2016 National Social Report
Hungary

1. Overview

The report focuses on the period between June 2015 and June 2016.

There were no notable political, governmental or structural changes in this period. Ministry of Human Capacities, the State Secretariat for Social Inclusion and the State Secretariat for Family and Youth Affairs are still responsible for the three major areas of social protection, namely, the fight against poverty and social exclusion, pensions, as well as the health and long-term care systems.
The National Reform Programme gives account of the significant measures of the Government taken in the area of social protection, while Chapter II and III of the National Reform Programme and the Convergence Programme describes the macroeconomic situation and the developments of economic policy.

This report summarizes some of the governmental measures, not or only peripherally touched upon in the National Reform Programme, relating to **child protection and guardianship**, **disabilities**, **health and family policy**, in the period considered.

The **main indicators demonstrating the social situation in Hungary** are summarized in the following:
Referring to Chapter IV.5 Social inclusion of Hungary's 2016 National Reform Programme, it can be concluded that the deterioration of the country's general social conditions, caused by the global financial and economic crisis stopped in the last few years. In fact, a good part of the indicators has showed remarkable improvement. The latest data show that the polarization of the society and the increase of the inequalities experienced since 2010, which always remained at a level below the EU average, have stopped (S80/S20 Eurostat 2010/11/12/13/14/15: 3.4/3.9/4.0/4.3/4.3/4.3).
It can also be seen, that the high poverty risk groups have somewhat changed. While, previously, children, youth, those living in a family with the family head holding only an elementary school qualification, families with a single parent, families with many children, those living with an inactive or unemployed family head, as well as the Roma, were the most vulnerable. The latest data show, that only those living in a family with the family head holding only an elementary school qualification, families with many children, households with an inactive or unemployed family head, households with only one employed person (the family head), as well as the Roma are considered to be at a high risk of poverty. The proportion of working poor people with children has increased. However, this is primarily due to the fact, that many of those, who used to live on aid are now considered to be employed owing to public works, resulting in them being included in this indicator. In order to improve the situation of low income families with children, , the Government introduced the family contribution allowance in 2014, meaning that the family tax benefit can be deducted not only from the basis of the personal income tax (PIT) (the gross wage), but also from the individual contributions (in-kind and cash healthcare contribution and pension contribution) subject to meeting the eligibility criteria. Introducing the family contribution allowance significantly increases the net wage of those, who were unable to claim the total tax benefit available to them. Similarly, the reclassification of those involved in public works in the category of employed persons is also the reason for that, although the proportion of in-work poor people who are working is generally low, the proportion of in-work poverty or people with low work intensity (0.2-0.45), but are not considered as working poor people, has increased.

2. Policy reforms for the period 2015-2016

2.1 Social policy, social inclusion

Chapter III.4 and IV of the 2016 National Reform Programme gives an account of the most important policy measures of the Government, including the sectors of education and health.

These include the review of measures to implement the **substitution strategy of institutional accommodation** in the area of **disabilities**, and the measures aimed at the **labour market activity of people with disabilities**, **increasing the number of those involved in supported employment**, **enhancing the conditions of those entering the open labour market** in the field of **occupational rehabilitation**, and, in the domain of **family policy** the measures taken to promote **the extension of free catering in kindergartens and day-nurseries as of 1 September 2015,** are as follows:

Government Resolution 1257/2011 (VII.21.) laying the foundation of the strategy for the **substitution process of institutional accommodation** is currently under reform. As a background to this, the proposal package, 'Development principles for the implementation of the strategy for the substitution of accommodation of people with disabilities at social institutions (2011-2041), 2015-2020' was prepared in summer 2015, with the involvement of a wide-ranging team of experts, in order to continue the process of de-institutionalization. Overall, as regards the modified strategy, it can be declared that the experiences of the first phase of the substitution program show that more attention is paid to the preparation of residents, as well as to local communities and the human resources of institutions. In order to facilitate the change, traditional (legislative amendments, organisational development and training programs) and innovative (professional community development and strengthening the network of stakeholders) measures are encouraged. Attention is paid to the location of new homes and supported housing services, and efforts are made to involve settlements with a more developed infrastructure in the process. It is essential, that a varied group of services and initiatives supporting employment, as well as their systematic and equal accessibility, is ensured. In addition to persons with disabilities moving away from the institutions, attention is also paid to the needs of persons with disabilities living in families. Planning and implementing the research and monitoring procedure, then following through the entire process is also an important element.
Pursuant to Government Resolution 1037/2016 (II. 9.) on the annual allocation of Human Resource Development Operational Programme (HRDOP), within priority 2 entitled *Infrastructural investments for strengthening social cooperation*, within HRDOP 2.2.2 scheme *Development of shift from institutional care to community-based services*, a planned budget of HUF 35 billion has been made available. The preparation of the project and the technical concept is in progress. In addition to moving 3,500 people from nursing homes to supported housing, the creation of an additional 500 new supported places of accommodation is planned.
HRDOP-1.9.1- CCHOP(Competitive Central-Hungary OP)/15 'PARTNER' project was launched on 1 April 2016, with a budget of HUF 2.5 billion. The main objective of this project is to ensure the methodological and professional background for the substitution of accommodation in social institutions, throughout the country, for social institutions providing personal care in various areas.
At the same time, the policy process relating to the amendment of Act III of 1993 on Social Administration and Social Services (and implementing decrees) in respect of supported accommodation is underway, which regulates supported accommodation as a new form of service by laying down the foundation of services, based on service elements and a novel differentiated funding for the future.

In the area of **cash and in-kind social services**, there were no fundamental changes in the policy affecting the eligibility for various forms of care or the scope of care in the period considered.

The measures carried out in the field of **occupational rehabilitation** between 2012 and 2014 have successfully supported the labour market activity of the people with disabilities, increased the number of those involved in supported employment, and the introduction of the institution of transit employment and the development of the system of labour market services enhanced the conditions for entering the open labour market. Starting from 2013, in each year, a constant number of 30,500 people with disabilities are employed at 350 employers by way of tendering in accredited employment, with central budget funding of HUF 34 billion. On the basis of transit employment, introduced in 2013, the placement of the workers to the open labour market has commenced, and much bigger numbers are expected to be involved in the coming years.; in 2015 out of the 30,500 people, 7,500 were transit employees, who could enter the open labour market after 3 years of rehabilitation. Starting from 2012, employers are eligible for a 27% contribution allowance, if a person with disabilities is employed with a rehabilitation card; in 2015 more than 8,000 employers benefited from the contribution allowance for 30,000 employees on average, which meant the recourse of HUF 600 billion as a monthly average allowance.
The demand for goods produced by employees with disabilities is increased by the amendment of the Act CXLIII of 2015 on Public Procurement (hereinafter: Public Procurement Act). The new Act came into force on 1 November 2015, based on which the procurement of goods and services produced by employees with disabilities at protected and accredited workplaces are released from the effect of the act, up to the value limit set by the EU.
There was positive change on 1 May 2016, which created consistency of the limit of occupational activity, whilst receiving rehabilitation and invalidity benefit. Previously, there was a limit of income from employment (income was limited to 150% of the minimum wage to remaining eligible for care) for those receiving invalidity benefit. Additionally, there was a limit on total working time (a maximum of 20 hours weekly without losing eligibility for care), for those receiving rehabilitation care. However, these provisions did not effectively encourage the recipients of social services to undertake full-time employment on the open labour market. According to its modification, the time limit of pursuing income-generating activities was removed, but eligibility for rehabilitation care is lost, if the income earned by the recipient in employment exceeds 150% of the minimum wage in three consecutive months.

In the field of **family policy**, the **extension of free catering in kindergarten and day-nursery as well as the decision to reform kindergarten care coming into force from 1 January 2017,** is outlined as follows:

<u>Extension of free catering in kindergarten and day-nursery</u>
Pursuant to the decision of the Government, starting from **1 September 2015**, **the number of children eligible for free catering in day-nurseries and kindergartens was nearly tripled**, increasing it from 95,000 to 269,000, that is, by 174,000, **in a given educational year**. Previously, only those children, who were socially in the greatest need, were provided with free catering, slightly more than one-quarter (27%) of the affected group, while children living in large families (in households with 3 or more children) or children living with a serious illness/disability (16%), were given a 50% allowance from the cost of catering, and the overwhelming majority (57%) had to pay the full cost of the service. In contrast, from now, the parents of children currently receiving catering at half price do not have to pay for this service either. Free catering is also provided to those children, whose families have a per capita income below 130% of the minimum wage (HUF 95,960). Hence, the proportion of children receiving free catering has increased to 77%, with only the wealthiest families, with an income above the average (23%) expected to pay for child catering.
There was positive change also in **child catering during the school holidays**, since local

governments are required to provide free catering of one hot meal per day, not only in the summer holiday, but also during all school holidays and periods of closure of the institution, for children in need (with a disadvantage or with multiple disadvantages, and/or receiving regular child protection allowance), whose parents have requested it. This option will be available to approximately 221,000 children in day-nursery, kindergarten or school in 2016, which is two-thirds, that is, 90,000 more than the number of children eligible in 2010 (131,000). In total, from 2016 HUF 71.7 billion and from 2017 HUF 73.9 billion will be spent on **child catering in institutions** (this is an increase by 2.5 compared to the budget of HUF 32.2 billion in 2010). In this figure, the budget allocated to child catering in institutions, during the school year, was increased from HUF 29.8 billion to HUF 67.2 billion (by approx. 25%), and the support for child catering, during school holidays was raised from HUF 2.4 billion to HUF 6.7 billion (nearly tripling it) in the course of seven years.

Reform of day-nursery and kindergarten care

In 2015, the Government decided to reform day-nursery and kindergarten care[1]. In line with the amendment of the law and the relevant decrees, the system of forms of care, for children under the age of 3, will change from 1 January 2017, thereby establishing new institutions and modifying the operation of the forms of care. A flexible, multi-stage, multiple-actor and differentiated institutional system (kindergarten, mini kindergarten, workplace day-nursery, family day-nursery, day care for children) will be created.

It will be the mandatory task of local governments to ensure the care of children under the age of 3, if the number of children under the age 3, living in the given settlement exceeds 40, and at least 5 applications for small children are received requesting the organization of the care.

The measure is expected to reduce current regional inequality, and increase the rate of employment among women. Development programmes should also lead to the creation of new jobs, and it will alleviate child poverty. By 2018, approximately 14,000 new places would be created.

The result of the measure will be outlined in periodical reports, following the completion of the reform.

2.2 Pensions

There were no legislative reforms or policy measures taken by the government resulting in significant changes in the area of pensions in the period considered. The continuing effects of previous measures (raise in the retirement age) will be contributing to the sustainability of the pension system and will improve these indicators.

2.3 Health

The most important governmental measures relating to health are reported in Chapter III.4 of the National Reform Programme.

In addition to these, **the health policy, health insurance and public health care measures** and **legislative changes,** occurring in the period after June 2015, are also notable, which are as follows:

- The measures taken **to reinforce primary care**:

[1]In the context of the reform of day-nursery and kindergarten care, the following amendments were introduced:

- Act CCXXIII of 2015, **amending** certain acts on social affairs, child protection, family support and other related **acts** (published in Volume 202 of the Hungarian Official Gazette of 2015)
- Decree 6/2016 (III. 24.) of MoHC(Ministry of Human Capacities), **amending Decree 15/1998. (IV. 30.)** of MoW(Ministry of Welfare) on the professional tasks and operating conditions of child welfare and child protection institutions and their staff providing personal care (published in Volume 40 of the Hungarian Official Gazette of 2016)
- Government Decree 191/2016 (VII. 13.), **amending** certain **government decrees** in relation to the reform ofday care of children (published in Volume 104 of the Hungarian Official Gazette of 2016)

- Act CXXIII of 2015 on primary health care is effective as of 1 August 2015. Also, Government Decree 204/2016 (VII. 21.), **amending certain government resolutions relating to primary health and speciality care** was published. One of the important elements of the amendment is the exhaustive list of income and expenditure items, which should be considered during the audits of the National Health Insurance Fund of general practitioners, family paediatricians and dentist entrepreneurs providing primary care. Also, as a result of the amendment, general practicioners may order home hospice care at his/her discretion.
- • **General practitioners obtaining their qualification as first specialisation after 31 August 2015, are also eligible for support under the 5-year Support Programme of Young Medical Specialists. The amount of the support, starting from January 2016, is a gross HUF 151,000 per month per person.**
- Together with the budgets of call **Territorial and settlement development Operative Programme (TSDOP) -4.1.1-15 Infrastructural development of primary health and call TSDOP-6.6.1-15, a total of HUF 22.272 billion was allocated for the support of the infrastructural development of primary care** (construction, renovation and procurement of instruments) **in 2016.**
- **In 2016, the medical practice substitution programme was also launched, which is a support for re-settlement and for purchasing medical practice rights for general practitioners.** In 2016, a budget of HUF 500 million is available for filling in permanently vacant **general practitioner** practices and HUF 250 million is provided to **general practitioners**, wishing to purchase medical practice rights.

- As of 1 September 2015, two pieces of **legislation** came into effect, making objective newborn hearing screening tests mandatory at neonatal and PIC departments. Also, the guideline describing the tools and methods to be used has been prepared.

- *Decree 51/1997 (XII.18.) of MoW (Minister of Welfare) concerning health services and the certification of screening examinations aimed at the prevention and early diagnoses of diseases, that may be accessed within the statutory health insurance scheme*
- *Decree 60/2003 (X. 20.) of MoHWF (Ministry of Health, Welfare and Family) on the minimum standards of providing health care services*

  Personal and material requirements were fulfilled through development within the TIOP 2.2.8 scheme.

- *Government Decree 439/2015 (XII. 28.) on the rules of management of the national blood inventory,* defined some of the fundamental concepts of management of the national blood inventory. **This legislation regulates the procedure to be followed in case the blood inventory does not cover domestic needs, as well as the cases of export to foreign countries, including export for humanitarian purposes. The strategic significance of establishing the national blood inventory requires, that industrial plasma donors give full blood donations at least on an annual basis.**

- Expert Centres of Rare Diseases were selected starting from 1 June 2015: the University of Debrecen, the University of Szeged, the University of Pécs, the clinical centres of Semmelweis University and the National Institute of Oncology. Some of the departments of these centres applied to join the European Reference Network, these applications were reviewed and supported; the assessment process (by The Board of Member States) of the possibilities of accession are still in progress.

The following measures were taken in the area of **health insurance and public health** in the reporting period:

- **the sanctioning of the 100% utilisation of the bed capacity of active inpatient departments was lifted**, since the performance volume limit (PVL) is in itself a guarantee for abiding by the health insurance fund. Hence, the monitoring and sanctioning of the utilisation of the bed capacity is a measure unnecessarily restricting medical activities;
- **the release of PVL for single-day care became possible** – the volume set of among single-day care providers with a volume contract was restructured, so that they can report in excess of their volume;
- **reduction in waiting lists** – in relation to the waiting list reduction programme allocated on a separate budgetary line of HUF 5 billion, within the Consolidated specialized care appropriation, numerous measures were taken starting from the reporting of achievements in April 2015:
    - cases shall be funded as PVL-free care;
    - the time committed to the care of patients treated using additional funds shall not be counted in accordance with the rule on the application of the so called 'percentage of bed capacity utilisation;
    - the 3-5 day limitation rule shall not be applied for relocation from an active department to a chronic department;
    - in case of surgeries performed against the appropriation, the case shall be funded with the weighting set in the legislation increased by 10%;
    - the preliminary examination of the patient can be settled PVL-free, against additional funds up to the normative figure, for each case in outpatient care, while in case of cataract surgery, up to 3,000 points and for other surgeries up to 10,000, regardless whether the surgery was actually performed or not;
- **it is now mandatory for publicly funded CT and MRI diagnostic providers** to perform a diagnostic examination **within 14 days for patients with the clinical symptoms of malign tumour being established**;
- **the funding necessary to enable cervical screening by health visitors for the purposes of public health** is at our disposal;
- **the number of days of sick leave for child care by parents was increased**,
- the harmonisation of Directive 2014/40/EU of The European Parliament and of The Council, on the approximation of the laws, regulations and administrative provisions of the Member States concerning the manufacture, presentation and sale of tobacco and related products and repealing Directive 2001/37/EC is currently underway with the amendment of relevant legislation. The harmonisation process is expected to end by 20 August 2020. However, the majority of legislative amendments has already come into effect on 20 May 2016. Among others, the use of electronic cigarettes was regulated: some of the rules concerning its consumption and sale. This meant that a regulation, which is equally stringent as the one applying to 'traditional' tobacco products was introduced in terms of production and sale, as well as prohibitions on smoking and areas designated for smoking. The concepts of a tobacco product, smoking, combined health protection warnings and collective packaging were defined more accurately, and the size of the health protection warning was increased.

2.4 Long-term care and nursing

There were no remarkable measures taken in the field of social services and long-term care and nursing in the recent period**.**

Annex 2 – Asylum

The session on health of the EPSCO Council of 19 June 2015 reviewed, among other items on the agenda, the health dimension of the European Migration Agenda. Then the informal session of the ministers of health on 24-25 September 2015 and of the ministers of employment and social affairs on 5 October 2015, discussed the management of the health dimension of migration, as well as examining the effect of migration on the labour market and social systems.

Mass migration in the period considered did not only affect the Mediterranean region, the Western Balkan route demanded the same level of attention. According to consolidated figures up to autumn 2015, more than 220,000 illegal migrants (mainly from Syria, Afghanistan, Pakistan and Iraq) arrived to Hungary (with more than 173,000 submitting an application for asylum), even though the intended final destination of most of them is not Hungary, but other member states of the EU.
Migration not only poses challenges of integration, but also of public health, where the aspects of health security, humanity and ethics shall be given prominence. There is no way to respond from the perspective of public health until the situation can be controlled and migrants can be convinced to cooperate with healthcare authorities.

Health and epidemiological situation of migrants in Hungary

Pursuant to the Act on Health (Act CLIV of 1997), all persons in the territory of Hungary shall be provided with:

- epidemiological care: **mandatory vaccination** (except for vaccinations necessary when travelling abroad), screening tests performed for epidemiological purposes, mandatory medical tests, epidemiological quarantine and transport of infectious patients;
- **rescue**, if the accidents resulting in physical injury, mass accident, health emergency, threat to life, or suspicion thereof, cases with acute or startling symptoms, or obstetric events require immediate treatment, due to severe pain or acute symptoms, severe disturbance of consciousness, critical health condition or the suspicion thereof;
- in case of **immediate emergency** they should be provided with **forms of care** set out in separate legislation, if these are necessary, owing to an.

Applicants for refugee status, subsidiary protection, temporary protection or postponement of removal are entitled for the specified range of medical care free-of-charge, if they fall ill. These include, among others, care by general practitioner, outpatient specialised care or inpatient-institutional care, as well as mandatory vaccination as required at a given age. **Individuals requiring so called 'special treatment', e.g. minors or the disabled,** are eligible for a wider range of services. **These individuals are eligible to use health services, rehabilitation, psychiatric and clinical special psychiatric care, as well as psychotherapeutic treatment.**

Health services provided to individuals with refugee status and beneficiaries of temporary protection is funded by the National Health Insurance Fund, while the care of applicants seeking asylum without a decision is paid by the Office of Immigration and Nationality, which was approximately HUF 55.2 million in 2015. The table below shows the costs for each form of care, which clearly demonstrates, that primarily outpatient and inpatient care were provided, but there were costly dialysis treatments as well.

Expenditure on the healthcare of foreign citizens funded by the Office of Immigration and Nationality in 2015

Form of care	2015 year												Total
	month												
	January	February	March	April	May	June	July	Aug.	Sept.	October	Nov.	Dec.	
	Cost of care (HUF)												
Outpatient specialised care	1,437,107	1,660,450	1,715,837	1,467,962	1,662,649	1,187,471	2,959,522	4,243,866	4,233,449	1,021,670	733,587	854,081	**23,177,648**
CT/MRI care	23,331	50,972	17,145		76,700	62,865	28,575	23,331	28,575	52,377	44,229	44,834	**452,933**
Inpatient care	1,707,387	1,026,692	1,500,290	569,859	2,000,685	1,823,773	3,347,334	3,015,036	915,863	4,838,508	939,915	2,377,784	**24,063,122**
Transport of patients	56,662	65,530	74,142	229,186	58,094	5,243	25,123	2,017	10,563	3,809			**530,369**
Dental care	2,983	7,625	10,043	6,990	12,876	7,776	13,284	11,328	9,345	11,675	28,308	11,729	**133,962**
Artificial kidney treatment	272,424	256,869	517,410	559,054	384,623	276,916	123,457	107,200	21,512		107,271		**2,626,735**
General practitioner care	600		600	1,200				7,200	1,800	600	1,200		**13,200**
Medication/ therapeutic appliances		172,927		649,442	649,442	654,489	649,442	649,442	653,100	108,467	3,824		**4,190,575**
Total	**3,500,494**	**3,241,064**	**3,835,466**	**3,483,692**	**4,845,068**	**4,018,532**	**7,146,736**	**8,059,420**	**5,874,206**	**6,037,105**	**1,858,334**	**3,288,427**	**55,188,543**

According to the analysis made by the National Public Health and Medical Officer Service (ÁNTSZ), **the wave of migration reaching Hungary does not pose an epidemiological concern for now, but carries an epidemiological risk.** The most prevalent infectious diseases among migrants are Hepatitis B and syphilis (measles), according to the results of screening tests, performed by district epidemiological institutions. Cases of Hepatitis C and HIV infections were also discovered. It is important to know about the above diseases that contagion is only possible through direct (sexual) contact and blood.

Regulation on migrant children and care of unaccompanied migrant minors

Pursuant to Act LXXX of 2007 on Asylum (hereinafter referred to as 'AoA.'), the definition of individuals requiring special treatment extends to both unaccompanied minors and, in general, single parents with minor children. Additionally, it provides that in the course of applying the provisions of the Act, the interests and rights of children shall be respected above all.

The placement of families arriving to Hungary with children is provided by the Office of Immigration and Nationality in reception centres, where families are placed together. If the child remains without parental supervision on or after arrival in our country, in each case placement in a child protection institution is ensured.

The personal scope of Act XXXI of 1997 on the protection of children and guardianship (hereinafter referred to as 'CP Act.') covers, in case of temporary care giving, children, young adults and their parents staying in the territory of Hungary with settlement permit, as immigrants or persons with postponed removal, furthermore with refugee status, as beneficiaries of subsidiary protection or enjoying temporary protection.. Accordingly, the option of temporary care under CP Act. is available to families with asylum status leaving the reception centres. Pursuant to CP Act., unaccompanied children arriving to Hungary, shall be given full care and legal representation within the child protection system. In 2011, a children's home was established in the state-funded Károlyi István Children Care Centre in Fót, as a separate specialised unit for providing care to unaccompanied minors. The Hungarian regulation is in line with the provisions of Directive 2013/33/EU of The

European Parliament and of The Council (recast reception directive). If the unaccompanied minor child has an adult relative capable and willing of raising him/her, then in order to unify families, the public guardianship authorities will cooperate to enable the child to be raised in his/her own family, if the information needed to achieve this is available. In our view, this is in the best interest of the child.

Legislative amendments and measures to ensure the care and legal representation of unaccompanied minors to enforce their rights

In Hungary, legal regulations provide that the legal representation of children placed in child protection specialised care, including unaccompanied minors accommodated in children's homes, is assumed by child protection guardians as of 1 January 2014. Child protection guardians are responsible for providing legal representation and representing the rights and interests of children. To this end, child protection guardians act independently in their competence, and are not related to any children care institutions.

There were numerous legislative changes in 2015 to recognise children's rights, and the need for special care of unaccompanied minors:

- In order to ensure the legal representation of unaccompanied minors within the shortest time possible, the Hungarian regulation was amended as of **1 August 2015,** by obligating **the public guardianship authority to assign a child protection guardian for unaccompanied minors, within eight days of receiving the request from the asylum authority.**
- The **Guardianship Department of Government Office for District V of Budapest was designated to deal with all unaccompanied minor's guardianship cases,** including the assignment of a child protection guardian, as a public guardianship authority of first instance, which works with centralized power in all cases of unaccompanied minors, who are placed temporarily in a children's home. Since 15 October 2015, the **Child Protection Centre and Territorial Child Protection Specialized Service of Budapest was designated to deal with child protection guardianship cases of all unaccompanied minors, who apply for asylum and who are placed temporarily into children's home**. Thus, the child protection guardian's **special skills and experience** (knowledge related to asylum proceedings and participating in these kinds of cases) needed for the task are guaranteed. It is important to emphasize, that full child protection services and legal representation by child protection guardians are ensured for all unaccompanied minors irrespective of whether he/she applied for asylum, or not. The **administrating staff of the designated guardianship office was increased** by 3, while that of the **child protection specialised service was extended** by 10 employees, in order to have sufficient capacity to handle the increased amount of work. Government Decree 1545/2015 (VIII. 6.) on the provision of resources necessary for managing the extraordinary immigration pressure also provided for the improvement of the material conditions of these two organizations.
- **Unaccompanied minors are also informed of the person of their assigned child protection guardians**, and the child protection guardian already contacts the minor during the period of the placement process, under which we emphasize the importance of the child protection guardian's obligation to inform the minor. This task is often assisted by an interpreter in the child protection institution.
- **Amendments of legislation entered into force on the 15 October 2015** defines tasks of temporary reception centres and children homes, where unaccompanied minors are placed and specific professional duties are regulated, particularly paying attention to interpretation into foreign languages and ensuring convenient placing and service according to the minor's religious and cultural customs and ensuring the required specialized professional staffing. As a result of modified regulations, the obligatory items of support during the period of crisis caused by mass immigration are clarified and guarantees were provided to enforce children's rights for temporarily placed unaccompanied minors.

Capacity expansions were realized through extra resources provided following decisions of the Government

- **Capacity for unaccompanied minors with temporary placement is constantly expanding in the Károlyi István Children Care Centre in Fót, along** with the human resources and assets needed. In the beginning of 2015, Fót had 34 places for unaccompanied minors, at the moment 72 places are provided. Soon there will be a total of 130 places available. The additional resource is guaranteed by Government Decisions 1519/2015 (VII. 27.) and 1741/2015 (X. 13.). In 2015, **5 additional children's homes and aftercare-homes were involved in supplying unaccompanied minors, who remain persistently in Hungary, are beneficiaries of subsidiary protection or were granted refugee status, as well as young adult beneficiaries of international protection who are supported with aftercare-home run by the state**.
- In order to prepare for the onset of a crisis situation caused by massive immigration, children's recreation institutes in the property management of the Directorate-General for Social Affairs and Child Protection, **were also assigned for the temporary placement of unaccompanied minors**. The resources needed for the renovation is guaranteed by the Government Decision 1741/2015 (X. 13.).

In addition, according to the Government's decision, with the aim of continuous monitoring, **every six months Hungarian authorities prepare a comprehensive report on the situation of children under international protection in Hungary**, in order to facilitate necessary decision-making. The latest (second) report was discussed by the Government in March 2016.

Provision and care of unaccompanied minors

Unaccompanied minors are **entitled for complete, full provision** in the child protection specialised system, regardless of whether they are within interim care or they are placed on the basis of international protection, according to the CPA. and in accordance with the UN Convention on the Rights of the Child.

This includes, inter alia, accommodation, catering, providing clothes and ensuring access to health services, education, development, psychological support as well as useful and organised leisure-time. Five meals a day are part of the full provision. In planning the menu, preparation of meals and ensuring leisure-time, the child protection system takes into consideration the religion and cultural customs of unaccompanied minors.

Unaccompanied minors arriving to Hungary **are given the same provision and care as any children with Hungarian citizenship placed in the child protection system or young adults entitled to after-care provision**, with their special needs taken into account. In addition, it is emphasized that legal representation of unaccompanied minors is regulated in the same way as Hungarian children's legal representation.

Number of unaccompanied minors in the period from June 2015 to June 2016

The number of unaccompanied minors placed in the child protection specialised system is published by the registry of Central Electronic Register about Persons Enlisted (Központi Elektronikus Nyilvántartás a Szolgáltatást Igénybevevőkről, KENYSZI) run by the National Office for Rehabilitation and Social Affairs. The number of children in the children's home contains the number of children, who are actually present on the given days, excluding the number of children leaving without permission.

Date	Number of unaccompanied minors recorded by KENYSZI	Number of children actually present in the children's home
30 June 2015	1669	293
31 July 2015	1813	99
31 August 2015	1749	30
30 September 2015	1575	116
31 October 2015	1194	20
30 November 2015	816	38
31 December 2015	689	18
31 January 2016	561	66
29 February 2016	509	70
31 March 2016	513	96
30 April 2016	888	198
31 May 2016	1117	93
30 June 2016 [2]	1136	75

Based on our experience, **unaccompanied minors do not arrive to Hungary as their intended final destination**, most of them would like to go to Germany or to Scandinavia, and approximately 98% of them leave the institution to continue their journey to the destination country. This takes place during the guardianship proceedings, without any permission to leave the children's homes. The temporary placement of unaccompanied minors should be terminated, if the minor leaves the institute and does not return within 60 days. However, during this period, the assignment of the guardian is still in effect. Therefore, if the minor returns to the children's home, the child protection guardian will re-establish contact with him/her, and the minor's care is thus still ensured.

Only a small proportion of unaccompanied minors placed in the children's home remain in Hungary. However, by comparison with the figures of the last six months, it is clear that **unaccompanied minors stay longer in children's homes and plan to stay in the country than in previous years**. According to the experiences of June 2016, **the number of unaccompanied minors, who stay more than 30 days in the children's home in Fót, is continuously on the rise**: 88 unaccompanied minors stayed in the children's home on 21 June 2016, 28 of them (31.8%) have been placed there for more than 30 days, and 32 out of 64 unaccompanied minors (50%) were staying in the Children's Care Centre of Fót for more than 30 days on 18 July 2016. [3]

At the moment, approximately 70 unaccompanied minors are staying in Hungary permanently. More than 80% of them have already reached the age of 18, they are granted international protection and, according to the decision made by the guardianship authority for their applications, they live in after-home care in the child protection specialised institute. About 20% of them were granted international protection, when they were under age, therefore in accordance with the CP Act., are raised in a Hungarian child protection specialized institute and after reaching the age of 18, they will be entitled for after-care until the age of 24.

Significant fluctuation can be observed in the number of temporarily placed unaccompanied minors, the daily number of actual recipients ranged from 8 to 206 in the first half of the year 2016. However, in the first half of this year, the actual number and the figures registered by KENYSZI are

[2] The number in registry was 962 on 9 August 2016, the number actually present was 44.

[3] 27 out of 44 (61.4%) minors placed in the children's home have been in the institution for more than 30 days.

both significantly lower than the corresponding values of 2015. Ensuring child protection provision, legal representation and dealing with the guardianship cases of unaccompanied minors demand a high degree of flexibility and efficiency from our professionals.

Features of unaccompanied minors

As the overwhelming majority of migrant children and young adults are accommodated in the institution in Fót, the general features of unaccompanied minors can be described using the characteristics of children placed in Fót.

99% of unaccompanied minors arriving to Hungary are male. Their countries of origin are Afghanistan (90%), Syria (9%), Kosovo (3%), and Somalia and Pakistan (1% respectively), as well as other countries (Bangladesh, Egypt, Iraq, Iran and Serbia) (1–4 children). 95% of unaccompanied minors are between the age of 14–18, and 5% under 14.

Their child protection status is temporarily granted for 98% of unaccompanied minors, while there are only 7 children taken into permanent care. This figure shows that the majority of unaccompanied minors are not taken into permanent care, because they leave the institution without permission during the procedure and continue their journey to their destination country..

Accordingly, the majority of children taken into care did not want to reach Hungary as a final destination, but get to Germany, France, other Western or Northern European countries to join their relatives or friends living there. They spend a short amount of time, from 2–3 days to 2–3 weeks in children's homes to rest and recuperate, and then eventually they leave the institutions.

It is not typical that unaccompanied minors arrive together with their siblings. The number of successfully organized international family reunions since 2011 was only 2.