8. A comparative analysis across reproduction policy fields in Hungary

Ivett Szalma and Alexandra Sipos

INTRODUCTION

This chapter gives a comparative overview on the trajectories and interactions of reproduction policies in Hungary starting from 1989, after the democratic reform, with a focus on the changes that took place after 2010 during the second Orbán government. We focus our analysis on this period, which had particular relevance to how reproduction is regulated across different policy fields. Notably, and as described by others (Szikra, 2018), the Orbán government has pursued a strongly pronatalist approach to family policy. It has been an explicit aim of the Orbán government to reach replacement-level fertility. As for the desired effects of these efforts, there was no increase in the number of births (90,335 live births in 2010, and 88,491 in 2022), and only a small increase of the total fertility rate (from 1.25 to 1.52) (HCSO, 2023a), which can be attributed to the growing number of reproductive women in the period. What this rather shows is the strong orientation in Hungarian politics towards pronatalism as an ideological and political project that aims to promote childbearing, assuming it is conducive to the wellbeing of society.

The pronatalist approach of the post-2010 Orbán government has been analysed extensively in the domain of family policies. For example, Szikra investigated the (in)consistencies of the ideological pattern in the Orbán government's approach to family policy (Szikra, 2018). Others examined gendered policy approaches to work–life reconciliation in the pronatalist context (Glass & Fodor, 2022; Inglot et al., 2022). According to Cook et al. (2023), neo-familialist ideologies that are dominant in Hungary emphasise traditional values encouraging women's roles and responsibilities in the private sphere, particularly in reproductive labour. They identify similar discourses on the relationship between family policies and the so-called demographic "crises" in Hungary, Russia and Poland, but distinguish different strands within the pronatalist discourse. Conservative discourses emphasise traditional values, whereas nationalist discourses highlight the survival of the nation and the

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outside "threat" of immigrants. It is precisely these cross-ideological discourse coalitions that allow many citizens with different views to identify with the pronatalist perspective. Moreover, in Hungary, pronatalism discriminates against poorer families, that is, better-off families are even more advantaged, and the poor are even more excluded from state transfers (Cook et al., 2023).

Beyond that research, Hungarian pronatalism has not systematically been examined across different fields of policies regulating reproduction. Previous studies focused on single policy fields or specific issues. For example, Takács (2018) examined how policies limit queer reproduction in Hungary, Szalma (2021) examined the access of individuals to medically assisted reproduction (MAR), and Neményi and Takács (2015) focused on the issue of adoption. This chapter is the first to comprehensively examine policies related to reproduction in the post-2010 era, including abortion, MAR, contraception, adoption, and sexual education. Through these policies, we aim to understand the broader policy landscape and point out interactions, biases, and potential (lack of) coherences in their goals concerning the Hungarian pronatalist approach.

CONCEPTUAL PERSPECTIVES

Pronatalism is often criticised for being a vaguely defined concept (Bergenheim & Klockar Linder, 2020). It has different conceptual meanings and connotations across social science disciplines. From the perspective of demography, all policies that encourage childbearing are pronatalist policies (Gietel-Basten et al., 2022). However, sociologists often point out that explicitly pronatalist political programmes imply antinatalist messages by othering those whose procreation is deemed undesirable (Hašková & Dudová, 2020; Szalma et al., 2022). In this context, pronatalism, which is "built on selective, heteronormative, and exclusionary measures can be called fragile" (Szalma et al., 2022, p. 83). In political science, pronatalism is considered as a political discourse that promotes and glorifies parenthood (Yuval-Davis, 1997). According to the feminist critiques of pronatalism (Graham et al., 2018), pronatalist policies amount to controlling and influencing women's reproductive decisions and thus limiting women to their role as mothers.

We understand pronatalism as an ideology and related policy measures implemented to reach certain ideological objectives. The ideology involves the understanding of gestational motherhood as valuable and as a social role of women. Increasing the fertility rate, which is seen to guarantee the survival of the nation and the continuity of the state, is viewed as desirable. The literature recognises "coercive pronatalism", which is aimed at regulating the sexual and reproductive health of individuals and couples (Heitlinger, 1991, p. 345), including the control over reproductive choices to influence fertility and birth rates, current and future demographic trends (Blake, 1972).

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We use the term "selective pronatalism" (Hašková & Dudová, 2020) to note that the universal pronatalist approach is selective as to which groups' fertility is prioritised and deemed deserving (Herke & Janky, 2023). The concept of "selective pronatalism" recognises that certain policies, in line with the pronatalist ideology, are not necessarily coercive per se, but may still be restrictive. We further differentiate heteronormative selective pronatalism, following Warner's (1993) definition of heteronormativity as normative heterosexuality, which orders biological sex, gender and sexuality in ways that appear natural and conform to heterosexual norms. These aspects often apply to the institution of marriage (Sipos, 2023), which may be a key ideological orientation in reproduction policy.

POPULATION POLICY IN HUNGARY

A strong pronatalist orientation prevails in Hungarian politics. Pronatalism is politically legitimised by invoking the ageing populations in European societies and the increasing old-age dependency ratios. It is frequently highlighted that the high share of the population aged 65+ years puts pressure on the working population (e.g. speech by Viktor Orbán at the Second Budapest Demographic Forum – Miniszterelnok.hu, 2017). Accordingly, family policy promotes fertility based on the assumption that the population's size or its growth is insufficient, which is argued to put the welfare and the very existence of the population at risk (Spéder et al., 2020). In this political discourse, women's bodies serve to an end, namely, to procreate for national development and survival, while at the same time pursuing an anti-immigrant Islamophobic political agenda (Bíró-Nagy, 2022).

However, the government does not evenly distribute the funds to encourage childbearing. Research on family policies shows that the Hungarian government does not follow a "universal" pronatalist population policy. Rather, single parents, same-sex couples, Roma, and low-income families are frequently excluded from the group incentivised to have children, or the policies place explicit barriers to their parenting (Szalma et al., 2022). In this so-called "selective pronatalism" there is now a well-defined target group: "white, cisgender, straight(-acting), affluent middle-class people whose procreation is worthy of encouragement with legislative frameworks, tax, and other benefits" (Takács, 2018, p. 78).

Moreover, "anti-gender" discourses are growing in Hungary. These discourses are commonly constructed in opposition to the liberalisation of policies abroad or globally towards abortion, gender-affirming care for transgender and intersex individuals. The "anti-gender" discourses also oppose comprehensive sexuality education, and "gender studies" in secondary and tertiary education (Vida, 2019). Additionally, these discourses threaten the recognition of sexual

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and reproductive health and rights as human rights and of their significance for achieving gender equality. It is important to examine the role of reproduction policies in these discourses, particularly the developments since 2010, to understand the scope of pronatalist politics in Hungary.

REPRODUCTION POLICY SINCE 2010

Abortion Policy

Access to abortion in Hungary has a long history in relation to women's health and self-determination. Gal (1994) identified three periods of abortion regulation in Hungary. The first period was a highly restrictive one (1949–1954), which is known as the "Ratkó period", where abortion was mostly banned to achieve an increase in birth rates. The second period was marked by the liberalisation of abortion (Council of Ministers Decision No 1047/1956 (VI. 3.)), which was followed by another more restrictive period starting between 1973–1974 that established so-called "abortion committees". The latter policy change granted access to abortion for particular groups of women, including the unmarried, those with at least two children, and those facing housing, financial, or health problems. These restrictions were rightly described as "unfairly privileging some social groups" (Gal, 1994, p. 264).

After regime change, Act LXXIX of 1992 on the Protection of Foetal Life, which is still in force today, was passed whose section 'Termination of Pregnancy' sets out the legal conditions for abortion. According to Article 6, a pregnancy may be terminated up to 12 weeks into pregnancy, if one of the following conditions is met: "the pregnancy is a serious threat to the pregnant woman's health, the foetus is medically diagnosed as suffering from a severe disability or other impairment, the pregnancy is the result of a criminal offense", or the pregnant woman is in a "serious crisis situation causing physical or mental distress or social incapacity" (Act LXXIX of 1992). After the 12th week, different rules apply to access to abortion. Until the 18th week, the procedure can be performed in case of previously not detected pregnancy beyond the pregnant woman's control or due to her limited capacity or incapacity.[1] Between weeks 20 and 24, abortion can be carried out only if serious health risks of the foetus are detected. Termination of pregnancy can take place irrespective of the pregnancy week, if there is a serious medical reason that endangers the life of the pregnant woman or if there is a foetal abnormality incompatible with life after childbirth.

As of 2010, a stricter abortion policy strengthened the pronatalist orientation and traditional views on gender roles – although the basic regulation of access to abortion has been retained as set out in the 1992 Act. The new approach aims to define no less than the beginning of life, the beginning of the capacity

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to act as a person, and the balance between women's right to self-determination and the foetus' right to life.[2] On 25 April 2011, the legislator took a step towards recognising the foetus as a legal entity. The Fundamental Law of Hungary formulated the right to life and the state's obligation to protect it in Article II as follows: "Human dignity shall be inviolable. Everyone shall have the right to life and human dignity; the life of the foetus shall be protected from the moment of conception." This was reiterated in Act CCXI of 2011 on the Protection of Families in Article 3 paragraph (1): "From the moment of conception, the foetus is entitled to protection, respect and support as provided by law" (Act CCXI of 2011). The Act and especially its preamble contains the pronatalist approach. It states that families are the most important national resource in Hungary, and they serve as a guarantee for the survival of the nation as well as a natural environment for the development of human personality.

This approach indicates a shift to limit the reproductive self-determination of women, which went beyond regulative changes in abortion law. For example, in 2011, a pro-life campaign was launched by the government using the following headline with a picture of a foetus: "I understand if you're not ready for me, but I'd rather you give me up for adoption and let me live!". In May 2012, there was an unsuccessful attempt within the Hungarian Parliament to make medication abortion (commonly known as the "abortion pill") available in Hungary. In both instances, adoption was presented as the better alternative to abortion, and the right to reproductive self-determination was questioned and/or denied.

Another crucial moment in the trajectory of abortion policy in Hungary was Decree No 29/2022 (IX. 12.) of the Minister of the Interior, amending Decree No 32/1992 (XII. 23.) on the implementation of the 1992 Act on the protection of foetal life. This became known as the "foetal heartbeat" amendment, introducing another requirement for the termination of pregnancy, namely that the pregnant woman be shown "foetal vital signs". After the news of the proposed amendments came out, protests were held in Budapest in front of the Hungarian Parliament (Kovács, 2022).

At the time of writing, abortion is accessible on request, considering the time limits set forth by the law, counselling sessions with a member of the Family Welfare Service, a waiting period after the first session and the latest restriction, the clear indication of foetal vital signs to be presented to the pregnant woman. All these obstacles contribute to restricting women's and pregnant people's self-determination by following a pronatalist approach. Access to abortion varies in who is able to use services in other countries (Vida, 2019, p. 14) as well as regarding the decision to access abortion procedures. Those with lower education levels and those residing in areas where a higher percentage of people face substantial material and social hardships within Hungary are

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more prevalent among those who have chosen to undergo an abortion (HCSO, 2023b).

The policy shift was in stark contrast with actual trends in the number of pregnancy terminations, which had been declining between 2010 and 2022 (HCSO, 2023b). This reveals the exclusively pronatalist objective behind the reforms, and the ideological stance of women as mere instruments of population policy. Notwithstanding, Hungary's population size is declining despite the government's "pro-family" family policy and economic initiatives (see Inglot et al., 2022). No serious long-term projection on the trends in population size and number of terminated pregnancies can be made following the recent decree from 2022.

Adoption

The regulation of adoption is considered in this chapter as a policy field that reflects the selective approach to supporting families in Hungary similar to other reproduction policies. Adoption was first regulated by Act IV of 1952 on Marriage, Family, and Guardianship (hereinafter: the Family Act) in the socialist context, then by the Hungarian Civil Code. The related procedures of adoption are further regulated in Act XXXI of 1997 on the Protection of Children and Guardianship Administration. The main goal of both the 1952 and 2013 Civil Code regulation was to establish a "family unit" through the adoption of those minors whose parents are unable or unwilling to raise them. With the Convention on the Rights of Children being the first international instrument adopted in Hungary after the state-socialist period – in addition to this decision's symbolic nature – the best interest of the child should be also considered.

Currently, Hungary allows both open and closed adoption (Civil Code Section 4:125–126) with the latter prohibiting contact between birthparents and adoptive parents and child. Regarding open adoptions, nine NGOs are officially authorised to facilitate the process under Government Decree 72/2014 (13.III.), whereas closed adoptions go through the state system (*Adoption in Hungary*, 2014). In both cases, applicants face several rounds of examination: psychological, medical, home study and income checks. Section 4:121 and 4:122 of the Civil Code defined several requirements regarding the adopter: full capacity to act, minimum of 25 years of age, the age difference between adopter and adoptee (minimum of 16 and maximum of 45 years), appropriate circumstances and a valid decision of suitability issued by the competent guardianship authority. Most of these remained in place, but the compulsory preparation course is now only recommended for prospective adoptive parents. Furthermore, the age gap has been raised to fall between 16 and 50 years in case the adoptee is more than 3 years old.

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In October 2020, the 35/2020 (X. 5.) Decree[3] amended several other decrees related to – amongst others – child protection institutions, surrogate and foster parents. Following this, priority shall be given to married couples over single applicants for adoption. In addition, following a legislative amendment in December 2020, the conditions for adoption by single persons became stricter, as the eligibility certificate issued by the guardianship authority requires the specific consent of the Minister responsible for family policy (Sipos, 2021, p. 13). On the surface, these amendments only seem to support married couples, but considering that only different-sex couples can marry, it further restricts same-sex couples' access to adoption. In summary, these changes adhere to selective pronatalism tied to the ideal of marriage and heteronormativity.

Regarding the selectivity inherent to the adoption system, several issues are at stake. Neményi and Takács (2015) find that, in the process of adoption, public and civil actors as well as potential adopters identify several forms of discrimination. For example, in the "redistribution" of children from disadvantaged families towards well-off ones, or in the length of the adoption procedures. Interviewees reported their impression that the longer children are placed and kept in foster care or a childcare home, the less likely they are to be adopted. Another aspect was the "waiting time" for adoptive parents: those who were willing to adopt older or Roma children or children with treatable medical conditions, seemed to adopt faster (Neményi & Takács, 2015, pp. 87, 92). Furthermore, adopters often indicate preferences regarding the age, gender, health, and other characteristics of the adoptee.

Overall, among the actors involved in the adoption procedure, family is seen to be marriage-based, including heterosexual couples with children. This is in line with attitudes in the population more generally and the ideas reflected in the legislation of adoption. In our focal period after 2010, several changes have been made to the adoption system which strengthened this selective pronatalist approach to adoption in Hungary. Apart from the different amendments to the Fundamental Law in 2013 and 2020 regarding the protection of family in Article L), the eligibility criteria and requirements were modified, for example as noted before the difference in age, removing the compulsory nature of the preparation course or "speeding up" the process of declaring children adoptable.

Contraception

Overall, contraception is a reproduction policy field considered of much less interest to the state in Hungary. However, from the perspective of selective pronatalism, the regulation of female sterilisation and vasectomy are of interest. State regulation differentiates between access to and funding of sterilisation

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for health reasons or family planning reasons respectively. Artificial sterilisation is regulated under Act CLIV of 1997 on Health Care and the related Decree 25/1998 (VI. 17.) on Artificial Sterilisation for the implementation of Act CLIV. Paragraph 1a of Article 187 of the Health Care Act covers the legal requirements for sterilisation. If sterilisation is requested for reasons of family planning, that is, to prevent having further children, the applicant must be at least 40 years old or should have at least three blood-related children. Here, the law treats women and men formally equal and implements a strongly pronatalist norm. Another requirement for sterilisation for family planning is mandatory counselling on alternative contraceptive methods, the sterilisation procedure and possible reversal, as well as a six-month waiting period. Even if the law is formally equal, the requirements are implied to be different for women and men (for example having three blood-related children), and indeed other contraceptive methods place more burden on women (e.g. hormonal contraception: dosage of hormones, cost, time, and regularity).

If sterilisation is requested for health-related reasons, there are different conditions. First, the law stipulates that surgical sterilisation can be performed in case a pregnancy would severely affect the health of the woman or the child born out of said pregnancy, and in case other contraceptive methods are not available (Act CLIV of 1997, 7. § a-b). In this case, the law concerns women's (and the foetus') health and body. Second, for people placed under custodianship by the court, resulting in limited capacity or no capacity, the law provides a set of requirements before artificial sterilisation can be performed, that is, no other contraceptive method is available, the procedure is done with the consent of the person, the person would suffer from serious health issues due to the pregnancy, there is a high likelihood of the prospective child having severe health issues, or there is a high likelihood of the person being unable to take care of the prospective child.

As for the coverage of costs for contraception in Hungary, regulations differ between different methods, although, in general, coverage is very limited. Hormonal contraceptives – including the so-called "plan B" pills – are prescription-only products that are currently not publicly funded. The state does provide funding for sterilisation, but given its pronatalist approach, sterilisation for non-medical reasons (e.g. family planning) is not covered by a public health care scheme (Act LXXXIII of 1997, 18. § (6) h)). To circumvent the challenges of the Hungarian system, people with the necessary financial means and information often travel to neighbouring countries (e.g. Slovakia) to access contraceptives, such as over-the-counter "emergency pills", which are not available in Hungary.

The different approaches to covering the costs of contraception and abortion for people with low incomes in Hungary reflect inconsistencies in state regulation of how unwanted parenthood may be avoided. According to an infor-

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mation leaflet from the Hungarian Civil Liberties Union, the costs for abortion can be partially or fully covered for people living in social institutions, minors who are in temporary or foster care, young adults who are in aftercare, people with disability allowances, and in case the pregnancy was the result of sexual violence (TASZ, 2023). This contrasts with the low generosity in covering contraception.

Medically Assisted Reproduction

In Hungary, MAR treatments were regulated by the state for the first time in 1981. Decree No. 12/1981 (IX. 29.) of the Ministry of Health stated that MAR can be performed upon request on a married woman under the age of 45, who has full capacity to act, a Hungarian citizen residing permanently in Hungary, and provides medical proof that she is unlikely to conceive a healthy child "naturally". This was a strict regulation, which reflected pronatalist principles in that it made MAR conditional on marriage and citizenship. After that, MAR policy did not see substantial changes, which can partly be explained with MAR being less common in the 1980s and 1990s than today, because the various types of in vitro fertilisation were not yet available (Szijártó, 2023), and because, overall, people became parents at a younger age and needed it less (Williamson et al., 2014).

With Act CLIV of 1997, which is still in force today, the Ministry of Health dealt with the MAR procedures in detail. It changed the previous legislation so that the procedure could now be performed not only on married, but also on heterosexual persons in a cohabitation relationship, provided that either party has been diagnosed with a medical condition (infertility), which means that a healthy child cannot be born spontaneously from the relationship. While the selectivity based on marriage ended, same-sex couples were still excluded.

The Act regulated the financing of MAR treatments for the first time. Until the system changed (after 1990), financing regulations were obsolete because the entire health care system was statutory. Act CLIV of 1997 states that MAR treatments are free of charge only if a medical indication is certified by a health service provider, who is financed for this purpose from the Health Fund. In addition to the actual treatment, the financing also covers the necessary medical examinations. A maximum of five cycles of in vitro fertilisation and six cycles of insemination can be financed by the Health Fund. If at least one child is born alive as a result of any treatment, then four additional cycles will be financed by the Health Insurance Fund. Compared with what is covered in other European health care schemes, this financing can be considered generous.

The next major amendment was Act CLXXXI of 2005, which extended the group of people with access to MAR. The amendment allowed access to

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treatment for single adult women who were not married or in a civil partnership at the time of the MAR procedure. Importantly, this was only available to single heterosexual women, but not lesbians. There was a grey area: women concealing their same-sex partnership could get MAR treatment, although any child born as a result of the treatment would only have a legal relationship with the gestating woman.

In 2020, the government moved further in its pronatalist agenda also in this policy field. A new law nationalised six fertility clinics and made both the cycle and the medication treatment costs state-funded (1011/2020 (I. 31.)). Previously, the medication treatments were not state-funded (only the cycles), and they were expensive. This amendment also means that only state funded fertility centres can operate, not private ones (Act CI of 2021 on certain property management issues and amendments to enhance the coherence of the legal system). Thus, financing the treatments themselves is not an option to reduce the long waiting lists. This is likely one of the reasons why many Hungarians choose to go abroad for MAR treatments, especially to Czechia (Serdült, 2021).

The bill argued that "the demographic challenges require a state role, so in the future, the performance of special procedures aimed at human reproduction will be the sole responsibility of a state-run health care provider and a clinical centre" (Justification of the Government Decision 1011/2020 (I. 31), 2021, p. 1327), which reflects that nationalisation was driven by pronatalist goals. More specifically, these are heteronormative pronatalist goals since homosexual couples are still excluded from access.

The latest reform has further increased funding, but this is selective too. While five cycles are fully covered and the necessary medication is provided free of charge, the clients of fertility centres are mostly better-off couples, who are now supported by the state. Treatment costs are not the only items that are to be taken into consideration (Bauer, 2022), but travel costs and time off from work can pose significant burdens. Additionally, all fertility centres are situated in urban centres, which means that they are less accessible for people living in more rural areas. Fertility treatments are time-costly, which is more reconcilable for people with teleworkable jobs, but not for blue-collar workers (Bauer, 2022). Knowledge about fertility treatments, which may be unequally distributed, is another factor. Knowledge deficits may originate in education, for example, our own ongoing research shows that secondary or vocational school curricula in Hungary do not include MAR.

Sexuality Education

While the introduction of school-based sexuality education in Western Europe started during the 1970s and 1980s, in the Central-Eastern European region,

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this development took off after the state-socialist period (WHO Regional Office for Europe & Federal Centre for Health Education (BZgA), 2010, p. 12). Furthermore, the content of sexuality education differs significantly in post-socialist Europe. In Hungary and Poland, so-called "family life education" became dominant, which aimed at teaching children "traditional" gender and family norms. In 2012, Orbán's FIDESZ government incorporated the concept of family life education into the national curriculum, which prescribed that children should be taught about family life in ethics as well as in Hungarian language and literature classes, environmental or nature studies, history, and biology (*National Framework Curriculum*, 2013). Family life education has remained the framework of sexuality education in Hungary until today (Pető & Kováts, 2017).

In 2020, the core curriculum for the education system was renewed so that family life education appears as a separate subject in the new National Core Curriculum. It aims to prepare school-age children for independent adult life, responsible relationships, and family life in order to have a "significant positive impact on unfavourable demographic and social processes" (Pusztai & Csók, 2022, p. 110). With this, family life education clearly reflects the government's pronatalist goal, that is, for Hungarians to have more children. In addition, family education also serves to reinforce traditional gender roles by teaching pupils that the main role of women should be to care for children, while men should be breadwinners. Overall, children are expected to adhere to traditional gender roles and to be prepared for parenting roles.

However, family life education reflects *selective* pronatalism in promoting a heteronormative family idea and excluding other family forms. This is also shown in the symbolic politicisation of sexuality education. Coinciding with the parliamentary elections in Hungary, a national referendum was held on LGBTQI issues. The referendum contained four questions[4] on whether sexual orientation and gender reassignment should be taught at public schools, insinuating a risk for children being exposed to these contents. Although the referendum was not valid because the participation quorum of 50 per cent was not reached, it is noteworthy that more than 92 per cent of the votes did not support classes on sexual orientation in public educational institutions. In summary, these developments show that the regulation of sexuality education has taken the direction of selective (heteronormative) pronatalism since 2010 in Hungary.

COMPARATIVE SUMMARY

Changes in reproduction policies have taken a general pronatalist turn since 2010 in Hungary, but they did not follow a coherent pattern across different reproduction policy fields. While some fields saw some liberalisation (e.g.

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Table 8.1 Ideological motives pursued in reproduction policies in Hungary

	Abortion	Adoption	Contraception	MAR	Sexuality education
Universal pronatalism	X	–	–	X	X
Selective pronatalism: marriage based	–	X	–	–	–
Selective pronatalism: heteronormative	–	X	–	X	X
Selective pronatalism: socio-economic status	(X)	–	–	X	X
Support of traditional gender norms	X	X	X	X	X

Notes: Assigns policy orientations to five reproduction policies in Hungary, that is, abortion, adoption, contraception, medically assisted reproduction, sexuality education, differentiating universal pronatalism from variants of selective pronatalism based on marriage, heteronormativity, socio-economic status, and from support of traditional gender norms.
Source: Based on Sipos and Szalma (2023).

MAR), others have clearly become more restricted (e.g. adoption, abortion). In terms of the ideological direction, the ruling government has followed a pronatalist agenda not only in the family policy domain as shown by previous research, but also in the domain of reproduction policy. However, as has been shown in previous research (Takács, 2018; Szalma et al., 2022), pronatalist policies are rarely universal in nature, but rather two-edged: while some groups are encouraged to have children, other groups may be discouraged. Table 8.1 shows which reproduction policies follow universal pronatalist principles and along which dimensions each policy can be considered to be selectively pronatalist.

Our analysis indicates that the policy fields have not followed the same pronatalist principles. What we refer to as “universal pronatalism” was reflected in the fields of abortion, MAR and sexuality education. Here, with the changes in legislation since 2010, the government’s intention was explicitly to increase the number of births. However, all the examined fields of reproduction policy contain some selective elements. Abortion policy reinforces traditional gender

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roles by allocating the responsibility for reproduction to women. Similarly, contraception policy reaffirms the "reproduction responsibility" of women who are seen as citizens primarily responsible for reproduction. Adoption policy reinforces traditional gender roles by making it more difficult for unmarried couples and single people to adopt a child from 2020 on. Making it conditional on marriage, which is only legal between a man and a woman in Hungary, also hinders same-sex couples' adoption. The same can be said for MAR policy, which is limited to heterosexual persons. In sexuality education, the "family life education" curriculum introduced in 2012 reinforces "traditional families" and teaches children traditional heteronormative gender roles. With this, traditional gender norms are the only element that equally applies to all reproduction policy fields we examined.

However, there are also conflicting principles in reproduction policies. While adoption is almost impossible for singles, MAR is allowed for single women through anonymous sperm donation. Another contradiction is that, while MAR is generously subsidised by the Hungarian state, knowledge on MAR is only available to certain groups of students in Hungary. For example, individuals trained in vocational schools may be at a disadvantage, because here MAR issues are not part of the curriculum. It is also a glaring contradiction that costs for contraceptives are not subsidised based on social need, but costs for abortion are.

The current Hungarian government's political agenda on reproduction policy is informed by both nationalism and conservativism. Hungarian women are viewed primarily as wives and mothers, considered as reproductive citizens of the nation to help overcome the "demographic deficit" of the country or to reinforce traditional family values. Through the recreation of a nationalist, conservative, heteronormative, discourse supporting the patriarchal family, which is explicitly "anti-gender" and anti-LGBTQI rights, the government seeks to undermine liberal democratic values, as well as the global and European human rights agenda.

With this chapter, we have contributed to understanding how reproduction policies are aligned and how they can contradict each other at the same time within a country. Our chapter also demonstrated a case of intensive selective pronatalism in Central-Eastern Europe. Some important topics remain for future research, such as the issue of forced sterilisation of Roma women, which should be further explored as a question of selective pronatalism.

NOTES

1. Incapacity or limited capacity to act is indicated in the Hungarian Civil Code, for example in the case of young ages (0–14, 14–18), or being placed by

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the court under legal custodianship (due to, for example, mental disorder, serious addiction).

2. The Constitutional Court of Hungary interpreted these rights related to the regulation of abortion in the following decisions: Decisions 64/1991 (XII. 17.) and 48/1998 (XI. 23.) and highlighted that it is within the Parliament's competence to determine whether the foetus is or not a legal person.
3. *2020-as jogi változások az örökbefogadásban* (2020, October 12). Örökbe.hu. https://orokbe.hu/2020/10/12/2020-az-orokbefogadasban/
4. Originally, the National Election Commission approved five questions, including the following: "Do you support the promotion of gender reassignment treatments for minors?" This question was excluded by the Curia, the highest judicial authority in Hungary, relying on the Fundamental Law of Hungary and the legal rules related to referendums in its reasoning (Decision Knk.II.40.646/2021/9. of the Curia).

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