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Strengthening community mobilisation on HIV and AIDS in Central and Eastern Europe

HIV/AIDS in Hungary

A non-governmental overview

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CONTENTS:


Budapest

Executive Summary

Based on missions in Hungary by AIDES representatives from France, in partnership with PLUSS

In Hungary today, drug users share needles and gay men have unsafe sex… but the reported number of HIV/AIDS cases is still very low. It seems that Hungary has simply been, so far, "geographically" protected from the HIV epidemic spreading across Europe. On European maps showing HIV prevalence, Hungary, with its very low rate, stands uncomfortably close to Switzerland and Italy to the west and Ukraine to the east, which are all among the countries most affected by HIV/AIDS in Europe. **Clearly Hungary should do all it can now to keep its low prevalence low, yet this hardly seems to be the case.**

Confidentiality and HIV testing

The Hungarian government started to respond very early to HIV/AIDS (in 1985, even before the first case was reported), but its strategies have been largely and very inadequately inspired by methods designed to combat syphilis and other sexually transmitted diseases. Up until the very recent reform of these practices, it was still almost impossible to get an anonymous HIV test in Hungary: if your result was positive, you had to report your full name and address to the health authorities and provide the names of all your former sexual partners (who were obliged to undergo HIV testing in turn). Starting in 1997 the government also streamlined a "two-step" process for HIV testing: if the first test (Elisa) is positive, the person is obliged to disclose his or her full identity in order to undergo the confirmation test (Western Blot). This controversial and highly unusual practice should stop, as it is very likely that people would rather not undergo testing in such conditions. We hope of course that recent legal reforms on this key-issue will durably change the practices of clinicians and health practitioners with regard to respecting the fundamental privacy and confidentiality of medical data.

Medical care

Medical care for all people with HIV/AIDS in Hungary is centralised in the Saint Lazlo Hospital in Budapest. On one side, medical practitioners there take great care to remain updated on the rapidly evolving international standards regarding AIDS treatments and are able to provide HAART* and monitoring to the 300 patients they follow. Nevertheless, some of the new anti-HIV drugs that have been approved by the European Agency for the Evaluation of Medicinal Products (EMEA), as well as Resistance Testing (now widely used in Western Europe), were still not available in Hungary as of 2003.

This centralisation of all AIDS medical services has many downsides; for example, medical practitioners across Hungary remain scarcely knowledgeable about HIV/AIDS and as a result, common AIDS related opportunistic infections are often not properly diagnosed. Many dentists also still refuse to treat people living with HIV (a specific dental care unit had to be set up at the Saint Lazlo Hospital). Instead of integrating HIV/AIDS into standard medical practice, the quality of AIDS care and treatment in Hungary relies exclusively on the willingness and commitment of the handful of medical practitioners who work for the AIDS unit of Saint Lazlo hospital.

Lack of local funding for NGOs...

When the former government dissolved the National AIDS Committee in 2000, almost all governmental funding attributed to NGOs to fight HIV/AIDS was stopped. PLUSS, the Hungarian association of people living with HIV/AIDS (PLWHA), for instance, remains active thanks to direct logistical support from Saint Lazlo Hospital. Overall, only NGOs with some funding from international sources have been able to maintain their activities: the Hungarian Civil Liberties Union received grants from the Ford Foundation for its comprehensive and forceful work on HIV and human rights and the NGO HATTER has been able to set up prevention projects for gay

men in partnership with an American university. But even though the National AIDS Committee has been re-established, major problems remain: a new budget line of 107,000 Euros to fund prevention and support work done by Hungarian HIV/AIDS NGOs in 2003 was never spent due to technical administrative issues (these funds may eventually be attributed in 2004). As a result, in 2003, Hungarian HIV/AIDS NGOs found themselves completing several tedious applications in the hope of receiving some of these funds, so far in vain.

Prevention and emerging risks

Thanks notably to a well established peer support programme targeting teenagers in school, young people in Hungary are on the whole rather well aware of issues and risks related to drug use and sexuality, including HIV/AIDS. However, no adequate information and support projects reach out toward other vulnerable groups such as intravenous drug users, male and female prostitutes, gay men, or immigrants originating from countries with a high prevalence of HIV. When such programmes exist, their scope is clearly insufficient (only 200 intravenous drug users were receiving methadone treatment as of late 2002). The rising incidence of hepatitis C among drug users and of sexually transmitted diseases among prostitutes (chlamydia and gonorrhoea) reveal that the risk of seeing the HIV epidemic rapidly increase is very real.

Perspectives

As Hungary is now very close to integrating into the European Union, the newly re-established AIDS committee will have a crucial role to play in improving the standards of HIV/AIDS care and prevention, as well as strengthening respect for the rights of PLWHA. It is also urgent for prevention strategies in Hungary to reach the people who need them most. There are numerous local NGOs in Hungary fully capable of setting up community-based outreach projects, but to do so they need to receive government support – and also hopefully get the chance to benefit from lessons learned abroad through European exchange programmes.

Finally, following recently voted laws, Hungarian health authorities should urgently allow the implementation of truly anonymous testing centres to foster trust in the health care system: all individuals who have taken risks regarding HIV should feel safe when getting an HIV test. Compiling nominative lists of people living with HIV/AIDS should be forever prohibited, as these have strictly no public health value. Likewise, mandatory testing and tracing of former sexual partners must also become a thing of the past. If the incidence of HIV is to remain low in Hungary, some specific groups will also need to change their behaviours: gay men and prostitutes will need to become much better at adopting and sustaining safer sex practices and drug users will need to have much easier access to disposable injection equipment and to appropriate health services such as substitution treatments. But such changes in behaviour will happen only if people are empowered and given the means to change, which will not happen in a system that does not respect human rights.

*HAART: highly active anti-retroviral treatment

EPIDEMIOLOGY

In Hungary, monitoring HIV/AIDS patients and reporting on infected people has been conducted since the second half of 1985. The monitoring of blood donors and of each blood sample has been continuously performed since July 1986. The first cases of HIV were diagnosed in 1985 in Hungary, and since then the number of registered HIV cases has risen to 1073. Between 1985 and the end of June 2003, 1073 HIV infected people were reported all in all, out of which 817 were male, 146 were female and 110 people were tested anonymously.

Number and gender distribution of registered HIV cases by year of detection

Year	Men	Women	Anonym	Total
1985	14	2	0	16
1986	65	4	0	69
1987	50	4	0	54
1988	24	5	0	29
1989	30	2	4	36
1990	39	0	1	40
1991+	43	6	6	55
1992+	44	4	14	62
1993+	35	7	13	56
1994+	38	4	23	65
1995+	53	4	24	81
1996+	38	11	13	62
1997+	49	11	12	72
1998+	58	16	0	74
1999+	51	11	0	62
2000+	38	10	0	48
2001	55	27	0	82
2002	65	13	0	78
30 June 2003.	27	5	0	32
Total	**817**	**146**	**110**	**1073**

+ Corrected data

The main transmission route is through men who have sex with men, but in the past few years there has been an increase in the number of heterosexual transmissions.

Distribution of HIV infections by risk groups

Year	Risk groups									
	Homo/ bisex.	Hetero sex.	Haemophyliac	Trans-fusion	I.V. drug users	Noso-comial	Maternal	Unknown	Anonym.	Total
1985	4	1	11	-	-	-	-	-	-	**16**
1986	48	3	17	1	-	-	-	-	-	**69**
1987	41	1	2	2	-	-	-	8	-	**54**
1988	14	6		2	-	-	-	7	-	**29**
1989	24	2	1	2	1	-	-	2	4	**36**
1990	32	-	-	5	-	-	-	2	1	**40**
1991	30	8	-	1	2	2	-	6	6	**55**
1992	30	7	-	2	-	2	1	6	14	**62**
1993	28	8	-	1	-	3	-	3	13	**56**
1994	24	6	-	1	-	1	-	10	23	**65**
1995	39	11	-	-	2	-	-	5	24	**81**
1996	28	11	1	1	-	1	1	14	13	**62**
1997	22	22	-	-	-	1	1	14	12	**72**
1998	36	22	-	1	1	-	-	14	-	**74**
1999	28	11	-	1	-	2	-	20	-	**62**
2000	17	16	-	-	1	-	-	14	-	**48**
2001	35	20	-	2	3	-	-	22	-	**82**
2002	35	26	-	-	1	-	-	16	-	**78**
30 June 2003.	14	9	-	-	1	-	-	8	-	**32**
Total	**529**	**190**	**32**	**22**	**12**	**12**	**3**	**163**	**110**	**1073**

In newly diagnosed infected people the number of non-Hungarian citizens has been steadily increasing from year to year. Among them, Romanian citizens have outnumbered all others. Furthermore, the estimated number of infections is now between 2000 and 3000, while the first AIDS case was diagnosed in 1986, and since then the number of AIDS cases has risen to 436.

The distribution of AIDS cases by year and gender

Year*	Men	Women	Total
1986	1	0	1
1987	6	1	7
1988	9	0	9
1989	15	0	15
1990	17	2	19
1991+	29	1	30
1992	31	2	33
1993+	28	4	32
1994	22	1	23
1995	28	3	31
1996+	41	5	46
1997	25	6	31
1998+	32	4	36
1999	35	2	37
2000	25	2	27
2001+	17	3	20
2002+	19	7	26
30 June 2003.	10	3	13
Total	**390**	**46**	**436**

Year* = AIDS diagnosis

+ Corrected data

A breakdown by risk groups is recorded only in AIDS patients, according to which 70% are homo- or bisexual, 15% heterosexual, 4,6% haemophiliacs, 2,8% transfusion recipients, and 6% have an unknown history. The less than 1% of HIV/AIDS patients who are or were intravenous drug users are not Hungarian citizens and did not become infected in Hungary. Altogether 253 people have died of AIDS related illnesses. [EPINFO, 2003]

AIDS deaths by year and gender

Year*	Men	Women	Total
1987	2	1	3
1988	8	0	8
1989	10	0	10
1990	6	1	7
1991	16	2	18
1992	16	0	16
1993	23	1	24
1994	34	0	34
1995	12	1	13
1996+	23	2	25
1997	22	3	25
1998+	20	0	20
1999	11	0	11
2000	10	5	15
2001+	5	3	8
2002	8	2	10
2003. II. n.év	5	1	6
Total	**231**	**22**	**253**

Year* = AIDS death

+ Corrected data

In the past few years there has been an upsurge in prostitution. Besides the "traditional" forms of prostitution in hotels and areas like Rákóczi tér (in Budapest), there are now newer forms, including roadside, truck stop, and massage parlour. At the same time, there has been an upsurge in male-to-male prostitution. The Hungarian and non-Hungarian prostitutes who used to work in Western Europe or other more infected areas, and who now work in Hungary after having been deported, compose an important group among PLWHA. There has been an increase in the number of foreigners in Hungary as well. The number of border crossings is over 100 million per year. For economic reasons, there has also been an increase in the number of refugees living in Hungary. New HIV infections among heterosexual women in Hungary have now often become related to unprotected sex with migrant men who come from the countries with the highest HIV/AIDS epidemics (such as African countries).

Specific prevention programmes should be created and implemented rapidly in order to avoid a further increase in new infections among migrants and their sexual partners. Hungarian authorities should also bear in mind the 1997 decision of the European Court for Human Rights, which judged that to deport a person with a severe illness to a country where access to adequate care could not be guaranteed was equivalent to torture, and should therefore be banned according to Article 3 of the Convention (Decision D. vs. United Kingdom of May 2, 1997). To tackle an anticipated increase in the HIV epidemic in Hungary, it is crucial for migrants to have free and anonymous access to testing centres and HIV/AIDS treatments.

TREATMENT

Dr. Dénes BÁNHEGYI

Report of Dr. Dénes BÁNHEGYI, Head of the Department of Internal Diseases #5 (Immunology) Budapest St Laszlo Hospital (2001)

During the 90s, the number of HIV positive people and the number of AIDS patients stabilised, with 55–80 cases in the former group and 30–45 cases in the latter group annually. In accordance with European trends since 1997, the number of AIDS diagnoses and deaths caused by HIV/AIDS has been decreasing, which is unambiguously due to the efficacy of antiretroviral treatments. Nevertheless, this favourable image is spoilt by the fact that 72% of AIDS cases reported in the past two years have been newly diagnosed HIV infections. In Hungary, people with symptomatic HIV infection and AIDS are treated exclusively at the Department of Infectious Diseases #5 at Budapest Szent László Hospital. (This has been criticized in the recent past, which makes sense from the viewpoint of democratic freedom of choice, but there is an economic contradiction due to the small number of PLWHA). Apart from necessary hospitalisation, the Department of Infectious Diseases also carries out day and home care treatments. Antiretroviral treatments for HIV/AIDS patients are conducted under Professional Protocol in the Department surgery and HIV/AIDS patients are regarded as outpatients. The antiretroviral medicines are available free of charge.

The scope of the surgery is to cater to the needs of HIV/AIDS outpatients who come from different parts of the country to undergo specialist medical examinations, blood samples, simple examinations by diagnostic equipment, or psychological counselling. Moreover, in compliance with international practice, late clinical day care has been widely adopted. Along with the higher number of patients with HIV/AIDS, there has also been an increase in the number of those who attend the outpatient surgery for daily infusions (some anti-virals, cytostatic drugs, etc.) To cope with these responsibilities and to pass on knowledge, the Department regularly holds specific trainings, extension courses, case discussions, and training for social workers.

Efficient treatment

Last year, 85 patients received combined antiretroviral treatment as outpatients. Since then, 69 new antiretroviral treatments have been initiated, out of which 10 patients have undergone a complete clinical examination, 6 patients from two new clinical examinations have been admitted to medication, 10 patients have been lost and 3 patients have left. That year in Hungary, 123 patients saw adjustments in their therapy (43,5 % of the patients under treatment, which complies with the international average) partly because of failure in viral response (development of resistance), partly because of hypersensitivity, and/or metabolic side effects. There has been no waiting list for new patients – treatment is instantly initiated provided the patient meets the requirements specified by the Professional Protocol.

When a new patient is offered a threefold antiretroviral treatment, apart from meeting highly strict professional standards, optimal costs are also considered. At the moment, 3/4 of the nearly 300 patients live in Budapest and its environs. The patients living in the rest of the country show an almost even dispersion; however, since international experiences have verified that patient quality of life, their chances at survival, and the efficacy of treatment largely depend on the professional skills of the medical staff, from a professional point of view, offering medical care to a small number of patients in newly established centres in Hungary cannot be justified.

Characteristic features of 2001

The number of new patients involved in treatment increased at a slightly higher rate than expected, and that of treatment combinations met estimates. As a result, the special extra fund of HUF 370 million granted by the National Health Fund was sufficient to cover the costs of the

antiretroviral treatments for the HIV/AIDS patients with symptoms. The efficacy of treatments regarding both the quality of life and life expectancy matches international standards.

Our achievements

Three additional units complemented the activity of the HIV/AIDS surgery:
1) a cell surface marker lab to check the cyto-immune state of patients,
2) a dental surgery to provide dental care for patients with HIV,
3) and as a new unit, a lab of molecular biology to measure the HIV-RNS count and examine the nucleoside analogous resistance of HIV by point mutation testing.

Changes in combined antiretroviral treatments in 2001 versus 2000


Prescription of ARV at St Laszlo Hospital

Treatment	2000	2001	Changes (%)
Combination of two (2NRTI)	79	60	- 31
Combination of three(PI+2NRTI)	67	31	- 46
Combination of three((NNRTI+2 NRTI)	47	106	+ 125
Mini ritonavir (mr)* (PI+mr+2NRTI)	27	31	+ 46
Emergency combination (2NRTI+NNRTI+PI)	12	46	+ 270
Clinical tests	14	6	- 57
Total:	234	285	+ 22

Abbreviations: *NRTI:* nucleoside reverse transcriptase inhibitor
PI: protease inhibitor,
"*mini" Ritonavir:* 2x100 mg ritonavir
(pharmacokinetic enhancer) + smaller dose of PI + 2 NRTI,
NNRTI: non-nucleoside reverse transcriptase inhibitor

Costs of combined antiretroviral therapy:
Combination of two medicines: HUF 0,8 – 1,1 million/year(-30 %)
Cost optimal combination of three medicines: HUF 1,5 – 1,7million/year
Combination of three medicines because of virus resistance: HUF 2,2 – 2,4 million/year (+47 %)
"Emergency combination" of four medicines: HUF 3,0 – 3,4 million/year (+100 %)

A continually re-emerging question is "when to start antiretroviral therapy?" This question implies and reveals a basic principle to achieve antiretroviral therapy success; meaning success can only be achieved with the full co-operation of the patient. Nevertheless, in the past five years, the chosen moment to start therapy has considerably changed. In terms of figures, 5 years ago the beginning of therapy (CD4+ cell count > 500 /µl) could be postponed almost up to the status of AIDS (CD4+ ~ 200 /µl). This was seen as a possibility of "saving" the patient from years of treatment. Now special emphasis is given to the patient's co-operation during therapy, along with methods to help patients properly take medicines, such as treatment calendars and reminder signals from watches and mobile phones. Simpler medication schemes, like dosing twice or three times a day have become common, and some pharmaceutical companies have taken into consideration some medicine variants with improved pharmacokinetic properties.

[1] DCI for the medicines cited, by order: Delavirdine, Didanosine EC, Efavirenz, Indinavir, Zidovudine + Lamivudine, Atazanavir, Lopinavir, Fosamprenavir boosted.
[2] DCI for the medicines cited, by order: Didanosin EC, Efavirenz, Atanazavir, Lopinavir/ritronavir, Enfuvirtine, Tenofovir,

PREVENTION

Since the first AIDS case, AIDS prevention has been a large part of anti-AIDS health policy. AIDS prevention became organised when the National AIDS Committee (NAC) was founded in 1992 as part of the Ministry of Health. The importance of fighting AIDS and prevention activities are reflected in government funding. The table below shows the NAC's budget in HUF for supporting activities that are not strictly prevention, but are part of the fight against AIDS.

Year	Budget - NAC	Supporting prevention	Prevention in %
1995	**145.000 eft**	**60.250 eft**	42%
1996	**135.000 eft**	**47.516 eft**	35 %
1997	**141.000 eft**	**52.500 eft**	37 %
1998	**143.000 eft**	**32.000 eft**	22 %
1999	**69.000 eft**	**19.260 eft**	28 %
2000	**80.000 eft**	**10.200 eft**	12 %
2001*	**40.000 eft**		00%
2002**	**30.000 eft**		00%
2003***	**NA**	**69.000 eft**	00%

* April 2001– the NAC was suspended, and its budget was given to ANTSZ. The Parliament accepted the "Johan Béla" Healthy Decade Program
** December 2002 – the NAC resumes
*** 28 million HUF was allocated to school prevention in May and other requests for proposals were made in September

• Areas of activity and topics

Prevention is addressed in brochures, handouts, posters, film production, videos, and radio information programmes. Support for civil organisations includes: the Anonymous AIDS testing site; street testing on December 1; outreach; a MSM project; hot line, prostitution, youth at risk, orphanage, prison, young recruits, peer education, and school programmes; support for HIV infected people; a national AIDS conference; AIDS Day; and needle exchange. At the beginning, ten to twelve programmes were supported, but due to a lack of funding, fewer programmes were funded later.

There was a dramatic change when the NAC was suspended in April 2001, which was ordered by the health minister of the previous (FIDESZ) government without giving any reason. Three months later the ministry spokesperson made a speech at the AIDS meeting of the UN emphasising the importance of the fight against AIDS and claming that Hungary did everything it could. After 5 months, on World AIDS Day 2001, a declaration was transmitted by state TV, saying that Hungary had finished the fight against AIDS because the number of infected people had decreased almost completely. This is why the problem is not alive in Hungary anymore – it has not been taken into consideration. No money has been made available for HIV tests, so if testing is discontinued, there will be no test results to show anything.

For about a year and a half, AIDS related affairs were not assigned to any forum. In May 2002, a new government was elected through democratic elections and on December 1, 2002, for World AIDS Day, the government announced the NAC would resume its activities. Thus the new NAC was born, but since then it has been neither organised nor operational. Civil society organisations expected to have contacts with the government though the NAC, but this never happened in 2003. The budget that was assigned to fight AIDS by the government as grant support was available though grant applications, but the money became available only in 2004. Civil society organisations were left to carry out actions without any financial support in 2003. The issue of prevention has also still not been addressed.

THE ROLE OF CIVIL SOCIETY ORGANISATIONS

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• THE HUNGARIAN SELF-HELP ORGANISATION OF PEOPLE LIVING WITH HIV AND AIDS

PLUSS was established on 18 August 1989 by a core of HIV-positive patients treated at Saint László Hospital in Budapest who discovered that some of their arrangements related to their positive status could hardly be sorted out without revealing it. This was obviously worsening their situation. It also appeared evident that the medical aspects of being HIV positive were only a part of their emerging problems. After a period of social concerns and shattered social relationships, a multitude of legal problems caused psychological distress. PLUSS was purposefully set up to alleviate these problems and make institutional arrangements. The organisation aims to solve the above-mentioned issues, support the needy, and maintain the anonymity of its members. Among the aims, it is critical to do everything possible institutionally to slow down the spread of the disease by raising awareness through effective communication campaigns. HIV-positive people are becoming increasingly poor because of their poor health status, which generates specific requirements. These requirements and daily experiences have led the organisation to adopt a new organisational framework and create a scope of suitable activities.

People with medical proof of positive status treated at Saint László Hospital are provided with information about PLUSS, but it is up to them to formally join. It has been known for years that those who suffer from *personality crisis,* fearing isolation because of their positive status, are likely to be relieved from stress when they can talk about their concerns in discussion groups with their fellow sufferers, either privately or in the formal and informal meetings set up by the organisation twice a month at its office. Any positive person in need of social care may get *social and psychosocial support* without holding membership in the organisation.

To provide psychosocial support PLUSS has developed, among other things, a *home-care* system. Organised home-care was launched step-by-step in early 1995 and has operated in response to necessity ever since. Optional psychosomatic care has also been given through courses on relaxation, which can be launched upon request. Annual 2 to 3-day recreational weekend activities in the country combined with education bears psychosocial, self-support and relationship supporting functions. Improvement in people's general condition along with

community development plays a decisive role in stabilising immune condition, and medical indications offering new knowledge and those on prevention serve as practical tools.

As a *non-profit* organisation, PLUSS answers calls for proposals from institutions that grant financial support. Main supporters and sources of aid have been the support fund of the National Assembly to social organisations, with ever decreasing amounts (in 1998, 500 thousand HUF, by 2002 as little as 170 thousand HUF), and the National AIDS Committee. Individuals and Hungarian representatives of some major pharmaceutical companies also provide donations.


Zsuzsa SZABO, PLUSS

Connections with organisations and institutions whose objectives coincide to some extent with those of PLUSS are regarded as vital. Organisations maintaining a dialogue with PLUSS include Anonym AIDS Consultancy (in Budapest and Pécs), the magazine 'Mások', Budapest Lambda, a Háttér Társaság a Melegekért (*Background Society for Gays)*, Habeas Corpus Jogsegély Szolgálat *(Habeas Corpus Legal Support Service),* a Társaság a Szabadságjogokért civil iroda *(Society for the Right to Liberty civilian bureau)*, Magyar Vöröskereszt AIDS Alapítványa *(AIDS Foundation of the Hungarian Red Cross)*, and a HIV-Pozitívokat és AIDS-betegeket Segélyező Alapítvány (*Charity Foundation for AIDS and HIV Positive People).* Prominent partner organisations from abroad include: the American AIDS Medicine & Miracle and the Vancouver based twin organisation that sends periodicals every two months, the European AIDS Treatment Group (EATG), and recently the European Coalition of Positive People (London); furthermore, contacts with Germany (Connect Plus) and Italy are being built. PLUSS also joined the European Integration Project run by the French NGO AIDES in 2002. The above-mentioned bodies regularly forward publications and monthly magazines such as *Body Positive* from London and *EATG News*. Though rather vague, we also have contacts with EuroCASO and UNAIDS.

In 2001 the organisation was accredited by the UN Secretariat, enabling PLUSS Hungary to participate in the special assembly of the UN in New York from 25 to 28 June, dedicated to AIDS, for the first time ever in the history of this world organisation.

The PLUSS *Year Book* has been published annually since 1990. *PLUSS magazine,* which has been published 2-3-4 times a year since 1993, and the website created in December 2000, are regarded as valuable vehicles of information. Overall, the organisation is open to all individuals or entities that are ready to adopt the objectives of PLUSS and are prepared to provide real support either to the organisation or individuals in need.

Information on any of the above issues is available either by mail, phone or fax.

• CURRENT ACTIVITIES OF PLUSS HUNGARY

PLUSS drew attention to the need for AIDS prevention with a concert in 2002. In 2003 such an event was financially impossible; however, PLUSS invited other civil society organisations to a press conference in 2003 just before World AIDS Day, where they expressed their views and concerns. This was the beginning of collaboration between civil society organisations, which gave birth to an umbrella organisation called Civil AIDS Forum (CAF). As a result of these activities, representatives from the Ministry of Health and the NAC started communicating with civil society organisations, which was a positive development but did not prevent civil society organisations from making more requests however.

WORLD AIDS DAY 2003: INTER-NGO STANDPOINT ON HIV/AIDS IN HUNGARY

(Translated from a text originally in Hungarian)

In our Central and Eastern European region, HIV is spreading at an even faster rate than in Africa. In the eastern neighbour country Ukraine, the number of HIV infected people used to be low, similar to the situation in Hungary, but recently, one in 100 people has become HIV positive and the epidemic keeps spreading.

The tools and policies to help Hungary avoid a similar situation are well known. Proposals on behalf of the UN, the World Health Organisation and the Council of Europe have provided clear guidance in this respect. In the autumn of 2002 the acting government committed to adopting modern epidemiological principles and tools over the debate on legislating anonymous testing, based on respect for human rights and co-operation with affected persons, such as infected and endangered people. Nevertheless, in the past one and a half years nothing has been done.

Overall, AIDS conditions are disastrous in Hungary: prevention programmes have been inexistent for years, and the population does not have access to authentic information about HIV infection, AIDS, and on the various ways the virus spreads; meanwhile more and more young people become infected every year. Because of misconceptions, HIV positive people have also become victims of serious discrimination regarding access to health care, education and employment. Furthermore, free and anonymous HIV testing and counselling are under threat of termination: the only centre offering such services in Hungary is run by medical staff from their own resources, but due to a lack of support, the Anonymous Counselling Service is likely to close down soon. And NGOs that have participated effectively in prevention work have been suffering seriously from shortages of financial resources for years. Making matters worse, Hungary has not adopted a comprehensive and accountable strategy on AIDS. Tracing back the part of the budget spent on AIDS prevention and testing is still impossible. And no sufficient attention has been paid by the state to the specific requirements of high-risk groups: gay men, young people, women, and sex workers. The Ministry of Social Welfare's endorsement around 1 December to provide support has proved to be mere rhetoric: the tenders promised either fail to be published, or if published, evaluation and payment see months of delays. Moreover, the National AIDS Committee (NAC) re-established on 1 December last year, whose task is to co-ordinate the fight against AIDS in Hungary, has not made any considerable achievements in this respect. The content of the civilian strategy proclaimed by the government last spring has been thoroughly ignored by the Ministry of Social Welfare and the National AIDS Committee, and agreements or co-operation with NGOs have only taken place occasionally in an effort to avoid awkward situations or scandals, whereas the state shows no signs of willingness to perform its duties more efficiently in the fight against HIV/AIDS. It seems as though achievements have only been made as a result of civilian democratic methods.

The Future

The Ministry of Health, Social and Family Affairs officially commemorated the 2003 World AIDS Day. As part of the events, the National AIDS Strategy* was presented. Parts of this strategy provide hope that the National AIDS Committee will awaken from its passivity and become active again, and also allow civil society organisations to be active in venues without which the National AIDS Strategy cannot be realised.

* For a copy of the Hungarian National AIDS Strategy in English please see: http://www.integration-projects.org/c_reports/hungary-annex.pdf

HIV/AIDS and Human Rights in Hungary

Judit FRIDLI of the **Hungarian Civil Liberties Union**, a NGO very active in promoting anonymous HIV testing

Current Effective Rules

In compliance with the Constitutional Court's decision, Parliament adopted Act LVIII./2002, which modified the Health Care Act and was designed to regulate HIV screening at the level of laws.
The most important of these achievements was the promotion of voluntary screening to the status of main rule. Voluntary screening may be done under the person's name or anonymously, and if a person opts for anonymous screening, he/she is not under an obligation to reveal personal identifiers either at the first or the second examination. Thus the provisions give persons (other than those included in classes specifically listed as under a duty to submit to screening) the option of availing themselves, if they express this wish, of reliable screening results under conditions of anonymity.

Compulsory Screening and Monitoring

The most profound difference between the old and new regulations is the express provision included in the new ones which enunciates that authoritative directions for HIV screening may be issued only with the knowledge and consent of the person concerned, unless he/she belongs to one of the classes of persons, listed item by item, falling in the purview of compulsory screening. In other words, the new regulations elevate voluntary screening to the status of main rule, and the person presenting for screening is entitled to refuse to provide personal identifiers, in other words, the screening is anonymous. The old regulations and the presently valid ones concur that blood as a raw material for pharmaceutical processing and blood stored for transfusion are to be tested for HIV, and persons donating tissue, organs and spermatozoa for artificial insemination are to be tested for HIV as well. Under the new rules it is no longer compulsory to screen the sexual partners of HIV positive persons however.

The rules on HIV screening in the new Act and Decree leave open a range of vocations that may give rise to a practical need for an HIV examination. Nevertheless, at present there is no rule, guideline or recommendation which could be regarded as being conducive to a unified practice concerning the class of occupations that fall under compulsory screening, such as to forestall problems arising from diverging interpretations of the law.

With respect to monitoring, a 1998 decree by the Ministry of Health and Public Welfare abolished access to anonymous AIDS monitoring. A ruling by the constitutional court invalidated the so-called SZEM decree of 5/1988 and all its amendments made later. On 1 January 2003 the new decree (18/2002 (28 12)ESZCSM) ("On necessary measures and the process of monitoring in order to prevent the spread of infection causing Acquired Immune Deficiency Syndrome") came into force, which restored anonymous access to testing again. In Hungary from 1989 to 1997, 110 HIV positive people were monitored under the anonymous system in Hungary.

Compulsory Care and Compulsory Treatment

The first case of HIV infection was diagnosed in Hungary in 1985. Until December 31, 2002, rules on HIV screening and the referral of HIV positive persons for care were enunciated in a decree issued in 1988. The regulations which became effective on **January 1, 2003,** put an end to previous discrimination in terms of manner of infection.

Hungary has witnessed the emergence of a strongly centralised system partly as a result of the predominance of traditional epidemiological attitudes and the relatively low number of HIV cases. This system, in effect, draws together in one single place the HIV infected, the physicians who treat them and the equipment and medicines available. Information about HIV infection and AIDS receives no emphasis in the curricula of medical universities, which in effect makes it difficult for qualified physicians to diagnose HIV, because physicians without appropriate training in identifying HIV are prone to identify it at a later time than physicians with such training. Another question relates to the extent to which this system would be capable of coping with a much

greater number of HIV cases than there are actually at present. The presently valid epidemiological rules seriously restrict the system's capacity for reacting to new challenges. It is therefore time, especially in view of the special nature of HIV/AIDS, for relevant legal rules to be tailored to well-known practical needs and expectations.

Health Care Services Available to Foreigners

All foreigners, including those without health insurance, are generally entitled to life saving treatment. The expenses of such life saving intervention are to be borne by the central budget. A foreigner in need of emergency treatment is to be provided for without delay and in exactly the same way as a Hungarian citizen would be. At the same time, only Hungarian citizens and foreigners with a residence permit, or those recognised as refugees, are entitled to receive certain kinds of medical treatment, especially expensive ones, at the expense of the National Health Insurance Fund and the central budget (unless specially extended to other foreigners by international agreements). These include therapeutic procedures conducted as part of medical biological research (a cure for AIDS still being also a research objective) and blood preparations provided free of charge (a foreigner's ability to pay is examined after the emergency treatment).

As part of Hungary's preparation for its accession to the European Union, the rules on alien immigration and residence were enlarged by a new chapter on citizens of the European Economic Area and their family members. Despite the undeniably more favourable conditions for permission, a citizen of the European Economic Region cannot be granted a residence permit if "prior to the first issuance of the residence permit he/she had a disease which was hazardous to public health". In other words, the regulations to come into effect following Hungary's accession to the EU continue to uphold the protection of public health interests through screening.

Intravenous Drug Use

There are three intravenous drug users among the persons officially registered as HIV positive in Hungary. This may not reflect the real proportion, however, as the therapeutic network comes in contact with as little as 5-10% of all Hungarian drug users. Since January 1, 2003, intravenous drug users have been outside the classes of persons subject to compulsory screening, but it continues to be obligatory to offer them the opportunity for HIV testing.

The Present State of Harm Reduction Programmes in Hungary

The importance of harm reduction programmes is mentioned in the National Drug Strategy adopted in 2000. And although present legislation does not encourage their introduction, it also does not rule them out. There are currently six methadone programmes operating in Hungary, two in Budapest and four in the countryside.

Between April 2001 and May 2002, 70-124 drug patients participated in maintenance programmes run in Budapest, Pécs and Veszprém while 17-34 persons were registered as participants in detoxification therapies. Persons presently in methadone treatment make up a mere 2-2,3% of all opiate addicts, which is a very low index in international comparison. Further programmes are going to be launched in the near future.

There are also six needle exchange programmes running in Hungary at the moment, two in the capital and four in the countryside. And although there is no "shooting gallery" in Hungary as yet, legal rules do not exclude the possibility of running this kind of service. In fact, plans entertained by the Ministry of the Child, Youth and Sports include the idea of supporting facilities of a similar kind. Advances are likely to be made in this area in the foreseeable future.

INTRAVENOUS DRUG USE IN HUNGARY

If drug users in Hungary have been affected very little by HIV so far, it is most worrisome that recent studies have shown the incidence of hepatitis C (HCV) on the rise: clearly, unsafe practices such as sharing needles are taking place – to combat this, drugs users in Hungary need to have access to harm reduction programmes (including information and self support, access to clean injecting equipment, and access to substitution treatments such as methadone).

The Blue Point Centre is one of the major harm reduction actors for drug users in Hungary.

3 Questions to Dr. Joseph Raczn, Director of the BLUE POINT Counselling Centre
(translated from an original text in Hungarian – interview carried out by PLUSS in November 2003)

1. What are the main activities of the Blue Point Centre?
The Blue Point Centre was founded in 1996 to diminish the damages and risks caused by drug use, both in the interest of the individual and of society. Our services include psychological and psychiatric support, and social work with drug users and their peers and families. We reach this vulnerable group both through our work in the streets and in parties. We have a mobile needle exchange unit. We also do prevention in schools.

2. Why have there been so few drug users contaminated by HIV in Hungary? Is this situation likely to last?
As far as I know, there are a cumulative total of 11 cases of HIV among intravenous drug users. In 2002, out of 76 drug users who came to see us for services, we found 1 case of HIV following a saliva test. Out of 121 drug users we have reached in the streets, 3 told us they knew they were HIV positive.

The reason for this low prevalence is the easy availability of syringes and condoms without restriction. We can talk about sexuality very freely, which has been the case since the 70s (contrary to Russia for instance). Also, the Hungarian population does not move much – we have few immigrants originating from high-prevalence countries.

Further, public health in Hungary did not come apart after the end of communism (as it did in Russia). Part of the reason is also sheer luck!

I would expect however, that the incidence of HIV will increase following the increase of hepatitis C we are now observing (30% of drug users are now HCV positive).

3. How many people benefit from your services?
Needle exchange:
Budapest (site 1) = 200 new clients (700 registered)
Budapest (site 2): 30 clients
Budapest (site 3) just started its operations.
Szeged: 500 clients
Pécs: 4-5 clients
Miskolc: 28 clients
Veszprém: 7 clients

Methadone centres: 2 sites in Budapest, also available in Veszprém, Pécs, Gyula, Szeged, and Miskolc. About 200-250 clients are on methadone treatment.

ONGOING DIFFICULTIES FACED BY THE ANONYMOUS AIDS COUNSELLING SERVICE IN HUNGARY

Testing for HIV conducted uninterruptedly by the Anonymous AIDS Counselling Service (AATSZ) for 15 years is in danger!

The National Health Department has ignored the importance of preventing the spread of AIDS. Dr. István Mikola, former Minister of Health and Public Welfare, stopped the activity of the National AIDS Committee (NAC), thus virtually failing to support the field and effectively making the Anonymous AIDS Counselling Service, which had functioned as an NGO for 15 years, and HIV prevention as a whole, unlawful. His successor, Judit Csehák, newly restored the committee in December 2002, but did nothing further for a whole year. Despite passing the Act on HIV-AIDS, anonymous HIV testing has fallen in danger of being trapped in the cobwebs of bureaucracy. Furthermore, in 2003, the health department spent no money on this domain!

AATSZ is the only organisation promoting the public interest of anonymous HIV testing, along with counselling by telephone and the Internet. But sadly, the organisation is at the verge of closure after 15 year's work—the organisation's operating costs are covered by physicians on their own who consider the issue vital, but these resources are hardly enough to cover blood sampling and the basic materials necessary for testing.

Furthermore, the majority of HIV positive people are spotted by chance: one in six HIV positive patients are discovered by AATSZ staff, while others are spotted by chance in various health institutions in the country.

All those seeking a free and anonymous service approach the organisation, which continually provides humane and responsible services, with confidence. Its website is one of the 100 most frequently visited websites in Hungary. But to maintain services and HIV prevention by AATSZ, HUF 9-10 million would be needed per year. AATSZ purchases tests necessary for HIV monitoring from its own resources, though promises have been made to give state support, which has failed due to continuously changing positions and regrouping of tasks within the government. The organisation does not even possess any assets of its own after 15 years of work; until 1988 it did not even have a PC, and the one available now is not suitable for Internet connection, even though 95% of candidates for HIV testing gain information on HIV/AIDS and other sexually transmitted diseases from the website www.anonimaids.hu.

For the evaluation of tests, after several solutions, the virology laboratory of the National AIDS Committee (NAC) has proved to be the most reliable, but the NAC laboratory is under the whim of professional and political developments (previously, AATSZ paid the National Health Authority (OTH) to analyse its blood samples, even though the OTH possessed the budget to cover the cost of testing under its capacity as the responsible institution for the task, along with the OEK).

The AATSZ repeatedly and urgently calls attention to the following:

Sex channels by cable television providers pose a danger as they fail to give special warnings on the hazards of having **"unsafe sex".**

Because of the shortage of information concerning sexually transmitted diseases and reproductive health, Hungarian women are also at risk. During anonymous monitoring, 50% of women polled said they did not think of sexually transmitted diseases at all, and practiced contraception against unwanted pregnancy with only pills. Young women in the sexually active age range were aware of not more than three types of sexually transmitted diseases. Women have never been made conscious of the fact that they are responsible for themselves and that

active protection against HIV with a condom is in their own interest. An AATSZ survey has disclosed that the majority of women these days decide to take protective measures, such as using condoms, by judging if their partner is “sympathetic”, and that condom use is mostly restricted to vaginal intercourse. Unfortunately however, 50 % of HIV positive people monitored by AATSZ over the past four years have been young women.

Curbing the spread of AIDS is a matter of public interest, as well as a private one!

The Hungarian state does not treat NGOs as equals, thus failing its mission to serve its citizens. The readiness of state officials to help falls short. Organisations dealing with HIV/AIDS prevention – less than 10 NGOs in Hungary – are generally not granted the chance to communicate directly with officials. Despite the explicit request of NGOs, they are not notified about ministerial tenders and action programmes which are HIV/AIDS prevention related. Besides this, the ministry is not prepared to receive EU tenders supporting HIV prevention, let alone manage partnerships, which is a criterion for entering a tender, or translate tenders into Hungarian, or forward them to the appropriate organisations, or grant a part of the budget as an own share. The ministry fails to invite tenders related to HIV monitoring and prevention, or when it does, it does so with considerable delay and modifies its conditions in the meantime. With the distribution of scarce funds, it also disregards priorities among NGOs. The modest amount to be spent on HIV prevention is distributed among many partners “so that everybody has their share”; but this policy results in sharing “happy poverty” among organisations willing to work for the same cause, but unable to finance operation costs on their own.

In the name of every Hungarian citizen AATSZ demands policymakers to exchange their promises for financial support and help AIDS prevention in Hungary. And as a member state of the European Union, anonymous HIV/AIDS monitoring and prevention programmes are imperative in Hungary.

THE WORK OF "HÁTTÉR", SUPPORT SOCIETY FOR GAYS AND LESBIANS IN HUNGARY

by Kárpáti József, Attorney at Law, Gay Legal Aid of Háttér for Háttér Társaság a Melegekért.


Members of HÁTTÉR

The present is a summary of the legal status of gays, lesbians, bisexuals and transgender people in Hungary, including the still operative discriminatory laws and possible directions of development.

In its resolution 37/2002 (IX. 4.) AB the Constitutional Court of the Republic of Hungary repealed, among others, §199. of the Penal Code ("unnatural sodomy"), and ordered that the previously ended non-appealable trials be revised, provided the convict had not yet been freed of its negative consequences. By this decision, the paragraph most severely discriminating against gays and lesbians was abolished; nevertheless, not all discriminatory laws were superseded.

The government is considering the creation of a law on equal treatment that would protect against discrimination also on the grounds of sexual orientation. In our point of view – to stress the importance of the current rule of law – the government would be acting correctly if after the resolution of the Constitutional Court, which exerts overall prohibition on discrimination against gays and lesbians, along with the preparation of the anti-discrimination law, it abolished the deeply rooted and severely anti-discriminatory rules of law that still exist in Hungarian legislation (the government has taken far from enough steps toward cleaning up the rules of law).

Four main issues linked with discrimination will be emphasized in the following summary: the first two trying to reflect on discrimination on the level of rules of law, the third criticising fragmented anti-discrimination laws, and the fourth discussing the lack of regulation concerning the situation of transsexuals. (The summary is based on the laws in force as of 31 October 2002.)

1. Marriage/partnership

According to §10. (1) of the Family Law, a marriage can take place between an adult man and an adult woman.

According to the definition of §685/A of the Civil Code, partners are, unless other regulations apply, two persons living together outside of marriage in a mutually kept household, in emotional and economic unity.

In its regulation 14/1995 (III.13.), the Constitutional Court declared that it is contrary to the constitution that the rules of law that apply to partners openly cohabitating outside of marriage in an emotional, sexual and economic unity and which define their rights and responsibilities, apply legal consequences only to the partners described in the Civil Code. At the same time, it suspended the procedure, and called upon legislators to pass a law about same-sex partnership in concert with this. The Parliament of the Republic of Hungary amended §578/G and §685/A of the Civil Code by the law XLII/1996, by which it extended the rule to apply to same-sex partners as well. The amendment entered into force on 19 June 1996.

At the same time, the regulation refused the appeal about the unconstitutionality of the institution of marriage with the argument that marriage is traditionally a bond between a man and a woman. The judgment can be deemed partially progressive however, particularly in the mid 90s, since it provides the possibility for same sex couples to cohabitate and to benefit from the legally definable goods that different-sex partners enjoy. On the other hand, as it became clear during the interpretation of the recently passed rules of law, it precludes gay and lesbian couples in an

indirect way from such benefits that are exclusively reserved for married couples. For example, the beneficiaries of the additional interest subsidy described in §13 (1) of the 12/2001 (I.31.) governmental act concerning state support of residential property can be married couples only. With respect to the fact that only two persons of different sex can get married, the rule of law excludes same-sex partners from requisition of this state benefit. The regulation is especially particular, since the birth of a child is not a prerequisite for the granting of the loan. The only condition as personal status is concerned, is the fact of an existing marriage.

The Hungarian Family Law theoretically does not preclude adoption by a homosexual person, although it is a very rare phenomenon in practice. Nonetheless, according to the referring regulations of the Family Law (§45 (5), §51 (2)), two persons can adopt a child mutually only if the foster parents are married partners.

According to §2 (1) e) XXXIX/2001 of the law on foreign citizens' entry and residence, a relative, unless other regulations apply, is the foreign citizen's married partner, dependent offspring, adopted child, foster-child, the married partner's offspring, the parent in the case of a minor, and the foreign citizen's and the married partner's dependent ancestor. The cohabitating partner is excluded from the definition. This is of special importance because it is the relative in several cases who can provide the necessary certificates for the foreign citizen's residence or domiciliation, besides getting certain benefits with respect to the relative (e.g. §14 (1) b)). Thus cohabitating partnership provides no grounds for residence under family reunion.

According to §4 (4) LXXXVIII/1993 about the rental of residential property and other rooms, unless the party entitled to assign the tenant rules otherwise, married partners in case of mutual request must make a contract (cohabitating partners are again left unmentioned).

Certainly, in some cases same-sex cohabitants have the possibility to provide for each other benefits that otherwise are not faculties by civil contract or statement (such as last wills or various statements of patients' rights). However, in the cases described above, since these are coercive rules, legislators tighten the circle of grantees by tools of public law so that same-sex couples are not included.

In the point of view of the Háttér Support Society for Gays and Lesbians in Hungary, the government should take steps toward providing same sex couples living in a long-term relationship with all those rights that are available to different-sex couples, with special regard to the benefits that are based merely on marital status and not on having a mutual child. The legislation could do this in a way that opens legal marriage also to same-sex couples, or a way that creates a special, registered relationship that is different from the Hungarian models of regulation and which could function as a quasi-marriage.

2. Military service

According to appendix 037 a) of the 12/1997 regulation of the Ministry of Defence about professional and contracted soldiers' medical, psychological and physical fitness, homosexuality is listed as a type of personality disorder. Háttér initiated a subsequent control of norms with the Constitutional Court because the aspect and wording of the regulation is contrary to current scientific opinion and violates the dignity of gays and lesbians. The process is ongoing.

Previously, appendix 037 a) of the 7/1996 (VII.30.) of the Ministry of Defence and Ministry of Social Welfare regulating military service done on liability ruled the same, until 9/2002 (II.28.) of the Ministry of Defence and Ministry of Health abrogated it. The latter regulation displays milder wording: only "disorders of gender identity and orientation" are deemed personality disorders. The International Classification of Diseases No.10. (ICD-10) does not classify homosexuality as a 'disorder of sexual preference' or a 'psychological and behavioural disorder related to sexual development and orientation'. The new rule of law would be requested to be more exact in its

wording, similarly to the 28/2002 (X. 17.) regulation of the Ministry of Home Affairs, the Ministry of Justice and the Ministry of Defence.

Previously again, homosexuality was treated as a personality disorder in the annotation to the code number 014 of the 21/2000 (VIII.23.) of the Ministry of Home Affairs, the Ministry of Justice and the Ministry of Defence regulating the declaration of mental and bodily incapacity to work and earn as a public or civil servant within the armed forces, in addition to the use of healthcare by such servants. This rule of law was modified by the regulation 28/2002 (X.17.) of the Ministry of Internal Affairs, the Ministry of Justice and the Ministry of Defence in such a way that its text complies with the definitions of ICD-10. The modification entered into force on 25 October 2002. The modification itself is to be highlighted because it solely involved the incriminated annotation pertaining to code number 014.

In Háttér's point of view, appendix 037/a of the 2/1997 (V.16.) regulation of the Ministry of Defence contains an appalling legislative discrimination that demands immediate remedy, whereas appendix 037/a of the 9/2002 (II.8.) regulation of the Ministry of Defence and the Ministry of Health require more exact wording.

3. Defects in the anti-discrimination legislation

Beyond direct legislative discrimination, we have to mention defects in the anti-discrimination legislation in Hungary. Hungarian law presently in force mentions the prohibition of discrimination on the basis of sexual orientation solely in §7 (4) CLIV/1997 of medical care, whereas all other basic rules of law such as §70/A of the Constitution, §76 of the Civil Code and §5 of the Labour Code prohibit discrimination on a general level, without actual reference to sexual orientation. It is the view of the Constitutional Court and courts of original jurisdiction that gays and lesbians, such as any other distinct groups of society, are entitled to equal treatment in the same way as other groups of minorities. But the Hungarian legal system leaves us with no clear understanding of the general definition of direct and indirect discrimination, or of the description and sanctioning of typical cases adhering to the practice of discrimination, such as victimization and harassment. Beyond these, there is almost no kind of special sanction system that would be effective enough to prevent or act as a deterrent from violations of laws by discrimination or homophobia.

The Penal Code deals with the offences originating in the afflicted person's religious, racial or ethnic background (c.f. §155 about homicide, §156 about Apartheid, §174/B about violence against the member of a national, ethnic, racial or religious group), but it never refers to sexual orientation as a possible motivation of offence.

An employer proven to be discriminatory can be liable only to the extent of a moderate offence (c.f. governmental act §93 28/1999 (XII.28.) about the regulation of offences), thus any Roma or homosexual whose personal dignity has been violated can only hope for a positive outcome in a civil case about the violation of his/her rights. However, such an ending is unforeseeable and has to be preceded by a lengthy civil case involving general rules of justification.

In Háttér's point of view, the answer to the latter problems could be a unified code of anti-discrimination. In the new rule of law, the sexual orientation of the afflicted party should be definitely mentioned as a possible motive of discrimination, the concept of direct and indirect discrimination should be defined in general, and phenomena that are instrumental to discrimination such as so-called victimization, harassment, and orders to discriminate, should be prohibited. An effective proportional system of sanctions needs to be introduced and an independent body should be set up to investigate cases of discrimination. It is unavoidable to amend some rules of law that regulate related fields. In cases related to discrimination, the afflicted person's obligation of burden of proof needs to be relieved. In some cases the obligation should be reversed or presumptions made. In the anti-discrimination law, obligation of positive accountable action should be prescribed and be debited to the government that aims to dissipate

prejudices in public and educational institutions. The prohibition of discrimination of gays, lesbians, bisexuals and trans-gender people should be explicated in the National Curriculum.

4. The rights of transsexuals

In Hungarian law, there is no norm as to the personal or legal status of people who intend to undergo a sex change. The juridical conditions of gender reassignment surgery and the financial coverage by the national health care system have remained without clarification. Changing the certificate of civil status and the name of the person who has undergone a sex change does not even occur to the legislator as a problem.

In Háttér's point of view, the government should create inclusive standards as to the rights and protection of transsexuals. The rules of recording the transitioned person's particulars in the certificate of civil status, the process of gender reassignment surgery in the health care system, and the rules of social insurance need to be clarified. The anti-discrimination law should include the prohibition of discrimination based on gender identity.

Budapest, 22 November 2002

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THE HUNGARIAN NATIONAL AIDS STRATEGY

(document posted in 2004)

People living with HIV, when their infection is proven, will be taken in care by the medical institutions. Medical care normally takes place in the National Institute for Dermatology and Sexual Pathology (Országos Bőr és Nemibeteg Gondozó Intézetben (OBNI)), and in the Department of Internal Diseases #5 (Immunology) of Budapest City Authority's St László Hospital (Fővárosi Önkormányzat Szent László Kórháza V. Immunológiai Belosztálya). The HIV positive patients undergo immunology and virology tests. Further treatments and therapies are dependent of laboratory results and clinical status. The Department of Internal Diseases #5 (Immunology) of Budapest City Authority's St László Hospital has exclusively been appointed to provide medical treatments. The most up-to-date treatment is accessible by all patients, which is free of charge; the costs are covered by a special fund of social insurance. Hungary's participation in international projects makes sure that the most advanced therapies are applied at the earliest.

• MONITORING, DIAGNOSTICS.

The order of diagnostics and monitoring is ruled by decree ESZCSM 18/2002 (27 12) („On necessary measures and the process of monitoring in order to prevent the spread of infections causing Acquired Immune Deficiency Syndrome").

Monitoring

The decree 18/2002 is laid down on the principle that prevention should be based on giving information to the affected and not on mandatory monitoring. Voluntary monitoring is to be extended. To achieve this, the network of institutions entitled to provide counselling and monitoring, including those for anonymous monitoring has to be developed.

Objectives:

To raise the number of voluntary tests to follow giving information in high-risk groups.
To reintroduce tests for HIV combined with anonymous counselling.
To perform and control statutory, regular, mandatory medical check-ups in prostitutes.
To give preventive treatment in health workers with job related exposure to HIV if they have contacted the virus.

Tasks:

1. A system stressing voluntary tests may not replace mandatory monitoring in the following areas:
In health workers engaged in invasive treatment which cannot be done by a contaminated specialist, for danger of infection;
In persons who may contact human blood, sperm, vaginal discharge while working;
In staff making out medical certificate for prostitutes;
In staff working with dead or live donors when transplanting organs;
In blood donors;
In milk donor mothers.

2. Monitoring based on voluntary tests:
Primarily, it stipulates the following mandatory tests which had been deregulated by former decrees:
In sexual partners of HIV infected persons;
In patients with sexually transmittable active venereal diseases and in the partners of these;
In HIV infected mother's offspring;
In intravenous drug addicts;
In inmates of penal institutions of custody and persons in youth custody;
In sperm donors e.g., when performing artificial insemination.

3. **Test covered by OEP (the National Health Fund):** Tests for HIV both in inpatient and outpatient care are frequently required. In such cases monitoring is covered not by the state but by the institution where monitoring is being done. In view that immediate results are often necessitated, quick testers can also be used. Examinations made by quick testers have to be repeated over the next routine examination.

4. **Anonymous monitoring:** A special emphasis is given to counselling and information in anonymous monitoring. In voluntary anonymous testing, sample identification marks free from personal details have to be recorded in health documents. When a sample tested is found positive, blood sampling has to be repeated to verify results. Results from anonymous examinations can never be issued under the bearer's name.

5. **Sentinel surveillance tests:** WHO in its so called first generation sentinel tests aimed at discovering infections in expectant mothers firstly, and in patients with venereal diseases, respectively (when the patients tested are unidentifiable). Nevertheless, the guidelines issued by UNAIDS in 2000 point out the importance of making tests in groups of high risk of HIV infection. According to these the new target groups are the followings: male homosexuals; prostitutes; intravenous drug addicts. According to the guidelines of the year 2000 with risk groups of such orientation, HIV monitoring has to be done anonymously so as to assess the frequency of HIV infection.

6. **Pay tests:** There has been an increasing demand for HIV tests as a service to instances which do not fall in with the above mentioned 5 categories. Payable services provide certificates to immigration, travelling, visas and employment.

7. **Confirmation tests:** Each HIV test result found positive has to undergo a so called confirmation test in order to exclude or confirm HIV infection. Throughout the confirmation process international practice and EU directives are to be adopted.
The confirmed HIV positive cases have to be reported to the Epidemiological Department of the National Centre for Epidemic for sake of epidemiological data collection. Communication on records which are free from personal details, must help with the Euro-conform, compatible evaluation of HIV/AIDS epidemiological situation based on qualitative research.

• AIDS-PREVENTION

Risks affecting the Hungarian population are related to the specific geographical situation of Hungary, with the transit traffic between West and East Europe and with migration between regions and continents. The increasingly worse epidemiological data on destructive, sexually transmittable diseases in the East – European region, with prostitution becoming international, the emergence of organized international criminal groups, the ever increasing number of migrants from countries of high HIV infection rate, along with the intravenous drug addicts, whose increase in number has slowed down the past few years, pose danger by themselves to the Hungarian population, especially to the sexually active, young generation.
All these risk factors can only be diminished by coordinated programs, activities which offer multiple approaches. From this point of view prevention plays a decisive role because in case of most sexually transmittable diseases tools for definitive recovery are not accessible yet. The emergence and spread of resistance to medicines has increasingly posed a risk factor in curable diseases, too.

Main objectives:

To diminish behaviour related risks of sexually transmittable diseases in Hungarian youth;
To diminish the infection rate of sexually transmittable diseases in groups of high risk of infection, to monitor the infected and to provide them care at an early stage;

Objectives:

Risk decrease at population level, primary prevention programs for low risk groups:
To widely disseminate authentic knowledge on sexual behaviour related psycho-somatic risks in public education by appropriate techniques regarding the age of the target groups;
To make and diffuse personal consultancy model programs for schools;
To launch information campaigns tailored to population needs e.g. campaigns to people travelling to regions of high rate of infection;
To influence the environment of sexually active young generation to promote safe sex;

To demonstrate sexual activity related risks and transfer, well grounded information to individuals of risk groups whose life conditions and social background prevent them from fully benefiting from programs in public education (prevention programs for young people living bereft from their families, for socially deprived young people, for gypsy youth).

Programs for prevention and care in high risk groups:
Programs to diminish harms in intravenous drug addicts, including programs aiming at diminishing the amount of drug intake;
Activities in gay culture to demonstrate psycho-somatic risks deriving from sexual behaviour;
Programs accessible to high risk groups to develop consultancy services on AIDS and sexually transmittable diseases, including the development of anonymous AIDS consultancy network and that of out-patient surgeries for sexually transmittable diseases.

Tasks:

1. **Youth / School**:
To involve basic knowledge on sexual life in the curriculum of subjects in public education, including psychosomatic risks, prevention by individuals, means of safe sex and contraception. At least 3 times 2 hours in each module in courses 8, 9 and 10 of schooling.
To involve experts from school health network into sexual education. To invite personal consultancy on contraception and sexual life in two hours a week to pupils in institutes of public education with the contribution of nurses and the school nursing system.
To overview the tasks and the ways of funding the above school health programs and to work out the techniques of tendering and the standard of health promotion for institutions of public education.

2**. Free time**:
To develop promotional material for travel agents, companies engaged in tourism, campaigns to raise awareness on risk factors of AIDS/HIV infection in travellers who are going to highly infected regions;
To launch multi-channel media campaigns repeatedly on particular risk factors of sexual activity in youth, addressing them through popular media (e.g. pubs visited by young people, university clubs, schools, beaches, giant bill boards placed for target groups, electronic media inserts in programs for young people);

3. **Condom**:
To improve access to condom, to set up condom vending machines in the toilets of public places, clubs. To generally extend these within five years to follow pilot tests, with amendments to legislation applicable to outlets;
To support free access to condom at events favoured by young people;
To promote the use of condom in youth magazines, in publications addressing young people.

4. **Deprived youth**:
To provide contemporary training programs, target oriented media campaigns and orientation to socially deprived young people, brought up in children's homes on the topics of contraception and safe sex, with the involvement of social workers and nurses, with NGO activists and members of target groups concerned. To organize on-street programs for promoting safe sex, accompanied by condom distribution and drug prevention activities. To find funding sources by means of supporting tendering.
To support in-service training programs for experts working with deprived, drug addicted, socially handicapped people on the topics of sexual abuse, abortion prevention and safe sex.

5**. Intravenous drug addicts**:
To promote syringe access programs with the involvement of social workers, surgeries for drug patients, and other drug addict care points, to set up automatic syringe dispensers, to help with programs aiming at decreasing drug dosage, lessening the scope for drug related prostitution.
To train social workers, NGO activists working with prostitutes to identify the symptoms and the consequences of drug abuse in order to take care of intravenous drug addict prostitutes by addiction treatment or other low threshold services.
To promote orientation and anonymous monitoring programs for intravenous drug addicts involving their social workers and surgeries for drug patients.

6. **Gays**:
To launch target oriented information campaigns involving organizations, media and public places for gay people in order to diminish sexual behaviour related risks and demonstrate condom use and techniques for safe sex.
To initiate public discussion within gay culture involving gay organizations on the inherent risks typical for groups of particular sexual behaviour, on the myths and misbelieves about sexual behaviour and gay identity. To promote a rational approach to the relationship between HIV infection and gay identity, involving the media to curb risky behaviour.

7. **Prostitutes, anonymous monitoring**:
To develop the organizational infrastructure of anonymous AIDS consultancy and monitoring. To involve one service provider a region at least by means of tendering in anonymous AIDS counselling, to work out the ways of funding tasks, to assure quality, to lay down the principles of access, to set up and support regional anonymous AIDS consultancy and monitoring centres, to establish the information functions of such centres (call service). The goal is to create by tendering a network of AIDS counselling centres in several points of the country, offering regionally relevant, up-to-date information, with the participation of health care service providers and NGOs, possibly co-operating with organizations and structures catering for drug addicts.
To set up mobile surgeries for sexually transmittable diseases, under the scheme of cost refunding, but with partial financing, to cater for prostitutes, cooperating with the highly affected regions and local governments. To increase pressure by the police on prostitution related criminal groups, to diminish health risk related to prostitution, to stop negative discrimination of prostitutes with no health certificate versus the ones with health record booklet and if necessary, to initiate amendments in legislation in order to raise participation in regular health check-ups.

8**. Immigrants, refugee and asylum seekers**:
To organize consultancy service in refugee camps;
To edit and distribute multilingual publications;
To work out HIV test policy for migrants;
To co-operate at departmental and inter-institutional levels;
To prepare experts and social workers from institutions dealing with migrates on the issue of HIV/AIDS prevention

Beside these, special programs to promote prevention targeting the population in the army and prisons have to be elaborated, as well.

• PREVENTION IN HIV INFECTED PATIENTS

Within a wider range of AIDS prevention there is a call for target oriented prevention among those having a life style with high risk of HIV infection and especially among people infected by HIV.

Objectives:

To diminish potential infection in people adopting risky behaviour;
To diminish the occurance of risky behaviour in the HIV infected population and to diminish the rate of infection transfer;
To prevent/slow down the development of AIDS;
To preserve health and the ability to work in infected people;
To inforce the role and participation of HIV infected patients in prevention programs;
To develop and reinforce social care for socially vulnerable HIV/AIDS patients.

As HIV spreads basically by sexual way in Hungary, the most important tool for promotion is safe sexual practice (including the use of condom, too), to promote relevant knowledge in a languge most appropriate to the target population.

Another kernel task in HIV/AIDS prevention is raising awareness on facts which help relieve the infected and the not-yet-affected alike, of myths and fears. To prevent the development of AIDS in HIV infected people is a peculiar task, which is also in line with calling for a healthy way of life. In the process of diminishing risk the key role is played by that how awareness of prevention and health promotion can be improved.

PLUSS, the Hungarian self-help organization of people with HIV and AIDS may play a decisive role in this field. This work can be made very successful by personal experience, community sympathy with fellow sufferers as well as the emotional commitment of non-positive members. It is vitally important to have an access to suitable means to professional preparatory work. Organizations should be notified about the most important professional events and to give them a chance to participate in them. Recreational trainings are efficient methodological tools where up-to-date information reaches the affected in a concentrated way or by the application of combined methods. To have a free access to publications all the time

is also of paramount importance. Condom use should be widely adopted and making it available free is also indispensible in secondary prevention.

• SOCIAL DISADVANTAGES AND AIDS STRATEGY

Being vulnerable to HIV/AIDS is basically due to social disadvantages, deprivation of different types. AIDS strategy aims at diminishing unequal conditions in this field and giving equal opportunities.

Objectives:

To diminish unequal conditions lying in HIV/AIDS risk factors in the Hungarian population;
To diminish vulnerability of target groups suffering from deprivation.

Rudimental challenges:

Basically negative impact of social and economic disadvantages on potential infection (sexual behaviour, drug addiction);
Exclusion from or poor access to health services (monitoring, care);
Difficulties in coping with problems;
Lack of social support, isolation;
Shortage of authentic, culturally accessible information related to HIV;

Among current socio-economic conditions the following groups require prime attention:
Romany population;
Migrants (immigrants, refugees);
Marginalized adolescents;
Young unemployed;
Certain deviant behaviour types, such as prostitution, are likely to be related to poverty and deprivation. However, particular sexual orientation may also result in social disadvantages.

Tasks:

To co-ordinate activities mainly in the sectors of social, educational and employment policy, at government and municipality levels;
To promote self organization of socially deprived groups, relying on and cooperating with relevant NGOs;
To open up vocational training (for social workers, district nurses), research, pilot tests;
To develop services to promote individual strategies in coping with problems;
To reinforce the network of social support;
To improve access to HIV/AIDS monitoring and care;
To provide targeted information to the deprived;
To stand up against prejudices causing segregation, to call for need for communication;

• MEDICAL TREATMENT, SOCIAL SUPPORT AND CARE FOR HIV PATIENTS

Outpatient care, Home care, Extension of clinical day care, Studies of cost efficiency

HIV/AIDS patients with manifest symptoms are treated at St László Hospital, Budapest, by the appointment of the Minister of Public Welfare in 1986. Medical care of such patients has been going on exclusively in this hospital ever since. The past 15 years have seen considerably improved conditions in patient care, which is partly due to the administration of antiretroviral medicines, and partly to the development in diagnostics of HIV disease and opportunistic complications. Special immunology tests, as well as HIV-RNA copy counts, new ways of patient care, day and home cares have also contributed to improved medical treatment of patients. Adult patients are treated in the ward of the Department of Internal Diseases #5 (Immunology), consisting of outpatient and in-patient wards. Whereas, infant care is provided at Paediatric Department of Infectious Diseases No 1 and at Paediatric HIV surgery.
The main scope of clinical care is to diminish the extent of immune harms caused by HIV disease, to prevent AIDS related complication, to diagnose it, to treat it and last but not least to provide psychic support to HIV/AIDS patients and to create a helpful environment for the patient and their family. Currently there are 440 HIV infected patients catered for by the centre,

out of which up to 360 are being given combined antiretroviral treatment. The number of patients under care and under treatment anually increases by 20 to 30 people. Procurement of antiretroviral medicines is carried out at the expense of the extra fund of the National Health Insurance Fund, which are given to the patients free of charge, and the therapy is made under a protocol annually renewed. The Centre regularly participates in international clinical tests, and in other European scientific tests, respectively (EuroSIDA, DAD).

Objectives:

To improve medical, psychosocial care in HIV/AIDS patients, to dramatically improve their life quality, prospects, ability to work;
To provide HIV infected patients with cost optimalized, combined antiretroviral treatment, free of charge who require therapy under medical protocol;
To diminish social, labour, community discrimination and segregation.

Tasks:

To provide HIV infected patients with medical and psycho-social therapy continually, at a high standard;
To annually update the medical protocol, to implement and adopt its content;
To introduce new diagnostic tests, to apply them clinically (to monitor therapeutical medication standards, to perform HIV resistance tests);
To elaborate and implement new methods to raise willingness in patients to cooperate (therapy compliance), to monitor long term alteration in metabolism, to diminish their harms;
To modernize HIV/AIDS patient care individually.

The wing of the hospital building presently used to accommodate patients, can remain so only for one or two years for bad general state of repair of the building. Within the project of general reconstruction of the hospital this task is also to be solved.
To raise the number of doctors, nurses with special training, laboratory staff according to needs who are in charge of treating HIV/AIDS patients.
To make a decision based on medical policy about the hospitalization of HIV infected patients who are active drug addicts using syringes, holding a special council of infectologists.
To establish an appropriate institutional and professional background for treating opportunistic complications in AIDS patients who are active drug addicts using syringes in the reconstructed pavilion.
To improve the standard of social care and that of institutional background, to employ social workers.

In-patient care is increasingly affected by a burden of social nature. The number of homeless people among HIV infected and AIDS patients is increasing. In them there is a high rate of patients suffering from antisocial personality complexes.