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CEDAW Secretariat
Office of the High Commissioner for Human Rights (OHCHR)
Palais Wilson
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Switzerland

The Committee on the Elimination of Discrimination against Women (CEDAW Committee)

Re: Supplementary information on Hungary scheduled for review by CEDAW during its 54th Session

Distinguished Committee Members:

This letter is intended to supplement the combined seventh and eighth periodic reports submitted by Hungary, which are scheduled to be reviewed by the Committee on the Elimination of Discrimination against Women (the Committee) during its 54th session. The Center for Reproductive Rights (New York), and PATENT Association (Hungary) are independent non-governmental organizations, hoping to further the work of the Committee by providing independent information concerning the rights protected in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

We hope that the Committee's review will cover several areas of concern related to the status of the reproductive health and rights of women and adolescents in Hungary. This letter is intended to provide a summary of the issues of greatest concern regarding (I) Hungary's failure to provide comprehensive health care and information to women and (II) gender stereotyping, which taints the country's reproductive health care – issues all of which have had detrimental impacts on the health and rights of women and girls in Hungary and constitute violations of this Convention. The letter will end with a list of recommendations and questions that we hope the Committee will raise with the official delegation from Hungary.

I. The Right to Comprehensive Health Care and Information (Articles 2, 10, 12, 14(2)(b), 16(1)(e)).

Reproductive rights are fundamental to women's health and equality and an explicit part of the Committee's mandates under CEDAW. As such, the obligation of state parties to guarantee these rights deserves serious attention. Article 12 calls on state parties to "take all appropriate measures to...ensure [...] access to health care services, including those related to family planning."¹ Article 14 requires that women are provided with "access to adequate health care facilities, including information, counselling and services in family planning."² Article 16 guarantees the "same rights [for women as for men] to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights"³ and Article 10 obligates states to provide "access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning."⁴ CEDAW General Recommendation 24 on Women and Health reaffirms the crucial role reproductive health services and information play in the

realization of women's equality and health. It urges state parties "to take appropriate [...] measures to the *maximum extent* of their available resources to ensure that women realize their rights to health care"⁵ and to "implement a comprehensive national strategy to promote women's health throughout their lifespan [...] [including] universal access for all women to a full range of high-quality and affordable health care, including sexual and reproductive health services."⁶ To ensure these rights are guaranteed, Article 2 obliges states, if necessary, to alter laws and regulations as well as "customs and practices."⁷

This Committee has urged Hungary in its last Concluding Observations to "take concrete measures to enhance and monitor access to health-care services for women."⁸ The undersigned organizations would like to raise six issues of particular concern that reflect shortcomings in Hungary's compliance with the provisions of CEDAW related to reproductive rights: (A) the absence of a comprehensive sexual and reproductive health and rights policy, (B) restrictions in the access to safe and legal abortion, (C) the unmet need for contraception, (D) the absence of adequate mandatory sexuality education in schools, (E) the inadequacy of reproductive health services for survivors of sexual violence, and (F) systematic Government interference with women's sexual and reproductive health and rights.

A. Absence of a Comprehensive Sexual and Reproductive Health and Rights Policy

This Committee has asked Hungary in the past to provide information on the Government policy on health⁹ and has admonished Hungary that "the Convention [should be] consistently used by the State party as a framework for all laws, policies and mechanisms aimed at achieving women's equality with men."¹⁰ The Human Rights Committee equally has urged Hungary to adopt a comprehensive approach to preventing and addressing gender-based violence in "all its forms and manifestations,"¹¹ which surely encompasses the realm of reproductive health. Despite these admonitions, the Hungarian Government has failed to elaborate and implement a comprehensive policy with respect to sexual and reproductive health and rights.

B. Restrictions in the Access to Safe and Legal Abortion

CEDAW guarantees women the right to reproductive health care and the ability to freely decide on the number and spacing of their children.¹² Like other United Nations Human Rights Treaty Monitoring Bodies (UNTMBs), this Committee has called on states to remove all barriers to safe and legal abortions¹³ so that women and girls do not face the often life and health threatening complications associated with undergoing them clandestinely. This Committee has repeatedly urged states to ensure access to safe abortion services in particular when the national law permits abortion.¹⁴

1. Constitutional and Legal Framework

The new Hungarian Constitution that was passed in 2011 contains numerous discriminatory and problematic provisions that have been criticized by civil society, the European Union, and the United Nations.¹⁵ Of particular concern, as this Committee noted in its list of questions to Hungary,¹⁶ is a provision that explicitly grants protection of life from the moment of conception.¹⁷ This provision creates grave concerns related to the exercise of women's fundamental rights, including rights to health, privacy and information.

As this Committee has emphasized, "it is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women,"¹⁸ which includes laws that criminalize medical procedures which are only necessary for women.¹⁹ Hungary's constitutional provision protecting life from the moment of conception encourages efforts to restrict access to abortion and could further limit women's access to other reproductive health care services, such as in-vitro fertilization and emergency contraception. This constitutional provision has serious potential for criminalizing abortion and poses a threat to Hungary's compliance with CEDAW.

2. Inaccessibility of Medical Abortion

Even if abortion is legally available, in order to comply with CEDAW, this Committee has noted that safe abortions also have to be accessible.²⁰ Although Act No. LXXIX of 1992 on the Protection of Fetal Life permits abortion,²¹ Hungary severely restricts women's *de facto* access to abortions by curbing the availability of medical abortions. The World Health Organization (WHO) has established that "medical methods of abortion have been proved to be safe and effective,"²² and highlights that "[r]egistration and distribution of adequate supplies of drugs for medical abortion [...] are essential for improving the quality of abortion services, for any legal indication"²³ - a suggestion that also reflects women's right to the enjoyment of the benefits of scientific progress.²⁴ Medical abortion has proven acceptable in low-resource settings²⁵ since it is relatively inexpensive; in comparison to surgical abortions, it is often safer for the woman; and it can reduce costs for the health care system overall.²⁶

Currently only the surgical method of abortion is legal in Hungary. Although Hungary registered a drug, Medabon,²⁷ for medical abortions in May 2012,²⁸ it only did so because of its obligations under EU law related to the decentralized procedure of drug administration.²⁹ Distribution of the drug cannot start, however, before permission of its distribution at the national level, which thus far has not happened. At the same time, the Government has stated publically that the pill will not be distributed in Hungary due to the fact that Hungarian experts cannot agree on its benefits and risks.³⁰ Hungarian human rights NGOs filed an official request for information with the Government asking for details of the controversial professional opinions expressed on the use of the abortion pill.³¹ The Government has not responded yet and instead has declared the whole procedure of drug administration confidential. By deciding not to distribute the pill the Government ignores both international medical expertise and the opinion of the Hungarian College of Obstetricians and Gynaecologists, which is in favor of medical abortion,³² and illustrates the Government's intent to inhibit the availability of medical abortions.

Further efforts by the Hungarian Government to obstruct women's access to medical abortion have been reported. After the registration of Medabon, mentioned above, one private clinic in Budapest started legally to provide medical abortions on the basis of a special permission to distribute. However the Government commissioned the Institute for Pharmaceutical and Medical Quality Control and Organisational Development³³ to develop strategies to interfere with this practice.³⁴ As a result of the Institute's recommendation, the National Public Health and Medical Officer Service audited the clinic in August 2012,³⁵ and it has since stopped providing medical abortions in September to prevent becoming the target of a political debate.³⁶ Thus, the Hungarian Government has not only hindered the distribution of medical abortion but also *de facto* interfered with private actors providing access, with serious negative consequences for Hungarian women's right to health.

3. Biased Counseling Requirements and Mandatory Waiting Period

Hungary's Act on the Protection of Fetal Life mandates two counseling sessions with a three-day waiting period between the sessions before a woman can obtain an abortion.³⁷ The mandated counseling is explicitly designed to dissuade the women from obtaining an abortion. Under Article 9 of the Act the objective of the first counseling session is to influence the women to continue the pregnancy. Women do not learn about their rights and the medical procedure until the second counseling session, which follows after three days mandatory waiting period.

Further, information provided to health care workers during trainings on counseling is aimed at deterring women from having abortions and invoking their maternal feelings.³⁸ Research conducted by PATENT in 2012 that was based on interviews with women and monitoring of the counseling sessions in Budapest and three smaller towns confirms that counseling is often biased and aimed at persuading women to continue their pregnancies.³⁹ The counselors generally exaggerated the physical and mental negative effects of abortion; they appealed to the women's so-called maternal instincts and societal role as child

bearers and highlighted the development of the fetus inducing feelings of guilt. Nurses who counseled the women often misleadingly claimed that abortion causes infertility⁴⁰ and exaggerated risks tied to the procedure, such as the danger of a perforated womb. They frequently showed pictures of fetuses in the week of gestation of the woman and illustratively described the state of the fetus including the development of the fetus's heartbeat and organs. The nurses also lectured women on their societal duty to bear children and downplayed the women's financial and personal burden of carrying the pregnancy to term. Last, abortion counseling offices were often located in the same hallway as pregnancy care, filled with brochures and posters that encourage the continuation of the pregnancy and were likely to invoke guilt feelings in women seeking an abortion.⁴¹

According to the former United Nations Special Rapporteur on Violence against Women (SRVAW), “[a]cts deliberately restraining women from using contraception or from having an abortion constitute violence against women by subjecting women to excessive pregnancies and childbearing against their will, resulting in increased and preventable risks of maternal mortality and morbidity.”⁴² Anand Grover, the United Nations Special Rapporteur on Health, has reaffirmed that mandatory counseling and waiting periods make abortion inaccessible⁴³ and therefore violate international human rights. Further, the 2012 WHO Guidelines on Safe Abortion call on states to ensure that women's decision to seek an abortion “should be respected without subjecting a woman to mandatory counselling.”⁴⁴ If a woman wishes to undergo counseling, the WHO emphasizes that it should be “voluntary, confidential, non-directive and by a trained person”⁴⁵ and the provided information must be “complete, accurate and easy to understand, and be given in a way that facilitates a woman being able to freely give her fully informed consent, respects her dignity, guarantees her privacy and confidentiality and is sensitive to her needs and perspectives.”⁴⁶ As the European Court of Human Rights has held, when a woman seeks an abortion, biased medical counseling as well as the dissemination of misleading information by medical staff violates her fundamental human rights.⁴⁷

According to the WHO, medically unnecessary waiting periods constitute a form of administrative and regulatory barrier to accessing legal abortions.⁴⁸ In addition to the unnecessary delay of the waiting period, requiring two medical visits often creates an undue personal and financial burden on the woman, as well as, according to the WHO, “demeans women as competent decision-makers.”⁴⁹ The WHO recommends that waiting periods that are not medically indicated should be eliminated and all services should be received promptly.⁵⁰ Since 85 % to 93% of women seeking an abortion in Hungary do not change their decision as a result of the counseling,⁵¹ the counseling requirement and the waiting period in themselves constitute unnecessary impediments which are not conform with the premises of CEDAW. In addition, since biased counseling in Hungary creates serious obstacles to women asserting their rights to health and to freely decide on the number of spacing of their children, Hungary violates their obligations under CEDAW to “respect, protect and fulfill”⁵² these rights.

4. Unregulated Practice of Conscientious Objection

Under the Act on the Protection of Fetal Life, “[n]o physician or other health care worker may be required against his will to perform a pregnancy termination or to participate therein, except if the pregnant woman's life is endangered.”⁵³ Although the Act mandates every state- or local government-run hospital with an obstetrical or gynecology ward to provide at least one medical group ready to perform abortions,⁵⁴ a rising number of hospitals have joined the so-called “abortion-free days” initiative organized by the anti-choice organization Alfa Alliance. The association calls upon the hospitals to completely avoid performing abortions on three days of the year: 28th December, the day of the Holy Innocents, 1st June, which anti-abortion groups have entitled the International Day of Life, and 25th March, which they call the Day of the Unborn Child. According to information provided by the association, 38 hospitals have joined their action up until now.⁵⁵

The state bodies' acceptance of this initiative, which *de facto* hinders women from accessing legal reproductive health care, is a direct consequence of the inadequately regulated practice of conscientious objection to abortion services. The existing regulation does not ensure oversight and monitoring mechanisms over the practice of conscientious objection, nor does it provide for complaint mechanisms in case a woman's right to access legal abortion services has been denied. In addition, the current regulation does not impose the most essential duties on objecting providers such as a duty to refer a woman to a non-objecting health practitioner and to inform her of all existing alternatives. Such regulation is inadequate, as it does not properly balance practitioners' option to refuse the provision of abortion services with the duties of the profession and the rights of the patient to lawful and timely medical care.⁵⁶ This Committee has repeatedly expressed concern over the lack of access to abortion services due to the insufficiently regulated practice of conscientious objection⁵⁷ and called upon state parties to "adequately regulate the invocation of conscientious objection by health professionals so as to ensure that women's access to health and reproductive health is not limited."⁵⁸

5. Poster Campaigns on Protection of Unborn Life (2011 & 2012)

In the past two years, the Hungarian Government has initiated two public anti-abortion campaigns with the goal of solidifying anti-abortion sentiments within Hungarian society. The first poster campaign was launched by the Ministry of National Human Resources in May 2011⁵⁹ as part of a larger awareness raising campaign on gender equality within the family. The posters, which were supposed to be displayed for two months in public spaces, showed the picture of a fetus with the words, "I understand it if you aren't ready for me, but rather put me up for adoption, let me live!" The campaign was partly financed by the European Union. However, after a few weeks the European Commission asked the Hungarian Government to immediately remove the posters stressing that the anti-abortion campaign did not conform to European values.⁶⁰ The Hungarian Government argued that the campaign was not an anti-abortion, but a pro-adoption campaign.⁶¹ Nevertheless, the Government finally succumbed to the pressure of the European Union and ended the campaign.

The Ministry of Human Resources is currently sponsoring a second "pro-life" campaign entitled "Life is a Gift." The campaign's posters show happy families with newborn babies. In September 2012, the Government funded a large pro-life conference with international speakers as part of the campaign.⁶² The campaign's website presents itself as an information source for future parents. Most of its content, however, focuses on abortion, and stresses its supposed harmful consequences, such as so-called post-abortion-syndrome, bleeding, bacterial infections, sepsis, removal of the womb, and weakened cervix.⁶³

6. Abortion Tourism

Women residing in Hungary have started to resort to abortion tourism, which sends a clear signal that the current legislation and practice of abortion is already unduly restrictive. The undersigned organizations have information about abortion tourism to Austria. It has been reported that approximately four to six Hungarian women visit a clinic in Vienna (Austria) weekly, and the number is increasing.⁶⁴ The Austrian clinic conducted a survey among these women, which revealed that the primary reason why they chose to terminate their pregnancies in Austria is that medical abortions are available. In addition, an increasing number of women who are only eligible for surgical abortion consulted the clinic for the procedure to avoid the unnecessary waiting period, counseling and any humiliating treatment by medical staff they were facing in Hungary.⁶⁵

C. Unmet Need for Contraception

In its previous Concluding Observations on Hungary, this Committee has voiced concern "that a comprehensive range of contraceptives is not widely available"⁶⁶ and requested the state party to "strengthen measures aimed at the prevention of unwanted pregnancies, including by making a

comprehensive range of contraceptives more widely available, without any restriction, and by increasing knowledge and awareness about family planning.”⁶⁷ Despite these recommendations, the Hungarian Government has not taken any steps to ensure unrestricted access to contraceptive services and information.

1. Lack of Contraceptive Coverage

This Committee has recognized that the right to access health care encompasses the right to affordable contraception.⁶⁸ In the past, this Committee has observed with concern that cost is an obstacle to access to contraceptives in Hungary.⁶⁹ The Committee on Economic, Social and Cultural Rights has explicitly stated that governments should ensure that all drugs on the WHO Model List of Essential Medicines, which includes a range of modern contraceptives including emergency contraception, be made accessible to all.⁷⁰ In addition, the Committee on the Rights of the Child (CRC Committee) in its Concluding Observations on Hungary observed “the rising cost of contraceptives, in turn linked to the high rates of adolescent pregnancies.”⁷¹

Although the Hungarian Government claims that it provides contraceptives “at reduced costs depending on need,”⁷² as part of the Government’s legal obligations under the Law on Protection of Fetal Life, in reality this cost reduction is not implemented. Currently a monthly dose of oral contraceptive costs between HUF 2300 to 3000 (USD 10,5 – 13,6). Women have to pay for contraceptives out of pocket, which has a particularly negative impact on low-income women, adolescents and women living in violent relationships.

2. Limited Access to Emergency Contraception

Emergency contraception “refers to methods of contraception that can be used to prevent pregnancy in the first few days after intercourse,”⁷³ which renders this method particularly beneficial for the protection of vulnerable groups like victims of sexual violence.⁷⁴ This Committee has repeatedly been alarmed by inadequate access to emergency contraception.⁷⁵ It has in the past requested states parties to make emergency contraception “more widely available and affordable.”⁷⁶

Several types of emergency contraception are available in Hungary, but the Government limits women’s access by imposing a prescription requirement.⁷⁷ This requirement delays women’s access, since they have to visit either a general practitioner or a gynecologist to obtain a prescription. The change in the status of the emergency contraception from the prescription to over-the-counter status proposed by the National Institute of Pharmacy (predecessor of the Institute for Pharmaceutical and Medical Quality Control and Organisational Development) during the previous leadership of the institute⁷⁸ has been rejected. At the latest meeting of PATENT and the Hungarian Civil Liberties Union (a Hungarian human rights NGO) with the representatives of the Hungarian College of Obstetricians and Gynecologists - which is the official body of doctors setting professional standards of medical care, and has a consultative status to the Ministry of Healthcare⁷⁹ - in May 2012, the representatives of the College explained that a prescription for emergency contraception was necessary so that doctors can examine the women for potential contraindications such as blood coagulation problems.⁸⁰

Requiring a prescription for emergency contraception runs contrary to international medical standards⁸¹ and is not a common practice in Europe, where emergency contraception is usually available over-the-counter.⁸² The prescription requirement severely limits Hungarian women’s access to emergency contraception while contributing little to the drug’s safe administration. The prescription requirement also increases women’s costs in obtaining reproductive health care, and functions as a disincentive for obtaining care especially for adolescents and women having been subjected to sexual violence. Moreover, the delay caused by obtaining a prescription creates the risk of lessening the effectiveness of emergency contraception since the drug’s effect decreases with the time passed since the intercourse.⁸³

3. Lack of Official Data on Contraceptive Need

This Committee has repeatedly expressed concern over the lack of information and data from state parties regarding women's reproductive health and access to health care services, including family planning and contraceptive services.⁸⁴ Accordingly, it has requested Hungary "to include in its next report further information on women's health and on the impact of measures it has taken to improve women's health, as well as information on women's access to health-care services, including family planning."⁸⁵ Since contraception is not subsidized by the state and the health insurances do not cover contraceptives, there is no official data collection on contraceptive need or use of contraception in Hungary. The only exception furnishes the oral contraceptive G03A –data on which revealed that its distribution has been decreased by 50% between 2002 and 2011.⁸⁶

D. Absence of Adequate Mandatory Sexuality Education in Schools

General Recommendation 24 mandates that "[p]articular attention should be paid to the health education of adolescents, including information and counselling on all methods of family planning."⁸⁷ Moreover, this Committee, as well as several other UNTMBs, has recognized that a lack of sexuality education is an obstacle to the states' compliance with their treaty obligations to ensure the right to life, health, non-discrimination, education and information.⁸⁸ In its Concluding Observations on Hungary in 2006, the CRC Committee "expresse[d] concern over the lack of reproductive health information available to teenagers"⁸⁹ and urged the state party to "strengthen its efforts to promote adolescent health, including sexual and reproductive health education in schools."⁹⁰

Hungary's failure to provide adequate sexuality education is the result of two main shortcomings: a flawed national curriculum as well as its lack of implementation. In its 2012 replies to this Committee, the Hungarian Government indicated that the Act on the Protection of Fetal Life provides for "[e]ducation about the value of health and human life, healthy living, responsible partner relationships, dignified family life and methods of birth control which are not harmful to health in primary and secondary schools".⁹¹ Indeed, a new national curriculum was issued in 2012 that makes it mandatory to cover sexuality education in schools as a part of other subjects such as natural science, biology and ethics classes instead of treating it as a separate subject. The curriculum provides for teaching about contraception in grades seven to eight and grades nine to twelve.⁹² Despite the fact that contraception is covered under the curriculum, it focuses primarily on information about healthy pregnancies, such as "knowledge of the stages of the full human life cycle before and after birth, understanding the value of these stages" and "arguments supporting conscious family planning and the responsible lifestyle of the pregnant mother."⁹³ The curriculum does, for example, not even specifically mention knowledge of sexually transmitted diseases and unwanted pregnancies, which is vital for comprehensive sexual health education. This approach reflects how little importance the Hungarian Government attributes to the dissemination of sexual health information to adolescents and raises serious doubts as to whether sexuality education will be implemented in classrooms and, if so, to what extent.

Concerns about the proper implementation of the curriculum are further aggravated by the fact that Hungarian teachers have shown little initiative in the past to realize requirements under old curricula to address sexuality in their classrooms. A study from 2006 about sexuality education in primary and secondary schools⁹⁴ showed that classes on health education took place only very sporadically. Often, not even the minimum number of prescribed health education classes was held. The teachers in this study noted that an individual teacher was responsible for these classes, and the same teachers frequently opposed the idea of teaching sexuality education to children in the first four classes of school, especially in smaller villages, and as a result, the level of health education varied drastically between schools. It is unrealistic to assume that the mere issuance of a new curriculum, lacking accompanying training of

teachers, will drastically change the attitudes of teachers and communities and dramatically increase their willingness to hold classes on sexuality education.

As a result of the lack of comprehensive sexuality education, the level of knowledge about reproductive and sexual health issues among students is alarmingly low. A study from 2010, in which 5000 teenagers from primary and secondary schools were interviewed,⁹⁵ showed that teenagers' knowledge was insufficient in every area of sexuality and reproduction, although many of the interviewees had already had intercourse.⁹⁶ Eight graders, for example, knew very little about issues such as sexual violence, different contraceptives methods, abortion, and sexually transmitted diseases. Although the new curriculum makes it mandatory to cover sexuality education, it is inadequate in the areas it covers and based on past research it is questionable whether the sexuality education mandated by it will be implemented. Therefore it is highly unlikely that Hungary will provide comprehensive sexuality education in schools, as its international human rights obligations mandate.

E. Inadequacy of Reproductive Health Services for Survivors of Sexual Violence

This Committee has repeatedly urged the states parties to provide access to medical and health services for survivors of sexual violence.⁹⁷ It has acknowledged that “gender-based violence is a critical health issue for women”⁹⁸ and called on states to ensure that appropriate health services are provided to victims of sexual violence.⁹⁹ In this context, this Committee has raised particular concerns about the lack of accessibility to safe abortion for victims of rape.¹⁰⁰ Other UNTMBs have equally admonished states that survivors of sexual violence deserve heightened attention in respect to their reproductive rights.¹⁰¹ The Committee against Torture, for example, has warned that survivors of rape or incest who are forced to continue their pregnancies are constantly reminded of the violation against them through their child, suffer from serious traumatic stress, and often have long-lasting psychological issues such as anxiety and depression.¹⁰²

Survivors of sexual violence are completely left on their own in Hungary. The Government has made no effort to ensure that reproductive health services are made available to this particularly vulnerable group. Health care providers usually do not even undertake basic services such as testing for pregnancy and sexually transmitted diseases. Whether such services are provided to victims of sexual violence strongly depends upon the knowledge and goodwill of the medical personnel in charge. As a result of the lack of proper treatment, many criminal proceedings against sexual perpetrators fail due to insufficient medical recording. A lack of support services as well as humiliating treatment of victims of sexual violence within the healthcare system are amongst the reasons why Hungary has one of the lowest reporting rate for rape among 33 European countries.¹⁰³ It is also one of only two countries in Europe where the reporting rate has been steadily declining since 1977.¹⁰⁴ The situation is so alarming that non-governmental organizations in Hungary that address violence against women recently published guidelines for professionals dealing with victims of sexual violence, due to the strong notion that these professionals lacked both knowledge and Government guidance on the issue.¹⁰⁵

F. Systematic Government Interference with Women's Sexual and Reproductive Health and Rights

CEDAW, Article 2, urges states “[t]o refrain from engaging in any act or practice of discrimination against women”¹⁰⁶ and to “take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise.”¹⁰⁷ In implementing Article 2, the Committee requires that a state party “[a]bstains from performing, sponsoring or condoning any practice, policy or measure that violates the Convention”¹⁰⁸ and actively “[t]akes steps to prevent, prohibit and punish violations of the Convention by third parties, including in the home and in the community.”¹⁰⁹ Since Article 2 is read in conjunction with all other articles¹¹⁰ including women's right to reproductive health under Article 12(1), the

Hungarian Government must not acquiesce to discrimination against women's reproductive rights by state actors or non-state actors and is further obligated proactively to take measures against such discrimination.

Not only does the Hungarian Government neglect its obligations to combat discrimination in the realm of sexual and reproductive health and rights of women, but it actively engages in discriminatory acts itself by proposing legislation that is meant to curb women's access to abortion, which violates Article 2(d) of the Convention. Late in 2011, Christian Democrat Members of Parliament, who are part of the Government coalition, sought to abolish the state subsidization of abortions for poor women and girls.¹¹¹ This proposed measure did not pass, but does point to a worrying trend of attempting to limit access to abortion.

The Government has also consistently condoned Hungarian politicians' attempts to interfere with the realization of women's reproductive and sexual rights. Politicians are openly trying to sway the public opinion towards restricting access to abortion by spreading misleading information on the "harmful" effects of abortion.¹¹² Government officials and politicians have repeatedly voiced their views that abortion is murder and stressed that the fetus should be treated as a human being.¹¹³ The Hungarian Government has made no efforts to stop such behavior from its representatives and is therefore acting contrary to its obligations under Article 2(e) of CEDAW. As the foregoing examples show, Hungary is not only neglecting its duty to ensure equality and health of women, but is also blatantly disregarding its obligations under CEDAW and appears to actively support the deterioration of the situation of women in Hungary.

II. Gender Stereotyping in Reproductive Health Care (Art. 5)

Under this Convention states parties must eradicate negative "gender-based stereotypes."¹¹⁴ Article 5(a) of CEDAW requires states "[t]o modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women."¹¹⁵ Since the right to health is one of the core tenets of this Convention, the mandate to eradicate stereotypes from the health sector deserves serious attention. In the realm of health care, gender neutrality presumes that "women are competent decision-makers with respect to their bodies and lives, and capable of accepting moral responsibility for their appropriately informed choices."¹¹⁶ Common examples of gender stereotypes in reproductive health are third-party consent requirements to obtain reproductive health services, restrictive access to these services, or laws and attitudes among society or health care workers that uphold the traditional role of women as caregivers with the sole purpose of bearing children.¹¹⁷

Hungary's reproductive health care system is deeply tainted with gender-stereotyping. In its latest Concluding Observations this Committee expressed concerns "about the persistence of patriarchal attitudes and deep-rooted stereotypes regarding the roles and responsibilities of women and men in the family and in society in Hungary,"¹¹⁸ and urged Hungary to "take proactive measures to eliminate gender stereotyping."¹¹⁹ As highlighted in this submission (section B.3), the first mandatory counseling session before obtaining an abortion uses stereotypes about women's supposed biological desire to rear children in order to dissuade the women from obtaining an abortion. Such biased counseling illustrates the presumption that women's decision to have an abortion tend to be irrational and incompetent. The prescription requirement for emergency contraception highlighted in section C.2 further shows that the Hungarian legislator does not trust women to make a competent and responsible decision about obtaining this contraceptive method. Hungarian society and the Hungarian Government display deeply rooted

patriarchic stereotypes that can be observed in the provision of health services as well as sexuality education and that run afoul of the tenets of CEDAW.

III. Proposed Recommendations and Questions to the Hungarian Government

We would like to suggest that the Committee issues the following recommendations for the Government of Hungary:

1. Adopt a comprehensive policy on sexual and reproductive health and rights based on the provisions of CEDAW and international medical standards, and allocate sufficient financial and human resources for its implementation. Involve women's and reproductive rights non-governmental organizations in the preparation and implementation of such policy.
2. Remove barriers in the access to abortion services such as the unavailability of medical abortion, biased counseling and the mandatory waiting period requirements. Remove inaccurate, scientifically not supported information from the training curriculum of abortion counselors.
3. Adequately regulate the practice of conscientious objection to abortion. Amend existing regulation, including adopt effective oversight and monitoring mechanisms in order to appropriately balance the exercise of conscientious objection with professional responsibility and the patient's right to access lawful health care services in a timely manner.
4. Ensure that the implementation of the provision on protection of life from conception in the Constitution does not interfere with the access to safe and legal abortion and other reproductive health services. End poster campaigns stigmatizing abortion and cease the interference with women's sexual and reproductive health rights that seek to negatively influence the public view on abortion and contraception.
5. Increase access to affordable contraceptive methods for all by covering the costs of a range of modern contraceptive methods under the public health insurance. Improve access to emergency contraception by eliminating the prescription requirement.
6. Systematically gather data on unmet need for contraception and contraceptive use. Ensure that all collected data are disaggregated by sex, age, social status and other characteristics as necessary.
7. Establish sexuality education as a mandatory subject in primary and secondary schools and revise textbooks and other teaching materials to ensure comprehensive, evidence-based sexuality education free of stereotypes. Sexuality education must be taught by teachers properly trained in this area. Ensure that sexuality education is actually taught to the same extent in all schools throughout Hungary.
8. Increase the access to reproductive health services for survivors of sexual violence. Ensure that survivors of such violence receive heightened attention in the health care system including the provision of testing for pregnancy and sexually transmitted diseases and improve the access to emergency contraception and abortion for victims of sexual violence. Provide appropriate documentation of sexual violence to bring perpetrators of gender-based crimes to justice.
9. Adopt measures aimed at eradicating gender stereotyping in reproductive health care. Ensure that women are seen as rational and competent decision-makers with respect to their reproductive health choices and eliminate patriarchic views on women's role in society.

In light of the above, we hope that the Committee will consider addressing the following questions to the Government of Hungary:

1. What legislation and policies have been adopted to improve women's equality in reproductive health care and family planning services as well as information about these services? Are there laws and policies designed to incorporate CEDAW into domestic Hungarian law? If such legislation and policies exist, what has been their impact on women's real access to reproductive health services?
2. What further measures does the state plan to undertake in order to develop a comprehensive sexual and reproductive health and rights policy that uses CEDAW as a framework? If further measures are planned, what is the timeline for their preparation and implementation? Will non-governmental organizations working in the area of sexual and reproductive health and women's rights be invited to assist in the drafting process?
3. What actions does the state take to provide women with the best access to safe and legal abortion? How does the state ensure that the new Constitution does not restrict the access to abortion? Why does the state not permit the provision of medical abortions? How does the state guarantee access to abortion for poor women? In what way does the state curb biased counseling? How does the state ensure that the mandatory waiting period between the counseling sessions does not unduly inhibit women's access to abortion?
4. How does the Government ensure access to safe and legal abortions in the light of health care providers' conscientious objections? Is the practice of conscientious objection overseen and monitored and is there an effective complaint mechanism in place? What measures are being taken to ensure that a sufficient number of non-objecting practitioners is available in all facilities providing abortion services, as well as within reasonable distance? How does the state guarantee that hospitals taking part of "abortion-free days" initiative comply with their legal obligation of continuous service provision?
5. What efforts does the state make to improve the access to modern contraception for all and what measures does it take to ensure its affordability? Why does the state not include contraceptives in its public health insurance scheme? Why does the state require prescriptions to obtain emergency contraception, which affects the most vulnerable groups of women such as adolescents and victims of sexual violence?
6. What measures has the state adopted to accurately evaluate the unmet need for contraceptives and their use in Hungary? Has the state collected, on a systematic basis, comprehensive data on reproductive health, including contraceptive use and unmet need for contraceptives?
7. What is the state's plan to remedy the lack of unified, human rights based sexuality education in primary and secondary schools? How does the new curriculum address issues such as unwanted pregnancies and sexually transmitted diseases? What measures has the Government taken to monitor that sexuality education classes are taught in schools? Does the state offer other initiatives or programs to teach adolescents about sexuality and reproductive rights?
8. How does the Government ensure that victims of sexual violence receive adequate health care including pregnancy tests and tests for sexually transmitted diseases? What measures has the Government taken to monitor whether adequate medical records are created in order to prosecute the perpetrators of sexual violence?

9. How does the Government justify its anti-abortion poster campaigns and conference in the light of its obligation to respect women's reproductive choices under CEDAW? What measures has the Government taken to ensure that women seeking reproductive health services are not stigmatized? What efforts has the Government undertaken to promote the acceptability of reproductive health services in Hungarian society?
10. How does the state intend to eradicate gender-stereotyping in its health care system? Has the state adopted training or other measures to sensitize health care personnel to the concept of women as rational and competent decision-makers in reproductive health decisions? Have there been efforts to ameliorate gender-based stereotypes of women by personnel in the health sector and in society at large?

The reality of women in Hungary in respect to their reproductive rights and health still drastically diverges from the standards established under CEDAW. The undersigned organizations appreciate the active interest that the Committee has taken in the reproductive health and rights of women and the strong Concluding Observations and General Recommendations it has issued in the past, stressing the need for state parties to take steps to ensure the realization of these rights.

We hope that this information is useful during the Committee's review of the Hungarian Government's compliance with the provisions of CEDAW. If you have any questions, or would like further information, please do not hesitate to contact us.

Sincerely,

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¹ Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, art. 12.1, G.A. Res. 34/189, UN GAOR (34th Sess.), Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981) (*ratified by Hungary* 22 Dec 1980) [hereinafter CEDAW].

² *Id.* art. 14 (2)(b).

³ *Id.* art. 16 (1)(e).

⁴ *Id.* art. 10 (h).

⁵ Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW Committee), *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 358, para. 17, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008), emphasis added [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*].

⁶ *Id.* para. 29.

⁷ CEDAW, *supra* note 1, art. 2 (f).

⁸ CEDAW Committee, *Concluding Observations: Hungary*, para. 29, U.N. Doc. CEDAW/C/HUN/CO/6 (2007).

⁹ CEDAW Committee, *Concluding Observations: Hungary*, para. 330, U.N. Doc. A/57/38(SUPP) (Part II) (2002).

¹⁰ CEDAW Committee, *Concluding Observations: Hungary*, para. 11, U.N. Doc. CEDAW/C/HUN/CO/6 (2007).

¹¹ Human Rights Committee, *Concluding Observations: Hungary*, para. 11, U.N. Doc. CCPR/C/HUN/CO/5 (2010).

¹² CEDAW, *supra* note 1, art. 12, art. 16(e).

¹³ CEDAW Committee, *Gen. Recommendation No. 24, supra* note 5, paras. 14, 27; *See also* Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 14: The right to the highest attainable standard of health (art. 12)*, (22nd Sess., 2000), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 78, para. 21, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*]; Human Rights Committee, *General Comment No. 28: Article 3 (The equality of rights between men and women)*, (68th Sess., 2000), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 228, para. 10, U.N. Doc. HIR/GEN/1/Rev.9 (Vol. I) (2008).

¹⁴ *See, e.g.*, CEDAW Committee, *Concluding Observations: Bolivia*, para. 43, U.N. Doc. CEDAW/C/BOL/CO/4 (2008); *Colombia*, paras. 22–23, U.N. Doc. CEDAW/C/COL/CO/6 (2007); *Jamaica*, paras. 35–36, U.N. Doc. CEDAW/C/JAM/CO/5 (2006); *Mexico*, paras. 32–33, U.N. Doc. CEDAW/C/MEX/CO/6 (2006); *Peru*, paras. 24–25, U.N. Doc. CEDAW/C/PER/CO/6 (2007); *Republic of Moldova*, para. 31, U.N. Doc. CEDAW/C/MDA/CO/3(2006); *Saint Lucia*, paras. 31–32, U.N. Doc. CEDAW/C/LCA/CO/6 (2006).

¹⁵ *See, e.g.* Ban Ki-moon, U.N. Secretary-General, Remarks at Joint Press Conference with President of Hungary, UN News Centre (April 18, 2011),

http://www.un.org/apps/news/infocus/sgspeeches/statments_full.asp?statID=1148 (“I am aware that there have been some concerns raised among Hungary’s European neighbours and around the world and there are similar concerns about certain provisions of Hungary’s new Constitution.”); Leigh Phillips, *Germany to Hungary: New Constitution Breaches EU Values*, EU OBSERVER.COM (April 19, 2011, 9:48 am), <http://euobserver.com/justice/32208> (““We are observing the developments in Hungary with great attention and some worry,” German deputy foreign minister Werner Hoyer said in an emailed statement.”).

¹⁶ CEDAW Committee, *List of Issues and Questions: Replies of Hungary*, para. 16, U.N. Doc. CEDAW/C/HUN/Q/7-8/Add.1 (2012).

¹⁷ MAGYAR ORSZÁG ALAPTÖRVÉNYE, art. II (*adopted* April 25, 2011) (Hung.) (“Everyone has the right to life and human dignity, the life of a fetus will be protected from conception”).

¹⁸ CEDAW Committee, *Gen. Recommendation No. 24, supra* note 5, at 358, para. 11.

¹⁹ *Id.* at 358, para. 14.

²⁰ *See, e.g.*, CEDAW Committee, *Concluding Observations: Bolivia*, para. 42–43, U.N. Doc. CEDAW/C/BOL/CO/4 (2008); *Colombia*, paras. 22–23, U.N. Doc. CEDAW/C/COL/CO/6 (2007); *Jamaica*, paras. 35–36, U.N. Doc. CEDAW/C/JAM/CO/5 (2006); *Mexico*, paras. 32–33, U.N. Doc. CEDAW/C/MEX/CO/6 (2006); *Peru*, paras. 24–25, U.N. Doc. CEDAW/C/PER/CO/6 (2007); *Republic of Moldova*, para. 31, U.N. Doc. CEDAW/C/MDA/CO/3, (2006); *Saint Lucia*, paras. 31–32, U.N. Doc. CEDAW/C/LCA/CO/6 (2006).

²¹ *See* Act No. LXXIX of 1992 on the Protection of Fetal Life (1992) (Hung.).

²² WORLD HEALTH ORGANIZATION (WHO), SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 42 (2nd ed., 2012), available at http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf [hereinafter WHO, SAFE ABORTION (2nd ed., 2012)].

²³ *Id.* at 96.

- ²⁴ International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, art. 15.1. (b) G.A. Res.2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc. A/6316 (1966) (entered into force Jan. 3, 1976) (succeeded to by Slovakia May 28, 1993).
- ²⁵ WHO, SAFE ABORTION (2nd ed., 2012), *supra* note 22, at 44, 76- 78.
- ²⁶ *Id.* at 79.
- ²⁷ Medabon contains a combination of mifepristone and misoprostol as active ingredients. *See* Medabon for Medical Abortion, <http://medabon.info/> (last visited Jan. 18, 2013). This combination is included in the WHO's Model List of Essential Medicines as the drug approved to induce medical abortions. *See* WORLD HEALTH ORGANIZATION, MODEL LIST OF ESSENTIAL MEDICINES 27 (17th ed.) (March 2011), *available at* http://www.who.int/selection_medicines/committees/expert/17/sixteenth_adult_list_en.pdf.
- ²⁸ Heads of Medicines Agencies, <http://mri.medagencies.org/Human/Product/Details/26878> (last visited Jan. 23, 2013).
- ²⁹ Mutual Recognition and Decentralised Procedures as defined in Directive 2004/27/EC amending Directive 2001/83/EC. Directive 2004/27/EC of the European Parliament and of the Council of 31 March 2004 amending Directive 2001/83/EC on the Community code relating to medicinal products for human use, 2004 O.J. (L 136/34).
- ³⁰ Veronika Gulyas, *Hungary Reopens Abortion Controversy with Pill Debate*, EMERGING EUROPE (May 24, 2012, 8:50 AM), <http://blogs.wsj.com/emergingurope/2012/05/24/hungary-reopens-abortion-controversy-with-pill-debate/>; Hír TV, *Tudtuk, hogy ez a probléma közelít* (May 21, 2012) <http://m.mno.hu/ahirtvhirei/szocska-tudtuk-hogy-ez-a-problema-kozelit-video-1077759>. The decision was made following a debate among Hungarian politicians over the efficacy and safety of medical procedure and allegations by Christian Democrat Members of Parliament that the introduction of medical abortion might lead to an increase of abortions and that the procedure caused more emotional harm to women. Hír TV, *supra* note 31; Hír TV, *Még nem lesz abortusztábla Magyarországon* (May 21, 2012), http://mno.hu/belfold_archiv/meg-nem-lesz-abortusztabletta-magyarorszagon-1077652.
- ³¹ Joób Sándor, *Ismeretlen szakmai véleménnyel jegelik az abortusztáblát*, INDEX (May 22, 2012, 23:17), http://index.hu/belfold/2012/05/22/ismeretlen_szakmai_velemenyel_jegelik_az_abortusztablettat/.
- ³² Ferenczi Ágota, *Kíméletesebb terhességmegszakítás*, Nők Lapja Cafe (Feb. 25, 2005, 00:00), http://www.nlcafe.hu/eletmod/20050225/kimeletesebb_terhessegmegszakitas/.
- ³³ Danó Anna (2012, August 23) *Próbálkozik a kormány, de nem korlátozhatja az abortusztábla alkalmazását*. NÉPSZABADSÁG. Retrieved from: http://nol.hu/belfold/20120823-kutadjak_a_tiltas_lehetoseget_de_hiaba.
- ³⁴ Danó Anna, *Próbálkozik a kormány, de nem korlátozhatja az abortusztábla alkalmazását*, NÉPSZABADSÁG (Aug. 23, 2012), http://nol.hu/belfold/20120823-kutadjak_a_tiltas_lehetoseget_de_hiaba.
- ³⁵ D.A.N., *Már meg is jelentek az ellenőrök a magánklinikán*, NÉPSZABADSÁG (Aug. 23, 2012), http://nol.hu/belfold/vizsgaljak_a_maganklinikat.
- ³⁶ Danó Anna, *Megszűnt a tablettás abortusz a Rózsacenterben*, NÉPSZABADSÁG (Sept. 12, 2012), http://nol.hu/belfold/megszunt_a_tablettas_abortusz_a_rozsacenterben.
- ³⁷ Act No. LXXIX of 1992 on the Protection of Fetal Life, art. 9 (1992) (Hung.).
- ³⁸ Egészségügyi Kozlony a Nemzeti Eroforras Miniszterium Hivatalos Lapja 603-605 (2012), *available at* <http://www.kozlonyok.hu/kozlonyok/Kozlonyok/6/PDF/2012/4.pdf> (highlighting that the training curriculum for future family protection service providers includes 10 hours of “protection of life – protection of the fetus”, which lists post-abortion syndrome as psychological harm caused by abortion and attempts to liberate “mater-feelings”).
- ³⁹ The research consisted of interviews conducted with 11 women right after they exited the first counseling session as well as one researcher's visit of nine counseling sessions. Interviews, PATENT Association (Jun.-Aug. 2012) (on file with PATENT Association); Rédei D., et al., *FINOM MANIPULÁCIÓ, KEDVES FÉLREINFORMÁLÁS. A KÖTELEZŐ ABORTUSZTANÁCSADÁS GYAKORLATA MAGYARORSZÁGON* (2013), *available at* http://abortusz.info/images/stories/abortusztanacsadas_kutatas_patent.pdf.
- ⁴⁰ *For information on the inaccuracy of this claim, see* Atrash H. K. és Hogue C. J. R., *The effect of pregnancy termination on future reproduction*, 4(2) BAILLIÈRE'S CLINICAL OBSTETRICS AND GYNECOLOGY 391–405 (1994); Hogue C. J. R., Cates W. és Tietze C., *The effects of induced abortion on subsequent reproduction*, 4(1) EPIDEMIOLOGIC REVIEWS, 1982 66–94 (1982 *cited in* Guttmacher Institute, *Abortion in Women's Life*, (2006), *available at* <http://www.guttmacher.org/pubs/2006/05/04/AiWL.pdf>.
- ⁴¹ The study showed that nurses generally exaggerated the effect of abortion on future fertility and long term psychological problems—claims which are not supported by literature—as well as the dangers of physical effects like a perforated womb. Further, the nurses often gave elaborate descriptions of how far developed the fetus was, showed pictures of the fetus of the given gestational age and reminded the women of their duty to have children

reaffirming societal stereotypes. The visual messages at the counseling offices additionally were likely to induce feelings of guilt in the women such as pictures of babies, brochures of pro-choice crisis pregnancy organizations, and pictures of developed fetuses. Last, counseling offices are often situated in the same hallway as pregnancy care, which leads to the risk of easy identification of women seeking abortions in small communities. Study conducted by PATENT Association (on file with PATENT Association).

⁴² Commission on Human Rights, *Report of the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy, in accordance with Commission on Human Rights resolution 1997/44, Integration of the Human Rights of Women and the Gender Perspective, Addendum: Policies and practices that impact women's reproductive rights and contribute to, cause or constitute violence against women*, para. 57, U.N. Doc. E/CN.4/1999/68/Add.4 (Jan. 21, 1999).

⁴³ Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Interim rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, transmitted by Note of the Secretary-General*, para. 24, U.N. Doc. A/66/254 (Aug. 3, 2011) (by Anand Grover).

⁴⁴ WHO, SAFE ABORTION (2nd ed., 2012), *supra* note 22, at 44, 36.

⁴⁵ *Id.* at 36.

⁴⁶ *Id.* at 97.

⁴⁷ P & S v. Poland, No. 57375/08 Eur. Ct. H.R. paras. 108, 111 (2012).

⁴⁸ See WHO, SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 91(2003) [hereinafter WHO, SAFE ABORTION (2003)].

⁴⁹ Joyce T, Kaestner R., *The Impact of Mississippi's Mandatory Delay Law on the Timing of Abortion*, 32(1) FAMILY PLANNING PERSPECTIVES 4-13 (2000).

⁵⁰ See WHO, SAFE ABORTION (2003), *supra* note 48, at 91.

⁵¹ ÁNTSZ ORSZÁGOS TISZTIFŐORVOSI HIVATAL, A CSALÁDVÉDELMI SZOLGÁLAT (CSVSZ) TEVÉKENYSÉGÉVEL KAPCSOLATOS FONTOSABB MUTATÓK ÖSSZEFOGLALÁSA (2009), available at https://www.antsz.hu/data/cms26776/CSVSZ_tev_kapcs_mutatok_osszefogl_20091230.pdf.

⁵² CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 5, at 358, para. 13.

⁵³ Act No. LXXIX of 1992 on the Protection of Fetal Life, art. 14 (1992) (Hung.).

⁵⁴ *Id.* Art. 13(2).

⁵⁵ *Abortuszmentes napokert*, ALFA SZOVETSEG (Mar. 21, 2008, 14:36),

http://alfaszovetseg.hu/index.php?option=com_content&task=view&id=158&Itemid=105; *Abortuszmentes napokat tamogatott a varpalotai abortuszgyu gyanusítottja*, VELVET (Feb. 22, 2012, 11:39),

http://velvet.hu/blogok/helyszinelo/2012/02/22/abortuszmentes_napokrol_kotott_megallapodast_a_varpalotai_abortuszgyu_gyanusítottja/.

⁵⁶ Draft resolution, *Women's access to lawful medical care: the problem of unregulated use of conscientious objection*, PARL. ASSEMB. EUR. DOC. 12347 (Jul. 20, 2010).

⁵⁷ See, e.g., CEDAW Committee, *Concluding Observations: Slovakia*, paras. 42-43, U.N. Doc. CEDAW/C/SVK/CO/4 (2008); *Poland*, para. 25, U.N. Doc. CEDAW/C/POL/CO/6 (2007).

⁵⁸ CEDAW Committee, *Concluding Observations: Slovakia*, para. 43, U.N. Doc. CEDAW/C/SVK/CO/4 (2008).

⁵⁹ See Gulyas, *supra* note 30.

⁶⁰ *EU Commission calls on the Hungarian authorities to stop anti-abortion campaign*, EUROPEAN WOMEN'S LOBBY (Jun. 9, 2011), http://www.womenlobby.org/spip.php?page=imprimir_articulo&id_article=1772&lang=en.

⁶¹ Interview with Miklós Soltész, state secretary for social, family and youth affairs. Hirado.hu, *Az örökbefogadást népszerűsíti a kormány – videóval AZ ESTE* (May 6, 2011),

http://www.hirado.hu/Hirek/2011/05/06/21/Az_orokbefogadast_nepszerusiti_a_kormany__videoval.aspx;

EU funds used for Hungarian anti-abortion campaign, EURACTIV (Jun. 17, 2011),

<http://www.euractiv.com/justice/eu-funds-hungarian-anti-abortion-news-505684>.

⁶² Conference programme (2012), http://azeletajandek.hu/hu/cikkek/28-az_elet_ajandek_konferencia_programja.html (last visited Jan. 27, 2013).

⁶³ *Hogyan Vegzik az Abortuszt es Milyen Veszelyei Vannak*, AZ ELET: AJANDEK (Oct. 14, 2012),

http://azeletajandek.hu/hu/cikkek/21-hogyan_vegzik_az_abortuszt_es_milyen_veszelyei_vannak_.html.

⁶⁴ C. Fiala, *Abortion Access in Europe. Where is the 'European Standard'?* in DISCUSSIONS ON REPRODUCTIVE RIGHTS (Patent Association, 2012).

⁶⁵ *Id.*

⁶⁶ CEDAW Committee, *Concluding Observations: Hungary*, para. 28, U.N. Doc. CEDAW/C/HUN/CO/6 (2007).

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- ⁶⁷ *Id.* para. 29.
- ⁶⁸ See, e.g. CEDAW Committee, *Concluding Observations: Lithuania*, para. 81, U.N. Doc. CEDAW/C/LTU/CO/4 (2008).
- ⁶⁹ See CEDAW Committee, *Concluding Observations: Hungary*, para. 254, U.N. Doc. A/51/38 (1996).
- ⁷⁰ ESCR Committee, *Gen. Comment No. 14*, *supra* note 13, at 78, paras. 12(a), 43(d), 44(a).
- ⁷¹ Committee on the Rights of the Child (CRC Committee), *Concluding Observations: Hungary*, para. 43, U.N. Doc. CRC/C/HUN/CO/2 (2006).
- ⁷² CEDAW Committee, *List of Issues and Questions: Replies of Hungary*, para. 16, U.N. Doc. CEDAW/C/HUN/Q/7-8/Add.1 (2012).
- ⁷³ WHO, MEDIA CENTRE, *Emergency contraception, Fact Sheet No. 244* (2012), available at <http://www.who.int/mediacentre/factsheets/fs244/en/index.html> [WHO, *Emergency contraception*].
- ⁷⁴ *Id.* (“It is intended for emergency use following unprotected intercourse, contraceptive failure or misuse (such as forgotten pills or torn condoms), rape or coerced sex.”).
- ⁷⁵ See, e.g. CEDAW Committee, *Concluding Observations: Mexico*, paras. 32–33, U.N. Doc. CEDAW/C/MEX/CO/6 (2006).
- ⁷⁶ See, e.g. CEDAW Committee, *Concluding Observations: Lithuania*, para. 81, U.N. Doc. CEDAW/C/LTU/CO/4 (2008).
- ⁷⁷ CEDAW Committee, *List of Issues and Questions: Replies of Hungary*, para. 16, U.N. Doc. CEDAW/C/HUN/Q/7-8/Add.1 (2012).
- ⁷⁸ *Szabadon vásárolható esemény utáni tableta*, NÉPSZABADSÁG (Jul. 21, 2011), http://nol.hu/lap/mo/20110721-szabadon_vasarolható_esemény_utáni_tableta; *Nem lesz vény nélkül kapható az esemény utáni fogamzásgátló tableta*, BABAFALVA.HU (Jul. 22, 2011), <http://szulok.babafalva.hu/nem-lesz-veny-nelkul-kaphato-az-esemeny-utani-fogamzasgatló-tabletta/>.
- ⁷⁹ 12/2011. (III.31.) NEFMI rendelet az egészségügyi szakmai kollégium működéséről [resolution of the Ministry of National Human Resources on the operation of the health care professional college] (Hung.).
- ⁸⁰ Representative of College of Obstetricians and Gynaecologists, personal communication, May 2012.
- ⁸¹ See, e.g., INTERNATIONAL CONSORTIUM FOR EMERGENCY CONTRACEPTION, IMPROVING ACCESS TO CONTRACEPTION, Policy Statement (July 2003), available at http://www.cecinfo.org/custom-content/uploads/2012/12/ImprovingAccess_EC_English.pdf (recommending the provision of contraception without prescription based on the benefits of easy access in various countries and the WHO’s recommendation to increase access to contraception).
- ⁸² EC Status and Availability: Hungary, International Consortium for Emergency Contraception.com, <http://www.cecinfo.org/country-by-country-information/status-availability-database/countries/hungary/> (last visited Jan. 22, 2013).
- ⁸³ WHO, *Emergency contraception*, *supra* note 73.
- ⁸⁴ See, e.g., CEDAW Committee, *Concluding Observations: Georgia*, paras. 29-30, U.N. Doc. CEDAW/C/GEO/CO/3 (2006); *Jamaica*, para. 35, U.N. Doc. CEDAW/C/JAM/CO/5 (2006).
- ⁸⁵ CEDAW Committee, *Concluding Observations: Hungary*, para. 29, U.N. Doc. CEDAW/C/HUN/CO/6 (2007).
- ⁸⁶ See Letter from the Ministry of Human Resources State Secretariat for Healthcare dated 4th April, 2012, on file with Hungarian Civil Liberties Union.
- ⁸⁷ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 5, at 358, para. 23.
- ⁸⁸ See, e.g., CEDAW Committee, *Concluding Observations: Burundi*, para. 62, U.N. Doc. A/56/38 (2001); *Jamaica*, para. 224, U.N. Doc. A/56/38 (2001); *Kazakhstan*, para. 106, U.N. Doc. A/56/38 (2001); *Lithuania*, para. 25, U.N. Doc. CEDAW/C/LTU/CO/4 (2008); *Slovakia*, paras. 32-33, U.N. Doc. CEDAW/C/SVK/CO/4 (2008); see also Human Rights Committee, *Concluding Observations: Poland*, para. 9, U.N. Doc. CCPR/CO/82/POL (2004); CRC Committee, *Concluding Observations: Bhutan*, para. 45(a-b), U.N. Doc. CRC/C/15/Add.157 (2001); *Cambodia*, para. 53, U.N. Doc. CRC/C/15/Add.128 (2000); *Comoros*, para. 36, U.N. Doc. CRC/C/15/Add.141 (2000); *Egypt*, para. 44, U.N. Doc. CRC/C/15/Add.145 (2001); ESCR Committee, *Concluding Observations: Bolivia*, para. 43, U.N. Doc. E/C.12/1/Add.60 (2001); *People’s Republic of China (including Hong Kong and Macao)*, para. 100, U.N. Doc. E/C.12/1/Add.107 (2005); *Poland*, paras. 28, 50, U.N. Doc. E/C.12/1/Add.82 (2002); *Senegal*, para. 47, U.N. Doc. E/C.12/1/Add.62 (2001); *Ukraine*, para. 31, U.N. Doc. E/C.12/1/Add.65 (2001).
- ⁸⁹ CRC Committee, *Concluding Observations: Hungary*, para. 43, U.N. Doc. CRC/C/HUN/CO/2 (2006).
- ⁹⁰ *Id.* para. 44.

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- ⁹² 110/2012, (VI. 4.) Korm. rendelet A Nemzeti alaptanterv kiadásáról, bevezetéséről és alkalmazásáról, *Magyar Közlöny* (66) 10635-10847, available at <http://www.ofi.hu/nat/mk-nat-2012>.
- ⁹³ *Id.* at 10739.
- ⁹⁴ The study worked with several focus groups composed of teachers from various counties and cities. FÁBIÁN R & SIMICH R, MEGLÉVŐ ÉS MŰKÖDŐ MODELLPROGRAMOK, VALAMINT AZ ISKOLAI SZEXEDUKÁCIÓS ESEMÉNYEK ÉRTÉKELÉSE, HIV/AIDS-PREVENCIÓ AZ IFJÚSÁG BIZTONSÁGOS SZEXUÁLIS ÉLETRE NEVELÉSE (2006), available at www.oefi.hu/modszertan8.pdf.
- ⁹⁵ SIMICH RITA, ISKOLA – EGÉSZSÉGFEJLESZTÉS – SZEXEDUKÁCIÓ, VESZÉLYEZTETETT KORÚ DIÁKOK PREVENCIÓS IGÉNYEI ÉS SZÜKSÉGLETEI [Health Development: Sexual education, demands and needs of students of an endangered age] (2010), available at http://www.oefi.hu/tanulmany_szex.pdf.
- ⁹⁶ The study showed that some 40% of a sample of 8th and 10th grade students had had sex. The average age of first intercourse, among those, was 13.6 for boys and 14 for girls. Some of the sampled youth had had sex as early as 9 years. *Id.*
- ⁹⁷ CEDAW Committee, *Concluding Observations: Algeria*, para. 45(b), U.N. Doc. CEDAW/C/DZA/CO/3-4 (2012); *Chad*, para 41(e), U.N. Doc. CEDAW/C/TCD/CO/1-4 (2011), *Nepal*, para 36(g), U.N. Doc. CEDAW/C/NPL/CO/4-5 (2011).
- ⁹⁸ CEDAW Committee, *Gen. Recommendation No. 24*, *supra* note 5, at 358, para. 15.
- ⁹⁹ *Id.* at 358, para. 15(a).
- ¹⁰⁰ *See, e.g.*, CEDAW Committee, *Concluding Observations: Dominican Republic*, para. 309, U.N. Doc. A/59/38 (SUPP) (2004); *Concluding Observations: Jordan*, para. 9, U.N. Doc. CEDAW/C/JOR/CO/4 (2007); *Concluding Observations: Myanmar*, paras. 129-130, U.N. Doc. A/55/38 (2000).
- ¹⁰¹ *See, e.g.* CRC Committee, *Concluding Observations: Argentina*, para. 59(d), U.N. Doc. CRC/C/ARG/CO/3-4 (2010) (admonishing states to ensure that “the provision on non-punishable abortion, especially of girls and women victims of rape, is known and enforced by the medical profession.”); Human Rights Committee, *Concluding Observations: Dominican Republic*, para. 15, U.N. Doc. CCPR/C/DOM/CO/5 (2012) (urging states to “make provision for exceptions to the general prohibition of abortion for therapeutic reasons and in cases of pregnancy resulting from rape or incest.”); ESCR Committee, *Concluding Observations: Peru*, para. 21, U.N. Doc. E/C.12/PER/CO/2-4 (2012) (“that abortion in case of pregnancy as a result of rape is not penalized”); Committee against Torture (CAT Committee), *Concluding Observations: Nicaragua*, para. 16, U.N. Doc. CAT/C/NIC/CO/1 (2009).
- ¹⁰² *See* CAT Committee, *Concluding Observations: Nicaragua*, para. 16, U.N. Doc. CAT/C/NIC/CO/1 (2009).
- ¹⁰³ JO LOVETT AND LIZ KELLY, CHILD AND WOMEN ABUSE STUDIES UNIT, LONDON METRO. UNIV., DIFFERENT SYSTEMS, SIMILAR OUTCOMES? TRACKING ATTRITION IN REPORTED RAPE CASES ACROSS EUROPE 66 (2009). 2009
- ¹⁰⁴ *Id.* at 18, 19, 65.
- ¹⁰⁵ KERET KOALÍCIÓ, MODSZERTANI AJANLASOK A SZEXUALIS EROSZAK ALDOZATAIVAL FOGLALKOZO SZAKEMBEREK SZAMARA (2012), available at http://mona-alapitvany.hu/wp-content/uploads/2012/12/KERET_Modszertani_ajanlasok.pdf.
- ¹⁰⁶ CEDAW, *supra* note 1, art. 2(d).
- ¹⁰⁷ *Id.* art. 2(e).
- ¹⁰⁸ CEDAW Committee, *General Recommendation No. 28: On the Core Obligations of States Parties under Article 2 of the Convention on the Elimination of All Forms of Discrimination against Women*, (47th Sess., 2010), para. 37(a), U.N. Doc. CEDAW/C/2010/47/GC.2 (2010).
- ¹⁰⁹ *Id.* para. 37(b).
- ¹¹⁰ CEDAW Committee, *General Recommendation No. 25: Article 4, paragraph 1, of the Convention (temporary special measures)*, (30th Sess., 2004), in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, at 365, para. 29, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 25*].
- ¹¹¹ *Egy KDNP-s módosító javaslat nem adna pénzt abortuszra*, ORIGO (Nov. 30, 2011, 11:31) <http://www.origo.hu/itthon/20111130-a-kdnp-nem-adna-penz-abortuszra.html>.
- ¹¹² *Abortusztabletta – sajtótájékoztató*, 2012, <http://kdnp.hu/media/videotar/abortusztabletta-%E2%80%93-sajtótájékoztató> (last visited Jan. 27, 2012); Sándor, *supra* note 32; *Semjen: Elegendő idő az alkotmányozásra*, FIDESZ (Jan. 24, 2011), <http://www.fidesz.hu/index.php?Cikk=157990>

Kálmán Nagy, Christian Democrat member of the parliament mentioned in the Parliament that abortion pills cause heavy bleeding and pose serious psychological burden on pregnant women.

¹¹³ *Abortusztabletta: együtt tuntut a Novak család es Semjen*, HVG.HU (May 23, 2012, 16:11),

http://hvg.hu/itthon/20120523_abortusztabletta_tuntetes; *Interju Gulyas Gergellyel, Meg Kellene mutatni as abortuszt videofelvetelrol a gimnazistaknak?*, MEDICALONLINE.HU (Mar. 5, 2011, 10:08)

http://www.medicalonline.hu/eu_gazdasag/cikk/az_abortusz_embertelen_beavatkozas.

¹¹⁴ CEDAW Committee, *Gen. Recommendation No. 25*, *supra* note 110, at 365, para. 7.

¹¹⁵ CEDAW, *supra* note 1 art. 5(a).

¹¹⁶ R.J. Cook et al., *Unethical Female Stereotyping in Reproductive Health*, 109 INT'L J. OF GYNECOLOGY AND OBSTETRICS 255, 258 (2010).

¹¹⁷ *Id.* 255, 256 – 257.

¹¹⁸ CEDAW Committee, *Concluding Observations: Hungary*, para. 16, U.N. Doc. CEDAW/C/HUN/CO/6 (2007).

¹¹⁹ *Id.* para. 17.