National Report of Hungary

I. Demographic context

The Hungarian population development over recent decades can be divided into two well separable parts: one is a period of population increase at moderate rates which lasted until 1980 and the other a period during which an actual population decrease showed in 1981 and has persisted since then. The population size of the country topped in 1980, when it was 10,710 thousand and decreased between 1980 and 1989 by 3.1 per cent and between 1990 and 1998 by a further 2.3 per cent. The decrease is the most significant among those of early age and the young and is moderate among the middle-aged. On the other hand the number of those aged over 60 has increased also over the last decade. Consequently the population decrease is taking place along with a further ageing of the population.

Over the past decades the fertility level has shown - though with fluctuations - a basically decreasing trend. After World War II it was in Hungary where - first in Europe - fertility dropped below reproduction level and this situation lasts for the longest time, already over thirty five years. The 1997 total fertility rate of 1.38 per cent and the completed fertility of the generations with an average number of children between 1.85 and 1.90 are behind simple reproduction by about 35 and 10 per cent respectively. By all this, the present fertility level does not belong to the lowest ones in Europe.

The inclination to marry has been on a gradual decline since the mid-1970s but has fallen sharply over the few past years. The demographic aspects of this trend are many-folded. The marriage rates have dropped considerably both among those marrying for the first time and among those re-marrying. The proportions of those living together without marriage and of children born out-of-wedlock are on the rise; the present 25 per cent proportion is the highest in this century. The fertility of the young has fallen considerably and induced abortion among them has become more frequent.

During the first five years (1990-1995) of the political, social and economic transformation fertility has not dropped so drastically in Hungary as in other countries of the ex-Soviet block. This can partly be attributed to maintaining a stable family policy, preserving the former allocations even at the expense of considerable budget expenditures, partly to the children-oriented scale of values of the Hungarian society. According to family planning surveys there is practically no deliberate childlessness in Hungary: a great number of surveys made in Hungary and abroad produces evidence that extremely high value is set on children and bringing up children in Hungary.

A specific feature of the Hungarian population situation is that mortality - compared to the socio-economic and cultural level of the country - is unacceptably high. The mortality level had gradually improved until the mid-1960s but, since then, has

significantly deteriorated. Between 1964 and 1980 the crude mortality rate increased by 36 per cent. More than one third of the increase has been due to the actual deterioration in mortality and the rest to ageing of the population. A further 3.5 per cent increase between 1980 and 1990 can mainly be explained by ageing of the population. In the early 1990s the mortality indicators signal a new trend of deterioration with a culminating point, i. e. mortality rate of 14.6 per cent in 1993. Since then the mortality rates have improved moderately but continuously. The mortality rate of 1997 was lower by over 6 per cent compared to that of 1993. The average life expectancy of males - which is 66,4 at birth - exceeds the 1993 level by 1.9 years, however is still below that of the best year ever, i.e. 1966 by over a year. The average life expectancy of females - which is 75.1 years - keeps rising continuously in the recent years but in international comparison belongs to the low ones even so.

Infant mortality has gradually decreased over the past decades, in 1990 for the first time it dropped below 15 per thousand and in 1997 below 10 per thousand. The mortality of infants, children and the young adults (aged under 30) makes 3 per cent of total mortality, consequently - even if a further necessary improvement takes place in the younger segment of the population - it can bring about no substantial change in the overall mortality conditions. The social, regional and cultural mortality differentials are significant. The social value of health has been considerably impaired over the past decades, although in the recent years a health-conscious approach has become general - at least in certain groups of the society. The risk factors involved in the established and still widely prevailing life-style, being detrimental to health, have no small contribution to the deterioration of mortality.

The 1998 data show a further decline in fertility, at a moderate improvement of mortality rate. Infant mortality has permanently been below 10 per thousand, hardly exceeding 9 per thousand. Since the decrease in fertility is of larger extent than the improvement of mortality rate, the pace of population decrease accelerated.

Fertility permanently below the reproduction level, high mortality and the resulting population structure have a decisive impact also on future population flows. All variants of the population projections, which seem to be realistic, expect a further lasting and significant population decrease. According to projections the ageing process is continuing. Due to the circumstances of the age composition of the population and to demographic processes the decrease in population size has become a self-generating process, however its extent can still be influenced by measures that have an impact on population trends.

II. Characteristic features of population policy

In Hungary, the population policy, designed to influence the population flows, has already a long past. As early as before Word War II efforts were made to change the demographic behaviour of the population, mainly in order to halt the gradual decline in the number of births. After World War II the mid- and long-term so-called population policy concepts, which adopted various sets of measures, had also a pronatalist intent, e.g. the respective government decrees of 1953, 1973 and 1984.

The government in office from 1990 to 1994 adopted a resolution on population policy in 1994 which is still legally binding, although the arrangements made in its framework have practically not been implemented. The contents of the government decree of 1994 and of the program of the government established in 1998 are in conformity, thus the essential elements of the decree can be realized in the future.

During the previous government period from 1994 to 1998 family policy has shifted to a poverty policy based on allowance systems. The allowance systems conditional upon a very low wage-limit have raised difficulties mainly for the middle classes in respect of inclination to bring up children. The restrictions which entered into force in 1996 found shape in the trend of the number of births: 100,000 births in 1997 represented the lowest level ever in history.

The position of the government established in 1998 is that the country's demographic situation is a national and social issue of great importance the solution of which calls for all-governmental responsibility and joining of forces of the society. The government counts on a moral renewal of the society and on intensification of the role of the communities and also of the church. Among the population-related aims are to moderate and, subsequently, stop the process of population decrease and - later on - to achieve a modest population increase under an age structure of the population becoming more favourable. Achieving an increase in fertility, improving mortality conditions and strengthening the financial and social situation of families are regarded as important tasks. These aims are to be achieved by continuous, wide-ranging and coordinated, well-timed measures.

Being aware of the population decrease during the recent almost two decades and of the responsibility for maintaining the population of the country, the government feels it necessary to put the population policy concept adopted into effect. The primary goal of the concept is to stop the population decrease and to establish a set of measures that result in a moderate population increase in the long run, hindering the acceleration of the ageing process and promoting the economic progress.

Besides having identified the aims, the government is fully aware of the limited financial means available for the implementation. The resources to be used for social, family and population policy purposes are partly subject to the economic position of the country, the present and future performance of the economy and partly to the enforcement of the priorities identified by the government.

In the interest of a most effective use of resources and of best arrangements the government assists research that provides a basis for the population and family policy and also the efforts aiming at the harmonisation of the research activities furthering comparisons on international level.

III. Policy and control of international migration

From the last third of the 1980s the phenomenon of migration is obviously a challenge for Hungary, the Hungarian politics, the government, the society, the public and statistics. After the former isolation of several decades migration has

become an essential process of the Hungarian society. When travel restrictions were lifted in 1998, the economic, political and social situation of the neighbouring countries and the ethnic conflicts launched a significant migration process, the target country of which was Hungary. This brought about a new situation because the country has become for a part of immigrants a target country, for the remaining part a transit station.

An increasing number of immigrants arrived in Hungary from the middle of the 1980s till 1990. Most people arrived in 1990, approximately 40,000 foreigners crossed the border who intended to live in Hungary for a long time. At the beginning of the economic, social and political changes in the Eastern European countries, the number of migrations rapidly increased, then began to decrease and it has become consolidated on a lower yearly level of a few thousand. In the early immigration phase mainly people of the Hungarian minorities living in the neighbouring countries moved to Hungary. The relevant policy of the government aims at establishing and furthering political, cultural and economic connections between Hungary and the Hungarian communities in the integration process taking place in Europe and promoting that Hungarians stay in their native land under improved circumstances.

The total number of emigrants, i.e. Hungarian citizens living abroad legally is estimated at over 100 thousand: Emigration from Hungary is usually a better founded decision than in several Central and Eastern European countries, emigrants are generally better educated and qualified, they adapt themselves better to the circumstances of the receiving country. Emigration from Hungary is of moderate extent, which can be explained partly by the improving trend of the national living standard and living conditions, partly by the restrictions imposed by the receiving countries.

During recent years the government and diverse institutions have responded to the challenge, the basic legal framework of addressing migration has been set up. Nevertheless, the complex migration strategy is under review, and the migration processes concerning Hungary have not completely stabilized either.

By setting up the fundamental elements of political democracy, the Hungarian government abolished the restrictions of the freedom of movement. In autumn 1989 an emigration act was passed, according to which no administrative restrictions are imposed on Hungarian citizens travelling from and to Hungary. Pursuant to the constitution, each person, staying legally in the country, has the right of the freedom of movement, of free choice of domicile and the freedom of leaving the residence (country).

Two acts passed in 1993 concern migration matters: the act on citizenship and the act on entry into and residence in Hungary of foreigners and on immigration. Both acts follow the practice known in Europe of strict control of immigrations.

The status of refugees is regulated basically by the Constitution. The primary rule is that the Republic of Hungary extends asylum to those prosecuted for racial, religious, ethnic, linguistic or political reasons. Hungary was signatory to the Geneva Convention on Refugees in 1989 and made a geographical reservation, namely the

possibility of application for refugee status was limited to incidents occurring in Europe. The evaluation of applications of immigrants arriving from outside Europe was made by the Representation of the UNHCR in Budapest. The Act on Refugees was passed by the Parliament in 1997 and entered into force in March, 1998. This act abolished the geographical restriction.

The standard employment opportunities of provisional immigrants are limited, work permits can be granted for them only in case of non-availability of properly qualified local workforce, as in most European countries.

The stipulations of the Schengen Convention will probably result in further increases in severity in respect of the conditions of migration to Hungary and the circumstances of border crossings in the future.

IV. Set of measures connected with fertility and family policy

A. Institutions for family support, mother and child health care services

In the past decades numerous measures have been taken in Hungary in order to promote readiness to have children and to help improving the financial situation of the families with children respectively. The government formed in 1994 cancelled or changed certain elements of institutions, which existed during the 1990s, in the middle of the decade. Some of these elements will be re-introduced by the government established in 1998.

The overwhelming part of the costs of the supports is covered by the state budget while a smaller part is provided for by the social insurance and the employers respectively. The local self-governments play a significant role in social support and in the maintenance and support of children's institutions.

The most important elements of the support system are the following:

- Maternity allowance (transformed first to pregnancy allowance, later on to maternity aid)
- Childbirth leave
- Maternity leave
- Family allowance
- Tax benefits
- Work-related benefits
- Children's institutions
- Mother and child health care services
- Allowances for those living in reduced circumstances

1. ***Maternity allowance*** was an instrument which existed until 1992 in the form of a one-time financial support to be paid after childbirth. Formerly it was due only to working mothers, later on to all mothers by subjective right. Its sum in 1992 was equal to two-thirds of the average net monthly earnings. In 1993 this one-time pay-out was replaced by a *pregnancy allowance* which was due from the 4th month of the pregnancy until the last day of the month preceding the month when the family

allowance for the child became due. In 1996 the pregnancy allowance was cancelled, instead a one-time maternity aid was introduced, totalling 150 per cent of the minimum old-age pension, being valid at the date of delivery.

2. ***Childbirth leave*** is a benefit due to working mothers for 168 days during which mothers receive 70 per cent of their previous wages (as pregnancy-confinement benefit) and can stay at home for the purpose of baby-care. 4 weeks of the maternity leave are to be taken out prior to childbirth.

3. Hungary was the first country where a ***child-care allowance*** (in addition to maternity leave) was provided for by law as early as in 1967, under which a specified amount has been paid for the parent being at home for child-care till the age of 3 of the child. In 1996 the former allowance due by subjective right was substituted by a benefit, conditional on a certain income-limit. At the same time the progressive system of child-care allowance was abolished and a monthly amount - unrelated to the number of children - making the minimum sum of the prevailing old-age pension has been paid. The present government re-instated the child-care allowance due by subjective right as from 1999.

In 1985 a new element in the family support system, i.e. the ***child-care fee*** was introduced; this measure made it possible for mothers to stay at home and take care of their children until the age of 2 while a fee amounting to 75 per cent of the average earnings of the year preceding childbirth had been payable to them. This establishment ceased in 1996. The new government is going to introduce an updated version of child-care fee as from 2000.

From 1993 on, the system has been supplemented by a childrearing support for those families in which the per capita monthly income does not exceed the threefold sum of the current minimum old-age pension. The childrearing support makes it possible for the mother to stay at home if in her own household three or more children under age are reared and the youngest of them is aged 3 to 8 years. The monthly sum of the support is equal to that of the minimum monthly old-age pension.

4. The most general instrument of support is the ***family allowance*** which is a regular monthly support. For the period 1990-1996 it was due for a child aged under 16 or aged between 16 and 20 respectively, who learned in a primary or secondary educational institution or who was durably ill or physically or mentally handicapped. The act passed in 1995 amended the family allowance system as well and granted family allowance by subjective right only for families having three or more children. Allowance for families with one child or two children was made depending on earnings and subject to an income limit.

Based on a motion of the new government formed in 1998 the Parliament re-established the family allowance system by subjective right and made it conditional upon school attendance from school age on.

5. In the period from the introduction of the personal income tax (1988) to autumn 1994 a ***tax benefit system*** existed ***for the families with children***, with some amendments. This tax benefit was cancelled on approving the budget for 1995. The

government formed in 1998 is going to re-establish the tax benefit system for families with children.

6. ***Additional leave*** is due to working mothers who have a child aged under 16, which makes 2 days for one child, 4 days for two children and 7 days for three children, all on yearly basis.

The mother/father is entitled to ***child-nursing allowance***, if she/he is nursing a sick child. There is no time-limit in case of children aged under 1, while 84 days are due for mothers with child aged between 1 and 3, 42 days in case of child aged 3-6 and 14 days in case of child aged 6-12.

7. The fees to be paid for children attending ***children's institutions*** are differentiated depending upon the income situation of the families and the number of children being brought up in them. Taking into consideration their social situation, those running these institutions - primarily local self-governments - can lower the fees to be paid down to complete gratuitousness.

8. The system of ***mother and child health care*** services is extraordinarily many-sided and developed. The expectant mother is under medical supervision throughout the whole duration of her pregnancy and can resort to pregnancy-consultation whenever she finds it necessary; expectant mothers are even obliged to attend this consultation at fixed intervals. Prenatal care by subjective right is free of charge. Favourable working conditions are due to pregnant women in employment. The proportion of deliveries in hospitals and obstetrical institutions is 99.4 per cent, however the medical attendance covers also mothers delivering outside such institutions and their child, too. Throughout the country a well-organized network of district nurses is operating. The task of the nurses is to visit mothers during their pregnancies and after delivery. The district nurses undertake nursing and advising in preparing expectant mothers for the childbirth and participate in looking after the babies afterwards. The medical (health) care for infants and children is free of charge. Children attending institutes are also under regular medical care in infants' and day-nurseries and schools, and so-called school-doctor services have also been established.

Conscious family planning and preparation for pregnancy are promoted by special institutes and family planning clinics, where possibilities are given for treating infertility, timing the childbirth according to wish and applying contraceptive methods according to individual needs and circumstances. At present the number of these institutes is still low, thus their services are not available everywhere and for everybody in the country.

9. Having financial contribution from the government, local self-governments may provide regular and occasional support in cash or kind for families, depending upon their financial situation. The local self-governments grant support for the families to finance also the costs of housing, depending on their financial situation.

B. Control of induced abortion, contraception

The regulation of abortion is stipulated by the 1992 act on the protection of foetal life. The standard basis of the law is protection of foetal life, the right of self-determination for the woman, her right of private life, founding a family, that of family life, while abortion is tolerated only within set limits and is not accepted as means of birth control and family planning.

Prior to that, the Constitutional Court of Hungary had declared that both the complete ban on, and unlimited availability of, abortion are anti-constitutional. The legislation had to decide upon the conditions under which the abortion could be performed.

After the elimination of the short-lived and harmful total ban, established in 1953, abortion became readily available in Hungary. Within a short time the number of abortions increased significantly and culminated in the late 1960s with 134 abortions per 100 live births. Modern contraceptives (mainly orally administered hormones) have been available from the second half of the 1960s, but became widespread in the mid-1970s. In the 1980s the use of IUD spread dynamically. As a result of all these, the use of modern contraceptives has become dominant among the women protecting themselves against unwanted pregnancies. In the mid-1990s about 73 per cent of women aged 18-41 - living in marriage or consensual union - protected themselves from an undesired pregnancy. Among them the use of the pill is estimated at 38 per cent, that of the IUD at 17 per cent and of the condom at 8 per cent. Further 10 per cent applied natural methods of protection. There is no separate legal regulation for contraception - except surgical sterilization -, the pill is available in pharmacies on medical prescriptions and IUD can be used under medical supervision. From the mid-1980s, the health act has been providing for a legal possibility of sterilization against payment, subject to age and number of children. All these steps contributed to a significant decrease in the number of abortions, compared to the mid-1970s, however it is still high - considering the proportion of up-to-date preventive means and compared to the West European countries. In 1997 there were 74 abortions per 100 live births.

Abortion as means of family planning is unacceptable. It would be desirable that no woman gets pregnant against her will. That is why prevention is important. The means of birth control should be contraception. A basic element of social consent is the applicability and availability of all accepted methods of contraception.

According to the prevailing law, pregnancy can be interrupted until its 12th week at the latest or, in certain special cases, until its 20th and 24th week, respectively. In emergency case pregnancy can be interrupted regardless of whether it is in advanced stage or not. The woman has to personally submit a request for abortion to a staff member of the Family Welfare Service, who conducts a conversation with her, informing and advising her. Afterwards she - after a compulsory three day waiting and consideration time - is free to decide whether she wishes to request abortion, referring to a grave crisis situation. For health-related reason and in case of crime, a conference of doctors makes decision in the matter in the hospital chosen by the pregnant woman. If a health-related reason or crime exists, the abortion is

free of charge, the connected costs will be borne by the Health Insurance Fund. In case of crisis situation the costs of the operation make about a quarter of the net average monthly earnings, nevertheless the amount fixed originally is to be paid for in 6 to 7 per cent of the cases, since the payable amount can be reduced unrestrictedly with regard to the social situation of the applicant. Half of the abortions is performed against payment of a sum equal in value to USD 5 to 10 and over one third for that equivalent of USD 15 to 20.

During one year from the introduction of the rules stipulated by the act on protection of foetus of 1993, the number of abortions dropped by 15 per cent. The law resettled the motives of approval of abortions, nevertheless included no essential increase in severity compared to the former legal rules. In 1994 the pace of decrease slackened to a great extent and in 1995 the trend changed and slow increase has been characteristic. However, - according to data of 1996-1997 - the rising tendency in the number of abortions has not continued. 74,500 abortions in 1997 represented a decrease by 2100 operations compared to the previous year and by 12,000 to the period prior to the introduction of the law in 1992. The decline could be observed mainly in case of married women with children and of those having already had abortion; among them the extent of decrease was over the average. The decline was smaller among the single, the teenagers and those having their first abortion. Since the early 1990s the social insurance has not paid any contribution to the costs of up-to-date contraceptives due to which mainly the young people face difficulties, among them the proportion of abortions has decreased to the smallest extent, and is still high.

V. Current policy relating to the state of health of the population and mortality

The Constitution of the Republic of Hungary recognizes the right to health and physical fitness among civil rights.

Health protection, the conditions and framework of health care are regulated by the law CLIV/1997.

The legislation aims at the improvement of the state of health of individuals and thus of the population by regulating the conditions and means affecting health. The law emphasizes the importance of establishing equal opportunity in respect of the availability of health services. Separate rules of the law provide opportunity for the sick people to preserve human dignity, identity, right to self-determination and all other rights without infringement.

The law includes general professional conditions and guarantees of health services. The legislation recognizes the enforcement of personal freedom and of the right to self-determination as basic principle. The cornerstone of the law is that the primary means of improvement of the state of health are preservation of health and prevention of diseases.

Financing of a health service on high professional level, based on providing equal opportunities is the responsibility of the social insurance representing the solidarity of society.

The program of the new government - harmonizing with the basic principle of the law - aims also at the implementation of a health policy focusing on preservation of health. Public health is more than the treatment of diseases and can be interpreted and treated with a social approach in the widest sense of the word.

Prior to making decisions, the government considers the impact of the planned measure on the state of health of the population. Health protection, anti-drug, anti-smoking and temperance movements are included in the subject-matter of instruction at school.

Mindful of an effective health care program, the government is going to establish a fund coming from a part of the accession tax imposed on alcoholic and tobacco products and to be expended on health care.

The government modernizes the systems of health care and propaganda and that of prevention of diseases and enacts a law on the protection of non-smokers.

The government pays special attention to avoidable deaths and takes urgent measures of intervention in the improvement of emergency care and in perfecting the hierarchic system of a nation-wide health care on adequate level.

VI. International co-operation in demography

Hungary, the Hungarian institutions and experts have been co-operating for decades with different international intergovernmental and scientific organizations as the United Nations and its specialized agencies, the IUSSP (International Union for Scientific Study of Population), EAPS (European Association of Population Scientists) or with non-governmental institutions like IPPF (International Planned Parenthood Federation) in population-related matters. The co-operation with the international organizations concerned is comprehensive and close.

Under the co-operation with the UN and their specialized organizations, Hungary attended the World Conference on Population held in 1974 in Bucharest and in 1984 in Mexico. In 1987 Hungary hosted the European Regional Conference. At the 1994 World Conference on Population the Hungarian delegation took also an active part and its head was elected as vice chair person of the conference.

The Hungarian delegation regularly participates in the sessions of the Population Commission of the UN, which elected a Hungarian chair person in 1996.

Hungary is ready also for further co-operation in international projects on population, similarly to our previous participation in the activities of the UN and its specialized agencies (i.e. in the World Fertility Survey, a mortality survey of the UN Population Fund, the research project for family planning practice, in establishing and updating demographic data bases and the UN projects covering the ageing of population).

We set high value on the European co-operation in the field of research and, in general, of demographic issues. This opinion can be explained not only by our

integration efforts but also by the fact that the demographic problems of the European countries are quite different from those in other continents and regions and especially in developing countries. Consequently, we give high preference to multi- and bilateral co-operation within the European region both on government level and with scientific and professional institutions.

Since 1990, the year of admission of Hungary to the Council of Europe, we have been taking active part in the work of the Population Committee of the Council of Europe, mainly in that of its working groups dealing with fertility and with the demographic circumstances of minorities. In 1998-1999 a Hungarian expert is chairing the Population Committee of the Council of Europe.

VII. Long-range basic principles of population policy for the next decades

To achieve the long-term demographic goals, the government has identified the following **long-range basic principles of population policy for the forthcoming decades**:

For increasing fertility:

1. The government regards it as the most important population-policy task to increase the readiness to have children. To increase fertility, a social atmosphere and a wide-ranging set of measures are to be created which make it possible that the number of childbirths continuously ensures in the short run a simple reproduction and in the long run - possibly in the first decades of the next century - a fertility level over simple reproduction and results in a moderate population increase later on.

2. To increase fertility, assistance is to be provided for parents to fulfil their double commitments, i.e. in the workplace and at home as parents. In the future, special emphasis is to be laid on educating people both at school and in the media to prepare themselves for the tasks of bringing up and taking care of children, first of all in creating a child- and family-conscious environment in every field of the society.

3. In the future, the readiness to have and bring up children is to be supported in a more definite, co-ordinated and target-oriented way than before. Thus, in addition to the improvement of the housing conditions of families with children and to ensuring the financial and institutional conditions for child care, it is necessary to improve the working conditions of mothers in employment, make flexible working hours and part-time jobs available, provide for safety of the workplace for mothers back from child-care leave and encourage parents to divide work at home in a more balanced way.

4. The basic instrument of financial support for the families continues to be the family allowance, the system of which will be developed by the government with regard to the diverging financial situation of families, to the costs of bringing up children and to the stability of the currency.

5. To promote the inclination of working women to have children and offset the connected loss of earnings of the family the institutions of child-care allowance and

child-care fee are to be re-established in a modernized form, according to a government decision.

6. When amending the regulations of the personal income tax system, the government makes efforts to establish a taxation which increasingly takes into consideration the position of children and other dependents.

7. It has to be provided for by adequate government measures and support of local governments, social, economic and church institutes that children attend children's institutions - infants- and day-nurseries and day-time homes of schools - of proper standard of quality and their parents can pay for the expenses.

8. On determining a long-range health policy, it has to be a basic principle and to be ensured by all means that the number of planned and wanted pregnancies increases and that of unplanned and unwanted ones decreases. Besides, the conditions of prenatal care, childbirth and those of care of new-born babies are to be improved.

9. Based on the fundamental principle of the law on the protection of foetal life, it has to be achieved that expectant mothers receive further increased care and the conditions of birth of healthy babies are to be established.

10. Further measures are to be taken, enabling individuals and married couples to exercise their right to planning the number and time of birth of their children freely and responsibly and to have the number of children, they desire. The attainment of the necessary knowledge and development of qualitative services of prenatal clinics are to be provided for.

11. In order to reduce the number of abortions and to achieve conscious family planning, a wider and cultured use of modern contraceptives - including also the promotion of methods of natural family planning - has to be ensured. In addition to sexual education and development of the family planning network a fast and easy access to modern contraceptives, covered partly by the social insurance, is to be provided for, in case of the young and those living in reduced circumstances, free of charge.

For the stability of families:

12. Well-founded marriages are to be promoted in a more distinct way than before. For this purpose, in addition to education, more definite measures are to be taken for establishing proper living conditions for young married couples. Special attention is to be paid to helping young couples and families with children to obtain housing of adequate size and quality.

13. Legal instruments are also to be used for the purpose of improving the stability of marriages. Consequently, the number of unfounded juvenile marriages is to be decreased and a possible reconciliation of couples in case of a ruined marriage is to be promoted not only by means of family law. The present situation could change for the better by setting up a proper network for family guidance and support in which all kinds of institutions of the society would take an increased part.

14. In addition to basic rights guaranteed for children and young people by law, the enforcement of their rights has to be based on growing up in own, well-functioning family.

15. To ensure gender equality, new legal rules, promoting equal socio-economic and political rights for men and women - including the responsibility of parents for bearing the family and mainly childrearing burdens equally, by common consent - are to be adopted.

For reducing mortality:

16. Effective measures are to be taken in order to improve the state of health of the population and to come close in the long run to the standard life expectancy of the majority of the European countries by a co-ordinated long-term health and social policy. Mindful of this aim, the elaboration and introduction of a set of measures is necessary to stop the deterioration process and gradually improve the health status of the population, resulting in a decreasing mortality and increasing life expectancy.

17. The population policy aiming at a decrease in mortality is to be directed towards prevention and more effective medication of fatal diseases. Proper set of measures - progress of preventive medicine, modernization of therapeutic measures and remedies, wider access to care systems - is to be established in order to decrease fatal diseases which are frequent at the moment. It seems to be necessary to set up a screening system on a wide scale to prevent diseases causing death or long-lasting grave illness and to increase the general availability of the screening services.

18. Besides the improvement of prevention and of treatment, a change in life-style, has to be achieved by proper education, propaganda, direct government measures and joining of the forces of the society. For this purpose it is required to press back harmful habits, i.e. excessive smoking, alcohol consumption, unhealthy eating habits, lack of physical exercise and overwork.

19. An earliest possible decrease in mortality calls for improvement of the state of health of the active population - mainly of men. A permanently favourable future mortality level is, however, subject to the health status and life-style of today's youth. That is why preservation of health of young people, popularizing healthy life-style among them, education and prevention by every possible means of screening are high priority.

20. Special attention is to be paid to the improvement of the state of health of certain classes of society at risk. For this purpose the infant mortality is to be decreased in the future too, by adequate preventive, educating and therapeutic measures, first of all by pressing back the reasons of the large proportion of premature deliveries.

21. The health status of old people is to be improved by proper care, establishing suitable conditions of cohabitation of several generations and the conditions of intergenerational provision of care and support. In this way old people could live a long life - due to an increased life expectancy - in good health. Special emphasis is to be laid on an increased rehabilitation of population, incapacitated for whatever reason, thus on re-integrating them into the society and also on improvement of their living, working and environmental conditions.