

Final Statement of the Public Defender of Rights in the Matter of Sterilisations Performed in Contravention of the Law and Proposed Remedial Measures

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1. Introduction

On September 9, 2004, the Public Defender received a complaint, via IQ Roma servis, from ten Romani women concerning their sexual sterilisation without due consent. They either claimed that they had not consented to the intervention at all, or admitted they had signed some documents but asserted that they had not been in a situation to make any judgment, due to a lack of information from attending physicians on what treatment they would undergo. These complaints fitted the context of previous events that suggested the Czech Republic would have to come to terms with the burning issue given the working title "the sterilisation of Romani women" for the purposes of this report.

The European Roma Rights Center addressed the Public Defender of Rights in February 2004. Based on its staff's interviews with Romani women, the Center had concluded that the problematic sterilisation of Romani women, a practice the Center asserts contravenes fundamental human rights, has taken place in the Czech Republic. To illustrate its suspicion, the Centre attached a list of people's names with the towns where sterilisation was purported to have happened to a request that the Public Defender of Rights investigate the cases. Because the Center's data did not give detailed identification of those affected, the Public Defender of Rights called on the Center to complete it, and respectively instructed the Centre on the requisites a complaint to the Public Defender of Rights must include to be acted upon. The Center took a long time to react to this. The stances were clarified only at a personal meeting of the Public Defender of Rights and the Center's representatives, where the conditions necessary for the Defender to take an active role in investigating cases the Center had highlighted were repeatedly stressed. These discussions resulted in enlisting the civic association IQ Roma servis, Liga lidských práv (League of Human Rights) and Vzájemné soužití (Living Together) to mediate contact between the sterilised women and the Public Defender of Rights, and the filing of the first complaints.

Quite apart from the activities initiated by the European Roma Rights Center, the Public Defender of Rights received a complaint from a man who, on behalf of his wife (also Roma), condemned her sterilisation, which had been performed even though as an illiterate deaf-mute she could not express her consent in a qualified fashion. This man began to co-ordinate the efforts of other women in his area who also objected to the dubious circumstances of their sterilisation.

In addition to this, it should be borne in mind that the European Roma Rights Center's complaint, and those of other associations or individuals who became active in gathering details on the affected women (IQ Roma servis together with Vzájemné soužití, and the League of Human Rights), came roughly a year after public discussion on the same topic had climaxed in Slovakia, stirred by publication of "Telo i duša" (Body and Soul) by the Centre for Reproductive Rights and the Counselling Centre for Citizenship, Civil and Human Rights. The Public Defender of Rights was aware of societal processes in coming to terms with similar issues in Sweden and Switzerland. Given these connections and the fact that the potentially problematic sterilisations of Romani women have been pointed out to a greater or lesser extent for more than 15 years, the Public Defender of Rights decided to pay the utmost attention to reports of involuntary sterilisations.

This issue is not typical of the agenda of the Public Defender of Rights. It became evident from the outset that a procedure restricted to the mere application of the Act on the Public Defender of Rights would not meet the expectations of complainants or public. It is important to be aware that the Public Defender of Rights is, in compliance with the provisions of Section 1 of Act No. 349/1999 Coll. on the Public Defender of Rights, as later amended, tasked with protecting persons against the conduct of authorities and other institutions specified in the Act on the Public Defender of Rights, if such conduct is in conflict with the law, the principles of a democratic legal state, the principles of good administration, or if authorities or institutions are inactive.

Complaints of involuntary sterilisation are not about any authority or institution specified in the Public Defender of Rights Act, but are rather against doctors and healthcare facilities. Strictly speaking the basic condition for execution of the Public Defender of Rights' authority in accordance with the Public Defender of Rights Act was not met. The Public Defender of Rights was conscious of this from the beginning. Therefore the Defender chose to act to some extent outside what the Act stipulates in the matter. He did so particularly because the women addressing him opened an issue they did not have the courage to speak on publicly, each for herself and formally in the presence of authorities, and thus expressed extraordinary trust in the Public Defender of Rights as guarantor of due investigation into the matter. This basic trust between a state institution and a citizen who has chosen to give evidence on the most intimate of concerns could not be trampled on by a formal refusal to act on this sensitive issue due to a lack of authority. Thus the Public Defender of Rights plumped

for an approach that enabled him to remain the mediator between the state and the women who had addressed him, and yet consequently to execute his basic mission in line with the Public Defender of Rights Act, i.e. to pay attention to the legality of the public administration authorities' conduct. Therefore, the Public Defender of Rights chose to pass the complaint to the Ministry of Health as the methodological starting point because the complaints are in a wider sense about healthcare given, while observing the process of complaint settlement by state administration authorities in healthcare and assessing the Ministry's steps after completion of the process. Besides, it was evident the whole case must be assessed in a wider, particularly historical and international, context, with special concern for the fact that the vast majority of the cases concerned Roma.

It is necessary to focus separately on cases prior to 1990, and those after. It is a historical fact that pre-November [1989] Czechoslovakia applied a set of measures against the Romani community aimed at its gradual assimilation into society as it was. These measures included efforts by social services to control the birth rate in the Romani community to stop it presenting a "social risk". However, no state policy concerning work with the Romani community counts on any pressure for Romani birth control after 1990, and the issue moves into the realm of doctor-patient interactions.

Rather than the final word on the cases of the women who addressed the Public Defender of Rights, this report is an attempt to present the issue in as broad a context as possible; an attempt that should become a focus of further consideration and discussion for Czech authorities; a document primarily for the Chamber of Representatives of the Czech Parliament, given the Public Defender of Rights is functionally linked with its monitoring role. The experience of the parliamentary initiative of Margrith von Felten, a Swiss National Council MP, revealed that a debate on the causes, course and implications of state-implemented sexual sterilisation as a social measure or an intervention in circumstances that would not meet the strict criteria of informed consent, should be held primarily in Parliament.

The report's chief purpose is to communicate the following fundamental message: The Public Defender of Rights believes that the problem of sexual sterilisation carried out in the Czech Republic, either with improper motivation or illegally, exists, and that Czech society stands before the task of coming to terms with this fact. The Public Defender of Rights is certain that accepting this unpleasant reality is the only way to bring about a catharsis, endorsing measures that would make the practices highlighted by this report impossible. The report contains proposed measures. However, undertaking the proposed measures without acceptance that something intolerable is taking place, something that the proposed measures respond to, would not accomplish the essential task staked out by the Public Defender - to set up grounds for reflection and changing the attitudes of those who believe that everything in the described conduct was and is correct.

2. The Course of the Inquiry

The Public Defender of Rights received complaints from 10 women, by means of general proxy, on September 9, 2004. These women stated in their complaints that they had been sterilised without consenting to the intervention, or respectively that their consent was not free and informed. They objected that they had suffered illegal interference in their physical and mental integrity, and thus an invasion of their rights.

Aware of the gravity of the issue, and that Slovakia had had to come to terms with similar accusations a year ago, the public Defender of Rights decided to initiate and co-ordinate the activating of standard control mechanisms that he believes should first take a view on the cases and guarantee their due investigation. Therefore, he asked Minister of Health, Milada Emmerová, in a letter dated September 22, 2004, to take on the complaints with the intention of inquiring into the medical personnel's conduct and to set up a central expert committee for this purpose in accordance with Section 2 of Decree No. 221/1995 Coll., on expert committees, as later amended.

Once the Minister of Health had declared her readiness to set up a central expert committee, on October 1, 2004, the Public Defender of Rights addressed it with a list of questions the committee was to answer in each case. The Minister of Health then stated in a letter dated October 4, 2004, that she would set up a central expert committee for the first ten cases and named its members.

On October 18, 2004, the Public Defender of Rights approached Minister of Labour and Social Affairs, Zdeněk Škromach, with a request to provide information, statistical data and other facts pertaining to the application of Section 35 and 31 par. 4 of Decree No. 152/1988 Coll., that permitted giving a social benefit of up to CSK 10,000 in association with a medical intervention "in the interest of a healthy population", i.e. sterilisation.

On October 25, 2004, the Public Defender of Rights addressed the Supreme Public Prosecutor, Marie Benešová, and asked for documentation gathered by the then General Prosecutor's Office of the Czech and Slovak Federative Republic as part of the inquiry into Roma sterilisation at the beginning of the nineties.

On November 8, 2004, the Minister of Health informed the Public Defender of Rights by letter that she had revised her initial decision to set up a central expert committee on the cases of sterilised women because the issue of sterilisations generally went beyond the committee's authority, given that it involved a need to inquire into the legality of the given acts rather than to inquire into the professional conduct of medical personnel while rendering healthcare ("lege artis" conduct). As a result of that, and the fact that the Council of Europe's representatives were seeking to take part in inquiring into the cases, the Minister decided to set up an advisory board instead, in compliance with Section 70 par. 6 of Act No. 20/1966 Coll., on Care of People's Health, as later amended.

The first advisory board hearing was held on December 20, 2004. On January 11, 2005, the Public Defender of Rights passed the complaints of 51 other persons to the Minister of Health, on April 22, a further 3 persons and one person's on May 25. A few other complaints followed; in total the Minister received 87 cases before this report was issued.

The Public Defender of Rights received the first information on the advisory board's conclusions from the Minister of Health on January 27, 2005, pertaining to January 18, 2005, i.e. the date of the second advisory board hearing. The advisory board issued a general statement on the first 10 cases and on each case separately. The statement included recommendations to the Minister. The advisory board recommended to the Minister to:

- support all forms of family planning,
- produce a unified informed consent to sterilisation process, including a consultation with a psychologist,
- reassess the present permitted indications for sterilisation,
- update a directive on sterilisations, particularly in association with the performing of a caesarean section.

After that the Minister of Health sent the results of the advisory board's inquiry continuously, on May 27, 2005 (minutes from the advisory board's meeting on March 29, 2005, April 11, 2005 and May 10, 2005), July 7, 2005, and July 15, 2005. Given the Health Ministry's time-consuming inquiry into the complaints, the Public Defender of Rights decided to conclude the first complete set of 50 complaints based on the Ministry's last letter and proceed to a thorough assessment.

In addition, the Public Defender of Rights sent eight cases concluded by the advisory board to the Supreme State Prosecutor's Office proposing that the factual circumstances imply a criminal act may have been committed (the advisory board actually also suggested passing three of the cases to the criminal prosecution authorities), on March 11, 2005. The Defender did the same with the remaining cases on August 2, 2005. The Supreme Public

Prosecutor's Office passed individual cases to local Regional Public Prosecutor's Offices for further proceedings in compliance with the Criminal Code.

On September 8, 2005, the Public Defender of Rights assessed the results of the advisory board's inquiry and sent an interim report on the inquiry to the Minister of Health in compliance with Section 18, par. 1 of Act No. 349/1999 Coll., on the Public Defender of Rights, criticising the advisory board for inadequate activity and asked what implication the Minister of Health was going to draw from the advisory board's and Public Defender of Rights' findings.

On September 29, 2005, the Minister of Health reported that another hearing of the advisory board would be held on November 14, 2005, on the new set of complaints. The board should then suggest corrective measures for cases where shortcomings were established within the scope permitted by Act No. 20/1966 Coll., on Care of People's Health, as later amended. Draft wording of the informed consent for patients prior to sterilisation and a draft amendment to legislation pertaining to sterilisation pending endorsing of the new draft act on healthcare were to be discussed at this hearing. Besides this, the Minister of Health referred to the drafted law on healthcare that is to treat the procedure for performing sterilisations in an entirely new way.

The government's draft law on healthcare that the Minister of Health referred to¹ treats the conditions for sterilisations in the provisions of Sections 45 et seq. differently. Sterilisation is permitted for health reasons, i.e. if illness would cause a serious threat to the health or life of the mother in case of a pregnancy, or if as a result of such illness the health or life of a future child would be at risk, as well as for other than health reasons (i.e. in fact as a family planning method).

Sterilisation on health grounds is conditioned by the consent of the person to be sterilised, i.e. assumes the sterilisation would be proposed by a doctor to prevent a future health risk. Sterilization on other than health grounds can be carried out only on the application of the person to be sterilised. In this respect the framework of the current treatment is preserved. The law will prescribe the written form for both acts, i.e. consent and application, while such interventions must be recorded in the medical records.

The draft law will also set out the doctor's duty to inform the patient of the nature of the treatment, its permanent consequences and the potential risks in any sterilisation. This information must be given in the presence of a witness - another doctor. The patient may, in accordance with the draft, ask for another witness of his/her choice to be present. A record is to be made of the informing process, signed by the attending physician, witnesses and patient. This will become part of the medical records.

Under the draft law, sterilisation may only begin after the patient has expressed his/her consent in compliance with Section 103 of the draft law, and this consent must be recorded in the medical records and signed by the attending physician and the patient. Consent under Section 103 of the draft law is probably the biggest novelty in the current legislation because it clearly specifies the requirements for informed consent. The draft will stipulate that healthcare, including diagnostic and therapeutic treatment (if we omit the classical exceptions of an emergency or a patient's incapacity to give consent) can be given to a patient only with his/her consent, which must be free, informed and qualified. Consent is deemed to be

1. free, if given without pressure,
2. informed, if the patient was given information under Section 99 par. 1 or Section 101, par. 1 of the draft prior to such consent, provided the patient's state of health permits giving such information,

¹ Concurrently discussed by the Chamber of Deputies of the Czech Parliament as Parliamentary Draft No. 1151/O.

3. qualified, if it is evident from patient's behaviour s/he has understood the information and is capable of assessing it.

The patient may withdraw the consent at any time. The attending physician must appropriately and comprehensibly instruct the patient of the consequences of consent's withdrawal. The withdrawal of consent must then be respected, unless irreversible diagnostic or therapeutic steps have been taken, or their disruption would represent a serious threat to the patient's life or health.

In compliance with the mentioned Section 99 of the draft, the attending physician must inform the patient appropriately and comprehensibly of their state of health and the essential medical procedures. The information is always given prior to the start of giving healthcare, as well as prior to a specific therapeutic or diagnostic step ("therapy"), and in the course of giving healthcare. Information must be given in a clear manner that the patient understands and so can consider the need for and purpose of the intended therapy and the ensuing risks, including discomfort, pain and other restrictions associated with the therapy, freely and without pressure. Such information will **primarily** contain:

1. appropriate, truthful and comprehensibly formulated information on the diagnosis and character of the illness and its presumed development (prognosis),
2. information on the therapeutic plan, procedures in the therapy and therapeutic rehabilitation; if there is a choice of several diagnostic care procedures or therapies, the patient must be informed of all the procedures, their appropriateness, advantages and risks; concurrently the attending physician will recommend the therapy, and potentially spa care, the attending physician deems best for the patient,
3. information on potential risks of therapy and individual therapeutic or diagnostic acts,
4. information on the expected benefit of the therapy and individual therapeutic or diagnostic treatment, and possibly on the consequences of non-treatment,
5. necessary data on the therapeutic regime and preventive measures suitable after specific therapeutic or diagnostic treatment, or after therapy termination as well as information on changes in medical competency if the state of health changes,
6. notification if information on the patient's state of health is filed to the National Health Information System under this law, the purpose of its filing and potential use; if personal information on a patient is sent to the National Health Information System the doctor will notify the patient of the scope of the information sent as well,
7. informing the patient of the right to make a free decision on further proposed healthcare procedures unless this law or special legal regulations completely rule this out.

The patient must also have an opportunity to ask supplementary questions within the scope stipulated in paragraphs 1 and 2, and the attending physician must respond.

The Public Defender of Rights deemed the Minister of Health's letter dated September 29, 2005, to be a statement on his report under Section 18 par. 1 of the Public Defender of Rights Act. Since the matter was not concluded satisfactorily by this letter, the Public Defender of Rights proceeded, in compliance with Section 19 of the Public Defender of Rights Act, to the framing of this report.

3. The Legal Admissibility of Sterilisation in Healthcare

The first part of the report will pay attention to sterilisation in general terms, and in terms of medical law. The prime issue is the conditions allowing the medical performance of sexual sterilisation to avoid illegally interfering with a person's physical or mental integrity. We can extrapolate from historical and social aspects of cases that refer to the "Roma issue" to assess the matter. Further chapters of this report will evaluate such aspects. This chapter will attempt to analyse cases to facilitate reaching generally applicable conclusions. These conclusions ought to apply to any case of healthcare provision regardless of the patient's affiliation to any nation, or social or ethnic group.

The Public Defender of Rights decided to split both aspects (i.e. general medical and legal, and specific "Romani") primarily by understanding that cases from the nineties show key deficiencies chiefly in applying the principle of so-called "informed consent" to health interventions. This has universal significance. The application of the concept of informed consent has been discussed for years in the medical literature. Nonetheless it seems doctors have yet to internalise this legal postulate, with all its practical implications.

3.1. The Legal Framework for Sterilisation

The human body's integrity, respectively its protection against external intervention without the person's consent, has been the focus of law from time immemorial. We can hardly find a single classical human-legal document that would fail to list the inviolability of the person in the catalogue of fundamental rights and freedoms. Inviolability of a person as stipulated in Article 7 par. 1 of the Charter of Fundamental Rights and Freedoms, is the right to the undisturbed preservation of person, i.e. preserving his/her integrity corresponding with a ban on disturbing that integrity, a right constitutionally and internationally proclaimed and protected. This prohibition acts *erga omnes* – i.e. in the sphere of private as well as public law. The mechanism of interference, how such an intervention in the inviolability of a person occurs, is immaterial – that can happen in any manner. It is the result, not the mechanism, which is relevant with respect to Article 7 of the Charter or the corresponding provisions of international treaties on human rights and freedoms.²

This approach to a person's right to the absolute inviolability of his/her physical and mental integrity along with prohibition of torture and cruel, inhuman or demeaning treatment (for instance Art. 7 par. 2 of the Charter, Art. 7 of the International Covenant on Civil and Political Rights, or Article 3 of the Convention for the Protection of Human Rights and Fundamental Freedoms) obviously has significant implications for healthcare. We must understand that medical interventions or procedures, including non-invasive diagnostic methods, can be interventions in the integrity of a human personality, regardless of the intent to preserve or improve health. Therefore, it is essential we steer clear of the reasoning that medical interventions on patients are not interventions into physical integrity because such integrity has already been violated by illness or injury and the intervention is designed to remove or lessen the results. The medical field may have this understanding, yet the inviolability of a person in legal terms expresses the fundamental right to the absence of external interference because the integrity of the person may be "violated" in a medical, psychological or other sense. Only the law under the conditions stipulated in Art. 4 pars. 3 and 4 of the Charter, or the consent of the person who enjoys this right to such non--interference, may change the right to preserve physical and mental integrity comprehended thus.

The applicable legislation for providing healthcare, dating from 1966, is based on an awareness of the need for the inviolability of a person. The provisions of Section 23 of Act No. 20/1966 Coll., on Care for People's Health, have survived virtually unchanged since its

² Pavlíček, V. a kol.: Ústava a ústavní řád České republiky, 2. díl, (or The Constitution and Constitutional Code of the Czech Republic) Práva a svobody, Praha 1999, pages 76-77.

inception, and stipulate that a doctor is always obliged to inform the patient or his/her family members if appropriate, of the nature of the illness and essential treatment and thus make them active participants in the therapeutic or preventive care. Diagnostic and therapeutic treatment can be only given with the patient's express consent, or if the consent can be assumed from the circumstances³.

The basic rule of diagnostic and therapeutic treatment with the patient's consent has a single exception - those situations stipulated in pars. 3 and 4 of the mentioned provision. Firstly, this applies to cases of urgent diagnostic or therapeutic treatment vital to preserve the life or health of a child incapable of making a qualified judgement on the acts' urgency due to his/her cognitive immaturity, or of a legally-incapacitated person when the parents or legal guardian refuse to agree to such treatment. The doctor has the right to decide on intervention in such cases. Secondly, the right to preserve physical and mental integrity in healthcare does not apply when against the public interest pertinent to the protection of public health and order, or possibly when against the interest of persons whose life and health are under threat yet are incapable of giving consent. It is therefore possible to perform diagnostic and therapeutic treatment without the patient's consent for conditions defined in special regulations where compulsory treatment can be imposed if a person exhibiting signs of mental illness or intoxication endangers him/herself or their surroundings, if it is impossible to ask for consent given the state of health and the treatment is needed to preserve life or health, and finally in cases pertaining to carriers of infectious diseases specified in special legal regulations.

This basic approach to medical intervention's admissibility has lately been shifting to the benefit of the patient's utterly free and responsible decision on healthcare treatment. As a result of a far-reaching change in the understanding of the doctor-patient relationship (partnership replacing paternalistic), the demand to let the patient decide what treatment to accept, once having been fully and comprehensibly informed of his/her health state, the proposed treatment, its nature and purpose as well as its implications and risks, has been mounting since the middle of the last century, chiefly in the USA and later in western Europe. This trend climaxed in Europe with the Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine (endorsed on April 4, 1997, binding on the Czech Republic since October 1, 2001, declared under No. 96/2001 Coll. of International Treaties) accepted by the Council of Europe.

The Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine defines a general condition for the admissibility of any intervention in healthcare – namely the free and informed consent of the person to be subject to such intervention (art. 5). In compliance with the article, informed consent means the patients must be duly informed in advance of the purpose and nature of the intervention, its implications and risks. A logical consequence of the general rule of the necessity of free consent is an explicitly stipulated right to withdraw such consent. The Convention on Human Rights and Biomedicine in articles 6 to 8 defined exceptions to this general rule where the application of this rule is prevented, as in the current Czech legislation, by the need to protect other interests.⁴

³ See below on "implied" consent under this provision.

⁴

Art. 6

Protection of persons unable to consent

1. Subject to Articles 17 and 20 below, an intervention may only be carried out on a person who does not have the capacity to consent, for his or her direct benefit

2. Where, according to law, a minor does not have the capacity to consent to an intervention, the intervention may only be carried out with the authorisation of his or her representative or an authority or a person or body provided for by law.

The opinion of the minor shall be taken into consideration as an increasingly determining factor in proportion to his or her age and degree of maturity.

As the Convention on Human Rights and Biomedicine directly applies and has priority over the provisions under Article 10 of the Czech Constitution, the informed consent rule should be preferentially applied over a country's internal regulation that might stipulate a lower standard. Therefore it is of utmost importance to focus on the content of the informed consent postulate a little closer, particularly in cases of sterilisation after October 1, 2001. This does not mean that significantly different rules would have applied to interventions prior to this date. The informed consent rule as stipulated by the Convention can be derived from the very substance of the doctor-patient interaction as a relationship of two private persons based on a legal act in compliance with material civil law.

Informed consent in legal theory rests in two fundamental mutually related rights of an individual affected by medical intervention. First is the patient's right to receive true, full, comprehensible and thorough information to enable him/her to decide whether to consent, prior to any intervention medical personnel intend to the patient's health. The second is the right for any healthcare intervention to be performed only on the basis of the patient's prior free consent granted after receiving information as outlined above.⁵

The rule of informed consent is also an expression of the fact that the relationship between the doctor (a medical employee) and patient in rendering healthcare is exclusively a private law relationship based on the equality of both parties (obviously with the above-mentioned public interest exceptions). *"While performing medical interventions doctor generally acts towards the patient as a legally equal provider of a service; not as a superior public authority. Medical intervention is a performance, a service rendering, not an act of public power. It is irrelevant whether it happens while rendering medical care under public health insurance or beyond the scope of such insurance based on contractual health insurance or for compensation in cash."*⁶

If the relationship between doctor and patient is a relationship between equals in legal terms, the doctor may intervene in a patient's psychological or bodily integrity only on their agreement (consensus) concluded with the patient's consent.

The patient's consent is undoubtedly a legal act under Section 34 *et seq.* of Act No. 40/1964 Coll., the Civil Code, as later amended. Should consent be seen as a legal act, i.e. a manifestation of the will of the person acting intended to instigate, change or terminate the rights and responsibilities that legislation associates with such a manifestation, the

3. Where, according to law, an adult does not have the capacity to consent to an intervention because of a mental disability, a disease or for similar reasons, the intervention may only be carried out with the authorisation of his or her representative or an authority or a person or body provided for by law. The individual concerned shall as far as possible take part in the authorisation procedure.

4. The representative, the authority, the person or the body mentioned in paragraphs 2 and 3 above shall be given, under the same conditions, the information referred to in Article 5.

5. The authorisation referred to in paragraphs 2 and 3 above may be withdrawn at any time in the best interests of the person concerned.

Art. 7

Protection of persons who have a mental disorder

Subject to protective conditions prescribed by law, including supervisory, control and appeal procedures, a person who has a mental disorder of a serious nature may be subjected, without his or her consent, to an intervention aimed at treating his or her mental disorder only where, without such treatment, serious harm is likely to result to his or her health.

Art. 8

Emergency situation

When because of an emergency situation the appropriate consent cannot be obtained, any medically necessary intervention may be carried out immediately for the benefit of the health of the individual concerned.

⁵ Svoboda, P.: Informovaný souhlas pacienta při lékařských zákrocích (or Informed Consent of the Patient to Medical Interventions) (Teoretická východiska, Convention on Biomedicine), in: Správní právo (or Administrative Law), 3/2004, page 140.

⁶ Ibidem, page 143.

manifestation of will must be actual - something that actually happens. Therefore such consent cannot be presumed. The previously mentioned provisions of Section 23 par. 2 of the Care of People's Health Act that subjects the admissibility of diagnostic and therapeutic treatment to consent or situations where such consent can be presumed, is thus misleading in this respect. The interpretation that Section 23 par. 2 institutes a legal presumption of consent is unacceptable from the perspective of the above-mentioned postulates. Subject to Section 35 par. 1 of the Civil Code, actual consent can be given expressly (in writing or orally), or be implied (manifestation by act or omission). Thus, an implied manifestation of will is any manifestation of will actually taking place, not necessarily expressed, but which does not invite doubt as to what the party intended. A presumed act is an act where it is unclear whether it actually happened, but law in its artificial construction creates a presumption based on stipulated conditions that it did take place. The provisions of the Act on care of People's Health on "presumed" consent can therefore be interpreted as if a patient's consent may also be implied, manifest or by omission.

Previous information on intervention must be regarded from the legal theory perspective, which perceives consent to medical intervention in physical or mental integrity as a legal act subject to Section 34 of the Civil Code. As mentioned earlier, a patient must be informed of the intervention in advance to be able to apply the right of free consent. The patient must also be informed of the intervention's purpose, i.e. of the essence of his/her illness, because the patient, usually a layperson, cannot work out the essence of the illness and propose an effective therapy. This information is the *conditio sine qua non* of the patient's decision. If the doctor fails to present any of the information, or the information is untrue or incomplete, the patient grants the consent in legally relevant error (Section 49a of Civil Code) capable of resulting in the invalidity of such a legal act, i.e. invalidity of the consent to the intervention, and thus illegality of the whole intervention.⁷

*"If legally relevant error is to be eliminated from a patient's consent to (refusal of) medical intervention, the decision must be made on the basis of a correct and full perception of two decisive facts: the intended intervention and the reason for the intervention, i.e. the character of the illness. This can be guaranteed solely by true and complete information, received from a doctor in advance. Without relevant information from the doctor, the patient cannot have any opinion on the intervention the doctor intends. Since the patient is usually a layperson, s/he has not and cannot have any qualified idea about their illness without relevant information from the doctor. If the patient has any idea, it is usually (1) a concept of the illness' symptoms, not its substance, and (2) possibly some idea of the illness' substance that tends to be a mixture of lay speculation (guesses), and not a qualified perception. This suggests that unless the doctor gives the patient information on some of the mentioned facts, the patient will not have any idea of them, or only a speculative idea (amateur and confused), i.e. devoid of reality. If the doctor does give the patient such information, yet it is largely untrue or incomplete, the patient will to some extent have an incorrect or incomplete idea of the decisive facts. If s/he decides on the basis of such absent, speculative, incorrect or incomplete ideas, the patient might well act in legally relevant error, which the other party, the doctor, has brought about by their omission or (merciful) lie, or at least had to know of in the evident circumstances (see Section 49a of the Civil Code)."*⁸

⁷ Intervention consented to in legally relevant error may have consequences ensuing from criminal law. Under Section 209 par. 1 of Act No. 140/1961 Coll., the Criminal Code, as later amended, a person causing serious damage to another's rights by misleading someone or using someone's error, can be punished by imprisonment for up to two years or fined.

⁸ Op. cit. in note 39, page 146.

In the case of sexual sterilisation, a treatment that virtually⁹ irreversibly affects (eliminates) reproductive ability of a human being, this basic framework of legal consequences of a medical intervention as an intervention in bodily or psychological integrity boasts another dimension. The free choice of the number and timing of the birth of children, the choice to freely use reproductive ability in a partnership, is rightfully one of the most private human rights that law respects in a special manner. Under Article 10, par. 2 of the Charter, everyone has a right to protection against wrongful intervention in private and family life. The provisions of Article 17 of the International Covenant on Civil and Political Rights stipulate that no one can be subjected to illegitimate interference with his privacy, family, home or correspondence and everyone has a right to the protection of the law against such interference or attacks. Under Article 8 par. 1 of the Convention for the Protection of Human Rights and Fundamental Freedoms, everyone has the right to respect for his private and family life, his home and his correspondence.

A number of decisions of the Constitutional Court and the European Court for Human Rights have considered the normative content of the above provisions, and thus the content of the "private and family life" term pertaining to the provisions is apparent from the judicature. The European Court for Human Rights opted for a broad interpretation of the term when it implied the right to respect for private and family life is not merely restricted to an individual's free decision-making on making information pertaining to their privacy accessible to other persons, and to protection against encroachments into the individual's rights (protection against making facts from an individual's private life public without their consent). The term "private life" under Article 8 par. 1 of the Convention cannot be restricted to an inner realm where the individual can live their private life at their pleasure and wholly exclude the external world. Respect for private life comprises of the right to establish and maintain relationships with other human beings, particularly in the emotional sphere, to have possibility to develop and fulfil one's personality (European Court for Human Rights judgement in the case of Niemietz versus Germany and judgment of the same court in the case of Beldjoudi versus France). Likewise, the Constitutional Court, in judgment No.: II. ÚS 517/99 for instance rejected excessive accenting of the positive component of the right to privacy (i.e. the right to freely decide what facts from their privacy an individual would reveal to the public), because it leads to an unacceptable narrowing down of protection to a mere not publicising of facts from private life without consent or a legally-recognised justification and thus avoiding interference with the inner integrity vital for the constructive development of a personality. The Constitutional Court does not share this narrow approach in its judicature, because respect for private life must include a right to establish and develop relationships with others, to a degree. Private life also consists of family life including relations among close relatives, while family life incorporates social and moral relations together with material interests (for example alimentary duty). Respect for private and family life, when approached in this way, also applies to the state's duty to act in a manner facilitating the normal development of such relations. Intervention in an individual's reproductive abilities without his/her consent, as described above, undeniably upsets private and family life because it affects the most intimate of human relations that gives rise to family life, which is, as we have seen, under constitutional protection.

Founding a family and the freedom to decide the number and spacing of children born enjoys special recognition and protection as an expression of full respect of the right to a private life in special provisions of lists of human rights. To name but a few, for instance Article 23 of the International Covenant on Civil and Political Rights ("The right of men and women of marriageable age to marry and to found a family shall be recognised"), the similarly worded article 12 of the Convention for the Protection of Human Rights and

⁹ The data on the success rate of refertilising operations varies in the literature, according to some sources "end-to-end" tubal anastomosis interventions are 70-80% successful, while other sources give a drastically lower success rate (about 30%). The success rate or in fact practical feasibility of refertilisation is dependent on the applied method of tubal sterilisation – particularly surgical, electro-coagulation and occlusive methods using chemicals cause devastation of a relatively wide-spread section of the tube, rendering its anastomosis by a refertilising operation often impossible.

Fundamental Freedoms, or, primarily, the UN General Assembly Declaration of Social Progress and Development dated December 11, 1969, recognising the exclusive right of parents to determine freely and responsibly the number and spacing of their children, in Article 4.

Irreversible intervention in an individual's reproductive ability may in specific cases also fall under another constitutionally secured area of religious freedom and conscience subject to Article 15 par. 1 of the Charter of Fundamental Rights and Freedoms. This freedom defines the absolute right of a person to control his decisions in compliance with his values arising from religious, philosophical or other convictions in the *fora interna* area. It is also important to realise that some religions (or better some beliefs within individual religions) for instance deem any artificial intervention in reproductive capacity morally unacceptable¹⁰, while this is similarly unacceptable in some societies for cultural and social reasons. Sterilisation performed without consent may therefore fall into this field as well and it is important to deal with this dimension in practice.

A special dimension ought to be mentioned to complete the human and legal stance on the sterilisation issue, i.e. taking into account that sexual sterilisation is distinctively a "women's" issue worldwide. It is a poignant fact that primarily women are the subject of sexual exploitation and inadmissible manipulation with human sexuality. Thus, law pays special attention to issues of women's sexual health. For that reason we refer here to the Convention on the Elimination of All Forms of Discrimination Against Women (declared under No. 62/1987 Coll.). Under Article 10 of the Convention, the state is supposed to ensure education for women as well as access to information to help to ensure the health and well being of families, including information and advice on family planning. Under Article 12, the state is to ensure appropriate healthcare services for women, including those concerning family planning. Under Article 16, the state shall ensure that women can freely and responsibly decide on the number and spacing of their children and have access to information, education and the means to enable them to exercise these rights. The Committee on the Elimination of Discrimination Against Women established under Article 17 of the Convention, interprets and develops the Convention's provisions and also issues general recommendations at their regular meetings. The Committee explains why women have the right to be fully informed, by properly trained personnel, of their options in giving consent to treatment, in point 20 of general recommendation No. 24 endorsed at the 20th session in 1999. This information should include the likely benefits and potential adverse effects of the proposed procedures.¹¹ In point 22, the Committee pays attention to making healthcare acceptable for women. According to the recommendation, services are acceptable when delivered in a way that ensures that a woman can give fully informed consent, respects her dignity, and guarantees her confidentiality and needs and views. The same point stipulates that states should not permit any form of coercion, in particular non-consensual sterilisation.¹²

If we descend from the level of human rights into simple law, we must pay attention to sterilisation treatment in the Act on the People's Health and its implementing regulations. The Act on Care of People's Health sets out a special regime for performing sterilisation in

¹⁰ Probably the most striking example within our cultural area is the Roman Catholic Church, which expressly bans sterilisation as entirely morally unacceptable, at least in the magisterium's statements (to name but a few: the *Casti conubii* and *Humanae vitae* encyclicals).

¹¹ "Women have the right to be fully informed, by properly trained personnel, of their options in agreeing to treatment or research, including likely benefits and potential adverse effects of proposed procedures and available alternatives." Source (November 21, 2005): <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom24>

¹² "States parties should also report on measures taken to ensure access to quality health care services, for example, by making them acceptable to women. Acceptable services are those which are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives. States parties should not permit forms of coercion, such as non-consensual sterilization, mandatory testing for sexually transmitted diseases or mandatory pregnancy testing as a condition of employment that violate women's rights to informed consent and dignity." Source (November 21, 2005): <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom22>

Section 27 as against the general rule in Section 23. Sterilisation under this provision may only be performed with the consent, or at the application, of the person to be sterilised, in compliance with the conditions stipulated by the Ministry of Health. These conditions are defined in the Czechoslovak Ministry of Health directive of December 17, 1971, on the performance of sterilisation.

Under this regulation, sterilisation is a medical intervention that eliminates fertility without removing or damaging the sexual glands (Section 1). The directive is structured on the construction of subjective and objective admissibility, i.e. combines the affected person's decision in the form of an application or consent as a condition of admissibility, as well as the objective medical criteria of admissibility. Under Section 2 of the directive, sterilisation is admissible if carried out at the application, or with the consent, of the person to be sterilised,

a) on the diseased sexual organs of a man or a woman with a therapeutic aim according to good medical practice,

b) on the healthy sexual organs of a woman if pregnancy or delivery would seriously threaten the life of a woman or cause her serious and permanent damage to health,

c) on the healthy sexual organs of a woman who has an illness that would threaten the physical or mental health of her children,

d) on the healthy sexual organs of a man if the man suffers a permanent condition that would threaten the physical or mental health of his children,

e) on the healthy sexual organs of a man whose wife has an illness that might be a reason for sterilisation under letters b) and c), if sterilisation could endanger her health or if she does not intend to be sterilised for other reasons,

f) on the healthy sexual organs of a woman whose husband has an illness that may be a reason for sterilisation under letter d) and the husband does not intend to undergo the intervention,

g) on the healthy sexual organs of a woman if the woman permanently meets the preconditions for the termination of pregnancy for health reasons.

The distinction between consent and application in the introductory provision of this provision is not coincidental – we should be aware that the first mentioned case of sterilisations is so-called therapeutic sterilisation, i.e. sterilisation performed as a therapeutic intervention on diseased sexual organs, and cannot be comprehended as primarily a contraception method in its purpose. The performance of such an intervention depends on the person's consent to the intervention proposed by the head doctor of the department treating the patient (see Section 5 par. 1 letter a) of the directive). Such cases will not be the subject of further detailed description.

Further attention must be paid to sterilisations defined under points b) to g). These are non-therapeutic interventions with the primary aim of permanent and reliable contraception. From a legal point of view these interventions are mutilation because they are carried out on healthy organs and result in permanent damage, though with a legally permitted purpose. As a result the free consent of the affected person to the intervention is extraordinarily important. Performance of such intervention without consent or with insufficient consent may, unlike the previously mentioned non-mutilating intervention without consent (see note 7), be a basis for criminal responsibility for the criminal act of bodily harm subject to Section 221 *et seq.* of the Criminal Code. The directive prevents such consequences by employing a special mechanism that ought to ensure such consent.

Therefore, unlike in therapeutic sterilisation, a medical commission set up for the purpose (a sterilisation commission) decides on the meeting of the objective criteria (i.e. medical indications) for the admissibility of non-therapeutic sterilisation under Section 5 par. 1 letter b), while an exhaustive list of medical indications permitting sterilization is incorporated in the directive's appendix. In accordance with the directive, the director of a

district health care institute attached to a hospital with health centre sets up a sterilisation commission. In the case of women's sterilisations the hospital must have in-patient women's department, and in the case of sterilisations of men, an in-patient urology department or surgery. The chair of the commission is the director of the hospital with health centre, while the commission panel is to include the head doctor of the women's in-patients department, or respectively of the urology or surgery department of a hospital with health centre, treating the woman or man, and a specialist doctor in the field of the indication or contraindication. No matter how obsolete the process for setting up sterilisation commissions as described in the directive is (given the non-existence of district hospitals with health centres), the existence of such commissions must be strictly required, though they would function without formal establishment. Their function is possible because the legislation clearly stipulates the commission's panel, based on the positions of individual members that are not interchangeable. According to Section 5, par. 2 of the Directive, the sterilisation commission was to apply for a statement from the genetic committee attached to the endocrinology section of the Czech Medical Association of J.E. Purkyně founded by the Ministry of Health when assessing the admissibility of sterilisation for genetic reasons.

The mechanism described in Section 6 *et seq.* of the Directive ensures meeting the subjective criteria for sterilisation admissibility. The person to be sterilised may apply for sterilisation intended primarily as contraception, in writing, or the doctor may apply for it with her consent, addressing it to the chair of the sterilisation commission, duly substantiating the motivation in the application.

The consent of the legal guardian is required for applications to perform sterilisation on minors and persons of restricted legal capacity. The legal guardian also files an application on behalf of a legally incapacitated person. When sterilisation is to be carried out due to mental illness and the person is not legally incapable or of restricted legal capacity, the consent of a carer appointed for this purpose by a court is required.

To ensure the transparency and reversibility of the sterilisation approval process, Section 10 of the Directive sets out that the commission chair will produce a protocol on every sterilisation application containing the name and address of the person to be sterilised, expert statements of the commission panel and minutes from the meeting, with the decision. The chair retains the original of the protocol signed by all the commission members.

Prior to the sterilisation the person to be sterilised and whose sterilisation has been approved, or her/his legal guardian (carer), should sign a statement that they consent to the sterilisation and acknowledge the written information on the extent of the sterilisation's reversibility, in accordance with Section 11 of the Directive.

The fulfilling of all of these requirements legitimising non-therapeutic sterilisation make it legally correct. Compliance with the subjective conditions for sterilisation admissibility, i.e. the existence of an attestable application to carry out sterilisation drafted either by the person to be sterilised or the attending physician with the person's attestable consent, acquire special importance with respect to the considerations above on free consent as the essential condition for any medical intervention. When assessing the legality of sterilisation performed on healthy sexual organs, the three requirements below should receive special attention:

1. The application or consent of the person to be sterilised. The application (consent) must manifest the person's free, serious and error-free will to undergo fertility elimination.
2. Consent of the sterilisation commission to sterilisation based on the objective existence of a medical indication according to the annex of the Sterilisation Directive.
3. Consent of the person to be sterilised to the intervention, while such consent must be based on full and precise information on the nature and implications of sterilisation.

3.2. Case Reports

This section will introduce five types of randomly selected case from the nineties¹³, to illustrate the procedures women that addressed the Public Defender of Rights underwent as against the ideal legal theory outlined above.

Each case starts with a summary of the patient's statement in the complaint addressed to the Public Defender of Rights (i.e. a subjective description of the case as she saw it at the time she addressed the Public Defender), followed by the findings of the Ministry of Health (the advisory board the Ministry presented to the Public Defender of Rights) from the medical records phrased in response to the questions of the Public Defender of Rights, a case assessment by the Ministry of Health, and finally an overall law-related assessment of the case by the Public Defender of Rights.

a) Ref. No.: 3100/2004/VOP/PM

The complaint

In her complaint Mrs. J. noted she has four children. The first two were born vaginally, and the latter two by caesarean. She did not know why she was delivered by caesarean, as she had no health complications. The gynaecologist told her everything was all right in the last pregnancy and that the birth would be natural.

On February 11, 1991, she was delivered by caesarean. On coming to after narcosis she was told by medical personnel that she had been sterilised and could not have any more children. No one gave her any reason for the intervention, or told her of possible risks; neither was she advised concerning the intervention's reversibility. The day after delivery her partner visited her in the hospital and she told him of the sterilisation. Mrs J. and her partner said that had they been informed of the nature of the intervention, they would never have agreed to it.

Advisory board findings

The advisory board found that the medical records contained an application for sterilisation signed by the patient, dated February 11, 1991, with information on the irreversibility of the intervention, with the signatures of the director, the head of the gynaecology-obstetrics department and a member of the commission, a urologist.

The consent is on a pre-printed form, and there is a sentence on the irreversibility of the intervention. A copy of the sterilisation commission protocol is available. The form is dated February 11, and the intervention was performed on the same day without giving the hour. The indication for the sterilisation was iterative caesarean section. The indication for the first emergency C-section was placenta praevia connected with haemorrhaging. The indication for iterative section was a foetus in a very irregular position failing to progress, a defect that can only be treated surgically.

3:43 hours had passed since admitting the patient for surgery.

The indication was the highly irregular position of the foetus precluding natural delivery.

The files contain no record that she had been notified of the possible indication to sterilisation in the course of pregnancy. According to records, her sterilisation application was only dealt with on the day of performance. The patient already had given birth to three

¹³ The full range would take up too much space.

living children prior to the performance (twice with uterus curettage), two abortions, and a previous caesarean section for acute haemorrhaging in central placenta praevia.

Besides transfusion, the anamnesis incorporated two induced abortions, delivery outside hospital, and while hospitalised the patient twice wilfully left the institution. The patient's state of health was not damaged by the performance; the quality of the administrative procedure was disrupted by time pressure. (*Underlined by PDR*). The Pomeroy method involves tubal ligation and cutting.

Assessment by the Public Defender of Rights

According to the medical records the advisory board drew on, Mrs. J. was admitted to hospital on February 11, 1991, at 11:00. At 12:50, the medical case notes contain the note: *"The pat. says she demands sterilization. She meets the criteria under part XIV – 1 and 3 of Directive."* Yet the note is not signed by Mrs. J. nor verified in any other way.

The delivery is timed at 13:43. The surgery took 40 minutes according to the anaesthesiology record.

The sterilisation application in the medical records is typed in a pre-printed form, signed by Mrs. J., and dated February 11, without a precise time. With respect to the above, Mrs. J. almost certainly signed after delivery, because only about 10 minutes had passed between the record in the case notes that the patient was applying for sterilisation, and surgery commencing.

The copy of the sterilisation commission minutes does not give a date, yet given the time pressure the advisory board also points out, it can be reasonable presumed that it may have met on the day of the intervention, but definitely after its performance.

Information on reversibility is in the application. If we conclude that Mrs. J. only signed the application after the intervention, giving this information had no meaning. Besides, the Directive presumes three separate steps: a justified application, the provision of information, and consent prior to intervention. In the case of Mrs. J. the application and provision of information were concurrent.

When it comes to consent immediately prior to intervention, Mrs. J. gave it "for the proposed surgery and any other intervention that turns out to be necessary in the course of the operation" in accordance with the wording of the consent. Consent to the proposed surgery and interventions necessary in its course cannot be deemed consent to sterilisation, even if it was the proposed surgery. (The second option – i.e. the necessity of the intervention in the course of the proposed surgery would not come into consideration at all, given that sterilisation is not an instantly life-saving intervention - a pressing treatment in other words). Sterilization is such a specific treatment that the proposed surgery classification is absolutely insufficient. Moreover, the consent should be linked with specific information on the particular intervention, and thus generalised consent fails to meet the conditions of informed consent. Informed consent must comply with the prior information. Such information in turn must specify the intended intervention. Generalised consent does not apply to a specific intervention (individual or type of) but to any intervention, and as such cannot comply with any previous information that determined the intended intervention.

To conclude, not all the conditions for sterilisation were met in the case of Mrs. J., and crucially, the patient did not consent to the intervention. Doctors wrongfully, in other words in a legally unacceptable manner, interfered with Mrs. J.'s physical integrity. Potentially sterilization could have been carried out after the delivery complying with all the requirements stipulated by legislation. However, the attending physicians did not allow Mrs. J. sufficient room for a legally free, true and error-free decision.

The complaint

Mrs. F. stated in a complaint dated October 10, 2001, that she gave birth to her second child aged 19. The pregnancy was free of complications. Nevertheless the doctors opted for a caesarean due to the patient's narrow pelvis. The doctor leading the delivery was young. Mrs. F. was her first patient. Just before delivery the head of department turned up and told the patient they were going to perform a sterilisation along with the delivery and asked for her consent. He told her at the same time that without sterilisation she would die because she would not survive another birth. The senior doctor asked her to give oral consent to the sterilisation. This was very shortly before delivery while under the influence of an injection. Mrs. F. asked to contact her husband to get his opinion. The senior doctor told her it was not his responsibility to contact her husband and she would have to make her own decision, yet she would die unless she agreed to the intervention. Mrs. F. gave her oral consent in the end. While pregnant she had attended regular check-ups at the same medical facility and yet no one had informed her that pregnancy might be so risky for her prior to the second birth, and she was not told the diagnosis of her illness nor the prognosis of its development. Neither did doctors inform her of the intervention's reversibility or what would be necessary if she wanted another baby.

Advisory board findings

The advisory board concluded that the medical record contains the patient's fully conscious consent to the proposed surgery, yet sterilisation is not explicitly mentioned, nor is the reversibility of the intervention.

On October 10, 2001, at 4:56, the doctor recorded the patient's application for sterilization. On the same day, without giving the hour, the patient signed a declaration that she consents to the surgery and any intervention that turns out necessary in the course of the surgery. The surgery consented to is not specified. The declaration of consent to the surgery is on a pre-printed form. The document does not give the hour. Among other things; *sterilisatio indicata* is noted on the surgery protocol.

The records did not contain an application for sterilisation. The indication was iterative caesarean.

The first caesarean was performed for a disproportion between the foetus' head and the size of the pelvis of an extraordinarily petite woman; simultaneously a cyst on the right ovary was removed, with the ovary. The second caesarean section was indicated due to failure to progress in the early morning hours for identical cause.

The indication to caesareans was *lege artis*. The section was not indicated in advance, and there are no documents suggesting a planned sterilisation in the course of the second pregnancy. A narrowed lower segment of the uterus with dehiscence, i.e. threatening rupture of the uterus at the site of the previous caesarean section, was exposed only in the course of the surgery. Uterus rupture is a life-threatening complication for the woman in the course of a subsequent pregnancy. It is also a threat when carrying out an abortion, in delivery, and therefore pregnancy should be prevented if possible. A number of adhesions from the previous operation were found around the uterus, which is probably why the surgeon did not perform a hysterectomy – uterus removal, and contented himself with a smaller, less demanding intervention – ligation and cutting the tubes. This procedure can professionally

be deemed *lege artis*. The patient suffered no actual bodily harm in the treatment and procedures. (Underlined by PDR).

Assessment by the Public Defender of Rights

A doctor's note in the case notes that the patient applies for sterilisation cannot be deemed an application in accordance with Section 6 of the Directive, though the patient's signature is set down under the note. It is also necessary to be aware that the record in question was made at 4:25 while Mrs. F. gave birth at 4:56. The commission did not approve Mrs. F.'s sterilisation.

With respect to the consent and provision of information, consent to the proposed surgery and acts necessary in its course cannot be deemed consent to sterilisation (see above).

The records also omit information on reversibility.

Therefore, the doctors intervened on Mrs. F.'s reproductive organs illegally. Potential sterilisation, if indicated for the condition of the uterus, could have been performed after delivery complying with all the requirements and Mrs. F. would have made the decision by herself whether to take the risk associated with another potential pregnancy. "Free" consent is required under the Convention on Biomedicine that was already in force at that time, to give the patient sufficient time and conditions to consider circumstances (mainly information) and duly decide whether to consent or not prior to the intervention. Also the patient should have enough time in case of larger operations to gain a second opinion, and to consult family or a close person. Sterilisation is not a major operation, but its serious implications turn it into a major intervention in the woman's body and life. Given that a decision is to be made on a woman's fertility she should have a chance to consult with her husband or partner. None of this happened in Mrs. F. case.

c) Ref. No.: 3104/2004/VOP/PM

The complaint

Mrs. D. related in her complaint that she had a DANA intra-uterine device inserted in January 2001 after her fourth birth in 2000. This measure failed in its purpose and Mrs. D. had an ectopic gestation. On July 27, 2001, Mrs. D. started haemorrhaging, was hospitalised and sterilised. She did not give written consent in advance and only had to sign a document as a part of an examination shortly prior to the operation, which she believes might in theory be the consent to sterilisation. Neither Mrs. D. nor her husband would ever have agreed to the sterilisation if they had been informed of the intervention in advance.

Advisory board findings

The advisory board related that the woman signed the application for sterilisation on a pre-printed form in compliance with Chapter XIV, paragraph 3, of Directive No. 1/1972 of the Ministry of Health bulletin on performance of sterilisation, on July 27, 2001. Medical records show the sterilisation commission approved the application prior to the sterilisation being carried out (*sic!*), on August 30, 2001. There is a conclusive record (surgery record of the gynaecologist) of the sterilisation. The reverse of the surgery record shows the woman's consent to the sterilisation (in the form of an entry into the medical records). The medical records do not contain times - only dates. The treatment was carried out 2.5 hours after surgical settlement of the ectopic pregnancy. Iterative caesarean was not an indication.

The advisory board concluded that the procedure was *lege artis*.

Assessment by the Public Defender of Rights

Mrs. D. only signed the application for sterilisation on July 27, 2001 between 19:45 when she was admitted and 20:00 when she was operated on. There are justified doubts whether in 15 minutes and under the given circumstances, the legal act carried out by Mrs. D. complies with the requirements for such. The sentence "Pat. requests sterilization. 27/7/2001" is also noted on the reverse of the surgery record. It is therefore possible the sterilization was made on this statement and a formal application signed subsequently.

The commission approved the application on August 30, 2001, that is over a month after the intervention. Therefore, the advisory board's conclusion that the sterilisation commission approved the application prior to intervention is wrong. The application's appraisal by the commission is intended to prevent cases of sterilization unless medically indicated. Retrospective endorsement of a completed intervention entirely loses its point.

It is similarly questionable what made the advisory board assert that the treatment was performed 2.5 hours after surgery on an ectopic pregnancy. The surgery record notes salpingectomy and *sterilisatio legalis sec. Pomeroy*. The treatment plan contains a note - admitted from OT, asleep, on analgesic, at 20:55 on July 27, 2001.

The wording: "I consent to surgery within the scope agreed with the doctor" is on the reverse of the surgery record under above quoted sentence. Consent to surgery within the scope agreed with the doctor cannot be deemed consent to sterilisation. Sterilisation is such a specific treatment that the above classification is in every respect insufficient. Besides specific information on the actual intervention should accompany the consent, and therefore generalised consent does not meet the conditions of informed consent. Informed consent is such as complies with previous information, while previous information must determine the intended intervention. General consent does not apply to a specified (individually or by type) intervention and as a consequence cannot comply with any previous information that determines the intended intervention.

Provision of information on reversibility is also missing from the records.

It is not possible to agree with the conclusions of the advisory board stating merely that the procedure was *lege artis*. Given the absence of a decision of the sterilisation commission prior to intervention, of consent to sterilisation and of provision of information on reversibility, the legal conditions for sterilisation were not met.

d) Ref. No.: 3108/2004/VOP/PM

The complaint

In her complaint, Mrs. B. said that following several miscarriages she fell pregnant in 1992 at the age of 25. From the start of the gestation, her pregnancy card had contained the instruction that she must be sterilised, as all pregnancies were risky. She did not know the meaning of the term sterilisation, and thought it referred to an intra-uterine device because she had previously discussed this possibility with her doctor. No one gave her the necessary information on sterilisation. At the last pregnancy examination (about two weeks before the birth) the gynaecologist informed her of the planned sterilisation. He did not explain what this meant, nor ask for prior consent. When the patient asked the grounds for such intervention, without being told of the nature and implications, the doctor gave the reason as a risky pregnancy. She did not seek any further information from the doctor because, as she says, she did not trust him. She does not remember giving written consent to sterilisation, although this is possible because she signed some documents before delivery, but she was not aware of their contents. She gave birth on November 13, 1992, and the sterilisation was

probably performed on November 15, 1992. Only after the intervention in November 1992 was she told she would never have any more children.

Advisory board findings

The advisory board asserted that the medical records do not contain an application for sterilisation and sterilisation commission approval. Only a note in the nurses' case notes is available from November 14, 1992. There is an attestable record of sterilisation in the medical records (gynaecologist's surgery record). The woman's consent to sterilisation is on the reverse of the operational protocol dated November 17, 1992 (in the form of entry in medical records). The time of day for the consent is missing. The sterilisation was medically *lege artis*. The indication was iterative caesarean section. The advisory board recommended passing the case to the criminal prosecution authorities.

Assessment by the Public Defender of Rights

The records do not contain an application signed by Mrs. B. As the advisory board already concluded, it is mentioned a few times in the nurses' case notes. A note on November 14: "asks for sterilization", the same on November 15. Note "sterilisation tomorrow" recorded on November 16. The conditions for a justified application were not met. There is also no approval of the sterilisation by the sterilisation commission. Information on reversibility was not provided, meaning that the patient's consent cannot be deemed informed. Moreover, it should also be taken into consideration that Mrs. B. was on medication (Dolzin and Atropin) since at least a day prior to giving consent.

The important point has to be made that a medical intervention without informed consent is illegal even when performed *lege artis*.

e) Ref. No.: 3763/2004/VOP/PM

The complaint

In her complaint, Mrs. H. said she was sterilised on delivery on September 13, 1995. She had been repeatedly visited by a social worker since the seventh month of pregnancy with her seventh child, persuading her to undergo sterilisation. She told Mrs. H. that she already had enough children. Neither Mrs. H. nor her husband agreed to the intervention. The social worker allegedly threatened to take away all the children and place the baby once born in care. This social worker also visited her gynaecologist to recommend the intervention. He did not agree with her however and said the pregnancy was all right and he saw no reason to perform sterilisation.

When Mrs H. went to hospital the social worker had allegedly already agreed with the doctors that they perform a caesarean and sterilisation. Doctors asked Mrs H. if she would like to be sterilised and told her that the social worker had called them. They persistently harassed Mrs. H. with these queries even though neither she nor her husband agreed with sterilisation. The doctors in the hospital also repeated that the H.'s had enough children as it was. While hospitalised, Mrs H was threatened by the doctors as well that the baby once born would be taken into care unless she signed the application. At that time, Mrs. H. had labour pains, became frightened the baby would be taken away, and finally signed.

Advisory board findings

The advisory board meeting concluded that the patient was admitted at 17:00 on September 13, 1995, as a 'risky pregnancy' in the 42nd gestation week, probably after commencing uterine contractions. An application for sterilisation dated September 13, 1995,

is pre-typed on an entry to the birth plan and signed by the patient. The documentation lacks the sterilisation commission's decision. At the time of admission the patient was 29 years old and had 7 spontaneous deliveries in the records (the last of them twins) and one termination.

The sterilisation was performed at 20:25 on the admittance day, i.e. September 13, in the course of a caesarean. The advisory board asserted the caesarean was indicated as a first c-section arranged in advance on the agreement of the outpatient gynaecologist, social worker and the couple for social reasons. (*Underlined by PDR*). This section was planned at the end of pregnancy and thus indicated beforehand.

The documentation lacks consent to sterilisation and provision of information to the patient.

The advisory board stated on the quality of the administrative procedure set out by the Directive: "The records do not contain the decision of the sterilisation commission. The patient's consent to the intervention as well as the provision of information are both absent."

Assessment by the Public Defender of Rights

Let us ignore the alleged pressure by the social worker for the moment. A further section of this report will deal with this aspect. With respect to medical law it is currently most important to focus on the explicit record made in the birth plan: *"Gestation to be terminated by caesarean and sterilisation due to the social inadaptability of the family, as agreed by the attending gynaecologist, the social worker and the married couple. The patient's consent to laparoscopic sterilisation after a spontaneous birth cannot be expected because she is unwilling to undergo the intervention as she has repeatedly shown in the past."*

It is therefore astounding the advisory board only noted it was the first caesarean planned along with sterilisation in advance on agreement of the attending gynaecologist, social worker and the couple for social reasons. The fact the caesarean was planned "for social reasons" only in order to sterilise a woman who had refused the intervention repeatedly in the past, is alarming. A caesarean must always be clearly indicated for obstetrical, and thus medical, reasons. There was no such indication in the case of Mrs. H. because the last pregnancy progressed normally and there were no grounds for planning a caesarean. The only reason for the caesarean was – putting it bluntly - that Mrs H. could have run away from the hospital again after giving birth and nobody could have then got her to be sterilised.

Given the above, the free manifestation of will by which Mrs H. was to have agreed with sterilisation is open to serious doubt.

Regardless of the above, the application in the form of an entry into the birth plan does not meet the formal requirements of the Directive.

The absence of the sterilisation commission's approval, of the consent of the patient and of her being informed in advance constitute a further infringement of the law. Thus, this intervention cannot be in any way considered an intervention carried out in accordance with the law. Besides, it is crucial to express serious concern over the fact the advisory board passed over without comment the totally inadmissible "indication" for a caesarean.

3.3. Evaluation

Similar traits to those above can be traced in effectively all of the cases assessed by the Public Defender of Rights. Although the women might have agreed to a fertility reducing intervention, it cannot be said that the women agreed to sterilisation, or that they were sufficiently informed of the substance and implications of the intervention to make their consent legally relevant.

Firstly it should be pointed out that it is impossible to make a direct link between failure to comply with the conditions of free, true and error-free manifestation of will – consent to sterilisation - and criminal responsibility, as the wider public tends to, and conclude that doctors perpetrated a criminal act in each case. Yet it also applies in reverse; if criminal prosecution authorities declare no crime was committed, it does not mean no fault occurred in such cases and that they are "above board". A potential criminal law review simply does not change the fact that the way sterilisations were performed in cases matching the previous accounts was illegal, in contravention of the law.

Their illegality derives from the fact that the interventions did not receive faultless and fully free consent as the civil law comprehends the term. Let us point out there was no objectively sufficient space for the proper provision of information and the patient's mature decision on the information provided in any of the mentioned cases (and this applies generally). As mentioned before, the patient may give free consent only if s/he has been informed about the intervention in advance. The patient must also be informed of the grounds of such intervention, i.e. the substance of the illness or (in case of non-therapeutic sterilisation), the risks to health or the life of the mother or foetus in case of future pregnancy. At the same time, information must be given on alternative treatment that could lead to the same result as sterilisation and an assessment of their appropriateness. If the doctor fails to give any of the information or submits substantially untruthful or incomplete information, the patient might grant the consent in legally relevant error (Section 49a of the Civil code) that makes the legal act, i.e. consent to the intervention, void. If any informing took place in the cases inquired into by the Public Defender of Rights, the information was very incomplete and misleading ("unless you submit to the intervention, you are going to die in the next childbirth", etc.).

The absence of the basic pre-conditions for granting legally relevant consent makes such intervention unauthorised interference in the person's physical integrity, and contravenes the provisions of Section 11 of Act No. 40/1964 Coll. of the Civil Code, as later amended. In the well-publicised case of Mrs. Helena Ferenčíková the court in the end reached the same conclusion.

In terms of medical law it is therefore essential to insist on the following:

Should a patient undergo sexual sterilisation that is not a necessary treatment of diseased sexual organs (i.e. has no therapeutic purpose but is exclusively contraceptive¹⁴), the intervention can be performed only once it has been ascertained that the patient has received all the information necessary for a qualified decision. That implies that she must be informed primarily of what her state of health is that requires avoiding future pregnancy, what potential gestation would entail, how she could avoid potential pregnancy, what advantages and disadvantages sterilisation offers and why the doctor believes sterilisation is the best option. The patient must have a chance to duly process the information given, i.e. sufficient time to decide. Contraceptive sterilisation is never a pressing treatment – there is no reason not to give a few days or weeks for the decision. The practice where between informing the patient and deciding only minutes elapse is henceforth indefensible.

The roots of the relatively serious failure to respect the informed consent rule described above can probably only be guessed at. Nonetheless, the basic impression from the cases from the nineties that the Public Defender of Rights inquired into was that doctors, who perhaps in good faith concluded that it is in the woman's interest or that of her future children that could be impaired not to fall pregnant again, found there is an objective indication under the Directive Annex for sterilisation, informed the woman of their opinion formally and persuaded her of the imperative need for the intervention, then settled for her signature and carried out the intervention.

¹⁴ Although elimination of future pregnancy is meant to prevent potential future complications associated with pregnancy or birth.

Such procedures show that doctors are generally unaware that their subjective belief in sterilisation's benefits does not make the intervention legitimate, and that indication of compliance with the Sterilisation Directive does not mean sterilisation is essential, only that it is an option. Such cases prove that a process of the doctor's complete communication of his/her opinion, with all pluses and minuses, to the woman, and of her decision-making, was not implemented between doctors and sterilised women.

The practice of asking women for their signature on the basis of a statement that the intervention is necessary, that they could die in a future pregnancy and similar, should be strongly opposed. This is incomplete and misleading information that cannot result in legally relevant consent to an intervention that is never – and this must be emphasised - urgent and life-saving treatment. Of course the reason for giving up on communication with the patient in such cases can be to some extent appreciated and "understood". It can be imagined how difficult it might be to comprehensibly present information on state of health and treatment alternatives to a patient from an entirely different cultural environment, who often does not behave in an orderly fashion while hospitalised, and poorly comprehends the information given due to insufficient grasp of the language. However, understanding the causes of failure to inform does not excuse it.

Medical staff have not fully digested and accepted the content and consequences of the legal institute of informed consent, but that is no excuse either. Even openly available sources such as various medical periodicals show this. On one hand, we can find articles by doctors (not lawyers or ethicists) that embrace the informed consent issue with solemnity and strive to promote its uncompromising application in practice¹⁵, while on the other, papers that designate the legal consequences of informed consent in compliance with the Convention on Human Rights and Biomedicine as a "victory of current law over medicine", warn against "the serious consequences of legal postulates that are imperfectly phrased yet enforced by force" and term the effort to replace a paternalistic relationship between doctor and patient with a partnership a "fashionable need".¹⁶ The role of informed consent in medicine as described earlier must not be viewed as open for discussion. It is possible to debate the forms of its compliance for individual interventions and much literature actually does. Nevertheless the very substance of informed consent as an essential condition is untouchable, because it is not a matter of fashion, and its substantial features were present in our legislation long before the endorsing of the Convention on Human Rights and Biomedicine. However, as the sterilisation cases the Public Defender had a chance to inquire into illustrate, this knowledge is not always present amongst doctors.

4. Sterilisation and the Romani Community

This part of the report focuses on setting the sterilisation cases the Public Defender of Rights investigated in the context of the Romani community's position in the Czech Republic. The "Roma" aspect was mentioned in the complaints from the very outset.

While assessing whether a medical intervention was performed in accordance with the law in each specific case is more or less simple and does not require accounting for many facts, judging whether the conduct that led to such unlawful procedure was motivated also by the unusual approach of the participants to Roma is no longer that straightforward. For the most part it is difficult to assess whether Roma sterilisation was a programme measure in pre-November [1989] Czechoslovakia as part of practical social policy and whether certain echoes of this policy still continue as a motivation even today.

This part of the report should not give an assessment so much as point out the context Czech society has to consider in its deliberations, a context that may signify a danger of

¹⁵ See for instance Lajkep, T.: Informovaný souhlas (or Informed Consent), *Zdravotnické noviny*, 2/2003, page 22; Sucharda, I.: Co je a co není informovaný souhlas (or What Is and Is Not Informed Consent), *Časopis lékařů českých*, 3/2002, page 75.

¹⁶ For instance Novák, K.: Informovaný souhlas – diskuse (or Informed Consent – Discussion), *Praktický lékař*, 3/2003, page 176.

discrimination in individual cases today and therefore must be discouraged by means of targeted measures.

4.1. Historical Initiatives Pointing Out Romani Women's Sterilisations

The fact the European Roma Rights Center drew attention to questionable practice in performing sterilisations on Romani women cannot be comprehended as an initiative that came, all of a sudden, out of nowhere. Civic initiatives in the former Czechoslovakia pointed out the questionable practice of sexual sterilisation as a social measure long before 1989.

4.1.1. Charter 77 Document No. 23/1978

The first document that pointed out the issue of Romani women's sterilisations in the context of state policy towards the Romani minority was Charter 77 Document No. 23 of December 13, 1978. Charter 77 found it necessary to point out even less obvious (because less "political") human rights violations, and specifically that represented by systematic discrimination against Roma. A group of Charter 77 signatories dealing with national minorities produced a legal reflection on the social position of Roma as an annex to Document No. 23, in particular from the perspective of breaches of then valid Czechoslovak legislation. The reflection was presented in document No. 23 to the state authorities and the public for discussion.

The reflection on the position of Roma in Czechoslovakia opens with a statement that *"the situation of the Gypsies-Roma in Czechoslovakia is not a subject that attracts attention and most people know virtually nothing about the issues of the most discriminated against minority. ... The attitude of the public oscillates between indifference and racism."* Like the parent document, the reflection elaborates a thesis of there being a dissonance between the proclaimed endorsement of international documents on human rights by the state authority of Czechoslovakia, and actual policy. This tension was demonstrated in relation to Roma by the obvious disregarding of the Romani community as an original cultural and social entity – a nation. From this critical position, the reflection continued by attacking the state's actual policy embodied in repressive measures resulting in gradual forced assimilation. It defines several areas of most concern where in the authors' opinion Roma's group rights were most clearly violated.

The reflection finds the practice of sterilising Romani women to be within the same context of tools of forced assimilation and the oppression of Roma group rights:

"Particularly serious is the sterilisation issue, which is admissible in cases with proper medical justification, sometimes perhaps necessary, although always dubious in moral terms. The consent of Romani women to sterilisation is obtained through persuasion, the impartiality of which is not guaranteed. In some districts sterilisations of Romani women are performed as a planned administrative measure and the officers' success is rated at external meetings by the number of Romani women they have persuaded to consent to sterilisation. Under such conditions impartiality is out of the question. In many cases a pecuniary reward is demagogically employed to obtain consent to sterilisation. Thus sterilisation becomes one of the policies of the majority population against the minority population directed at preventing childbirths in the minority ethnic group."

The authors of the reflection identify the motivation of the repressive assimilation in that *"the social authority identifies the final solution of the Romani minority issue in the extinction of the minority through its merging into the majority. A minority problem is to be removed by removing the minority."* The authors believe that this goal is theoretically justified by a doctrine according to which Roma represent a declining ethnic group destined for extinction. The authors make the same assumption in phrasing their final statement:

"Unless persistent failures of the policy result in a consistent review of all its components, Czechoslovak institutions will very soon reach a situation in which they will face charges of committing a crime against section 259 of the Criminal Code (the genocide act). ... If, in particular, the forced removals of children from Romani parents and sterilisation of Romani women continue as they have so far, no secrecy and no unlawfulness in the area of justice will help avoid the bringing of formal charges founded on evidence."

We can therefore highlight from the above for the purpose of this Report that a group of Charter 77 signatories had pointed out the use of sterilisation as a tool of such policy as early as 1978, at the time of the most active implementation of the state assimilation policy towards the Romani minority, labelling it without hesitation as a technique on the verge of meeting the attributes of genocide.

The available materials do not suggest that Charter 77 document No. 23 generated any major social discussion; it is nevertheless the first document that explicitly mentions sterilisation under criticism of the state policy towards the Romani community, in a considerably escalated context. We will soon learn that this was not the only document that mentioned the sterilisation of Romani women in the outlined context.

4.1.2. Ruben Pellar's and Zbyněk Andrš's Initiative

Romanologist Ruben Pellar has concentrated systematically on the sterilisation of Roma women in Czechoslovakia since 1988. His interest was spurred by Section 31 in association with Section 35 of Decree of the Ministry of Health of the Czech Socialist Republic No. 152/1988 Coll., implementing the Act on Social Security and Czech National Council Act on the Mandate of Czech Socialist Republic Authorities in Social Security. Section 35 of the Decree allowed giving a one-off monetary benefit or material allowance (a monetary benefit up to CSK 10,000, a material allowance up to CSK 5,000, in exceptional cases up to CSK 10,000) to citizens undergoing medical intervention under special regulations in the interest of a healthy population and overcoming unfavourable living conditions of the family (sterilisation) within one year of the intervention.

Ruben Pellar described the application of "sterilisation benefit" as a motivating measure, the potential abuse of which was pointed out in the above-mentioned reflection by Charter 77, for himself in this way: *"The Act's authors have failed to grasp that they are essentially carrying on in the legal thinking traditions that resulted in the origin of the German 'Über die Verhütung des erbkranken Nachwuchses' Act ('on the prevention of congenitally sick offspring' – note of the compiler). The Czechoslovak measure has a similar implication to the German law, i.e. increasing the number of sterilised healthy persons of a different race (Roma)."*¹⁷

The conviction that "sterilisation with benefit" is a tool of inadmissible eugenic policy lead to an attempt to statistically evaluate data on the sterilisation of Romani women and the effect of the benefit given. Between 1988 and 1989 Ruben Pellar and Zbyněk Andrš launched a field study amongst Czech and Slovak Romani women to map sterilisation practice between 1967 and 1989. The outcome of the research was a Report on the Examination in the Problematics of Sexual Sterilisation of Romanies in Czechoslovakia [Translator's note – authors' English version].¹⁸

¹⁷ Personal interview of the Deputy Public Defender of Rights with Ruben Pellar on October 11, 2004.

¹⁸ Pellar, R.; Andrš, Z.: Report on the Examination in the Problematics of Sexual Sterilization of Romanies in Czechoslovakia, 1989, not published independently. Statistical data attached to the Report published in: Ofner, P.; de Rooij, B.: Het Afkopen van vruchtbaarheid: Een onderzoek naar sterilisatiepraktijken ten aanzien van Romavrouwen in Tsechoslowakije, uitgevoerd door Paul Ofner en Bert de Rooij in opdracht van de Vereniging Lau Mazeril en de Stichting Informatie over Charter 77, Lau Mazeril Foundation, Amsterdam, 1990.

The Report evaluates a statistical set of 156 Romani women from the Czech part of the former federation, sterilised between 1967 and 1989. The data was gathered between 1988 and 1989, using standardised interviews with those affected, questionnaires, interviews with family members and assembling data from the literature to collect information. The evaluation criteria conformed to the research objective.

Given the study's purpose of mapping the potential influence of a special social benefit in motivating decision-making that should have been essentially completely free and independent in compliance with already applicable legislation on sexual sterilisation, or to point out flagrant violation of legal regulations applicable to sexual sterilisation (particularly with respect to the absence of a health indication or absence of a woman's consent to the intervention), the authors primarily evaluated the amount of the benefit rendered in correlation with the woman's age and number of children, were interested in internal and external motivation for undergoing the intervention, meeting indication criteria for the intervention and compliance with the administrative.

The authors conclude:

1. A steady increase in sterilisations culminating in 1988 and 1989 can be followed in the period under scrutiny. 38% of the set were sterilised in the last two years, i.e. two fifths of all cases from the 22-year period. As a result, the authors deduce an apparent correlation with increased social benefit given for sterilisation from the original CSK 2,000 (prior to 1988 the benefit was given only against a methodological instruction in the amount of CSK 2,000) to as much as CSK 10,000.
2. At the time of sterilisation, 17% of the examined set of women were between 18 and 25 years old, 70.5% were aged between 26 and 35 and 12.5% were over 35. Following the ages at the time of intervention is important for assessing compliance with the indication criterion for "a large number of children up to a certain age of a woman" as one of the grounds for sterilisation's medical admissibility. Women around the age 35 can undergo sterilisation for a large number of children only if they already have four or more children. The abstract shows 87.5% of the examined set fell in this age group.
3. The Report's authors found that 33.7% of women in the set failed to meet the criterion of four or more children before the age of 35. The authors admit that sterilisation could in some cases have been performed on other medical grounds, yet they wonder at the number and presume that legislation was violated in the case of some women in the group.
4. When it comes to correlating the amount of social benefit and the number of children, the authors pointed out that the highest figures on average paid out in association with sterilisation went to childless women from the examined set. As the number of children grew the amount of benefit progressively dropped.
5. Approximately every tenth (9.6%) woman from the set alleged she was only told of the sterilisation after the surgery (mostly cases where sterilisation was performed along with a caesarean or abortion). Rarely women reported they learned about the intervention coincidentally (general practitioner) after a long interval (most often when they confided in the doctor that they had unsuccessfully tried to conceive).
6. As to the grounds for the subjective decision to undergo sterilisation, the authors let the respondents speak spontaneously. Of the examined set, 68.8% of the women gave the social workers' persuasion and campaign as the main motive, 17.2% gave the financial motivation of the promised benefit and 10.6% directly described a situation where social workers made further social care subject to sterilisation.

Ruben Pellar's and Zbyněk Andrš's initiative had no direct consequences. However, the information gathered caused Ruben Pellar to ask the then General Prosecutor's Office to investigate some of the cases (see below for the results of the Prosecutor's Office inquiry). Ruben Pellar's and Zbyněk Andrš's initiative can be linked to fairly intense international criticism of "sterilisation with benefit" that was stirred up prior and chiefly immediately after the political changes at the end of 1989. In 1988, a critical article was published in Romaniya¹⁹, an American Romani magazine encouraging protest against this "inhumane and racist policy". Ruben Pellars claimed that English Romanologist Donald Kenrick also protested. In 1990, Tilman Zülch, chairman of the Society for Threatened Peoples (Göttingen, Germany) approached then Minister of the Interior Richard Sacher and president Václav Havel with a protest letter. Miklos Duray, Charter 77 signatory and leading member of dissent prior to 1989 also sent an open letter on the matter of Romani women's sterilisations to president Havel. Reports on Romani women's sterilisation were published in the media of various European countries (the Netherlands, Germany, France and Italy).

4.1.3. Charter 77 Document No. 3/1990

Unlike the 1978 document (or in fact its annex), document No. 3 of January 28, 1990, deals exclusively with the issue of Romani women's sterilisation. It states in the introduction that *"some state officials have recently become aware of the total fiasco of the official approach to solving the so-called Romani issue" and "the programme of their [Roma] forced assimilation as an incapable population group was replaced by responsiveness to the idea that Roma should be allowed to directly participate in the solving of their problems."*

However, this fundamental change in the attitudes of state authority representatives was in contrast according to Charter 77 with the practice it had pointed out, although marginally, in its previous "Romani" document, and specifically the sterilisation of Romani women. Compared with the previous document the criticism of sterilisation is much sharper.

The document contains the accusation that the criteria of objective admissibility of sterilisation set by the legislation (notwithstanding the subjective criterion of informed consent to the intervention) given by health condition, number of children and age, do not apply where Romani women are concerned. These, according to the authors of the document, were persuaded to undergo sterilisation en masse and systematically – which is the only explanation for the fact that 1,111 Romani women had been sterilised in one year in the then East Slovakian Region alone. The authors of the document contrast this with the fact that the number of non-Romani women requesting sterilisation was very small, stating that in some regions the sterilisation option was used virtually by nobody other than medical personnel who were well informed of it.

The document notes that there were a number of cases in which an officer of a National Committee (the body in charge of social care at the time) or a doctor had persuaded to undergo sterilisation a healthy Romani woman aged between 19 and 25, a mother of one or two healthy children living in satisfactory conditions.

The document further mentions a practice where women had been persuaded to undergo sterilisation without a medical examination that would conclude with an indication to sterilisation. The indication background for sterilisation would allegedly (the document mentions this practice in Most) be "obtained" by directing young women with few children (who would not meet the indication criterion of high age and a high number of previous births) to a psychiatric examination to identify a psychiatric diagnosis from the indication list of the sterilisation directive (such as imbecility). The document also maintains that cases were noted in which Romani women had been informed that they had been sterilised only after the intervention took place. They had not applied for the intervention; it had been performed without their awareness during a different surgical treatment.

¹⁹ Romaniya, 11/1988.

The document even mentions the case of a Romani woman persuaded to have a termination of pregnancy after a sterilisation intervention with the explanation that she had no right to a child after being paid for the sterilisation. In another case a 22-year-old mother of one child had been forced into sterilisation by the threat that the next child would be taken into care.

Cases are even mentioned where the provision of social care such as social benefits or other aid had been made conditional on sterilisation.

Like the above-mentioned report by Ruben Pellar and Zbyněk Andrš, the Charter 77 document points out that the allowance granted in connection with sterilisation increases progressively for younger women with fewer children.

The document quotes the justification of Roma sterilisation used in a fully official way at the time:

"...this concerns citizens showing an extensively negative attitude to work and learning, a high crime rate, an inclination to alcoholism, female promiscuity, and last but not least, lagging behind the cultural and social development of other population groups."²⁰

The authors of the document judge the approach of the quoted article as follows:

"The prevalence of alcoholism, unconfirmed just like the predications on Roma women's promiscuity, lack of interest in learning, etc., all this is attributed to a population group by race and is therefore, in the opinion of the two authors, sufficient basis for interventions in the birth rate among the women in the group. Such and similar deliberations appear entirely frankly and do not generate any effective opposition. Their proponents and probably many readers of such articles seem unaware that the principle proclaimed here was the main feature of the NSDAP ideology that caused, among other things, the slaughter of the Czech and Moravian Roma during the Nazi occupation and was condemned after the war by the international tribunal in the Nuremberg trial."

Like the previous document, this document too mentions that the proclaiming of such a principle and particularly its implementation in practice may qualify as genocide; it therefore resolutely condemns the sterilisation campaign against Romani women.

4.2. The Reaction of State Authorities to Criticism of "Romani Sterilisation"

4.2.1. The Inquiry by the General Prosecutor's Offices of the Czechoslovak Socialist Republic, the Czech Republic and the Slovak Republic

As the first attempt of public authorities in Czechoslovakia after 1990 at dealing with the accusations brought by the civic initiatives concerning the sterilisation of Romani women, the General Prosecutor's office of the Czechoslovak Socialist Republic (and, respectively, the Czechoslovak Federative Republic) pursued an inquiry, employing its authority to perform what was called "general supervision over observance of the law". The General Prosecutor's Office initiated its inquiry in 1990 following a complaint by Ruben Pellar, Zbyněk Andrš and Josef Vohryzek as well as based on Charter 77 document No. 3/1990 and a letter from the Human Rights Committee. The Office kept its inquiry into the said complaints under three file reference numbers. The Charter 77 complaint was kept under No. III Gd 1690/89, the complaint by Ruben Pellar, Zbyněk Andrš and Josef Vohryzek under No. III Gd 369/90 and the complaint by the Human Rights Committee under No. Gd 6055/89. The Office forwarded

²⁰ Posluchová, E.; Posluch, J.: Problemy plánovaného rodičovstva u cigánskych spoluobčanov vo Východoslovenskom kraji (or Family Planning Problems Among Gypsy Fellow-citizens in the East Slovakian Region), in: Zdravotnícka pracovnička, 1989, pages 220 to 223.

the complaints to both states' General Prosecutor's Offices, which carried out their own inquiries and forwarded the results to the federal level.

Given that the complaints based on which the General Prosecutor's Office pursued the inquiry mentioned essentially two types of negative phenomena in connection with the performing of sexual sterilisations – i.e. a social benefit in place granted in connection with sterilisation and non-observance of generally binding legal regulations treating the admissibility of performing sterilisation, the two General Prosecutor's Offices examined these issues separately.

Concerning the social benefit granted in connection with sterilisation, the General Prosecutor's Office of the Czech Republic requested a statement from the Ministry of Health and Social Affairs of the Czech Republic. The Office was essentially at one with the statement or at least did not comment on it, restricting itself to interpreting it to the initiators of the complaint for the Office. The statement of the Ministry of Health and Social Affairs of the Czech Republic of April 5, 1990, states the following on the social benefit issue:

"For the purposes of ensuring a positive population trend, i.e. in particular a sufficient number of children being born, but also healthy children and in such families as can provide them with everything for an overall healthy bodily and mental development and proper social inclusion, certain pro-population measures were adopted in the 1970s to this end. One such measure (apart from for example Act No. 17/1971 Coll. on maternity allowance, Act No. 99/1972 Coll. increasing child allowances and benefits where the payment of such is bound to proper care for the children) was the granting of a social benefit – a one-off allowance in cash after the medical intervention of sterilisation. The granting of the allowance was treated by an internal act of the management of the Ministry of Labour and Social Affairs of the Czech Socialist Republic of 1973, Ref. No. IV/1-8750-13.9.1973/7 and later by social security regulations, i.e. Act No. 121/1975 Coll. on Social Security, Czech National Council Act No. 129/1975 Coll. on the Mandate of the Czech Socialist Republic Bodies in Social Security and the implementing decree of the Ministry of Labour and Social Affairs of the Czech Socialist Republic No. 130/1975 Coll. to both acts, including instructions from the Ministry of Labour and Social Affairs of the Czech Socialist Republic issued for the same purpose. The one-off allowance and a material benefit were copied into the social security regulations valid from October 1, 1988, i.e. Act No. 100/1988 Coll. on Social Security and sections 31 and 35 of the Decree of the Ministry of Health and Social Affairs of the Czech Socialist Republic No. 152/1988 Coll. Under these provisions a one-off allowance in cash and a material benefit can be granted by the District National Committee to citizens who have undergone a medical intervention under special regulations in the interest of a healthy population and overcoming adverse life circumstances of a family. This benefit was moved from the sum of social benefits for families with children into a separate provision because one-off as well as recurring allowances in cash and the material benefit can also be provided by Local National Committees in nodal municipalities and Municipal National Committees, which has generated problems before. Granting of the benefit is decided upon by the National Committee after considering all relevant facts causing the adverse situation of the family; in particular the standard of childcare, ability of parents to provide childcare and to ensure children's prosperous development, health condition of individual family members, children born with disabilities, number of children without means, their age, and conditions in which the family lives, including how effectively the benefit will be used. ... It is a general arrangement of benefits for families with children, without focus on any specific population group."

....

"The purpose of the allowance in cash and the material benefit in the meaning of section 35 of the decree of the Ministry of Health and Social Affairs of the Czech Socialist Republic No. 152/1988 Coll. is by no means to restrict the Romani population, but instead to deepen social care for those families where this is needed, to increase their living standard,

but also to influence giving birth to such numbers of children as the parents are capable of caring for and bringing up.

"With respect to the complaints sent, the Ministry of Health and Social Affairs of the Czech Republic has examined the quantity of allowances granted in the Czech Republic, in some of the locations mentioned in the complaint. As noted above, social benefits were granted to 34,707 recipients in 1989, of which 803 were paid the benefit following sterilisation, and where 419 cases involved Romani women. In the territory of the capital city of Prague the benefit was granted for this reason to 58 women, of whom 13 were Roma; the average amount of the allowance and material benefit was CSK 2,560. In the Most district it was granted to 105 women, of whom 65 were Roma; the average amount of the benefit was CSK 8,619. In the Děčín district the benefit was granted to 26 women, of whom 16 were Roma; the average amount of the allowance was CSK 4,230.

"The increased number of recipients of the said allowance in cash and the material benefit including the increased average value in some locations (in particular the town of Most) is due to the quantity of citizens of Romani origin in whose families the social situation is far more difficult or indeed utterly desperate in some cases. The examination has shown that these are families with many children insufficiently cared for by the parents, as a result of which court supervision, institutional care or another form of foster care have been ordered; where there are less children, the parents are incapable of bringing them up, the children or their parents are genetically afflicted, the adolescents or their parents commit crimes, abuse alcohol or other substances, lack financial means, have insufficient housing, et cetera.

"The benefit cannot be referred to as an incentive to opt to undergo a medical intervention, because the woman opts for the surgery in an entirely voluntary way, in the interest of her health and after being provided with information by the doctor; she is allowed to apply for the allowance only after hospitalisation, being aware that the benefit may not be awarded.

"On the complaint proposing that the granting of the allowance in cash and the material benefit be lifted, it should be noted that section 35 of Ministry of Health and Social Affairs decree No. 152/1988 Coll., as part of the regulation on social security, was subject to a proper legislative process to which there were no reservations and comments in the amendment proceedings. Whether to halt the allowance and the material benefit or to leave them in the social security regulations is a social and political question which must be considered by all the competent authorities."

The issue of granting the allowance was commented on somewhat differently, with an attempt to at least adopt a position of its own, by the General Prosecutor's Office of the Slovak Republic in a letter to the General Prosecutor's Office of the Czech and Slovak Federative Republic dated May 3, 1990:

"I find the provision on the granting of a special allowance in cash and a material benefit under Section 35 of Decree No. 151/1988 Coll. to be incorrect, and in contravention of the principles of social policy, the reason being that the legislator makes social assistance under the said provision conditional on performing a medical treatment that avoids further fertility of the person concerned. Thus the legislator binds the granting of the allowance to a specific legal fact that in itself does not have an immediate effect on changing the social circumstances of the person who has undergone the intervention or the opposite, the person's social status (social dependence) will not deteriorate through sterilisation. It is therefore illogical for the state to grant in such cases any other social care benefit than that to which the person concerned is entitled before the medical treatment is performed.

"It should be noted however that according to the attached rules of the Ministry of Labour and Social Affairs of the Slovak Socialist Republic of May 30, 1986, the said allowance is granted solely if the sterilised person or the person's family is socially dependent. Therefore the complainants' proposition that the social allowance under Section 35 of the quoted decree is granted to every person of Romani origin who has undergone sterilisation is not true. Even in such cases the intensity of social dependence is crucial, which also has an effect on the amount of the allowance granted. It is obviously possible to assume that the percentage of sterilisation allowances is considerably higher in the Romani population and it is impossible to rule out that in certain periods it was equal to the number of sterilisations performed.

"I find another shortcoming of the said legal provision in the fact that the granting of the sterilisation allowance may by its nature act as an incentive particularly among backward Romani population groups. From this perspective I am essentially at one with the complainants' views even though the findings so far do not suggest such a conclusion."

....

"At the same time it should be noted on the other hand that the Ministry of Health and Social Affairs of the Slovak Republic finds sterilisation to be an important means of improving population quality, dealing with the undesirable birth rate of feeble-minded and otherwise mentally backward children, etc." (Underlined by PDR)

The Ministry of Health and Social Affairs of the Slovak Republic itself stated on the allowance issue in its letter to the General Prosecutor's Office of the Slovak Republic of April 28, 1990:

"It has been proven in practice that the benefit was substantiated in dealing with the social situation of dysfunctional and socially deprived families, creating a better material background for children living in large families, but on the other hand it is necessary to accept that in some cases the possibility of providing higher amounts of assistance may act as an incentive, and in these contexts it is necessary to accept the recurring view that it interferes with human rights. Given the above it is recommended following agreement with the Ministry of Health and Social Affairs of the Czech Republic and the Federal Ministry of Labour and Social Affairs at the joint meeting held between April 9 and April 11, 1990, to delete section 35 of the decree of the Ministry of Health and Social Affairs of the Slovak Socialist Republic No. 151/1988 Coll., and to do the same in the legal regulation of the Czech Republic, and specifically upon the nearest amendment of the said legal regulations that are to become effective as of October 1, 1990 or as of January 1, 1991 at the latest and which are already being drafted." (Underlined by PDR).

It is clear from the documents that the attitudes of Czech and Slovak bodies differed in the issue of social benefits granted in connection with sterilisation. On the one hand we encounter the silence of the General Prosecutor's Office of the Czech Republic, which solely interprets the conclusions of the Ministry of Health and Social Affairs of the Czech Republic, the latter trying to defend the allowance being in place and failing even to admit that the use of the allowance might possibly contravene reproductive freedom as a fundamental human right. On the other hand we encounter the very reserved position of the General Prosecutor's Office of the Slovak Republic; even the Ministry of Health and Social Affairs of the Slovak Republic admits the incentive potential of the benefit is problematic. It is also reasonable to assume that it was the Slovak party at the above-mentioned meeting of the Czech and Slovak ministries of health and social affairs in April 1990 that promoted the deletion of sterilisation benefits from the social security system.²¹ There is agreement however between the Slovak

²¹ It should be added on the margin that the allowance in cash and the material benefit granted in connection with sterilisation actually disappeared from the social care benefits system; for the Czech Republic with the decree of the Ministry of Labour and Social Affairs of the Czech Republic No. 182/1991 Coll. coming into effect, i.e. as of May 27, 1991.

and Czech bodies in their proposition that the findings on the targeted incentive use of the benefits to persuade women to undergo sterilisation are by no means provable.

For the second part of the inquiry, i.e. observance of generally binding legal regulations on sterilisation in specific cases, the General Prosecutor's Office of the Czech Republic and the General Prosecutor's Office of the Slovak Republic forwarded for inquiry by district prosecutors' offices the cases of persons identified by the complainants upon request of the prosecutors' offices.

In relation to the then Czech part of the federation, the General Prosecutor's Office of the Czech Republic summarised the results of the inquiry in a letter to complainants Ruben Pellar, Zbyněk Andrš and Josef Vohryzek of May 25, 1991. For obvious reasons the communication of the General Prosecutor's Office of the Czech Republic deserves to be quoted more extensively. We have chosen parts that in our opinion represent dubious situations, are identified by the prosecutor's office itself as violations of legal regulations or where an evaluation had been made²² (personal data of the persons giving testimony have been excluded for obvious reasons):

Kladno

"... The files reviewed suggest that not a single intervention was performed separately but instead always in connection with a termination of pregnancy or delivery. Applications for sterilisation are contained in the files. However, a document showing whether the women had been informed of the nature and implications of the intervention before the latter was performed was always missing in the medical records. Records of application hearings lack the necessary requirements; two of them (O. D. and V. K.) do not specify what decision the commission reached. Minutes of the hearing are missing entirely."

...

"In the case of J. G. the intervention was performed for health reasons on her third delivery, which was like the previous two by caesarean. ... This woman however had not consented to the sterilisation and as her testimony shows, the consent had not even been requested."

"The practice of the Kladno district medical authorities should be assessed as one that did not always comply with the legal regulations. The prosecutor's office however has not established any abuse of the legal provision on the performing of sterilisations on Romani citizens."

Ostrava

"... On M. P. who was 23 years old at the time the sterilisation was performed and had two children, the intervention was performed with surgery on an ectopic pregnancy; the woman concerned stated at the prosecutor's office that the intervention was performed without her awareness. The medical records ... do not contain consent to the sterilisation."

"The findings do not suggest psychological coercion of Romani women aimed at achieving their consent to sterilisation. Apart from the exceptions below the Romani women identically stated that they had been informed of the implications of sterilisation for health, although solely in the sense that they would no longer be able to become pregnant. ... Consent to sterilisation and provision of information are not contained in the medical records of M. T. who, on the other hand, is illiterate."

...

²² The inquiry by the prosecutor's office obviously identified even cases where no shortcoming was identified, and the letter contains some additional information and details. For the purpose of this Report however it is necessary for understanding of the context to present specifically such cases as were pointed out already by the inquiry at the time or suggest in what respects the complainants' propositions might be identical with the findings of the prosecutor's office.

"In reviewing the files, the Municipal Prosecutor's Office identified non-observance of binding provision No. 1/72 of the bulletin of the Ministry of Health of the Czech Socialist Republic (hereinafter the Binding Provision). In contravention of section 11 of the said legal regulation, copies of records of application hearings are not included in medical records, the commission panel did not always meet the requirements set out in section 5 par. 1 letter b), and fragmentary and incomplete recording failed to satisfy the requirements set out in section 10 of the said legal regulation."

...

Vsetín

"The interviews with the women ... suggest that they feel aggrieved in connection with sterilisation, particularly in the financial respect, and specifically by the amount of the special allowances in cash and the value of the material benefits granted to them in connection with sterilisation under the social security regulations. They mostly appeared at the prosecutor's office expecting that if they prove coercion to sterilisation, the prosecutor's office bodies would ensure higher amounts be additionally awarded and paid to them. The alleged coercion meant repeated persuasion of the Romani women into sterilisation as they attended social care bodies administering their applications for various social benefits. None of the interviewed women claimed to have been threatened or that their legitimate claims would have been denied to them while being persuaded to undergo sterilisation. Only five of these women claimed that they had been promised an allowance in cash while being persuaded, without themselves asking about the possibility of obtaining it."

"The District Prosecutor's Office in Vsetín interviewed those officers of social care bodies most often identified in the Romani women's accounts as those persuading the women to undergo sterilisation. All these officers resolutely denied that they had influenced the Romani women in any way. In some distinct social cases they informed the Romani women of the sterilisation option as a way of avoiding further social decline in families with increasing numbers of children. According to their account Romani women were appearing on their own initiative to inquire about the amount of allowances in cash and the value of material benefits that might be available to them in connection with sterilisation. After being informed, some of them requested help in drafting the sterilisation application. The quantity of such applications increased particularly before Christmas with the clear objective of obtaining money." (Underlined by PDR).

...

Ústí nad Labem

"The medical records of the Romani women ... reveal that in all these cases sterilisation proceedings were initiated at the persons' request. However, the declaration in the meaning of section 11 of the Binding Provision is always missing. This fact, as well as interviews with the Romani women, suggests that they were not informed before the sterilisation of its level of reversibility and alternatively about additional complications it might entail. It has not been proven however that the Romani women were coerced."

...

Most

"In all the cases reviewed, the sterilisations of Romani women were decided upon based on the woman's application. The applications were justified by the number of children; if the number of children did not satisfy the above legal regulations, the application was supported by a psychiatric recommendation. The carer's consent was however not required."

"The patient's written declaration, submitted before the actual treatment, that she consented to the treatment and acknowledged the provision of information on sterilisation's implications is usually missing from the medical records (this had been practiced until

1988, from then on section 11 of the Binding Provision was observed). The inquiry by the district prosecutor's office did not objectively establish that Romani women had been coerced in any way whatsoever to undergo sterilisation. The motives for filing the applications included, apart from the number of children, the attempt to obtain financial means, as also confirmed by the Roma Civic Initiative representative in the Most district." (Underlined by PDR).

...

České Budějovice

"The District Prosecutor's Office established a practice of medical authorities in the performing of sterilisation where the patients had signed what was called a surgical waiver before the actual surgery that contained information that the patient had been familiarised with potential complications and implications. The medical records contained neither applications for sterilisation nor consent to it.

"All the women whose questionnaires had been presented were summoned to the District Prosecutor's Office in České Budějovice. ... In most cases they stated that they had undergone the intervention because of the financial reward paid to them.

"In the cases of A. M., L. G. and D. B. the age criteria set by law had not been observed."

Sokolov

"... Sterilisations on E. D. and J. P. were performed upon delivery based on the actually established health condition. E. D. had already undergone two deliveries by caesarean section, a major pathological disorder had been established and her uterus had had to be removed as a lifesaving treatment. J. P. had suffered from a poorly healing incision on her uterus (she had also undergone delivery by caesarean section). A narrowed uterine wall threatening to rupture had been established upon the repeated caesarean section. Any additional gestation would have threatened her health and therefore sterilisation had been performed. ..." (Underlined by PDR).

Cheb

"... Sterilisation on P. P. seems to have been indicated under section 2 letter g) of the Binding Provision; no record of the proceedings was produced and no document exists in the documentation of the provision of information to the person concerned on the intervention's reversibility. The sterilisation was decided upon by the director of the hospital and the head doctor under Section 5 par. 1 letter b) of the Binding Provision.

"Only the director of the hospital had decided upon the sterilisation of K. Š. instead of the commission; consent of the person concerned before the intervention and provision of information on reversibility have not been identified.

"The sterilisation of M. D. was indicated under section 2 letter a) of the Binding Provision; the performing was decided upon by the head doctor. No document proving consent of the person concerned to the intervention and provision of information on reversibility has been identified."

Rokyčany

"... The interviewed women had reservations only concerning the amount of the benefit in cash (of CSK 2,000), because CSK 10,000 is allegedly paid out in Slovakia. They believe they should receive additional money from the state for the intervention performed."

The General Prosecutor's Office of the Czech Republic concluded its inquiry by giving an instruction to all the district prosecutors' offices that had established a breach of legal regulations when reviewing the above cases to give advice to all the medical authorities at

which shortcomings had occurred under the contemporary section 17 of Act No. 60/1965 Coll. on Prosecutor's Offices²³ and to pay increased attention to observance of the law in sterilisation permitting proceedings. However, no information is available as to the results of this measure. No other measures were taken: the legal provision on the performing of sterilisations advised by the General Prosecutor's Office in its letter to the complainants was not changed either.²⁴

4.2.2. The Inquiry of the Office for the Documentation and Investigation of the Crimes of Communism

Investigative bodies turned to the case of Romani women's sterilisations once again in 1997. On September 23, 1997, Ruben Pellar addressed the Office for the Documentation and Investigation of the Crimes of Communism with essentially the same complaint he had addressed before to the General Prosecutor's Office of the Czech and Slovak Federative Republic. The Office for the Documentation and Investigation of the Crimes of Communism ("ODI") kept its inquiry under File No. ÚDV – 18/VvP – 97.

The ODI's inquiry brought essentially no new findings as the main factual inputs the ODI based its action on were the materials of the then General Prosecutor's Office from 1990–91 and the facts contained in Ruben Pellar's complaint. Thus the ODI restricted itself to adopting a statement on the approach of the General Prosecutor's Office and the results of the latter's inquiry.

An official ODI record dated January 26, 1998, adopts statements on different parts of the file kept by the General Prosecutor's Office, and it seems reasonable to quote at least portions of these statements here. The ODI primarily comments on the statements of the General Prosecutor's Office of the Czech Republic and the General Prosecutor's Office of the Slovak Republic on social benefits bound to sterilisation (quoted on pages 40–42 of the present Report):

"I essentially agree with the interpretation in these statements that are based on the applicable legal standards. An attempt to retrieve an instruction from the Ministry of Health and Social Affairs of the Czech Socialist Republic, applicable to sterilisations issued for this purpose, was unsuccessful. This implies that there was no special legal regulation or sterilisation scheme in place for the Romani population that would treat the sterilisation of Romani women. The higher number of interventions among these women is due to the higher birth rate among Romani women and more births at a young age, as a result of which more of them fell under medical indication XIV par. 3. This gives an additional possibility of yet another medical indication for which sterilisation is permitted, such as multiple health complaints and diseases after deliveries in a quick sequence. Apart from this, there are more diseases involving diseased female organs (ovaries, uterus) where sterilisation is indicated. In these cases it is the chief doctor of the department where the woman is treated who decides on the indication, rather than the commission. The fact that there are more sterilisations of Romani women in a specific region is given primarily by the greater concentration of that ethnic group.

²³ § 17

(1) Public prosecutors give advice to the Ministries and other state administration bodies, national committees, management and other organisations with a view to eliminating the breaching of laws and other legal regulations as well as the causes thereof.

(2) Unless a different deadline is set in the advice, the body to which the advice has been given shall discuss the advice, take measures to eliminate breaching of laws and other legal regulations as well as the causes thereof within thirty days and present a report to the Public Prosecutor on the result of the discussion and the measures taken.

²⁴ "The findings of the General Prosecutor's Office of the Czech Republic suggest that the Commission of the Chief Expert for Gynaecology and Obstetrics in Prague is preparing draft amendments to the legal regulations on sterilisation."

*A special one-off allowance in cash could be granted to citizens (**all of them rather than just Roma**) who underwent a medical intervention under special legal regulations in the interest of a healthy population and overcoming the adverse life circumstances of a family. The allowance was paid by the relevant National Committee, which also decided who met the conditions and on the amount of the allowance to be granted, both under section 31 par. 4 of Decree of the Ministry of Labour and Social Affairs of the Czech Socialist Republic No. 152/1988. A question may arise here regarding the extent to which this allowance could have been a motivation for undergoing sterilisation specifically among Romani women, as well as in what form it was presented to these women by social workers. However, legal regulations indicating sterilisation always had to be observed."*

In the said statement, the ODI also comments on an apprehension of those who filed the original complaint at the General Prosecutor's Office that by combination of the provisions of sections 31 and 35 of Decree No. 152/1988 Coll. with the directive on the performing of sterilisations from 1972, the risk may arise that implementation of these legal regulations in practice comes into conflict with the Constitution and may even qualify as the crime of genocide through the sterilisation becoming coerced and unlawful in cases where the woman's decision-making process leading to a decision on future infertility is influenced by psychological manipulation accompanied by the incentive of a social, financial or other benefit:

"The controversial section 35 of Decree 152/88 implementing the Act on Social Security sets forth that the allowance in cash can be granted to those citizens who have undergone a medical intervention under special legal regulations in the interest of a healthy population and overcoming adverse life circumstances. It was granted by district National Committees. The criteria are given in section 31 par. 1 and apply to socially deprived families, families with many children and single parents. It is true that specifically Romani families fell here. An intention of the then government to curb the birth rate among Romani women specifically by this provision cannot be demonstrated. Theoretically, there would have to be a governmental order or an internal ruling for the district National Committees following which social workers would target Romani women to offer them sterilisation, in return for which the women would have been paid an allowance in cash in accordance with the decree. The conditions applicable to sterilisation and indications for it are set forth in Binding Provision No. 1/1972 which had to be observed."

In terms of shortcomings in the process of approving sterilisation interventions, the ODI once again evaluates these similarly to the General Prosecutor's Office, interpreting them as mere administrative shortcomings without any impact on the legal status of the sterilised women. The official record therefore concludes:

"The inquiry by the General Prosecutor's Office implies that in certain cases legal regulations were not observed, which is interpreted as administrative shortcomings. This nearly always means insufficient clinical records. (Missing written declaration signed before sterilisation; lacking sterilisation commission minutes; presenting just results of the commission's meeting; commission panel is incompliant with the legal regulations; in some cases there are no clearly defined diagnoses for acute gynaecological interventions accompanied by sterilisation). These are generally shortcomings of medical personnel that differ in different districts and are not found in just a single location. Where indication to sterilisation under XIV. 3) (number of children conditional on the woman's age) was lacking, the sterilisation was carried out on different indications. It can be demonstrated from interviews with the women that they filed applications for sterilisation, gave consent to the same, that the intervention was not carried out against their will, although not always were they duly advised of sterilisation's implications. Coercion into sterilisation or psychological coercion cannot be demonstrated. Where giving testimony on record, social workers deny these. Although most women mention financial incentives for sterilisation, the conditions applicable to sterilisation and indication to the same were observed. The women subject to the inquiry did not file complaints requiring an additional inquiry. There was not a single case in which the women would be found to have rejected sterilisation and

to have been punished in any manner by the District Authority Child Care Department. (Removal of children, refusing to grant social allowance)."

The ODI file also contains transcripts of testimony by Romani women from different towns on sterilisation practice recorded in 1997 by Czech Television reporter Dana Mazalová (see Annex). The ODI did not review this input and did not check the women's statements.

The ODI finalised its inquiry on August 8, 2000, through a resolution under section 159 par. 1 of the Rules of Criminal Procedure, suspending the matter due to finding no alleged crime and concluding that the matter was not to be dealt with otherwise. The ODI justified its resolution by stating that the legal provisions on sterilisation applied equally to all citizens, whether men or women, regardless of nationality or ethnic group. Regarding the allowance under section 35 of Decree 152/1988 Coll. the ODI stated that this was a general arrangement of benefits for families with children, without any focus on Roma. On the issue of the potential misuse of such legal provisions the ODI states that there was not a single complaint giving specific inputs that would imply a misuse of legal regulations. Archive materials and witnesses' accounts also failed to establish facts, according to ODI, that would confirm the complainants' suspicions.

4.2.3. Digression – The Investigation in Slovakia²⁵

Within the account of official responses to doubts concerning Roma sterilisations, it seems suitable to mention the inquiry that took place in Slovakia in 2003. Although Slovakia is now independent, it formed a single state entity with the Czech Republic until 1993 and the baseline that formed the approach to Roma, before as well as after 1989, was essentially analogous.

In early 2003, the proposition appeared in the Slovak media that forced sterilisations of Romani women were taking place in Slovakia. These were a response to a report produced by the Center for Reproductive Rights located in New York City (hereinafter "the NY Center") and the Centre for Civil and Human Rights in Košice (hereinafter "the Košice Centre"), published in Slovakia on January 28, 2003, entitled "Body and Soul, Forced Sterilisation and Other Assaults on Roma Reproductive Freedom in Slovakia" (hereinafter "Body and Soul").

According to the authors of the publication, the report was based on a fact-finding mission to the east of Slovakia from August to October 2002. The mission revealed extensive human rights violations, according to the authors, and specifically violations of the reproductive rights of Romani women in Eastern Slovakia, including in particular the following:

1. coerced and forced sterilisation,
2. misinformation in reproductive health matters,
3. racially discriminatory access to healthcare resources and treatment,
4. physical and verbal abuse by medical providers; and
5. denial of access to medical records.

The publication implied that out of the 230 interviewed women, over 140 had been coercively or forcibly sterilised, or there were strong indications that they had been forcibly sterilised. Approximately 30 of these 140 women were supposed to have been sterilised under the sterilisation policy propagated during the communist era.

In response to the situation, the General Director of the Section of Human Rights and Minorities of the Office of the Government filed a criminal complaint against an unknown perpetrator for involuntary and forced sterilisations of Romani women that alleged the crime of bodily harm. Following this criminal complaint and criminal complaints filed by an

²⁵ The information on the Romani women's sterilisation case in Slovakia was drawn up for the purpose of this Report from annexes to Slovak Republic Government Resolution No. 1018 of October 29, 2003.

additional two women as well as the published articles and statements, the police investigator of the Regional Office of the Judicial Police in Košice initiated a criminal prosecution. As part of the criminal investigation, the Medical Faculty at Comenius University in Bratislava was immediately engaged to provide an expert opinion and to clarify whether sterilisation had been unavoidable in six specific cases and for what reasons it had been carried out.

In March 2003, at the request of the investigator, and following a subsequent order by the Minister of Health, an Inspection Team comprising representatives of the Ministry of Health as well as gynaecology and obstetrics specialists performed an expert inspection at the maternity wards of the Hospital with Health Centre (HHC) in Krompachy and the HHC in Gelnice. The inspection concentrated on the question of whether the segregation of Romani women was taking place in the maternity ward of the Krompachy hospital, an assessment of the level of medical and preventive healthcare and on the compliance with the Ministry of Health directive on the performing of sterilisation from 1972. The inspection in the Gelnice hospital focused on similar issues, just like inspections in other healthcare facilities (VSŽ Nemocnice a.s. Košice Šaca, HHC in Bardejov, MUDr. V. Alexander HHC in Kežmarok, HHC in Levoča, HHC in Poprad, HHC in Spišská Nová Ves, HHC in Vranov nad Topľou, University HHC in Košice, L. Pasteur University HHC in Košice, and the J.A. Reiman University HHC in Prešov). The report on the results of the inquiry by the State Control Section at the Ministry of Health implies, *inter alia*, that the alleged segregation and genocide were not established in the inspected facilities. Inspections at individual maternity wards established no incompliance with medical indications. The Ministry concluded that all the inspected sterilisations had been carried out in accordance with the medical indications given in the directive on the performing of sterilisation. However the report further implies that not all of the sterilisations had complied with the required administrative steps. This did not lead the inspection to conclude that the sterilisations had been carried out illicitly, because all of them were duly documented and justified in clinical records and operation diagnoses, but from an administrative perspective not all the practices given in the directive had been observed. The inspection concluded that such local violations of legal regulations had affected citizens regardless of their ethnicity.

More than 20 Romani women sterilised at the Krompachy HHC were interviewed at an early stage of the police investigation. Their accounts varied: ten women stated that they felt aggrieved. The investigation established that four of these women had been sterilised as minors.

Given that the authors of Body and Soul refused to release lists of the sterilised women and the members of the specialised team had no other way of lawfully obtaining the list of these women, a decision was made to publish an appeal to all women of Romani origin who believed they had been sterilised against their will or without their consent and felt aggrieved, to appear before any Police department and obtain details from the policemen on duty on how to contact the specialised team investigating the allegation of illegal sterilisations.

Following the appeal from the specialised team, an additional 10 women appeared – 9 Romani women and one non-Romani. Of these women, 5 Romani women felt particularly aggrieved in that they had not been paid the social benefit promised to them for voluntary sterilisation under the population policy of the previous regime.

More than thirty doctors and other medical personnel were also interviewed. They identically stated that the sterilisations had been carried out in accordance with the law. In addition, four legal guardians of female minors were interviewed.

Gradually, broader medical circles began to deal with the approach of doctors to patients in the area of reproductive health in relation to the Body and Soul report. On May 15, 2003, an international conference entitled "Gynaecological/Obstetric and Paediatric Care and Ethnic Minorities in Slovakia" took place in Lučenec. The conference was organised by the Slovak Health University (SHU). The conferees generally criticised the Body and Soul publication, questioning the authors' expertise. However the SHU chancellor as the person in

charge of the conference as well as other participants at least welcomed the publication as a document generating discussion on important issues that needed to be dealt with urgently in connection with general developments (a review of sterilisation regulations, explicit patient's consent in a special form, etc.).

The Minister of Health, Rudolf Zajac, stressed in a political declaration that the Slovak Republic should draw on U.S. experience. His criticism of the "not very trustworthy" Body and Soul publication was extensive. He criticised the authors for refusing to provide the investigators with the relevant data used by them for their publication. He further referred to the domestic and international contexts of the case that in his opinion had the potential of influencing even the coming referenda on approval of the treaty of accession of Slovakia to the European Communities.

In response to the critical statements made at the conference, the Centre for Civil and Human Rights and the Centre for Reproductive Rights issued a press release on the conference on May 16, 2003, in which they criticised the doctors and their attitudes as presented at the conference. The press release further noted that the gynaecologists' appearances, whether as papers or in the discussion, demonstrated very widespread and deeply rooted racial prejudices and discriminatory attitudes among gynaecologists in the region. *"This conference demonstrates that segregation does exist in the gynaecological care system"*, said Ladislav Fízík, chair of the Romani Parliament and advisor to the Slovak Interior Minister. The criticism of the conferees by both NGOs in the press release was due to the fact that in their attitudes the gynaecologists openly presented their racist views of the Romani community and Romani women in particular, questioning *inter alia* their intellectual capacity and cultural level. Statements like *"...promoting further childbirths in the settlements is irresponsible..."* were heard as well as *"...more funds for contraception and sterilisations should be obtained..."*. The gynaecologists present at the conference also discussed informed consent issues, directly admitting non-observance of the duty to obtain informed consent with respect to sterilisations: *"...there is no time to explain anything; they are simply told that they will have no more children..."*, stated the head gynaecologist of the Spišská Nová Ves district.

In late May 2003, the Košice Centre and the NY Center presented material to Slovak and a number of foreign institutions in which they criticised developments in the Romani women's sterilisation case in Slovakia so far:

"...the investigation was not impartial and consistent under the principles of a state of rule of law and respect for victims' rights; the investigating entities have drawn quick conclusions; ignoring key facts, they have created an air of intimidation for the victims with a tendency to deter them from voluntarily presenting their complaints; without reviewing the circumstances under which the Romani women's consent were obtained, the investigators requested a medical statement to identify cases in which sterilisation had been necessary – however, sterilisation is never an unavoidable intervention; as for the sterilisations of minors, although these have been confirmed, the Interior Minister insists that no shortcomings occurred on the part of hospitals and medical personnel; the investigators have focused their attention on certain hospitals and the period from 1999 to 2002 only, inquiring solely into the crime of genocide; a conflict of interest among expert witnesses – the investigation team uses at least one expert witness who concluded during the Ministry of Health inquiry that no regulations had been violated; premature conclusions – the statement of the Interior Minister that no trespass has been established; the Ministry of Health inspection is insufficient, with unjustified and undocumented conclusions drawn from it on the non-establishment of the crime of genocide that may have an adverse effect on Ministry of Health inspections in other facilities; the Ministry of Health only sought the patient's signature instead of informed consent; in its report, the Ministry of Health admitted two cases of sterilisation of minors while ignoring the same in its conclusions; the Ministry of Health failed to examine allegations of discrimination in healthcare facilities; healthcare facilities have refused to provide sufficient access of patients to medical records; local gynaecologists have refused to evaluate the victim's

damage in pecuniary terms; the victims have been harassed and intimidated by the investigators and verbally abused by doctors; the criminal complaint filed against the authors of the report represents an attempt at intimidation and harassment of the author and, indirectly, Roma, as well as at deflecting attention from the allegations; by disparaging the report and harassing and intimidating Romani women and their advocates, the Slovak authorities have attempted to deflect attention from their responsibilities; the government has shown no determination to establish an independent commission...".

In conclusion to the said material, the Košice Centre and the NY Center made the following recommendations:

1. the criminal investigation should encompass all crimes (covering the entire period after 1989 and all relevant crimes, including violation of the right to healthcare, bodily integrity and autonomy);
2. prosecute clear violations of law – including cases in which minors were sterilised without the consent of a legal guardian;
3. respect the rights of victims and their right to be treated with dignity during the investigation;
4. the inspection by the Ministry of Health should be thorough and comprehensive, investigating the practice of forced and coerced sterilisations throughout the post-1989 period and at all maternity wards, especially those in Eastern Slovakia;
5. the Ministry of Health inspection should examine the circumstances under which consent was given, reviewing compliance with the practice of obtaining informed consent and examining observance of practices (i.e. approval of sterilisations by the relevant commission before the intervention),
6. the Ministry of Health should order hospitals to ensure access to medical records;
7. in the matter of complaints against doctors, the Ministry of Health, higher regional offices and the Slovak Medical Chamber should decide on the doctors' duty to evaluate damage;
8. raise awareness among Roma about reproductive rights, in particular through a government strategy;
9. draft comprehensive reproductive health regulations based on respect for reproductive rights, including the right to non-discrimination, informed consent and to comprehensive family planning information and services;
10. publicly drop the criminal complaint filed against the authors of Body and Soul;
11. establish an independent commission to examine the sterilisation practice comprising of independent and highly qualified members; the body's mandate should be to investigate the full extent of coerced and forced sterilisations under communism and in the post-communist period, propose institutional and administrative measures to prevent the recurrence of the practice and recommend financial and other reparations for victims.

The first specific results of the inquiry were summarised at a co-ordination conference of the Office of the Slovak Republic's government on August 19, 2003. Representatives of the Slovak Ministry of Health described the inspection content and results as follows:

1. the inspection examined all clinical records for the period from 1993 to 2003 with a focus on whether the indication to sterilisation intervention was correct and whether the clinical records contained a signed application; as a result, the inspection ruled out the alleged genocide,

2. physical inspection and interviews with the patients examined as to whether separate examination rooms, hospital rooms, dining rooms, etc. existed or whether Romani patients were provided a different standard of preventive healthcare; the Ministry concluded that none of the above allegations of racial segregation were demonstrable,
3. the inspection established general observance of the binding provision No. 9/1972, with the exception of two cases that however were not a serious violation of the law, according to the Ministry (although these included sterilisations of minors where consent of legal guardians was not attached to the application; yet the Ministry evaluated the case as an insignificant violation of the law, referring to the fact that these were medically justified interventions performed under time pressure).

In spite of the fact that the Ministry of Health essentially established no significant violation of the law from its perspective, the Central Ethics Commission drafted an act that:

1. set the minimum age for sterilisation at 25 years,
2. reduced the role of medical personnel in sterilisation decision-making,
3. introduced a requirement for informed consent of patients in the form of an application clearly explaining the nature and implications of the intervention,
4. entirely avoids a definition of medical indication to sterilisation, i.e. does not even imply a "life-threatening situation" that would entitle doctors to perform sterilisation without providing room for informed consent of the patient,
5. assumes that in most cases sterilisation will be a medical intervention not covered from public health insurance.

The Government of Slovakia closed the case of the Romani women's sterilisations in Slovakia on October 28, 2005, through Resolution No. 1018. The Government primarily made note of the report on the developments with respect to the alleged forced or coerced sterilisations of Romani women and the steps and measures taken, a large part of which has been conveyed above in the present Report. In addition, as part of the Resolution, the Government approved an official Government Statement, which we feel is worth quoting here in its full version:

"Over the past fourteen years, Slovakia has travelled a difficult road in the process of building democracy and strengthening the rule of law. On this road, Slovak governments have had to cope with a variety of challenges and face diverse impacts of the remnants of the recent past. Under the accelerated pace of achieving our visions, rebuilding our institutions, implementing reforms and creating concepts, the gradual change in people's thinking and their adaptation to the new, more democratic pillars of our society, based on a new philosophy and founded on the protection and observance of human rights, have appeared to be the most complex issue.

"In this process of change, an important role has been played by reports on the observance of human rights, which have served as a mirror of these efforts. The Government of Slovakia was surprised to note the appearance of the publication Body and Soul abroad, which claims that there are widespread violations of Slovak laws in Slovakia in the form of illegal sterilisations. The publication was published abroad before and without even informing Slovak authorities or relevant organisations of this step. The Government of Slovakia considers such conduct unacceptable and rejects all forms of manipulation of the topic of alleged sterilisations.

"Upon initiative of members of the Government, all constitutional authorities that ought to take action in such cases in a state of rule of law have done so. An expert group

was created under the patronage of the Ministry of Health of Slovakia, which examined the published information from an expert standpoint. The Minister of the Interior set up a specialised team of investigators (three out of its four members were women) and its investigations took place under the oversight of the General Prosecutor's Office of Slovakia and the Parliamentary Committee for Human Rights, Nationalities and the Status of Women. Representatives of the civic sector were also engaged in the process.

"The Body and Soul report has also raised concerns on the international political scene. These concerns related not only to the issue of the alleged illegal sterilisations themselves, but also fear of criminal prosecution of the authors of the publication, which was refuted by competent Slovak authorities. At the same time, the Government made it possible for experts from international organisations and institutions to examine the whole issue directly in Slovakia. The Government has taken note and will make use of their recommendations in the resolution of the situation.

"Shortcomings of a procedural nature were found in the thorough investigation of certain sterilisations of women. The Government has therefore initiated a revision of the relevant healthcare legislation of Slovakia to bring it in line with EU legislation and Slovakia's international commitments. The Government is prepared to organise further training for healthcare staff, police, the social services and public administration in order to further humanise the services they provide."

Even though the Government reiterated in its Statement the criticism of the Body and Soul authors' initiative and even though the criminal investigation had not reached the point of bringing a criminal charge, and the inspection by the Ministry of Health had not established any major shortcomings, Resolution No. 1018 allocated the individual Ministers with extensive tasks aimed at future far-reaching changes in sterilisation practice.

Under the Resolution, the Interior Minister was to continuously improve training for policemen in the area of human rights with a focus on respecting victims' rights.

The Resolution tasked the Minister of Health with the following:

1. by December 15, 2003, to perform an in-depth inspection and analysis of all medical facilities with a view not only to reviewing allegations of involuntary sterilisations, but also to identify discriminatory practices against Roma and observance of the obligation to provide medical treatment solely on the basis of informed consent of the patient,
2. also by December 15, 2003, following the inspection by the Ministry of Health at the gynaecology–obstetrics facilities, to invoke liability of the doctors and facilities as such that demonstrably violated the valid legal regulations applicable to the provision of healthcare in reproductive health and performing sterilisations,
3. by January 31, 2004, to present to the Government a draft act on healthcare to comprehensively treat human rights aspects of reproductive health and define a clear legal framework for performing sterilisations,
4. to ensure, under standards treating the rights of patients, legal provisions concerning the right to non-discriminatory access to healthcare including a prohibition of both direct and indirect racial segregation, all other forms of racial discrimination including verbal and physical abuse in medical facilities as well as effective sanctions against individuals and facilities,
5. to amend, following a comprehensive analysis of the applicable legal regulations from the perspective of applying the principle of voluntary and informed consent, the relevant healthcare legislation with a view to incorporating the principle of obtaining voluntary and informed consent of patients in the provision of healthcare and achieving compliance of the legislation with the obligations adopted on signing the Convention for the Protection of Human Rights and

Dignity of the Human Being with Regard to the Application of Biology and Medicine, and

6. by December 31, 2003, to provide legislation treating access to medical records including the possibility to make photocopies of the records for the person on whom they are kept and the person's legal guardians (including authorised representatives), again compliant with the Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine.

The Plenipotentiary of the Slovak Government for Romani Communities was tasked to draft, under preparation of the National Programme of Reproductive Health, a programme aimed at raising awareness of reproductive rights among marginalized groups, in particular through activities focused on education in such communities.

The Minister of Foreign Affairs was tasked to continuously provide information at international forums on activities of Slovak authorities with respect to the investigation of allegations of forced sterilisations of Romani women in Slovakia.

In September 2005, the UN Committee on the Elimination of Discrimination against Women also took note of the Slovak investigation results and the measures taken by the Slovak government on the basis of the investigation.

4.3. Social Workers' Practice in Work in the Romani Community

Both the Charter 77 initiatives and the initiative of Ruben Pellar, Zbyněk Andrš and Josef Vohryzek referred to a state Roma assimilation policy in place before 1990 that had specifically targeted Romani women using financial incentives with a view to persuading them to adopt of methods that prevent conception or giving birth to more children, including sterilisation and termination.

The text above shows that although paying attention to this context, the inquiry by the General Prosecutor's Office in 1990 and that by the Office for the Documentation and Investigation of the Crimes of Communism in 1997 were satisfied with definite denial of such practice by the interviewed social workers. Yet a centrally controlled, conscious and targeted birth control policy expecting social workers to influence individuals' decisions is a serious issue for the evaluation of the cases of Romani women's sterilisations. Unfortunately the inquiry by the General Prosecutor's Office and that by the Office for the Documentation and Investigation of the Crimes of Communism did not analyse archive materials that were preserved to document to a certain extent the public administration's actions in dealing with the Roma issue before 1989; instead, the inquiry was satisfied with mediated evaluations.

It is no longer possible to exactly piece together the level of involvement of a social worker in a particular case concerning a particular woman's decision to undergo sterilisation (while considering an unbiased picture can be obtained through interviews is even less an option). Files of welfare officers that could contain records on dealings with clients as well as birth rate control issues are no longer available. Given that the period before 1990 is concerned, the shredding date for these files has elapsed; it should also be taken into consideration that the state policy influencing life of the Romani community until 1990 has entirely crumbled since then including, *inter alia* in connection with the reform of public administration, all its organisational structures established to implement the policy. On the other hand one cannot accept claims that no archive documents exist from which to deduce the amount of co-ordination and premeditation within public administration in the issue of Romani birth rate control.

It would be wrong to believe that the relation of the pre-November [1989] Czechoslovakian state authority to Roma was random, uncontrolled and lacking co-ordination. It is also impossible to agree that no documents exist on the practical shape of

Czechoslovakia's Roma policy. Rather the opposite; there are already the first complete historical studies that map the development of Roma policy, drawing from preserved archive documents.²⁶

It seems appropriate to make a little digression here to at least outline the development of Czechoslovakia's policy towards Roma before 1989, including the development of institutional backing. The amount of indoctrination and steering of individual social workers in their individual work can be derived from the amount of co-ordination among the elements of the state machinery ensuing from the centrally controlled policy in place.

4.3.1. The Development of Roma Policy in Czechoslovakia

The second half of the 1950s was crucial for the birth of the Roma policy that was defining for Czechoslovakia until the end of the 1980s. In 1956, the serious situation in Romani issues began to be dealt with by regional National Committees as well as the Central Committee of the Communist Party of Czechoslovakia (CCCPC) and the Ministries. Proposals for solving the Romani issue varied from harsh repressive measures aimed at the promptest possible conformation of Roma with the majority way of life to proposals inspired (although somewhat naively) by the Soviet Government's policy in the second half of the 1920s that had provided Roma with broad cultural autonomy and promoted their natural integration.²⁷

The CCCPC Politburo Resolution of April 8, 1958, "on Work with the Gypsy Population in the Czechoslovak Republic" was a critical moment for the formation of Roma policy. The Resolution clearly supports the idea that Roma cannot be considered an original ethnic group; instead they are solely a "socially and culturally backward population featuring characteristic lifestyles". From that moment the process of a centrally controlled assimilation of the Romani population aiming at a gradual elimination of the "backward lifestyle" was to become a binding directive for actions of the state machinery. From the same goal stemmed the orientation of the entire assimilation policy toward Romani groups leading, by the language of the time, a "nomadic" or "semi-sedentary" lifestyle. In the initial stage settling down and involvement in the labour-process were to become the main tools.

For the actual implementation of the earliest assimilation scheme, a crucial legal step was required, Act No. 74/1958 Coll. on the Permanent Settlement of Nomadic Persons (see Annex). The original concept was to begin by making a list of "nomadic" and "semi-nomadic" persons, after which the National Committees would call the nomad's attention to individual provisions of the act and call upon them to settle at an appointed location and participate in work.

Another goal of the listing effort and mandatory controlled settling was to prevent places with a high concentration of the Romani population. However, the preserved archival documents suggest that the ideas of National Committee officers concerning practical implementation were very vague in one part and naively optimistic in another.²⁸ Thus the results of the entire mandatory settling effort were rather dubious. The actual list of the nomadic and semi-nomadic population was far from capturing all those it was targeting, while rather the opposite, even people long since sedentary in a given place found themselves listed by the baffled public authority representatives. As a result of mandatory settling, Roma in many a city were forced to settle down in utterly inconvenient, makeshift conditions. The attempt to prevent the concentration of Roma in large groups was also unsuccessful. As for positive results of the listing effort, healthcare was probably the only one worth mentioning –

²⁶ Much inspiration can be drawn from the following document: Pavelčíková, N.: Romové v českých zemích v letech 1945–1989 or The Roma in the Czech Lands Between 1945–1989, in: Sešity, Volume 12, Office for the Documentation and Investigation of the Crimes of Communism, Prague 2004.

²⁷ Op. cit. in footnote 26, page 58.

²⁸ Op. cit. in footnote 26, page 63 and following

a number of diseased people were identified by means of the list and provided with effective treatment.²⁹

As part of the radical assimilative resolution of the Romani issue along the lines of the 1958 concept, a planned centrally controlled removal of Romani settlements in Slovakia and dispersion of Roma from the settlements throughout the territory of the state were to take place. Given however that free movement was prohibited to a large portion of the Romani population, perfect co-operation among National Committees would be necessary for the plan to succeed. The latter were to prevent uncontrolled movement of persons from the list on one hand while on the other hand organising extensive transfers accompanied by the provision of housing and jobs. This was an unrealistic idea as the National Committees were not capable of creating the list and pursuing the settling effort.

The 1960 administrative reform caused a total crumbling of any prospects for the "ambitious" 1958 scheme being implemented. The reform (and a similar situation will recur after 1990) nearly erased the entire system of organisation dealing with Romani issues that had been created before. In most regions the commissions "for work with the Gypsy population" fell apart and any interest at this level to at least monitor Romani issues subsided in general.

By 1964 however the existing approach by the country's central bodies faced a wave of criticism from the regions, resenting in particular the insufficient co-ordination. Even the central bodies themselves concluded at this time in official evaluations of compliance with the 1958 concept that a uniform national scheme for dispersion of the Romani population from "places of undesirable concentration" was lacking. The said dispersion was still regarded by the central bodies, along the 1958 perceptions, as a crucial assimilation method for most Roma. Consequently the CCCPC Presidium phrased a new Resolution on June 15, 1965, redefining the existing Roma policy to a certain extent and at the same time setting basic tasks for the individual central bodies. It decided to create a government committee to deal with Gypsy population issues as an advisory, initiating and co-ordinating government body. Similar co-ordination commissions were to emerge also at regional and district levels. The schedule for the long-term removal of "places of undesirable concentration of Gypsies" and dispersion of their population was set by the CCCPC Presidium as the primary and main task for the machinery.

From the Resolution of the CCCPC Presidium of June 15, 1965, a straight path led to Government Resolution No. 502 of October 13, 1965, establishing a government committee for Gypsy population issues. The committee's sessions produced the so-called Rules for Organising the Dispersion and Transfer of the Gypsy Population of December 18, 1965, which were then gradually detailed by individual local bodies to reflect their own perceptions of "the removal of undesirable concentrations of population of Gypsy origin".

The central government committee once again had a rather ambitious plan: 611 of the total approximately 1,300 Romani settlements in Slovakia were to be removed by 1970 plus the arising Czech urban Romani ghettos were to be dispersed. Once again however, instead of organising the planned transfers directly, in a directive manner, the government committee used something of a recommendation on the basis of which Czech and Slovak regions were meant to agree between themselves. This is what the bodies concerned later labelled as the greatest shortcoming of the whole project, because most institutions at the time were incapable of acting independently without a clear order. In addition to this some Slovak districts began hastily demolishing settlements and getting rid of their inhabitants without considering any plans regarding rates and dispersion routes. Combined with the negligible will and willingness of Czech target districts to receive Roma, this doomed the second scheme of Romani assimilation through a centrally controlled settling policy.

The collapse of the second unrealistic Roma settling, urbanisation and assimilation scheme in the late 1960s fully revealed the actual implications of the existing policy³⁰:

²⁹ Ibidem, page 77.

1. Urbanisation of Roma artificially induced by administrative interventions had not resulted in a prompt merging of most Romani communities with the majority society and adoption of the latter's lifestyle, i.e. achievement of the assimilation policy's chief goal. At most it had destroyed natural, ancient and respected coexistence rules of the traditional Romani community based in particular on family relations, without replacing them with anything else. It had resulted in a dilution of the gradually improving social and educational standard, health condition and other individual aspects of Romani life that had been achieved.³¹
2. Apart from the destruction of inner social bonds, traditional bonds to the majority population had been severed in the original settlements as a result of the forced migration and urbanisation. Although living at a very low level of social hierarchy in the settlements, Roma had lived in transparent relations with the specific local community as a result of their dependence on the community. Every individual had had a place there. With only minor exceptions, the majority in the Czech Lands had not accepted Roma moving in. As a result, all Roma were already at this time (rather than after 1990 as many believe) becoming dependent on the state in economic and social terms. The state was unable to provide a deeper motivation for Romani groups to "open up" and incorporate themselves organically and informally into majority society.
3. In all documents dealing with the Romani community, proclamations could always be found on the necessity to remove illiteracy and to improve the level of education among the Romani population, while an integrated scheme of primary and further education of Romani youth was never created. Until the late 1960s, there was a lack of belief even in practice that higher education of Roma would deserve any attention at all. The focus in practice was on the goal of providing Roma with primary education extended with an undemanding apprenticeship following which they would be fit for work in industry.
4. Traditional Romani culture went into a deep decline in the twenty years following February 1948. Firstly it was suppressed by Communist Party representatives as a "display of the backwardness of the Gypsy population", after a certain period of toleration and attempts to employ Romani culture in the integration process, and secondly it was dying spontaneously in the artificial urbanisation process. The shift of entire families from Slovak settlements to Czech industrial centres pushed Romany out from the position of external, and later even internal, communication. Already the second generation of migrants began to use ethnolect (a mixture of Romany, Czech, Slovak, and sometimes Hungarian language elements), featuring simplified and lowbrow language tools. The frequently mentioned handicap of Romani pupils was not so much a problem of "Romany primitiveness"; instead it had to do with Romany being expelled by ethnolect. The loss of communication language and urbanisation was connected with a gradual fading of original lyric works and other displays of folk literature. The migrant families abandoned the systematic pursuit of original customs and ceremonies. Such a crumbling and removal of traditions obviously went in parallel with those aspects of

³⁰ For a more detailed analysis of the consequences see op. cit. in footnote 26, page 101 and following

³¹ This consequence is concisely characterised by the Slovak cultural anthropologist M. Dubayová in: Dubayová, M.: *Poznávanie kultúry rómskych skupín a problém kultúrnej zmeny* (or *Understanding Roma Groups Culture and the Issue of Cultural Change*, *Slezský sborník* 95, 1997, page 205: ".... as a rule in cultural anthropology, the more closed a culture type, the stronger are the destructive effects of non-systematic inputs and the less the "cultural corpus" is "capable of regeneration and revitalisation."

life in Romani communities that were capable of enriching the life of the entire society and helping Roma in their integration (cohesion, strict inner order in Romani families, modesty, private joint relief).

The crumbling of the traditional Romani community brought a number of additional negative accompanying phenomena, in particular types of criminal conduct that had been unusual among Roma until then (prostitution, violent crime).

In 1968 the unsuccessful attempt at dispersion of the Romani settlement population was terminated and the government committee for Gypsy population issues voided. The committee's powers were assumed by Federal and State Ministries of Labour and Social Affairs. In November 1970 the Czech Ministry of Labour and Social Affairs noted in a report on the progress of solving the Romani population issue in the Czech Socialist Republic that the existing attempts at assimilation and dispersion of Roma *"did not respect the distinctions of this ethnic group"*. It was criticism marking an attempt to shape a new policy.

This attempt was launched by the Government of the Czech Socialist Republic through its Resolution No. 279/1970. Its justification report primarily condemned any amendment of Act No. 74/1958 Coll. prohibiting a nomadic lifestyle; restrictions on the free movement of the Romani population were identified as an anti-constitutional approach. The Resolution once again ignores attempts at emancipation of Roma as an original ethnic group, but it already refers to an entirely new necessity of a "comprehensive solution" of the Romani issue using methods of group and individual social work, field surveys and analyses.

The Resolution as well as the following documents between 1971 and 1972 place emphasis in particular on the issues of employment, education and placement of Romani youth and solving the overall social situation of Roma (housing, healthcare). Also following the Resolution, a body was established to deal exclusively with the Romani issue in the Czech Lands, the so-called Commission of the Government of the Czech Socialist Republic for Gypsy Population Issues. The commission of nineteen persons led by the Minister of Labour and Social Affairs comprised representatives of other Ministries, representatives of regional commissions for Romani population issues and representatives of the National Front organisations.

Until disbanded in 1988, the Commission met regularly, participating in the preparation of strategy materials, co-ordinating and checking the work of the individual Ministries and other central administrative bodies and requesting for review regular reports on observance of government resolutions on the Romani issue from central administrative bodies and National Committees. Based on relatively detailed reports from the National Committees' commissions for Romani population issues, the Commission was setting further directions Roma policy should take.

The new design of official policy towards the Romani population was definitively shaped through Resolution of the Government of the Czechoslovak Socialist Republic No. 231/1972. According to the Resolution, the fundamental task for the further development of the Romani ethnic group in the Czechoslovak Socialist Republic was the so-called all-embracing cultural and social integration of Roma, intended to rest on a gradual levelling up of the average living standard of the Romani population to that of the majority. The Government stressed in the document that it conceived the task as a long-term one, therefore placing an extraordinary emphasis on upbringing and education of the young generation from preschool age to completed primary education, further learning and vocational training. The plan was to encompass an all-embracing development of cultural and social activities of the young Romani generation based *inter alia* on nurturing traditional Romani culture (sic!).

This Government Resolution opened a new stage of the state administration's work towards the Romani community that was indisputably more systematic, professional, consistent, and in many aspects effective and beneficial. Following government resolutions from 1970 and 1972, model statutes were drawn up for the National Committees' commissions for Romani population issues. In places with the highest concentration of

Roma, National Committees began to establish sites for systematic social work with the Romani population. It is to be regretted that solely majority [non-Roma] personnel were invited to participate in the work.³²

It was the new policy towards the Romani community in the 1970s that may have created grounds for more targeted interventions of the social services in Romani families, possibly including the influencing of their sexual behaviour. If we want to look for indicia that the social services purposefully influenced the number and timing of childbirths in the Romani community, it is the documents from this period that should be reviewed. And it is as late as this period that in terms of organisation such a focus of social work can be hypothesised as a centrally organised one.

4. 3. 2. Sterilisation As a Tool of Social Work in Practice

As already mentioned, regular reports by district National Committees on observance of the tasks laid on the basis of resolutions of the governments of the Czechoslovak Socialist Republic and the Czech Socialist Republic in the area of solving the Romani population issues are a valuable background for a general assessment of the social workers' approach. In the reports, essentially from the entire 1970s and 1980s, a number of mentions can be found of attempts of the social services to influence the reproductive behaviour of Roma.

Although there is not a single government resolution on the Romani issue in the period concerned (between 1970 and 1988) where one would find mention that the reproductive behaviour of Roma should be influenced for whatever purpose, almost every situation report from district and regional National Committees deals with this issue. This may suggest that the central bodies in fact welcomed such initiatives. A certain illustration of the justified assumption that the thought of using sterilisation in the solving of the Romani issue was not entirely foreign even to the central level is offered by minutes of the meeting of the Central Committee of the Union of Gypsies–Roma of May 12, 1970, sharply criticising an attempt of the Ministry of Labour and Social Affairs to include a proposal for the sterilisation of women of unsatisfactory background in material on solving the Romani issue. On the other hand a representative of the Ministry of Health sharply objected to the same proposal at a meeting of the Commission of the Government of the Czech Socialist Republic for Gypsy Population Issues and the requirement no longer occurred at the central level.

The official 1976 handbook of the Ministry of Labour and Social Affairs of the Czech Socialist Republic "Work with the Gypsy Population" may serve as a certain road to understanding the place of sterilisation in the deliberations of social workers working with the Romani community. In the chapter "Health and Educational Care for Gypsy Citizens", the following is stated in clause 6 (guidance to parenthood):

"The biological (reproductive) function is one of the fundamental functions of the family. As already mentioned, the purpose of marriage is to start a family. However, giving birth to children should not be left to chance; the number of children in the family and the time they are born should be planned, and if possible, children should be born based on the parents' conscious decision.

"Opinions still survive among the Gypsy population that a woman is a woman as long as she gives birth to more and more children. It is therefore necessary to explain to them that gestation and deliveries in too frequent a sequence are a considerable burden for the woman, that they weaken her organism and may even have unfortunate effects (such as metrorrhagia, profuse bleeding to exsanguination, amniotic fluid embolism, etc.), with potentially fatal consequences.

"It is therefore specified among the medical reasons for sterilisations of women for example that a woman younger than 35 years who already has four children or a woman

³² This later resulted in increased problems and generally questionable effectiveness of their efforts. They very frequently failed to build a respected position among the Roma, suffered from similar prejudices towards them as most in their own population, failed to understand their mentality and find their bearings in their problems.

older than 35 years who has at least three children may have the intervention done. In relevant cases Gypsy women and men should be notified of this option, although co-operation is always required with the relevant gynaecologist who should upon recommendation of the social worker invite the woman, and possibly her husband, to discuss with them the birth control issue or the options for sterilisation for medical reasons. If the sterilisation is not only in the woman's interest but also in the interest of population quality, the district National Committee may grant an allowance to the woman in rates differentiated by the overall situation of the applicant, the duration of the woman's hospitalisation during which the husband (the children's father) is drawing justified time off, etc. (information is available at the Department of Social Affairs and Healthcare of the District National Committee or the Regional National Committee). (Underlined by PDR).

"If parents have only as many children as they can provide with proper conditions, the family lives better and they can give the children a better upbringing, education, vocational training and material well-being. The socialisation/upbringing and economic functions (material well-being) are further fundamental functions of the family.

"Where children are born without any control and parents are unable to ensure good conditions for the proper care and upbringing of the children, the family generally fails in its upbringing, socialising and material well-being functions. Children lag in their development, because their parents do not manage to cope with proper care for them; they are less successful in school than their talents would allow; they fail to complete even primary education; are unable to obtain qualifications for a later vocation and their future living and cultural standards decline. It is therefore necessary to take all means to ensure that the parents understand the purpose of family planning, that they try to control the birth rate and also that they properly rear their children so as to become healthy and happy citizens beneficial to society." (Underlined by PDR).

The quotation clearly shows that for the authors of the handbook, sterilisation was one of the options to be proposed by the social worker as a family planning method. Obviously the primary effort was to appeal to responsible parenthood with two basic objectives: social (ensuring that the family meets the objectives placed on it by the contemporary perception of a properly functioning family) and, importantly (see below), eugenic (population quality), the meeting of which is supported, although in a mere hint, by mentioning the potential availability of financial aid.

It is clear from the context of the National Committee reports for the Commission of the Government of the Czech Socialist Republic for Gypsy Population Issues that pressure towards birth control was taken as an entirely standard part of social provisions in field practice. A high birth rate is frankly labelled as a significant "risk factor" that "impeded" efforts to assimilate the Romani community. In the language of the reports, the Romani population was viewed as of low quality, in the sense that due to their low social and economic status, Romani families were unable to "properly" care for their children or suffered from health complaints or development derangement more often than the majority population due to their poor social conditions.

What the text of the handbook merely hints is named in an entirely open manner in the reports from the National Committees. The Roma's inability to meet social workers' requirements in terms of childcare often resulted in removals of Romani children and their placement in foster care. Such an approach obviously burdened the social system in a significant way, for which reason birth control was also perceived as prevention of the necessity of taking childcare measures (today called social and legal protection of children).

Like in the investigation by the General Prosecutor's Office of the Czech Republic, it seems suitable to quote for illustration the actual National Committee materials:

The South Moravian Regional National Committee names its report on evaluation of the state of social care for the Gypsy population of December 28, 1970, "the promotion of modern contraception to regulate population in Gypsy families".

Similarly, the National Committee of the City of Brno proposes in its evaluation of care for the Gypsy population of December 15, 1970, "activity of medical enlightenment to curb the birth rate and thus avoid undesirable overgrowing of Gypsy families".

A report evaluating the state of social care for the Gypsy population by the North Bohemian Regional National Committee of December 30, 1970, states:

"The most serious problem in Gypsy families is a lack of family planning that mostly results in a low-quality population, mentally defective children being born."

Similarly, the South Moravian Regional National Committee in its report of June 30, 1972:

"The explosion of the Gypsy population in our region brings a number of adverse consequences. The quality of the Gypsy population worsens and in particular social, economic and cultural standards of Gypsy families themselves worsen as well."

The East Bohemian Regional National Committee in its report on compliance with Government Resolution No. 279/1970 of June 28, 1972:

"Special healthcare is provided to pregnant women and mothers. For women with more children, medical enlightenment focuses on contraception, and applications of Gypsy women for termination are preferred. All these actions are just partly effective."

The report of the South Bohemian Regional National Committee of July 6, 1972, informs us that *"applicants for termination of pregnancy are treated very benevolently and virtually free of charge."* It is stated, somewhat disappointedly, that *"contraception is not very popular among Gypsy women."*

The District National Committee in Tachov states in its report on compliance with Government Resolution No. 279/1970 of June 14, 1974:

"Cases of undesirable pregnancy are approached under the act on termination of pregnancy and solved by the district commission for pregnancy termination without any delay and free of charge. At the same time doctors, other healthcare personnel and gynaecology carers employ the potential of the act on legal sterilisation, using the option of granting a sterilisation allowance under notification of the Ministry of Labour and Social Affairs of the Czech Socialist Republic Ref. No. IV/1 8150 of September 13, 1973, that is paid upon our proposal after the Department of Social Affairs and Healthcare of the District National Committee reviews the circumstances."

In a report on compliance with Government Resolution No. 279/1970, the District National Committee in Karlovy Vary states on May 30, 1974:

"Thanks to increased effort, pregnant women are identified in time; although some women use contraception, terminations remain frequent."

An undated draft report of the West Bohemian Regional National Committee on compliance with Government Resolution No. 279/1970 for the period between 1971 and 1974 states in a section on healthcare:

"...Care for mother and child has improved significantly. In spite of these positives, the still high and undesirable birth rate is accompanied by an increase in mentally defective youth. Specifically imbeciles have the highest numbers of children within the Gypsy population, thus supplying not only schools for the educationally subnormal, but social care institutions in particular. Medical propaganda has once again concentrated on the sterilisation possibility here as well as on reducing these adverse phenomena."

A report by the České Budějovice District National Committee of 1979 states:

"After childbirth, women of Gypsy origin receive priority invitations for contraception, which in their case is mostly introduced free of charge. ... In some cases

women are successfully persuaded to undergo sterilisation. There were two such women in 1978."

The following can be quoted from a report of the District National Committee in Přerov of June 17, 1977, serving as a background for a meeting of the Commission of the Government of the Czech Socialist Republic for Gypsy Population Issues:

"Care for mothers comprises the following:

"a) performing contraception and termination for women of Gypsy origin free of charge,

"b) in indicated cases and upon recommendation by social workers and consent of the sterilisation commission, sterilisation by laparotomy is performed,

"c) field nurses for women pay extra attention to women of Gypsy origin, especially in the meaning of timely identification of pregnancy and providing family planning enlightenment, ..."

The report further states that *"good results are achieved in family planning issues, including the mediation of contraception and termination..."*.

The East Bohemian Regional National Committee states in a report for a meeting of the Commission of the Government of the Czech Socialist Republic for Gypsy Population Issues of March 1, 1978:

"The increase in the number of women using contraception is a positive thing. In terms of sterilisation offered in justified cases, it is mostly rejected in spite of all medical enlightenment work and benefits offered."

The Central Bohemian Regional National Committee states in an evaluation of social care provided to the Gypsy population of February 21, 1978:

"Women are steered towards family planning and advised on contraception and sterilisation."

The South Bohemian Regional National Committee states in a report on fulfilment of tasks in care for the Gypsy population on June 14, 1978:

"After childbirth, mothers are being persuaded to undergo contraception and sterilisation. 18 Romani women were sterilised in the South Bohemian Region in 1978..."

The District National Committee in Tábor informs the South Bohemian Regional National Committee on May 14, 1979:

"15 Gypsy children were born in our territory in 1978, of which three were with a low birth weight; all the children are alive. In 12 cases termination was performed and sterilisations were performed on four Gypsy women. In all cases the intervention was performed due to a high number of children in the family."

The District National Committee in Písek states in its report of June 4, 1979:

"Women who already have several children are persuaded to undergo sterilisation."

The Central Bohemian Regional National Committee proposed on July 24, 1989, in comments on a framework synopsis of background for a report on the solving of Romani population issues in the Central Bohemian Region addressed to the Ministry of Health and Social Affairs of the Czech Socialist Republic:

"To accelerate Romani integration, it would be suitable to promote a family model with a maximum of three children for the family to be capable of safeguarding its life both in terms of upbringing and in material terms – here we recommend that the amount of family allowance be substantially increased for three children, the existing amount decreased for additional children and family allowance provided as a facultative benefit for 6 and more children. ... This should definitely contribute to gaining a healthier population

of better quality. As an additional means of ensuring a healthy population of a high quality, it would be suitable to consider the possibility of enacting sterilisation for medical reasons once 6 and more children are reached. It is generally known that many families of Romani origin live off child allowances – Romani women know that the more children the higher the income for the family. It is for these reasons that they reject contraception and sterilisation."

The North Bohemian Regional National Committee summarises in a report on developments in the solving of Romani population issues of May 6, 1989:

"The number of women of Gypsy origin who have begun to use oral contraception has increased by about 100 per year. Sterilisation is performed on 70 to 110 women per year."

It is most clear from the reports that the effort to control the birth rate in a targeted way was a constant part of social care bodies' provisions from the 1970s to at least 1989. Romani women were persuaded by social workers to use contraception, to undergo termination and sterilisation, including, as we have seen, benefits being offered. "The effort to improve the quality of the Romani population" is the main thread justifying the approach in all reports.

With only a few exceptions, the mentioned reports do not contain more detailed information on the number of women who had undergone sterilisation after the social workers' intervention and do not specify what benefits (with the exception perhaps of a single mention of the allowance for sterilisation being used as an incentive – see above) were offered. As a minimum however, it can be assumed based on the reports that persuading to undergo sterilisation was one of the standard methods of contemporary work with the Romani community. On the other hand, the suggested findings do not indicate that one could speak about an organised sterilisation campaign of genocidal nature prior to 1989. They do indicate that as one of the social provisions³³ expected to provide a solution to the gloomy situation of the Czechoslovakian Roma, the state promoted a targeted action of the social sector towards controlling the birth rate in the Romani community with a view to achieving the ideal majority-fashion family model, whereby one of the tools used was to persuade to undergo terminations or sterilisations women, most of whom already were mothers of several offspring. It is impossible however to attribute to state a goal of destroying the Romani community by avoiding births.

4.3.3. Case Reports

Like in the previous chapter, we present here five model cases. These cases illustrate the potential involvement of the social services in the decision-making of Romani women on undergoing sterilisation before 1990.

a) File Ref.: 3852/2004/VOP/PM

The complaint

Mrs Č. stated in her letter that she had been visited by a social worker in 1980 before delivery and encouraged to undergo sterilisation, because she had already had four children. Mrs Č. had not known what this was and the social worker had kept persuading her that she had to have the sterilisation done. At that time Mrs Č was 32 years old. The social worker had finally coerced her into the intervention. Mrs Č. also sent a copy of a report to the attending physician stating that the commission had permitted the sterilisation. Mrs Č. notes that she had not been present at any commission meeting.

The mentioned report further suggests that she appeared to undergo sterilisation permitted by the sterilisation commission. When hospitalised for the sterilisation, Mrs Č. was

³³ However, the aggregate of social provisions was otherwise very extensive, including the provision of housing, finding employment, holidays organised by the trade unions with an enlightenment programme, practical training courses, camps for children, etc.

fit, free of complaints and had an intra-uterine device (IUD) fitted. The last delivery had taken place in 1975. None of the deliveries had ended with a caesarean section.

Advisory board findings

The advisory board stated that the patient had filed an application signed in her own hand on July 10, 1980. The patient was 32 years old and she had already had four children. According to the application, the indication is under item XIV/3 of the annex to the directive (obstetrics-gynaecological indication – after many children; after four children for women up to 35, after three children for women over 35). It is stated in the surgery record that the sterilisation commission permitted the sterilisation, but the commission's record is not available. According to the surgery record the sterilisation was performed on August 21, 1980. The documentation lacks the patient's consent to the surgery as well as information on the reversibility of the treatment.

On the quality of the administrative procedure set by the directive, the advisory board stated that consent to the surgery was not enclosed. No record of providing information concerning the reversibility of the treatment is enclosed. It is stated in the surgery record that the commission had permitted the sterilisation, but the commission's record is not available.

Assessment by the Public Defender of Rights

The application was typed and signed by Mrs Č. The style and phrasing clearly show that the application was written by another person on behalf of Mrs Č. The main reason indicated in it is that she and her husband are trying to properly care for their children, furnish their apartment and meet all the needs of their children. They therefore do not want to have another child. She would not be able to care as well for more children. She is 32 and still might become pregnant. She has therefore opted to undergo sterilisation. From a purely formal perspective, the application meets the directive's requirements. It is nevertheless a question whether Mrs Č. knew what she was signing; the style of the text rather suggests authorship by another person (most likely a social worker). This allows for the conclusion that the testimony of Mrs Č. regarding the social worker's coercion does not lack factual substantiation.

In this context it is necessary to consider to what extent Mrs Č. was free to choose given the persistent persuasion of the social worker. The freedom to manifest consent lies also in that the person concerned does not find him/herself in a state of distress in the meaning of section 49 of the Civil Code. In this case consent would not be entirely free. Under the established court practice of the Constitutional Court, distress is "such an economic, social or even psychological state as bears down on the acting party in such a way and with such a weight that they perform a legal act they would otherwise not have performed or they would not have contracted in the case of bilateral acts" (for example ruling of the Constitutional Court of the Czech Republic I. ÚS 221/96). At the same time distress cannot be perceived as a one-off act, but rather in a broader context as a long-term process that causes the natural person to perform an act they would otherwise not have performed in a state of rule of law (see ruling of the Constitutional Court of the Czech Republic IV. ÚS 101/96).

It is also questionable whether the condition of the intervention being permitted/approved by the sterilisation commission is satisfied. The commission's permission is mentioned several times in the surgery record as well as in the report to the attending physician, but no record of the commission's meeting is available.

Even if we disregard the doubts accompanying the application for sterilisation, other requirements set by the directive were not met. Informed consent to the intervention is missing and even a mere signature to the consent (without demonstrating being informed) does not exist. The written information on reversibility is also missing.

In addition, it is useless to discuss whether Mrs Č. knew what she was signing or if the sterilisation commission had met, because the informed consent is missing. Performing sterilisation without this is unlawful.

b) File Ref. 4263/2004/VOP/PM

The complaint

Mrs Č. stated in her letter that she was sterilised in 1979 as a 36-year-old in the Ostrava-Fifejdy municipal hospital. She does not remember the name of the doctor who performed the intervention.

In 1979, nine months after the birth of her sixth child, her son Jaroslav, Mrs K. (she believes she worked at the Regional National Committee) visited her several times together with another lady whose name she does not remember. Mrs. Č. knows that they visited other Romani women from Ostrava-Hrušov as well. Both ladies persuaded her to undergo sterilisation, claiming that she had already had enough children. Mrs K. said that she would get money or furniture in return. She visited Mrs Č. several times and kept persuading her until she agreed to the intervention. Mrs K. assured her that it was not dangerous. After the surgery she received CSK 2,000, half by a postal order and for the other half she was allowed to buy food in department stores.

Advisory board findings

The advisory board stated that the patient's application for sterilisation to be performed was missing in the documentation. Although the sterilisation commission had met, the panel and record of the meeting are missing. There is an invitation dated June 13, 1979, on a very tattered card. The invitation states: "Appear for a hearing at the Obstetrics-Gynaecology Department Ostrava I., Nemocniční No. 20. Your sterilisation has been permitted". On July 19, 1979, Mrs Č. was received for sterilisation to be performed, and the sterilisation was performed on July 23, 1979, according to the surgery record. There is a signature of Mrs Č. on the reverse side of the surgery record under the following sentence: "I agree to the proposed surgery and treatments necessary during the surgery". Information on the reversibility of the intervention is missing in the documentation.

On the quality of the administrative procedure as set by the directive, the advisory board noted that the providing of information was missing.

Assessment by the Public Defender of Rights

No application by Mrs Č. is available. No copy from the commission's meeting is available, but it can be assumed that the commission approved the sterilisation. On the other hand it is not entirely clear on what basis the commission acted as the patient's application is missing.

Since the record from the sterilisation commission's meeting is missing, it is impossible to establish when it met and what the panel was, and hence if the directive requirements were met.

Although Mrs Č. does not deny her consent to the sterilisation, many shortcomings exist in the administrative procedure. It is primarily necessary to examine as to what extent the manifestation of the will of Mrs Č. was free and serious, as she had been persuaded to undergo sterilisation by the social worker Mrs K.

In the second stage it is necessary to examine to what extent Mrs Č. was advised of the nature of the intervention. Concerning the requirement for consent and provision of information, consent phrased as consent to a proposed surgery and treatment necessary during the same cannot be regarded as consent to sterilisation, whether in terms of the proposed surgery or a treatment necessary during the same. The second option, given that sterilisation is not a life-saving intervention, cannot be the case.

Sterilisation is indeed such a specific treatment that the notion of proposed surgery is entirely insufficient. In addition, specific information on the particular intervention should accompany the consent, and hence a general consent fails to meet the requirements of

informed consent. Informed consent is that which complies with previous information, and the previous information must identify the intended intervention. General consent relates not to an (individually or typologically) identified intervention, but to any intervention or any interventions, as a result of which it cannot comply with any previous information identifying the intended intervention³⁴.

Provision of information on reversibility is also missing in the documentation.

It is therefore impossible to agree with the conclusions of the advisory board that found the missing provision of information for the patient to be the only shortcoming in the administrative procedure. The advisory board has failed to draw conclusions from this shortcoming in relation to consent.

c) File Ref. 4256/2004/VOP/PM

The complaint

Mrs G. stated in her letter that she was sterilised in 1979 in a Most hospital. Nobody had justified the need for the intervention to her. A social worker had been retaining her child allowance for two-and-a-half years until she would undergo sterilisation. In the hospital she had been told that she would no longer be able to have children. She had signed a paper as she had had to. Mrs G. stated that she found both writing and reading difficult. She had been promised CSK 2,000 for the intervention, which had later actually been paid.

Advisory board findings

The meeting of the advisory board established the following. Mrs G. was received by the hospital on June 4, 1979. An application for sterilisation was enclosed with the documentation, probably from March 26, 1979, and the data was verified on the same day. The application was signed in the applicant's own hand.

The sterilisation commission minutes are also dated March 26, 1979. The Commission approved the sterilisation due to seven previous deliveries. Item XIV/3 of the annex to the directive was given as the indication to sterilisation. The documentation also contains an invitation of May 4, 1979 for Mrs G. to appear at the Gynaecology Department of the Most hospital to discuss the date on which she will be received by the hospital to perform the surgery she has applied for. Mrs G. was asked to bring her internal examination results. The documentation also includes a lung examination record, once again from March 26, 1979.

The sterilisation was performed on June 6, 1979. The patient's consent to the intervention is missing. In terms of provision of information on reversibility, the advisory board stated that there is a record of informing the patient in the case notes.

On the quality of the administrative procedure, the advisory board stated that the patient's consent to the treatment in writing was missing. There is a record of informing the patient in the case notes, but no signed consent and declaration of the information provided.

Assessment by the Public Defender of Rights

The application for sterilisation is filled in on a printed form. It indicates that Mrs G. is applying for sterilisation because she has had seven children. The application is signed and dated September 26, 1979 (this is an obvious typing error, it was March 26). The data was verified on March 26, 1979.

Thus in formal aspects the directive conditions were met. It is nevertheless also necessary to ask whether the will of Mrs G. was free at the time of signing the application. Mrs G. stated that she had to sign because her child allowance had been retained for two-and-a-half years. The freedom to manifest consent lies also in that the person concerned does

³⁴ Svoboda, P.: Informovaný souhlas pacienta při lékařských zákrocích (or Informed Consent of the Patient to Medical Interventions). Správní právo (or Administrative Law), issues 3-4, 2004, page 155

not find himself or herself in a state of distress. After considering all circumstances, in particular historic sources available to the Public Defender of Rights, it is reasonable to doubt that the manifestation of will by Mrs G. was fully free and therefore valid. The circumstances of the case suggest that in its legal meaning the social worker exploited the distress of Mrs G. and influenced her will to undergo or not to undergo sterilisation.

The directive's condition in the sense of sterilisation permission by a commission was met. It is also obvious that in this respect the administrative preparation for the intervention was very careful. The data in the application was verified and there is a document on a specialised examination in the documentation. Nevertheless, another basic prerequisite for the medical intervention to be lawful is missing: consent to the intervention, as well as provision of information on its reversibility are not available. It is only noted in the typed case notes: "informed of the surgery, responses adequate to the situation". This note can in no way be regarded as the provision of information on reversibility. The record has no informational value in terms of the nature and implications of the intervention and is not even signed.

The advisory board examined the performance of the intervention purely from the perspective as to whether the requirements as set by the directive had been met. It therefore cannot be reproached for not dealing with the circumstances under which the application had been filed. In any case it is necessary to point to the fact that the advisory board drew no conclusions from the absence of provision of information under section 11 of the directive; it merely noted the absence. And it is already this error in the procedure as set by the directive that makes the intervention unlawful.

d) File Ref. 3824/2004/VOP/PM

The complaint

Mrs T. stated in her complaint that a female social worker and a male social worker had offered (not only to her as she states) sterilisation, claiming that they would pay her in return. She had signed some paper before the surgery. She had learned that she had been sterilised from the doctor on the following day. She had received a voucher for children's clothing for the intervention.

Mrs T. cannot read and write.

Advisory board findings

The advisory board stated that the patient was admitted on November 27, 1983. A signed application for sterilisation from November 14, 1983 is enclosed with the documentation. A record of a meeting of the sterilisation commission is enclosed with signatures of the panel from November 27, 1983. The commission approved the application. The indication to sterilisation under item XIV/3 of annex to the directive (obstetrics-gynaecological indication – after many children; after four children for women up to 35, after three children for women over 35. The surgery record of November 28, 1983, documents that the planned sterilisation was performed. The patient's consent to the intervention is missing. The record in writing of the provision of information given concerning the nature of the treatment and irreversibility of the treatment is missing.

On the quality of the administrative procedure as set by the directive, the advisory board commented that the patient's consent to the treatment was missing as well as the record in writing of the provision of information concerning the nature of the treatment and irreversibility of the treatment.

Assessment by the Public Defender of Rights

Like those of other women in the Vsetín region, the application is standardised (it obviously arises from a single pen; the same reasons recur, pointing in particular to unsatisfactory social conditions; the synopsis of the applications is identical, the woman has

always opted freely based on an arrangement with her husband who agrees to it, according to the text of the application). It is obvious from the style that the application was not written by Mrs T.; she only signed it. It can actually be ruled out with near certainty that all the women concerned could have written absolutely identical applications. Given the assumed involvement of a third party in drawing up the application, it is a questionable whether Mrs T. actually identified herself with what she signed. The advisory board does not pay the slightest attention to this fact at any point.

Nevertheless, formally the application meets the directive's requirements. A second application contained in the same document as the record from the commission's meeting refers to the application signed in the applicant's own hand. The second application states among the social reasons that Mrs T. is Romani.

On the very day Mrs T. signed the application, she was sent by her gynaecologist for internal examination before the planned surgery. This obviously happened before the doctor concerned could have been informed of the application of Mrs T. by the sterilisation commission.

The commission meeting on November 27, 1983, took place in accordance with the directive.

The requirements in section 11 of the directive were not met. Consent to sterilisation as well as provision of information on reversibility of the intervention are missing.

It can be summarised that the conditions of the directive for performing sterilisation were not met.

e) File Ref.: 4075/2004/VOP/PM

The complaint

In her complaint, Mrs T. stated that the need for intervention had been justified to her by claiming that she had had many children (7). Before the intervention, nobody had informed her of the nature and implications of the intervention. She had signed a written document after the surgery, but was unaware of the content since she could not read. She had learned about having been sterilised after the surgery from the doctor. The social department promised her a payment of CSK 2,000, which she never received.

Advisory board findings

The advisory board noted that the patient had signed an application in writing in her own hand on October 19, 1982. A record of the meeting of the sterilisation commission from February 21, 1983, documents that the sterilisation was discussed and approved. Sterilisation indication had been set under item XIV/3 of annex to the directive.

A surgery record from February 21, 1983, confirms the planned sterilisation was performed. There is a signature in the patient's own hand on the reverse of the surgery record confirming her consent to the proposed surgery and that she was advised of the scope of the act as well as the possible implications. In the advisory board's opinion the directive had thus been complied with.

Assessment by the Public Defender of Rights

The application of Mrs T. is dated October 19, 1982. Again, the application style clearly reveals that it was written by another person and merely signed by Mrs T. and her husband. The question may therefore be asked of whether they were aware of the content of the document and knew what they were applying for. In formal terms nevertheless the application meets the directive's requirements.

The commission approved the application of Mrs T. as late as February 21, 1983. A repeated application typed on a typewriter with the signature of Mrs T. is filled in on the

same form with the same date. Among the reasons for the application, "Romo" is indicated as the social reason (sic! – more such applications have been gathered from the same town among the complaints obtained by the Public Defender of Rights, clearly sharing the identical "hand" of a single author, probably a social worker; these applications fail to show the slightest attempt at pretending that a proposed sterilisation would have any other than a purely socio-prophylactic purpose, and besides, the said purpose is captured by the word "Romo"). The commission approved the application for "meeting" the indication under item XIV/3 of the annex to the directive.

The following can be stated on compliance with the requirements as set out in section 11 of the directive. The following sentence is printed in the surgery record: "I agree to the proposed surgery and have been informed as to the scope of the act and the possible implications." It is unclear from the above wording what intervention "informed" refers to, what consequences could possibly occur, etc. There is no mention of sterilisation and the intervention's reversibility. The surgery is identified neither specifically nor typologically. Therefore the above provision of information has a non-informative nature and cannot be regarded as provision of information pursuant to the directive. In addition, provision of information must always precede consent, because it is only based on information obtained that the patient opts to give consent to a specific intervention or not. In the case concerned however the provision of information and consent are merged.

Given the above, section 11 of the directive was violated, and the conclusion of the advisory board that the directive conditions were met cannot be accepted.

4.3.4. The Dubiousness of Sterilisation As a Social Measure

The materials presented in the previous chapter in combination with the preserved documents collected in the individual cases of the Romani women sterilised prior to 1989 suggest that of the aggregate of the pre-1989 sterilisation cases under examination, a majority suggest a relatively large-scale interference by social workers based on persuading women into, preparation and administrative/organisational procurement of sterilisation. It is a conclusion supported not only by the subjective accounts of the women who have undergone sterilisation, but even more by the very reports from the National Committees on actual practice as well as the individual papers preserved in the women's medical records. It is entirely typical for example that applications for sterilisation from a single town were written into entirely identical forms, often clearly on a single typewriter, using identical justifications (as the most remarkable evidence, there are several applications from a single town giving "social indication – Romo" as the reason for the application).

It is with regard to the mentioned historical context that the interference of the social workers seems dubious in several respects.

The interference of social workers generates doubt primarily in cases where their role did not restrict itself to offering sterilisation as contraception by claiming that it would avoid a difficult personal situation becoming even more complicated; instead, it was accompanied by coercion in the form of threatening to remove social benefits, to remove children or apply another intervention, or by promising privileges in the form of a chance to be granted benefits under the provisions of section 35 decree No. 152/1988 Coll.

It is in particular the function of this benefit that should be looked at. In terms of the inappropriateness of the very existence of the benefit, one should fully identify with the conclusions the Slovak General Prosecutor's Office reached already in 1990. And it clearly followed from the inquiry by the General Prosecutor's Office of the Czech Republic that the benefit had actually acted as an incentive in the women's decision-making (see for example the reference to the fact that they wanted to undergo the intervention repeatedly³⁵). The fact that women consented to sterilisations for financial reasons cannot excuse the intervention.

³⁵ In addition this fact suggests that the women completely lacked understanding of the nature of the intervention they had undergone.

Rather the opposite; it is a reason for a serious concern, because the state had in an entirely conscious way established conditions for short-term financial considerations to have a legitimate place in sterilisation decision-making, which had obviously been anticipated given the generally known social status of Roma. Attempts to interpret this social benefit as insignificant and problem-free are therefore unacceptable.

The attempt to use social work methods to guide towards responsible family planning groups of people who live in social exclusion, with impetuous bearing of more children complicating their inclusion, is obviously also dubious given that in individual cases, some social workers were trying to "sell" to Roma the social engineering concept of an ideal number of children at any cost. On the other hand it is impossible to conclude from the existing evidence that social workers were ordered for example to primarily opt for persuading to be sterilised. The way of choosing the means meant to result in contraception as well as the way of choosing the persuasion methods seems to have been very individual. However, using sterilisation as a first choice option was supported by the general aversion of Roma to intra-uterine or hormonal contraception as well as by the already mentioned social benefit being in place.³⁶ Hence primarily the hierarchy of the chosen types of contraception and the persuasion method generate doubts. In general the practice in this contraception campaign can be labelled as a practice that contravened the already mentioned Convention on the Elimination of All Forms of Discrimination Against Women by failing to sufficiently distinguish between forms of contraception and failing to provide accurate information on them.

What should be primarily condemned from today's perspective is that the state-controlled social services set itself controlled birth rate curbing in the Romani community as one of its socio-prophylactic and unconcealed eugenic measures (see the constant references to improving the quality of population) and that for this purpose it developed practical administrative procedures leading in individual cases as far as the legally and morally dubious persuading of women to undergo sterilisation, i.e. a virtually irreversible intervention. Such a model of social measures should be condemned as unacceptable primarily because it may result in the tragic consequences known in the European context from the Swiss and Swedish examples. The pre-1989 social services practice in Czechoslovakia, taking sterilisation as a social tool, shows significant correspondence with the tendencies of some European countries to employ the findings of eugenics in practical social measures. These attempts generally had dubious results, and if we really want to cope with the cases of sterilisations of Roma before 1989, it is necessary to explicitly point to the suggested context in the following digression.

5. Digression – Eugenically-Oriented Social Systems

As already suggested in the conclusion of the previous chapter, the examples of Sweden and Switzerland illustrate and can give guidance for coping with the dubiousness of the social services practice that uses sterilisation as a measure for social and eugenic purposes. In the following text we therefore present a relatively detailed overview of the relatively recent processes that took place in the two countries.

³⁶ To put it very explicitly, it was much simpler to persuade a woman to undergo sterilisation, which would not fail, using a financial incentive than to persuade her to use pills that were expensive and the woman could cease to take, or into using Dana that could fail and had a limited lifetime.

5.1. Sweden³⁷

Between 1935 and 1975, around 63,000 people were sterilised in Sweden, of which 93% were women. About 40% were sterilised without their consent. In the historical context of the Swedish welfare state ("folkhem") of the first half of the 20th century, it was admissible to subordinate individuals' rights to the intended welfare state ideal. Especially in the 1930s and 1940s, the welfare state idea was associated with the vision that organised eugenic measures could increase the quality of "human material", and the Swedish state claimed the right to decide who was worthy to have children with regard to "healthy" social development.

Sweden officially prohibited marriages between persons suffering from a "mental disease" or "hereditary epilepsy" from 1915. In line with the virtually Europe-wide development between the wars, eugenic movements were growing stronger in Sweden and the state was taking up their ideas as part of building the folkhem idea. Thus in 1922 a state Institute of Racial Biology was founded in Uppsala and in 1927 Parliament began to deal with the first legal provisions on sterilisation. These however were approached too narrowly for contemporary legislators, anticipating merely voluntary sterilisation and involuntary sterilisation of persons affected with hereditary diseases.

A new draft was produced in 1932, already taking into account sterilisation for general socio-prophylactic reasons, and even without the consent of the person concerned. The draft was adopted in 1934. The purpose of the legal provisions was partly to prevent the transfer of negative characteristics from persons viewed for various reasons as inferior, to their offspring, and partly to guarantee to children that they would grow up in a socially secure environment. Three years later, a termination law followed the legal provisions on sterilisation, which permitted termination of pregnancy, and once again for humanitarian and eugenic reasons. At the same time a special state allowance was introduced for mothers after delivery, the payment of which was however linked among other things to the woman whose pregnancy was found undesirable undergoing sterilisation. From 1941, another sterilisation act treated sterilisations based on consent of the persons concerned. From 1950, the number of eugenic sterilisations under the 1935 legal provisions gradually decreased and between 1960 and 1970 voluntary sterilisations based on the wishes and in the interest of the persons concerned prevailed.

As already mentioned, Swedish sterilisation laws stemmed from the practical application of eugenic theories. Eugenics was regarded as a realistic option for coping with the huge changes in the population that had occurred in connection with the rapid industrialisation and urbanisation of societies that had so far remained largely agrarian.

The eugenic movement was institutionalised in Sweden as early as 1909, when the Swedish Racial Hygiene Society was founded in Stockholm. The 1934 work by Alva and Gunnar Myrdal was very significant in promoting the eugenic tendencies in practical politics. In their work, the authors outlined an ideology of social planning and reform eugenics.³⁸ The main question dealt with by the publication was how to reverse the ongoing rapid decline in the birth rate through targeted support to families with children. At the same time all children were to be ensured a chance to grow up in a socially secure environment with appropriate wealth. The birth rate support was therefore to be selective and in no instance targeted at large families from socially deprived population groups. The authors contemplated to what extent individual differences within a single population group were hereditary and to what extent they depended on the external environment. In the authors' opinion, external influences could merely change the intensity with which undesirable inherited characteristics manifested themselves in an individual's life. The logical conclusion stemmed from this theory that the best solution was to prevent at the outset the hereditary

³⁷ The basic source of information for this part were official reports of the Swedish Government SOU 1999:2 "Steriliseringsfrågan i Sverige 1935 – 1975. Ekonomisk ersättning", SOU 2000:20 "Steriliseringsfrågan i Sverige 1935 – 1975 – Historisk belysning – Kartläggning – Intervjuer", SOU 2000:22 "Från politik till praktik. De svenska steriliseringslagarna, 1935 – 1975"

³⁸ Myrdal, A., Myrdal, G.: *Kris i befolkningsfrågan*, Nya Doxa, Stockholm, 1997.

transfer of undesirable characteristics that caused the individual affected to become sooner or later a burden on society. The authors therefore proposed a "corrective social reform" under which sterilisation was to prevent "unviable individuals" from spreading their undesirable traits.

Eugenic sterilisation gradually became the subject of professional criticism in the 1960s. In the 1970s Swedish society experienced the process of strengthening awareness of the individual's right to self-determination and sexual freedom, obstructed by the old sterilisation laws of the first half of the 20th century. The latter were therefore replaced by completely new legal provisions that already counted solely on voluntary sterilisation as a method of contraception, the performing of which was bound exclusively to the informed and free decision of the sterilised person.

A social debate, accompanied by criticism of the eugenic sterilisation period under the folkhem ideology, began as late as 1997 in Sweden when a series of articles were published by journalist Maciej Zaremba in the *Dagens Nyheter* daily on the history of sterilisations in Sweden. Following his articles, a turbulent public debate ensued, resulting in the establishment of a government investigation commission that finished its work in 2000.

The investigation commission appointed by the Swedish government had essentially three tasks. Primarily it was to map the history of the debates preceding the phrasing of the 1934 and 1941 sterilisation regulations and to analyse the scientific and political debates taking place during the implementation of the sterilisation acts until the latter were replaced by the new legal provisions. An additional purpose was to ascertain and describe the attitudes and the responsibility of state representatives and scientific community representatives for phrasing eugenic programmes.

The second basic task for the commission was to ascertain to the highest possible level of accuracy as how many people had been sterilised under the 1934 and 1941 sterilisation acts, for what reasons and what consequences the sterilisation had had in their later life.

Finally the commission was to process the issue of potential reparations for those sterilised against their will or at a third person's instigation. Already when constituting the commission, the Swedish government justified interest in an inquiry into the cases and a clear orientation from the very beginning on the preparation of a reparation campaign by the fact that until 1976 a large number of people had been sterilised under the sterilisation acts whereby the way of applying the same in practice had often been characterised by the perceptions of eugenics prevailing among legislators, scientists and doctors in the first half of the 20th century in Sweden and other countries alike. Many people who had been sterilised had fallen victims to such perceptions even though Swedish society had relatively early condemned them in principle, among other things after the experience with the misuse of eugenics in Nazi Germany. The government therefore took it as a priority that those sterilised without their consent or at the instigation of a third person should receive reparation regardless of the fact that the state was not formally obliged to pay such reparations.

During validity of the 1934 and 1941 sterilisation acts (i.e. until 1976), about 63,000 people were sterilised in Sweden. The commission dealt seriously with the question of what extent the interventions had taken place with the free consent of the sterilised people. It concluded that it was impossible to say that most sterilisations performed in the period concerned had lacked consent. This, according to the commission, had already been shown by comprehensive studies carried out in the late 1950s and the early 1960s. According to the studies carried out five to ten years after surgery, almost 80% of the patients were entirely satisfied with the sterilisation. Negative responses were generally identified in women subject to coercion and strong persuasion in connection with sterilisation, or in childless women. Historical studies also suggest that especially in the 1960s and the 1970s, for most sterilisations performed based on the consent of the sterilised persons, the consent was indeed free.

During the investigation however there was a minority of cases that could be distinguished and classified as those where formal consent of the sterilised person had been given, but in fact the sterilisation had been performed without the consent of the person concerned. The commission classified the following model situations where the free will of the sterilised person could be generally doubted:

In several cases sterilisation had been a strict qualification for release from a correctional institute or another facility or had been performed during the stay in such a facility in exchange for a relaxed regime. Such practice had been sharply criticised as early as 1947 in the annual report of the Swedish Ombudsman.

The 1941 act had also been applied to minors and legally incapacitated persons. Until 1969 the age of majority was 21, between 1969 and 1973 it was 20, and it became 18 as late as 1974. The 1941 sterilisation act had deliberately failed to give an age limit for sterilisation; the justification report had noted that even without such a provision, the approving body, i.e. the National Health Institute, should take into account the age of the person concerned when considering approval and that it should hear the legal guardian. However, the legal guardian's consent to the sterilisation had not been required and under the instructions issued by the National Health Institute the person who had applied for sterilisation would always be entitled to sign the application in person regardless of their age or legal capacity. Thus cases in which sterilisations of minors or persons lacking legal capacity had been performed against the will of the legal guardian were not exceptional.

One of the relatively common reasons for sterilisation, at least until the 1950s, was a doctor's declaration that the person concerned was mentally retarded. In such a case performing sterilisation had been allowed for both eugenic and socio-prophylactic reasons, although provided that other formal qualifications had been satisfied. However, mental retardation had been a notion so broad that even problems of a social nature had been placed under it and in many cases it had been used in a routine way and based on very limited and doubtful documentation.

The 1938 termination act had been interconnected with the sterilisation act through a special provision contained in the earlier. According to the provision, pregnancy termination for eugenic reasons was not allowed without at the same time sterilising the woman concerned. Practice had extended the provision to cases where the indication to termination had been other than eugenic.

Under the 1920 marriage act, persons suffering from epilepsy or mental disease as well as the mentally retarded had not been allowed to marry. A marriage licence had still been potentially available for those of such persons who had undergone sterilisation.

In addition, some benefits had been made conditional on sterilisation being performed; typically in the 1940s this had been maternity benefit, i.e. an allowance to persons in need superior to child allowances.

The government tasked the commission to propose a reparation scheme for persons who had been sterilised against their will or at the instigation of a third party.

In terms of those sterilised under the 1934 act, the commission concluded that the reason for sterilising these persons was that they had been generally regarded as incapable of their own discernment in terms of the implications of their consent or the implication of the sterilisation as such, and hence incapable of giving consent to the sterilisation. Such sterilisation had been performed *a priori* without consent after an application had been filed, almost without exception, by a person in an official position. The commission therefore concluded that in such cases it was impossible to speak of free consent in any form and it proposed awarding reparations to all these persons.

In terms of the 1941 act, the situation was somewhat more complicated. In formal terms, the documentation contained the consent or application of the sterilised person in a majority of the cases examined by the commission. It was nevertheless clear with regard to

the already mentioned circumstances that in a number of cases the consent could not be regarded as truly free. However the commission discovered that it was generally very difficult to obtain detailed information from archive materials that would support the individuals' claims of having been sterilised against their will. The commission therefore selected a number of standard situations generally pointing to a sterilisation performed against the actual will of the sterilised person (see above). Following such situations, the commission identified four groups of persons who in the commission's opinion should receive reparation without investigating the circumstances in detail:

1. minors and legally incapacitated persons, because they had a limited possibility to understand in full the implications of sterilisation and a smaller chance to influence their own situation than an adult and legally capable person would have,
2. prisoners in correctional institutes and inmates in residential facilities sterilised during their stay in the facilities or in connection with being released, because historical sources reveal that the applications for sterilisations had been influenced by hopes and promises such as furlough, conditional release, work outside the facility, release or threats of postponing release – thus the applications had been filed under quasi-coercion,
3. persons labelled as mentally diseased, mentally retarded or epileptics, although they had not stayed in a facility, because in the commission's opinion these persons had a limited capacity to fully understand the implications of sterilisation; in addition the information obtained suggested that in many cases sterilisation had been presented as an alternative to various forms of residential treatment and threatening had often occurred that an individual failing to undergo the intervention would be placed in an institution or their children would be removed;
4. persons who had been sterilised because sterilisation had been a qualification for another official decision such as a marriage licence, termination permission or granting social benefits.

In addition to these general categories, the commission dealt with other situations that should be subject to reparation, because the persons in such situations had been persuaded by a state authority to undergo sterilisation in a way that must be regarded as incorrect from today's perspective. This was primarily the case of the so-called 'asocial persons'. Based on documentation and personal observers' accounts, the commission concluded that a number of sterilisations had been performed after obtaining consent from the person concerned under targeted coercion in various forms, such as under the threat that the person's children would be removed to institutional care; by making a termination to be performed on other than eugenic indication conditional on the undergoing of sterilisation at the same time; or by persuading women during delivery. The commission noted that such coercive actions showed great variability in terms of time and place.

Sometimes sterilisation was the theme of a general discussion between the social worker, doctor and the person concerned as one of the options for solving a difficult social situation. It is obviously impossible to conclude from this that every situation where a state official proposes and recommends sterilisation should be automatically considered inappropriate influence that precludes free consent. However the commission came to the conclusion that for reparation to be applicable, such interactions between social workers, doctors and the persons concerned had to have the nature of coercion or strong persuasion. Being unable to identify this group through a generally valid criterion, the commission came to the conclusion that to qualify for reparation, such persons should supply, with regard to the situation in which they had consented to sterilisation, a trustworthy description of circumstances that would suggest in the particular case that consent had been given in a coercive situation. In legal terms, the commission demanded in these cases that the person concerned prove a likelihood of having given the consent under coercion. Thus the point is not proving the deed, but instead proving the likelihood of the deed having occurred. In this context the commission stated that proving likelihood would be based primarily on the actual

account and experiences of the person concerned rather than provable official records. Even where it would be impossible to compare the persons' accounts with, for example, written records, the commission pleaded for reparation to be provided if the account is at least somewhat trustworthy.

As compensation, the commission proposed a one-off identical sum for all cases. While the commission still worked (i.e. before completion of the historical assessment) a reparation act was adopted on the basis of which almost 1,600 persons affected received reparation of 175,000 Swedish crowns in the period from 1999 to 2002 (2,100 people had applied for reparation).

5.2. Switzerland³⁹

In Switzerland, the case of involuntary sterilisations was dealt with by the National Council (the Swiss Parliament) based on a parliamentary initiative launched by member of parliament Margrith von Felten. On October 5, 1999, Margrith von Felten suggested to the National Council of Switzerland in the form of a general proposal to adopt legal regulations that would enable reparation for persons sterilised against their will. According to the proposal, reparation was to be provided to persons who had undergone the intervention without their consent or who had consented to sterilisation under coercion.

Margrith von Felten noted in justification of her proposal:

"In 1997, the history of eugenics alarmed the Swedish public for good. The investigation commission established that about 63,000 people were coercively sterilised between 1935 and 1975. Almost exclusively women were affected. Most were sterilised because of a bodily disability, a mental disease or for being "asocial". The state justified sterilisation with the necessity of "social selection" and wanted to economise on the cost of care for such people. In early 1999 the Swedish government decided to pay 20,452 euros (32,723 francs) compensation per person coercively sterilised. The reparation is available to those who effectively claim that the intervention on them took place without their consent. The entitlement also applies to women whose consent to sterilisation was coerced.

"The history of eugenics in Switzerland remains insufficiently explored. Research programmes are in progress. However, individual studies and facts are already available. For example:

"The report of the Institute for the History of Medicine and Public Health "Mental Disability and Sexuality. Legal Sterilisation in the Vaud Canton between 1928 and 1985" points out that coercive sterilisations took place until the 1980s. The act on coercive sterilisations of the Vaud Canton was the first law of this kind in the European context.

"Hans Wolfgang Maier, head of the Psychiatric Clinic in Zurich pointed out in a report from the beginning of the century that 70% to 80% of terminations were linked to sterilisation by doctors. In the period from 1929 to 1931, 480 women and 15 men were sterilised in Zurich in connection with termination.

"Following agreements between doctors and authorities such as the 1934 "Directive For Surgical Sterilisation" of the Medical Association in Basle, eugenic indication to sterilisation was recognised as admissible.

"A statistical evaluation of the sterilisations performed in the Basle women's hospital between 1920 and 1934 shows a remarkable increase in sterilisations for a psychiatric indication after 1929 and a steep increase in 1934, when a coercive sterilisation act came into effect in nearby National Socialist Germany.

"A study by the Swiss Nursing School in Zurich, published in 1991, documents that 24 mentally-disabled women aged between 17 and 25 years were sterilised between 1980 and 1987. Of these 24 sterilisations, just one took place at the young woman's request.

³⁹ The source of information for this part was parliamentary protocol of the Swiss National Council No. 99.451.

"Having evaluated sources primarily from the 1930s (psychiatric files, official directives, court files, etc.), historians have documented that the requirement for free consent to sterilisation was in most of cases not satisfied. Authorities obtained the "consent" required by the law partly by persuasion, and partly by enforcing it through coercion and threats. Thus the recipients of social benefits were threatened with removal of the benefits, women were exposed to a choice between placement in an institution or sterilisation, and abortions were permitted only when women simultaneously consented to sterilisation.

"More than fifty years after ending the National Socialist dictatorship in Germany, in which racial murder, euthanasia and coerced sterilisations belonged to the political programme, it is clear that eugenics, with its idea of "life unworthy of life" and "racial purity" permeated even democratic countries. The idea that a "healthy nation" should be achieved through targeted medical/social measures was designed and politically implemented in many European countries and in the U.S.A in the first half of this century. It is a policy incomparable with the inconceivable horrors of the Nazi rule; yet it is clear that authorities and the medical community were guilty of the methods and measures applied, i.e. coerced sterilisations, prohibitions of marriages and child removals – serious violations of human rights.

"The theme of the presented initiative is coerced sterilisation in Switzerland. Coerced sterilisation is connected with severe irreversible damage to bodily integrity; it is a crime that can never be justified – not even by a contemporary "Zeitgeist". Historic research must discuss victims' injuries and the perpetrators' motives and liability. Today's political authorities have a moral duty to admit an injustice committed in the name of the state and award reparation to the victims of the past racist/social selection madness.

"Many victims of coerced sterilisations have died; many have grown very old. It is necessary that the state act quickly. Many years will elapse before the history of eugenics in Switzerland is processed. Waiting patiently for so long is impossible. The need for action is given. Creating a legal framework for reparation to take place in is urgent."

A commission of the National Council for legal issues unanimously recommended in its report that the National Council proceed in accordance with Margrith von Felten's initiative. Like the initiator herself, the commission opined that political authorities were bound to draw consequences from the issue of coerced sterilisations in Switzerland and provide reparation to those harmed by the practice. Given that at the time of discussing the initiative there were no clear legal provisions in place to treat the performance of sterilisations, the commission proposed not only a law to be adopted that would enable reparations for coerced sterilisations victims, but also a law that would treat the future conditions and admissibility of sterilisation for all groups (capable and discerning; discerning and incapable; non-discerning) so that "involuntary" sterilisations could no longer occur.

The National Council commission for legal issues dealt primarily with the existing state of legal provisions on sterilisation. It stated that legal aspects of sterilisation were not explicitly treated at the confederative level. Nevertheless, the doctrine is that the option to have children, the right to sexual life as well as the right to give up one's reproductive ability are fundamental rights and freedoms. From this perspective the commission concluded that sterilisation in contravention of these fundamental rights and freedoms represented a violation of various constitutionally guaranteed fundamental rights – the right to respect for and protection of human dignity, prohibition of discrimination of a bodily, mental or psychological disability, and the right to preserve bodily and mental integrity. At the same time, from the criminal law perspective such a sterilisation constitutes the crime of grievous bodily harm.

In 1981, the Swiss Academy of Medical Sciences published medical/ethical directives for the performing of sterilisations. The directives assume that mentally healthy, discerning persons may opt for sterilisation. Even a person with a mental disability may opt for such an intervention if capable of comprehending its nature and implications (discernment

qualification). A sterilisation is regarded as inadmissible if performed on a non-discerning person. In 1999, the Academy presented to the amendment proceedings draft new directives for the performing of sterilisations. In the draft, sterilisation of non-discerning persons was no longer *a priori* condemned; the Academy nevertheless suspended amendment of the directives as a result of criticism from the parties to the amendment proceedings and the commencement of Margrith von Felten's parliamentary initiative. On the contrary, the Academy issued an additional recommendation to the existing directives in June 2001, in which it reconfirmed the principle that sterilisation should be regarded as an "*ultima ratio*", the performing of which requires the explicit consent of the person concerned. Thus it persisted in the position that sterilisation of mentally disabled, non-discerning persons is precluded.

The commission also had to cope with the historical context of performing sterilisations. It chose several specialised studies published shortly before commencement of the legislation drafting as background for its work. The studies give an overview of the legislative and actual practice in different cantons and medical facilities.

Given that only the Vaud canton had had legal provisions on the performing of sterilisations until the 1980s, an analysis of the application of the act contained in a study published in 1998 proved very valuable.⁴⁰ The 1928 act of the Vaud canton contained a provision from the very beginning setting out that "contraceptive medical interventions on a mentally diseased or mentally deficient person may be performed if the person is incurable under existing knowledge and by all assumptions can only conceive unhealthy offspring." The provision remained in force until 1985. A total of 378 sterilisations were performed on the basis of the act; 324 of them on women, and about 100 interventions had been permitted by the authorities on the basis of the quoted provision on eugenic sterilisation.

A study of sterilisation and other coercive measures to control the birth rate in the city of Zurich in the 20th century⁴¹ points to the effect of eugenic and racial/hygienic theories between 1910 and 1930 and tries to examine the individual reasons used to justify the necessity of involuntary sterilisation. For example the study quotes an assertion by Paul Pflünger, a theologian and member of the Zurich Municipal Council, who believed that sterilisation of socially, mentally and morally inferior people was a good tool for preventing the social vice of alcoholism, housing distress and youth running wild.

The commission states that the studies available to it suggest that the eugenic doctrine strongly influenced Swiss psychiatry and social science in particular in the early 20th century. All the studies suggest that in a majority of cases the sterilisations were performed on young women of low social status, mostly previously diagnosed with a form of mental disorder (about 79% of cases in the Vaud canton). Among the diagnoses however, one can often read verdicts like "congenitally infirm character", "mental deficiency" or "poor intellect".

Extramarital pregnancy and promiscuity were routinely accepted as sterilisation admissibility criteria, as was a woman's inability to manage a household (with the "logical" explanation that only a "mentally subnormal" woman is unable to manage a household; the inability to manage a household points to a mental disorder that justifies sterilisation).

Exploration of individual sterilised people's fates also proves that although many people were sterilised with their consent, the consent can in no instance be regarded as voluntary. The threats of marriage prohibition, placement in a facility or denial of release from a facility were important coercive tools used to enforce consent to sterilisation.

The studies further point to the fact that before the far-reaching changes in society's perception of the doctor-patient relationship in the late 1970s, doctors' professional authority

⁴⁰ Gilles Jeanmonod, Jacques Gasser, Geneviève Haller: La stérilisation légale des malades et infirmes mentaux dans le canton de Vaud entre 1928 et 1985, Institut romand d'Histoire de la Médecine et de la Santé, Genève 1998.

⁴¹ Thomas Huonker: Anstaltsanweisungen, Kindswegnahmen, Eheverbote, Sterilisationen, Kastrationen, in Fürsorge, Zwangsmassnahmen, Eugenik und Psychiatrie in Zürich zwischen 1890 und 1970, Zurich 2002.

and social prestige often resulted in acceptance of interventions without anybody asking about their legal and ethical admissibility.

Given the historical circumstances and the existing legal state, the commission agreed on the necessity of adopting comprehensive confederative legal provisions on sterilisation. The discussion in the commission showed that in particular the issue of sterilisations on incapable and non-discerning persons posed a huge challenge to legislators.

In addition, in spite of some dissentient voices in the external amendment proceedings that pointed out in particular respect to the forfeiture principle and the impossibility of judging past events by present standards, the commission proposed confederative legal provisions comprising reparations for involuntarily sterilised persons. The commission proposed legal provisions on reparation relating to all persons who had undergone coerced sterilisation, with the legal provisions encompassing all sterilisations performed at any time before the effective date of the reparation act insofar as they exhibited the attributes of coerced sterilisation.

The commission defined coerced sterilisation as follows:

1. any sterilisation on a person below the age of 16, even if performed with the consent of a legal guardian or carer,
2. a sterilisation that has been performed without free and informed consent (the person concerned did not enjoy freedom of will as a result of coercion or threats, was misguided, his or her dependent position was misused),
3. a sterilisation on a discerning person at the age of 16 to 18 if the person's legal guardian did not consent, if the consent was not in the sterilised person's sole interest or the sterilisation was not the last available resort,
4. sterilisations on non-discerning persons unless performed exclusively with a view to avoiding traumatising the sterilised person in connection with delivery, parenthood or separation from child.

As a tool of redress, the draft defined adequate redress at 5,000 francs for coercively sterilised persons. The reparation entitlement was designed as a personal one; transfer on the basis of a contract or inheritance was precluded save that the reparation proceedings were initiated before the affected person's death. The draft anticipated a three-year period for assessing reparation applications.

Jurisdiction for implementation of the act was to be given to cantons that were also to determine an authority to be in charge of administering applications. The cantonal jurisdiction was to be governed by the location at which the sterilisation was performed or the authorities which ordered the sterilisation or consented to it.

According to the draft, half of the cost of reparation and adequate redress was to be borne by the confederation, the rest by the cantons.

After discussing the proposals from the National Council's commission for legal issues and the statement of the Federal Council, the parliament decided to support the new draft legal provisions treating the terms of sterilisation admissibility, with slight modifications of the commission's proposal.

However, the parliament refused to adopt the reparation scheme. The basic arguments against adopting the reparation act were doubts concerning the appropriateness of viewing the past through present standards; doubts concerning the possibility to refer today's understanding of law to a past state of legal provisions (or rather lack of provisions); apprehensions were voiced of a selective approach to the victims of historic injustice as well as doubts concerning the practical feasibility of ascertaining retrospectively the circumstances of the individual cases. Another strong argument heard was that not a single right-to-privacy lawsuit had taken place after the changes in perception of sterilisation admissibility. The legislators also fundamentally condemned the idea embodied in the draft

that liability for injustice should be assumed by the entire confederation in addition to the cantons.

5.3. The Eugenic Movement in Czechoslovakia

The Swiss and Swedish examples reveal that the approach of their societies to sterilisation was, particularly in the first half of the 20th century, significantly influenced by eugenic theories. However extreme the Swedish and Swiss examples may seem, let alone the atrocious experience with the misused racial hygiene theory by Nazi Germany, it is a historic fact that even Czech society was not spared similar development at the time eugenic theories were at their peak. The ideas and proposals of Czech eugenicists are entirely comparable with concepts developed elsewhere in Europe. The only difference is that due to political developments, the eugenic movement in Czechoslovakia never achieved practical implementation of its ideas. It is a major debt of Czech historiography that very little literature has been dedicated to the Czechoslovak eugenic movement so far and that treatment of this chapter of Czech history is not consciously worked with in society. Yet specifically in connection with the theme of this report, it is entirely relevant to ask to what extent the unprocessed and non-reflected Czech or Czechoslovak eugenics may to this day influence (at least indirectly by us not being sufficiently aware of its risks) the approach of the public to the issue of reproductive freedom of the individual, and in particular, to what extent it influenced practical social policy towards Roma before 1989.

The motivation of Czech efforts to enhance and strengthen the nation based on a practical application of eugenic theories in the early 20th century should be seen in the light of the very strongly perceived threat of a crisis of civilisation resulting in a decline (degeneration) not only of individuals, but also of whole populations. Pessimistic deliberations and discussions on the ongoing degeneration of individuals, nations and finally races, its forms, manifestations and particularly consequences gave a dynamic to eugenics by providing it with self-confidence and an appearance of full legitimacy for its individual demands. The alleged deterioration in population quality had yet another important aspect in the Czech context, and specifically an assumed impact on quantitative conditions. Czech eugenics had to deal with these with national emancipation efforts in the background (in the meaning of emancipation of the Czech nation in the political sense), because specifically quantitative conditions compressed into a variable power paradigm between the minority and the majority had been closely connected with preservation of the nation as an original entity within the given territory in the Czech Lands until 1918.

As proof of the alleged degeneration and at the same time an explanation of it, a key role was attributed to heredity at this time, as was already shown in the Swedish and Swiss examples. The influence and meaning of heredity were contemplated in a number of scientific fields dealing with human beings. At the same time the issue of pathological heredity appeared to be the most urgent, and not only from the doctors' perspective. In this context, one of the first efforts to define a place for deliberations on the influencing of undesirable pathological heredity in the sphere of public healthcare should be mentioned. Ladislav Haškovec, a prominent neurologist and leading representative of the Czech eugenic movement, writes in 1912: *"The question is whether medical science has gathered enough reliable facts for establishing specific regularities of pathological heredity. If there are such regularities, another question is what guidance mankind should take from them and how public healthcare potentially could and should use them for mankind's well-being. Whether mankind can be protected from infirmity arising through hereditary effects and what role falls on public healthcare. Mankind rightfully expects answers to these questions today."*⁴²

Ladislav Haškovec was also author of the first proposals for the introduction of practical measures aimed at avoiding the consequences of the predicted "monsterisation" of

⁴² Haškovec, L.: *Snahy eugenické (or Eugenic Efforts)*, Prague 1912, pages 4 and 13.

the Czech population in the 20th century, in the form of what was called a "eugenic marriage review", comprising compulsory pre-marriage examinations with a marriage prohibition competence.

In 1914 the pioneer of Czech genetics Artur Brožek published a summary outline of the ideas of American eugenics entitled "Cultivating Mankind". Specifically Brožek's case demonstrates why in particular emphatic practical measures of eugenic and prophylactic nature introduced by the individual states of the Union and the Swiss confederation cantons had an impact also in the Czech Lands, just like elsewhere in Europe. In our country too, specifically with an eye to overall population quality, great emphasis was placed on care for the family, in particular marriage and procreation of offspring. And specifically in this respect there is an interesting consensus among the contemporary representatives of public healthcare on the need for intervention by the state and its institutions, in particular as far as controlling marriage contracts and family establishing are concerned. Under the American model Brožek demanded, already in 1912, the harshest of *"measures through which the state and society in general could intervene wherever the self-love of sick and degenerated individuals might possibly oppose the strengthening of the nation, since if society has the right to penalise its members by death, it certainly also has the right to either isolate members who are sick parts of its body while their procreative ability persists, or to prohibit marriages of congenitally sick people such as lunatics and idiots, conduct compulsory examinations of betrothed pairs paid by the state, or to introduce state genealogical registries and other eugenic measures of the same kind. Where such measures would not suffice, it would certainly have the right to achieve induced infertility as is already the case for example in some American states."*⁴³

The forming of Czech eugenics culminated on May 2, 1915, through the establishment of the Czech Eugenic Society. The establishment of the Czech Eugenic Society is a milestone in the history of the Czech eugenics movement. It accelerated and institutionally backed the refining of theoretical starting points for Czech eugenics in the period from 1915 to 1918 as well as the forming of a programme for "after", i.e. as soon as World War I were to come to an end. The process culminated in the outlining of a programme of practical measures, setting a sequence and timing and, last but not least, institutional backing.⁴⁴

Czech eugenics research was to be accomplished in three stages in the deliberations of the Czech Eugenic Society: an exploration stage (eugenics statistics; medical genealogy; medical examinations; experiment; collection of data at institutes of forensic medicine, treatment and care institutes, penitentiaries and prisons; breakdown of the nation into lineages), an analytical stage (evaluation of data and creation of medical registries), and an executive stage (propaganda; eugenic consultancy and measures of legislative nature including eugenic marriage revision, prophylaxis, confinement and removal of reproductive ability).⁴⁵

The programme clearly shows that the Czech eugenics movement also dealt with the issue of sterilisation as a practical measure. Czech and Czechoslovak eugenics understood sterilisation as a therapeutic and prophylactic selection method, expecting that when applied, it would bring under control the sexual life of the inferior and define inferiority boundaries.⁴⁶

⁴³ Brožek, A.: *Eugenika, nauka o zušlechtění a ozdravění lidu, založená na pravidlech dědičnosti* (or *Eugenics, a Teaching on the Cultivation and Strengthening of the Nation Based on Heredity Rules*), *Pražská lidová revue* 8, 1912, Volume. 6, page 177.

⁴⁴ The contemporary reader may be somewhat surprised to discover that in 1919, specifically as a potential institutional backing for the implementation of eugenic measures, the Czech Sokol Gymnastic Community was admitted into the Czech Eugenic Society as a founding member.

⁴⁵ On the same matter see Šimůnek, op. cit. in footnote 22, page 84.

⁴⁶ "Sterilisation is an act of kindness both for the affected family, which suffers from seeing an afflicted child, and for the afflicted themselves whose being born for an inferior life represents suffering." (Veselá, J.: *Sterilizace: problém populační, sociální a kriminální politiky; or Sterilisation: the Problem of Population, Social, and Criminal Policies*, Prague 1937).

In line with the interwar practice of the European countries and the U.S.A., three indications to sterilisation were considered: social, eugenic and fiscal. Sterilisation for social reasons was understood as a measure that "liberates" the family from uncontrollably increasing of the number of children beyond the ability to sustain them. The eugenic indication on the other hand aimed at preventing the transfer of "negative" qualities to the next generation. Where social and eugenic reasons intersected, a requirement for sterilisation of the inferior ensued.

In the contemporary perception, the notion of the inferior encompassed the categories of those physically, mentally or socially afflicted, and therefore "unfit" persons. The "mentally deficient" and "insane" posed the greatest risk for eugenics, because *"the inferior procreate inferior offspring and have on average lower abilities to properly care for and raise their offspring."*⁴⁷ Thus the social affliction ensuing from a mental or psychological deficit added social reasons to the demand for sterilisation of those perceived as hereditarily afflicted in the contemporary understanding. The reasons for eugenic indication to sterilisation were presented in particular as population quality ones. They stemmed from a generally accepted premise at the time *"...that in countries with a high civilisation standard, inferior population elements reproduce relatively more than the groups of average or above-average talent. ... However, the risk of population quality deterioration is not documented solely by the relatively more rapidly increasing number of defective persons, but also by their increased prolificacy."*⁴⁸

Although fiscal reasons for sterilisation (relief for socially deprived groups and an improved economic standard of superior groups, mitigation of the social burden borne by the state) were essentially unacceptable for the sterilisation movement in Czechoslovakia, we still find references in the contemporary discussion to the financial burden posed by residential treatment, as a supporting argument for eugenic sterilisation. Above standard or indeed luxury living conditions of the "insane" and "mentally deficient" in residential facilities were very frequently referred to for publicity. Hinting at Darwinian "natural selection", Czech eugenics representatives even pointed to the "noxious effect" of an altruistic culture:

*"Charity is rightfully reproached for its blame in proliferating the inferior, in the degeneration of mankind; that thousands of the abnormal who would have perished alone in dirty corners are preserved with care and love, while hundreds of thousands of the normal lack such love and care."*⁴⁹

It is not surprising given the above that the Czech Eugenic Society explicitly welcomed sterilisation already in 1923 in a comment on a parliamentary proposal to anchor eugenic measures in legislation:

*"It is wiser to prevent pregnancy, be it through sterilisation, than to expose the woman to abortion, which is a not insignificant treatment, moral terms inclusive."*⁵⁰

The discussion of the place of eugenic sterilisation in legislation was stirred up in particular by publication of the sterilisation act in National Socialist Germany in 1933, which generated contradictory reactions in Czechoslovakia. The eugenics movement received the German act positively, while negative reactions came rather from the general public. The broader medical community was at one with Czech eugenics. For example the Czech Association of Doctors stated to the Czech Eugenic Society at their meeting on December 11, 1933:

*"... there is no difference of opinion between us and the Association will spare no effort to support these eugenic efforts, especially those that aim to sterilise individuals also dangerous to and unwelcome in society."*⁵¹

⁴⁷ Veselá, op. cit. in footnote 56, page 10.

⁴⁸ Veselá, ibidem, page 17 and 20.

⁴⁹ Ibidem, page 23.

⁵⁰ Ibidem, page 121.

The effort to anchor sterilisation in legislation intensified in Czechoslovakia after the German sterilisation act was released. On February 24, 1934, the issue of degenerative effects on the state of the population was the theme of the first discussion evening of the Czechoslovak National Council. The domestic debate was ignited by many international congresses with Czechoslovak participation. Among the most important was the 1935 congress on criminal law and the prison system in Berlin.

A questionnaire of the Eugenic Society organised on May 5, 1936, on the expedience and necessity of sterilisation, met with a positive response among the society members and it was unanimously approved at a meeting that a recommendation be made for the enactment of eugenic sterilisation. The Institute for National Eugenics was charged with creating draft Czechoslovak sterilisation legislation. A sub-committee of the Eugenic Committee subsequently drew up a memorandum containing directives for the legal provisions on sterilisation and on March 21, 1937, a decision was made on publishing the memorandum for broader professional circles. Upon request, the memorandum of the Czechoslovak Eugenic Society was sent to the Ministry of Health:

*"1. Sterilisation through an induced medical intervention is permitted solely for eugenic reasons, i.e. on persons with a risk of offspring afflicted by serious hereditary diseases or defects. 2. In every individual case the performing of the sterilisation would be bound to a) permission of the person on whom the intervention is to be performed (or, if incapable, permission of the legal guardians and care authorities), b) decision of a special commission comprising of experts in medical eugenics and legal experts."*⁵²

In terms of the right to propose sterilisations, the memorandum recommends the following:

*"The possibility to file a sterilisation proposal should be primarily with persons suffering from a hereditary defect or sickness; secondly the mandate of official institutions that come into contact with persons of this kind (care, medical and social institutions) should be treated in this direction. The impulse for commencement of such an action could come from these authorities, each time obviously based on the consent of the persons themselves or their legal guardians."*⁵³

The Eugenic Commission of the first department of the Masaryk Academy of Work joined the sterilisation movement drawing up a summarising text on the history and expedience of sterilisation, which was sent by the Academy to Parliament as well as to the Senate, the Ministry of Public Health and the Ministry of Justice. In an accompanying letter the Academy demanded that appropriate weight be attached to population trends in the Czechoslovak state. More detailed legislative work failed to take place due to political events. War experiences combined with the post-war political developments cast the Czechoslovak eugenics movement into official oblivion.

5.4. Eugenic Deliberations in Social Practice Before 1989

Although the ambitious eugenic schemes fell into oblivion after World War II, attempts at influencing social reality through directed influence on the reproductive behaviour of selected groups seems to have persisted in contemporary thinking – otherwise the social workers' statements quoted above would be hard to understand.

Particularly alarming is the fact that the motive of ensuring a "better quality population" is more frequent in the reports from the National Committees than that of improving the existing social situation of a particular family. In this context, reference should once again be made to the decree repeatedly mentioned here, No. 152/1988 Coll., as well as the methodological instructions preceding the same. Section 35 of the decree (and previously of the methodological instruction) stated:

⁵¹ Ibidem, page 122.

⁵² Ibidem, page 127.

⁵³ Ibidem, page 128.

"Citizens who have undergone a medical intervention under special legal regulations in the interest of a healthy population and overcoming adverse life circumstances of a family may be granted a one-off allowance in cash or a material benefit by the district National Committee under Section 31 par. 4 of this decree, within one year from the medical intervention."

Payment of the allowance was therefore bound not to the social circumstance as such (adverse life circumstances in the family) as would be reasonable to expect from a social benefit⁵⁴, and what is more, it was not bound solely to undergoing the medical intervention with a view to improving one's specific individual situation (although even such a construct should be condemned for reasons identical with those that led the General Prosecutor's Office of the Slovak Republic to condemn it – see page 37 of this Report); instead, potential provision of the benefit was bound to undergoing sterilisation also **in the interests of a healthy population**. Thus the eugenic aspect was a significant motive for constructing one of the social benefits, and state authorities never responded to this during any of the efforts to investigate the sterilisations of Roma.

If such a frankly eugenic deliberation appears in a legal regulation concerning benefit, it is no surprise that field social workers derived their practical steps from some sort of eugenic perceptions, although probably based on little theoretical substantiation. Such a more or less lay perception of the level of reproduction of negative social phenomena in following generations, which for that matter is still latently and subconsciously prevalent⁵⁵, could have logically, along with the now (hopefully) overcome conviction of lower intellect among Roma and confusing consequences of unsuccessful assimilation for existent traits of a psychopathic nature, resulted in a perception that contraception for Romani women would primarily represent a suitable tool for "strengthening" the Romani population.

A parallel can therefore be drawn, in the opinion of the Public Defender of Rights, between these deliberations of the social services in pre-November [1989] Czechoslovakia and the practice pursued by them, and the Swiss and Swedish practices. It is for their generality and non-discerning summarising that the efforts of the social services to improve the state of human species through measures in the area of human reproduction are always prone to misuse, fatal errors and inhumanity. For this reason they should be condemned in principle. The mission of social work is to offer individual solutions to the adverse social circumstances of individuals instead of "breeding" the human species through eugenic selection. These attempts can be and probably still are very tempting, but historic experience gives an obvious warning that they always result in tragedy.

Thus if we want to look at the practice of the pre-1989 social services with full openness, we must always take into consideration that the offer of sterilisation to Roma in individual cases could have been motivated, depending on the circumstances, not only by a deliberation that this would be the best measure to solve an individual social situation, but also that it would be a suitable means of pursuing a eugenic goal. From this perspective the potential coercion by the social workers attains a new dimension, which however falls not so much on their own heads; it is much more likely attributable to the state – the central levels of the state authorities that released references to contraception methods as eugenic measures without clearly defining them. The authorities let them live their own life, content to sit back and let them be bent into whatever shape was wanted.

⁵⁴ According to social security theory, the social security system is based on the state or another social security system carrier providing benefit depending on whether a social situation has occurred that adversely affects the benefit recipient's social circumstances.

⁵⁵ For that matter, the case kept under File Ref. 3763/2004/VOP/PM presented in chapter 3 of this Report suggests the same thing.

6. Summary

Throughout 2005, the Public Defender of Rights received over 80 complaints concerning illegitimately performed sterilisations. Given that the Public Defender of Rights lacks a mandate for dealing with the complaints of natural persons about medical facilities, he forwarded the complaints to the Ministry of Health and was then able to check the work of the Ministry.

The Ministry appointed an advisory board to carry out an inquiry into the cases. The advisory board was tasked with examining not only whether the interventions had been performed according to good medical practice, i.e. *lege artis*, but also whether the legal qualifications for performing them had been satisfied.

Given the time taken by the advisory board's inquiry, the Public Defender of Rights decided to conclude his inquiry under the Public Defender of Rights Act after dealing with 50 cases. He therefore drew up a report on these cases under section 18 par. 1 of the Public Defender of Rights Act, reproaching the Ministry, or effectively the advisory board whose results had been approved by the Ministry, for an inadequate inquiry as well as faulty, or even lacking, conclusions from findings of facts.

The Minister of Health responded to this report by stating that another hearing of the advisory board would be held in November 2005 on the new set of complaints. At the hearing the board was to suggest corrective measures for cases where shortcomings were established within the scope permitted by Act No. 20/1966 Coll., on Care of People's Health, as later amended. A draft of the informed consent process for patients prior to sterilisation and a draft amendment to legislation pertaining to sterilisation pending endorsement of the new provisions in the draft act on healthcare, were to be discussed at this hearing. Besides this, the Minister of Health referred to the draft act on healthcare, which is to treat the procedure for performing sterilisations in an entirely new way.

After receiving this statement, the Public Defender of Rights drew up a report in the meaning of section 19 of the Public Defender of Rights Act, proposing remedial measures.

In terms of assessment of the set of complaints of the sterilised women, it should be highlighted as the most fundamental fact that sexual sterilisation is a medical intervention causing the permanent loss of reproductive capacity. Given that it is performed as a preventive intervention in its nature rather than for directly therapeutic reasons, legislation sets out special conditions for its performance intended to guarantee that the intervention be performed with free and informed consent. Presently, the basic legal provision that treats the performing of sterilisations is the directive of the Ministry of Health of the Czech Socialist Republic of December 17, 1971, on the performing of sterilisation. Let us restate its full text at this point:

P-252.3-19.11.71.

*Directive of the Ministry of Health of the Czech Socialist Republic
of 17 November 1971
on the performing of sterilisation*

The Ministry of Health of the Czech Republic sets out the following under Section 27 of Act No. 20/1966 Coll., on Care of People's Health:

Section 1

Sterilisation is a medical treatment that eliminates fertility without removing or damaging sexual glands.

Section 2

Sterilisation is admissible if performed at a medical facility at the request or with the consent of the person to be sterilised,

a) on the diseased sexual organs of a man or a woman with a therapeutic aim according to good medical practice,

b) on the healthy sexual organs of a woman if pregnancy or delivery would seriously threaten the life of a woman or caused her serious and permanent damage to health,

c) on the healthy sexual organs of a woman who has an illness that would threaten the physical or mental health of her children,

d) on the healthy sexual organs of a man if the man suffers a permanent condition that would threaten the physical or mental health of his children,

e) on healthy sexual organs of a man whose wife has an illness that might be a reason for sterilisation under letters b) and c), if sterilisation could endanger her health or if she does not intend to be sterilised for other reasons,

f) on the healthy sexual organs of a woman whose husband has an illness that may be a reason for sterilisation under letter d) and the husband does not intend to undergo the intervention,

g) on the healthy sexual organs of a woman if the woman permanently meets the preconditions for the termination of pregnancy for health reasons.

Section 3

A list of the indications that might be a reason for sterilisation under section 2 letters b) through f) is in an annex to these directives; indications to sterilisations under section 2 letter g) are identical with those for induced termination of pregnancy if they are of a permanent nature.

Section 4

Sterilisation cannot be permitted if health reasons exist against it (contraindications). All disorders that preclude surgical intervention are contraindications. An overall internal examination prior to the surgery is therefore required.

Section 5

(1) Sterilisation indication is to be decided upon by the following:

a) in cases under section 2 letter a) the head doctor of the department treating the man or woman,

b) in cases under section 2 letters b) through g) a medical commission set up for the purpose (sterilisation commission). The sterilisation commission is set up by the director of the district healthcare institute attached to a hospital with health centre, for women's sterilisations of such hospital as has an in-patient women's department, and for sterilisations of men such that has an in-patient urology or surgery department. The chair of the commission is the director of the hospital with health centre, and the commission panel shall comprise of the head doctor of the women in-patients department, or as the case may be, urology or surgery department of the hospital with health centre, treating the woman or man, and a specialist doctor in the field of indication or contraindication.

(2) When assessing sterilisation for genetic reasons [§ 2 letters c) and d)] the sterilisation commission must request a statement from the genetic commission attached to the endocrinology section of the Czech Medical Association of J. E. Purkyně founded by the Ministry of Health of the Czech Socialist Republic.

Section 6

Sterilisation for the reasons given in section 2 letters b) through g) may be applied for in writing by the person to be sterilised, or by the doctor with the person's consent, to the chair of the sterilisation commission competent for the relevant place of residence, employment or school attended. They shall duly justify their motivations in the application.

Section 7

Consent of a legal guardian is required in the case of applications for performing sterilisation (section 6) on minors and persons with restricted legal capacity. The legal guardian also files the application on behalf of a legally incapacitated person. When sterilisation is to be carried out due to mental illness (section IX of the list of indications) and the person is not a legally

incapacitated person or a person under restricted legal capacity, consent of a carer instituted for this purpose by court under section 29 of the Civil Code is required.

Section 8

The chair of the commission shall ensure without delay that the person to be sterilised undergoes the required examination by the commission panel and informs the person or where applicable the person's legal guardian (carer) where and when to appear for the examination. The required expert examinations shall be performed in such a way as to ensure that the chair obtains expert statements not later than three weeks from receiving the application and is able to summon the commission to discuss the application.

Section 9

The commission permits the sterilisation if the inquiry establishes that there is an indication to sterilisation.

Section 10

The commission chair will produce a protocol on every sterilisation application containing the name and address of the person to be sterilised, expert statements of commission panel and minutes from the meeting with a decision. The chair retains the original of the protocol signed by all commission members.

Section 11

If the application is accepted, the chair refers the applicant to an in-patient women's (or, as the case may be, urology or surgery) department headed by a commission member. The chair will send there a copy of the protocol, which now becomes part of the clinical records. For the purposes of legislation the person to be sterilised or their legal representative (carer) shall sign a declaration that they agree to the sterilisation and have taken into consideration the written provision of information on the level of reversibility of the sterilisation intervention.

Section 12

If the application is declined, the chair communicates the result to the applicant or the legal representative (carer) including a justification, advising him (her) of the possibility to review the decision under section 77 of Act No. 20/1966 Coll.

Section 13

*Sterilisation may be permitted to those foreign nationals who reside in the Czechoslovak Socialist Republic on a long-term basis. **)*

Section 14

These directives supersede directive of the Ministry of Health No. 29/1968 of the Ministry of Health Bulletin on the performing of sterilisation.

Section 15

These directives become effective as of January 1, 1972.

Minister:

Dr. Prokopec in his own hand

The text of the directive clearly shows that an examination must be made in each case as to whether three basic requirements have been met, i.e. application or consent of the person to be sterilised under section 2 in combination with section 6 of the directive, a decision of the sterilisation commission under section 5 of the directive and provision of information before the intervention under section 11 of the directive. Such an examination however cannot be restricted to ascertaining whether a record of these acts is contained in the medical records – i.e. formal proof - but instead the material content of the acts should be examined, and in particular the question as to whether the application and consent of the sterilised person actually were free, serious and error-free legal acts.

If the basic task of the advisory board of the Minister of Health or indeed the Ministry of Health as such was to examine the legal admissibility of the sterilisations under inquiry in addition to whether the sterilisations were performed *lege artis*, i.e. according to good medical practice, the board should have dealt primarily with the material content of the acts captured in the medical records. The ministry failed to satisfy this requirement. A fundamental defect in the approach of the Ministry of Health was emphasis and reliance on formal aspects that failed to capture the broader context of the cases, with an impact on the legal assessment of the quality of the legal acts made by the sterilised persons. For that matter, the previous attempts of state authorities at an inquiry into the matter featured a similar basic defect.

Specifically the question of whether the women who addressed the Public Defender of Rights and who addressed state authorities in the preceding years gave legally relevant consent to the interventions is the primary matter to be examined. This is even more relevant considering that in a number of cases the formal requirements of the directive were satisfied. This fundamental question applies regardless of whether the sterilisation took place before 1990 or later, in a state or a private hospital, with a social worker contributing or without such involvement. Through his inquiry the Public Defender of Rights concluded that in the cases under examination, shortcomings are identifiable in the legal quality of the sterilised persons' consent. The main reservations can be summarised as follows:

1. From a legal perspective the unlawful nature of the sterilisations lies in the fact that consent, that was without error and fully free in the human rights sense, was not given to the interventions. This conclusion applies to all cases without exception. It is therefore common both to cases taking place before 1990 and later.
2. There are essentially two types of reason as to why the women's consents were not fully informed and free:
 - a) In medical and legal terms it should be pointed out that the cases examined generate doubt about the process of properly informing the patient in a way that would enable her to make a mature decision on the basis of the information presented. As already noted, both crucial requirements for sterilisation admissibility, i.e. the application for sterilisation and consent to its being performed are legal acts that are correct only if the patient is duly informed of the intervention. The cases examined present situations where the doctor is the first who mentions sterilisation as an available solution. For his proposal to generate a legally unchallengeable reaction of the patient in the form of an application for sterilisation and consent to the intervention, the patient must be primarily informed that her health condition requires her to avoid future pregnancy, what potential gestation would entail, how she could avoid potential pregnancy, what advantages and disadvantages sterilisation offers and why the doctor believes sterilisation is the best option. It is further necessary to ensure that the patient has a chance to duly process the information given, i.e. primarily to give her sufficient time to decide.
 - b) There is yet another element in the sterilisations of Roma before 1990. Medical personnel's conduct that casts doubt on the legal quality of Roma's consents to the intervention combines with the social workers' conduct. The inquiry by the Public Defender of Rights has gathered indicia that in practice the Romani women were persuaded, with a tacit approval and support from the management, into reducing the number of their children. Sterilisation was one of the methods offered and the potential availability of a relatively high social benefit acted as an incentive element for the Romani women's decision-making as to whether to undergo sterilisation. This conduct of the social workers, regardless of how we perceive it

historically, from a legal perspective meant and means that free forming of will of the persons exposed to such conduct was significantly compromised.

7. Closing Recommendations

A) – Legislative measures

As noted above, the government's draft act on healthcare, which the Minister of Health referred to, treats for the first time in an entirely clear way the requirements for informed consent (see chapter 2 of this Report).

From the legislative perspective the proposed legal provisions can be regarded as a good basis. In practice however it is not the legal provisions that are dubious – **essentially identical demands were placed on the legal quality of consent already in the existing legal provisions.** It is the practical implementation of the legal provisions that poses a difficulty.

Although the new draft act on healthcare contains high-quality legal provisions, the Public Defender of Rights still proposes that it be amended by including two points.

a) Given that according to the proposed legal provisions and indeed according to the existing doctrine of informed, free and qualified consent, such consent is qualified solely if it is clear that the patient has understood the information provided and is capable of making an assessment, and given that sterilisation has major non-medicinal implications, it would be most suitable if the legal provisions on sterilisation defined a reasonable period between providing the information and consenting to the intervention in the meaning of section 49 of the draft. The provisions could for example take the following form:

"The provisions of section 49 are amended by inclusion of the following sentence:

A reasonable period of time must elapse between providing information in accordance with section 48 and expressing consent in accordance with the previous sentence and; this period must not be shorter than 7 days."

b) The purpose of a sterilisation for health reasons is to avoid a future pregnancy that in combination with the mother's illness might put her health or life at a direct risk or where there would be a risk of damage to the child. Even in such cases, sterilisation is primarily a contraceptive intervention. To satisfy the requirement for informed consent, a doctor proposing sterilisation in such a situation must at the same time provide information on alternatives, i.e. other options of avoiding conception in the particular case. We therefore propose that the first sentence of the provisions of section 48 of the draft be amended as follows:

"Before performing sterilisation for health reasons or for other than health reasons, the doctor has a duty to inform the patient of the nature of the intervention, its permanent consequences and potential risks **as well as the available alternatives to sterilisation.**"

B) – Methodological measures

The Public Defender of Rights further proposes the following measure that should be taken by the Ministry of Health in the non-legislative area:

1. Produce a handbook explaining in a detailed way comprehensible to the lay public the essence and implications of sterilisation. The handbook will be given to patients along with oral information under section 48 of the draft

act on healthcare, or as the case may be pending endorsement of the new legal provisions, before signing consent or at the time of filing an application under the existing legal provisions.

2. Given that the findings of the Public Defender of Rights suggest a still insufficient or distorted picture of the background and content of the patient's rights among a part of broader medical circles and that a communication deficit occurred in some contacts due to insufficient respect for patients' different social, cultural and ethnic backgrounds, the Ministry of Health should ensure sufficient compulsory lifelong learning of doctors on the main principles of patients' rights and create mechanisms of supervision over the doctors' approach to patients so that doctors are steered not only towards observance of legal provisions, but in particular towards an ability to apply these in communication respecting the patient in his or her uniqueness. For the same reason the ministry should ensure consistent teaching of the legal provisions on informed consent with its human rights background at medical faculties as well as a consistent ethical preparation of future doctors for contact with patients from different social and cultural environments.

C) – Reparation measures

One of the requirements of the affected women's representatives was adoption of legal provisions on reparation applicable to all those who have undergone unlawful sterilisation. The question of whether to adopt special legal provisions on reparation arises also when making comparisons with Sweden or Switzerland.

In considering whether the state could adopt legal provisions enabling the provision of reparations (redress) to those affected without their claiming such performance through a legal action, the crucial aspect is whether the state is in any way liable for the damage that has been inflicted upon those affected.

Where interventions in the patients' personal rights occurred exclusively through incorrect conduct by doctors (this applies primarily to cases in the 1990s and current cases), such liability of the state seems not to follow. The state indeed adopted clear legal provisions on sterilisation as early as 1972, which were compatible with the requirements of the law for the admissibility of performing such an intervention. Thus it remains the doctors' personal liability that they failed to comply with the requirements of the law. For this reason it seems that the fair option would be if those affected addressed the courts with right-to-privacy lawsuits.

The situation is different where involvement of the social services is identifiable in the process of the woman's decision-making on sterilisation. Is the state liable for the social workers' conduct and its consequences in these cases? The question implies an additional question, and specifically whether there was a state policy aimed at controlling the Romani birth rate. It has been noted elsewhere within this Report that in the government's resolutions dealing with the Romani community there is no official instruction for social work to influence the reproductive behaviour of Roma. In fact the state authorities never opposed the approach of practice in the field even though being aware of the forms it took. Thus they left room for applying procedures that partly ensued from hints in the official methodological handbooks and partly were given by the contemporary perceptions of the "social risk" of there being many children among Roma and the unhealthy nature of the Romani population. These perceptions were supported and encouraged by there being an assimilation policy that set itself the goal of creating the "correct family" model in the Romani community. The state supported these deliberations (for the first time already in 1973) by enacting a financial benefit potentially available for undergoing sterilisation, which had an inherently incentive nature and it can be taken as proven that it was the chief motivation for

undergoing sterilisation in a number of cases. Even though the state issued no instruction, liability for the approach of the social services towards clients that is unacceptable from present perspectives can be found in the state's approval and support of the practice.

In this case therefore the Public Defender of Rights proposes considering the adoption of legal provisions that would make possible reparation for those affected. The Swedish legal provisions can serve as a model for constructing such legal provisions. The period to which the potential reparation might apply should most likely be limited to the period in which legal entitlement to payment of the benefits for sterilisation existed, that is the years 1973 to 1991.

Brno, December 23, 2005

JUDr. Otakar Motejl
Public Defender of Rights