BJOG An International Journal of Obstetrics and Gynaecology

DOI: 10.1111/1471-0528.16204
www.bjog.org

Commentary

Redressing forced sterilisation: the role of the medical profession

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Accepted 2 March 2020.

Please cite this paper as: Gilmore S, Moffett L. Redressing forced sterilisation: the role of the medical profession. BJOG 2020; https://doi.org/10.1111/1471-0528.16204.

Forced sterilisation has been used by many states to control or diminish minority groups. Historic examples of forced sterilisation include those conducted by the Nazis, acting against Jewish, Roma and Sinti peoples, and the Imperial Japanese Army in Korea during the Second World War, its historic use against Native Americans in the USA, and more recent practice in Peru and in First Nations people in Canada. Although it is prohibited under international criminal law, forced sterilisation often involves medical practitioners, with little reflection on the context and drivers of such violations being demonstrated within the profession. This article sets out the historic and contemporary struggles for accountability and redress for forced sterilisation, focusing on the role of medical practitioners in such violations. Drawing from interviews conducted in Peru in May 2019, the article also suggests new ways of establishing reparations and offers a critical reflection of ethics for medical practitioners and their role in redress.

Forced sterilisation

Sterilisation is considered a permanent surgical form of contraception, either through occlusion or interruption of the fallopian tubes in females or more effectively through vasectomy in males.[1] Forced sterilisation occurs when informed valid consent is not obtained for the procedure, either through coercion or through the omission of consent.[2] A number of medical bodies, including the International Federation of Gynecology and Obstetrics (FIGO), have issued guidance on properly obtaining consent and the ethical issues surrounding sterilisation.[3] Forced sterilisation is an assault on sexual and reproductive health (SRH), and yet there are limited examples of accountability and redress.

Accountability and redress for forced sterilisation

During times of conflict and under authoritarian regimes, violence is not only directed at those living but also at future generations through forced sterilisation, which can amount to genocide. However, there have been very few successful instances of justice and there are limited forms of reparations for the victims. Accountability is about ensuring that those responsible for violations are made to answer for their wrongdoing before an individual or an institution, including an enforcement process for imposing sanctions on those who violate their duties.[4] Redress has the more victim-oriented perspective of providing a means to seek a remedy for the harm caused. The WHO's statement on forced sterilisation recognises that accountability is 'central to preventing human rights violations' and, for victims, an 'avenue to air their grievances and seek redress'.[4]

After the Second World War, 23 Nazi doctors and public health staff were prosecuted in the 'Medicine case' or 'Doctors' Trial' for murder and torture, as war crimes and crimes against humanity. Eight of the individuals were charged with forced sterilisation, including human experimentation with X-rays, surgery and medication, of thousands of Jewish people and other persecuted groups in Auschwitz and Ravensbruck concentration camps (this is criminalised under the ICC Rome Statute Article 7(1)(g) and Articles 8(2)(b)(xxii) and Article 8(2) (e)(vi), Rome Statute; ICC Elements of Crimes (2011); and Article 2(1)(g), Prevention and punishment of crimes against humanity, International Law Commission A/CN.4/L.935, 15 May 2019).[5] Three of the accused were convicted and executed – mainly those who were involved in developing the policy and oversight of the use of forced sterilisation – but not the doctors, such as Adolf Pokorny, who was acquitted despite writing a letter to Himmler recommending sterilisation.[5] After the Doctors' Trial in Nuremberg the judges formulated the Nuremberg Code for experiments on human subjects that places voluntary consent as its first principle.

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Today, forced sterilisation is considered a crime against humanity and a war crime under the International Criminal Court (ICC).[5]

As a result of victim and civil society advocacy, Peru is investigating forced sterilisation as a crime against humanity. Forced sterilisation was introduced in Peru in the 1990s by the Fujimori regime through a public health campaign of 'voluntary surgical contraception'. It was intended to reduce the national birth rate using measures such as sterilisation quotas, incentives and penalties, thereby coercing some professionals.[6] Approximately 300 000 persons, mainly women but also 21 000 men, were forcibly sterilised.[7] Rural indigenous Quechua-speaking persons were disproportionately targeted, exploiting intersecting vulnerabilities of race and ethno-lingual identity, low socioeconomic status, gender (predominately women) and postpartum accessibility to healthcare facilities. Such coercion included deceiving people by telling them that they would be breaching domestic child policy laws if they had more children and forcing illiterate patients to sign consent forms without an interpreter.

Forced sterilisation has been used in a number of non-authoritarian settled democracies, such as in Bangladesh, Sweden and Switzerland. This reflects the role of discrimination or racism in such procedures, as found by two healthcare professionals' external review of tubal ligation in aboriginal women in the Saskatoon Health Region in Canada.[8] This discrimination can affect not only the consent process but also the quality of intraoperative and post-operative care and accuracy of medical records. As a result of unclear documentation in Peru, some victims have also been asked to verify their sterilisation through medical evaluations such as hysterosalpingography. However, some victims described returning to health centres and undergoing invasive gynaecological investigations as traumatic and 'emotionally damaging'.[9] The role of the medical profession in carrying out such violations creates challenges for victims seeking remedies and looking for healthcare providers in whom they can trust.

Appropriate reparations

Reparations are measures to remedy, as far as possible, the harm caused. In human rights law, remedying violations like forced sterilisation requires the use of a complementary range of reparations, including restitution, compensation, rehabilitation, measures of satisfaction and guarantees of non-repetition.[9] These components remedy harm to individuals, e.g. in the form of compensation, and more collective harms, e.g. through a memorial for the harm to a victim group. Those responsible for making reparations can include individuals, corporations and states. Reparations can contribute to accountability by obliging responsible actors to make amends for their wrongdoing.

In recent years, Virginia and North Carolina have introduced compensation for victims of forced sterilisation.[10] Similarly, Canada has been called by the Inter-American Commission to introduce reparations for First Nation victims. Many victims of forced sterilisation may face social and practical barriers in coming forward to claim reparations. They may be silenced through social stigma and shame of lost reproductive capacity, or they may be concerned over confidentiality. In Japan, reparation for forced sterilisation was only legislated for in 2019 after victims started to bring litigation through the courts; however, some victims were prevented from bringing claims by time limits. Delays may limit the options for reparation, such as sterilisation reversal, if appropriate, or urgent socio-economic support and shelter for victims and their children, if ostracised by their family. Thus, non-public disclosure of their identities as well as the option to apply for reparation through civil society organisations can allow access for those who continue to face stigma.

The role of the medical profession in forced sterilisation may create barriers to victims coming forward, in particular when they are required to be medically assessed in order to make a claim for reparations. In Peru, some victims expressed concerns that healthcare professionals may be reluctant to engage in these issues when it puts their profession into disrepute, and generates a review of current cultures of medical practice for past violations.[10] For instance, victims of forced sterilisation in the German reparation programme had to demonstrate that their sterilisation was performed for racial reasons, not medical ones, and former Nazi doctors often assessed them, tending to reject or reduce their compensation.[11] Pross found that a doctor's role and power as a healer obscured their 'social function' as a state actor implementing policy that disrupted the patient–doctor relationship and created 'mutual distrust'.[11]

Despite the Peruvian Ministry of Health's apology in 2002 for forced sterilisation, it had little effect on victims and negligible change on the doctors' perception of the policy as legitimate and not a crime against humanity. Similar apologies in Romania by some institutions and a national day to commemorate Roma victims have been criticised for not situating forced sterilisation abuses within a historical narrative of responsible actors. Beyond accountability, guaranteeing that these actions are never to be repeated requires public and professional engagement, such as using school textbooks to inform the next generation and introducing medical curricula that include medical ethics and details of human rights violations committed in health care.

The medical profession, in particular the speciality of obstetrics and gynaecology, can take a positive role in shaping appropriate reparation for SRH violations. To illustrate,

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reparation with free traumatic fistula repair surgery can provide rehabilitation and restoration by means of re-establishing continence.[12] The reversal of forced sterilisations under the reparation principle *restitutio in integrum* (restoration to original position) has been a low priority. This is perhaps because of the, often significant, time lapse between the violation and the years or decades that it takes for reparations to be implemented, meaning that many females can no longer be fertile. Victims and reparation designers may also be unaware of medical options such as sterilisation reversal or in vitro fertilisation, however. Possible reasons for this lack of awareness include limited input from medical experts, the requirement for procedures that are not considered routine or widely available, the need for individualised assessment to determine suitability and the potential cost implications.

Raising awareness of forced sterilisation is also required. There needs to be increased public consciousness that forced sterilisation is a violation. Victims may need to understand that what happened to them was a crime, and a breach of medical ethics, and need educating about the right to reparation. Societal awareness raising can increase social mobilisation and exert pressure on states to investigate allegations and issue reparation, as in the case with Peru. The creation of the Registry of Victims of Forced Sterilizations (REVIESFO) in Peru, in 2015, has assisted with investigations of claims, but unfortunately there has been no associated reparation programme or educational and institutional reforms to prevent such violations from happening again. Different accountability processes are needed to remedy the wrongdoing of individual and collective actors.

Conclusion

Medical professionals have played a role in causing violations in the past but can remedy the psychological or physical harm by providing appropriate care for those who have been harmed. Forced sterilisation in Nazi Germany and in Fujimori's Peru were legal at the time, and in other settled democracies have been part of public policy. Medical practitioners involved in the development of public health policies should resist public pressure to support any form of forced sterilisation. In many countries the marginalisation of victimised groups targeted for forced sterilisation means that they often face discrimination, thereby inhibiting their ability to gain public support to seek redress for their suffering. This must not be compounded by the biases and even discrimination that medical professionals may personally hold. In international criminal law, medical professionals may be individually criminally responsible for their role in forced sterilisation, despite what the domestic law states. International criminal law does not recognise collective criminal responsibility. Nonetheless, to address their past role in such violations, there may be moral grounds for responsible medical professionals to make reparations, such as apologies, institutional reforms and education to prevent repetition. The medical profession should not only strongly articulate concerns over possible inappropriate medical interventions, such as forced sterilisation, but should also advocate for more timely and appropriate reparations.

Disclosure of interests

None declared. Completed disclosure of interests form available to view online as supporting information.

Contribution to authorship

SG conceived the idea for the paper, planned key content, provided an analysis of medical profession reparations and contributed towards the writing up. LM contributed towards the planning and writing up, particularly regarding cases of international law and aspects of international criminal law.

Details of ethics approval

This research was ethically approved by the ethics committee in the School of Law at Queen's University Belfast in May 2017 and complies with the 2015 ESRC framework for research ethics.

Funding

This research was carried out as part of the Arts and Humanities Research Council funded 'Reparations, Responsibility and Victimhood in Transitional Societies' project (AH/P006965/1).

Acknowledgements

None. ■

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