employed persons ought to be acquainted with the provisions of the Labour Act) (Art 47 Para 3 CC).

### 10.3. PROPOSALS REGARDING THE IMPROVEMENT OF STATUS OF WORKERS LIVING WITH HIV

1. A formalised workplace policy on HIV needs to be developed in order to include all the elements contained in international guidelines as mentioned in 10.1.
2. All Ordinances containing provisions on mandatory testing need to be reviewed and the circumstances of mandatory testing need to be limited in accordance with the requirements of the LA.<sup>80</sup>
3. Raising awareness of the need for positive discrimination in the employment of people living with HIV would be welcomed (The Labour Act foresees the option of positive discrimination).
4. The amount of evidence required to prove the existence of discrimination needs to be lowered - it would be sufficient to prove a causal relationship instead of seeking to prove the existence of intention.
5. The initiation and administration of legal proceedings should be made possible even after the death of a person living with HIV (e.g. for particular groups, especially when there is a question of systematic discrimination).
6. Legal proceedings should be optionally administered under a pseudonym and the use of technical devices during the examination of parties/witnesses should be made possible in order to protect their identity and avoid stigmatisation.
7. Free legal assistance should be provided to people living with HIV who need help in the administration of legal proceedings related to their health condition.
8. It would be helpful to introduce an Ombudsman who would be responsible for the protection and promotion of the human rights of handicapped persons, advise the government with regard to their needs and problems, monitor compliance with international regulations in this field, and so on.

79. For more detailed information on misapprehension about the nature of the act refer to PETAR NOVOSELEC, GENERAL PART OF THE CRIMINAL CODE 250-58 (2004).

80. In their commentaries on this text, the Ministry of the Sea, Tourism, Transport and Development emphasised that the enactment of the new Ordinance on the Definition of Health Conditions Required of Maritime Vessel and Inland Navigation Vessel Crew Members falls under the competence of the Ministry of Health and Social Welfare, and asked the Ministry to initiate proceedings to enact the new Ordinance.





11.  
HIV AND  
SOCIAL  
WELFARE

People living with HIV might be entitled to "assistance in overcoming particular difficulties" (Art 14 Para 1 of the Social Welfare Act - SWA). Such assistance may include housekeeping, the management of finances, organisation of studying for children, provision of clothing, inclusion in soup kitchen services or clubs, finding employment, dealing with problems related to housing, admission into pre-school institutions, and so on. These provisions are not applicable to people living with HIV who have not developed symptoms of AIDS and consequently do not suffer from any physical symptoms. Such symptoms, as they occur, are subject to assessment by the responsible bodies in accordance with the Ordinance on the Constitution and Working Methods of Expert Witness Bodies in Procedures for Realising Social Welfare Rights.

A person suffering from AIDS may exercise his/her rights in line with the SWA if all the necessary conditions have been met. There is no single provision specifically referring to people living with HIV.

Regarding rights related to accommodation in foster-families, please refer to chapter 9.3.







12.  
HIV AND  
RIGHT TO  
ASYLUM

The Croatian Asylum Act prohibits the forcible eviction or any other means of return of a refugee to the country where his/her life or freedom might be put at risk due to race, religion, nationality, belonging to a certain social group or due to sharing a certain political opinion. Neither can a person be returned to a state where he/she might be tortured or exposed to inhumane or humiliating treatment or punishment (Art 3 Para 2 AA). According to the jurisprudence of the ECourtHR, the return of a person living with HIV to his/her country of origin might represent inhumane or humiliating treatment, thus violating Art 3 of the EConventionHR if in the country of origin he/she cannot be provided with adequate medical treatment conditions, i.e. the same conditions for medical treatment as in the country in which asylum is sought. The Republic of Croatia should bear this in mind if they decide to deport a person living with HIV.

According to Art 3 Para 2 of the AA, the prohibition of forcible eviction or return of refugees is not applicable to a person who is suspected with good reason of being able to jeopardize the state's security or public order in the Republic of Croatia or who represents a risk to society following a valid sentence for a serious crime. Since Art 3 of the EConventionHR quotes an absolute right not allowing for exceptions, deportations should not be possible in the above-mentioned cases if they could either result in exposing a refugee living with HIV to torture or inhumane or humiliating treatment.

According to Croatian laws, HIV testing of asylum-seekers is not mandatory. Asylum-seekers are entitled to the provision of medical services in accordance with regulations on the health care of foreigners, while their children enjoy complete health care, equal to that of Croatian citizens (Articles 23 and 29 AA). Accommodation centres for asylum-seekers do not provide healthcare education nor do they carry out preventive measures against the spread of HIV. Asylum-seekers should be entitled to free HIV testing (if they so wish) as well as to relevant education (lectures, brochures, condoms). This should be one of the strategic goals of the National Programme for Prevention of HIV.

Art 40 of the AA regulates that it is possible to put restrictions on an asylum-seeker's movement in order to prevent the spread of infectious diseases. This restriction has its basis in

81. Ref. B.B. v. France (47/1998/950/1165).



the PPIDA. HIV, however, is not on the list of infectious diseases requiring restriction on the movement of people.

The Ministry of Interior believes that preventive examination of asylum seekers, including HIV testing, should be stipulated. If it is stipulated, such testing is usually justified in terms of public health and/or economic reasons. The UNAIDS/IOM Statement on HIV/AIDS-related Travel Restrictions<sup>82</sup> emphasizes that restrictions on the right of movement of people living with HIV has no public health justification, and economic justifications should be provided in each individual case. The Statement also opposes mandatory testing in such circumstances and recommends voluntary testing with informed consent. We, therefore, find the proposal of the Ministry of Interior unacceptable.

82. June 2004, available at [www.unaids.org](http://www.unaids.org)





13.  
BURIAL OF  
AIDS-  
INFECTED  
PEOPLE

The Ordinance on the Conditions and Methods of Transporting, Burying and Exhuming Deceased People mentions in Art 3, among other things, that a person who has died from AIDS can only be transported in a closed and soldered metal coffin put inside a timber coffin. The deceased person must be covered with linen soaked in disinfectant and the rest of the metal coffin must be filled with sawdust. This provision has its basis in Art 50 Para 1 of the PPIDA, which states that transportation and burial of a person who has died from AIDS can only be executed under specific conditions and in accordance with the instructions provided for by special regulations.

Both of these provisions are unnecessary, because HIV infection is difficult to transmit in comparison with other diseases stated in the above-mentioned provisions, i.e. cholera, typhus, diphtheria, anthrax, plague, typhoid, enteric fever A and B, viral hemorrhagic fevers (Ebola, Lassa and Marburg), viral hepatitis or yellow fever. In addition, HIV is not a source of infection that can survive after the death of an infected person and cannot be transmitted in such a way as to require these kinds of protective measures. If a person dies from any of the above infectious diseases due to Acquired Immune Deficiency Syndrome (AIDS), the relevant infectious disease should be regarded as the cause of death. Therefore, in this case, too, provisions for special burial methods for persons who have died from AIDS prove to be unnecessary.





14.  
CONCLUSION



The above analysis has shown that there are certain provisions of a discriminatory character in relation to people living with HIV in the Republic of Croatia (e.g. testing under medical supervision is still compulsory for persons of certain professions and in certain cases relating to prisoners; people living with HIV are not allowed to perform certain jobs; it is possible to institute mandatory treatment for commercial sex workers; it is requested that death certificates contain a specific note stating that the person had AIDS as well as the corpse being treated in a specific way, etc.) Apart from this, we have pointed out a number of cases of discrimination against people living with HIV that have occurred in practice independently of legal provisions or due to a lack of relevant legal provisions and/or applicable legal protection of people living with HIV (insufficient protection of people's privacy and of their right to self-determination, lack of adequate medical care at all times, experience of discrimination in the education system, at work etc.) In this text, we have also pointed out a number of legal shortcomings and suggested where there should be interventions by the Croatian legislature in order to prevent discrimination and/or stigmatisation of people living with HIV, as well as to ensure better protection of their rights.

There is not a single reason pertaining to public health protection that would require the restriction of the rights and freedoms of persons only because they are living with HIV. Discrimination against people living with HIV is not justified either in employment or in the education system or in relation to housing. However, since discrimination and stigmatisation of people living with HIV can be found very often at all levels of our society, it is not sufficient to just amend and/or improve the existing legal framework and introduce new provisions outlined in this text into our legislation. There is also a need for the adoption of an anti-discrimination law that would guarantee people living with HIV their rights and protect them from public and private abuse. The protection of people living with HIV from discrimination would motivate the people in question to undergo voluntary testing, seek advice and would also enable them to obtain easier access to education, healthcare and social welfare. An anti-discrimination law would be a good foundation for the education of employers, teaching staff, doctors and others, showing them how to avoid discriminatory treatment of people living with HIV. In addi-



tion, besides its normative and educational effects, an anti-discrimination law would also serve as a means of alarm or prevention against future discrimination for all citizens, and would enable people who are discriminated against due to their living with HIV to seek legal protection. Bearing in mind the rather insensitive character of Croatian society towards the problems of all kinds of disabled persons and also taking into account the frequent discrimination against them, it seems better to adopt a single anti-discrimination law relevant to all disabled persons, including people living with HIV, instead of the adoption of a separate anti-discrimination law exclusively referring to people living with HIV. In addition, in this law HIV would be treated like any other disability and the adoption of such an anti-discrimination law would meet much greater public support. The Americans, with the Disabilities Act of 1990 or the anti-discrimination law adopted in Argentina in 1992 or in Hong Kong in 1996, as well as the work on the UN Convention on the Rights of Persons with Disabilities, could serve as models for us.<sup>83</sup> It is likely that an anti-discrimination law would not change people's beliefs, but it could change their behaviour towards people living with HIV, who, as a consequence, could be guaranteed equal treatment and respect for their rights. Therefore, this law should have more of an educational than penal character, where the judiciary would be used only as the last resort in resolving disputes. Moreover, the adoption of an anti-discrimination law would be an important contribution to strengthening the prevention of and fight against the spread of HIV in the Republic of Croatia.

Hence, the analysis we have carried out reveals the need for intervention at four levels:

#### 1. Adoption of an anti-discrimination law for disabled persons

- a) it is necessary to adopt an anti-discrimination law that would refer to all persons with disabilities including people living with HIV and non-HIV positive persons who are thought to be HIV positive as well as family members and persons who are in contact with the above-mentioned persons;
- b) an interdisciplinary and interdepartmental body consisting of experts from various legal fields (constitutional law, penal law, public health law, civil law, labour and social law, administrative law, etc.), as well as from other fields (medicine, social welfare, education, etc.), should be set up to this end;
- c) the law should include protection against discrimination (direct and indirect) in the domains of the healthcare system, employment, social security, education, sport, associations, accommodation, trade unions, transportation, insurance, access to goods and services, and so on;
- d) education programmes should be conducted to inform the public of anti-discrimination regulations which would eventually result in a change of discriminatory behaviour and attitudes.

#### 2. Amendments to existing legal acts and by-laws where they are discriminatory towards people living with HIV or where such persons are not guaranteed sufficient protection

- a) an interdisciplinary legislative commission needs to be set up with the authority to examine Croatian legislation and suggest necessary amendments;
- b) this report represents a good foundation for the work of such a commission, since it identifies problem points within Croatian legislation and proposes potential amendments (each chapter is concluded by suggested crucial legal interventions);
- c) legal amendments themselves are insufficient - people should be assisted in the exercise of their rights, which includes the education of judges, lawyers, state attorneys and the police, the introduction of free legal aid to people living with HIV who

83. For more details refer to the Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities [www.un.org/esa/socdev/enable/rights/adhoc-com.htm](http://www.un.org/esa/socdev/enable/rights/adhoc-com.htm). Last checked on July 19, 2005.





cannot pay for it due to their financial status, as well as free legal advice that could be provided either by NGOs or some state institutions, etc.

3. Protection of the rights of vulnerable groups (women, children, intravenous drug users, homosexual men) - special attention should be given to:
  - a) protection of women against sexual violence and all kinds of abuse, the introduction of sex education in schools where, among other things, the importance of safe sex using condoms (and other protective measures) should be particularly highlighted;
  - b) children should be guaranteed information on different ways of avoiding infection; testing of children with their consent should be introduced (meaning that parental consent is not necessary as long as children are able to give consent themselves); adoption of children living with HIV should be facilitated by improving the relevant legislation and provision of social support in cases of adoption of children living with HIV;
  - c) the issue of the desirability of legalisation of prostitution and decriminalisation of soft drugs.
4. A handbook on the rights of people living with HIV (rights related to testing, protection of privacy, medical treatment, education, compensation for damages, employment and work, travel, health and social insurance, housing etc.) intended for:
  - a) people living with HIV with the purpose of informing them better and facilitating the exercise of their rights;
  - b) persons in contact with people living with HIV either at work or otherwise (doctors, lawyers, state attorneys, police, judges, social workers and others) with the purpose of understanding the disease better, thus decreasing the risks of discriminatory practices and attitudes towards people living with HIV.





15.  
APPENDIX

## 15.1. LIST OF INTERNATIONAL DOCUMENTS:

Universal Declaration of Human Rights (GA Resolution 217 A (III) of December 10, 1948)

**IPCPR** International Pact on Civil and Political Rights  
(Official Gazette/OG - International Agreements, No. 11/95)

**EConventionHR** European Convention for the Protection of Human Rights and Fundamental  
Freedoms from 1950 (OG - International Agreements, No. 6/99)

Convention for the Protection of Individuals with regard to Automatic  
Processing of Personal Data (CETS No.: 108; <http://conventions.coe.int>)

Convention of Human Rights and Biomedicine (OG -  
International Agreements, No. 13/03)

Convention on the Rights of the Child  
(GA Resolution 44/25 of November 20, 1989)

Declaration of Commitment on HIV/AIDS (GA Resolution S-26/2 of  
June 27, 2001 - available at <http://www.ohchr.org/english/law/hiv.htm>)

HIV/AIDS and Human Rights International Guidelines  
(Office of the UN High Commissioner for Human Rights and the  
Joint UN Programme on HIV/AIDS, HR/PUB/98)

UNAIDS/WHO Policy Statement on HIV Testing  
(<http://www.who.int/hiv/pub/vct/statement/en/>)

ILO Code of Practice on HIV/AIDS and the World of Work (ILO, 2001)

EU Directive on Blood and Blood Components  
No. 2002/98/EC (CELEX No. 32002L0098)



Manual of Civil Aviation Medicine  
(JAA, Joint Aviation Authorities Committee, 1 February 2005)

Medical Certification of Air Traffic Controllers  
(European Organisation for the Safety of Air Navigation)

## 15.2. LIST OF ACTS:

	Constitution of the Republic of Croatia (OG, No. 56/90; consolidated text OG, No. 8/98, 124/00, 41/01)
AA	Asylum Act (OG, No. 103/03)
CC	Criminal Code (OG, No. 110/97, 27/98, 129/00, 50/01 - the Constitutional Court of the Republic of Croatia has overturned Paras 2 and 3 of Art. 204 of the CC, 129/00, 51/01, 190/03 - the Constitutional Court of the Republic of Croatia has entirely overturned the Modifications and Additions Act to the CC - OG, No. 111/03, 105/04)
Civil PA	Civil Proceedings Act (OG, No. 53/91, 91/92, 112/99, 88/01 and 117/03)
COA	Civil Obligations Act (OG, No. 35/05)
Criminal PA	Criminal Proceedings Act (OG, No. 110/97, 27/98, 58/99, 112/99, 58/02, 143/02; consolidated text Official Gazette, No. 62/03)
CRTHOA	Conditions for the Removal and Transplantation of Human Organs Act (OG, No. 177/04)
FA	Family Act (OG, No. 162/98, 116/03)
HCA	Health Care Act (OG, No. 121/03)
HIA	Health Insurance Act (OG, No. 94/01, 177/04)
LA	Labour Act (OG, No. 137/04)
MPA	Medical Practices Act (OG, No. 121/03)
MPMDA	Medicinal Products and Medicinal Devices Act (OG, No. 121/03)
NA	Nursing Act (OG, No. 137/04)
PDPA	Personal Data Protection Act (OG, No. 103/03)
PDSA	Protection of Data Secrecy Act (OG, No. 108/96)
MIPPA	Protection of Mentally Ill Persons Act (OG, No. 111/97, 27/98, 128/99, 79/02)
PPIDA	Protection of the Population from Infectious Diseases Act (OG, No. 60/92)
PPRA	Protection of Patients' Rights Act(OG, No. 169/04)
SPSA	Serving of Prison Sentences Act (OG, No. 190/03)
SWA	Social Welfare Act (OG, No. 73/97, 27/01, 59/01,103/03)
	Same-sex Unions Act (OG, No. 116/03)



Primary Education Act (OG, No. 59/90; final draft Official Gazette, No. 69/03)

Gender Equality Act (OG, No. 116/03)

Secondary Education Act (consolidated text OG, No. 69/03)

Science and Higher Education Act (OG, No. 123/03)

### 15.3. LIST OF INSTRUCTIONS:

Instructions for the Implementation of Organ Removal Programme (OG, No. 75/98)

### 15.4. LIST OF DECISIONS:

Decision on the Monthly Allowance Rate for Accommodation in Foster-families/homes (OG, No. 82/02)

Decision on Defining the List of Medications of the Croatian Institute for Health Insurance (OG, No. 05/05, 19/05)

### 15.5. LIST OF ORDINANCES:

OBBC Ordinance on Blood and Blood Components (OG, No. 14/99)

OKPRFA Ordinance on Keeping Personal Records and Files concerning Adoption (OG, No. 66/99)

OMRID Ordinance on the Methods of Reporting Infectious Diseases (OG, No. 23/94)

OPMECID Ordinance on the Performance of Medical Examinations of Carriers of Infectious Diseases (OG, No. 23/94)

Ordinance on the Composition and Working Methods of Expert Witness Bodies in the Procedure of Realization of Social Care Rights (OG, No. 39/98)

Ordinance on the Definition of Health Conditions Required of Maritime Vessel and Inland Navigation Vessel Crew Members (OG, No. 111/02) Ordinance on the Definition of Health Conditions Required of Aircrews and Conditions to be Fulfilled by Medical Institutions Performing Medical Examinations of Aircrews (OG, No. 129/05)

Ordinance on the Methods of Definition of General and Specific Health Conditions Required of Guards and Security Guards in Private Security Services (OG, No. 38/04)

Ordinance on Standards and Methods of Definition of Mental, Physical and Health Capacity of Mine-Clearing Experts (OG, No. 26/96)

Ordinance on Measures to Ensure the Safety and Quality of Human Body Parts for Medical Use (OG, No. 143/05)



Ordinance on Tasks that Must not be Performed by Women (OG, No. 44/96)

Ordinance on the Conditions and Methods of Transporting, Burying and Exhuming Deceased People (OG, No. 23/94)

## 15.6. LIST OF REGULATIONS:

Regulation on the Manner of Keeping Records of Personal Data Filing Systems and Pertinent Record Forms (OG, No. 105/04)

## 15.7. LIST OF INSTITUTIONS:

ECourtHR	European Court of Human Rights
CAF	Croatian Armed Forces
CAHIV	Croatian Association for HIV
CIHI	Croatian Institute for Health Insurance
CIPH	County Institute of Public Health
CMA	Croatian Medical Association
CMC	Croatian Medical Chamber
CNIPH	Croatian National Institute of Public Health
CNIOM	Croatian National Institute of Occupational Medicine
CNITM	Croatian National Institute of Transfusion Medicine
ILO	International Labour Organisation
MD	Ministry of Defence
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organisation

