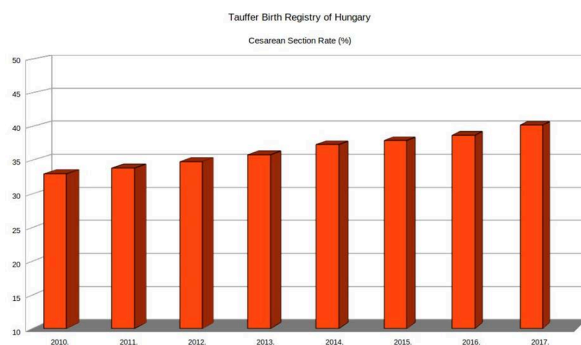


Submission on the issue of
**Mistreatment and violence against women during reproductive health care with
a focus on childbirth,**
as the subject of the next thematic report of the United Nations Special Rapporteur on
violence against women

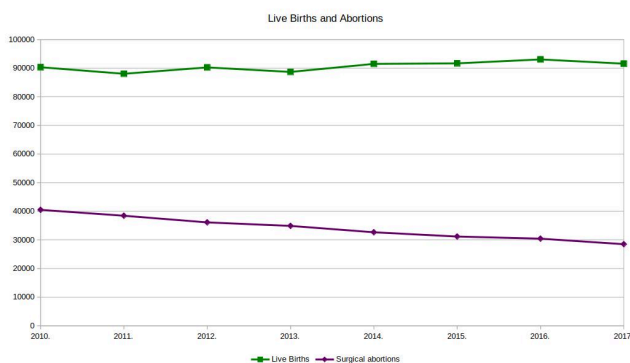
1. Limited availability and transparency of data

Legislation regarding the accessibility of data of public interest changed in 2011, and then again in 2015 further restricting access, and it became easier for government bodies to decline data requests or demand unreasonable cost reimbursement for the requested data. Therefore the national Cesarean rates have not been published in a user-friendly and easily accessible format since 2013.

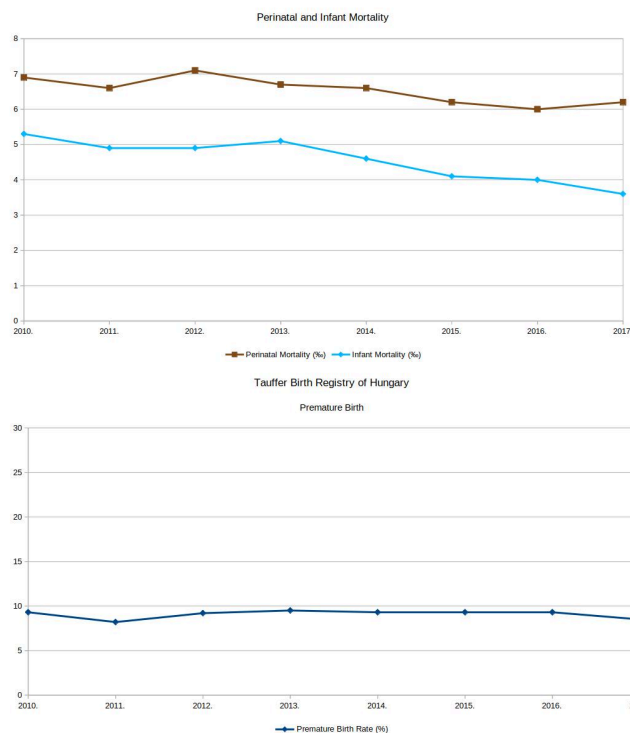
The below data is taken from the Tauffer obstetric database¹. The **national average of C-section rates was 40,2% in 2017, continuously increasing from 2010**, with hospitals ranging from 50 to 11%. The underlying cause of this significant difference can not be completely explained by the level of care or the rate of complicated cases served by a given hospital.



Other baseline data from the Tauffer database:



¹ The database is accessible here: <http://193.225.50.35/webgy/regbe/belepes.php>, the data was processed and presented by <https://www.facebook.com/csaszarmetszesek.hu/>



Further data (rates of episiotomy, induction, augmentation, epidural anesthesia, instrumental deliveries, VBAC, availability of waterbirth, of non-pharmacological forms of pain relief, breastfeeding rate, etc) are rather difficult to obtain, as there is no centralized, uniform data collection scheme in place. A consumer advocacy group SzülészetiVálasztó² (“Picking a maternity unit”) requests such data annually, but the results are based on the voluntary data provided by the hospitals, and so not always reliable.

The difficulty of obtaining the data reflects a general trend towards **limiting access to public data**, but also a lack of strong advocacy and lack of effective consumer protection in the field of maternity services.

2. Corruption

The Euro Health Consumer Index³ specifically names Hungary as a country with poor position on patients rights, information, accessibility and outcomes. The report lists Hungary at the second worst ranking regarding "**under-the-table-payments**" - this problem is especially significant in maternity care, as ob-gyns (and surgeons) receive most of these payments.

Transparency International Hungary⁴ and Hungarian Women’s Lobby is running a program on corruption and its effects on maternity care (this “under-the-table” or „gratitude money”, a kind of informal payment prevalent in the Hungarian health care is a kind of corruption, and maternity care is one of the most infected areas)

² 2017 data, only in Hungarian: https://issuu.com/kangaegyessel/docs/zsebi-2017-08szuleszetvalaszto-issu_bf95b1e44fe84c

³ The report is available at <http://www.healthpowerhouse.com/index.php?Itemid=55>

⁴ Report “Cherchez la Femme! Gender and Corruption, with special regard to violence against women and gratitude payments in maternity care” is available at https://transparency.hu/wp-content/uploads/2019/03/cherchez_la_femme_summary.pdf

A 2017 study on informal cash payments⁵ also confirmed the problem: mothers ensure the presence of a selected ob-gyn by paying informal cash payments, not being aware that in many cases this leads to **higher rates of interventions**.

Demanding or expecting “gratitude money” or suggesting to women that this is the “usual fee” is against the law, and against the Code of Ethics of the Hungarian Medical Chamber, nevertheless it is a common and widely accepted practice. There have been only very few cases where demanding “gratitude money” resulted in any legal or other consequences, including a 2-year prison sentence, and a few cases of being dismissed from the hospital after several complaints from patients (in these cases the health professional could continue working in another institution without any problem).

3. Lack of skilled health care professionals

At least **20,000 health workers are missing** from the Hungarian health system, including physicians, nurses, midwives and other health care professionals. This has a negative impact on the accessibility and the quality of maternity services as well, leading to extra working hours, additional administrative burden and increased pressure on health care staff, without having access to peer-support, professional supervision or counseling services. This leads to higher rate of burn-out and, understaffing also leads to lower standards of care, having a direct impact on disrespectful communication and mistreatment of birthing persons and their babies.

3. Unkept promises

Changes in maternity care have been promised for years, but not implemented. These are the areas where favorable changes have been “almost ready” for years.

- **Financing rules hinder early discharge of mothers and babies.** The regulation regarding financing should be changed so that mothers and babies can leave the hospital after an uncomplicated birth within 24 hours. Currently the hospital gets reimbursed if mother and baby stays at least 72 hours after birth, so the financial interests of the hospitals prevent earlier discharge, even if there is no medical indication to keep mother and baby hospitalised.

- **Midwives can't really offer prenatal care within their scope of practice.**
According to the legal framework, prenatal care can be offered by midwives, but in practice they are often made jump through hoops to get licensed. Ob-gyns, family physicians, midwives and health care visitors are all taking part in prenatal care - but only midwifery prenatal visits are not covered by social security.
- **Lack of evidence-based practice guidelines on physiological/normal birth or intrapartum care.** The development process for up-to-date, evidence-based practice guidelines was initiated several times over the years. In some cases the guidelines were almost ready, but finally were not adopted, due to unknown reasons. Other guidelines (post-date pregnancy and induction) has been out of effect since 2015, without being revised or renewed.

⁵ [Baji P, Rubashkin N, Szebik I, Stoll K, Vedam S](https://www.ncbi.nlm.nih.gov/pubmed/28787630): Informal cash payments for birth in Hungary: Are women paying to secure a known provider, respect, or quality of care?
Available at: <https://www.ncbi.nlm.nih.gov/pubmed/28787630>

In 2019, with the coordination of the Human Resources Ministry a working group was set up developing „Practice guideline on family friendly maternity services”. After increasing pressure from NGOs and grassroots organizations, certain steps of the negotiation process became open for other stakeholders, but then again the decision-making steps went under the radar.

The process is not transparent, mothers, families and other consumer groups are not involved, their experiences and needs are not channeled into the system, despite earlier promises.

4. The voice of mothers

Másállapotot grassroots movement started in 2016 (Changes in maternity care – the Hungarian name literally means “different state, different condition”, which is also a name for pregnancy, and also refers to the need of a different state of affairs in maternity care).

The 2017 UN Report of the Working Group on the issue of discrimination against women in law and in practice on its mission to Hungary found “the over-medicalization of practices related to childbirth, which is not in accordance with WHO indicators or guidelines.”⁶ The situation has not change since then.

Ever since launching the Másállapotot Facebook page⁷, birth stories describing the experiences of mothers keep coming in, giving a picture of obstetric violence and traumatic births across the country. The below is not an exhaustive list of the problems reported:

- **mistreatment, disrespectful, humiliating communication** during prenatal care, labor, birth and the postpartum period
- **being coerced to interventions**, done too often, routinely without proper medical indication, without providing information and/or consenting. Interventions performed **without informed consent** include among others manual dilatation of the cervix or aggressive membrane sweeping or placing cytotec or prostaglandin during a manual cervical examination close to term (from week 39, without signs of labor), with the aim to induce birth, without prior information provided to the woman. Membranes are broken and/or oxytocin is often given without informing the woman that her birth is being induced or augmented.
- Usually all consent forms must be signed by the mother upon arrival to the hospital in active labor, without the chance to ask for clarification. The procedures are not explained and the consent forms are not given to the woman during prenatal care, only when she shows up at the labor ward in active labor, which is inherently not a suitable occasion to discuss the risks, benefits of all interventions and alternative options - though providing this information is mandatory according to the Act on Health Care Services⁸
- **Lack of intimacy and privacy**, some labor wards are separated by curtains, or doors are not closed, while women lie with their legs apart facing the open door and corridor where staff, other patients and complete strangers are coming and going
- Unconsented presence of medical students, unconsented procedures done by students for the purpose of their “practicing”
- Being denied the presence of fathers and doulas at the same time

⁶ <https://www.refworld.org/topic,50ffbce582,50ffbce5121,593a99b64,0,,HUN.html>

⁷ <https://www.facebook.com/masallapotot/>

⁸ English version available at <https://www2.ohchr.org/english/bodies/cescr/docs/E.C.12.HUN.3-Annex10.pdf>

- Being denied the presence of any support person during Cesarean section, miscarriage and stillbirth
- Disrespectful care and no treatment options offered for spontaneous abortion, D&C done routinely, without prior education on options or consent
- **Being denied eating and drinking during labor**, “allowing” only putting wet textiles or cotton wool balls to the mouth of the laboring woman
- **Performing surgical procedures** and other invasive interventions **without proper anesthesia**. This includes cases where the mother states during surgery or perineal repair that the anesthesia is without effect and she is fully aware of all pain, but the care provider continues with the Cesarean section or surgical repair or other invasive procedure, dismissing the woman’s pain (“Nevermind, it will be over soon”. “It cannot be that painful”. “You must tolerate this pain” etc.)
- Being subjected to invasive and painful interventions without prior information or consent, or **despite the explicit refusal and active protest of the mother**. These interventions include: frequent vaginal examinations, often by several different care providers immediately one after the other (e.g. midwife, medical student, physician on-call, physician in charge), forced manual cervical dilatation during vaginal examination, artificial rupture of membranes (in these latter two cases often telling the mother in advance that it would be a regular vaginal examination, and when she feels pain, the procedure is simply denied and her pain is made fun of, such as “How will you be able to push the baby out if you already complain?”), fundal pressure (Kristeller), episiotomy, placement of uterine catheter, pulling of the cord to hurriedly remove the placenta while it is not separated yet, manual uterine palpation of the scar internally (in the case of vaginal births after Cesarean), postpartum uterine exploration and manual sponge curettage (in some hospitals done routinely after every birth). Often mothers are told that they only get an IV line for normal saline to help them stay hydrated, and they later find out that pitocin was also added to the IV fluids. Other drugs or medications might also be administered to the woman without informing her.
- If the woman is not considered cooperative by the health care staff, they sometimes used **physical violence**, like slapping the face of the woman or forcibly holding her legs down, or kneel on her legs, hands or abdomen to keep her from moving while interventions are made on her against her will (e.g. forced manual examination, forced manual cervical dilatation, Kristeller maneuver, manual removal of the placenta instead of a normal physiological third stage, without medical emergency).
- Forced and painful procedures are sometimes framed as a kind of punishment, such as “If you had behaved better, you could have avoided this. You should have obeyed what we had told you to do”.
- “Mandatory” supine position during labor. In some of the hospitals different maternal positions and mobility are tolerated (though not encouraged) during the first stage of labor, but women must take the lithotomy position during the pushing stage, even using stirrups in some hospitals.
- **Undue separation of mother and baby** during the immediate postpartum and during their entire hospital stay. In some hospitals, no skin-to-skin contact is ensured after birth, the baby taken away for “cleaning up” or measurements, even if the mother explicitly requests that any non-emergency interventions be postponed. Routine separation of mothers and babies in the postpartum period in different wards, up to 24 hours, even if there is no medical condition of either mother or baby that would require their separation

- Unduly restricted visiting hours for other family members, meaning that for example fathers/partners have only a 20-30 minutes timeframe throughout the entire day to see mother and baby, or in some hospitals, only the mother can come out to the visiting room, without the baby. Siblings are allowed to visit only in a few institutions and only exceptionally.
- Some hospitals have “VIP family rooms”, meaning that more affluent families can have access to a private room during their hospital stay together with the baby. They are allowed a free flow of visitors, while others, who can’t afford, are placed in multi-person wards, without rooming-in and restricted visiting hours.
- In the case of miscarriage or stillbirth no opportunity to see or hold the fetus/baby, and inhumane treatment of products of conception, denial of funeral arrangements, no bereavement support offered, attendants are often not skilled in supporting a mother who is losing a baby
- Attendants are not prepared to support survivors of childhood sexual abuse, often triggering and retraumatizing women
- Very **limited options for VBAC** (vaginal birth after cesarean), only a few care providers across the entire country offer VBAC. Vaginal birth after multiple Cesareans is practically non-existent. Access to vaginal breech birth or vaginal birth of twins is also extremely limited.
- **Sexual abuse** of women during prenatal care, birth or postpartum (such as making “funny” remarks about the sexual performance, the appearance, weight or attractiveness of their body while making a vaginal examination, or asking the partner during stitching up an episiotomy “how tight do you want her to be?”, the unsolicited stimulation of the clitoris of women during manual examinations, inappropriate touching of breasts during a breast examination)
- Babies are often subjected to interventions (bathing, scrubbing, vaccinating, administering medication, starting an IV line, drawing blood, giving formula or glucose solution etc.) without informing the mother, or against her explicit will, or later denying that any such intervention has been made

Interventions done without consent are also underlined by the 2019 study of Szebik et al.⁹: “Labour was induced in 22.2% of all deliveries and it was done without permission in 25.4%. Episiotomy was done in 39.9% of women having vaginal delivery in the Sample 2 group and in 72.2% of women having vaginal delivery in the Sample 1 (representative) group. Women undergoing episiotomy were not asked for consent in 62.0% in the Sample 1 group and in 57.1% in the Sample 2 group. Freedom to choose labour position for women having vaginal birth was restricted in 65.7% in the Sample 1 group and in 46% in the Sample 2 group.”

⁹ Szebik. I. Susánszky É., Szántó Zs., Susánszky A., Rubashkin. N.: “ETHICAL IMPLICATIONS OF OBSTETRIC CARE IN HUNGARY: Results from the Mother-Centred Pregnancy Care Survey”. Available at: http://real.mtak.hu/81412/1/ejmh_2018_1_szebik_et_al_51_69.pdf

5. Ombudsman reports regarding common practices in maternity care

- a) 2016 Ombudsman report on homebirth, especially the availability of Rhogam (Anti-D) to homebirthing mothers¹⁰

In this report the ombudsman recognizes the **discrimination of homebirthing mothers** both by not providing equal funding for midwifery services from social security funds, and also by not ensuring that mothers have equal access to Rhogam in out-of-hospital settings, as midwives do not have the right to prescribe medications, so a physiologist must be involved, requiring extra costs and efforts. In addition Rhogam must be paid by the family, while for mothers birthing in hospitals it is provided free of charge. Despite the report the situation has not changed since.

- b) 2019 Ombudsman report on rooming-in¹¹

“In his report, the Commissioner emphasized that the convenience of the roommates, the lack of a baby-friendly accreditation of the health care institution, the financial and infrastructural conditions of the hospital, the position taken by the hospital management, the work schedule or daily routines established at the hospital department, or the attitudes of the staff working at the department in question cannot constitute a legal obstacle to the development of child-friendly solutions.” – These are the arguments used by hospital management for **not ensuring 24-hour rooming-in** of the mother and the newborn.

- c) 2019 Ombudsman report on the care of preterm babies¹²

Perinatal Intensive Centers should ensure the **best available care for babies born preterm**, which includes not only access to medical technology, but also kangaroo-care, breastfeeding support, donor milk support and unlimited access of parents to their preterm babies.

6. State of autonomous midwifery

Hospital-based midwives are not allowed to work autonomously (with some rare exceptions), they are mostly assistants to physicians, despite the legal framework that gives them the competence (with some limitations, for example they cannot order or administer drugs or medicines). The reasons behind this: 1. the hierarchy of the health care system, fuelled by the “gratitude money” (see point 2 on Corruption), where the informal payment goes to the ob-gyn in charge, 2. inadequate training system of midwives, not equipping them with the required clinical skills

Homebirth midwives are under increasing pressure in Hungary. Although there is a regulation, the working conditions, the very limited scope of practice restricted competences, the administration, the price of malpractice insurance, the lack of cooperation and the lack of respectful working relations with hospital staff not only put undue pressure on midwives, but also jeopardize safety of mothers. The hostile media environment and the fear of prosecution

¹⁰ Available only in Hungarian: https://www.ajbh.hu/documents/10180/2500969/Jelent%C3%A9s+az+otthon-sz%C3%BC1%C3%A9s+szab%C3%A1lyoz%C3%A1s%C3%A1r%C3%B3+2350_2016/af95de52-e12a-4e4f-9e83-af35acde4c25?version=1.0

¹¹ Available at https://www.ajbh.hu/zh/web/ajbh-en/-/the-commissioner-for-fundamental-rights-on-the-practice-of-rooming-in?inheritRedirect=true&redirect=%2Fzh%2Fweb%2Fajbh-en%2Fmain_page

¹² Available only in Hungarian: <https://www.ajbh.hu/zh/-/az-alapveto-jogok-biztosanak-jelentes-a-koraszulott-ellatas-helyzeterol>

(as a result of ambiguous or contradictory elements of the regulation), unreasonable administrative burdens, financial hardship, and other factors lead to burn-out and to midwives giving up their practices, thus further limiting birth options of women living outside Budapest (the capital) and putting more workload on the other practicing midwives. As a result, the free choice and decision-making autonomy of the birthing persons and their families is severely compromised.

Ágnes Geréb homebirth midwife was sentenced to 2 years in prison, and although she was granted presidential clemency, this clemency only covers the prison sentence, other legal consequences, including the effect of criminal record and ban to practice medical professions are still in effect, meaning that she is not able to work as a physician, as a psychologist, or homeopathic doctor either, while she must reimburse the costs of the legal procedures.

Felícia Vincze, another homebirth midwife was forced to close her practice due to defamation and libeling attacks by the media and legal prosecution initiated by nearby hospitals following otherwise uncomplicated birth center-to-hospital transfers

7. Breastfeeding support

Although the many positive effects of breastfeeding on maternal and child well-being and health are well documented, breastfeeding rates in Hungary are still below the desirable level. Maternity leave up to the age of 3 is a positive element in our country and there are supporting legislation for working breastfeeding mothers, too. However, in health care, including maternity and community care, **mothers do not receive the information and support that would be necessary for breastfeeding** their children for the recommended period of time.

In maternity facilities, the **separation of mothers and their newborns is a common practice**, that makes bonding and establishing breastfeeding difficult. In the absence of adequate training, the knowledge and practical skills of the staff are insufficient to effectively support breastfeeding: the mothers regularly receive inappropriate information and the newborns are frequently supplemented with unnecessary infant formula - both of which act as a hindrance to breastfeeding. Many times the **negative or offensive communication** of the health care providers undermines the self-confidence and/or self-esteem of the mothers.

The knowledge of professionals working at community health care services is also often incomplete, which makes it impossible for them to provide effective help in case of breastfeeding difficulties; moreover it commonly leads to unnecessary prohibition of breastfeeding eg. over a certain age of the child or in case of maternal illness.

Public breastfeeding is not regulated by law in any form in Hungary, ie it is not prohibited, but not explicitly supported. From time to time, mothers report exposition to atrocities when trying to breastfeed their babies in a public place.

In addition to all of the above there is no effective protection from harmful commercial interests. The regulation on infant formulas and follow-on formulas contains some paragraphs on labeling and advertising, but it is incomplete and concerns only infants under 6 months of age. There is no legal instrument to guarantee the compliance with the law and no sanctions are imposed for the violation. As a result, the **marketing of breastmilk and breastfeeding**

substitutes is rampant in Hungary, undermining the efforts of mothers, professionals and volunteers to accomplish successful breastfeeding; it also interferes with the right of children to achieve the highest attainable standard of health; has adverse effects on the economic status of the families and on the environment; and abolish the capacity of breastfeeding in reducing inequalities.

Theoretically there is a National Committee for Breastfeeding in Hungary, but in the last few years it has virtually no effect due to **lack of funding and unclear status**. The NCB is also the coordinating organization of the Baby-Friendly Hospital Initiative in Hungary, so the cessation of its operation means the end of BFHI, too. This is definitely a step back and, given that Europe's first designated baby-friendly hospital was a Hungarian facility, it is sad.

Setting up again a National Infant Feeding Strategy Board or National Breastfeeding Committee tasked with developing a comprehensive Infant Feeding Strategy and implementation plan is imperative in Hungary. We need to implement evidence-based initiatives that support breastfeeding, including the Baby Friendly Initiative, across all maternity, health visiting, neonatal and children's centre services. Protecting babies and their families from harmful commercial interests by adopting, in full, the International Code of Marketing Breastmilk Substitutes is also essential in our country.

8. Discrimination against disadvantaged groups

a) Roma women

The alternative CEDAW report of 2013¹³ already underlined that problems regarding reproductive health (family planning, access to abortion, preterm birth, low birth weight etc.) are more common among disadvantaged groups, including disabled women, Romani women, women with HIV or AIDS, and asylum-seeker women.

The context: In Hungary, the Roma constitute the largest ethnic minority, and practically the only „visible” minority group – given the low proportion of migrants in the population, compared e.g. with Western European countries. Unlike in Western Europe, the overwhelming majority of the Roma living in Hungary are citizens of the country (living sedentary lifestyle). During the population census in 2011, slightly more than 3% of the general population identified themselves as Roma;¹⁴ however, according to reliable estimations (based on academic research), the proportion of the Roma may be higher than 8 % of the population of Hungary.¹⁵ The Roma population is significantly younger in comparison to the overall Hungarian population, due to lower life expectancy (the average life expectancy of a Roma is approximately ten years lower than the mainstream average, owing to health problems closely related to low socioeconomic status), moreover, compared to the ratio of the Roma population in general, the proportion of Roma children is significantly higher: according to the latest available estimations, the share of Roma among all newborns in Hungary is 15 %.¹⁶

The Regina Foundation Miskolc (*Regina Alapítvány Miskolc*)¹⁷, a pro-Roma women’s NGO working in Borsod-Abaúj-Zemplén County (in the economically disadvantaged, North-Eastern region of the country, where the population rate of the Roma is high¹⁸) identifies several problems related to the access of Roma women to reproductive health care services:

- While non-Roma women are provided with adequate assistance and information during prenatal health care and childbirth, the same **support is not provided for the members of marginalized Roma communities**. Socially marginalized Roma women are not informed appropriately about their health care rights, which is a form of discrimination itself.
- In the public hospital of Miskolc (the largest city of Borsod-Abaúj-Zemplén county), **Roma and non-Roma women are placed in separate wards after giving birth**, as an informal practice. The system of segregated maternity wards is not based on an official policy, but is in place due to the pressure coming from the majority population, i. e. non-Roma women prefer not to be placed with Roma women, referring to cultural differences. The hospital does address this issue on an institutional level.

¹³ https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/HUN/INT_CEDAW_NGO_HUN_13260_E.pdf

¹⁴ See Tóth, Á., Vékás, J. (2018): National and Ethnic Minorities in Hungary in the Period 2001–2011 – Ethno-Demographic Trends as Reflected in the Census Data, *Hungarian Statistical Review*, Special No. 17, pp. 95-112, available at: http://www.ksh.hu/statszemle_archive/2014/2014_K17/2014_K17_095.pdf

¹⁵ See: Péntes, J., Tátrai, P. and Pásztor, I. Z. (2018), A roma népesség területi megoszlásának változása Magyarországon az elmúlt évtizedekben (Changes in the Spatial Distribution of the Roma Population in Hungary During the Last Decades), *Területi Statisztika*, 58(1). pp. 3-26., available at <http://www.ksh.hu/docs/hun/xftp/terstat/2018/01/ts580101.pdf>.

¹⁶ Kemény, I., Janky, B., (2005), Roma Population of Hungary, 1971–2003, in Kemény, I. (ed.) *Roma of Hungary*, East European Monographs New York: Columbia University Press.

¹⁷ See <https://www.facebook.com/reginamiskolc/>

¹⁸ See e.g. a map published by the Library of the Hungarian Parliament on the dispersion of Roma population in Hungary: http://mtatkki.ogyk.hu/terkepek.php?map=2011_roma_cigany

- Another problematic practice of the same hospital is that Roma and/or socio-economically disadvantaged woman **are hindered to exercise their right to be accompanied during childbirth by a relative** (an adult family member, a friend or a doula) of their choice. This right is provided by the Act on Health care Services,¹⁹ however, the hospital charges a relatively high fee for the ‘visitor attire’ (a disposable hygienic suit, to be worn in the delivery room by the companion of the woman), which is not affordable for families living in poverty. Thus, in many cases, Roma mothers (among them young girls under the age of 18 years) have to spend the hours of labor and childbirth without a supporting companion.
- Moreover, Roma women sometimes have to face **harassment during childbirth by staff members of the public hospital in Miskolc**, according to the accounts of members of local Roma communities.

The European Roma Rights Centre (ERRC)²⁰ addressed the latter two of the above mentioned issues within the framework of strategic litigation:

- In 2016, a Roma woman from Borsod-Apaúj-Zemplén county turned to the Equal Treatment Authority based on the following facts: while she was giving birth in the public hospital in Miskolc, she cried out with pain and the midwife yelled at her ‘if you shout once more I will push the pillow into your face’; then, a doctor warned her that if she kept shouting, he would call for a psychiatrist and might have her child taken into state care, in which case she would not receive a family allowance, and he added ‘You, Gypsies, you only give birth for the money, anyways’.²¹ The Equal Treatment Authority established harassment (creating a humiliating environment and violating the dignity of the complainant) based on the grounds of ethnicity and color, and imposed a fine of HUF 500,000 (approx. USD 1,700) on the hospital.²² The ERRC provided the complainant with legal aid during the hearings before the Equal treatment Authority.²³
- The ERRC sued the Miskolc county hospital in 2017 for direct and indirect discrimination, regarding the practice of charging the companions of birthing mothers for the ‘visitor attire’. In its decision from October 2018,²⁴ the Regional Court of Miskolc found direct discrimination based on pregnancy/ maternity (which is a protected ground in Hungarian anti-discrimination legislation) and indirect discrimination based on Roma ethnicity and social status.²⁵ This judgment was upheld on appeal by the Debrecen Court of Appeal in January 2019.²⁶ The hospital

¹⁹ Hungary, Act CLIV of 1997 on Health Care Services (1997. évi CLIV. törvény az egészségügyről), Article 11 (5).

²⁰ See: <http://www.errc.org/>

²¹ See the overview of the case in English: <https://www.equalitylaw.eu/downloads/4069-hungary-roma-woman-harassed-in-hospital-while-giving-birth-pdf-110-kb>

²² Hungary, Decision no. 349/2016, available at: <https://www.egyenlobanasmod.hu/hu/jogeset/ebh3492016>.

²³ See the press release of ERRC (2017, January 18): ‘Romani Woman Harassed by Racist Hospital Staff during Childbirth Wins Case’, available at: <http://www.errc.org/article/romani-woman-harassed-by-racist-hospital-staff-during-childbirth-wins-case/4543>

²⁴ Hungary, Regional Court of Miskolc, decision no. 10.P.22.249/2017/19., available at:

http://www.errc.org/uploads/upload_en/file/5102_file1_hungary-miskolc-court-decision-october-2018.pdf

²⁵ See the press release of ERRC (2018, November 12): ERRC ends discriminatory hospital charges affecting Romani mothers, available at: <http://www.errc.org/press-releases/errc-ends-discriminatory-hospital-charges-affecting-romani-mothers>

²⁶ Hungary, Debrecen Court of Appeal, decision no. Pf.I.20.749/2018/8, available at:

http://www.errc.org/uploads/upload_en/file/5106_file1_anonymised-version-of-the-judgment-in-hungarian-2018.pdf

was fined for HUF 2,000,000 (approx. USD 6,800) and obliged to cease the unlawful practice.

Moreover, the ERRC is involved in the case of non-Roma woman (Ms. G.H., who married a Roma man, and lived in a segregated Roma neighborhood, thus she was considered as a Roma by the mainstream society) who was sterilized without her informed consent in a public hospital in 2008, during an emergency medical procedure (removal of her dead twin fetuses). The case reached the European Court of Human Rights, but the application of Ms. G.H. (who was provided with legal representation before the Strasbourg Court by the ERRC) was found inadmissible:²⁷ she was deprived of her victim status, because of the fact that she had already received some compensation from domestic courts.²⁸ The ERRC brought the case to the UN CEDAW Committee, the case is currently pending.

The above sections have been submitted by the European Roma Rights Center.

There are official restraints to the availability of country-wide statistical data (e.g. the ethnicity of patients is not recorded in the documents), so data is only available from individual cases or small-scale studies. In 2016 Birth House Association ran a program on the situation of Roma women in maternity care, through conducting in-depth interviews with affected women.²⁹ This program was also implemented in the economically disadvantaged, North-Eastern region of the country, where the aforementioned Regina Foundation Miskolc works.

Women living in disadvantaged rural areas have extremely **limited access to prenatal care**, due to the distance of the health care facility, the lack of money to pay for travel, and the unsuitable timetables of rural traffic, making a 20-minute prenatal visit to a health care visitor a full-day program in an area without affordable and accessible childcare options.

Roma women are at higher risk to being subject to interventions without informed consent, as they have a lower level of self-advocacy skills, and they are less likely to ask questions or ask for clarifications if not provided appropriate information. They do not receive culturally competent care, their birth traditions, personal preferences and values are not respected. These women usually can't afford (or the health care staff assumes that they can't afford) paying "gratitude money", as a result they are **often neglected physically and emotionally**, their requests or complaints are ignored, they are often humiliated and verbally abused, they are often left alone during labor, birth and the postpartum period. Roma women are sent to a different postpartum ward separated from non-Roma women, often at the end of the corridor, isolated from the other wards, and nurses visit them less often. This finding is in line with the experiences of Regina Alapitvany Miskolc working in north-east Hungary, but there are reports of segregated wards from other hospitals of the country as well.

b) Maternity care of asylum-seekers

Asylum-seekers arriving to Hungary from Serbia are placed in the transit zones at the Southern border of Hungary (Tomba, Röszke)³⁰. To our knowledge, about 10 babies have been born to asylum-seeker women since 2016.

If the labor of a woman starts in the transit zone, she is taken to the nearest hospital (Szeged or Kiskunhalas) by ambulance, **without any accompanying person** (the presence of the

²⁷ G. H. v. Hungary, Application no. 54041/14, decision of the ECtHR of June 9, 2015.

²⁸ For the analysis of the reasoning of the ECtHR, see: Weiss, A, Gellér, J (2016, September 14), G.H. v Hungary: Victim Status in Cases of Forced Sterilisation, *Strasbourg Observers*, available at: <https://strasbourgobservers.com/2015/09/14/g-h-v-hungary-victim-status-in-cases-of-forced-sterilisation/#more-2971>

²⁹ The full text of the report is available only in Hungarian at http://www.szuleteshaz.hu/wp-content/uploads/2016/04/ROMA_final_online.pdf

³⁰ http://www.bmbah.hu/index.php?option=com_k2&view=item&layout=item&id=1220&Itemid=1791&lang=en#

father at birth is not usual for these women, but on the other hand they are not informed of their right to it). The father is taken for a visit to the hospital by police on the next working day (not during weekends). Keeping in touch with other family members and especially siblings is problematic during hospital stay. Because the couples do not have their marriage certificate with them, the children receive the name of the mother, which is unsettling for the fathers. If the parents have no documents to verify their identity (which is not unusual in situations of forced migration) the newborns nationality is registered as 'unknown' on the birth certificate. Changing such registration at a later stage is difficult and thus increases their risk of becoming stateless. Unfortunately there is no information available about the circumstances of their birth, we have no information on any complaint made.

Having a female doctor present during their birth would be an expectation, but usually it does not happen. **Usually no interpretation is available** during their care, in which cases they cannot give their informed consent to any procedures done, including a Cesarean section, and the woman cannot make her needs heard either during labor and birth. The lack of interpretation in one case led to a birth certificate issued mistakenly with the mother's name. In another case an examination revealed high risk of a genetic disorder, and amniocentesis was offered to the woman, but without interpretation she could only understand that there is some problem with the baby. Finally a female and native speaker ob-gyn was found and the situation was settled (the baby turned out to be healthy).

c) Maternity care of inmates

According to relevant legislation, as a general rule babies born to a woman during her prison sentence can stay with the mother up to 1 year of age (in a special department of a prison³¹). The 2013 statement³² of the Commissioner of Fundamental Rights (ombudsman) proposed that infants younger than 1 year of age should be able to stay with their mother, even if born before the beginning of the prison sentence.

In one case scrutinized by the ombudsman, the baby was taken 5 days after the birth from a female inmate, due to her incapability, and though the action itself was lawful, its implementation was not³³.

Newborn babies are not with their babies constantly, they are brought to their mothers at fixed times for feeding, which does not support breastfeeding on cue.

There is no information available on the circumstances of the birth of women giving birth during their prison sentence, or their access to prenatal and postnatal care.

d) Childbirth in psychiatric institutions

The Commissioner of Fundamental Rights compiled a report³⁴ in 2015 regarding the demise of a baby born to a woman in a psychiatric hospital. The staff did not recognize the signs of labor, though they were aware of her pregnancy. The woman was chemically and physically restrained. The baby was born, but soon deceased due to inappropriate care during delivery. The report states that **laboring and birthing the baby while strapped to the bed** is itself a humiliating and inhumane practice.

³¹ See <https://bv.gov.hu/hu/anya-gyermek-reszleg>

³² Full report available in Hungarian at:

http://www.ajbh.hu/documents/10180/111959/201200329.pdf?utm_source=mandiner&utm_medium=link&utm_campaign=mandiner_201905

³³ Press release in Hungarian: <http://www.ajbh.hu/kozlemenyek/-/content/qzyKPkTyQAvm/jogszerusegeben-is-lehet-jogserto-az-ombudsman-a-buntetes-vegrehajtasi-korhazban-szulo-gondnok-sag-alatt-allo-anya-gyermek-ek-elhelyezes-rol>

³⁴ Full report in Hungarian:

http://www.ajbh.hu/documents/10180/2500969/Jelent%C3%A9s+egy+pszichi%C3%A1tri%C3%A1n+levezetett+sz%C3%BCI%C3%A9s+vizsg%C3%A1lat%C3%A1r%C3%B3+524_2016/2caecdc8-5940-429d-98ec-df0157294ba2?version=1.0

9. Complaints and compensatory mechanisms

In 2016 the Integrated Right Protection Service³⁵ as an independent unit of the Ministry of Human Capacities was established, protecting and enforcing patients' and children's rights. Their website gives the below orientation regarding possible measures taken in the case of patients rights violation.

Pursuant to the Act on Health Care Services³⁶, patients have the right to file a complaint regarding their health care

- a) Directly to the management of the hospital or other health care institution
- b) the body or institution financially operating the hospital (e.g. local municipality, private foundation, church, ministry etc.)
They must react to the complaint within 30 days.
- c) To the public health authority, to the authorities issuing the operating licence and supervising the operation of the institution
 - within 6 months after the case in the complaint. If the complaint is filed later than 6 month but not later than 1 year, then it might be considered by the authority, however if the complaint is filed later than 1 year, then it will be refused without consideration.
 - The complaint is also refused if the person submitting the case cannot be identified or if other complaint on the same case is being processed at the same time.
- d) To the Hungarian Medical Chamber³⁷, or the Ethical Committee of the Chamber of Health Care Professionals³⁸, in the case of ethical complaint
- e) Claims for damages or other court cases can be filed at the competent court, and the patient might request legal assistance if needed.
- f) If fundamental rights are violated, then the case can be submitted to the Commissioner for Fundamental Rights (ombudsman)³⁹
- g) If discrimination is experienced, then the case can be submitted to the Equal Treatment Authority⁴⁰
- h) Questions about financing issues or legislation: Ministry of Human Capacities⁴¹, National Health Insurance Fund⁴²
- i) Each hospital has an appointed „patients rights representative”, who (in theory) helps the patient to
 - o Have access to all documents and ask for clarification regarding their health care documentation, supporting the protection of personal data
 - o Formulate and file a complaint, initiate the revision procedure
 - o If authorized, the representative can file the complaint on behalf of the patient
 - o Represent the patient at the competent authorities.

³⁵ See <http://www.ijsz.hu/>

³⁶ Hungary, Act CLIV of 1997 on Health Care Services (1997. évi CLIV. törvény az egészségügyről),

³⁷ See <https://mok.hu/>

³⁸ See <https://meszk.hu/info.aspx?sp=8>

³⁹ See <http://www.ajbh.hu/>

⁴⁰ See <https://www.egyenlobanasmod.hu/>

⁴¹ See <https://www.kormany.hu/hu/emberi-eroforrasok-miniszteriuma>

⁴² See <http://www.oep.hu/>

- o The representative could also initiate changes of hospital protocols, to prevent similar cases in the future, and help to ensure compensation mechanisms to patients

In practice these rights are not enforced. The contact data and office hours of the representatives are not always placed visibly in the medical institutions. Representatives often informally tell patients that „it makes no sense to file a complaint, nothing will change, you really can't do anything about it, that's just the way it is". Therefore **patients are often deterred from filing a complaint**. As such, the low amount of complaints does not reflect appropriately the standard of care.

In addition, there is **no systematic feedback or evaluating scheme** in place, so neither the individual birth attendants, nor the hospitals nor the ministry has an appropriate understanding on the scale and volume of the problem.

As a result, authorities and decision-makers often claim that violation of human rights is not a common phenomena during childbirth, only isolated, exceptional cases happen from time to time, and they do not need to be addressed at a policy level.

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