

# Eliminating forced, coercive and otherwise involuntary sterilization

An interagency statement



OHCHR  
UN Women  
UNAIDS  
UNDP  
UNFPA  
UNICEF  
WHO



World Health  
Organization



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## Acronyms and abbreviations

CRPD	United Nations Convention on the Rights of Persons with Disabilities
OHCHR	Office of the High Commissioner for Human Rights
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

## Introduction



Among other contraceptive methods, sterilization is an important option for individuals and couples to control their fertility. Sterilization is one of the most widely used forms of contraception in the world (1). When performed according to appropriate clinical standards with informed consent, sterilization methods such as vasectomy and tubal ligation are safe and effective means of permanently controlling fertility (1–5). In this document, sterilization refers not just to interventions where the intention is to limit fertility – for example tubal ligation and vasectomy – but also to situations where loss of fertility is a secondary outcome.

Like any other contraceptive method, sterilization should only be provided with the full, free and informed consent of the individual. However, in some countries, people belonging to certain population groups, including people living with HIV, persons with disabilities, indigenous peoples and ethnic minorities, and transgender and intersex persons, continue to be sterilized without their full, free and informed consent (6–16). Other individuals may also be at risk of coercive sterilization, such as persons with substance dependence (17, 18). While both men and women are subject to such practices, women and girls continue to be disproportionately impacted (9, 19, 20).

Sterilization without full, free and informed consent has been variously described by international, regional and national human rights bodies as an involuntary, coercive and/or forced practice, and as a violation of fundamental human rights, including the right to health, the right to information, the right to privacy, the right to decide on the number and spacing of children, the right to found a family and the right to be free from discrimination (21, para 23; 22, para 27; 23, para 36; 24, para 31; 25, para 24m; 26; 27, paras 37 and 38; 28, paras 31 and 32; 29, paras 33 and 34; 30, para 38; 31, para 34 and 35; 32; 33, para 18). Human rights bodies have also recognized that forced sterilization is a violation of the right to be free from torture and other cruel, inhuman or degrading treatment or punishment (34; 35, para 60).

International human rights bodies and professional organizations have explicitly condemned coercive population policies and programmes, noting that decisions about sterilization should not be subject to arbitrary requirements imposed by the government (36–38) and that states' obligations to protect persons from such treatment extend into the private sphere, including where such practices are committed by private individuals, such as health-care professionals (35, paras 15, 17, 18 and 22; 39). Coerced and/or forced sterilization of women has also been characterized as a form of discrimination and violence against women (25, para 24m; 37; 40, para 22; 41, para 23a; 42, para 28, 31 and 36; 43, paras 51–56). Any form of involuntary, coercive or forced sterilization violates ethical principles, including respect for autonomy and physical integrity, beneficence and non-maleficence (37, 44).

This statement aims to contribute to the elimination of forced, coercive and otherwise involuntary sterilization. It reaffirms that sterilization as a method of contraception and family planning should be available, accessible, acceptable, of good quality, and free from discrimination, coercion and violence, and that laws, regulations, policies and practices should ensure that the provision of procedures resulting in sterilization is based on the full, free and informed decision-making of the person concerned. It highlights guiding principles for the prevention and elimination of coercive sterilization and provides recommendations for legal,



policy and service-delivery actions. It is based on scientific evidence, draws on lessons learnt from historical and contemporary practices, and is anchored in international human rights norms and standards.

The statement uses the terms “involuntary”, “coercive” and “forced” depending on the context and in line with how human rights, professional and ethical bodies have described specific practices.

## Background

Coercive and involuntary sterilization with the aim of improving the genetic constitution of the human species became an instrument of population and public health control during the heyday of eugenics, between 1870 and 1945 (45, 46). In the early 20th century, laws permitting and encouraging coercive sterilization were passed in many countries, including Germany, Japan and the United States of America. Many hundreds of thousands of people, particularly those with disabilities or from ethnic, religious and other minorities, were sterilized without their consent (45–52). In the years after the Second World War, most countries reformed their laws and practices, abandoning eugenic sterilization and strengthening the requirements for informed consent. However, in some countries it took longer to move away from eugenic sterilization (53–56).

During the period from the 1960s to the 1990s, coercive sterilization has been used in some countries (including in Asia, Europe and Latin America) as an instrument of population control, without regard for the rights of individuals (57–59). A range of incentives or coercive pressures have been employed to secure agreement to sterilization, including offers of food, money, land and housing, or threats, fines or punishments, together with misleading information. Under some government programmes, rewards have been provided for health workers who met sterilization targets, while those who missed the targets were at risk of losing their jobs (7, 60, 61). People living in poverty, indigenous peoples and ethnic minorities have been particularly targeted by such programmes (7, 44, 61). In many countries, information is not made available in accessible formats and local languages, and informed consent is not obtained before these procedures are carried out (62). Moreover, these procedures may be carried out in unsafe and unhygienic conditions, without follow-up care (7, 60–62).

Some groups, such as transgender and intersex persons, also have a long history of discrimination and abuse related to sterilization, which continues to this day. Such violations are reflected, for example, in the various legal and medical requirements, including for sterilization, to which transgender and intersex persons have been subjected in order to obtain birth certificates and other legal documents that match their preferred gender (15, 16, 63). Intersex persons, in particular, have been subjected to cosmetic and other non-medically necessary surgery in infancy, leading to sterility, without informed consent of either the person in question or their parents or guardians. Such practices have also been recognized as human rights violations by international human rights bodies and national courts (15, 64).



# Forced, coercive and otherwise involuntary sterilization of persons from specific population groups



## Women

Historically, women have been disproportionately subjected to forced, coerced and otherwise involuntary sterilization, especially in connection to coercive population policies.

The International Conference on Population and Development in 1994 and the Fourth World Conference on Women in 1995 brought a significant shift towards a rights-based approach to population policies and the provision of comprehensive sexual and reproductive health policies and programmes. States agreed to support the principle of voluntary choice in family planning, and to move away from targeted approaches to practices such as sterilization and towards empowerment of individuals, especially women, to enable them to make autonomous, informed decisions about their reproductive options (65, 66). Since then, international human rights norms and standards, as well as an increasing number of regional human rights standards, have consistently reinforced these principles. In some settings, however, people from groups that typically face discrimination or social marginalization are still subjected to involuntary sterilizations as part of government strategies to reduce population growth (61, 67).

Women often face discrimination and coercion on multiple and intersecting grounds, because they are women, live with disability or HIV and/or belong to indigenous populations or ethnic minorities. Each section of this statement pays particular attention to the needs and human rights of women.

## Women living with HIV

Women living with HIV may choose sterilization as a contraceptive method (68, 69). However, it has been documented that women living with HIV in some countries are being sterilized without their full, free and informed consent (9, 10, 13, 14, 68, 70–72).

The provision of high-quality contraceptive and family planning information to women living with HIV is often undermined by pervasive misconceptions among policy-makers and health-care providers regarding HIV transmission. Often the information provided about prevention of vertical transmission, or regarding the ability of women living with HIV to care for their children, is inaccurate (72). This can lead to stigmatization, violence and discrimination, including coercive sterilization practices (9, 73, 74), despite the evidence, which shows that a combination of safer infant feeding practices and antiretroviral treatments taken by women prenatally and during labour and breastfeeding can significantly reduce the chances of transmission of HIV to their babies. When such interventions are being effectively provided, rates of transmission of HIV from mothers to children can be reduced to less than 5% (75, 76). In some instances, women living with HIV agree to sterilization on the basis of lack of information or misinformation about their reproductive options (9, 13, 70, 77).



In other instances, it has been documented that women living with HIV have been coerced to sign consent forms for sterilization procedures, as a condition of receiving antiretroviral and other HIV treatment and prenatal care for a current pregnancy, or other reproductive health services (13, 70). Pregnant women have also been asked to sign consent forms in situations of duress, such as during labour and while in severe pain, believing that the forms relate to authorizing a caesarean section and not sterilization procedures. In these cases, the women have not been given information on the sterilization procedure, its permanent nature, or alternative methods of contraception (9, 13, 70, 77). In other cases, spouses or parents have also given consent for sterilization on behalf of women without their knowledge, and often on the basis of being misinformed themselves (70).

Human rights standards recognize that women living with HIV have a right to contraception and other reproductive health services on the same grounds as all other women. These standards state that safe and affordable means of contraception should be available and that women should have the right to freely choose or refuse family planning services (including sterilization services). They require that health-care providers should be non-coercive and respectful of autonomy, privacy and confidentiality, and that reproductive freedom should not be restricted as part of a family planning, HIV prevention or other public health agenda (73; 78, para 55; 79).

## Indigenous and ethnic minority girls and women

Indigenous peoples and ethnic minorities are particularly vulnerable to acts of violence, including coercive sterilization (7; 66, para 115). Coercive sterilization policies and practices against indigenous peoples and ethnic minorities, particularly girls and women, have a long history across the globe (42, 80, 81). These discriminatory practices are often founded on wrongful stereotyping based on gender, race and ethnicity (11; 82; 83, para 2).

The United Nations Declaration on the Rights of Indigenous Peoples (2007) (84) specifically guarantees indigenous peoples' equality with respect to the enjoyment of the right to health. In the past several years, however, the population policies of some countries have targeted indigenous women from the most deprived sectors of society. Efforts to meet government-mandated quotas have resulted in thousands of indigenous women being sterilized without consent (81, 85). Often, indigenous girls and women are not provided with a full choice of contraceptive methods (86). Moreover, information is often not made available in accessible formats and in indigenous languages (87).

Roma, one of the largest minority groups in Europe, have suffered discrimination and severe human rights abuses throughout history, resulting in many Roma living in conditions of extreme social and economic exclusion. They have been victims of coercive sterilization policies and practices since the eugenic era, during the Second World War, and they remain so currently (88). Reports and cases brought to national, regional and international courts and human rights bodies from some central and eastern European countries show that while state-financed incentive programmes targeting Roma ceased after the fall of communism, the practice of sterilizing Roma women without their informed consent, and in violation of the law, has continued (8, 11, 88, 89).

Recent decisions and reports by national and international human rights bodies describe sterilization of Roma women without their informed consent or even knowledge; for example, during caesarean sections. Women have been presented with consent forms for the first time during labour or delivery, when they are under great pain and duress. In many cases, women are not informed of the permanency of the procedure, or of alternative methods of contraception. Alternatively, information is presented in overly complex formats, for example using unfamiliar medical terminology, or there is misinformation, for example the procedure is claimed to be necessary on life-saving grounds (8; 26; 33; 88; 90; 91; 92, paras 11.2, 11.3, 11.5; 93–95). While some states have, in recent years, strengthened their legal frameworks and policies to prevent recurrence of these practices, new cases continue to be reported (88).



Human rights bodies have affirmed that the failure to provide reproductive health information and to ensure full, free and informed consent for sterilization procedures for women belonging to ethnic minorities is a violation of basic human rights, including the right to information, women's right to determine the number and spacing of their children, the right to be free from inhumane and degrading treatment, and the right to private life. They have also found that it is a manifestation of multiple discrimination on the grounds of gender and race. Responding to coerced sterilization of indigenous and minority women, particularly Roma women, human rights bodies have emphasized the need to take legal and policy steps to prevent such violations from occurring and to ensure effective remedies, including apologies, compensation and restoration of fertility for victims (26; 33, para 10; 83, para 5d; 85; 90–92; 95).

## Persons with disabilities

Persons with disabilities are very often perceived as asexual or sexually inactive. However, they are sexual beings in the same way as other people, and may also wish to become parents and should not be deprived of their sexual and reproductive rights (96, 97). Various forms of control over sexual behaviour and reproduction, including coercive and involuntary sterilization, are used as methods of fertility regulation for persons with disabilities, often without their informed consent (6; 37; 43, paras 36 and 37; 98–106). Women with intellectual disabilities are particularly vulnerable to coercive and involuntary sterilization (20, 107), but men with intellectual disabilities may also be subjected to sterilization and to treatments that suppress sexual drive, sometimes including castration (108). Women with intellectual disabilities are often treated as if they have no control, or should have no control, over their sexual and reproductive choices; they may be forcibly sterilized or forced to terminate wanted pregnancies, based on the paternalistic justification that it is “for their own good” (42, para 36). Rather than indicating individual choices, sterilization rates often reflect the policies of residential institutions or community services (109). Sterilization or long-term contraception are often provided to persons with disabilities on a precautionary basis (103, 104, 110).

Human rights bodies have recognized that sterilization of persons with disabilities without their consent constitutes discrimination, a form of violence and torture, or other cruel, inhuman or degrading treatment (35, paras 40 and 41; 111 para 37, 34, 35, 42; 112, para 17). They have called on states to prohibit such practices and adopt legislative changes clearly defining the requirements of full, free and informed consent with regard to sterilization of women with disabilities, in accordance with relevant international standards (35, paras 70–76; 42, para 98; 112, para 18; 113, paras 35 and 43).



In particular, the United Nations Convention on the Rights of Persons with Disabilities (CRPD) affirms the legal capacity of persons with disabilities and their right to equality and non-discrimination in all aspects of life, including the rights to found and maintain a family and to retain their fertility (114, arts 3, 5 and 23). The CRPD recognizes that persons with disabilities should have access to sexual and reproductive health services, which include voluntary sterilization and any other method of contraception, on an equal basis with others (3; 114, art 25; 115–117) and that these services must be based on full, free and informed consent in accordance with Articles 12 and 25. The Committee on the Rights of Persons with Disabilities has called for states to revise laws and administrative measures and to take other appropriate measures to prohibit forced sterilization and forced abortion (29, para 34; 30, para 38; 31, para 35). The Committee has also called on states to take appropriate measures to enable persons with disabilities to marry and found a family (30, para 37; 31, para 27), including providing access to sexual and reproductive health services (112, paras 59 and 60).

Various motivations for performing sterilization without the consent of persons with disabilities are not justified under the CRPD. Parents or guardians may have different motivations for persuading persons with disabilities, including those aged under 18 years, to opt for sterilization, often in the absence of full, free and informed consent (102, 118–121). Parents or guardians may be concerned about avoiding unwanted pregnancy, because of vulnerability to sexual abuse (97, 99, 122–127). However, sterilization does not protect against sexual abuse, and does not remove the obligation to provide protection from such abuse. Furthermore, enabling persons with disabilities to retain their fertility is rarely prioritized, even though less permanent contraceptive options are available (100, 128, 129). Instead of providing persons with intellectual disabilities with the necessary support to look after any children they may have, sterilization is offered to them as a way of avoiding the distress of having any potential children removed from their care (97, 106, 130).

“Menstrual management” should not be used as a pretext for contraceptive sterilization. Sterilization may be a secondary outcome of measures advocated by families and medical professionals for the purposes of menstrual management (127), which is a clinical term referring to suppression of menstruation in women who have or are perceived to have difficulties coping with or managing menses, or whose health conditions (such as epilepsy) or behaviour are negatively affected by menses (131). Women and girls with intellectual disabilities may receive involuntary surgical treatments, such as endometrial ablation and hysterectomy, to induce amenorrhoea, on grounds of menstrual hygiene or menstrual management; treatments that result in sterility (37, 132–134). Depending on the jurisdiction, procedures carried out on clinical rather than contraceptive grounds may or may not require court authorization (121, 123). However, sterilization is never the only option for menstrual management (128, 129, 135) and any procedure resulting in sterilization must be provided on the basis of full, free and informed consent.

Some states, family members, guardians, courts, review boards or tribunals are permitted under national law to take decisions on behalf of persons with disabilities; this is referred to as substitute decision-making (121, 122). Article 12 of the CRPD reaffirms that persons with disabilities have the right to recognition everywhere as persons before the law, and that states must ensure that persons with disabilities have access to the support they may require in exercising their legal capacity (114). This may include supported decision-making where supporters, advocates or other systems assist persons with disabilities to make their own decisions, free of conflict of interest or undue influence, and without transfer of decision-

making rights to third parties (as opposed to traditional substitute decision-making or guardianship) (114). The Committee on the Rights of Persons with Disabilities has consistently urged States Parties, including with respect to sterilization, to adopt laws and policies that replace substitute decision-making systems with a supported decision-making model that upholds the autonomy, wishes and preferences of the individuals concerned (28, paras 31 and 32; 29, paras 33 and 34; 30, para 38; 31, paras 34 and 35; 136, paras 37 and 38).



No child, including those with disabilities, should undergo non-therapeutic sterilization, without full, free and informed consent of the child. The United Nations Committee on the Rights of the Child has specifically addressed forced sterilization of persons with disabilities under the age of 18 years as a form of physical violence (136, para 23). The Committee has called upon states to prohibit, by law, the forced sterilization of children on grounds of disability (41, paras 23a and 41d; 137, para 60), and to provide these children with adequate information on relationships and sexual and reproductive health, as well as guidance and counselling (3; 5; 12; 41; 137, para 59; 138, art 24; 139, para 17).

## Transgender persons and intersex persons

In many countries, transgender and often also intersex persons are required to undergo sterilization surgeries that are often unwanted, as a prerequisite to receiving gender-affirmative treatment and gender-marker changes (16, 64).

According to international and regional human rights bodies and some constitutional courts, and as reflected in recent legal changes in several countries, these sterilization requirements run counter to respect for bodily integrity, self-determination and human dignity, and can cause and perpetuate discrimination against transgender and intersex persons (15, 64, 140, 141–146).

Intersex persons may be involuntarily subjected to so-called sex-normalizing or other procedures as infants or during childhood, which, in some cases, may result in the termination of all or some of their reproductive capacity. Children who are born with atypical sex characteristics are often subjected to cosmetic and other non-medically indicated surgeries performed on their reproductive organs, without their informed consent or that of their parents, and without taking into consideration the views of the children involved (64; 147, para 57; 148; 149). As a result, such children are being subjected to irreversible interventions that have lifelong consequence for their physical and mental health (64; 150, para 20; 151).

Medical procedures that might result in sterility may sometimes be justified because of benefits to health, including the reduction of cancer risk (152). Such treatments may be recommended for transgender or intersex persons; however, they may be proposed on the basis of weak evidence, without discussing alternative solutions that would retain the ability to procreate (151, 153–157). Parents often consent to surgery on behalf of their intersex children, including in circumstances where full information is lacking (151, 158, 159).

It has been recommended by human rights bodies, professional organizations and ethical bodies that full, free and informed consent should be ensured in connection with medical and surgical treatments for intersex persons (64, 150) and, if possible, irreversible invasive medical interventions should be postponed until a child is sufficiently mature to make an informed decision, so that they can participate in decision-making and give full, free and informed



consent (15, 149). It has also been recommended that health-care professionals should be educated and trained about bodily diversity as well as sexual and related biological and physical diversity, and that professionals should properly inform patients and their parents of the consequences of surgical and other medical interventions (149; 150, para 20; 160–162).

Discrimination on the basis of gender identity has been recognized by international human rights bodies as a human rights violation. Human rights bodies have condemned the serious human rights violations to which transgender and intersex persons are subjected and have recommended that transgender and intersex persons should be able to access health services, including contraceptive services such as sterilization, on the same basis as others: free from coercion, discrimination and violence. They have also recommended the revision of laws to remove any requirements for compulsory sterilization of transgender persons (39, para 21; 163, para 32; 164; 165; 166).

## Guiding principles for the provision of sterilization services



Special care must be taken to ensure that every person makes a voluntary and informed choice regarding the use of any contraceptive method (3). This is particularly important for sterilization, since it is a surgical procedure that is intended to be permanent.

The following principles should be respected in connection with the provision of contraceptive sterilization services or interventions that may result in permanent sterility of the person.

### Autonomy in decision-making

Respect for dignity and the physical and mental integrity of a person include providing that person with the opportunity to make autonomous reproductive choices (40, para 22; 114, art 23; 167, art 16). The principle of autonomy, expressed through full, free and informed decision-making, is a central theme in medical ethics, and is embodied in human rights law (168, 169). People should be able to choose and to refuse sterilization. Respecting autonomy requires that any counselling, advice or information given by health-care providers or other support staff or family members should be non-directive (119), enabling individuals to make decisions that are best for themselves, with the knowledge that sterilization is a permanent procedure and that other, non-permanent methods of fertility control are available. Clear guidelines that indicate the requirement of full, free and informed consent should be available and should be well understood by practitioners and the public, especially the affected populations (92, para 24).

Persons with disabilities may require support in decision-making about contraception and sterilization, as mandated by the United Nations CRPD (114, art 12). Safeguards may be required to ensure that this support respects the rights and preferences of the person concerned, that there are no conflicts of interest or undue influence, and that the support is proportional and tailored to the circumstances. International human rights law requires these procedural measures in all cases involving sterilization of persons with disabilities who may either appear functionally incapable of, or be legally restricted from, either deciding freely or giving full, free and informed consent (117, art 12).

Neither contraceptive nor therapeutic sterilization (e.g. menstrual management) are emergency procedures. Sterilization for prevention of future pregnancy cannot be justified on grounds of medical emergency, which would permit departure from the general principle of informed consent. Even if a future pregnancy might endanger a person's life or health, there are alternative contraceptive methods to ensure the individual concerned does not become pregnant immediately, and the individual concerned must be given the time and information needed to make an informed choice about sterilization (37). For example, sterilization can be discussed with a pregnant woman as an option, should the need for caesarean section arise later (170).

Requiring third party consent or authorization (including from a spouse, partner, medical practitioner or public officer) for contraceptive sterilization compromises decision-making authority and the enjoyment of human rights. In making a decision for or against sterilization,



an individual must not be induced by incentives or forced by anyone, regardless of whether that person is a spouse, parent, other family member, legal guardian, health-care provider or public officer (28; 36, para 20; 114, art 25; 136, para 38; 164; 171, para 20; 172, paras 31 and 32; 173, para 22).

## Provision of information and support

In order to make an informed decision about safe and reliable contraceptive measures, comprehensive information, counselling and support should be accessible for all people, including people living with HIV, persons with disabilities, indigenous peoples and ethnic minorities, and transgender and intersex persons. Individuals have the right to be fully informed by properly trained personnel. A provider performing sterilization has the responsibility to convey accurate, clear information, in a language and format that is readily understandable to the person concerned, together with proper counselling, free from coercion, to achieve full, free and informed decision-making (40, para 22; 78; 92, para 24; 173, para 22).

Sterilization is one among many methods of contraception that should be considered, taking into consideration each individual's health and social needs, and autonomy in decision-making should be respected (5, 37). Censoring, withholding or intentionally misrepresenting information about sterilization can put health and basic human rights in jeopardy (174).

## Access to medical records

The right to effective access to information regarding one's health includes access to medical records. All persons are entitled to know what information is being collected about their own health (176, art 10). The right to respect for privacy and family life includes being able to find out about whether or not sterilization has been performed, and the precise procedure used (177, para 44). Lack of access to their medical records makes it hard for individuals to get information about their health status or receive a second opinion or follow-up care, and can block their access to justice (177, para 65).

## Ensuring non-discrimination in provision of sterilization services

All individuals have the right to decide the number and spacing of children and the right to found a family on an equal basis (167, art 16e; 178, art 23b; 179, para 5). State family planning policies should not be discriminatory or compulsory (179, para 5).

Laws, regulations and policies should aim at eliminating stereotypes and discriminatory attitudes that lead to the practice of forced, coercive and otherwise involuntary sterilization, and should guarantee non-discrimination on all grounds (78; 82; 86; 114, arts 4 and 5; 167, art 2; 171; 173, 178, arts 3 and 26; 180, arts 2.2 and 3; 181, art 2; 182–185).

States parties' obligation to respect the right to health requires that they abstain from imposing discriminatory practices (40, para 14; 164, para 18). This includes an obligation to respect the rights of persons with disabilities and transgender and intersex persons, who also have the right to retain their fertility and the right to have access to sterilization and



### Box 1. Information required for making choices about sterilization

The information provided to people so that they can make an informed choice about sterilization procedures should emphasize the advantages and disadvantages, the health benefits, risks and side-effects, and it should enable comparison of various contraceptive methods. Counselling on sterilization should include the following points (3):

- The procedure is considered to be permanent.
- People who may want to have a child in the future should choose a different method of contraception.
- There are alternative temporary methods of contraception, including long- and short-term methods (details of available methods should be provided).
- Sterilization is a surgical intervention, and as such it may entail some risks.
- There are potential side-effects of the sterilization procedure, and follow-up care will be required (details should be provided).
- The person can change his or her mind and withdraw consent at any time.
- Sterilization does not protect a person from HIV, other sexually transmitted infections, or abuse.
- The decision to undergo contraceptive sterilization is a decision to be made by the individual only.

Information should be provided in a language and format, both spoken and written, that is understandable, accessible and appropriate to the needs of the individual. Factors such as educational level, physical or intellectual impairments and the age of the individual should be considered in counselling. Alternative and augmentative formats – such as braille, sign language or simple communication – should be provided, as appropriate to individual needs and preferences (5, 175). Persons with disabilities should be provided with all the necessary support for making their decisions (114, art 12). Extreme caution must be exercised, especially in the case of individuals who have limited ways of being understood by others, to ensure that decisions that should be made using the process of supported decision-making are not de facto substituted decisions.





other family planning services on an equal basis with others. Forced, coercive and otherwise involuntary sterilization may reflect multiple forms of discrimination, as such practices are often directed towards women because of their biological role in reproduction and also because of their ethnicity, disability, health, gender identity and expression, or other status.

## Accountability, participation and access to remedies

Accountability is central to preventing human rights violations and to ensuring that laws, policies and programmes are properly developed and implemented. Accountability mechanisms also assist in identifying individual and systematic human rights violations, as they provide victims with an avenue to air their grievances and seek redress.

International human rights standards require states to ensure effective accountability processes (including monitoring and evaluation), the availability of effective remedies, and the participation of a wide range of stakeholders in the development, implementation and monitoring of laws, policies and programmes (114). Individual, community and civil society participation – including of women living with HIV, persons with disabilities and transgender and intersex persons – in the development and monitoring of laws and policies, including budgets and use of public funds, is an important avenue for accountability (164).

Accountability can be achieved through a variety of processes and institutions that vary from country to country, and include both national and international mechanisms. Some examples include courts, national human rights institutions, professional disciplinary proceedings, and reporting to international and regional human rights bodies, including the United Nations. For instance, the International Coordinating Committee of National Human Rights Institutions has committed to monitor the exercise of reproductive rights and the right to sexual and reproductive health, including in cases of forced sterilization (182).

Regarding the right to effective remedies, treaty-monitoring bodies have noted that states parties should conduct fair and effective investigations of reports of coercive sterilization, prosecute perpetrators, and provide effective remedies and compensation for all victims of such practices (26; 33, para 18; 92, para 24; 183, para 6n; 184, para 10; 185, para 12; 186, para 12). Legal aid should be provided where people lack the means to access accountability mechanisms (181).

## Legal, regulatory, policy and practice actions



Human rights bodies have called upon states to take all appropriate measures to prevent coercion in relation to fertility and reproduction and to provide effective remedies for when such violations occur. They have specified that these measures may include clarifying and strengthening legal frameworks that ensure and clearly define full, free and informed consent; ensuring that such measures are well understood among practitioners and by the public; and training health professionals on patients' rights (29, para 34; 33; 40; 111, para 35; 92, para 24; 136, paras 37 and 38).

The following legal, regulatory, policy and practice actions may be relevant to stakeholders involved in regulating, monitoring or providing sterilization services, including but not limited to governments, parliamentarians, nongovernmental organizations, professional medical associations, ethical bodies, community groups, representative organizations of persons with disabilities, international agencies, bilateral and private donors, and international, regional and national human rights bodies. Accountability, however, rests with states, to prevent coerced sterilization, to explicitly prohibit such practices, to respond to the consequences of these practices, to hold the perpetrators responsible, and to provide redress and compensation in cases of abuse.

The specific suggestions that follow are based on a review of available information on involuntary, coerced and forced sterilization and their human rights implications, and some may be more appropriate in certain contexts than others.

### Laws, regulations and policies

- Provide legal guarantees for full, free and informed decision-making and the elimination of forced, coercive and otherwise involuntary sterilization, and review, amend and develop laws, regulations and policies in this regard.
- Review, develop, implement and monitor ethical and professional standards for the prohibition of discrimination and stereotyping on all grounds in connection with sterilization, in conformity with international human rights law and ethical standards.
- Provide legal guarantees to prohibit the sterilization of children, and review, amend and develop laws in this regard. In the case of medical necessity for procedures in children that may result in sterilization, the best interests of the child should always be the primary concern, giving due weight to the views of children in accordance with their age and maturity, and taking into account their evolving capacity for decision-making.
- Ensure that sterilization, or procedures resulting in infertility, is not a prerequisite for legal recognition of preferred sex/gender.
- Provide procedural safeguards protecting the rights of those who are at high risk of being subjected to medical interventions without informed consent. Appropriate legal, medical and ethical scrutiny should be applied for "menstrual management" interventions, such as endometrial ablation and hysterectomy, which result in sterility even though they are not defined as sterilization procedures. This might involve second opinions, independent advocacy or other measures.



- Prohibit public or private programmes or strategies that provide incentives for patients to undergo or for providers to perform sterilizations, and review, amend and develop laws, regulations and policies in this regard.
- Review, revise and amend laws to ensure that sterilization is available, accessible, affordable and of good quality for all individuals who desire the procedure, as one of a full range of contraceptive methods. Subsidize voluntary sterilization services for individuals, alongside the full range of contraceptive methods. Ensure that laws and policies do not impose rigid conditions for sterilization, such as rules about age, number of children, age of last child or marital status.

## Health services

- Ensure that services are based on appropriate clinical health standards and provided in a way that respects and fulfils human rights, with attention to the needs of populations that are vulnerable to involuntary, coercive and forced sterilization.
- When counselling about sterilization, provide accessible information on the risks and benefits of the procedure, its consequences and alternatives, in ways that respect the autonomy and dignity of the individuals and protect their confidentiality.
- Ensure that any procedures undertaken are performed based on the full, free and informed decision-making of the individuals themselves. Provide the time and, if necessary, the support required for individuals to make their decision. Ensure that health-care providers do not pressure individuals to use a particular method of contraception. A provider must respect the individual's informed choice, regardless of the provider's recommendations.
- In obtaining informed consent, take measures to ensure that an individual's decision to undergo sterilization is not subject to inappropriate incentives, misinformation, threats or pressure. Ensure that consent to sterilization is not made a condition for access to medical care (such as HIV or AIDS treatment, vaginal or caesarean delivery, abortion or gender-affirming treatment) or for any other benefit (such as recognition of identity, medical insurance, social assistance, employment or release from an institution).
- Where women face contraindications to pregnancy, offer sterilization as one possible method from the full range of contraceptive options available. There are no legitimate medical or social indications for contraceptive sterilization.
- As sterilization for the prevention of future pregnancy is not a matter of medical emergency, ensure that the procedure is not undertaken, and consent is not sought, when women may be vulnerable and unable to make a fully informed decision, such as when requesting termination of pregnancy, or during labour, or in the immediate aftermath of delivery. Consent for sterilization should be distinguished from consent for caesarean section. However, they may be discussed at the same time if such a decision can be made before the onset of active labour.
- In the absence of medical necessity, when the physical well-being of a person with an intersex condition is in danger, if possible, postpone treatment that results in sterilization until the person is sufficiently mature to participate in informed decision-making and consent.

- Ensure that individuals are advised about, and offered, follow-up examinations and care after any procedures.
- Ensure that the performance of sterilization is clearly documented in the medical record, which should be easily accessible for the individual concerned.



## Training and awareness

- Provide training to health-care providers and policy-makers regarding the principles of voluntary sterilization, with special attention to the content and meaning of full, free and informed consent.
- Provide training for health-care providers to ensure that they do not hold prejudicial or discriminatory attitudes towards people from disadvantaged groups, and that they can communicate effectively with them.
- Provide awareness training for journalists, to ensure that they do not promote and publish misleading, inaccurate or prejudicial information regarding sexual and reproductive health, particularly sterilization.
- Promote improved awareness of violations of human rights associated with sterilization.

## Supportive measures

- Provide supported decision-making systems that enable individuals with disabilities to exercise their capacity to make informed decisions for themselves. Ensure that these systems truly support decision-making, with respect for the will and preferences of the individual, rather than substituted decision-making under a new name.
- Provide assistance and support to parents with disabilities, so that they can raise their children.
- Provide assistance and support to women and girls with disabilities to help them manage their menstrual cycle, including promoting the availability of and access to sanitary products.
- Provide support and information to parents who have intersex children, for example through psychological counselling and peer support or self-help groups, as well as support for intersex children.
- Provide counselling for survivors of coercive sterilization.

## Remedies and redress

- Recognize past or present policies, patterns or practices of coercive sterilization, and issue statements of regret or apology to victims, as components of the right to remedy for these practices.
- Provide notification, through appropriate and humane means, to people who have been subjected to coercive sterilization, and who may be unaware of their situation, and provide information on the possibility of seeking administrative and judicial redress.



- Promptly, independently and impartially investigate all incidents of forced sterilization with due process guarantees for the alleged suspect, and ensure appropriate sanctions where responsibility has been established.
- Provide access, including through legal aid, to administrative and judicial redress mechanisms, remedies and reparations for all people who were subjected to forced, coercive or involuntary sterilization procedures, including compensation for the consequences and acknowledgement by governments and other responsible authorities of wrongs committed. Enable adults to seek redress for interventions to which they were subjected as children or infants.
- Guarantee access to reversal procedures, where possible, or assisted reproductive technologies for individuals who were subjected to forced, coercive or otherwise involuntary sterilization.

## Monitoring and compliance

- Establish monitoring mechanisms for the prevention and documentation of forced, coercive and otherwise involuntary sterilization, and for the adoption of corrective policy and practice measures.
- Collect data regarding forced, coercive and otherwise involuntary sterilization, in order to assess the magnitude of the problem, identify which groups of people may be affected, and conduct a comprehensive situation and legal analysis.
- Providers of sterilization services should implement quality improvement programmes to ensure that recommendations aimed at preventing forced, coercive and otherwise involuntary sterilization are followed and procedures are properly documented.
- Establish mechanisms for obtaining patient feedback on the quality of services received, including from marginalized populations.

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