SUBMISSION TO THE SPECIAL RAPPORTEUR
ON THE RIGHT TO SEXUAL AND REPRODUCTIVE HEALTH
CHALLENGES AND POSSIBILITIES DURING COVID-19
June 2021

Másállapotot a szülészetben! (Changes in maternity care!) is a grassroot movement established in 2016 in Hungary, with the aim of amplifying the voice of women and channeling their experiences to the decision-making process regarding maternity care. The Hungarian name literally means "different state, different condition", a term that is also used in the meaning of pregnancy, and it also refers to the need of a different state of affairs in maternity care.
The focus of our work is the childbearing year, including conception, pregnancy, birth and the postpartum period, however we address other areas of reproductive health as well.

Contact Details

Type of Stakeholder (please select one)	☐ Member State ☐ Observer State ☒ Other: CSO
Name of State Name of Survey Respondent	Hungary Másállapotot a szülészetben (Changes in Maternity Care) movement
Email	masallapotot@gmail.com
Can we attribute responses to this questionnaire to your State publicly*?	Yes No

In Hungary the first wave of the coronavirus pandemic started in early 2020, the government declared a special state of emergency on 11 March 2020[1]. In order to release the pressure from health care institutions, special measures came into effect, usually via governmental decrees. Lockdown measures affected schools, public institutions, public events, workplaces, and of course hospitals and all other health care services. Planned and scheduled operations and services were postponed. 60% of hospital beds were cleared up in April 2020[2], sending home many people who would have required constant care and/or supervision. Acknowledging the need for extraordinary measures, we are convinced that some of the actions taken were unnecessary and disproportionate. We followed the unfolding of the situation with great concern, as it became apparent that maternity services and women's rights are being de-prioritised. Hard-earned, slowly progressing positive trends reversed during the pandemic. The standard of care received by women is already depending upon their socio-economic status, their financial situation, their ability to navigate the system, their access to information and their self-advocacy skills, so population groups lacking any of these resources are at higher risk of receiving suboptimal care.

[1] Government decree on special state of emergency, available at https://net.jogtar.hu/jogszabaly?docid=a2000040.kor
[2] https://koronavirus.gov.hu/cikkek/korhazak-orszagszerte-felkeszulnek-tomeges-megbetegedesekre

1. **Presence of birth companions**

The total ban on visitors in hospitals was among the first measures. The Chief Medical Officer[3] and the ombudsman[4] clearly communicated that visitor ban does not affect the right of minors and the right of birthing women to an accompanying person. However, many hospitals throughout the country banned birth companions, or made their presence dependent upon flu vaccination status, or recent negative PCR tests or a full personal protection equipment (PPE) - at that stage of the pandemic these were practically inaccessible or unaffordable, making the exercise of a human right depending on money. Such measures cause an insurmountable barrier for disadvantaged populations, including Roma and poor families. In some hospitals the presence of the birth companion was restricted to the pushing stage, and not included the earlier stages of labor, when the emotional and physical support would have been also essential. Women going though miscarriage were also denied the presence of a support person. Despite the constant affirmation by all government resources that birth companions should be allowed, hospitals still continue this arbitrary practice.

2. **Destaffing and closing of maternity units**

There had already been a shortage of healthcare professionals before the pandemic. At least 20,000 health workers are missing from the system, including physicians, nurses, midwives and others. This situation has been aggravated by regulation changes regarding the legal standing and employee rights of health workers in March 2021,[5] when additional 5500 people left the sector. Some health workers were directed to care for Covid patients, some were even deployed to other geographical areas to specialized Covid hospitals, resulting in understaffed and closed maternity units. The persistent lack of professionals working in the field of women's health is combined with the restricted scope of competence of midwives, not allowing their autonomous work, despite the legal framework and their qualifications enabling them to do so. As a result, maternity units are under constant threat of being closed. A draft policy document[6] revealed a plan for having certain maternity units open only during the day, and other hospitals offering services during the night. Considering that birth cannot be scheduled, and a normal, physiological labor could last more than 12 hours, the plan seems detached from reality. Such a set-up would likely lead to the increase of non-medically indicated interventions (among others induction, augmentation, scheduled Cesareans), which would jeopardize the health of birthing persons and their infants. Restricted access to 24-hour maternity services would further increase the already existing geographical health inequalities, as rural women already have less choice in their health care, less services available and at a larger distance.

Evidence shows that midwife-led continuity of care (as opposed to obstetrician-led model of maternity care) is linked to better health outcomes: intervention levels are

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[3] Press Conference of the Chief Medical Officer, available at https://index.hu/belfold/2020/03/10/koronavirus_operativ_torzs_sajtotajekoztato_elo_kozvetites_facebook_live/
Decision of the Chief Medical Officer on visitor ban, exempting birth companion: https://tasz.hu/a/img/HATAROZAT-latogatasi-tilalom-elrendelese-42935-1_EUIG.pdf

[4] The ombudsman's statement on birth companion during the pandemic, available at https://tasz.hu/a/files/Ombudsmani-valasz_apas-szules.pdf

[5] Law on legal relations in health care https://net.jogtar.hu/jogszabaly?docid=A2000100.TV&searchUrl=/gyorskereso

[6] „Considerations for the restructuring of hospital care", available at https://rtl.hu/dokumentumok/2021/korhazi.pdf

lower, breastfeeding rates are higher and mothers' overall satisfaction is higher[7], so the way forward solving the lack of health professionals would be to support and promote the autonomous work of midwives and to open stand-alone midwifery units, birth centers and other community alternatives.

3. Gaps in prenatal care

During the pandemic hospitals, the offices of general practitioners (GP) and health visitors (a special network of community-level health care professionals providing obligatory prenatal care to all women) shut down or limited their services, including prenatal visits. Some of these offices managed to offer online services, but there was no central coordination, technical or methodological support for them to switch to telemedicine. The Hungarian prenatal care system is already quite fragmented and involves many actors (ob-gyn, GP, midwife, health visitor), and includes many screening tests (ultrasound and blood tests) to the extent that it could be considered over-medicalized. During the pandemic many check-ups and screening tests were cancelled or rescheduled, leaving women feel neglected and their needs ignored.

4. Lack of communication

Very often the main problem was the lack of clear and transparent communication and the lack of clear guidelines, so women and families could hardly navigate the system and its ever-changing rules. Hospital childbirth education classes were cancelled, without providing other, online available resources. Homebirth midwives, doulas and independent childbirth educators started to offer online courses to fill the information vacuum. Self-organized groups tried to spread information on community media regarding the current rules of any given institution, but these sources were not always reliable, so it was often difficult to keep track.

5. Medically non-indicated prolonged hospital stay

In Hungary, hospitals get full financial reimbursement only if the mother and baby stay for 72 hours after the birth – this is not a medical necessity, but a financial regulation, unchanged for decades. Many professional organizations and advocacy groups have been pushing for change in this matter for more than 10 years now, to ensure the option of early discharge (12-24 hours after the birth) for healthy mothers and babies.

Though some hospitals eased their rules to enable early discharge, many women had to stay for a minimum of 72 hours after birth without getting the necessary help as staff was overloaded and visitors were banned. New mothers often stayed in 4-6 room wards together with other patients, sometimes with unknown Covid-19 status.[8] Medically not justified hospital stay limits personal autonomy and also increases the risk of infection for mothers and babies. In some cases, prolonged stay was aggravated by separating mother and baby while they were in the hospital.

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[7] Midwife-led continuity models of care compared with other models of care for women during pregnancy, birth and early parenting, available at https://www.cochrane.org/CD004667/PREG_midwife-led-continuity-models-care-compared-other-models-care-women-during-pregnancy-birth-and-early

[8] Information based on the results of the online survey „Birth during the coronavirus" available at https://docs.google.com/forms/d/e/1FAIpQLSew9ODoTbeDsRuARd7kNbaf3WDEWS2wHF9hc1OUxulfdWX-RA/viewform

6. Separation of mothers and babies

Most of the Perinatal Intensive Care Units (PICU) applied visitor ban on premature babies and other infants in intensive care, although parents are not visitors. According to the relevant ombudsman report, PICUs should ensure the best available care, involving kangaroo-care, breastfeeding support, donor milk support and unlimited access of parents to their preterm babies.[9] Both scientific evidence and the human rights approach underline the need for non-separation of vulnerable infants and the huge health benefits of kangaroo-care. During the pandemic, WHO[10] and other relevant evidence-based sources, including the relevant Hungarian neonatology guidelines[11] consistently recommended taking care of mother and baby as one unit, and isolate the mother and baby together, even in the case of Covid positive mothers. Nevertheless, separation of mothers and babies was rampant, not only in PICUs, but also in the case of healthy term newborns, citing lack of adequate staff or infrastructural barriers to rooming-in, for example renovation of the building or the need for clearing up space for Covid patients. An earlier report on rooming-in by the ombudsman clearly indicated that infrastructural circumstances could not justify the violation of human rights.[12]

7. Overmedicalization, obstetric violence, lack of informed consent

The rate of interventions had been high in maternity care before the pandemic, episiotomy (cutting through the perineum) is routinely performed in about 70% of vaginal births, Cesarean section rates have been steadily on the rise and well over the medically acceptable 10-15% recommended by WHO[13]. During the pandemic the rate of interventions increased further in certain institutions. Despite relevant international guidelines[14] and the statement of the National Public Health Authority[15] saying that a positive Covid test in itself is not an indication for a Cesarean, several hospitals automatically scheduled a C-section for asymptomatic, Covid positive mothers. Access to VBAC (Vaginal Birth After Cesarean) was also restricted in some places, using the pandemic as an excuse (while other institutions continued to offer this option).

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[9] Available only in Hungarian: https://www.ajbh.hu/zh/-/az-alapveto-jogok-biztosanak-jelentese-a-koraszulott-ellatas-helyzeterol

[10] WORLD HEALTH ORGANIZATION: *Q&A: Pregnancy, childbirth and COVID-19* of 18 March 2020, available at https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/q-a-on-covid-19-pregnancy-and-childbirth

[11] https://tasz.hu/a/img/Neonatologia-Tagozat.pdf

[12] Full report of the ombudsman in Hungarian: http://www.ajbh.hu/documents/10180/2932608/Jelent%C3%A9s+egy+gyermek+%C3%A9s+anyja+k%C3%B3rh%C3%A1zi+elhelyez%C3%A9se+%C3%BCgy%C3%A9ben+605_2019/
In English: 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

[13] WHO Statement on Cesarean Section Rates, April 2015, available at http://apps.who.int/iris/bitstream/handle/10665/161442/WHO_RHR_15.02_eng.pdf?sequence=1

[14] ACOG Guideline available at https://www.acog.org/en/Clinical%20Information/Physician%20FAQs/COVID%2019%20FAQs%20for%20Ob%20Gyns%20Obstetrics?fbclid=IwAR0R7vh0JdqtWHJfD8kzrUM2kNHBLpdr1U-MqqbkxDrjFiHsa2y3mDiLy4k
WHO Guideline available at https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/coronavirus-disease-covid-19-pregnancy-and-childbirth
Hungarian Covid-19 obstetric protocol: https://tasz.hu/a/img/Szuleszet-Nogyogyaszati-Tagozat.pdf

[15] Answer of the National Public Health Authority regarding the obstetric care of Covid-19 positive women, in Hungarian, available at https://drive.google.com/file/d/1YO2BA-IJcdtG_ezyjnJ6SBHDBvEwDas-/view?fbclid=IwAR1JkCTE6mJ8XOCL0ij49H6zLTBMtxOC6VdmGGe1w1iJfVFA8t-QkRdMBbE

Various forms of obstetric violence, including unnecessary and unconsented interventions, sexual harassment and abuse of women during prenatal care, birth or postpartum also occur in Hungary. Several studies[16] and internet-based surveys[17] found that the right of women to informed consent and best available treatment is frequently and seriously violated in obstetric practice, in spite of explicit provisions in Hungarian law. Women often do not receive appropriate, relevant and evidence-based information to facilitate their decision-making, they are not offered options and alternatives, their decisions are often simply overruled, they are pressured or bullied into compliance if they raise questions, sometimes even "punished" for trying to exercise their right to informed decision-making (such punishment might involve additional blood drawing or screening tests performed on their babies, separation of babies, extended hospital stay, threatening to call the police or notifying child protection services).

8. Vaccination of pregnant and breastfeeding women

In Hungary health authorities started the vaccination of pregnant and breastfeeding women (Pfizer and Moderna vaccines being authorized for this population) from 26 March 2021.[18] The roll-out of the vaccine was initially slightly troublesome, with administrative loopholes and long queues, however the main concern is the complete lack of follow-up and monitoring, not enabling the easy and smooth report of adverse effects or the timely treatment thereof.

9. Prohibiting informal payments in maternity care

The Euro Health Consumer Index[19] specifically named Hungary as a country with poor position on patients' rights, information, accessibility and outcomes. The report listed 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 a large chunk of such payments. According to several studies, the system of hiring a selected ob-gyn for the birth has contributed not only to a vast amount of grey-zone financial transactions, but also to a higher rate of interventions[20].

The management of this problem has been long overdue, so when the regulation abolishing this practice came into effect in March 2021, it might have been welcomed by women. However, it was not. The main reason is the unpredictability of the system, due to regional and individual differences in the standard of care, as well as the lack of consistent implementation of evidence-based practice guidelines. Women have no control whatsoever over what is happening to them and to their babies during labor and birth, because obstetric violence is wide-spread, they are often subject to unconsented and non-evidence-based interventions, they are bullied into choices against their will, and their decisions are not respected. Women had tried to ensure respectful care by paying for it – prohibition of this practice is not a solution without ensuring that human

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[16] 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, Available at: http://real.mtak.hu/81412/1/ejmh_2018_1_szebik_et_al_51_69.pdf

[17] Results of online survey made by Ablak a világra available at https://ablakavilagra2.wixsite.com/ablakavilagra/szuleszetiadabtazis

[18] https://koronavirus.gov.hu/cikkek/az-oltast-kero-varandosok-regisztraljanak-majd-azutan-jelezzek-oltasi-szandekukat

[19] Euro Health Consumer Index**,** available at https://healthpowerhouse.com/publications/

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

rights are always respected during all phases of labor, birth and postpartum care.

10. Endometriosis treatment

As a result of the above-mentioned changes in the employment form of health care workers, many specialists left state-financed hospitals to work instead in the private sector. This immediately resulted in further delays in the treatment of endometriosis, where waiting lists had already been several months long. Endometriosis affects about 200.000 women in Hungary, and it is often associated with severe pain and suffering. Now women needing surgery must either go to expensive private care or wait for up to a year. The government initially refused, then postponed changes in financing the treatment of this intensely painful condition (the case is still unresolved as of June 2021).[21]

11. Access to abortion and emergency contraception

Access to abortion did not became more restricted during the pandemic, however only surgical abortion is available in the country, medical abortion is not. In 2012 the EU-wide registered abortion pill Medabon received the marketing authorization in Hungary, but later it was not introduced to the market based on political reasons. Compelling women to go through invasive procedures when other methods are available is incompatible with women's human rights. Weekly at least 10-15 women used to travel to Vienna, Austria for a medical abortion[22] – this option was available only for women who could afford and organize the travel, but lockdown and travel restrictions hindered their access as well.

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[23]. The declaration was signed by 32 countries first hand. 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*". 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.

Due to the chaotic state of health services, the access to emergency contraception (morning after pill, 72-hour pill) became even more arbitrary. None of the contraceptives are subsidized in Hungary, and contraception is expensive. According to the regulation, general practitioners (GP) and any on-call ob-gyn could prescribe the medication (so it is not available over the counter, despite the fact that in 2015 the European Commission decided that emergency contraception ellaOne[24] can be available over the counter in the EU), but in practice GPs often refuse prescription. So the woman must go to a hospital, and then the process is made more complicated by requiring

[21] Latest update available on 5 May 2021:
https://www.facebook.com/1653058488294569/posts/2894064264193979/

[22] Joint Stakeholder Submission by PATENT and Sexual Rights Initiative, available at
https://sexualrightsinitiative.com/sites/default/files/resources/files/2021-05/UPR%2039%20Hungary%20PATENT%20and%20SRI.pdf

[23] https://www.hhs.gov/sites/default/files/geneva-consensus-declaration-english.pdf

[24] https://www.ec-ec.org/european-commission-decision-grants-120-million-women-direct-access-to-ellaone/

repeated visits to the doctor's office (which is unreasonable in the case of a time-sensitive procedure!), requiring a negative pregnancy lab test (home test is not necessarily accepted) or forcing a manual cervical check before prescription. The system has always been erratic and haphazard, and the pressure on the health care system during the pandemic further aggravated these problems.

12. Access to fertility treatments and assisted reproduction services

Currently there are about 150.000 couples in Hungary receiving fertility treatment. In Hungary there were government-financed and private options (since 1992) for obtaining fertility treatments, including hormonal therapy, insemination, IVF, and - under very strict legal requirements - egg donation. Pre-implantation genetic screening of the embryo is not legal in Hungary.

Fertility treatments were also temporarily suspended in the early stage of the pandemic, though later resumed. Private services now (as of June 2021) will be outlawed, and fertility treatments will only be allowed in state-owned hospitals. This process started at the end of 2019, when 6 of the private fertility clinics became state-operated. This also meant that all of the examinations and available treatment options became financed by public health insurance. Now the remaining 3 private clinics will also be part of the state health care system according to a recent draft law[25]. Clients of these clinics are afraid that this will lead to longer waiting lists and lower standards of care. There are also concerns about treatments already in progress and about embryos that until now had been stored by the private clinics, under civil law agreements. Another ramification of this problem is that so far Hungarian private fertility clinics could cooperate with institutions in the Czech Republic, where egg donation and pre-implantation screening are both legal (this screening could be crucial after repeated miscarriages). Until now families had access to some stages of the necessary treatment here in Hungary, and other stages in the Czech Republic. This option will no longer be available.

13. Adoption by same sex couples

Under the special provisions of the state emergency, the government changed the rules for adoption, almost excluding single mothers and same-sex couples - their option to adopt became dependent on the case-to-case decision of the Minister for Family Affairs[26].

Sincerely

Anna Ivanyi
On behalf of Másállapotot a szülészetben!
masallapotot@gmail.com
www.masallapotot.hu
https://www.facebook.com/masallapotot

[25] Draft law inlcuding a paragraph on fertility clinics: https://www.parlament.hu/irom41/16369/16369.pdf
[26] Draft law on the regulations of adoption, came into effect in February 2021: https://www.parlament.hu/irom41/13648/13648.pdf