**Universal Periodic Review of Hungary**
**39th Session**
**October - November 2021**

**Joint Stakeholder Submission**

**PATENT Patriarchátust Ellenzők Társasága Egyesület / PATENT Association of People Opposing Patriarchy (Budapest)**
www.patent.org.hu

PATENT was established in 2006 as an expert organisation providing legal aid for victims of violence against women (VAW). It is the only legal aid organisation in Hungary that focuses on women. In 2010, PATENT added the area of sexual and reproductive health and rights (SRHR) to its fields of activity, and is currently the only organisation framing SRHR as a women's rights and feminist concern in the country. We conduct a wide range of activities in these two areas, including legal aid, research, advocacy and awareness-raising. Combining the VAW and SRHR foci, the organisation also introduced a sexual education stream of activity in 2016. We established the Hungarian women's legal aid fund in 2020 to provide financial support for women who cannot afford the costs of seeking justice.

**and**

**Sexual Rights Initiative [SRI]**
Rue de Monthoux 25, Geneve, 1201
www.sexualrightsinitiative.com
Email: carrie@srigeneva.com

The Sexual Rights Initiative is a coalition of national and regional organizations based in Canada, Poland, India, Argentina, and South Africa that work together to advance human rights related to sexuality at the United Nations.

**Key words:** women's human rights; sexual and reproductive health and rights; contraception; emergency contraception; abortion; pregnancy termination; compulsory abortion counselling; medical abortion; pregnancy and childbirth; sterilisation; assisted reproductive services; sexual education

**Executive Summary**

1. On the subject of women's and girls' sexual and reproductive health and rights, none of the recommendations accepted in the previous cycle of Hungary's UPR have been thoroughly implemented; notably, in several fields, matters took a turn for the worse. The state incentivises creation of large families, preferably by middle-class, married, heterosexual parents – even if the types of stimulus, restrictions and ideology employed to achieve this, results in significant human rights concerns and violations.

2. In this submission, we highlight three fields in which human rights have not improved or deteriorated since the previous cycle: preventing and terminating unwanted pregnancy; pregnancy and birthing; and sterilisation and assisted reproductive services.

**I.1. Preventing and terminating unwanted pregnancy**

1. The state is obligated to subsidize contraception under the law (1992. LXXIX. 2/a), however, to our knowledge, **no contraceptive is subsidised** in Hungary. Contraception is expensive, and there is no data on how many individuals benefit from subsidised access.

2. Women without high school education (and consequently, worse economic conditions) have 7,5 times more abortions than women with higher education[1]. This is due to many factors, including: having less access to information about **contraceptive methods**; they **cannot afford contraception**; and they **cannot afford a child or additional children**, regardless of whether they would want to keep their pregnancy.

3. Regarding the lack of information on contraceptive methods, it is important to note that **comprehensive sexuality education does not exist** in Hungarian public education. Instead, there is a curriculum on 'educating for family life', which exists as a subject of its own and is also mainstreamed into the curriculum of other subjects. It is geared towards an abstinence approach; frames contraception as girls' responsibility; promotes motherhood as the purpose of a girl's life; takes a purely biological approach to sexual life; contains nothing about sexual violence-prevention (no mention of mutuality and consent); and contains little about intimate partner violence-prevention, taking an ignorant approach that frames it as individual aberration rather than a form of gender-based violence and an outcome of patriarchy and gender inequality.

4. **Economic hardships can also account for pregnancy-termination,** even if the woman would prefer carrying the pregnancy to term. There is no significant long-term financial support for child-rearing (only in the early period through CSED, GYED and GYES[2]). While the state is incentivising childbirth and establishing large families (e.g. loan benefits for married couples if they contract to have 3 children), once those children are born, the state leaves families and single parents behind with the long-term burden of raising children. Monthly state allowances for families raising children is extremely low, ranging from €32 (1 child) to €46 (3+children), and €62 to €70 for chronically ill and children with disabilities.[3] Single-parent households do not receive a significantly higher support compared to households supported by two working parents, and 35% of single-headed households (typically female-headed) live in poverty.[4] There is not enough childcare

[1] http://www.ksh.hu/apps/shop.kiadvany?p_kiadvany_id=1028828&p_temakor_kod=KSH&p_lang=hu , p.13

[2] CSED: Csecsemőgondozási díj/Newborn care allowance (up to 5.5 months); GYED: Gyermekgondozási díj/Infant care allowance (typically up to 2 years); GYES: Gyermekgondozási segély/Infant care benefit (for stay at home parent, typically up to 3 years).

[3] https://officina.hu/belfoeld/38-csaladi-potlek

[4] https://demografia.hu/kiadvanyokonline/index.php/demografia/article/view/2768/2674

infrastructure, which makes working full-time and earning enough to support children unfeasible for many. All this results in many women terminating not only unwanted, but also wanted pregnancies; and women who are mothers staying with their abusive partners for a well-founded fear of impoverishment should they leave and raise their children alone, especially if they relied on the offer of joint loan incentives from the state.

5. Despite its risks and side effects, hormonal, **medical contraception is routinely prescribed** to women and young, developing girls with any type of gynecological complaints as a one-size-fits-all approach. Any other medication with such high incidence of serious side effects would fall under more scrutiny, had these effects also threatened men's health.

6. In 2015, the European Commission decided that the emergency contraception ellaOne can be available over-the-counter in the EU[5], while Hungary remained one of the few EU member states that **kept the 72-hour pill upon prescription**. The prescription is often hard to obtain, as the practices and guidelines followed by healthcare providers vary widely: some make it conditional upon a gynecological examination, some don't; some GPs state that as GPs, they are not authorised to issue a prescription, however, some do; and some hospitals are authorised points of emergency, some aren't. Though no public statement is available on measures taken to this effect, women report that accessing emergency contraception is becoming increasingly complicated in recent years: fewer hospitals are allowed to prescribe it, and the prescription is not instantly made available. Given the time-sensitive nature of the pill, it is highly distressing that one may not be sure whether and how she can obtain a prescription, and may have to visit several different providers before she might obtain one. Emergency contraception is also disproportionately and extremely expensive and there is no financial support provided by the state.

7. In Hungary, **only surgical abortion** is available. Although in 2012 the EU-wide registered abortion pill Medabon received a marketing authorization in Hungary, the respective ministry decided that supply, production and needless to say, state-subsidy will not be taking place, thus ending medical abortion access and availability.[6] Numerous European countries (the United Kingdom, the Netherlands, Sweden, Austria, Belgium, Denmark, Finland, and Germany) have granted access to medical abortion. It has also been declared safe, acceptable, and empowering by the WHO.[7] Medical abortion can be safely done via two sets of pills: Mifepristone and Misoprostol. Both medicines are on the Core Model List of Essential Medicines by the WHO, and neither are available in Hungary[8]. Medical abortion done in the first 59 days of the pregnancy was proven to be 98% effective[9] and safer than regular childbirth[10].

8. Despite these numbers, in 2012 the Hungarian government declared that they do not support the pills to enter the Hungarian health care system, basing their argument on false information in denial of the above. The reasoning provided was that this restriction protects women from the responsibility and shock of taking these pills, and the government expressed their concerns that should medical abortion become available, the number of abortions would increase as women would take abortions less seriously. In reality, the state prefers women to undergo invasive procedures if they opt to terminate a pregnancy, rather than granting them the option of a safer and less painful method. This can be easily interpreted as a manner of 'punishment' for not carrying a pregnancy to term.

[5] https://www.ec-ec.org/european-commission-decision-grants-120-million-women-direct-access-to-ellaone/
[6] See in Hungarian: http://abortusz.info/tenyek-az-abortuszrol/item/252-abortusztabletta-1
[7] WHO: ttps://apps.who.int/iris/bitstream/handle/10665/332334/WHO-SRH-20.11-eng.pdf?sequence=1&isAllowed=y
[8] WHO: https://apps.who.int/iris/handle/10665/325771
[9] See research: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3766037/
[10] WHO: https://www.who.int/news-room/fact-sheets/detail/maternal-mortality

9. As the result of banning Mifepristone and Misoprostol, Hungarian women only have one option left if they want to access medical abortion (and avoid the 2 compulsory counselling sessions). Namely, they need to go to a neighbouring country like Austria, where medical abortion is safely accessible under medical supervision in clinics. According to the closest abortion clinic in Vienna, at least 10-15 Hungarian women travel there per week to access medical abortion. Despite the ongoing COVID-19 pandemic, women continue to travel abroad, risking their health and safety to access medical abortions. Given the added fees of travelling abroad and paying for the medical service, this option is only affordable for women with better economic circumstances. At the same time, local (surgical) abortion services are costly as well. Women need to pay around €90 for the surgical procedure in advance. This amount already can cause serious financial burdens on women and their families, and state support is granted only sparingly.

10. Surgical abortion is done by vacuum aspiration or curettage.[11] When inquiring about the procedure of surgical abortion, a number of gynecologists reported that in order to dilate the cervix before the abortion, they do not always use prostaglandin (a pill which was proven to be effective and is used during delivery), but they use a plastic medical tool, which is reportedly **causing more (unnecessary) pain**. This may be due to lack of resources in the underfunded Hungarian healthcare system, attempting to save costs at the expense of women in vulnerable positions by using a reusable tool rather than providing medication. At the same time, on a more ideological level, there is a strong narrative in Hungary which suggests that women who need abortions deserve to suffer. By using a painful method of dilation rather than a medical one (echoing the same principle that makes medical abortion unavailable in Hungary), doctors have the power to 'punish' and let their opinions on abortion be known. Compelling women to go through invasive procedures when other methods are available is incompatible with women's human rights.

11. Besides the medical and financial difficulties, surgical abortion is only available on the condition of attending **two compulsory counselling sessions**,[12] with the first session aiming at dissuading the woman from terminating her pregnancy, as is set in the law (1992. LXXIX.). Research showed that these sessions provide selective information on the risks of abortion vis-a-vis carrying the pregnancy to term, and employ guilting strategies that violate women's dignity.[13] The curriculum of healthcare and public service employees (state nurses) authorised to provide counselling is becoming increasingly pseudo-scientific (e.g. refer to "dormant motherly feelings" to be woken up in women seeking termination). Furthermore, some religious organisations now also have permission to provide counselling recognised by the state.

12. The government is framing these sessions as "successful" insofar as less women go for the second counselling session than the first one, and less go on to terminate pregnancies than go for the first session. However, they do not consider the other reasons women opt not to go to the second counselling or the procedure: that they have natural miscarriages; that their circumstances changed resulting in them keeping the pregnancy; that they seek abortion in other ways not involving the Hungarian state. Even if the sessions are "successful"

[11] This procedure is done under anaesthesia and is performed by a gynaecologist in one of the assigned hospitals. Surgical abortion can also be a safe procedure, but due to anasthesia, women lose control over their bodies during the whole process (unlike in the case of medical abortion).

[12] "[T]hese new laws and policies undermine women's health and well-being, fail to respect women's human rights, and reinforce harmful gender stereotypes and abortion stigma" (Hoctor, Lamačková 2017) https://obgyn.onlinelibrary.wiley.com/doi/10.1002/ijgo.12288 ; "Making pre-abortion counseling mandatory, does not only go against the fundamental human rights of the woman, the right to self-determination and her reproductive autonomy, but could deter a great number of women from getting access to safe abortion services, and to turn to clandestine abortion care providers." (Luchuo Engelbert Bain, 2020) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7250210/; "Most women do not seem to want or need pre-termination counselling therefore policies aimed at mandatory counselling, would be contrary to women's wishes. Counselling should be targeted at women with risk factors for psychological complications post-termination." (Charlotte Baron, Sharon Cameron Anne Johnstone, 2015) https://pubmed.ncbi.nlm.nih.gov/26106104/; "Abortion is a safe and legal medical procedure that does not require expanded counseling." (Guttmacher Institute, 2020)
https://www.guttmacher.org/evidence-you-can-use/mandatory-counseling-abortion#

[13] http://abortusz.info/kutatas/2014/item/download/12_5e43f66859209e6bfe84185a8cd22234

in some cases, all this means is that some women are not terminating their pregnancies as a result of manipulation and successful inducement of guilt. By and large however, women report that they are not dissuaded by these counselling sessions, but many view it instead as a (deserved) punishment and humiliation for their decision to not carry a pregnancy to term.[14]

13. In 2017, the Hungarian media reported that two church-run hospitals in Budapest received large **state funding on the condition that they will not perform abortions** in the new obstetrics and gynecology unit established from the funding, based on the cooperation of the two hospitals.[15] Another article also revealed that a training course (promoted/announced by the Catholic Charity and funded by the Ministry of Human Capacities) set the condition for attendance that the participant will not use contraception pills and methods, nor artificial insemination, at least until 31 December 2019.[16]

14. In October 2020 the Hungarian government together with five other states co-sponsored a virtual gathering for signing the Geneva Consensus Declaration On Promoting Women's Health and Strengthening the Family. The declaration was signed by 32 countries first hand.[17] The document stated that "there is no international right to abortion, nor any international obligation on the part of States to finance or facilitate abortion, consistent with the long-standing international consensus that each nation has the sovereign right to implement programs and activities consistent with their laws and policies".[18] The signature raises questions **whether the government plans to introduce further restrictions on abortion.** Hungary has hosted three so-called Demographic Summits to date, where politicians gathered to share strategies on raising birth rates in response to decreasing and aging populations, and where restrictions on abortion were presented as laudable policies to this effect.

**I.2. Recommendations on preventing and terminating unwanted pregnancy**

15. [Recommendation 1] In light of recent developments, especially the co-sponsoring of the 'Geneva Consensus Declaration' in October 2020, we call on the Hungarian government to ***reaffirm that it will ensure continued rights and access to abortion,*** as it stated in the previous UPR cycle (A/HRC/WG.6/25/HUN/1, F/27, in response to 95/14). That is, the state should guarantee that:
    a. It will not use its rewritten Constitutional text as grounds to force women to carry unwanted pregnancies to term, and
    b. Will keep the 1992 law (securing the right to abortion, also in case of non-medical or criminal, but personal reasons) in place, mirroring the permissive stance towards abortion held by the vast majority of its population.[19]

16. [Recommendation 2] Take all necessary measures to ***enable informed decisions*** on reproductive health and rights. This requires:
    a. Insofar as compulsory counselling prior to abortion is kept in place, giving *balanced and scientifically correct information* on the risks of both terminating and of keeping the pregnancy, aiming to support the pregnant woman in making an informed decision, identifying the best decision for herself. These sessions should refrain from pseudo-scientific or religious content, and from further increasing the violation of women's dignity by attempting to manipulate, guilt, and humiliate women.

[14] *Ibid.*
[15] See in Hungarian: https://444.hu/2017/02/09/ket-korhaz-a-kormanytol-kapott-penzert-cserebe-vallalta-hogy-nem-vegez-abortuszt
[16] See in Hungarian: https://rontgen.444.hu/2019/03/18/meregdraga-tanfolyamon-stromankent-hasznalja-az-emmi-a-katolikus-szeretetszolgalatot
[17] https://www.hhs.gov/about/news/2020/10/22/trump-administration-marks-signing-geneva-consensus-declaration.html
[18] *Ibid.*
[19] 78% of Hungarians agree that women should be the ones to decide whether they keep their pregnancy (i.e. support women's bodily autonomy and their right to opt for abortion).
http://medicalonline.hu/eu_gazdasag/cikk/igy_gondolkodunk_az_eutanaziarol_es_az_abortuszrol

b. Providing *financial support for, information on, and access to contraceptive methods* to disadvantaged women and providing financial support for abortion.
c. Obliging gynecologists to exercise due diligence in taking women's and developing girls' concerns seriously and investigating gynecological complaints, offering *informed options of treatment* rather than automatically prescribing contraceptives as a universal solution to any issue.
d. Refraining from further entrenching harmful stereotypes and approaches to sex and the relationship between the sexes through its 'education for family life' curriculum, and instead *provide sexual and relationship education* that focuses on shared responsibility, mutuality, consent, and that is adequate for violence-prevention and making informed reproductive decisions.

17. [Recommendation 3] The state should, echoing numerous recommendations accepted from the previous UPR cycle (see especially 128.171, 128.62, 128.57, 128.172, 128.61, 128.55, 128.59, 128.63**)** provide the necessary *support, services and infrastructure to ease the long-term economic burdens of child-rearing*: enable single-parent families to survive; prevent the impoverishment of women with children; and make it possible for mothers to exit abusive relationships with their children, without the risk of becoming destitute. The state should *revise its policies that incentivise the establishment of large families* while providing little long-term support to smaller, especially female-headed single-parent households, and households with chronically ill and children with disabilities (and ceasing long-term support later on to larger and splitting families as well).

18. [Recommendation 4] ***Make emergency contraception available without prescription*** and subsidized by the State. Ensure practices around emergency contraception are transparent and consistent across health facilities, and that those affected are appropriately informed of where they can access it.

19. [Recommendation 5] ***Grant access to medical abortion*** as an alternative to surgical abortion. Regulate unnecessarily painful medical practices throughout the process of pregnancy termination and provide the resources necessary to use medical methods of dilation.

**II.1. Pregnancy and birthing**

20. Notwithstanding the declared aim of making women into mothers, the rates of **obstetric violence during pregnancy and delivery** is rampant in Hungary. Obstetric and gynecological training is outdated and does not prepare doctors for respecting women's bodily autonomy, and there are no significant advancements to enabling women's exercise of autonomy in deciding about their birthing experience (e.g. choosing home birth or other, alternative treatment during birthing).[20] Hungary still follows an over-medicalised approach to childbirth,[21] despite scientific evidence that midwife-led continuity of care (as opposed to the other, obstetrician-led model of maternity care) is linked to better health outcomes: intervention levels are lower, breastfeeding rates are higher and mothers' overall satisfaction is better.[22]

21. A recent study[23] found that **the right of women to informed consent and best available treatment is frequently and seriously violated** in obstetric practice in Hungary, in spite of explicit provisions in Hungarian law[24]. The study's results show that labour had been inducted in 22% of all deliveries and 1 out of 4 women were given labour induction without consent. Freedom of women to choose labour position was restricted in

[20] http://www.youngfeminist.eu/2016/08/stop-bawling-obstetric-violence-in-hungary/
[21] https://www.cochrane.org/CD004667/PREG_midwife-led-continuity-models-care-compared-other-models-care-women-during-pregnancy-birth-and-early?fbclid=IwAR09D7RGaM3fbmWsfZFS1Bqf40Ha24-yi4Vt6s4_ctx8vCBf9BX78swa82c
[22] https://www.cochrane.org/CD004667/PREG_midwife-led-continuity-models-care-compared-other-models-care-women-during-pregnancy-birth-and-early
[23] ETHICAL IMPLICATIONS OF OBSTETRIC CARE IN HUNGARY: Results from the Mother-Centred Pregnancy Care Survey, Szebik et al, *European Journal of Mental Health 13 (2018) 51–69*
[24] Act CLIV of 1997 on health care, 15. § (3)

2/3 of vaginal births and episiotomy[25] was done in 72% of cases[26], at the same time 62% of women were not asked for consent to the procedure. In fact, several women had undergone episiotomy in spite of their explicit refusal. Another 1 out of 10 women who had undergone C-section were subjected to the procedure without consent, and 1 percent of them explicitly refused undergoing cesarean section[27]. These findings show the violation of informed consent on one hand, and the extreme proportion of medically unnecessary interventions on the other. These are highly likely to cause additional physical and psychological **harm to the health of women** giving birth. Similar concerns about practices and experiences of women who had given birth are presented in civil society initiatives[28].

22. **Sexual harassment and abuse of women during prenatal care, birth or postpartum** also occurs in Hungary. A grassroots women's rights movement (Maternity Care Movement/Másállapotot a szülészetben mozgalom) has been collecting **stories of abuse, mistreatment and traumatic experiences** from pregnant women and mothers. Women reported numerous experiences of: inappropriate remarks made during vaginal examination by physicians about the supposed sexual performance, appearance, weight or attractiveness of the pregnant/postpartum woman; the frequent practice of the "husband stitch"[29]; the unsolicited stimulation of the clitoris of women during manual examinations; and inappropriate touching of breasts during a breast examination.[30] Given that there is no forum for general feedback on the received care, these cases remain unknown and without consequences or remedy.

23. Until the end of 2019, there has been no directive or protocol in place concerning the practice of health care facilities' obstetric care departments. Despite advocacy efforts and expectations of women's rights groups that the directive underway would finally specify comprehensive, obligatory and appropriate requirements in maternity care – a responsibility neglected since 2013 – the finally adopted directive's[31] approach is rather limited. Relevant women's rights NGOs and professionals were involved only in certain parts of the discussion concerning the directive, and most of their input was not taken into consideration. The directive as a whole lacks a human rights perspective, which is certainly well indicated by the fact that **the concept of informed decision was omitted** from the section of the directive on communication with the mother-to-be. The pregnant woman is not considered to be a decision-making adult in light of this directive, which is openly expressed in its regulations: instead of declaring the woman's right to self-determination in birthing, professionals might "allow" her certain activities, like eating, going to the toilet, or holding the newborn baby. It clearly does not treat the woman as a competent adult while **maintaining a relationship of subordination** between the physician and the mother. Further, the directive is considered to be a recommendation, merely declaring the *possibility* of using non-invasive/alternative interventions instead of setting them as the required norm. The directive also did not set any deadline for the implementation of scientifically substantiated international good practices[32].

[25] A significant surgical incision between the perineum and the posterior vaginal wall.

[26] According to the World Health Organization's guidelines, the overall ratio of episiotomy should not exceed 10% in vaginal deliveries (WHO 1996).

[27] The high number of C-sections indicate the probability that the interventions were not performed for medical reasons.

[28] See in Hungarian: https://ablakavilagra2.wixsite.com/ablakavilagra, https://emmaegyesulet.hu/ and http://masallapotot.hu/rolunk/

[29] A practice sometimes used after performing an episiotomy, under which the doctor sews the women's vagina narrower with an extra stitch, often accompanied by remarks that the intervention is "for the sake of the husband" to constrict the vaginal opening for "his pleasure". There is no official statistic on the prevalence of this intervention, but accounts of women having undergone this practice show it to be an existing and alarming health and human rights violation, on par with female genital mutilation. See more in Hungarian: https://nlc.hu/egeszseg/20210204/gatmetszes-ferjoltes-szuleszeti-eroszak/

[30] See in Hungarian https://www.facebook.com/masallapotot/posts/2875312279354969 https://nlc.hu/egeszseg/20210204/gatmetszes-ferjoltes-szuleszeti-eroszak/?fbclid=IwAR075TOaCUZADMoQSk59shAXqarR3PH604Rd861ui13ANqdgrhyy9GSxPuc

[31] http://www.kozlonyok.hu/kozlonyok/index.php?m=0&p=kozltart&ev=2019&szam=20&k=6

[32] See in Hungarian: https://merce.hu/2020/02/19/jar-is-a-magyar-noknek-korszeru-szuleszeti-ellatas-meg-nem-is/

24. **"Gratitude payments"**, a practice where pregnant women give informal payment to physicians in hopes of better treatment and care, were accepted **in 68 percent** of birth deliveries[33]. The reason behind this practice is the need of pregnant women to feel safe and be able to foresee the care received from a chosen doctor. Since clinical practices vary enormously among different healthcare facilities – and even among different doctors within a single facility – choosing a certain doctor and paying them to ensure availability for the pregnant woman at any time, gives the feeling of having at least a modicum of control over one's bodily autonomy in the extremely vulnerable situation of giving birth. However, this practice has several negative effects: studies found that **medical interventions were more frequent**[34] in cases when the women were giving birth with a chosen doctor based on informal payment, while the respectful treatment of the women showed only a 20% difference in better treatment compared to women who gave birth with the obstetrician on duty. Furthermore, this practice clearly disadvantages women who are not economically stable.

25. After long-standing demand for reform concerning the practice of gratitude money, a draft bill[35] was submitted in October 2020, including paragraphs on the payment and employment of healthcare personnel. **The bill** was adopted within 24 hours, which **was heavily criticised** by the Hungarain Chamber of Doctors[36]. The bill changed several acts: the crime of bribery in the Penal Code now includes sections on the prohibition of the *acceptance of financial or non-financial undue advantage*[37], while the Act on health care specifies the exact content and limits of what may constitute *"financial or non-financial undue advantage"*[38]. The changes entered into force on 1st January 2021, leaving many pregnant women afraid and alone, **not knowing in which facility and with which doctor they may give birth**, shedding light on the high insecurity concerning adequate treatment, as well as the fear from the diverse, unforeseeable and harmful practices in obstetric care in Hungary, which women try to avoid.[39]

26. It is legally possible in Hungary for women to give birth outside of the institutional framework, including home-birth.[40] Nevertheless, the free and informed decision of a woman regarding where to give birth to her child is overshadowed by the **stigmatization of home birth and giving birth with the help of a midwife**, which peaked at the infamous trial and conviction of midwife Ágnes Geréb in 2018[41]. The controversial trial and prison sentence sparked expressions of national[42] and international[43] solidarity towards Geréb and amplified concerns of midwives in Hungary due to the fear mongering of the media and the lack of clear regulations, resulting in feeling under threat when conducting midwifery practice[44]. There is increased concern over undermining the professional legitimacy and autonomy of midwifery practice. Additionally, the Hungarian Ombudsperson expressed his opinion that the **state is not fulfilling its obligation** to protect the rights of pregnant women, as long as home birth is **not financed by social security,** while giving birth in an institution (e.g. hospital) receives comprehensive social security financing[45]. This regulatory gap is interfering

[33] https://k.blog.hu/2021/01/02/maternity_english?fbclid=IwAR3v-gXlLUks-MrXCYM5T_sda6EGjjm-5sd8_pOWhXvIjWZlr1DYUG7KSEU
[34] ibid, https://www.researchgate.net/publication/318603795_Informal_cash_payments_for_birth_in_Hungary_Are_women_paying_to_secure_a_known_provider_respect_or_quality_of_care
[35] Draft bill no. T / 13174. on the legal status of the health service, 20.-21. § (submitted: 5th October 2020, adopted 6th October 2020)
[36] See in Hungarian: https://magyarorvosok.hu/cikk_tul-sokba-kerulne-az-orvosoknak-es-a-betegeknek-a-kormany-beremelesi-terve&category=H%C3%ADrek
[37] Act C of 2012 on the Criminal Code, 290. § (6), 291. § (6)
[38] Act CLIV of 1997 on health care, 138/A. §
[39] See in Hungarian: https://www.valaszonline.hu/2021/02/16/szuleszet-halapenz-fogadott-orvosi-rendszer/?fbclid=IwAR1AwqY6vHHn4RZzG78uXxEwXyXBGI1LrzQHSStGHjE7zLEgqX-nDhSCVJE
[40] Regulated in Government Decree 35/2011. (III. 21.)
[41] See in Hungarian: https://magyarnarancs.hu/publicisztika/az-eretnek-108789
[42] See in Hungarian: https://444.hu/2018/01/20/tobb-ezer-viraggal-mondtak-halat-gereb-agnesnek
[43] Solidarity statement of Human Rights in Childbirth: https://www.facebook.com/HumanRightsInChildbirth/posts/1394715633972255
[44] See in Hungarian: https://merce.hu/2018/03/05/elhalasztjak-gereb-agnes-buntetesenek-vegrehajtasat-ader-donteseig/
[45] See the statement of the Ombudsperson in Hungarian: https://www.ajbh.hu/-/az-alapveto-jogok-biztosa-az-otthonszules-allami-finanszirozasarol-es-erdemi-valaszthatosaganak-biztositasarol

with the right of women to self-determination, including the possibility to choose the place of giving birth - within the framework provided by law. The current situation holds obstacles, legal uncertainties and may result in the unfavourable position of less wealthy women when choosing the place for giving birth.

27. Whereas the position of pregnant women is overall disadvantageous in obstetric care, there is also evidence of the additional **discrimination faced by Roma women**, such as: provision of worse care, rooms and facilities for rural Roma women than non-Roma women, and even performing sterilisation without consent during delivery.[46][47]

**II.2. Recommendations on pregnancy and birthing**

28. [Recommendation 6] Enforce the rights laid down in Act CLIV of 1997 on health care, with special emphasis to the principle of ***informed consent***. As part of this effort:
    a. *Patient legal representatives* need to have adequate tools to protect patients' rights, exceeding their current function of merely giving information about rights.
    b. Establish a *unified system of feedback and accountability* in hospitals, quality monitoring and assurance to filter out inadequate practices and rights violations, thus improving the quality of care and safety for women and newborn children.
    c. Immediately *ban gynecological and obstetric practices that are performed on women without prior information or consent*, such as the "husband stitch" and forced episiotomy.
    d. Healthcare professionals' *training should incorporate a consent-based approach and professional guidelines* setting women-centered care as a minimum standard. Pregnancy and giving birth is not an illness, but a natural physiological process, and the treatment of pregnant women, women in labour, and newborns, as well as the training for obstetricians should be performed accordingly.

29. [Recommendation 7] Not penalise and marginalise, but give *space, legitimacy and appropriate funding to alternative gynecological and obstetric approaches* that center women's needs, particularly midwifery-led care. Steps to this direction involve:
    a. Actively and substantially *including professional and civil society organizations and individual experts in the development of any regulation* aimed at improving the situation and treatment of pregnant women in the healthcare setting.
    b. Eliminating funding practices that are discriminatory against midwifery-led care, and instead *providing legal, financial and practical support of midwifery-led care*, including training of midwives (establishing adequate conditions enabling the proper training of midwives). Midwifery-led care is evidence-based, good for the health of mother and the baby, thus needs to be an active part of the healthcare system serving pregnant women.
    c. Reviewing the scope of healthcare services connected to birthing currently covered by social security, and supporting women's right to choose from all existing options for giving birth by *widening the scope of eligible, state-supported services*.

**III.1. Sterilisation and assisted reproductive services**

30. In 2014, the **legal conditions for voluntary sterilization became more stringent**: sterilization for family planning (non-medical reasons) is allowed only for a person who is over 40 years old or already has 3 biological children.[48] This is a discriminatory practice and it poses health concerns, especially to women who have not reached the required age but do not want to have any or less than 3 children, and are not able to or

[46] See in Hungarian: https://www.life.hu/eletmod/20160419-romanok-helyzete-es-lehetosegei-a-magyar-szuleszeti-ellatasban-szuleteshaz-egyesulet.html
[47] See in Hungarian: https://24.hu/kozelet/2020/08/31/roma-anyak-diszkriminacio-kuria/
[48] Act CLIV of 1997 on health care, 187. § (1) a)

do not want to use other methods of contraception, including birth control pills due to related health risks[49]. It also further disadvantages women who cannot access hormonal or other contraceptive methods due to their high cost; inaccessibility, especially in rural areas; and/or their partners' refusal to use condoms. Meanwhile, sterilization is considered an admissible method of birth control by the WHO[50].

31. On the other hand, **forced sterilization** is an existing threat not only for Roma women, as mentioned above, but also for people living with cognitive disabilities, according to a publication[51] of ÉFOÉSZ (Hungarian Association for Persons with Intellectual Disability). They also express their concern of the restriction on sexuality of people living with disabilities, both in institutional and family environments. The practice of obligatory contraception use in institutional facilities concerning disabled women, as well as observing the regularity of women's periods is mentioned in a three-year independent study[52]. We have no knowledge about any steps taken or considered to be taken to improve the reproductive health and rights situation of women living with disabilities. It must also be taken into account that consent is a more complex subject for those living with severe mental disabilities. There is also no clarity on who should bear the care burdens that may result from childbearing of parents with severe disabilities in the lack of appropriate support.

32. In Hungary, **assisted reproductive services** (artificial insemination and IVF) are available for married heterosexual couples or heterosexual couples who are living together in partnership. Since 2016, single women can also apply for ARS if they have 2 medical opinions confirming their infertility or ARS is advised due to their age (1997. CLIV. §167).[53] Even if ARS only consists of artificial insemination, which is a primary choice for lesbian women, an aggressive hormonal treatment therapy is required preceding the procedure. In 2020, after the state took over control of fertility clinics, the government has announced to provide free fertilisation treatment to married couples.[54] That is, ARS are primarily tailored to support married heterosexual couples that have difficulty to conceive, but when the reason for ARS is not infertility (but being a single/lesbian woman without a male partner) and only artificial insemination (not IVF) is required, there are unnecessary deterrents and treatments. Requiring aggressive hormonal treatment as a condition of artificial insemination (when the cause of opting for assisted reproductive services is not medically proven infertility) should not be used to deter single and/or lesbian women from the procedure. This constitutes discrimination expressing preference for heterosexual, partnered parenthood.

**III.2. Recommendations on sterilisation and assisted reproductive services**

33. [Recommendation 8] ***Remove the conditions of voluntary sterilisation*** to ensure access to people under 40 and those with no/less than 3 children.

34. [Recommendation 9] Establish and implement policies ***preventing discrimination against*** Roma women and women living with disabilities in the entirety of obstetric care and during deliveries, including forced sterilisation.

[49] https://www.plannedparenthood.org/learn/birth-control/birth-control-pill/how-safe-is-the-birth-control-pill
[50] https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception
[51] See in Hungarian: A nőiség és a nemiség kérdései értelmi fogyatékos felnőttek csoportjaiban, Az Értelmi Fogyatékossággal Élők és Segítőik Országos Érdekvédelmi Szövetségének kiadványa, 2016, p. 25-26.
[52] See in Hungarian: AZ ESÉLYEGYENLŐSÉGTŐL A TAIGETOSZIG? KUTATÁSI ZÁRÓTANULMÁNY, Nemzeti Kutatási, Fejlesztési és Innovációs Hivatal – NKFIH, ELTE BGGYK, Fogyatékosság és Társadalmi Részvétel Intézet, 2017, p. 171-172., https://core.ac.uk/reader/84467090
[53] http://www.neak.gov.hu/felso_menu/lakossagnak/ellatas_magyarorszagon/egeszsegugyi_ellatasok/meddosegkezelesi_eljarasok , https://www.hazipatika.com/eletmod/meddoseg/cikkek/lombik_egyedulallo_noknek_ki_lesz_az_apa/20170209145809
[54] https://www.bbc.com/news/world-europe-51061499 , https://index.hu/gazdasag/2020/01/13/meddoseg_klinika_kaali_intezet_szuletes_demografia_novak_katalin2/

35. [Recommendation 10] ***Eliminate discrimination between the recipients of assisted reproductive services***, so that it becomes as accessible and supported for single women, women living in lesbian partnerships, and unmarried couples, as it is for married heterosexual couples.