Research Report: The Practice of "Counselling Aiming at Keeping the Foetus"

PATENT, 2014

Contents

Background

Introduction

In 2012, PATENT Association conducted a research on mandatory counselling, a prerequisite of abortion in Hungary.[i] The research focused on whether counsellors respected women's decision, the information they provided and the treatment of clients. Although the sample size of this research project was small, it directed our attention at several problem areas and provided us with an orientation when we were preparing for a larger-scale research. We had the opportunity to conduct this new research in May 2014, within the framework of a grant program entitled "Keeping Abortion Accessible," funded by the Open Society Institute, the Global Fund for Women and the Center for Reproductive Rights.

The aim of the reserarch

The aim of the research was to examine whether women's right to decide and their human dignity were respected. We also examined counsellors' communication, client treatment and the information clients were provided with during counselling. We wanted to find out whether the dignity and feelings of women who had to participate in mandatory counselling were respected or were at times hurt.

Methodology and focus

Our methodology was similar to the one applied in 2012: we conducted a qualitative research. The interviews were made by six interviewers at 25 venues of mandatory counselling: 13 of these were in Budapest[ii], and the rest were in Dabas, Gyöngyös, Veszprém, Vác, Gödöllő, Szentendre, Jászberény, Székesfehérvár, Dunaújváros, Nyíregyháza, Kisvárda and Nyírbátor. Interviewers asked women who were leaving from counselling sessions.[iii] They made 101 interviews altogether: 92 in or right next to the buildings of Family Protection Services, and 9 in other institutions or at the home of respondents. 35 respondents out of the 101 had gone through both counselling sessions by the time of the interview: they were asked about both the first and the second occasion. The interview was of a mixed type: it consisted of both open-ended and close-ended questions.

As we did not ask respondents to identify the maternal and child health nurses providing counselling and the interviewers seldom met them, we can only estimate the number of the counsellors we heard about. Based on interviewers' observations and our information regarding the number of the maternal and child health nurses working at the specific venues, we estimate this number to be around 25.[iv]

The aim of this research was primarily to reveal rights violations. Its basic question was whether women's rights to human dignity and autonomy were violated during mandatory counselling, and if they were, what was the form of these violations. It did not aim at representativeness and providing decisive data on the proportion of counsellors or counselling occasions that violated rights and those that were fair and balanced. Our colleagues who made in interviews did not return to venues where (based on previous interviews) they thought clients' rights were most probably not violated, but they did return on more than one occasion to places where (also based on previous interviews) they suspected

we coud gain information on unlawful practices. Nevertheless, we think it is useful to assess the types of violation our 101 respondents experienced, so we provide data on the proportion of occurences. Although we found several positive examples, this research aimed at exploring the types of rights violations, therefore these are more emphasized in the present evaluation.

We asked respondents mostly directly in the street: our researchers were standing in front of the FPS building, and asked women who were leaving right after the counselling session. They interviewed those who stopped and were willing to respond. As for applying this research methodology, it occured to us that the women who were really upset after the counselling session (either because of the counselling or for personal reasons, or both) were not likely to stop and answer our questions. However, as the research did not aim at mapping representative proportions, this shortcoming does not influence the results of the research, even though we probably lost some valuable information regarding rights violations.

The interviews lasted for 15-20 minutes in general, but their length depended on the willingness and needs of respondents, so some of them took less and some of them took more time. When we only had the possibility to make a shorter interview, we asked less questions: the ones that were prioritised keeping the focus of the research in mind. The interviewers tried to conduct private interviews, and they managed to do this on 72 occasions. At other times, a family member or friend of the respondent was also present. The interviewers deemed that the respondent's state of mind was sad, upset or emotionally unstable right after the counselling session in 22 cases. In 63 cases, they perceived the respondents' state of mind as calm, and in 4 cases relieved and cheerful.

The questionnaire treated the two mandatory counselling sessions separately. This is evidently important because we intended to examine the observance of the act on the protection of foetal life, which prescribes different contents for these two occasions. The main difference is that while the first counselling session must be aimed at „keeping the foetus," the second should be about providing information and administration only.

Not all respondents answered each question, so sometimes we provide data that reflect a smaller number of respondents than 101. When we mention 98 respondents and analyse or cathegorise their different responses, it signifies that the other (3) respondends did not anwer the given question.

Statistical data about abortion in Hungary

The number of abortions (just like the number of births) have been gradually decreasing in Hungary since 1990.[v] According to the latest data, this tendency has continued in 2013, too: 34.891 abortions were performed during this year, which means a 3.1% decrease compared to the previous year[vi], and the decrease is 61.3 % compared to 1990[vii]. In the long run, this may be related to the spread of contraceptive methods and their increased availability. However, the number of Hungarian women terminating their pregnancy abroad has also increased.[viii]

As for the demographic distribution of abortions, the data provided by the Hungarian Central Statistical Office for the period between 2000 and 2011 show that except for the youngest

teenagers, the number of abortions have decreased in all age groups. Although this decrease characterises women aged 20-34 especially, it is still this age group that has the most abortions.[ix] In 2011, this meant 62% of all abortions. 25.8% of all interventions were performed on women older than 34, and 12.2% on women younger than 20.[x]

As for women's marital status, most of the women who want to terminate their pregnancy are unmarried. Until the late 1990s, the opposite was true,[xi] but since then the number of marriages has also decreased in the population.[xii] While in 2000 the proportion of married and unmarried women were more or less the same among those who terminated their pregnancy (44.8 and 43.7% respectively), in 2011 the proportion of unmarried women was 60.2% and the proportion of married women was 29.6%. The proportion of divorced women has remained relatively constant: about 10%.[xiii]

As for women's education, the proportion of those who seek abortion is highest among those who finished primary school, and it gradually decreases with the growth of their education level. (Those who did not finish even primary school are an exception: the number of women seeking abortion is the lowest among them.)[xiv] In 2011, among those women who had primary education only, the abortion ratio per 100 live births was 96, while this number was less than 13 among those who finished college or university.[xv]

As for regional differences, while in the 1970s Budapest exceeded the country average by 1/3 regarding the number of abortions, in 2011 it had the third lowest number of terminations of pregnancy when comparing counties in Hungary. During the period of 2000-2011, the difference in proportion has increased between the Eastern and Western parts of Hungary: the proportion of abortions is the highest in Heves, while it is the lowest in Vas county.[xvi]

According to the information PATENT Association gained from the Office of the Chief Medical Officer, 27.4% of the women who applied for abortion did not have children, 24.8% of them had one, 24.6% two, 13.6% three, and 9.6% had four or more children at the time we asked for these data. Half of the women seeking to terminate their pregnancy had already had an abortion, and half of them had not. Among those in the first group, 25% had had one, 11.7% two, 7.2% four or more, and 6% had had three previous abortions. At the time of the examination 87.5% of the women were 5-9 weeks pregnant, 10.7% passed this period (9-12 weeks), and 1.8% did not (1-4 weeks).[xvii]

The operation of Family Protection Services

In Hungary, the law prescribes two mandatory counselling sessions when someone applies for abortion. The counselling is provided by Family Protection Services (FPS). In 2012, there were 93 venues in the country operating within the framework of the National Public Health and Medical Officer Service, with 97 maternal and child health nurses providing counselling. 40.756 women turned up for counselling „A", that is, the first mandatory counselling session aimed at „keeping the foetus," and 37.862 women turned up for counselling „B", the second mandatory counselling session (of whom 36.118 had an abortion[xviii]).

According to a survey performed by Family Protection Services, answered voluntarily and anonymously by women participating in counselling, 15.1% of those who turned up for the first counselling session considered it important that she got a request form as soon as possible, 42.2% expected exact and clear information, and 41.5 % wanted help in making the

most responsible decision. As for clients' expectations towards maternal and child health nurses, 12.2% wanted adequate responses for their questions, 25.4% marked helpfullness, 30.7% a sympathetic attitude, 20.3% expected that their decision was respected, and 11% expected that nurses create a tranquil athmosphere.[xix]

Among those who filled in the FPS questionnaire after the first counselling session, 43.7% of women thought the nurse was understanding, 41.6% felt solace and relief, 8.6% got uncertain, while 2.6% reported that their fears got worse, 1.8% got more nervous, and 0.2% got angry during or after the counselling.[xx]

Legal background

Different regulations apply to the two counselling sessions: these are described in the relevant chapters of this report. The most important information is that both counselling sessions are mandatory, and while during the first session „the nurse, after a declaration of the intention to terminate the pregnancy, informs the client in the interest of keeping the foetus, preferably in the presence of the father of the foetus, respecting the feelings and dignity of the pregnant woman" (9. § (1) of Act LXXIX of 1992 on the Protection of Foetal Life), the second session is merely for providing information and administration.

Research

A few data on participants

Of the 101 research participants, 97 revealed their age. The youngest was 17, the oldest 43 years old. 8 respondents were 24 years old, 8 were 28; these groups were followed by the age groups of those who were 19, 21, 22 and 29, then the group of women who were 25-26, and finally those who were 27, 31, 32, 33 and 38.

In our sample, most women were childless or had one or two children; of the 98 respondents 31 were childless, 29 had one, and 23 had two children. (Besides them, we interviewed 9 women who had 3 children, 4 who had 4, 1 who had 5, and 1 who had 6 children.) As for earlier abortions, almost half of our sample had already had an abortion earlier, and the other half had not: of the 95 respondents 49 belonged to the first group, and 46 to the second.

The following chapters describe the venues of the research, the space and the physical environment of Family Protection Services, and then our respondents' experiences during the counselling sessions.

The Physical Environment of Family Protection Services

Most of the counselling venues are not separate institutions but are placed in a bigger health center, characteristically next to the prenatal care services department. In most FPS venues, the women who turn up for counselling have to wait in the same room with or physically very close to pregnant women. This arrangement neglects the state of mind of women who decide to apply for an abortion as well as the possible psychological effects of this situation. (Respondends did mention the tension they felt while waiting together with pregant women.

E.g.: *„Was there anything you found unpleasant? Yes, all those pregant women in the other room."*) It is also characteristic that the room where FPS visitors have to wait is placed in a way that all other visitors can easily see who arrived for counselling; this stigmatizes and humiliates these women.

Although 92 of the 94 respondents were satisfied with the circumstances during the counselling session itself (nurses paid attention to shutting the door, sending bigger children outside, counselling was not interrupted by phone calls or other activities), there were 2 cases in which the environment did not seem to suit the purpose of an intimate discussion.

In the first case, both the inadequacy of the consulting room and the disturbance of the discussion was suggested:

> *„I don't know how it should happen in general. I was there with my mother, and one could hear everything that was told outside, too, as I had also heard the previous woman, and another nurse came in, too."*

In another instance our interviewer described that although the nurse did see a (quite desperate) woman who had not made an appointment, she began to ask her about her motivation already in the crowded waiting room, thus increasing her defenselessness.

It is characteristic of the physical environment of waiting rooms that they are full of posters and leaflets about pregnancy:

> *„It was full of these posters and flyers with babies, mothers and prenatal vitamins."*

> *„I saw a huge poster depicting a baby and one about why pregnant women must wash their hands often."*

These posters and leaflets usually do not contain information about abortion. Only information materials about contraception may contain relevant information for the women who come for counselling: 4 respondents mentioned such publications (e.g.: „Loving safely" and „The possibilities of contraception"). In other cases, information materials were about the possibilities of conception (e.g..: „We want a family, a child," or „Life is a miracle") and about the development of the foetus (e.g.: „A test towel for the detection of amniotic fluid"). This environment is not useful for these women, but is an effective tool of influencing emotions and arousing remorse.

The FPS in Budapest is also shaped in a way that aims at affecting emotions: its fence is decorated with hand-painted children's drawings, and there are also advertisements of kindergartens and day-nurseries placed on it. This cannot in any way be relevant regarding the counselling process; its only impact is that it arouses remorse in the women who come for counselling.

None of our respondents or interviewers found informative posters or flyers for battered women (e.g. information on where they can turn for help), which is a serious omission on the part of counselling services.

The first counselling session

According to the provisions of the 1992 Act on the Protection of Foetal Life, the counsellor must proceed in the interest of keeping the foetus during the first counselling session, although „respecting the feelings and dignity of the pregnant woman." The first counselling session has to meet the following requirements: the counsellor must inform the applicant about the possibility of available state and other support, about organizations offering moral and material help in case a woman has a baby, about the possibilities and conditions of offering a child for adoption, about the help the state, local governments or social services offer in case of crisis, about the possibility of leaving a newborn child in an incubator, about conception, the development of the foetus, the dangers of terminating a pregnancy and its possible impact on a later pregnancy.[xxi] Although the law assigns the subjects that should be mentioned during counselling, it allows nurses to decide what they wish to emphasize. As the wording of the law is itself controversial (it expects nurses to do everything to persuade the women concerned to keep the foetus while respecting their dignitiy and feelings), it creates a difficult situation for nurses who have to observe the rules. Thus it is nurses who decide how much emphasis they place on persuading women to keep the foetus, and whether they think this emphasis fits the passage on women's rights. Consequently, the information provided to those who participate in counselling shows great differences regarding its quantity and quality and this applies to the tone of counsellors, too.

Hurts unrecognized

At the beginning of the research, we asked our interviewees to describe how they had felt during the counselling session. Approximately one fourth of the respondents told it was a negative experience.

When evaluating responses, two facts must be kept in mind. On the one hand, we often realized that our interviewees had already blamed themselves and felt guilty, so they felt the guilt arousing behaviour of nurses was rightful and behaved by them. When we asked whether the nurse had respected their decision, many of them gave similar answers:

> *„Well, it is strange, one does not think about this in these terms… This is not something to be respected."*

> *„No one has to respect this. They only have to accept it. Not to look down on ot. This is what I think. I don't think it is good. I condemn it, too, and would not do it if I did not have to."*

We could also see when examining the answers provided by this bigger sample that there are women who think that it is only consonant with the nurse's duty to try to infleunce their decision and feelings (as we had also seen in the previous research[xxii]).

> *„Everyone knows this is not a good thing. Some say it's murder. In the end, they are there to tell me that there is a new life inside me. They told this to me, but not that I would get into prison or something."*

> *„Neutral. Of course it is her duty to persuade me to keep the child, but she was not drastic."*

This shows that some of the women whose rights are violated do not realise this, or regard these attitudes as the natural attendants of counselling. If the subject feels that her dignity, feelings and her own decision do not deserve respect, she will not recognize they were not respected, or finds this natural and well deserved.

The majority of those who described counselling as a negative experience were not dissatisfied with the nurse but with the situation or the obligatory nature of counselling itself.

> *„It was not a good feeling, but not because of the nurse. The situation was such that it was not good."*

> *„I don't see why this is needed. I will not make up my mind even if they order me back five times, I crearly have my reasons and I made this decision."*

> *„It was awful. It is a very difficult decision and it is very embarrassing to have to discuss it with a complete stranger. I did not come to this decision out of fun."*

Explicit hurts

Of the 98 women who answered this question, 8 highlighted that they were dissatisfied with the nurse's behavior itself. This usually concerned the persuasion to keep the child or an indoctrinating attitude lacking empathy:

> *„She kept suggesting that I should change my mind, even though I told her clearly that I could not keep this. I did not tell her everything about my life as she has nothing to do with it, but they way she pushed was really disturbing."*

> *„I could hardly wait to get out. I don't want to talk about my life with strangers, especially when I feel she wants to have a say."*

> *„I only wanted to get through it, but I expected a bit of kindness."*

> *„I felt she only wanted to have me off her hands."*

> *„I felt they did not really care, they wanted me to leave as soon as possible."*

> *„She was quite condescending. She did not respond when I asked something. She was only typing, and did not even look at me."*

> *„Well, honestly, I felt she was patronizing. She talked to me as if I was a small child. I felt bad."*

Information provided during the first counselling session

On conception and the development of the foetus

Of the 89 who answered this question, 38 (that is, less than half of the women) got information about conceiving and the development of the foetus. When this subject was not brought up, many of the respondents told it was because they had children, so it was self-evident that they knew, or because they had signaled that they did not want to talk about this.

When this was discussed, it was usually contraceptive methods and foetal development that were brought up. Women got oral information about contraception; only one nurse showed contraceptive instruments (intrauterine devices, pills) to a client. To display the development of the foetus, nurses used visual aids, illustrations and scale-modells (which can easily become instruments of emotional pressure) in 17 cases. This happened in one drastic case, when the nurse, while talking about the development of the foetus, showed one single picture representing a nine months old, fully developed foetus to one of the interviewees. As abortions can only be legally performed until the 12th week, showing a 9 months old foetus could not at all be relevant during counselling; its sole aim must have been emotional pressure, which questions wether the woman's feelings were respected according to the regulation. The reasoning that the foetus „already looks like a baby" (which also aims at affecting emotions besides being false) was used on two occasions.

When asked about the usage of visual aids, interviewees gave different evaluations. As the information yielded was known to most of them, only three of them told it was useful, while seven stressed that they considered it completely unnecessary:

> *„I dont' think it was necessary. I know all these."*

Seven more interviewees told that it was very unpleasant:

> *„It annoyed me, so I didn't really pay attention. When I saw what she was showing, I moved back and tried not to look. I was not interested."*
>
> *„I don't understand why they have to do this. If I wanted to look at such images, I could do that alone. They only make you feel uncomfortable, even if this is their job."*
>
> *„I think these are for women who want to keep their babies and are waiting for giving birth."*
>
> *„I think she showed me these images about the development of the foetus to influence me, to make me change my mind."*

On the dangers of abortion and on offering the child for adoption

The fact that 44 of the 91 respondents had not been informed about the dangers of abortion and its impact on later pregnancies shows the contingency of providing information. This subject was brought up by nurses in 34 cases, and in 3 cases the client herself asked questions about this. The most frequently mentioned risks were those concerning later pregnancies; the danger of infertility and damages to the uterus were almost always mentioned. Post-abortion trauma, sadness or depression were mentioned by nurses in 8 cases, the danger of cancer 3 times (of which one was an answer to a respondent's question). In 4 cases, these risks were described as grave, and in one case the nurse told they were frequent, even though none of these nurses mentioned the sources of these data or described what they meant by graveness or frequency. This is a reason for concern because the health risks of abortion are still debated in the medical profession, and the psychological trauma caused by abortion has not been proved.[xxiii] Many claim that the „trauma" is caused by the ignominious atmosphere these women have to endure: the fact that they are forced to worry and feel guilty.

In the rest of the cases this subject was only mentioned, and in 3 cases the nurse told that risks were less and less frequent.

As for the possibility of offering the baby for adoption, 35 of the 90 respondents had been informed about this, and the possibility was mentioned in 52 cases. The vast majority of respondents do not consider giving birth and offering the baby for adoption an option: most of them would keep the baby if they could not terminate the pregnancy.

> *„... If I have a baby, I would not give her to anyone, as I have already raised a child, and I don't want that… who knows where she would get?"*

Phrasing

The information on the heartbeat of the foetus played an important role during counselling sessions. 13 of our interviewees mentioned this first when we asked them about the information provided. We can interpret this as the obligatory information about the development of the foetus prescribed by the law, but the words used and the aims behind them make a huge difference, as phrasing is an exceptionally effective instrument of influencing people.

In 4 of the 13 cases mentioned, nurses told things like „o, its little heart is already beating," which is definitely not the official tone, and clearly tries to affect client's emotions. We must also mention that the embryo (0 to 8 weeks) or the foetus (from the 8th week) was referred to as a baby or a child, and the client as mother or mum in half of the cases (in the case of 40 out of 82 respondents).

The most radical form of arousing guilt and hurting women is when nurses call abortion a murder or killing, which happened in 14 out of 77 cases.

> *„… that the baby is killed during the abortion, and that if I do not keep the first one, it may be difficult to become pregnant again later."*

> *„She told that the baby is killed during the abortion."*

Mentioning murded is explicitly an instrument of arousing guilt, as it was put in one case:

> *„You have to deal with your own conscience."*

It is impermissible that a representative of the institution uses words that unambigously aim at arousing guilt and influencing clients' emotions during a mandatory and official counselling session, especially when the law prescribes that women's emotions and dignity should be respected during counselling, in accordance with the constitutional rights guaranteed for everyone.

The opportunities to provide help

We got 67 responses about the information women got about state and non-state organizations offering moral and material help in case a woman does not terminate her pregnancy and gives birth to a child. The nurse mentioned support possibilities, family care centers and foundations providing similar services in 19 cases; in 41 cases clients did not get

any information about these. (In the rest of the cases, the respondent had told she did not need information about these, as she knew and / or did not want to hear about them.)

Help in turning for support was offered in 8 out of 62 cases. The possibility of placing the baby in an incubator was also brought up in 8 cases (although this may be because most interviewees immediately told that they were not interested in this option).

Treatment during the first counselling session

The most important question of the research was what kind of treatment respondents experienced during the counselling sessions. Did the counsellor try to infleunce their decision, and if yes, how? Did they have a sense that their feelings and dignity were respected? What arguments were used by the counsellor for or against keeping the foetus or terminating the pregnancy?

26 out of the 78 respondents to this question felt that nurses tried to influence their decision in the course of the counselling.

> *„I felt that this woman wanted to hear that I changed my mind."*

> *„Well, I would say she obviously wanted to talk me out of it."*

The arguments used by the counsellors were quite different, and they usually did not react to the special situation these women were in but to some truth considered universal by the counsellor. The legitimacy of these „truths" in the context of counselling is highly questionable. Some of them were general statements about the age or marital status of the women concerned, aiming at persuading them that „now is the time" for having a child.

> *„She said I was old enough to have a child."*

> *„Yes, she argued that I should keep it, as it was the best time to have another child. (I have a ten-year-old son.)"*

We should also mention the subjective opinion of counsellors, which should not be part of the counselling either:

> *„She also said I could bring them up easily, because it is easy with twins, as they are there for one another."*

And there are also the universalist remarks alluding to emotions, built upon the beauty of being a mother:

> *„… that I already have a child, I am a mother, and perhaps this time it would be a boy. (I have a daughter.)"*

> *„That being a mother is so wonderful. This is what she said."*

> *„Well, that I am already a mother, this is also my kid, what happens if I regret it and want another child but cannot have one later."*

More serious versions of this are cases (already mentioned when analysing the problem of phrasing) when the counsellor personalizes the foetus, calls it a child or a baby, and regards abortion as a murder.

> *„That I might become infertile and that this is already a life."*
>
> *„She said things like I had to know as a mother that this was a new life, and that its heartbeat could be heard…"*
>
> *„That the baby is killed durig an abortion and that if I do not keep the first one, it may be more difficult to become pregnant later."*
>
> *„That I am deciding about a life, and that I should think twice."*
>
> *„That I should keep it, this is my child, too, just like the three aleady at home."*
>
> *„She said it was a kid just like the others I have."*
>
> *„They only told that if I already had one child, I know what it feels like to be a mother, and that in a few weeks time I would find out whether it's a boy or a girl."*

We can also mention cases when the nurse talked to the client about data that were irrelevant regarging the counselling, or about the future characteristic features of the foetus.

> *„Yes, she asked me about the size of the baby, looked at medical papers, told how big it was, and asked me about its sex."*

Nonverbal communication can also be an instrument of pressure, as it happened during counselling sessions. For example:

> *„Well, she did not want to exercise an influence on me directly. But when I told her that I had already decided, she made a sad face."*

11 of our interviewees emphasized that they had a bad experience when nurses tried to persuade them about keeping the foetus.

> *„I was quite unwell already, and this made me even more upset."*
>
> *„It was humiliating."*
>
> *„I was annoyed. This is such a private matter. I'll decide what I want, why should I talk about this to a complete stranger."*
>
> *„I think this is incorrect."*

We asked 94 interviewees whether they thought there was a connection between the counsellor's behaviour and any of their characteristics (age, social or ethnic origin, social or material situation). This, however, was not characteristic: 4 respondents suspected there were such reasons behind the counsellor's behaviour, but none of them could cite actual remarks. Two of these cases reffered to women's age, for example:

„She did not explicitly say this, but I think she talked so much about contraception because she saw my age and perhaps thought I was not aware of these."

In two other cases interviewees thought the nurse referred to their ethnic origin:

„She referred to this indirectly, and told that I was not the only one with this problem, as everyone else was also turning to her all the time." (The interviewee herself assumed that Roma women have many abortions, and she assumed that the nurse made his remark because of her Roma origin.)

„She did not say anything but she may have been so dejected because of my origin."

Arousing guilt

The most elemental form of arousing guilt is when clients are blamed. It is difficult to see the use of this practice, especially as many women already feel guilty when they turn up for counselling: partly because they had got pregnant (which of course was not up to them alone), and partly because of her decision. If in this already defenseless state an official person also blames them and puts them under emotional pressure, this may have serious psychological consequences, and we cannot say that their feelings and dignity were respected.

13 of 98 respondents felt that the nurse treated them as if they were not adults who could decide. One respondent told that the very institution of counselling showed women were not recognized as people who could decide:

„If I was treated like an adult who can decide, I would not have to come here, would I."

The most common form of blaming was questioning the justification of women's decisions:

„She told that if I leave no stone unturned, the reasons I had spoken about could be solved."

„I felt she wanted to suggest that I should see I had made a bad decision."

„I felt she expected me to change my mind."

In some cases the counsellors suggested that the clients were irresponsible:

„They asked me what kind of contraception I used, I told condoms, and the nurse said condoms were of no use, how come I had not known this?!"

„No, she did not consider me a victim, but rather an irresponsible mother."

In one case, the counsellor questioned the rightfulness of a woman's decision referring to her relationship:

„She was against abortion. She told I could make up my mind until the last minute, and asked me whether my partner wanted to have a baby. And if he did, why I didn't want to keep it."

Arousing guilt as a method of reasoning may only lead to intensifying the psychological burden, or manipualting women through this feeling. This is unethical within the framework of official and mandatory counselling.

The attitude of counsellors

Neutral, supporting abortion, against abortion – these are the three options we gave respondents when we asked them to answer a question about nurses' attitudes. Although it is not professional for nurses to represent their personal opinion, attitude and judgment during counselling, 24 out of 75 respondents felt that the nurse was obviously against abortion. 49 respondents told that the nurses were neutral, and 2 supported abortion (in the given situation).

The law's passage that says the first counselling „aims at keeping the foetus" prescribes and induces the questioning of women's decision from the start. This entails that the counsellor may use her own personal views and standpoint in order to reach this goal. However, in order to respect dignity and personal decisons, it is just the contrary that would be needed: that nurses turn to clients objectively, non-judgmentally, but empathically. Arousing guilt, blaming someone and voicing obvious personal judgements are incompatible with „respecting dignity and feelings".

On the second counselling session

Out of the 101 women we talked to, 35 were already past the second counselling session. According to the law, at least 3 days have to pass between the two sessions.[xxiv] Based on our previous research and similar research findings abroad, we realized that it was important to examine whether some counsellors might delay the appointment for the second session, risking that the woman misses the legal time limit of the abortion (until the foetus is 12 weeks old).

Out of the 23 women who answered this question, only one signaled a problem with fixing an appointment, but this one case was very serious:

> *„I told her the first time that I'd like to come back soon, as I would not change my mind. And then they told that three days would have to pass, and that there are many women waiting. So it became two weeks. But when I was there for the first time, and wanted to fix another appointment, she did not let me do that. She said I should call back later, during the following week, when the three work days would have passed."*

The nurse is not obliged by the law to fix another appointment if it is asked for during the first counselling session. However, this would be of key importance. Furthermore, the law does not say that the three days between the two sessions must be work days, so the information quoted above is misleading. Two weeks can easily be desicive within the short legal period, so the above quoted procedure constitutes a significant violation of rights.

Out of 28 respondents, 25 chose the same counselling institution for the secound session; the most decisive factor was that these were the nearest places. The 3 respondents who chose a different venue did not report any negative experiences that would have influenced their decision about changing the venue.

We got 26 responses about the thoughts of the interviewee between the two counselling sessions. 24 of them were not affected by the counselling, as they were quite secure in their decision even before they turned up for counselling.

> *„It did not really affect me, as I had talked it over with my family and my partner."*

> *„Well, I didn't really care. I would not keep it and that's that. You know, she may be sad, but it's not my business…"*

Two women told that they thought a lot about their decision after the first counselling session, but they also showed up for the second counselling, which means they probably decided to have an abortion.

We got 26 responses about women's experiences during the second counselling session. 5 of them told that only paperwork was finished during the second session (as it is prescribed by the regulation).

> *„Nothing. It was only paperwork. She was not offensive at all."*

> *„It was short. Paperwork, and nothing else."*

6 interviewees evaluated the second counselling session negatively. One critique was that it was pointless, while women also mentioned that it was not informative at all:

> *„It was needless, there's no point in having to come two times, whoever wants will get information anyway."*

> *„I was not told anything concretely. Only that I should take a sanitary package into the hospital."*

These two contradictory evaluations reveal that women have different needs when they arrive for counselling: thus it would be practical to shape this service according to clients' needs. Counsellors could ask questions. As we shall see bellow, there are positive examples related to this. In the above case, the nurse could have asked whether the client wanted more information e.g. on what is going to happen in the hospital.

Information provided during the second counselling session

According to the Act on the Protection of the Foetus, clients must be informed about the legal conditions of terminating their pregnancy during the second counselling session. This happened in 19 out of 29 cases; one respondent reported that she had been informed about this both times, while three said she got this information during the first and not the second counselling session.

19 out of 28 respondents were informed about the operation, or asked whether they needed sunch information. Those who had already had at least one abortion usually indicated which topics were known for them.

Only 8 out of 31 respondents got information about the health institutions performing abortions, even though this is also prescribed by the law. Although 7 clients were probably not informed because they told they knew the institution or had already been informed by her

doctor, and in 2 cases this information had already been provided during the first counselling session, 14 respondents were not informed about this at all.

Out of 30 respondents, only 7 were offered help provided by the family protection services after the operation, even though this is also prescribed by the law. In one case, they offered the possibility of help, but also suggested it was very difficult (making the impression that the offer was rather theoretical):

> *„They said I could come later, too, if I had questions, but I would have to make an appointment, and there are too many clients, but I should try anyway."*

Treatment during the second counselling session

Out of 35 respondents, 4 felt that the counsellor still tried to infleunce their decision during the second counselling session:

> *„Yes, she hinted at how I should change my mind and keep it."*

In 3 cases, the counsellor argued for keeping the baby, even though this cannot be part of the second counselling session according to the law either. In two cases, the nurse showed illustrations about the development of the foetus again, which, besides violating the law, obviously reveals the intention to question the client's decision and influence her, and is thus unacceptable.

2 out of 27 respondents felt that the counsellor blamed them for their decision and tried to make them feel guilty. For example, they suggested that they must have failed to use contraception properly, as we could also see when describing women's experience during the first counselling session.

Our research and the statistical data quoted above show that counselling seldom influences women's decision. This means that the aim of reducing the number of abortions cannot be reached by this instrument as it works at present. However, with arguments and remarks that affect emotions and blame clients, counselling makes this already difficult decision (which, however, has already been made by the women concerned) quite traumatic for at least part of the women. Furthermore, the very prescription of counselling and often the way it is realized questions women's freedom to decide, and does not respect the dignity and feelings of these citizens. Such cases should not occur during a mandatory counselling; counsellors should be empathetic and respect the feelings and dignity of their clients. It would be of great help if the law itself did not make it possible or arguably even prescribed such behavior.

Positive examples

The image we paint about the present practice of counselling would be one-sided without mentioning that some of our respondents had good experiences; these are also examples that show that it is possible to provide counselling services while respecting women's dignity, their freedom to decide and their feelings even in a legal environment that is worrisome and prompts counsellors to influence women.

29 of those who had participated in the first and 7 of those who had participated in the second counselling session told that they had had a positive experience (at least to the

extent it is possible in this situation); they told that the nurse had an empathetic and comforting attitude during counselling. Approximately 60 percent of the women we asked felt that their decision was respected during the first counselling session. Among those who attended the second counselling session, this proportion was almost 90 percent. Approximately half of all respondents judged that the tone of the nurse was positive; the most common adjectives they used were „kind," „supportive" and „calm." After the counselling sessions, most women said that they did not feel the nurse had blamed them or tried to arouse guilt.

Nevertheless, we should not forget that there are clients who did not realize they were hurt during counselling. As we have already stated, many women feel she deserves to be hurt or blamed. Also, as we have indicated in the chapter on methodology, we must assume that we did not get information on several grave cases because of the emotional impacts of humiliatory treatment.

Conclusions

All in all, 13 percent of the 101 respondents participating in our research experienced offense (pressure or emotional pressure, blaming) during counselling. Furthermore, one half of them did not get the prescribed information either regarding the quantity or quality of the information ordered by the law. Considering that in the humiliating situation of the counselling subjects are inclined to accept the nurse's behaviour without criticism, as well as the fact that the women who were really upset did not want to give even short interviews right after the counselling session, we may assume that the proportion of counselling sessions that had a negative impact on women's life and hurt their dignity is in fact higher.

Besides the physical environment of counselling (posters, flyers, being forced to wait together with women who arrived for prenatal care) and showing images about the development of the foetus, influencing happens mostly through the phrases counselling nurses use – phrases that are off the record, and do not correspond to what is officially prescribed. The most frequent and grave examples of this are when abortion is identified as murder, the embryo and the foetus are called a child or a baby, and words that are used to affect emotions like „its little heart is already pondering" are employed. Although the law orders that women's feelings and dignity should be respected, there is nothing to prevent nurses from voicing their own subjective opinion or telling generalized „great truths" or using judgmental arguments that affect women's conscience. The personal feelings of nurses have no place at counselling sessions. It is of basic importance to respect the feelings of women who attend counselling, and for this, providing balanced information and the usage of fair, factual and objective phrasing are prerequisites.

PATENT's recommedations

„31. The Committee urges the State Party to:*:*
(c) Ensure access to safe abortion without subjecting women to mandatory counselling and a medically unnecessary waiting period as recommended by WHO;"
(UN CEDAW Commitee, Concluding Observations on the combined seventh and eighth periodic reports of Hungary, 2013.)

1. We recommend that abortion counselling does not take place next to or in the same room as prenatal care, and that women arriving for counselling should not wait together with women arriving for prenatal care examinations. Those who arrive for abortion counselling should not be unambigously identifiable by other visitors of the institution in which the counselling takes place.

2. Counselling should always take place in an intimate, protected space so that the conversation cannot be heard or disturbed by anyone else. Besides the pregnant woman and the person(s) accompanying her, only one FPS worker should be present.

3. There should not be images and flyers about pregnancy, giving birth, babies and raising children either in the waiting room or in the room where the counselling session takes place; on the contrary, there should be informative brochures about abortion, the rights of women who apply for abortion, about contraception and contraceptives as well as their accessibility, about the legal and non-legal services available in the case of sexual violence, and about non-violent partnerships placed in these rooms.

4. We recommend that young people get informative and human rights based sexual education at school, which includes a detailed introduction to contraceptive methods as well as the legal and medical procedure of abortion, also outlining the rights and lawful treatment of women choosing abortion.

5. We recommend that the counsellor only touches upon sections (1) a)-d) of § 9 of Act LXXIX of 1992 during the first counselling session aimed at keeping the foetus, and dispense with the contents listed in section e), which admit emotional pressure.

9. § (1) The nurse, after a declaration of the intention to terminate the pregnancy, informs women in the interest of keeping the foetus, preferably in the presence of the father of the foetus, respecting the feelings and dignity of the pregnant woman (…)
a) about the possibility of applying for state and other (material and in-kind) support in case the woman decides to keep the child;
b) about organizations offering moral and material help in case a woman has a baby;
c) about the possibilities and conditions of offering a child for adoption;
d) about the help the state, local governments or social services offer in case of a crisis, offering her help in having resort to these, while also providing information about placing the child in an incubator operated by health institutes that meet the requirements defined by a separate law, with the intention of consenting to adoption;
(e) about conception, the development of the foetus, the dangers of terminating a pregnancy and its possible impact on a later pregnancy.

6. Counsellors should aim at listening to women empathetically and respectfully, and at taking cognizance of their decision without showing emotions. It is not the counsellor's task to express either approval or disapproval. We find it indispensable that providing information should happen through the exposition of facts. There is no space for emotional pressure, manipulation and arousing guilt and remorse at the counselling. The family protection service provides a service in an equal relationship, not aiming at hierarchy.

7. We recommend that instead of informing women about „the dangers of terminating a pregnancy and its possible impact on a later pregnancy" as prescribed by the law, counsellors inform them about the fact that according to the WHO, abortion performed by trained personnel among proper circumstances is at present one of the safest medical interventions.

8. We recommend that the necessary information should always be provided without the use of visual aids representing the development of the foetus, and that mentioning heart sounds, making womem listen to them, showing ultrasound images and photos of babies are dismissed.

9. We recommend that the training of nurses providing pre-abortion counselling includes appropriate phrasing, from which the counsellor should not diverge. We recommend that they use the term embryo until the 8th week of pregnancy and the term foetus afterwards, and that they should not call the pregnant woman a mammy.

10. We recommend that the waiting period of three days should not be allowed to be extended whatever excuses or administrative impediments are brough up.

11. We recommend that counsellors should provide all the information listed in the law fully and compulsorily, and at the same time dispense with unlawful agitation in order to persuade mothers to keep the foetus.

9. § (2)
a) about the legal conditions of abortion;
b) about the circumstances and ways of terminating a pregnancy;
c) about the medical institutions performing abortion and
d) about the help offered by the family protection service after the abortion, and at the same time offers help in order to ensure appropriate family planning by providing personalized information on the methods of contraception;
e) about the possibility of having resort to contraceptive instruments at a reduced rate.

12. We recommend that contraceptive instruments and medicine should be funded by social security taxes.

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Notes

[i] Rédai – Szabó: 2012.

[ii] The only accredited family support service not maintained by the state but by the Calvinist Mission Center (*Református Misszió Központ*) was not included in our research.

[iii] According to the latest data (from 2012), there are 93 venues in the country operating within the framework of the National Public Health and Medical Officer Service. Office of the Chief Medical Officer: Családvédelmi Szolgálat Helyzete, 2011-2012 („The Situation of Family Protection Services 2011-2012").

[iv] According to the latest data (from 2012), there are 97 maternal and child health nurses providing counselling at the venues operated within the framework of the National Public Health and Medical Officer Service. Office of the Chief Medical Officer: Családvédelmi Szolgálat Helyzete, 2011-2012 („The Situation of Family Protection Services 2011-2012").

[v] KSH (Hungarian Central Statistical Office): 1.1 *Population and vital events (1941 -)*

[vi] KSH (Hungarian Central Statistical Office): Magyarország (Hungary) 2013, p. 11.

[vii] KSH (Hungarian Central Statistical Office): 1.1 *Population and vital events (1941 -)*

[viii] Unfortunately there are no data about the number Hungarian women traveling to neighbouring countries in order to have an abortion. However, several news sources have confirmed that an increasing number of women travel to Austria to seek abortion or have access to the abortion pill. The number of Hungarian clients have been growing at a Viennese Clinic during the last few years. Cf. Ágnes Dreissiger: „Heti tíz magyar nő jelentkezik abortuszra a bécsi klinikán" ("Every week, ten Hungarian women seek abortion at a Viennese Clinic"). http://www.nlcafe.hu/ezvan/20140128/abortusz-becsi-klinika/ (28 January 2014)

[ix] KSH (Hungarian Central Statistical Office): 2012, p. 1.

[x] KSH (Hungarian Central Statistical Office): Terhességmegszakítások száma és megoszlása a nő korcsoportja szerint, 2000–2011. („The number and division of abortions according to women's age groups, 2000-2011.")

[xi] KSH (Hungarian Central Statistical Office): 2012, p. 2.

[xii] KSH (Hungarian Central Statistical Office): 1.1 *Population and vital events (1941 -)*

[xiii] KSH (Hungarian Central Statistical Office): Terhességmegszakítások száma és megoszlása a nő családi állapota szerint, 2000–2011. („The number and division of abortions according to women's marital status, 2000-2011".)

[xiv] KSH (Hungarian Central Statistical Office): 2012, p. 3.

[xv] KSH (Hungarian Central Statistical Office): 2012, p. 5.

[xvi] KSH (Hungarian Central Statistical Office): 2012, p. 6.

[xvii] A countrywide summary on the women applying for abortion at the Family Protection Services (2011-2012).

[xviii] KSH (Hungarian Central Statistical Office): 1.1 *Population and vital events (1941 -)*

[xix] Országos Tisztifőorvosi Hivatal (Office of the Chief Medical Officer): *A CSVSZ „A" tanácsadást felkeresők által, önkéntesen, anonim módon kitöltött kérdőív (Kérdőív az „A" tanácsadásról) eredményei országos összesítő (2011-2012).* (Report on a survey answered voluntarily and anonymously by those who asked for counselling at Family Protection Services. A countrywide summary, 2011-2012.)

[xx] Országos Tisztifőorvosi Hivatal (Office of the Chief Medical Officer): *A CSVSZ „A" tanácsadást felkeresők által, önkéntesen, anonim módon kitöltött kérdőív (Kérdőív az „A" tanácsadásról) eredményei országos összesítő (2011-2012).* (Report on a survey answered voluntarily and anonymously by those who asked for counselling at Family Protection Services. A countrywide summary, 2011-2012.)

[xxi] Act LXXIX of 1992 on the Protection of Foetal Life

[xxii] Rédai – Szabó: 2012, p. 27.

[xxiii] The summary of the Guttmacher Institute in Hungarian: http://abortusz.info/tenyek-az-abortuszrol/posztabortusz-szindroma

[xxiv] Act LXXIX of 1992 on the Protection of Foetal Life