



PROVISIONAL version

25 April 2013

Putting an end to coerced sterilisations and castrations

Revised report¹

Committee on Social Affairs, Health and Sustainable Development

Rapporteur: Ms Liliane MAURY PASQUIER, Switzerland, Socialist Group

I. Draft resolution²

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, 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 and persons with disabilities, and the marginalised, stigmatised, or 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 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.

¹ Reference to Committee: Doc. 12444 Reference No. 3739 of 24 January 2011, (extended) deadline for adoption: 24 January 2014.

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

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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 historic coerced sterilisation or castration;

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 the vulnerable, including through awareness-raising and human rights education.

8. The Assembly encourages the Council of Europe Anti-Torture Committee (CPT) and the Council of Europe Human Rights Commissioner to continue to pay attention to the issue of coerced sterilisations and castrations in Council of Europe member states.

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II. Explanatory memorandum by the Rapporteur, Ms Maury Pasquier

1. Introduction

1. I would like to begin this explanatory memorandum with a citation of the first paragraph of the motion for a resolution³ which gave rise to this report, since, for me, it encases the stance the Council of Europe and its 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 a motion presented by myself and 21 other colleagues.⁴ At its meeting held in Paris on 16 September 2011, the Committee held a hearing with the following experts (and one victim from my own country),⁵

Ms Gwendolyn ALBERT, 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 Council of Europe Anti-Torture Committee (CPT), Sweden

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

³ Assembly Doc.12444.

⁴ Ibid.

⁵ The minutes of the meeting can be found in AS/Soc (2011) PV 6 add.

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 report⁶ during the January 2012 part-session, and authorised a fact-finding visit to Sweden and the Czech Republic. This visit took place on 6-7 November 2012 (Prague) and 8-9 November 2012 (Stockholm). I am very grateful to my colleagues in the Czech and Swedish parliaments, and the Secretariat 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 practiced coerced sterilisations and castrations at some time in the past.

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,⁷ or via recent judgments of the European Court of Human Rights),⁸ or 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, the minutes of which are available from the Secretariat⁹, and whom I will cite later in this report.

6. Five groups of people have been particularly subject to coerced sterilisation and castration in the past: Roma women,¹⁰ convicted sex offenders, transgender persons and persons with disabilities (“eugenic” motives), and the marginalised, stigmatised, or 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 the brutal killings of eugenic euthanasia as of 1939.

⁶ AS/Soc (2011) 48.

⁷ For example, in Assembly Doc. 12236 of 28 April 2010, “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.

⁸ V.C. v. Slovakia (2011), N.B. v. Slovakia (2012), L.G. and others v. Slovakia (2012).

⁹ AS/Soc (2013) PV 03 add2.

¹⁰ 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”.

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 USA which initiated the early-twentieth-century wave of compulsory sterilisation law, beginning with Indiana’s 1907 Act. It was also in the USA that the Supreme Court 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."*¹¹

10. Sterilisation (in particular in institutions such as asylums, prisons or hospitals) thus became “fairly widespread by the 1930s, permitted by legislation in many U.S. and Canadian states and provinces, in the Swiss canton of Vaud, in Scandinavian countries, in Germany, Japan, and Veracruz (Mexico), as well as in Czechoslovakia, Yugoslavia, Hungary, Turkey, Latvia, and Cuba.”¹² The targeted groups were comprised disproportionately of poor, non-white, or otherwise socially marginalised people,¹³ and women were more often targeted than men.

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.¹⁴ 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.¹⁵ In the USA, more than 60,000 people underwent forced sterilisation. The practice was largely abandoned after World War II, 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

¹¹ Cited in: Harry Bruinius, *Better for All the World: The Secret History of Forced Sterilization and America's Quest for Racial Purity*, 2007, available on <http://betterforalltheworld.brown-bear.com/p3.htm>.

¹² 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.

¹³ 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.

¹⁴ Harry Bruinius, *Better for All the World: The Secret History of Forced Sterilization and America's Quest for Racial Purity*, op.cit.

¹⁵ 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.

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 1977.¹⁶

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.¹⁷

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 UN Special Rapporteur on violence against women, its causes and consequences, Ms Radhika Coomaraswamy, labeled forced sterilisation a human rights violation:

“51. 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.”¹⁸

14. As pointed out in a recent article by Christina Zampas and Adriana Lamačková, UN 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.¹⁹

15. In his most recent report of 1 February 2013,²⁰ the UN 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 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”.²¹

16. The UN 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”.²² 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.

¹⁶ Matthias Tydén, *The Scandinavian States: Reformed Eugenics applied*, in: *Oxford Handbook of the History of Eugenics*, Oxford University Press 2010, kindle version.

¹⁷ See a campaign by Advocates for Human Rights, “Stop violence against women”, at http://www.stopvaw.org/forced_coerced_sterilization.

¹⁸ UN 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.

¹⁹ 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.

²⁰ http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf.

²¹ *Ibid*, paragraph 84.

²² *Ibid*, recommendation c.

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 (ECHR) in several cases now.²³ However, unfortunately the Court again declined to rule in November 2012 on whether the forced sterilisation of Roma women in Slovakia constitutes discrimination under article 14 of the ECHR. In an unrelated case (not of a Roma woman), *G.B. and R.B. v. Republic of Moldova*, on 18 December 2012, the Court held that there had been a violation of Article 8 of the Convention.²⁴

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.²⁵

19. 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.²⁶ The guidelines, updated in 2011, specify, amongst others:

19.1. 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.

²³ The latest – *LG and others versus Slovakia* –, decided 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.

²⁴ 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.

²⁵ 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 (AI) 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 characterized the concept of coercion as: “how much, and what kind of, influence or pressure deprives actions and decisions of their autonomous character” (definition by Bonnie Steinbock in relation to the concept of coercion and long-term contraceptives, 1996). But perhaps the most convincing is the policy document titled “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. <http://www.law.utoronto.ca/documents/reprohealth/HC1-BridgingTheGapPolicyBrief.pdf>, p. 8-9.

²⁶ For the full guidelines and recommendations, please see <http://www.figo.org/files/figo-corp/FIGO%20-%20Female%20contraceptive%20sterilization.pdf>.

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

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

19.4. 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.

19.5. 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.

19.6. 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.

19.7. Information should be provided in language 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

20. 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 Slovakia (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.

The Czech Republic

21. 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, Romani 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 Slovakia.²⁷ 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 Romani women by social workers, to address what was officially termed their “high, unhealthy” reproduction rate compared to the non-Romani 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 Romani women during C-section deliveries, often telling them that not only the C-section but the sterilisation itself had been “emergency, life-saving” measures.²⁸

22. 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, 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,

²⁷ See the declassified minutes of the hearing, AS/Soc (2011) PV 06 add.

²⁸ *Ibid.*, p. 4-5.

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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.

23. 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 critiqued the ministry in 2005 for failing to conclude that the documented procedures violated not only human rights, but the law. The ombudsman’s report became the basis for international human rights bodies to recommend 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 sanction. Civil lawsuits brought by individuals have only rarely resulted in compensation awards due to statutes of limitations²⁹ (I am aware of only two such successful cases).

24. 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 there are 77 valid out of a total of 89 applications received, 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.

25. On 1 April 2012, the Czech Republic adopted a new law on sterilisation which seems to be more in conformity with 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.³⁰

Slovakia

26. Romani women were also forcibly sterilised in the Slovak part of Czechoslovakia starting in the 1970s. By 2002, Romani 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, including the U.S. Commission on Security and Cooperation in Europe, 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 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 for Human Rights in Strasbourg, finding in favour of the applicants (see paragraph 14).

²⁹ See the declassified 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.

³⁰ Assessment of Ms Anna Šabatová, Chairperson of the Czech Helsinki Committee, whom I also had the privilege to meet.

4.2. Convicted sex offenders

27. As Stefan Krakowski, member of the Council of Europe Anti-Torture Committee (CPT) from Sweden, 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. Though 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.³¹

28. 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 recognized 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 (i.e. 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 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*.³²

29. The CPT has criticised both the Czech Republic and Germany³³ for recent recourse to surgical castration. However, laws introducing compulsory "chemical" castration in particular for sex offences against minors are becoming a certain trend in some member states, as well, such as Poland and 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.

30. However, following a conversation I had with Doctor 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 stop 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). Doctor Rohmer underlined that in treating sex drive (both through chemical or surgical castration), the offender's main pathology – that of wanting power of 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.

³¹ See the declassified minutes of the hearing, AS/Soc (2011) PV 06 add, pp. 7-8.

³² Ibid.

³³ 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) had been rejected by an expert commission, composed of two doctors (including one psychiatrist) and a lawyer with the qualification of a judge; and no application had been submitted to the expert commission during the past two years.

31. Following this conversation, I decided to invite the CPT's most eminent current expert on both chemical and surgical castration to our Committee's meeting in Strasbourg on 23 April 2013, Ms Veronica Pimenoff from Finland, to shed further light on the matter. You will find a sub-chapter on chemical castration added below.

32. 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.

Surgical castration: The Czech Republic

33. 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 rare cases where all other treatment options have been exhausted.

34. Following diagnosis as a sexual "paraphiliac" based on Czech courtship disorder theory, convicted sex offenders are referred to 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,³⁴ 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 in the community is to offer them treatment which helps them to manage their sexual impulses.³⁵ 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.

35. 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. 10 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 prior, a young man who had been treated in the hospital since 2006 after having served an 8-year prison term for having raped and murdered a woman at age 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 and such a high sex drive, but he reported a good sex life and feeling happier now. He had been offered to store his sperm, but had decided he didn't want children. He was due to be conditionally released in January 2013.

36. 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 2-year study is being prepared on behalf of the government following the entry into force of the new law on 1 April 2012. 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.³⁶ There has been no surgical castration since the entry into force of the new legislation.

³⁴ Mr Petr Weiss and Mr Jaroslav Zvěřina.

³⁵ According to the comments of the Czech national parliamentary delegation to my introductory memorandum of 16 January 2013, the treatment is based on "comprehensive adaptation therapy".

³⁶ 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 the complete ban of castration. 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.

37. 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 offense, have been diagnosed with sexual deviation and a high probability of recidivism. All other methods must have failed or be contra-indicated. 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.

38. Like Ms 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 both the efficacy of the intervention and 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.

“Chemical” castration

39. From the available scientific evidence, Ms Veronica Pimenoff, Psychiatrist and Head of Department of Helsinki University Psychiatric Hospital (Finland), 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 of 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.

40. Ms Pimenoff emphasised that there was no demonstrable evidence-based effect on reoffending rates also with “chemical” castration. 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’s Lanzarote Convention protected offenders from mandatory castration, and only allowed for “chemical” castration on a voluntary basis with the free and informed consent of the offender.

41. 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 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 thus popular in many quarters. However, we know from history that mandatory castration – i.e. 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

42. 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 UN 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 sterilization 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.

Sweden

43. 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 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”³⁷ – sterilisation was a way to ensure there would be no pregnant men.

44. It is unclear how many sterilisations of transgender persons took place since the law came into effect, but around 600 people were 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 per year for sex change are received (only a very small number of which are refused – because of a refusal to divorce or be sterilised). Interestingly, the 1972 law makes sex-reassignment surgery no requirement for the legal recognition of the sex-change.³⁸ But the sterilisation requirement of the 1972 is a complete one: even sperms or eggs in banks need to be destroyed.

45. The Swedish National Board of Health and Welfare³⁹ 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,⁴⁰ the Swedish parliament passed a law which abolishes the sterilisation requirement with effect from 1 July 2013 as a consequence. 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 Administrative Court of Appeals, i.e. that the sterilisation requirement in order to change legal gender marker is a violation of Swedish constitutional law as well as the European Convention of Human Rights, which mean the verdict stands. So this will mean whoever applies for a change of 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.

³⁷ Meeting with Ms Linda Almquist, Legal advisor, Department of Regulations and Licenses, the Swedish National Board of Health and Welfare.

³⁸ Probably, also because the results of woman to man surgery are apparently still not very satisfactory.

³⁹ Which spearheaded two investigations into the matter, in 2007 and in 2010, with very different conclusions.

⁴⁰ 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.

46. The next question facing Sweden now 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 NGOs⁴¹ are asking for 200,000 Swedish Crowns⁴² - 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.⁴³ Indeed, quality healthcare in general for transgender persons is a problem in many countries, but this is not the subject of this report.

47. It is interesting to note that, in his most recent report, the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment calls upon 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”;⁴⁴ He also calls upon 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*

48. Article 23(1) of the UN 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.”

49. The World Health Organisation (WHO) estimates that over a billion people in the world, or approximately 15 percent 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.⁴⁵

50. The UN 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”.⁴⁶ 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”,⁴⁷ after having noted the wide documentation of forced sterilisation of girls and women with disabilities.⁴⁸

51. In 2011, five women with mental disabilities brought their case before the European Court of Human Rights (*Gauer and Others vs. France*). Each had involuntarily 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.

⁴¹ Such as RFSL, the Swedish Federation for Lesbian, Gay, Bisexual and Transgender Rights.

⁴² The victims of the eugenic sterilisation programme received 175,000 Swedish crowns in 1999.

⁴³ 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 contra-indication 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.

⁴⁴ Op. cit. (footnote no.16), paragraph 88.

⁴⁵ Malgorzata Stawecka, *Involuntary Sterilisation Threatens Rights of Disabled Women*, 20 September 2012, <http://www.ipsnews.net/2012/09/involuntary-sterilisation-threatens-rights-of-disabled-women>.

⁴⁶ Op. cit. (footnote no. 16), section IV D.

⁴⁷ Op. cit. (footnote no. 16), paragraph 89 d.

⁴⁸ National law in some countries allows for the sterilisation of minors who are found to have severe intellectual disabilities according to his report.

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

52. 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. Though 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.

53. As a result of centralised administration from the very start, the files of more than 60,000 persons 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”-lineage⁴⁹), 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.

54. 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.⁵⁰

55. 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 worth less (“*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**

56. During the Committee hearing in September 2012, 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 from my own country, Switzerland. Much of her testimony – which I am appending to this report – 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 forced administrative measures, Mr Hansruedi Stadler, will now consider legal, historical and financial aspects

⁴⁹ There were few Sinti (and practically no Roma) in Sweden. One group which was targeted were the “Tartari”, poor travelers (tinkers) considered “gypsies” by most Swedes at the time, but who had local origins. It is estimated that only 500-1,000 Tartari women were sterilised, as they avoided the authorities as much as they could. Some women of the Sami minority were also targeted for sterilization.

⁵⁰ 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.

which must follow. I warmly welcome these developments and hope that the Round Table negotiations can quickly be brought to a satisfactory conclusion.

57. My conclusion from the foregoing is twofold:

57.1. 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.

57.2. 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.

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Appendix: Address by Bernadette Gächter, victim of a forced sterilisation, Switzerland, at the Committee hearing on 16 September 2011 in Paris

Ladies and Gentlemen, Thank you for your invitation. It is a pleasure for me to address you.

In 1972, in Switzerland, I was forced to undergo an abortion and sterilisation at the age of 18. Let me describe to you the events that led to this outcome:

At my birth, my mother, who was unable to look after me, got in touch with a Catholic institution, the *Seraphische Liebeswerk*, which placed me in a foster family. When they were no longer able to look after me I was entrusted to another family with a view to adoption.

That is how I found myself living with a childless couple who were devout and very pious Catholics. They made sure I was always clean and well dressed. When I was four years old my foster parents had a child of their own with the result that, under the law in force at the time, they could no longer adopt me.

In 1961, when I was seven years old, my foster parents began to have doubts about me. As I was an impulsive and stubborn child and they thought that I was masturbating in secret, on their GP's advice they took me to the children's hospital in Zurich. The hospital's paediatrician delivered his diagnosis: "infantile organic psychosyndrome". This is what we now call "attention deficit disorder". Some 10 % of children suffer from this pathology but, to date, there is nothing in my childhood to prove that I suffered from the disorder.

This diagnosis was the bane of my life for many years. Even the experts who were subsequently consulted did not question it, despite the fact that they never found any symptoms. From that time onwards, every night after my bedtime prayer, my foster mother tied my legs together right up to the hips with an elastic bandage. She even washed me herself. Every Saturday she gave me a bath. She soaped me, rubbed me and rinsed me with water like a little baby. Nothing I could say would change anything. If I disobeyed, I was immediately punished: she would beat me and lock me up in the cellar or the toilets. Throughout my schooldays I was regularly taken to psychiatric clinics where electric wires were attached to me so that my brain could be examined. Electrodes were even put up my nose, which was extremely painful.

After spending a year in French-speaking Switzerland, I began an apprenticeship as an office clerk. At 18 I learned by chance that I was not biologically related to my family. My world fell to pieces and I felt as if I was falling into a bottomless pit. No other explanation was given to me concerning my origins. I felt that I had been abandoned, that nobody was interested in me and I was convinced that no-one had ever loved me.

I started staying out at night later than I was allowed to. I thought that by going out with men I would find the love I didn't have in my foster family. When I came home in the middle of the night my foster mother would shout at me. She said I was a whore just like my mother, but she had never met my mother. It was awful. I felt as if I had lost my identity.

Finally I got pregnant and I tried to hide the fact because I was afraid of the verbal and physical abuse that would follow. However, the doctor in whom I had confided informed my foster family.

My foster father suddenly burst into my room and asked me "Bernadette, what have you done?!". Nobody wanted to help me. They said I had to go to the mayor and tell him I was pregnant. I had no idea why. My foster mother sent me to the priest to confess. I also had to go to the family GP with her to clarify the situation. How long this all took and how often I had to go to the doctor's I can't remember. I can only remember one thing very clearly: the sudden declaration that I had brain damage and that they considered me to be mad. However I had gone through primary and secondary school without great difficulty. My foster mother said to me, word for word "You know, Bernadette, it would be better if you got rid of the child because you are suffering from brain damage and as it is hereditary your child will have the same problem as you. You don't want your child to be mad too, do you?".

The doctor and my foster mother put so much pressure on me that I finally gave in and signed the piece of paper they kept on pushing at me. I had just agreed to have an abortion and to be sterilised without

realising the exact consequences. I did not want any of that to happen to me but I was unable to defend myself. I had no one to help me stand up to the “respectable” figures of my childhood.

My foster family, the family GP, the priest, and the psychiatrists were all in league with one another. Accompanied by my foster parents, I was forced to go to the county psychiatric clinic in Wil to explain the situation. I can still see myself sitting at the huge oval table, surrounded by psychiatrists asking me stupid, meaningless questions that had nothing to do with my pregnancy or my alleged brain damage. They had decided on my abortion and sterilisation before I even met them.

Later when I was married I was operated on twice to see if the sterilisation could not be reversed. My then husband and I had to explain everything to a psychiatrist before permission was given for the operations, both of which proved to be in vain.

Years later, when I gained access to my medical files, I became fully aware of the extent of the injustice I had suffered: I spent two years studying my files and doing research until, in 1991, I discovered an article several pages long in a weekly newspaper. From the documents I had studied I had discovered that my biological mother had also been sterilised and labelled as unstable and ruled by sexual desire, and locked away because her behaviour was non-conformist. When he recommended my abortion and sterilisation for eugenic reasons, the expert at the Wil psychiatric clinic based his diagnosis on knowledge of my mother's case. It was terrible to discover all this. In 1972, someone wrote the following about my mother in her medical file: “and to think that, somewhere, this woman has a seriously handicapped not to say mad daughter”.

More than ten years later, Jolanda Spirig wrote a biography of my life entitled “Widerspenstig. Zur Sterilisation gedrängt” (Forced to undergo sterilisation because she was rebellious), which was published in 2006 by Zürcher Chronos.

I now know that I was only one of thousands of victims.

I know how difficult it is to ‘bear’ such a burden, if it can be borne at all.

I know how much energy is required to survive.

I have not been able to found a family, to have a child, whereas there was nothing in the world I wanted more than to become a mother. The sight of mothers with their children was painful to me. And now it is just as painful to see grandmothers with their grandchildren. Nobody can give me back what was taken from me. The operation was irreversible!

I had to learn to live with all that and to make a new life for myself. I had to accept the idea that I was the victim of an incredible injustice that had caused me serious physical damage. If I did not accept it, my life would be unbearable. Since the age of 34, I have been working as an administrative assistant in a business company. I have often been asked how I manage to lead a normal life. And when I look at my past I ask myself the same question. I have always refused help as I look on psychiatrists as my enemies.

I have not fully recovered from the injustice I have suffered and it will follow me for the rest of my days. There is only one solution: one has to learn to live with the past and to make oneself a new life. I have accepted my lot in life and I have faced up to it for the past 25 years. Sometimes it is extremely painful and sometimes it is hardly bearable. But I have resigned myself to what happened and learned to live with it.

The perpetrators of these acts have never apologised for what they did. And yet there are piles of files in the archives containing incredible lies. And that really bothers me, for everyone knows the ease with which such documents can resurface!

If I were to have problems in the future, nobody would be interested in the fact that I have been working for the same company for 34 years to everyone's entire satisfaction or the fact that I earn my living without any outside help or assistance. All that will count is what is written in these documents and again I will be judged according to what they say about me. That is why I ask that all of these documents be handed over to me. I want to decide myself what should and should not be done with them. Thank you for your attention.