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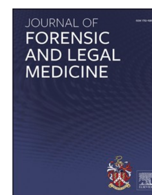

Research Paper

Physician complicity in human rights violations: Involuntary sterilization among women from Mexico and Central America seeking asylum in the United States

Deborah Ottenheimer [a], Zoha Huda [b], Elizabeth T. Yim [b], Holly G. Atkinson [b,*]

[a] , Women's Health Services, Gotham Health, Morrisania1225 Gerard Avenue, 3rd Floor, Bronx, NY, 10452, USA
[b] CUNY School of Medicine, 160 Convent Avenue, Harris Hall, Suite 113, New York, NY, 10031, USA

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ABSTRACT

Involuntary sterilization is a violation of human rights and grounds for asylum in the United States. Forensic medical evaluations can be useful in documenting this form of persecution and supporting asylees' claims for immigration relief. We conducted a retrospective case analysis of the personal and medical affidavits of 14 asylum-seeking women from four Latin America countries who all reported they had been involuntarily sterilized. Sixty-four percent said that "consent" was coerced; the remainder were unaware of having been sterilized at the time of the procedure. In all cases, findings on hysterosalpingogram were consistent with sterilization, revealing that all 14 had undergone a tubal ligation. Eighty-six percent of the women had been sterilized at the time of childbirth. The healthcare providers involved in the 14 cases failed to obtain informed consent, misled patients about sterilization, engaged in discriminatory behavior, and/or breached patient confidentiality regarding their HIV-status. All 14 asylum cases were defensive; of the 7 cases (50%) that have been decided to date, 100% have been granted asylum.

1. Introduction

Sterilization is defined as a process or act that renders an individual unable to sexually reproduce.[1] As a voluntarily chosen form of contraception, it is a safe and effective method of controlling fertility and one of the most commonly used contraceptive methods around the globe.[2,3] By contrast, involuntary sterilization is a phenomenon encompassing both *forced sterilization*, in which an individual is sterilized without her or his knowledge or without informed consent; and *coerced sterilization,* when misinformation, intimidation tactics, financial incentives, or withholding access to health services or employment are used to compel a person to agree to the procedure.[4] Involuntary sterilization has been recognized as a human rights violation by numerous international covenants and treaties, including the Convention of the Elimination of All Forms of Discrimination against Women and the International Declaration on the Elimination of Violence against Women.[5,6]

Involuntary sterilization also constitutes a grave breach of medical ethics.[7] The International Federation of Gynaecology and Obstetrics (FIGO) states that "Forced sterilization constitutes an act of violence, whether committed by individual practitioners or under institutional or governmental policies. Healthcare providers have an ethical responsibility in accordance with the guideline on Violence Against Women."[8] FIGO specifically recognizes informed consent for medical treatment related to reproductive health services and childbirth as a fundamental human right.[8] The World Health Organization has defined six criteria for informed consent for sterilization that must be discussed with the patient prior to a provider carrying out the procedure: "1) sterilization is a surgical procedure; 2) it has risks and benefits; 3) it will prevent future pregnancies; 4) it is considered permanent; 5) refusing the procedure will not result in the loss of any benefits; and 6) non-permanent contraceptive alternatives are available."[9] Unfortunately, many women "consent" under circumstances in which these criteria are not met. Reasons for this may include a lack of explanation of the surgical nature of the procedure; provision of misleading information regarding the permanence of the procedure; and/or the presence of overt or subtle pressure to give "consent," often in life-threatening situations.[10,11,12,13]

Some countries have tried to promote women's rights to bear

* Corresponding author.
E-mail addresses: deb@ottenheimerhealth.com (D. Ottenheimer), zhuda000@citymail.cuny.edu (Z. Huda), eyim000@citymail.cuny.edu (E.T. Yim), holly.atkinson@reasonmedical.com (H.G. Atkinson).

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children and protect against reproductive rights abuses through various legal frameworks. For example, in Latin America, laws have been passed in several countries to establish civil and/or criminal liability for healthcare workers who sterilize women without their informed consent, whether under government direction or as autonomous practitioners.[14] In 2004, Argentina established a legal framework with respect to childbirth, using a human rights-based approach, that granted women the right to a "humanized childbirth experience."[12,15] In 2007, Venezuela enacted precedent-setting legislation, creating a comprehensive framework structured to protect the "right of women to a life free of violence," with specific reference to protection from disrespect and violence perpetrated by physicians against pregnant women, including involuntary sterilization.[12] The Venezuelan law criminalizes several types of "obstetric violence."[†] In 2009 Argentina, following Venezuela's example, enacted a law to prevent and punish gender-based violence, including a specific article in the law that addressed obstetric violence.[15] Others countries have specifically addressed the issue of sterilization, for example, Brazil (1996), Bolivia (2013) and Ecuador (2014) have criminalized forced sterilization within their jurisdictions ("forced sterilization" in Brazil and Bolivia, and "forced deprivation of reproductive capacity" in Ecuador).[16] This paper focuses in particular on four countries—El Salvador, Guatemala, Honduras, and Mexico—all of which have legal statutes that address in some manner sterilization or involuntary sterilization specifically (Supplementary Table 1). All four countries also have various domestic laws concerning informed consent regarding medical procedures.[16,17] Further, all four nations are State Parties[18] to the Rome Statute of the International Criminal Court, which specifies "enforced sterilization" or any other form of sexual violence of comparable gravity as crimes against humanity and war crimes.[19]

However, despite international covenants and treaties recognizing involuntary sterilization as a human rights violation, professional medical societies promulgating ethical guidelines that center women's dignity and rights and requires informed consent, and legislation specifically prohibiting involuntary sterilization, the practice persists in numerous countries around the world.[10,12,20,21] Involuntary sterilization has been well documented in a number of Latin American countries, including Chile, Dominican Republic, El Salvador, Honduras, Mexico, Nicaragua, and Venezuela.[11,22]

In general, women are disproportionally affected by involuntary sterilization and often face broad societal discrimination on a number of intersectional grounds, including gender, ethnicity/race, socioeconomic level and certain personal stigmata.[23,24] Historically, across the globe, women of color, poor women, and women and girls with disabilities have borne the brunt of involuntary sterilization.[24] Women who are HIV positive are at particular risk.[11] Kendall and Albert, in a 2015 study, surveyed 285 women living with HIV in El Salvador, Honduras, Mexico, and Nicaragua and found that on average 23% reported having been pressured by doctors and nurses to be sterilized. The women who received their diagnosis during their prenatal care visits or became pregnant after their diagnosis were six times more likely to be pressured by their healthcare providers to undergo sterilization.[11]

Across Latin America, HIV prevalence is ~0.4% overall in the adult population, however the distribution of HIV disease is not uniform across regions or countries, and is particularly high among certain vulnerable groups.[25] The Garifuna, an ethnic minority of African descent living primarily in Honduras, is one such group; the Garifuna are broadly discriminated against in employment, housing, and health services, and suffer widespread acts of violence rooted in conflicts over land and natural resources, extensive corruption and "the limited ability of the government to protect the rights of vulnerable communities."[26] The Garifuna bear a disproportionate burden of HIV disease, affecting approximately ~4.0% of the population, 10 times the average prevalence across Latin America.[27] Garifuna women in particular endure multiple forms of discrimination across all aspects of economic, social, and political life.[28] A 2014 study found that Garifuna women had more than twice the rate of HIV disease as compared to men, 4.9% vs. 1.6%.[29] Garifuna women living with HIV/AIDS face additional stigmatization and discrimination.

In 1996, the United States (U.S.) Congress passed the Illegal Immigration Reform and Immigration Responsibility Act (IIRIRA), an amendment to the existing Immigration and Nationality Act that, among other mandates, directly addressed the issue of involuntary sterilization. IIRIRA offers victims of coercive population measures an opportunity for asylum. IIRIRA defines coercive population control as persecution based on "political opinion" and establishes that asylum seekers who 1) have experienced either forced abortion or involuntary sterilization, 2) have been persecuted for refusing such a procedure, or 3) have a well-founded fear that they would be subjected to such measures or persecution for refusal or resistance (as for example, under the one-child policy mandated by the Chinese government between 1980 and 2015) are eligible for asylum in the U.S.[30]

We report a case series of 14 women from four Latin America nations who sought asylum in the U.S. and stated in a sworn testimony that they underwent forced/coerced sterilization at the hands of their health care providers in their countries of origin. We undertook the study to identify factors associated with involuntary sterilization and to illuminate the unethical practices of the involved medical personnel.

2. Methods

We conducted a retrospective qualitative descriptive study[31] of women with a history of involuntary sterilization who were seeking asylum and underwent a forensic medical evaluation as part of their asylum claim between June 2016 and February 2021.

Inclusion criteria were: 1) adult women >18 years of age at the time of evaluation who were applying for asylum in the U.S.; 2) a history of sterilization as part of their asylum claim; 3) availability of both client and medical affidavits. Fourteen cases were identified, all of which had been referred by immigration attorneys to a single forensic medical evaluator (first author).

This study was reviewed and met the criteria for exemption of human subject research by the CUNY School of Medicine Institutional Review Board (IRB File #2021–0565).

For each case, we conducted a qualitative content analysis of the client's personal affidavit and the evaluator's medical affidavit(s) utilizing a data collection tool created in REDCap, a secure web application for creating and managing online surveys and databases. We developed the data collection form based on categories of information outlined in the Istanbul Protocol and our (first and senior authors') 40+ years of combined experience writing and evaluating forensic affidavits for immigration claims. The data collection form included information in the following major categories: 1) client demographics, 2) client social background and medical history, 3) client interaction with physicians and other medical professionals during the time of sterilization, 4) client forensic medical evaluation, and 5) information regarding the client's legal application for asylum relief.

Client demographics included age, country of origin, ethnicity/race, marital status, and number of children at the time of evaluation. Client social background and medical history included information regarding socioeconomic status both as a child and at the time of sterilization, HIV status, and the client's history of having experienced other forms of sexual/gender-based violence, such as physical, psychological/emotional, and sexual violence, as well as kidnapping, labor, trafficking, and/or neglect. The subcategories of sexual/gender-based violence were

[†] Under the Venezuelan law, "obstetric violence" is defined as the "appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones, bringing with it loss of autonomy and the ability to decide freely about their bodies and sexuality, negatively impacting the quality of life of women.

informed by an established coding tool for documenting various forms of gender-based violence.[32] Details regarding the client's interactions with the medical team included when and how sterilization occurred; whether consent had been obtained and, if so, the circumstances under which it was obtained; and reports of discriminatory comments on the part of the healthcare team. Information regarding the forensic medical evaluation included hysterosalpingogram findings, as a definitive corroboration of the client having undergone sterilization. Information regarding the asylum application was recorded, including type of case, grounds for asylum, nexus, and asylum outcome.

The REDCap data collection form was initially revised iteratively by all four members of the team via analysis of a randomly selected case among the 14 cases. For those items that generated discrepancies, the team collectively refined the data form elements. Following finalization of the data collection form, all other cases were reviewed and coded by at least two members of the research team. The entire team then performed a review of all data entries for each case; all discrepant answers were discussed and resolved by consensus.

3. Results

3.1. Demographics

Fourteen cases met the inclusion criteria (Table 1). Mean age of the women at the time of forensic evaluation was 37 years old (SD = 6.4). The 14 women originated from four countries: El Salvador, Guatemala, Honduras, and Mexico (Fig. 1). Eleven of the 14 women came from Honduras (79%); 10 (71%) were of Garifuna ethnicity. Seven women (50%) were HIV positive; seven (50%) had partners at the time of sterilization. All 14 women had children, averaging 2.7 children (range of 1–5) at the time of evaluation.

Table 1
Asylee characteristics (n = 14).

Mean age at time of evaluation(SD)	36 (6.4)
Country Origin	**n (%)**[a]
El Salvador	1 (7%)
Guatemala	1 (7%)
Honduras	11 (79%)
Mexico	1 (7%)
Ethnicity	
Garifuna	10 (71%)
Unknown	4 (29%)
HIV Status	
Positive	7 (50%)
Negative	7 (50%)
Poverty at time of sterilization	
Yes	8 (57%)
No	4 (29%)
Unclear	2 (14%)
History of Sexual/Gender Based Violence[b]	
Physical violence	11 (85%)
Psychological/emotional violence	11 (85%)
Sexual violence	10 (77%)
Kidnapping	2 (15%)
Labor trafficking	1 (8%)
Neglect	6 (46%)
Physical violence as a minor	7 (54%)
Sexual violence as a minor	6 (46%)
Psychological/emotional violence as a minor	5 (39%)
Aware of sterilization at the time entering US	
Yes	9 (64%)
No	3 (21%)
Unknown	2 (14%)
Hysterosalpingogram finding	
Positive for sterilization	14 (100%)
Negative for sterilization	0 (0%)

[a] Percent rounded to the nearest whole.
[b] The majority of women experienced more than one of these types of SGBV.

3.2. Themes

Several themes emerged from our qualitative analysis: the presence of pervasive poverty; experiences of multiple other forms of sexual/gender-based violence; lack of protection from law enforcement; and unethical, discriminatory, and/or coercive experiences with medical professionals (See Supplementary Tables 2 and 3 for quotes from the women's affidavits regarding these themes.).

3.2.1. History of poverty

Ten women (71%) indicated they were raised in poverty and eight (57%) were living in poverty at time of sterilization. A designation of "poverty" was assigned if the client made direct statements in her affidavit affirming specifically that she was "poor". The designation was also given in the setting of statements such as: the client was sent away as a child because the family could not afford to keep her; the client had to work as a child or work for long hours to feed the family; the client was living with multiple family members in a single room; and/or the client often went hungry.

3.2.2. History of sexual/gender-based violence and lack of protection from law enforcement

Thirteen women (93%) had a history of one or more additional types of sexual/gender-based violence: 11 (85%) reported physical violence, 11 (85%) reported psychological and/or emotional abuse, and 10 (77%) reported sexual violence. Eleven (79%) of the affidavits had some reference to the client's interaction with or opinion about the role of law enforcement for protection. Of these, three (27%) reported contacting the police and none were aided by the officers. The remaining eight (73%) indicated they ultimately did not contact the authorities because they considered it futile or potentially dangerous.

3.2.3. Interactions with the medical team

All the women in this case series underwent sterilization via tubal ligation, 12 (86%) of which occurred during labor and delivery or the immediate post-partum period. Of these women, 10 (71%) women underwent sterilization during Cesarean section and two (14%) underwent sterilization immediately after vaginal birth. Of the remaining two cases, one woman was sterilized when she presented with an ectopic pregnancy, while the other woman underwent involuntary sterilization unassociated with pregnancy after being forced to consent by her abusive partner. Upon arrival in the U.S., nine (64%) of the clients were aware that they had been sterilized, three (21%) were not aware, and in two (14%) cases, their awareness was unknown. Eleven (79%) of the women indicated that physicians were responsible for explaining the procedures (e.g., Cesarean and/or sterilization) to them, and, in the cases where the women (9, 64%) "agreed" to sterilization, the physicians coerced the "consent" from the women or misled them about the procedure. All 14 (100%) women underwent hysterosalpingograms as part of their asylum evaluation, and 100% had findings consistent with sterilization.

Four major themes were identified in the affidavits regarding behaviors of the physicians and other medical personnel: 1) failure to obtain informed consent; 2) provision of misinformation; 3) discriminatory behavior; and 4) breaches of patient confidentiality.

(1) *Failure to obtain informed consent.* The WHO criteria for informed consent were not met in any of the 14 cases. Six (43%) of the women understood that the surgery would render them permanently infertile and did not want to be sterilized but felt coerced into it. Many women in their affidavits commented on the duress that they were under when giving their "consent." Five women (36%) had no idea that sterilization had been performed.
(2) *Provision of misinformation.* Three (21%) women were misled by physicians about the permanence of sterilization and gave consent under false pretenses, having been told that sterilization is a

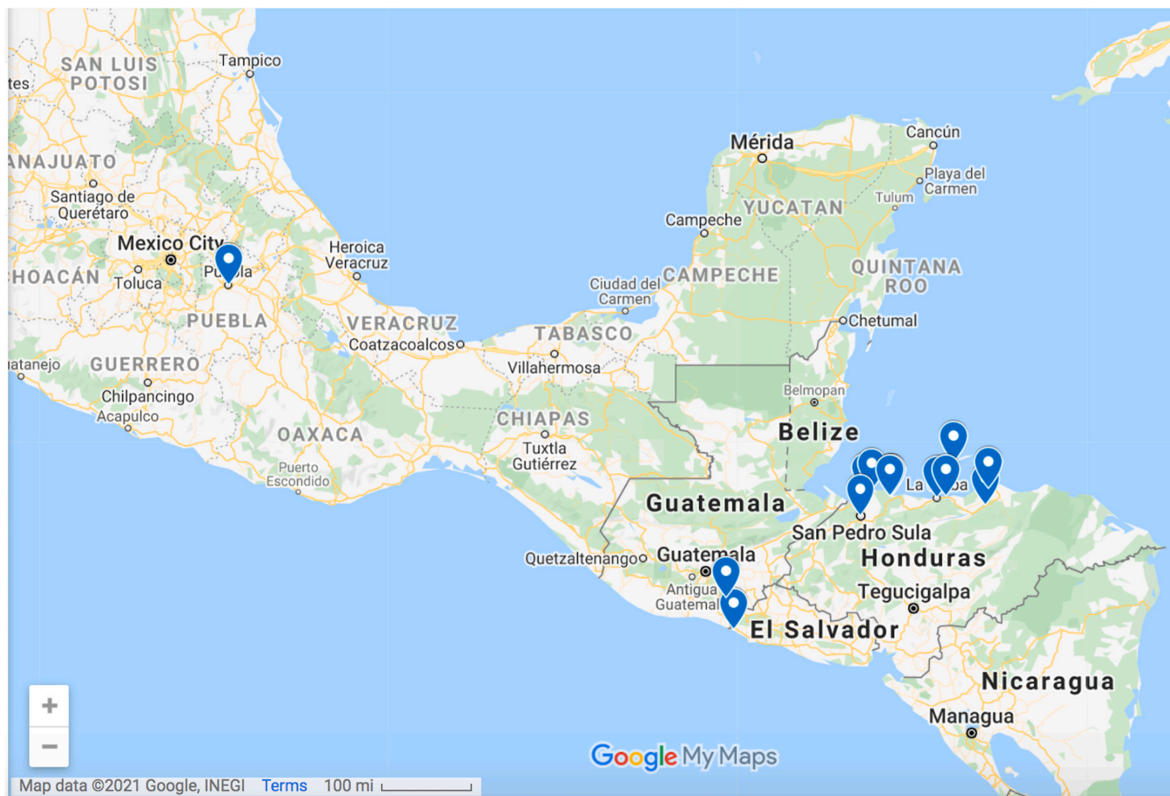

Fig. 1. Shows the countries (El Salvador, Guatemala, Honduras, and Mexico) of birth of the 14 women. Of note, there are only 12 pins because two women are from the city of San Juan, Honduras. Additionally, Tornabe and San Juan, Honduras are located close to each other and appear as one pin on the map. Copyright Google 2021.

temporary procedure that could be easily "reversed" or "undone" in the future.

(3) *Discriminatory behavior on account of race/ethnicity.* Seven (50%) women experienced overt discrimination and disrespect demonstrated by health care providers. Women reported behaviors such as physicians treating "lighter skinned people" before people of color and thus making them wait for hours in waiting rooms; being called insulting names such as 'negra'; receiving highly judgmental lectures about bringing more children into the world; being left naked in medical wards, which were sequestered according to race/ethnicity; and not receiving appropriate health care (e.g., access to physicians, access to medications, appropriate nursing care).

(4) *Breaches of patient confidentiality regarding HIV-positive status.* Health care providers sometimes breached patient confidentiality. Three of the seven (43%) HIV-positive women reported their HIV-status was inappropriately revealed. Some violations of confidentiality were passive, for example women reported that some clinics had special sign-in sheets or designated service areas for people with HIV/AIDS. Other breaches were active, with some women reporting that medical staff sometimes called family members and told them about the patient's HIV status or revealed their HIV status to the others in the community.

3.3. Characteristics of the asylum case

All 14 (100%) of the cases were defensive cases, (e.g., asylum cases that are adjudicated before an immigration judge within the Executive Office for Immigration Review). Of the five possible grounds for asylum (membership in a particular social group, nationality, political opinion, race, or religion), the mean number of grounds among the 14 women was 1.79. Membership in a particular social group and political opinion were the two most common grounds for the asylum claim (Table 2). To date, 7 (50%) of the cases have been decided, and, of these, 100% have been granted asylum.

4. Discussion

4.1. Interpretation of findings

We undertook this qualitative analysis of 14 cases involving women who had applied for immigration relief in the U.S. and testified that they had undergone involuntary sterilization. On examination, the forensic medical evaluator determined that the physical, psychological, emotional, and radiographic findings were highly consistent with their

Table 2
Case characteristics (n = 14).

Type of asylum case	n (%)[a]
Affirmative	0 (0%)
Defensive	14 (100%)
Grounds for asylum application[b]	
Member in a particular group	13 (93%)
Political Opinion	6 (43%)
Race	5 (36%)
Nationality	1 (7%)
Religion	0 (0%)
Number of grounds claimed	
One ground	8 (57%)
Two grounds	2 (14%)
Three grounds	3 (21%)
Four grounds	1 (7%)

[a] Percentages rounded to the nearest whole.
[b] Because individuals can claim more than one of the five established grounds for asylum intheir application, total n is > 14 and percent is >100%.

narratives of coerced or coerced sterilization. The fact that, at the time of writing, all the women who have appeared before an immigration judge were granted asylum indicates they were found to be credible in court.

Among the cohort of women, most were from Honduras, with a few from El Salvador, Guatemala, and Mexico. All four countries have various domestic norms concerning informed consent regarding medical procedures, such as laws, technical guidelines, or resolutions of health institutions, as well as relevant jurisprudence. Nevertheless, involuntary sterilization is still occurring. All four of these nations are well known for entrenched cultural and institutional discrimination against women.[33] A 2019 UNICEF report states: "Latin America and the Caribbean is the region with the most inequality, discrimination and violence [against women] on the planet."[34]

Race, HIV-status, and/or socio-economic status appear strongly associated with involuntary sterilization in this cohort of women. Almost three-quarters were known to be Garifuna, a group who suffers wide-spread discrimination. Half of the cohort was HIV positive, which confers another stigma and is a known risk factor for undergoing involuntary sterilization. Nearly all the women were raised in poverty and/or lived in poverty at the time of sterilization. Poor women across the globe are more likely to experience discrimination and abuse, including intimate partner violence, child marriage, and reproductive coercion.[35]

Most women in our case series had also experienced one or more types of sexual/gender-based violence, including physical violence, psychological/emotional abuse, and/or sexual violence. Some of them had experienced years of unrelenting, severe violence and abuse at the hands of multiple perpetrators across the arc of their lives. Few of the women in this cohort received or expected protection from law enforcement: sexual/gender-based violence is often considered to be a "private matter" not worthy of intervention and poverty and racism are often excuses for slow or non-existent punishment of perpetrators.[36] In addition, "women are considered to be the property of their male partners or relatives, and men are considered to be justified in using violence to control or punish their daughters, wives, or partners."[37] Overall, the women in this cohort experienced systemic, intersectional discrimination based on race, positive HIV-status, poverty, and a history of gender-based violence, that made them vulnerable to reproductive coercion.

Our findings also reveal the complicity of physicians in perpetrating involuntary sterilization among our cohort of asylum-seeking women. The physicians attending to the women participated in denying their patients numerous rights: the right to informed consent, the right to patient autonomy, and, especially, reproductive freedom as defined within the broader construct of universal human rights. In almost two-thirds of the cases, the physicians sought signed paperwork from the women, although under false pretenses, indicating their awareness of the requirement for informed consent. The widespread cultural acceptance of violence against women helps set the stage for obstetrical violence and involuntary sterilization by amplifying the power dynamics of inequality inherent in the physician/patient dyad and enabling an environment permissive for unethical medical practices.[38]

Writing in the *AMA Journal of Ethics,* Rebecca Kluchin points out that the factors contributing to physician complicity in involuntary sterilization include paternalistic attitudes and support (explicit or implicit) of eugenics, informed by the notion that certain types of women should not be allowed to reproduce.[39] Coercion in medicine is facilitated by the intrinsic inequality in the patient/provider interaction.[40] Women are particularly susceptible to coercion by misinformation because of pervasive gender stereotyping and cultural norms, which often impede access to a full array of reproductive health information and services.[41]

Autonomy in reproductive health decision making is often further curtailed for women who do not conform to social norms and thus are stigmatized, such as those who are HIV-positive; of a minority race/ethnicity; or of a non-heteronormative sexual orientation and/or gender identity. FIGO states that "stereotypical thinking about women, their roles in society and in their families, their capacities and preferences, has permeated health care in general, and reproductive health care in particular."[41] These cultural biases form the foundation of and justification for obstetric violence, particularly in the form of involuntary sterilization, and reflect prevailing patriarchal constructs around the world: e.g. women are inferior, thus their agency over their bodies, their sexuality, and their reproductive function is routinely dismissed. While physicians who engage in involuntary sterilization procedures do so as individuals, they are acting within the larger context of gendered structural violence, in which there is both institutional and cultural support for usurpation of women's rights.[12] The resolution of this issue in medicine will entail a substantial rebalancing of the uneven power dynamics that still exist throughout the field of medicine, including, of course, obstetrics and gynecology. The resolution of this issue in broader society will entail not only the passage and enforcement of laws against harmful discriminatory practices—including involuntary sterilization in those countries that currently lack such laws—but, ultimately, profound cultural transformation as well.[38]

4.2. Study limitations

Limitations of this study include a small sample size and restricted geography, as all women were from four countries in Latin America applying for immigration relief while residing in New York state. Additionally, the women were all seeking asylum, had legal representation, and were referred to the first author because of the attorneys' awareness of the 2018 publication of our initial case study of two HIV-positive Garifuna women who sought asylum in the U.S.[22] This explains why Garifuna women predominated in this case series. While our findings may not be generalizable to a larger population, this cohort reveals that the practice of involuntary sterilization is more widespread among women seeking asylum than previously documented. It is critical that attorneys and medical evaluators aggressively explore this pivotal issue as grounds for the asylum application.

4.3. Asylum and the forensic medical evaluation

4.3.1. Involuntary sterilization as grounds for asylum

The 1996 IIRIRA Act definitively defined involuntary sterilization and forced abortion *as* persecution and specifically *linked* it to the asylum ground of "political opinion," thus building the nexus into the law. This makes coercive population control claims different than most asylum claims, because such asylum seekers need only to demonstrate *that they did not provide consent for the procedure and were forced or coerced*.[30] They are not required to establish *why* they were persecuted. It should also be noted that coercive population control claims are different than other claims based on various other forms of sexual/gender-based violence, such as rape, severe domestic violence, or female genital cutting, which are generally found to be amongst the categories of harm rising to the level of persecution. In the case of sterilization, women may *choose* to undergo sterilization as an intentional, independent act. As Connie Oxford relates in her article "Coercive Population Control and Asylum in the U.S.":

> During my many other observations of the immigration court hearings based on other gender-based forms of persecution, asylum seekers are never asked if they wanted to be beaten, raped, or have their genitals cut. Conversely, asylum seekers fleeing coercive population control policies are asked to go into greater detail about the abortion or sterilization that establishes that they were forced to have these procedures.[30]

The necessity to establish that the sterilization was either forced or coerced has major implications for history taking from an asylum applicant. Within the Immigration and Nationality Act, "forced" is defined as when a reasonable person 1) would objectively view the threats for refusing the procedure to be genuine, and 2) the threatened

harm, if carried out, would rise to the level of persecution.[42] "Force" is a broad concept that includes not only physical harm but also encompasses being compelled, obliged or constrained by mental, moral or circumstantial means.[43,44] Thus, gathering extensive detail about the interactions that a woman who reports involuntary sterilization had with her medical team is critical in establishing "force" and building a stronger case for asylum.

4.3.2. The role of the forensic medical evaluator in asylum cases

The forensic medical evaluator has come to play an important role in the adjudication of asylum claims and other forms of immigration relief (e.g., U-Visa, T-Visa, VAWA claims).[45] Forensic medical evaluators—physicians, psychologists, social workers—are trained to undertake such evaluations based on the Istanbul Protocol, a manual that sets out rigorous guidelines on how to conduct an effective medical investigation into allegations of torture and other cruel, inhuman or degrading treatment and document the findings in the form of an affidavit.[46] These affidavits are then used by adjudicators in immigration proceedings, providing immigrant officials with additional, and often critical, facts and evidence on which to base their decisions. Forensic medical evidence often provides details corroborating or expanding the applicant's personal account, and thus enhances the credibility of the applicant in the eyes of the judge or asylum officer. Sometimes, evaluators will act as expert witnesses, testifying in court before immigration judges. It has been shown that applicants for various forms of immigration relief in the U.S. whose case file includes an affidavit prepared by a forensic medical evaluator are almost twice as likely (82% vs. 42%) to be granted relief versus those who do not have access to such an evaluation.[45]

4.3.3. Evaluating the claim of involuntary sterilization

Because involuntary sterilization is prevalent around the world, it is critical that both attorneys and forensic evaluators have a high index of suspicion when evaluating women who are seeking asylum. Attorneys and evaluators may fail to probe for a possible history of involuntary sterilization, especially when the legal strategy focuses on other grounds for asylum, such as membership in a particular social group defined by gender in a case involving severe domestic violence or sexual/gender-based violence. It is essential that asylum-seeking women be screened for involuntary sterilization and, if suspected, the forensic medical evaluation needs to focus in detail on the interaction between the applicant and the medical providers involved in the sterilization procedure.

To uncover a history of involuntary sterilization, forensic medical evaluators should include a review of an applicant's reproductive history, including any reports of infertility and a detailed account of her obstetrical and surgical experiences. *The documentation of the force, deception, and/or coercion employed by the medical provider is critical to the case*. This evidence can substantially buttress and/or alter the applicant's grounds for asylum and may improve the likelihood of a grant of asylum.

When taking a history, the attorney and the forensic medical evaluator should explore the specifics regarding the applicant's interactions with *all* medical staff who were involved with her care. What did the physicians, nurses, nurse practitioners, and others say during prenatal care visits? What exactly transpired during labor and delivery, or during another surgery when the sterilization was performed? Was her care delayed? Was she segregated into a different ward? Were derogatory or discriminatory statements made? Were alternatives offered to her? Was she required to sign a document, and were the contents therein explained to her? Was she coerced or forced into signing and if so, under what circumstances? Were threats issued and if so, what exactly were they? If the applicant was HIV positive, did her healthcare provider explain her condition and the availability of treatment? Was her HIV status used in any way to coerce her into giving "consent" for sterilization, such as threats regarding access to follow-up care or misinformation about effects upon her newborn?

Documenting any emotional distress suffered by the applicant during or after the procedure and any long-term psychological sequelae she may manifest is also important in establishing the level of harm and the applicant's credibility. Women who undergo forced and coerced sterilization are often deeply traumatized by their experience and suffer emotional and psychological injury, much like women who report negative psychological sequelae from traumatic childbirth experiences.[47,48] Forensic medical evaluators can employ several validated tools such as the Patient Health Questionnaire-9, Generalized Anxiety Disorder-7, and Clinician-Administered PTSD Scale for DSM-5 to screen for symptoms of depression, anxiety, and post-traumatic stress disorder, respectively. All these survey tools yield scores, which can be included in the medical evaluator's affidavit. If sterilization is suspected after conducting a thorough history and physical, medical evaluators must obtain a hysterosalpingogram (HSG) to confirm it.

4.3.4. Preparing the affidavit focused on involuntary sterilization

In preparing the affidavit, the forensic medical evaluator is tasked with synthesizing the historical, physical, psychological, and HSG findings into a coherent narrative that attests to the extent of the physical and/or psychological harm caused by involuntary sterilization. Details regarding the applicant's report of the use of force/coercion by healthcare providers should be highlighted. It is important to note that the forensic medical evaluator's role is not to *prove* that the applicant's claim of being forced or coerced into sterilization is true. Rather, the evaluator should state in the affidavit how consistent the evaluation findings are with the applicant's story. The Istanbul Protocol articulates five levels of consistency: a) not consistent; b) consistent; c) highly consistent; d) typical of; and e) diagnostic of.[46] It is the role of the immigration judge or asylum officer to ultimately determine the veracity of the claim. Legal statutes and case law governing asylum law outline that a *credible, persuasive, and specific* testimony should *alone be enough* to meet the applicant's burden of proof.[49] The medical evaluator's affidavit can offer corroborating evidence when an applicant's testimony alone does not meet the credible, persuasive, and specific requirements.

Finally, the evaluator can also address in the affidavit the prevailing "country conditions" an applicant faced in her country of origin, including tolerance of involuntary sterilization, pertinent laws or regulations, and the extent of sexual/gender-based violence and other human rights violations, particularly against women and/or stigmatized groups.

4.4. Next steps

Future studies should be conducted to enhance our understanding of the global prevalence of involuntary sterilization among asylum seekers as well as further illuminate the predisposing risk factors among various populations. We also need to further investigate the dynamics at play in the medical profession at large that continue to perpetuate these abuses. Training programs and professional medical societies around the world should make concerted efforts to further educate physicians and other healthcare providers on their ethical obligations. Such continuing education programs must address issues of unconscious bias, power dynamics, informed consent, professional duty, and local and/or national legal mandates with respect to reproductive health care and women's rights to prevent the continuance of such egregious practices. In those countries that currently do not have specific criminal statutes against involuntary sterilization, international and local advocacy organizations need to promote legislation against it. Finally, physicians and other health care professionals who engage in the practice of involuntary sterilization should be held accountable under any existing local, national, or international laws and/or ethical regulations for their perpetration of these egregious human rights violations.

5. Conclusion

We have presented a case series of 14 women seeking asylum in the U.S. from four Latin American countries, all of whom reported involuntary sterilization at the hands of physicians. All 14 women underwent tubal ligation, the majority during Cesarean section. In almost two-thirds of the cases, the women stated they "consented" under coercive conditions, while the remainder were unaware of having been sterilized. Both scenarios satisfy the U.S. legal definition of involuntary sterilization, and as such, all 14 are eligible for immigration relief under U.S. immigration law, regardless of the legal framework in the applicant's home country. Given the prevalence of involuntary sterilization around the world, we recommend that all women seeking asylum in the U.S. be screened for signs of involuntary sterilization. Any suspicion of involuntary sterilization should be followed up with a comprehensive forensic medical examination that focuses on *establishing the force or coercion used by the medical provider(s)* during the interaction with the applicant, and procurement of a hysterosalpingogram for confirmation of sterilization. The collection and narration of the physical, psychological, emotional, radiologic, and situational evidence in these cases is critical to the preparation of an effective affidavit. Finally, systemic change in global medical practices that are permissive of the practice of involuntary sterilization must be confronted and transformed, and medical providers who perpetrate these human rights violations and breaches of medical ethics must be held accountable.

CRediT authorship contribution statement

Deborah Ottenheimer: Conceptualization, Methodology, Formal analysis, Resources, Writing – original draft, Writing – review & editing. **Zoha Huda:** Data curation, Formal analysis, Writing – original draft. **Elizabeth T. Yim:** Data curation, Formal analysis, Writing – original draft. **Holly G. Atkinson:** Conceptualization, Methodology, Formal analysis, Resources, Writing – original draft, Writing – review & editing, Visualization, Supervision, Project administration.

Declaration of competing interest

None.

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Appendix A. Supplementary data

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