Parliamentary Assembly
Assemblée parlementaire
https://pace.coe.int

COUNCIL OF EUROPE
CONSEIL DE L'EUROPE

Doc. 13215
28 May 2013

Putting an end to coerced sterilisations and castrations

Report[1]
Committee on Social Affairs, Health and Sustainable Development
Rapporteur: Ms Liliane MAURY PASQUIER, Switzerland, Socialist Group

Summary

Coerced, non-reversible sterilisations and castrations constitute grave violations of human rights and human dignity, and cannot be accepted in Council of Europe member States.

There have been rare cases of forced sterilisations in member States in the most recent past: they mostly concern persons with disabilities, as well as a small, but significant number of both sterilisations and castrations which would fall under the definition of "coerced", mainly directed against transgender persons, Roma women and convicted sex offenders. They must stop.

The Parliamentary Assembly should thus urge member States to revise their laws and policies as necessary to ensure that no one can be coerced into sterilisation or castration in any way for any reason; to ensure that adequate redress is available to victims of recent (and future) coerced sterilisation or castration; to issue official apologies and offer at least symbolic financial compensation to surviving victims of coerced sterilisation or castration programmes; and to work towards eliminating prejudice, stereotypes, ignorance and paternalistic attitudes which have a negative influence on the capacity of medical providers to provide vulnerable persons with evidence-based health care respectful of free and informed consent.

1. Reference to committee: Doc. 12444, Reference 3739 of 24 January 2011.

Contents **Page**

A. Draft resolution 3
B. Explanatory memorandum by Ms Maury Pasquier, rapporteur 4
1. Introduction 4
2. A brief history of coerced sterilisation and castration 5
3. Coerced sterilisation and castration: a violation of human rights, human dignity, as well as of sexual and reproductive rights 6
4. Coerced sterilisation and castration in the recent past in Europe 8
4.1. Roma women 8
4.2. Convicted sex offenders 10
4.3. Transgender persons 13
4.4. Persons with disabilities 14
4.5. The marginalised, stigmatised or persons considered unable to cope 15
5. Conclusions and recommendations 15
Appendix – Dissenting opinion by Ms Kateřina Konečná, member of the Committee on Social Affairs, Health and Sustainable Development, on behalf of the delegation of the Czech Republic to the Parliamentary Assembly 17

A. Draft resolution[2]

1. Coerced, non-reversible sterilisations and castrations constitute grave violations of human rights and human dignity, and cannot be accepted in Council of Europe member States.

2. Defining the element of "coercion" in sterilisations and castrations is not as self-evident as defining "forced" sterilisations and castrations, which historically have involved physical force or procedures performed without the knowledge of the victim or without the opportunity for the victim to provide consent. The concept of "coercion" is currently evolving in human rights law, based on the definition of the lack of free and informed consent. Thus, even where consent is ostensibly given – also in written form –, it can be invalid if the victim has been misinformed, intimidated or manipulated with financial or other incentives. New concepts of "emotionally coerced sterilisation" and "pressure that diminishes a patient's autonomy" are currently emerging. Some of these concepts go as far as considering as coercion the lack of freedom from any bias introduced, consciously or unconsciously, by health-care providers, and power imbalances in the patient-provider relationship which may impede the exercise of free decision-making, for example by persons who are not accustomed to challenging persons in positions of authority.

3. In the first half of the 20th century, a considerable number of European States – not just Nazi Germany – engaged in often massive forced or coerced eugenic sterilisation and castration programmes, some of whose victims are still alive. Five groups of people were particularly targeted: Roma women, convicted sex offenders, transgender persons, persons with disabilities, and the marginalised, stigmatised, or those considered unable to cope.

4. There are very few sterilisations and practically no castrations in Council of Europe member States today and in the most recent past which can clearly be labelled as "forced": most of these concern persons with disabilities. However, there is a small, but significant number of both sterilisations and castrations which would fall under the various definitions of "coerced". These are mainly directed against transgender persons, Roma women and convicted sex offenders. Neither forced nor coerced sterilisations or castrations can be legitimated in any way in the 21st century – they must stop.

5. The Parliamentary Assembly believes that clear safeguards need to be built up against future abuses, including preventive work to change mentalities: there is a need to fight stereotypes and prejudice against those who appear "different". There is also a need to fight paternalistic attitudes in the medical profession which facilitate abuse.

6. The Assembly also believes that proper redress to victims of coerced sterilisation and castration needs to be ensured, whoever they are, and whenever the abuses occurred. In recent cases, this includes the protection and rehabilitation of victims and the prosecution of offenders. But in all cases, as rare, individual or historic as they may be, official apologies and at least symbolic compensation must also be given.

7. The Assembly thus urges the member States of the Council of Europe to:

   7.1. revise their laws and policies as necessary to ensure that no one can be coerced into sterilisation or castration in any way for any reason;

   7.2. ensure that adequate redress is available to victims of recent (and future) coerced sterilisation or castration, including the protection and rehabilitation of victims, the prosecution of offenders, and financial compensation which is proportionate to the seriousness of the human rights violation suffered;

   7.3. issue official apologies and offer at least symbolic financial compensation to surviving victims of coerced sterilisation or castration programmes;

   7.4. work towards eliminating prejudice, stereotypes, ignorance and paternalistic attitudes which have a negative influence on the capacity of medical providers to provide evidence-based health care respectful of free and informed consent to vulnerable persons, including through awareness-raising and human rights education.

8. The Assembly encourages the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) and the Council of Europe Commissioner for Human Rights to continue to pay attention to the issue of coerced sterilisations and castrations in Council of Europe member States.

---

2. Draft resolution adopted unanimously by the committee on 25 April 2013.

B. Explanatory memorandum by Ms Maury Pasquier, rapporteur

1. Introduction

1. I would like to begin this explanatory memorandum with a citation of the first paragraph of the motion for a resolution[3] which gave rise to this report, since, for me, it encases the stance the Council of Europe and its Parliamentary Assembly must take on the issue: "Coercive, non-reversible sterilisations and castrations constitute grave violations of human rights and human dignity, and cannot be accepted in Council of Europe member States."

2. The Social, Health and Family Affairs Committee was originally entrusted with the preparation of a report on this issue on the basis of the motion presented by myself and 21 other colleagues. At its meeting in Paris on 16 September 2011, the committee held a hearing with the following experts (and one victim from my own country):[4]

– Ms Gwendolyn Albert, non-governmental organisation (NGO) activist (Czech Republic)

– Ms Bernadette Gächter, victim of a forced sterilisation (Switzerland)

– Dr David Gerber, Consultant Psychiatrist, National Health Service (NHS) Greater Glasgow and Clyde (United Kingdom)

– Mr Stefan Krakowski, member of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) (Sweden)

The hearing provided the committee with a good overview of the problem and possible solutions.

3. The Social, Health and Family Affairs Committee was merged with two other committees by decision of the Assembly with effect from the first day of the January 2012 part-session. It was thus the newly created Committee on Social Affairs, Health and Sustainable Development which considered my outline report[5] during the January 2012 part-session, and authorised a fact-finding visit to Sweden and the Czech Republic. This visit took place on 6 and 7 November 2012 (Prague) and 8 and 9 November 2012 (Stockholm). I am very grateful to my colleagues in the Czech and Swedish parliaments, and the secretariats of the two delegations to the Assembly, who organised the visits excellently. All the meetings I had requested were arranged, and I was thus able to form an informed opinion on the situation in both countries. I would like to underline here that this is not a report on coerced sterilisations and castrations in Sweden and the Czech Republic: it is a report on coerced sterilisations and castrations in the whole of Europe. Most, if not all, Council of Europe member States have practised coerced sterilisations and castrations at some point in time.

4. This is not the first time that the Council of Europe and its Parliamentary Assembly are dealing with the issue of coerced sterilisations and castrations. However, so far, there has been no comprehensive report on or overview of the practice. Instead, it has been dealt with on the basis of reports, for example, on the discrimination of the Roma (in the Assembly,[6] or via recent judgments of the European Court of Human Rights),[7] discrimination of transgender people (former Human Rights Commissioner Hammarberg), or on the situation in specific countries (a CPT report on the Czech Republic as regards convicted sex offenders).

5. The added value I hope to create with this report is a comprehensive, human-rights based approach, which puts coerced sterilisation and castration in a historical perspective, and highlights the link between the practice and the fear of certain sections of the majority of all that appears "different" – and thus deemed inferior, and sometimes threatening, to the point that the majority develops a desire to control these differences, or at least their propagation and reproduction. I was most impressed with the explanations of the Swedish journalist who first focused attention on the country's history of eugenic sterilisation in the 1990s, Mr Maciej Zaremba, which have convinced me that my interpretation of both current and past events is not entirely mistaken. He kindly agreed to come to an exchange of views with the committee on 23 April 2013 in Strasbourg[8] and I will cite him later in this report.

---

3. Doc. 12444.
4. The minutes of the hearing can be found in document AS/Soc (2011) PV 6 add, available from the committee secretariat.
5. Document AS/Soc (2011) 48.
6. For example, in Doc. 12236, "The situation of Roma in Europe and relevant activities of the Council of Europe", opinion tabled on behalf of the Committee on Equal Opportunities for Women and Men (Rapporteur: Ms Elvira Kovács, Serbia, EPP/CD).
7. *V.C. v. Slovakia* (2011), *N.B. v. Slovakia* (2012), *L.G. and others v. Slovakia* (2012).
8. The minutes are available from the Secretariat, document AS/Soc (2013) PV 03 add 2.

6. Five groups of people have been particularly subjected to coerced sterilisation and castration in the past: Roma women,[9] convicted sex offenders, transgender persons, persons with disabilities ("eugenic" motives), and the marginalised, stigmatised, or those considered unable to cope. For me, it is self-evident that coerced sterilisation and castration is a serious violation of human rights and human dignity, and it should thus be abolished once and for all, whatever the motivation and whatever the target group. Even those countries which have abolished the practice sometimes find it difficult to acknowledge that they have committed these serious violations of human rights in the past. Large numbers of victims are thus still awaiting compensation or apologies from the authorities: I hope that this report will make a contribution to changing that situation.

2. A brief history of coerced sterilisation and castration

7. The history of coerced sterilisation and castration fills whole bookshelves. All I can attempt here is the briefest of histories for 20th-century Europe, with a view to explaining how a clear human rights violation could be seen as socially acceptable, even desirable, in many countries – before (and sometimes even after) the horror of 1933 Nazi Germany compulsory sterilisations laws (aimed primarily at Germans with mental or physical disabilities) that ended in brutal killings by eugenic euthanasia as of 1939.

8. Eugenic sterilisation (and to a much lesser extent, castration), popular in many regions of the world in the first half of the 20th century, not just in Europe, was one of the consequences of modern, new ideas in science (including social science) meeting the social, material and political conditions of the turn of the century. In societies with often rapidly expanding "underclasses" of some sort (be they urban proletariats, rural paupers, the immigrant poor, racial or other minorities, or indigenous peoples), conditions were ripe for a marriage of several mutually reinforcing ideas which legitimised eugenics in the eyes of a majority of the population. A combination of (neo-)Malthusianism, social Darwinism, nationalism, racism, and even modernising, reformist zeal made the idea attractive across the political spectrum (from left to right), in both democracies and dictatorships. If a population was to stay "healthy" and "productive" (also in order to be able to compete as a nation during the era of the nation-State), and was not to be swamped by the poor and the criminal, it was going to be necessary to encourage the reproduction of the "fit" and check the birth rate of the "unfit".

9. At the beginning, the theory of eugenics focused more on the "positive" rather than the "negative". In the United States of America, there were, for example "fitter families"-contests and the like. But the fear of "degeneration" (with the birth rate of the "unfit" allegedly out of control), and the burden on society that might ensue, led to the popularisation of negative eugenics, including forced sterilisation, as a more humane alternative to "natural selection" or infanticide. It was the United States which initiated the early 20th-century wave of compulsory sterilisation laws, beginning with Indiana's 1907 Act. It was also in the United States that the Supreme Court judge, Oliver Wendell Holmes, Jr, in the majority decision *Buck v. Bell*, in 1927, gave the (in)famous – never repealed – justification for eugenic compulsory sterilisation laws:

> *"We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. Three generations of imbeciles are enough."*[10]

10. Sterilisation (in particular in institutions such as asylums, prisons or hospitals) thus became fairly widespread by the 1930s, permitted by legislation in many US and Canadian States and provinces, in the Swiss canton of Vaud, in Scandinavian countries, in Germany, Japan, and Veracruz (Mexico), as well as in Yugoslavia, Hungary, Turkey, Latvia, and Cuba.[11] The targeted groups were comprised disproportionately of poor, non-white, or otherwise socially marginalised people,[12] and women were more often targeted than men.

---

9. The term "Roma" used at the Council of Europe refers to Roma, Sinti, Kale and related groups in Europe, including Travellers and the Eastern groups (Dom and Lom), and covers the wide diversity of the groups concerned, including persons who identify themselves as "Gypsies".

10. Cited in: Harry Bruinius, Better for All the World: The Secret History of Forced Sterilization and America's Quest for Racial Purity, 2007, http://betterforalltheworld.brown-bear.com/p3.htm.

11. Philippa Levine and Alison Bashford, "Introduction: Eugenics and the Modern World", in: *Oxford Handbook of the History of Eugenics*, Oxford University Press, 2010, kindle version. The authors also include Czechoslovakia in their list of jurisdictions permitting sterilisations, but they seem to have erred. According to the "Final Statement of the Public Defender of Rights in the Matter of Sterilisations Performed in Contravention of the Law and Proposed Remedial Measures" (Brno, 23 December 2005, JUDr. Otakar Motejl, Public Defender of Rights of the Czech Republic), "the ideas

11. According to Harry Bruinius, the American quest for racial purity influenced the Nazis. Though the United States was the pioneer in the legal, administrative, and technical aspects of eugenic sterilisation, Nazi Germany borrowed its ideas and applied them in an unprecedented way.[13] One of the first laws passed by the National Socialist government of Adolf Hitler was the "Law for the Prevention of Genetically Diseased Offspring" in 1933. At least 375 000 individuals were sterilised by the German authorities, and there were an estimated 5 000 deaths from complications.[14] In the United States, more than 60 000 people underwent forced sterilisation. The practice was largely abandoned after the Second World War, but North Carolina didn't officially end its programme until 1974. Similarly, Sweden's eugenic sterilisation laws created over 60 000 victims from 1935 to 1975. Indeed, while the Scandinavian sterilisation laws did not allow for the use of physical force (unlike Nazi Germany), the eugenic acts were abolished and replaced by sterilisation laws based on voluntary consent in Denmark only in 1967 and 1973, in Sweden in 1975, and in Norway in 1977.[15]

12. Coerced sterilisation and castration is not confined to the history books, as we know, but nowadays the programmes are not, or not openly, eugenic in nature. They range from the coerced sterilisation of women in China and Uzbekistan to that of HIV-positive women in many parts of the world. Although the procedure is performed on both men and women, women are much more frequently victimised because of vulnerable, gender-specific situations such as childbirth, which make them more susceptible to unwanted procedures. As in the past, marginalised communities are most commonly targeted for sterilisation campaigns since they are less protected.[16]

3. Coerced sterilisation and castration: a violation of human rights, human dignity, as well as of sexual and reproductive rights

13. In 1999, the then United Nations Special Rapporteur on violence against women, its causes and consequences, Ms Radhika Coomaraswamy, labelled forced sterilisation a human rights violation:

> *"A severe violation of women's reproductive rights, forced sterilization is a method of medical control of a woman's fertility without the consent of a woman. Essentially involving the battery of a woman – violating her physical integrity and security – forced sterilization constitutes violence against women."*[17]

14. As pointed out in a recent article by Christina Zampas and Adriana Lamačková, United Nations treaty monitoring bodies have noted that forced and coerced sterilisation is a violation of various international human rights, including the right to health, the right to bodily integrity, the right to be free from violence, the right to be free from torture and inhuman and degrading treatment, the right to decide on the number and spacing of children, and the right to be free from discrimination.[18]

15. In his most recent report of 1 February 2013,[19] the United Nations Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Mr Juan E. Méndez, reframed violence and abuses in health-care settings as prohibited ill-treatment. Citing the recent general comment No. 3 (2012) of

---

and proposals of Czech eugenicists are entirely comparable with concepts developed elsewhere in Europe. The only difference is that due to political developments, the eugenic movement in Czechoslovakia never achieved practical implementation of its ideas" (p. 68). It appears that legislation was prepared up until the late 1930s, but not enacted: "More detailed legislative work failed to take place due to political events. War experiences combined with the post-war political developments cast the Czechoslovak eugenics movement into official oblivion" (p. 71), http://www2.ohchr.org/english/bodies/cerd/docs/ngos/Public-defender-rights.pdf.

12. Susanne Klausen and Alison Bashford, "Fertility control: Eugenics, Neo-Malthusianism, and Feminism", in: *Oxford Handbook of the History of Eugenics*, Oxford University Press, 2010, kindle version.

13. Harry Bruinius, "Better for All the World: The Secret History of Forced Sterilization and America's Quest for Racial Purity", op. cit.

14. Paul Weindling, "German Eugenics and the Wider World: Beyond the Racial State", in: *Oxford Handbook of the History of Eugenics*, Oxford University Press, 2010, kindle version.

15. Matthias Tydén, "The Scandinavian States: Reformed Eugenics applied", in: *Oxford Handbook of the History of Eugenics*, Oxford University Press, 2010, kindle version.

16. See a campaign by Advocates for Human Rights, "Stop violence against women", at www.stopvaw.org/forced_coerced_sterilization.

17. United Nations report "Integration of the human rights of women and the gender perspective; violence against women", Report of the Special Rapporteur on violence against women, its causes and consequences, Ms Radhika Coomaraswamy, in accordance with Commission on Human Rights Resolution 1997/44, Addendum, Policies and practices that impact women's reproductive rights and contribute to, cause or constitute violence against women, Economic and Social Council, E/CN.4/1999/68/Add.4, of 21 January 1999.

18. Christina Zampas and Adriana Lamačková, "Forced and coerced sterilization of women in Europe", in: *International Journal of Gynecology and Obstetrics*, 114 (2011), pp. 163-166.

19. www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf.

the Committee against Torture on the right to a remedy and reparation, he underlined that the Committee considers that the duty to provide remedy and reparation extends to all acts of ill-treatment, so that it is immaterial for this purpose whether abuses in health-care settings meet the criteria for torture per se. He believes that "this framework opens new possibilities for holistic social processes that foster appreciation of the lived experiences of persons, including measures of satisfaction and guarantees of non-repetition, and the repeal of inconsistent legal provisions".[20]

16. The United Nations Special Rapporteur thus recommends at the end of his report that member States: "Conduct prompt, impartial and thorough investigations into all allegations of torture and ill-treatment in health-care settings; where the evidence warrants it, prosecute and take action against perpetrators; and provide victims with effective remedy and redress, including measures of reparation, satisfaction and guarantees of non-repetition as well as restitution, compensation and rehabilitation".[21] In the body of his report, he explicitly mentions forced, coerced and involuntary sterilisations as falling within the scope of his report, and gives several examples.

17. In Europe, the European Court of Human Rights has judged the involuntary sterilisation of Roma women a human rights violation in contravention of Article 3 (prohibition of inhuman or degrading treatment) and Article 8 (right to respect for private and family life) of the European Convention on Human Rights (ETS No. 5, "the Convention") in several cases now.[22] However, unfortunately the Court again declined to rule in November 2012 on whether the forced sterilisation of Roma women in the Slovak Republic constitutes discrimination under Article 14 of the Convention. In an unrelated case (not of a Roma woman), *G.B. and R.B. v. Republic of Moldova*, the Court held, on 18 December 2012, that there had been a violation of Article 8 of the Convention.[23]

18. The question of consent is crucial in determining whether or not a sterilisation or castration is a human rights violation. In cases where physical force is used, the victim is sterilised/castrated without his/her knowledge, or is not given an opportunity to provide consent, the case is clear-cut, and referred to as forced sterilisation. But even where consent is ostensibly given, even in written form, it can be invalid if the victim has been misinformed, intimidated, or manipulated with financial or other incentives. This type of coerced sterilisation is the human rights violation at the heart of this report.

19. In the comments on my introductory memorandum of 16 January 2013, the Czech parliamentary delegation claims that my definition of "coercive" is "excessively broad and does not correspond with the term's common meaning". If anything, my definition is not broad enough. Recent human rights publications (from respected sources, such as Amnesty International or the Center for Reproductive Rights, or in academic publications such as the Harvard Human Rights Journal) make reference to terms such as "emotionally coerced sterilization" or to "pressure that diminishes patient's autonomy". One scholar has characterised the concept of coercion as: "how much, and what kind of, influence or pressure deprives actions and decisions of their autonomous character".[24] But perhaps the most convincing is the policy document entitled "Bridging the Gap: Developing a Human Rights Framework to Address Coerced Sterilization and Abortion" published by the (Canadian) University of Toronto Faculty of Law, which details principles of free and informed decision-making – including freedom from any bias introduced, consciously or unconsciously, by health providers, and further refers to the power imbalances in the patient-provider relationship which may impede the exercise of free decision-making, for example by women who are not accustomed to challenging persons in positions of authority[25].

---

20. Ibid., paragraph 84.
21. Ibid., paragraph 85, recommendation *c*.
22. The latest – *L.G. and others v. Slovakia* –, delivered on 13 November 2012, concerned two Roma women and followed the similar cases *V.C. v. Slovakia* (2011) and *N.B. v. Slovakia* (2012). The applicants were sterilised while undergoing caesarean sections at a public hospital. While in the hospital, each applicant was asked to sign a document. They were told the document was required for delivery by caesarean section, and it was not until years later, during an investigation, that the applicants learned that the documents were actually requests for sterilisation. Additionally, the two applicants were legally minors at the time of the procedure, and the hospital also failed to obtain the consent of their legal guardians.
23. This was a case involving the removal of the first applicant's ovaries and Fallopian tubes during a C-section, without obtaining her permission, leading to her early menopause at the age of 32.
24. Definition by Bonnie Steinbock in relation to the concept of coercion and long-term contraceptives, see: "The Concept of Coercion and Long-Term Contraceptives", in: *Moral and Policy Challenges of Long Acting Birth Control*, Ellen H. Moskowitz and Bruce Jennings, Editors, 1996.
25. www.law.utoronto.ca/documents/reprohealth/HC1-BridgingTheGapPolicyBrief.pdf, pp. 8-9.

20. When Mr Zaremba informed the committee at the second hearing on 23 April 2013 about the Swedish experience of eugenic sterilisation, he also answered the question of how the Swedes had been able to continue their programme after the Second World War, which should have discredited a system based on coercion. Mr Zaremba underlined the insidious character of the law: "On paper, the sterilisation was 'voluntary' – a person had to apply to be sterilised. In reality, of course, the sterilisation was anything but voluntary: the victims were under irresistible pressure to sign the consent forms. They were threatened with losing custody of their children, or their discharge from an institution was made dependent on their agreement to be sterilised. The stigma of being labelled an 'inferior' human being was immense: most victims stayed silent about their fate until the scandal broke in 1997. Poor single mothers, vagabonds, gypsies and travellers, the mentally sick and the 'feeble-minded' (people who broke social norms) were targeted as 'undesirable human material' (contemporary citation). There had been a complete lack of transparency, a commission decided on the sterilisation, and there was no possibility to appeal that decision."[26] I think that this is an instructive example illustrating the way sterilisation can be considered "voluntary" by some, but is in reality "coerced" or even "forced".

21. In this context it is important to note that the International Federation of Gynaecology and Obstetrics (FIGO) has strong guidelines on "Female Contraceptive Sterilisation," recognising the long history of forced and coerced sterilisation of marginalised women and providing detailed recommendations for when and how consent to sterilisation can be obtained.[27] The guidelines, updated in 2011, specify, amongst others:

– Only women themselves can give ethically valid consent to their own sterilisation. Family members, including husbands and parents, legal guardians, medical practitioners and public officials cannot consent on their behalf.

– Sterilisation should not be performed within a government programme or strategy that does not include voluntary consent.

– Sterilisation to prevent future pregnancy is never an emergency procedure and does not justify departure from general principles of free and informed consent.

– Consent to sterilisation should not be made a condition of access to medical care, such as HIV/AIDS treatment, delivery of a baby, or termination of pregnancy, as well as any other benefit, such as medical insurance, social assistance, employment, or release from an institution.

– Consent to sterilisation should not be requested when women are vulnerable, such as when requesting termination of pregnancy, going into labour, or in the aftermath of delivery.

– Women considering sterilisation must be informed that it is a permanent procedure, which does not protect against sexually transmitted diseases, and provided information on non-permanent options for contraception.

– Information should be provided in a language that the women understand, through translation if necessary, in plain, non-technical terms, and in an accessible format, including sign language or Braille.

4. Coerced sterilisation and castration in the recent past in Europe

4.1. Roma women

22. Roma women have long been victims of marginalisation and discrimination, wherever they live. Some countries have had more or less official, government-sponsored programmes in the past targeting Roma women for sterilisation; in other countries, Roma women have become victims of prejudice held by individual health-care providers. The cases of the Czech Republic and of the Slovak Republic (and, to a lesser extent, Hungary) are particularly well-known, mainly due to the activism of the victims themselves in their quest for justice. However, this means neither that coerced sterilisations of Roma women are still common practice in these countries, nor does it mean that they do not happen in other countries. Since the Czech Republic so kindly received me for a fact-finding visit in November 2012, I will describe the situation in this country in some more detail.

26. AS/Soc (2013) PV 03 add 2, pp. 1-2.

27. For the full guidelines and recommendations, please see www.figo.org/files/figo-corp/English%20Ethical%20Issues%20in%20Obstetrics%20and%20Gynecology.pdf (pp. 122 ff).

4.1.1. The Czech Republic

23. In her presentation to the Social, Health and Family Affairs Committee in September 2011, Ms Gwendolyn Albert, an NGO activist from the Czech Republic, explained that in communist Czechoslovakia, Roma women were forcibly sterilised starting in the 1970s, and the practice continued after the 1989 transition to democracy and the 1993 breakup of the country into the Czech Republic and the Slovak Republic.[28] While the exact numbers of victims put forward by Ms Albert are in dispute, it is undisputed that during communism, tubal ligation was disproportionately promoted to Roma women by social workers, to address what was officially termed their "high, unhealthy" reproduction rate compared to the non-Roma population, using either the promise of financial incentives or the threat of various sanctions to coerce or force compliance. After the Czechoslovak Prosecutor-General reviewed these incidents post-1989, incentive payments for sterilisations were discontinued. Subsequent instances of forced sterilisations did not involve social workers; instead, doctors sterilised Roma women during C-section deliveries, often telling them that not only the C-section but the sterilisation itself had been "emergency, life-saving" measures.[29]

24. The case of Ms Elena Gorolová, Spokesperson of the "Group of Women Harmed by Forced Sterilization", whom I had the privilege to meet, is a case in point: following a risk pregnancy entailing regular doctor's visits, she was sterilised without her knowledge during her second C-section in 1990. The doctor told her he had sterilised her only the day after. Just before the C-section, she was made to sign two papers: one for the name of the child, the other to consent to the C-section (and, as she later found out, to the sterilisation). She was one of the first Roma women to speak out and raise the issue with the Czech ombudsman in 2004. Silence is unfortunately often the norm in coerced sterilisation cases, as many victims feel shame, fear or unworthiness, in particular since the Roma culture puts such a premium on women having many children, and also because there is often a certain distrust of the authorities.

25. In November 2009, the Czech Government expressed regret for "individual failures" in the performance of sterilisations by tubal ligation. Complaints about the programme were filed with the ombudsman in 2004. After ordering a Czech Health Ministry investigation, the ombudsman then criticised the ministry in 2005 for failing to conclude that the documented procedures violated not only human rights, but also the law. The ombudsman's report became the basis for international human rights bodies to recommend that the Czech State take urgent action to redress the victims of these practices. Criminal investigations into these incidents were shelved and none of the perpetrators have been subjected to civil, criminal or professional sanctions. Civil lawsuits brought by individuals have only rarely resulted in compensation awards due to statutes of limitations[30] (I am aware of only two such successful cases).

26. However, in 2011, the Czech Human Rights Committee recommended that the victims of coerced sterilisations be awarded compensation. The proposal is still being discussed, as some cases are hard to prove. In view of the fact that the number of victims entitled to such reparation would be relatively low (following a call for applications from NGOs, the Ministry of Health believes that out of a total of 89 applications received, 77 are valid, the Ministry believing to have established that in 12 cases, no sterilisation had been performed), I do hope that the country can quickly decide to compensate these women. Indeed, my fact-finding visit left me with the impression that there is broad agreement across the political spectrum that the issue needs to be settled soon.

27. On 1 April 2012, the Czech Republic adopted a new law on sterilisation which seems to be more in conformity with the FIGO guidelines on female sterilisation than the previous one (I will deal with the questions of castration and of sterilisation of women without legal capacity in separate chapters). Thus, the new law institutes obligatory waiting periods between a doctor's proposal of sterilisation and the actual operation, and requires a last-minute second consent the day of the operation. The minimum age for sterilisation is 18 for health reasons, and 21 for other reasons (contraception). Most importantly though, doctors' attitudes to sterilisation seem to be changing in the Czech Republic, as they become more aware of possible human rights implications – and a little less paternalistic in their attitudes.[31]

28. See the declassified minutes of the hearing, AS/Soc (2011) PV 06 add.
29. Ibid, pp. 4-5.
30. See the minutes of the hearing, AS/Soc (2011) PV 06 add, p. 5. I would add that these statutes of limitations may well have been amongst the reasons which discouraged victims from bringing court cases in the first place.
31. Assessment of Ms Anna Šabatová, Chairperson of the Czech Helsinki Committee, whom I also had the privilege to meet.

4.1.2. Slovak Republic

28. Roma women were also forcibly sterilised in the Slovak part of Czechoslovakia starting in the 1970s. By 2002, Roma women were still being sterilised without their informed consent, according to human rights activists. The government investigated for "genocide" and found no evidence of it. International observers in the Commission on Security and Cooperation in Europe (United States), called the investigation flawed because human rights activists and potential victims were threatened with criminal charges for speaking out. In that same year, the Council of Europe's Commissioner for Human Rights said he found the allegations credible, recommending that the government "offer a speedy, fair, efficient, and just redress" to the victims. In 2006, the Slovak Constitutional Court ruled that the government's report had not adequately clarified the facts and ordered the investigation into forced sterilisation to be re-opened. But in 2007, after interrogating the alleged perpetrators and victims, the Slovak Prosecutor announced no crime had been committed or rights violated, and discontinued the proceedings. Several cases have recently been judged by the European Court of Human Rights, finding in favour of the applicants (see paragraph 17).

4.2. Convicted sex offenders

29. As Stefan Krakowski, the Swedish member of the CPT, remarked at the September 2011 hearing, there seems to be a growing trend from political quarters in at least some member States, demanding castration for convicted sex offenders. Although surgical castration on other than somatic indications is still legal in many countries, it is either no longer carried out or has become extremely rare. One reason is alternative options in the combining of psychotherapy, anti-androgen treatment and intensive monitoring.[32]

30. The CPT has expressed its fundamental objections to the use of surgical castration as a means of treatment of sexual offenders. The reasons given by Mr Krakowski on behalf of the CPT were:

– Firstly, such an intervention has irreversible physical effects; it removes a person's ability to procreate and may have serious physical and mental consequences.

– Secondly, surgical castration is not in conformity with recognised international standards, and more specifically, is not mentioned in the authoritative "Standards of Care for the Treatment of Adult Sexual Offenders" drawn up by the International Association for the Treatment of Sexual Offenders (IATSO).

– Thirdly, there is no guarantee that the result sought (namely a lowering of the testosterone level) is lasting. As regards re-offending rates, the presumed positive effects are not based on sound scientific evaluation. In any event, the legitimate goal of lowering re-offending rates must be counterbalanced by ethical considerations linked to the fundamental rights of an individual.

– Fourthly, given the context in which the intervention is offered, it is questionable whether consent to the option of surgical castration will always be truly free and informed. A situation can easily arise whereby patients comply rather than consent, believing that it is the only available option open to them to avoid indefinite confinement. To sum up, surgical castration is a mutilating, irreversible intervention and cannot be considered as a medical necessity in the context of the treatment of sexual offenders. In the CPT's view, surgical castration of detained sexual offenders could easily be considered as amounting to degrading treatment.[33]

31. The CPT has criticised both the Czech Republic and Germany[34] for recent recourse to surgical castration. However, laws introducing compulsory "chemical" castration, in particular for sex offences against minors, are also becoming something of a trend in some member States, such as Poland and the Republic of Moldova. I personally oppose such laws as both ineffective and a violation of human rights. However, "chemical" castration is, in general, considered reversible, and thus the scale of the violation is not as high as with surgical castration. This is why I had originally decided to concentrate on coerced surgical castration in this report.

---

32. See the declassified minutes of the hearing, AS/Soc (2011) PV 06 add, pp. 7-8.
33. Ibid.
34. According to Mr Krakowski, in the case of Germany, resort to surgical castration appears to be quite rare, not only in Berlin but throughout Germany. According to unofficial statistics available to the committee, during the last ten years, the total number of surgical castrations of sexual offenders in Germany has been fewer than five per year. Moreover, in Berlin, more than half of the applications which had been submitted since 2001 (five out of nine) were rejected by an expert commission, composed of two doctors (including one psychiatrist) and a judge; and no application had been submitted to the expert commission during the past two years.

32. However, following a conversation I had with Dr Jean-Georges Rohmer, Psychiatrist at Strasbourg Hospital and Regional Head of the centre responsible for treating perpetrators of sexual abuse, on the margins of the 11th Network meeting of the contact parliamentarians committed to stopping sexual violence against children, on 22 January 2013, I would like to underline his view that it is a common misconception that sexual crimes are mainly linked to "sex" (and sex drive). As has been proven in relation to violence against women, the main motivation for a man to rape a woman is usually one of power: by abusing a woman in this most intimate way, the damage to the victim is not just physical, and this procures a feeling of absolute power to the rapist. (This is also the reason why in all-male settings such as prisons, it is common for heterosexual men to rape other men). Dr Rohmer underlined that in treating sex drive (both through chemical or surgical castration), the offender's main pathology – that of wanting power over other human beings – was left untreated. Such offenders had a great propensity to re-offend in other than sexual ways, for example, by torturing future victims.

33. Following this conversation, I decided to invite the CPT's most eminent current expert on both chemical and surgical castration, Ms Veronica Pimenoff from Finland, to our committee's meeting in Strasbourg on 23 April 2013, to shed further light on the matter. A sub-chapter on chemical castration can be found below.

34. It appears that the Czech Republic is the only member State of the Council of Europe which has used surgical castration extensively in the recent past, which is why I will be concentrating on the findings from my November 2012 fact-finding visit there.

4.2.1. Surgical castration: The Czech Republic and Finland

35. It is my feeling after having spoken to many eminent doctors and politicians during my visit that they honestly believe that some sex offenders should be allowed to opt for surgical castration as the treatment of last resort in the rare cases where all other treatment options have been exhausted.

36. Following diagnosis as a sexual "paraphiliac" based on the Czech courtship disorder theory, a convicted sex offender is referred for compulsory "protective" treatment either after serving a prison sentence or immediately, some as outpatients, but most in a psychiatric hospital. According to the members of the Czech Sexuological Association whom I met,[35] about 10% of sexual offenders are sexual deviants who have need of such treatment. They considered that since such patients remained dangerous during their whole lifetime, the only way of substantially decreasing the high risk of their causing harm to others and thus enabling their reintegration into the community is to offer them treatment which helps them to manage their sexual impulses.[36] Such treatment comprises primarily psychotherapy, sociotherapy and the use of psychotropic and anti-libidinal drugs, but, where such treatment is not efficient or is contraindicated for health reasons, also surgical castration. They considered the side effects of surgical castration to be minimal (a tendency to obesity, osteoporosis and depression). Sterilisation was not the aim: the possibility of storing sperm in a sperm bank was offered, but not many took it up.

37. A visit to the Bohnice Psychiatric Clinic was kindly arranged for me, which has a 20-bed residential programme of such "protective" treatment. As explained by its Director, Mr Martin Hollý, the three pillars of this comprehensive treatment are biological treatment (including chemical castration, and surgical castration only as a last resort), psychotherapy and sociotherapy. Ten surgical castrations had been performed in the hospital in 10 years, the last three in February 2012. I was able to speak to a patient on whom the procedure had been performed one-and-a-half years earlier, a young man who had been treated in the hospital since 2006 after having served an eight-year prison term for having raped and murdered a woman at the age of 16. He considered that his biggest problem was aggressiveness and a high sex drive due to very high testosterone levels. He had tried chemical castration, but had not liked the side effects and had not been able to control his sexual impulses. He had wanted to be "calmer" – he had thought about surgical castration for a month before deciding to undergo the procedure. He reported no longer feeling so aggressive or having such a high sex drive, but said that he now had a good sex life and felt happier. He had been offered the possibility of having his sperm stored, but had decided he didn't want children. He was due to be conditionally released in January 2013.

38. The Czech Republic reports low recidivism rates for surgically castrated sex offenders, but the evidence presented to me seemed outdated and/or anecdotal. It is thus to be welcomed that a new two-year study is being prepared on behalf of the government following the entry into force of the new law on 1 April 2012.

---

35. Mr Petr Weiss and Mr Jaroslav Zvěřina.

36. According to the comments of the Czech national parliamentary delegation on my introductory memorandum of 16 January 2013, the treatment is based on "comprehensive adaptation therapy".

Similar to the changes regarding female sterilisation, the changes are meant to provide more safeguards against abuse regarding surgical castration of sex offenders – not only as a reaction to international criticism of the old legal provisions, but also to domestic criticism.[37] There has been no surgical castration since the entry into force of the new legislation.

39. As the Deputy Minister of Health explained to me during our meeting, the new law makes the following requirements for surgical castration: the person must have committed a violent sexual offence, have been diagnosed with sexual deviation and a high probability of recidivism. All other methods must have failed or be contraindicated. Upon a written application of the patient and his informed consent, a central Ministry of Health Committee must authorise the procedure after having heard the patient. The procedure is now not allowed to be used in prison. The minimum age for surgical castration is 25; no castration of incapacitated patients is permitted.

40. Like Ms Monika Šimůnková, the Czech Commissioner for Human Rights, whom I also had the pleasure to meet, I do appreciate the new legislation and the much stricter rules. However, like the CPT, I remain unconvinced of either the efficacy of the intervention or the validity of the free consent of a person whose choice may be between lifelong detention in a psychiatric clinic or surgical castration. I believe that every human being has inalienable rights, including offenders, and that society must find a way to preserve these rights. It is a question of human dignity.

41. In this context, I would also like to mention the Finnish experience, which Ms Veronica Pimenoff, Psychiatrist and Head of Department of Helsinki University Psychiatric Hospital (Finland), included in background information she shared with me on the occasion of the second hearing on 23 April 2013. Ms Pimenoff has so far looked into 85 files of men who in the time space of 1950 to 1970 according to the castration law of that time could have been castrated against their will because they had committed sexual offences like incest, sexual abuse of children, homophilia (a crime at that time), zoophilia or rape. None of the men concerned were castrated because the central medical authority did not think that they would be dangerous. The interesting point is that the files contain the opinion of the men concerned, written down themselves by hand. They are of different length and reveal different levels of education. All the men had been explained the consequences of the surgical castration threatening them, and many men came from an agricultural background and knew something about castrating animals. All the persons (in the 85 files thus far examined) vehemently opposed the intervention. Many wrote that they could not go back to society and family if they were castrated and viewed surgical castration as destroying their life and being worse than death. A very important thing is that all these men were in prison (for some months up to eight years), they knew that they would come out on a defined date. They did not have to choose between freedom and being castrated, but they felt that they could not meet other people in the outside world as accepted citizens if they were castrated. I believe that this Finnish experience – though historical – strengthens my argument on human dignity.

4.2.2. "Chemical" castration

42. From the available scientific evidence, Ms Pimenoff underlined at the Committee's second hearing on 23 April 2013 that both surgical and "chemical" castration of a sexual offender offered no guarantee that the person would not re-offend, in particular if the offender was in denial (as was frequently the case), since a simple injection of testosterone could bring his hormone levels to pre-castration levels. The only guaranteed result of castration was a loss of reproductive ability, as well as a very likely loss of self-esteem. She cited the definition of the European Court of Human Rights on what constituted degrading treatment (or punishment) in the sense of Article 3 of the European Convention on Human Rights. She believed that surgical castration fitted this description, although the European Court of Human Rights had yet to rule on such a case. She emphasised that the right to be protected from degrading treatment or punishment was an absolute right which could not be derogated from, no matter how heinous the crime of the offender.

43. Ms Pimenoff emphasised that there was no demonstrable evidence-based effect on reoffending rates with "chemical" castration either. However, in combination with psychotherapy amongst motivated patients, it could perhaps be regarded as a valuable supplement. However, was this treatment not degrading simply because it could be stopped? In particular as there was no guarantee that all sexual functions could be restored after longer-term use? This was why the Council of Europe Convention on the Protection of Children

37. Ms Monika Šimůnková, the Czech Commissioner for Human Rights, pointed out during our meeting that the government council of human rights' committee on torture and inhuman treatment had recommended a moratorium on castration until the Government adopts a final decision on this issue. Ms Anne Šabatová, the Chairperson of the Czech Helsinki Committee, alleged that in the past there had been cases of non-violent defendants being surgically castrated.

against Sexual Exploitation and Sexual Abuse (Lanzarote Convention, CETS No. 201) protected offenders from mandatory castration, and only allowed for "chemical" castration on a voluntary basis with the free and informed consent of the offender.

44. Ms Pimenoff thus confirmed the findings of the CPT as presented by Mr Krakowski already two years ago. Indeed, she has also furnished me with an impressive list of scientific literature on which she has based her findings. I thus believe even more strongly than before that even "chemical" castration, when it is coerced (or mandated by law), is a violation of human rights and human dignity, made worse by its inefficacy. The recent legislation mandating "chemical" castration of certain sex offenders (such as those having committed sexual violent crimes against children) in Poland and the Republic of Moldova is thus clearly the wrong way to go. As a Parliamentary Assembly committed to human rights, we must work with the parliaments of these countries to repeal these laws now, and should not wait for a ruling of the European Court of Human Rights which may come too late to right the wrong. I realise that my position on this issue is not a popular one, since populist pressure on parliamentarians to be seen to "act decisively" to protect children against sexual violence is strong, and mandating castration for sexual offenders is therefore popular in many quarters. However, we know from history that mandatory castration – namely coerced or forced castration – is a slippery slope… and calls for the death penalty for certain sexual offenders will be next. It is up to us to raise the awareness of the general public that there are ways to protect children against sexual violence which are both more effective and more respectful of human rights.

4.3. Transgender persons

45. In many European countries, either sterilisation or sex-reassignment surgery or both are a requirement for the country to legally recognise a transgender person in his or her new gender. According to RSFL, the Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights, 29 out of the 47 Council of Europe member States have a sterilisation requirement. According to the United Nations Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Mr Juan E. Méndez, in 11 States where there is no legislation regulating legal recognition of gender, enforced sterilisation is still practised. Few countries are as progressive as the United Kingdom, with its Gender Recognition Act of 2004, which could serve as model legislation in this field. I would like to concentrate on the case of Sweden here, which kindly received me on a fact-finding visit at the time of immense change in transgender legislation in the country.

4.3.1. Sweden

46. The current law on the sterilisation of transgender persons applicable in Sweden dates from 1972. It was the first legal recognition of transgender persons internationally. A Swedish citizen over 18 years old could be legally recognised in his/her new gender if the person was not married (which implies divorce for some people), and was sterile (either sterilised or naturally unable to reproduce). As the responsible officer on the Swedish National Board of Health and Welfare explained, the sterilisation requirement was due to a certain wish of the government at the time to "keep an order in the system"[38] – sterilisation was a way to ensure there would be no pregnant men.

47. It is unclear how many sterilisations of transgender persons have taken place since the law came into effect, but around 600 people have been registered in their new sex since then. It can be assumed that most of them will have been surgically sterilised as a requirement for the legal recognition in their new sex. Currently, around 50 applications for sex change are received every year (only a very small number of which are refused – because of a refusal to divorce or be sterilised). Interestingly, the 1972 law does not make sex-reassignment surgery a requirement for the legal recognition of the sex change.[39] But the sterilisation requirement of 1972 is a complete one: even sperms or eggs in banks need to be destroyed.

48. The Swedish National Board of Health and Welfare[40] now recognises these sterilisations as coerced, as persons do not want to be sterilised, but only consent in order for their sex change to be legally recognised. After a huge national debate,[41] the Swedish Parliament passed a law abolishing the sterilisation requirement with effect from 1 July 2013. However, the Forensic Legal Council (an independent legal body within the Board) of Sweden's National Board of Health and Welfare decided very recently not to appeal a verdict of the

38. Meeting with Ms Linda Almqvist, Legal advisor, Department of Regulations and Licenses, Swedish National Board of Health and Welfare.
39. Probably also because the results of woman to man surgery are apparently still not very satisfactory.
40. Which spearheaded two investigations into the matter, in 2007 and in 2010, with very different conclusions.
41. Sparked by the refusal of a very small minority party in the government coalition, the Christian Democrats, to agree to the repeal of the sterilisation requirement.

Administrative Court of Appeals, namely that the sterilisation requirement in order to change a legal gender marker is a violation of Swedish constitutional law as well as of the European Convention on Human Rights, which means the verdict stands. So this will mean that anyone wishing to apply for a change of a gender marker and personal identification number (in Sweden frequently used in almost every form for interaction with authorities, schools, universities, contract partners and services) can already do this pending the entry into force of the new law itself on 1 July 2013. The requirement not to be married was already abolished by a parliament decision of June 2012 which came into force on 1 January 2013, and which also widens the scope of the law to Swedish residents.

49. The next question now facing Sweden is whether transgender victims of coerced sterilisation should be compensated by the State (as were the victims of the historic eugenic sterilisation programme). Victim groups and NGOs[42] are asking for 200 000 Swedish Crowns[43] and an official apology for the suffering caused. The hope is that legislation will be forthcoming, so that a class action suit and a fight in the courts can be avoided. But, as in other countries, one of the problems is a rigid and paternalistic mindset amongst some members of the medical profession.[44] Indeed, quality health care in general for transgender persons is a problem in many countries, but this is not the subject of this report.

50. It is interesting to note that, in his most recent report, the United Nations Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment calls on all States "to repeal any law allowing intrusive and irreversible treatments, including forced genital-normalizing surgery, involuntary sterilization, unethical experimentation, medical display, "reparative therapies" or "conversion therapies", when enforced or administered without the free and informed consent of the person concerned".[45] He also calls on them to outlaw forced or coerced sterilisation in all circumstances and provide special protection to individuals belonging to marginalised groups. It should be obvious that I fully share his opinion.

4.4. Persons with disabilities

51. Article 23(1) of the United Nations Convention on the Rights of Persons with Disabilities imposes the duty upon States to ensure that "persons with disabilities, including children, retain their fertility on an equal basis with others".

52. The World Health Organization (WHO) estimates that over a billion people in the world, or approximately 15% of the global population, have disabilities. According to a WHO report, disabled women are particularly vulnerable to involuntary sterilisation. Forced sterilisations on disabled women are often performed under the auspices of medical legal services or with the consent of court-appointed guardians, who have the authority to decide on behalf of the patient. Various justifications are offered for the procedure, including disabled women's inability to parent, protection from sexual exploitation and abuse, population control, or so-called "menstrual management".[46]

53. The United Nations Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment devoted a whole section of his recent report to "persons with psychosocial disabilities".[47] In his recommendations, he specifically recommends that member States "revise the legal provisions that allow … any coercive interventions or treatments in the mental health setting without the free and informed consent by the person concerned",[48] after having noted the wide documentation of forced sterilisation of girls and women with disabilities.[49]

---

42. Such as RFSL, the Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights.
43. The victims of the eugenic sterilisation programme received 175 000 Swedish crowns in 1999.
44. One doctor had made the continuation of hormone therapy dependent on the patient's consent to sterilisation only three weeks before our November 2012 fact-finding visit. Many doctors are quick to propose sterilisation – even the removal of reproductive organs – to both transgender and intersex people, also in cases where there is a lack of medical indications. Some doctors consider the wish to have children a contraindication to the transgender diagnosis (and without an official diagnosis, there is no official treatment either, of course). One transgender person we met found it ironic that being transgender is considered one of the few mental disorders curable by surgery.
45. Op. cit. (footnote 17), paragraph 88.
46. Malgorzata Stawecka, Involuntary Sterilisation Threatens Rights of Disabled Women, 20 September 2012, www.ipsnews.net/2012/09/involuntary-sterilisation-threatens-rights-of-disabled-women.
47. Op. cit. (footnote 17), section IV.*D*.
48. Op. cit. (footnote 17), paragraph 89.*d*.
49. National law in some countries allows for the sterilisation of minors who are found to have severe intellectual disabilities, according to his report.

54. In 2011, five women with mental disabilities brought their case before the European Court of Human Rights (*Gauer and Others v. France*). Each had involuntary undergone the process of tubal ligation without their informed consent. Unfortunately, the case was declared inadmissible on technical grounds at the close of 2012. I hope that another case will be brought before the Court which will allow for a judgment on the merits.

4.5. The marginalised, stigmatised or persons considered unable to cope

55. During our fact-finding visit to Sweden, we had the privilege to meet with Mr Maciej Zaremba, a journalist whose articles in 1997 brought the eugenic sterilisation laws of women back into the limelight, and sparked national discussion and soul-searching, and who also brought his conclusions to the committee at the second hearing on 23 April 2013. Although the sterilisation programme is historic, and has to be understood in this historical context (see chapter 2), I think it is worth giving some more details on the functioning of this programme.

56. As a result of centralised administration from the very start, the files of more than 60 000 people sterilised from 1935 to 1975 are still available at the archives of the Swedish National Board of Health. Looking through some of these files, Mr Zaremba was struck at how little it took for a woman or a young girl to be targeted for sterilisation. A sample of some of the reasons given included: the wearing of red nail polish, "Carmen"-looks (this may refer to "Gypsy"-lineage[50]), or being a young, poor virgin living close to army barracks. Mr Zaremba underlined that the practice was directed mainly against women who risked becoming a burden to the developing Swedish welfare state. A lack of morality was quickly interpreted as a lack of intelligence, as another eminent historian we met, Mr Matthias Tydén, pointed out: The target groups for eugenics – "mental defectives" in particular – were described as unsuitable parents and a burden to society. This was later widened to include the "socially" as well as the genetically unfit for sterilisation. Sterilisations were initiated not only in mental hospitals and institutions for the mentally disabled, but also by local-level social workers, and, according to Mr Zaremba, even local (Lutheran) parish priests.

57. On paper, the laws were based on voluntariness, except operations "without consent" following third-party applications, in cases of "severe mental deficiency" or "legal incompetence". It was nonetheless coerced sterilisation, as it was nearly always under pressure, as a precondition for discharge from a mental institution, from a home for the "feeble-minded", or for permission to get a "eugenic" abortion. At the height of the programme (in the years after 1945), 80 to 100 decisions were taken per day by the Board's Committee which ordered sterilisation – and which could not be appealed.[51]

58. As in many countries, women who had been coercively sterilised under the programme mostly maintained silence – sterilisation was considered shameful, as it had been targeted at people who were deemed to be worthless ("*minderwertig*"). When the practice came to light in 1997, an official apology was tendered, describing the programme as "barbaric", and a commission was quickly established to look into the details and make recommendations, including on compensation. In the end, financial compensation of 175 000 Swedish crowns (around 20 000 euros) was paid out to some 1 600 individuals sterilised against their will or under questionable circumstances (from more than 2 000 applications).

5. Conclusions and recommendations

59. During the committee hearing in September 2011, I was particularly touched by the testimony of Ms Bernadette Gächter, a victim of forced abortion and sterilisation in 1972 at the age of 18 in my own country, Switzerland.[52] Much of her testimony mirrors that of what can be found in the Swedish archives of eugenic sterilisation. When I started working on this report, she had never received an apology from the State, let alone compensation, unlike her fellow victims in Sweden. I am glad to report that this has changed: on 11 April 2013, a solemn ceremony was held in Bern for all victims of "forced administrative measures", including of forced sterilisations, during which an official apology was given on behalf of the Swiss Government by its member, Ms Simonetta Sommaruga. A round table under the Chairmanship of the new Delegate for victims of

---

50. There were few Sinti (and practically no Roma) in Sweden. One group which was targeted were the "Tartari", poor travellers (tinkers) considered "gypsies" by most Swedes at the time, but who had local origins. It is estimated that only between 500 and 1 000 Tartari women were sterilised, as they avoided the authorities as much as they could. Some women of the Sami minority were also targeted for sterilisation.

51. It is ironic in a way how the German law, which allowed physical force to be used, foresaw (and put into practice) a right of appeal, while the Swedish law did not, but, though mostly eschewing force, arrived at its end using blackmail and manipulation.

52. See the minutes of the hearing, document AS/Soc (2011) PV 6 add, and the book which Ms Gächter has written: www.medienarbeit.ch/buecher-widerspenstig.php.

forced administrative measures, Mr Hansruedi Stadler, will now consider legal, historical and financial aspects which must follow. I warmly welcome these developments and hope that the round table negotiations can quickly be brought to a satisfactory conclusion.

60. My conclusion from the foregoing is twofold:

– We must put an end to coerced sterilisation and castration. Who can read Ms Gächter's testimony or the history of eugenic sterilisation all over Europe without feeling an overwhelming sentiment of "Never again!"? There is an urgent task for us as parliamentarians to revise our laws and review our State policies in order to build up clear safeguards against future abuses. We need to prevent coerced sterilisation and castration also by working for a change in mentalities: we need to fight stereotypes and prejudice against those who appear "different" and thus sometimes considered by the bigoted to be worth less, be they Roma women, sex offenders, transgender persons, persons with disabilities, or any other marginalised or stigmatised group. We must fight paternalistic attitudes in the medical profession and raise awareness of coerced sterilisation and castration as a serious human rights violation which brings shame not on the victims, but on the perpetrators.

– We must ensure proper redress to victims of coerced sterilisation and castration, whoever they are, and whenever the abuses occurred. In recent cases, this includes the protection and rehabilitation of victims and the prosecution of offenders. But in all cases, as rare, individual or historic as they may be, official apologies and at least symbolic compensation must also be given. Only then will we have lived up fully to the ideals of the Council of Europe.

Appendix – Dissenting opinion by Ms Kateřina Konečná, member of the Committee on Social Affairs, Health and Sustainable Development, on behalf of the delegation of the Czech Republic to the Parliamentary Assembly[53]

Regarding surgical castration, the rapporteur states that she remains unconvinced of either the efficacy of the intervention or the validity of the free consent of a person whose choice may be between lifelong detention in a psychiatric clinic or surgical castration. It appears from the explanatory memorandum that if the possibility of being released is part of the patient's calculation when he considers whether to choose a treatment such as medical or surgical castration, the resulting consent cannot be free and therefore the treatment he has chosen is coerced. In this dissenting opinion, we explain the reasons for which we cannot agree with these assertions.

There is no doubt about the real risk some persons suffering from mental disorders present to themselves and/or to others. It is therefore generally accepted that, in high risk cases, the patient can be involuntarily placed into a psychiatric establishment. Once confined, the patient should be able to benefit from adequate medical treatment suited to his condition and based on his free and informed consent. Certainly, such treatment, based on sound medical diagnosis, must be therapeutically efficacious and therefore not a form of punishment or solely a mechanism of social control (as was the case of eugenic practices).

Regarding the patients who are confined to a psychiatric hospital by a court order, it is clear that due to the nature of their circumstances they are rightly regarded as vulnerable and should therefore be given special ethical considerations. However, provided they are competent, they should not be considered as incapable of making a free and informed decision and should not be denied access to a treatment which has a therapeutic benefit. Instead, such a treatment should be made available on the condition that it is accompanied by appropriate procedural safeguards, such as a review by an independent body.

It is often overlooked that the group of people to which various forms of treatment, including medical and surgical castration, are made available are not sex offenders in general, but only a small subgroup of those who suffer from paraphiliac disorders. This subgroup is defined primarily by medical diagnosis, not by criminal behaviour. They are treated primarily as patients, not as offenders.

Paraphiliac disorders are internationally recognized mental disorders listed in the World Health Organization classification manual.[54] Their causes are complex and include various psychological, organic and other factors. Consequently, their treatment is equally complex and comes in various forms, depending on the type and intensity of the disorder.

It is generally recognized that such treatment comprises primarily psychotherapy, sociotherapy and the use of psychotropic drugs. Interventions are mostly designed to increase voluntary control over sexual arousal, reduce sex drive, or teach self-management and relapse prevention skills to individuals who are motivated to avoid acting upon their sexual impulses. It is also recognized that these forms of treatment may not be efficient on their own in patients suffering from severe paraphilias. In such cases, the only remaining option for alleviating the patient's condition is androgen deprivation therapy (ADT). This therapy aims at decreasing the level of testosterone, either by hormonal treatment ("chemical castration" or "medical castration") or, where such treatment is not efficient or is contraindicated for health reasons, by surgical castration. It should be pointed out that both forms of ADT are used also in the treatment of prostate cancer.

There is a large body of scientific data documenting that paraphilic reoffending can be significantly lowered via ADT. ADT, by lowering testosterone, clearly benefits the patient by his gaining greater capacity for self-control, obtaining relief from intrusive erotic obsessional fantasies, and by avoiding the necessity for placement in a psychiatric establishment. In the presence of a proper treatment protocol designed either to prevent or to minimize side effects, should they develop, the risks associated with ADT are generally within the same range as those associated with many other commonly prescribed psychotropic interventions.[55] In

---

53. Rule 49.4 of the Assembly's Rules of Procedure: "The report of a committee shall also contain an explanatory memorandum by the rapporteur. The committee shall take note of it. Any dissenting opinions expressed in the committee shall be included therein at the request of their authors, preferably in the body of the explanatory memorandum, but otherwise in an appendix or footnote."

54. International Classification of Mental Diseases (ICD-10th). According to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV-TR) paraphilias are defined as sexual disorders which are characterized by "recurrent, intense, sexually arousing fantasies, sexual urges or behaviours, generally involving (1) non-human objects, (2) the suffering or humiliation of oneself or one' s partner, or (3) children or other nonconsenting persons that occur over a period of 6 months", which "cause clinically significant distress or impairment in social, occupational, or other important areas of functioning".

55. Berlin FS: Commentary: Risk/Benefit Ratio of Androgen Deprivation Treatment for Sex Offenders, Journal of the American Academy of Psychiatry and the Law 37, 2009.

the context of a rehabilitative approach, it is ethical to offer ADT as treatment with proven efficacy to achieve a reduction of androgen action and potentially improve control of sexual impulses and thus alleviate the patient's condition.

Surgical castration and pharmacological hormonal treatment result in equivalent suppression of testosterone; in fact, the *castration* level of testosterone is used as a benchmark for evaluating the efficacy of various pharmacological agents used in hormonal treatment. Therefore, should surgical castration be rejected as a treatment on the grounds of its alleged inefficacy, medical castration would have to be rejected on the same grounds. It should be noted that medical castration is mentioned among the effective measures which should be made accessible to sexual offenders under the Council of Europe Lanzarote Convention.

Voluntariness, as an element of informed consent, requires conditions free of coercion and undue influence. Coercion occurs if one party intentionally and successfully influences another by presenting a credible threat of unwanted and avoidable harm so severe that the person is unable to resist acting to avoid it[56]. Undue influence, by contrast, occurs through an offer of an excessive, unwarranted, inappropriate or improper reward or other overture in order to obtain compliance[57]. Medical interventions where the patient's consent has been obtained through one of these forms of external pressure are involuntary and in violation of the patient's human rights. The definition of the term "coerced" used in the memorandum is excessively broad and does not correspond with the term's common meaning, as defined by the European Court of Human Rights[58] and other authoritative sources.

No doubt that the choice the patient is faced with may be difficult. Like many other treatments, both medical and surgical castration have their side effects, some of them reversible, some of them not (though the permanent loss of reproductive ability, the main side effect of surgical castration, can be avoided by storing sperm in a sperm bank). However, the difficulty of choice does not necessarily remove the voluntariness of the decision. The choice made by the paraphiliac patient about his treatment cannot be considered coerced or otherwise involuntary simply because the treatment offers him the possibility of acquiring control over his dangerous behaviour and, consequently, the possibility of being released. This is why the Lanzarote Convention allows offering medical interventions to sexual offenders in prison on a voluntary basis. Offering a treatment that shows a promise of therapeutic benefit (in which the possibility of release is inherent) cannot be equated with exercising coercion or undue influence. Neither can it be considered a violation of human dignity. On the contrary, denying access to such treatment would interfere with the patient's right to health and condemn him to years of further confinement, hardly a dignified outcome.

56. Faden, Beauchamp: A History and Theory of Informed Consent, p. 339.
57. The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research.
58. The term "coercion" in its ordinary meaning implies an action directed at making an individual do something against his or her will by using force or intimidation to achieve compliance (*Jehova's Witnesses of Moscow and Others v. Russia*, judgment of the European Court of Human Rights of 10 June 2010, paragraph 110).