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Involuntary sterilization among HIV-positive Garifuna women from Honduras seeking asylum in the United States: Two case reports

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ABSTRACT

Voluntary sterilization is one of the most widely used forms of contraception by women worldwide; however, *involuntary* sterilization is considered a violation of multiple human rights and grounds for asylum in the United States. Women have been disproportionately affected by this practice. We report two cases of involuntary sterilization in HIV-positive Garifuna women from Honduras who sought asylum in America and were medically evaluated at the request of their attorneys. Key lessons can be drawn from these cases with regard to the importance of medical evaluations in establishing persecution. These include the need for a detailed account of the events surrounding sterilization, radiologic proof of tubal blockage if at all possible, and confirmation of significant and enduring mental distress as a result of the involuntary sterilization. Immigration attorneys and medical evaluators need to be attuned to the possibility of a history of involuntary sterilization among at risk women seeking asylum in the United States.

1. Introduction

Sterilization is one of the most widely used forms of contraception around the world.¹ When provided with full, free and informed consent, sterilization is a safe and effective means of controlling fertility.² However, when sterilization is involuntary – either coerced or forced¹ – it is considered a violation of a number of fundamental human rights, including the right to health, the right to information, the right to privacy, the right to decide on the number and spacing of children, the right to found a family, the right to be free from discrimination.^{3,4} It is also a grave breach of medical ethics.⁵ In some countries (including in Asia, Europe and Latin America), coercive sterilization has been used as a means of population control, targeting certain groups, including people living with HIV, people living in poverty, transgender people, ethnic or racial minorities, and women and girls with disabilities.⁴ Women and girls with intellectual disabilities have been, and continue to be, particularly targeted by the practice of forced sterilization.^{6–8} Overall, women have been disproportionately affected by involuntary sterilization and often face discrimination based on a number of intersecting grounds, including gender, disability, ethnicity/race, and HIV status.³

Numerous reports have documented that women living with HIV (WLHIV) in Africa, Asia, Central America and South America have

undergone coerced or forced sterilizations.⁹ In some cases, women agree to undergo sterilization based on lack of information or on misinformation purposely provided to them by healthcare providers about their choices. In other cases, women have been coerced to sign consent forms for sterilization procedures as a condition for receiving medical care, including medication for HIV treatment, ongoing prenatal services, or obstetrical care during labor and delivery.⁹ Forced sterilization has been practiced during cesarean delivery without women knowing.^{10,11} There are also reports of parents or spouses giving consent to sterilize women without their knowledge or consent.¹²

The practice of coerced or forced sterilization has been well documented in a number of Central and South America countries, including the Dominican Republic,¹³ Venezuela,¹⁴ Chile,¹⁰ El Salvador, Honduras, Mexico and Nicaragua.¹⁵ Kendall and Albert, in a 2015 study of 285 women living with HIV from four Central American countries (El Salvador, Honduras, Mexico and Nicaragua), found that about 25% reported that their healthcare providers pressured them to undergo sterilization.¹⁵ Women who were either diagnosed with HIV during prenatal care or had a pregnancy after diagnosis were almost six times more likely to be pressured by their healthcare providers to undergo the procedure. To coerce sterilization, healthcare providers reportedly told the women that their HIV status annulled their right to choose their

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¹ Coerced sterilization occurs when misinformation, intimidation tactics, financial incentives, or access to health services or employment are used to compel an individual to accept the procedure. Forced sterilization occurs when a person is sterilized without her or his knowledge or without informed consent. Source: Open Society Foundation. *Against her will: forced and coerced sterilization of women worldwide*. New York: Open Society Institute; 2011.

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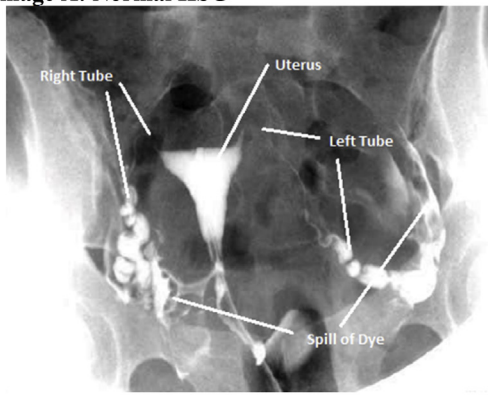


| Hysterosalpingograms | Radiographic Findings |
|--|--|
| <p>Image A: Normal HSG</p>  <p>Labels: Right Tube, Uterus, Left Tube, Spill of Dye</p> | <p>Image A</p> <p>Findings show a normal HSG. The uterine cavity is filled with delineation of the both fallopian tubes, including the fimbriated ends. The contrast dye is shown spilling into the intra-abdominal cavity, indicating patency of the both tubes.</p> |
| <p>Image B: HSG of Ms. A</p>  | <p>Image B</p> <p><u>Findings:</u> The right fallopian tube fills almost completely to the fimbriated end. The distal ¼ of the tube is dilated suggesting a mild hydrosalpinx. There is no intra-peritoneal spill of contrast from the right tube. The left fallopian tube is foreshortened, however it is normal in caliber. There is no evidence of intra-peritoneal spill on the left. <u>Impression:</u> Capacious uterine cavity, multiple persistent filling defects in the endometrial cavity suspicious for polyps. Bilateral tubal obstruction. The fimbriated end of the right tube is dilated compatible with a mild hydrosalpinx. The left tube is foreshortened and has a blunted end.</p> |
| <p>Image C: HSG of Ms. B</p>  | <p>Image C</p> <p><u>Findings:</u> Approximately 2.5 cm of the right tube fills and demonstrates a blunted end and is suspicious for a previous salpingectomy. The left fallopian tube fills for approximately 4 cm however there is no evidence of spill from the left tube. There is venous intravasation of contrast seen bilaterally, however around the left tube there is lymphatic intravasation. <u>Impression:</u> Capacious uterine cavity. Probable bilateral tubal ligations. There is venous and lymphatic intravasation bilaterally.</p> |

Fig. 1. Images A, B & C: Compared to normal findings on hysterosalpingogram (Image A), HSGs studies on both Ms. A (Image B) and Ms. B (Image C) revealed bilateral tubal obstructions, substantiating their history of involuntary sterilization. *Images provided courtesy of Richard Katz, MD of East River Medical Imaging, PC, New York, NY.*

contraceptive method as well as the number and spacing of their children; used misinformation about the consequences of a subsequent pregnancy on the women's and children's health; and initially denied them medical services necessary to prevent vertical HIV transmission. Healthcare providers also sometimes undertook sterilizations during cesarean delivery without the women's knowledge.

In Central America, Honduras has the highest concentration of HIV/AIDS cases with an estimated adult HIV prevalence of 1.5%.¹⁶ Recently, the HIV/AIDS epidemic has intensified along Honduras' northern coast, particularly affecting the Garifuna, an ethnic minority group of African descent, who have a reported prevalence of 8%.¹⁶ The Garifuna are widely discriminated against and have suffered ongoing systemic human rights violations and abuses—including issues related

to land rights, housing, water, health care and education, as well as attacks and intimidation in reprisal for their efforts to defend their human rights—by the Honduran government.^{17,18} Honduran women, despite the enactment of national laws that accord them the same legal rights and status as men, still experience extensive discrimination and are subject to various forms of violence and violations of their sexual and reproductive rights.^{17,19} In particular, Garifuna women face multiple forms of discrimination across all aspects of social, political and economic life.^{18,20} Garifuna women who are living with HIV (WLHIV) suffer the additional burden of stigmatization and discrimination.

We report two cases of involuntary sterilization in HIV-positive Garifuna women from Honduras who sought asylum in the United States and were medically evaluated at the request of their attorneys.

2. Case reports

2.1. Case 1

2.1.1. History

Ms. A, a 34-year-old woman of Garifuna descent, came to the US from Honduras in 2014 to escape extreme discrimination based on her ethnicity and HIV-positive status, and her inability to obtain appropriate medical care, as well as in hopes of reversing her involuntary sterilization. Since her arrival in the U.S., Ms. A has been taking antiretroviral medications and her HIV disease has subsequently improved on all measures.

Ms. A contracted HIV at age 17 from her first sexual partner Mr. X, and was diagnosed at age 22 when she became symptomatic. Mr. X knew he was HIV + when he began his relationship with Ms. A, but chose not to tell her and did not use condoms. Ms. A went to the local doctor after showing signs of extreme weight loss, at which time testing revealed her HIV + status. Prior to exhibiting weight loss, Ms. A had noticed intermittent fevers, recurrent skin rashes and vaginal symptoms consistent with candidiasis. Ms. A reports she had great difficulty in obtaining proper care for her HIV disease. She was often unable to afford the medications or tests for frequent monitoring and, as a result, received only intermittent treatment. Ms. A reports she was unable to finish high school and was repeatedly denied employment based on widespread discrimination against WLHIV in Honduras.

In 2011, Ms. A met Mr. G. He was HIV negative and aware of Ms. A's HIV + status. Nonetheless, he did not use condoms during sexual intercourse, and Ms. A became pregnant. Ms. A continued to struggle to afford antiretroviral medications, and travelled for several hours each week to obtain medical care. Ms. A had scheduled a cesarean delivery with her usual clinic provider, however she went into early labor. She went to two local hospitals before finding one that was equipped to do a cesarean section, which was recommended in her case due to unknown viral loads and inadequate access to consistent antiretroviral treatment during pregnancy.²¹ The doctor on duty refused to do the procedure unless she also gave consent for tubal sterilization. In order to protect her child, Ms. A agreed to sign a document while in active labor and under duress, though she was and remains devastated by her sterilization.

2.1.2. Findings

Physical exam was significant only for a well-healed, 8-cm vertical, infra-umbilical scar consistent with her history of cesarean section. Hysterosalpingogram confirmed bilateral tubal blockage (see Fig. 1, Image B). Ms. A completed the Hopkins Symptom Checklist-25 (HSCL-25), a widely used screening instrument that measures symptoms of anxiety and depression.²² Individuals with a score of > 1.75 in three domains (anxiety, depression and overall) are considered to be symptomatic. Ms. A had positive anxiety score of 3.1, a positive depression score of 2.47, and a positive overall score of 2.72. On review of her Hopkins 25 responses, she reported a number of symptoms that she experienced either “quite a bit” or “extremely” (choices are recorded on a 4 point scale, 1 = not at all, 2 = a little, 3 = quite a bit, and 4 = extremely). These included: suddenly scared for no reason; faintness, dizziness, weakness; nervousness or shakiness inside; trembling; feeling tense or keyed up; spell of terror or panic; feeling restless or can't sit still; crying easily; feeling blue; and feeling no interest in things.

2.1.3. Defensive case

Ms. A was apprehended at the US border by agents when she attempted to cross without documentation and was placed immediately into removal proceedings. Her defensive case was argued on the grounds of persecution based on race (Garifuna), membership in a particular social group (gender and HIV-status) and political opinion, for having undergone forced sterilization. In Ms. A's trial, the focus was on whether the sterilization process involved “force.” Ms. A testified that it did. The judge granted asylum and the government waived appeal.

2.2. Case 2

2.2.1. History

Ms. B, a 38-year-old woman of Garifuna descent, came to the US from Honduras in 2014 to escape extreme physical and sexual domestic violence. Ms. B contracted HIV from her abusive partner Mr. Y, who she believes knew he was HIV + but failed to disclose his status to her. Ms. B reports that she was diagnosed with HIV at the time of a routine prenatal exam during her second pregnancy. Ms. B faced significant difficulties in obtaining adequate care for her HIV infection because she lacked the money to pay the fees for the required blood tests and antiretroviral medications. In addition, Ms. B faced overt discrimination in the community as a result of her HIV status and was reportedly fired from her job as well.

Upon the advice of her physician due to her HIV status, Ms. B scheduled a cesarean section for the delivery of her son. She describes her experience as follows: “When D was born, I had to go to the ... Hospital to have the child. I told the doctor there that I planned to have at least one more child after D. The doctor said that he could “tie my tubes,” which would be an easily reversible procedure. The doctor had me sign a paper that said that the procedure I would undergo was to tie my tubes. Later, I went to a gynecologist, who told me that the doctor lied and I had actually been sterilized. I talked to other HIV positive women, who said that they had also suffered from the same procedure. The doctors violated our right as women to have children.”

Ms. B was reassured by the doctor that tubal ligation was a completely reversible procedure and that it was in her best interest to avoid a pregnancy in the near future. It was not until she sought care for infertility from a gynecologist in the US, after her arrival in 2014, that Ms. B learned that her sterilization was permanent.

2.2.2. Findings

Physical exam was significant for several scars and a broken tooth consistent with her reported history of severe domestic violence at the hands of her partner. Ms. B was noted to have a well-healed, 7-cm vertical infra-umbilical scar consistent with her history of cesarean section. Bilateral tubal blockage was confirmed on HSG conducted as part of her asylum medical evaluation (Fig. 1, Image C). Ms. B also completed the Hopkins Symptom Checklist-25 (HSCL-25). Ms. L-M had positive anxiety score of 2.8, a positive depression score of 2.4, and a positive overall score of 2.56. On review of her Hopkins 25 responses, she reported a number of symptoms that she experienced either “quite a bit” or “extremely”. These included: suddenly scared for no reason; feeling fearful; faintness, dizziness, weakness; heart pounding or racing; trembling; spells of terror or panic; blaming herself for things; crying easily; feeling blue; feeling lonely; feeling of being trapped or caught; and worrying too much about things.

2.2.3. Defensive case

Ms. B had crossed the US-Mexico border without documents, was apprehended by the authorities and placed in removal proceedings. Her defensive case was argued on the grounds of persecution based on 1) membership in a particular social group (both severe domestic violence and HIV-status), 2) race (Garifuna), 3) political opinion (feminism and forced sterilization), and 4) Convention against Torture. In her testimony before the immigration judge, she relayed her experience of severe domestic/sexual violence, her history of HIV infection and lack of adequate treatment, and her experience of having undergone forced sterilization. The judge issued a short order granting asylum.

3. Discussion

3.1. Hondurans fleeing human rights violations

Over the past several years, the United States has been experiencing a renewed influx of migrants from the Northern Triangle Countries—El

Salvador, Guatemala, and Honduras. Honduras continues to be plagued with serious human rights problems, including corruption, intimidation, and a weak justice system following the 2009 coup, which lead to widespread impunity.¹⁸ Both state and non-state actors (including street gangs, transnational drug cartels and multi-national companies) contribute to the pervasive societal violence. Given the deteriorated conditions in the country, increasing numbers of Hondurans fleeing north have claimed refugee status through the U.S. asylum process. Honduran asylum claims have increased from 1157 in 2011, to 8332 in 2015.²³ According to the 2016 U.S. State Department figures, more individuals had sought affirmative asylum from the Northern Triangle Countries (El Salvador, Guatemala, and Honduras) in the previous three years than the prior 15 years combined.¹⁹ In 2015, Honduras ranked number five in the leading countries of nationality of persons granted either affirmative or defensive asylum: granted claims increased from only 199 in 2013 to 1416 in 2015.¹⁹

While the number of granted claims for Hondurans has increased recently, historically, Honduran claims for asylum have been granted at a much lower rate than those from other countries around the world because the legal framework for asylum claims heavily favors those who have been clearly persecuted by state actors on account of “traditional grounds” such as race, nationality or religion.²⁴ In countries like Honduras where there is a weak rule of law and widespread violence, “proving that an individual has been specifically targeted on account of a particular trait can be difficult, since motives for violence are complex.”²⁴ Because it may be harder for Hondurans to show that they have both a well-founded fear of persecution in their country and are a member of one of the groups protected under the 1980 U.S. Refugee Act, they often have been denied asylum by U.S. courts. A late 2017 analysis of more than 370,000 cases (which excluded defensive cases) heard in all 58 U.S. immigration courts over the past 10 years showed that individuals from Honduras had the highest deportation rates compared to all other countries, at 83.60%.²⁵

3.2. Forced sterilization as grounds for asylum

Forced sterilization has been recognized as grounds for asylum in the United States, having been defined as political persecution in 1996.²⁶ It arose out of the U.S.’s recognition of China’s politically contentious “one child” rule. The American Immigration and Nationality Act (INA), which states a person is eligible for asylum if she/he is a “refugee” as defined by the Act, was amended through § 601 of the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) to include the following sentence:

“For purposes of determinations under this Act, a person who has been forced to abort a pregnancy or to undergo involuntary sterilization, or who has been persecuted for failure or refusal to undergo such a procedure or for other resistance to a coercive population control program, shall be deemed to have been persecuted on account of political opinion, and a person who has a well-founded fear that he or she will be forced to undergo such a procedure or subject to persecution for such failure, refusal, or resistance shall be deemed to have a well-founded fear of persecution on account of political opinion.”²⁷

The amended refugee definition thus created four new, specific categories of refugees in the U.S: persons who have 1) been forced to abort a pregnancy; 2) been forced to undergo involuntary sterilization; 3) been persecuted for failure or refusal to undergo such a procedure or for other resistance to a coercive population control program; and 4) a well-founded fear that they will be forced to undergo such a procedure or subject to persecution for such failure, refusal, or resistance.

Given there may be difficulties in establishing grounds for asylum from populations fleeing generalized violence such as that occurring in the Northern Triangle, it is particularly important to explore the whether or not HIV-positive, asylum-seeking women have experienced involuntary

sterilization. A history of involuntary sterilization may be easily overlooked or completely missed while conducting asylum medical evaluations, especially when the primary legal strategy may focus on membership in social group, defined by gender (e.g., history of severe domestic violence, or feminist beliefs), or on race as grounds for asylum. Many of the women who are fleeing the Northern Triangle have extensive histories of physical and sexual violence,²⁸ and the medical evaluator often focuses the history and physical on the details of interpersonal or social violence, not on the women’s interactions with healthcare providers regarding maternal health services.

3.3. Probing for a history of involuntary sterilization

Medical evaluators need to explore an applicant’s reproductive, obstetrical and surgical history, as well as gather details regarding the interaction with the medical team especially around the time of the applicant’s labor and delivery. It is important to probe for any indications that, first, the woman might have been sterilized and second, whether the procedure was forced or coerced. Forced sterilization allows for an asylum claim to be made solely on the basis of persecution based on political opinion, without having to substantiate other forms of persecution (such as membership in a social group). Further, because the change in law in 1996 made forced sterilization *per se* harm on account of political opinion, these cases probably require less proof of the persecutor’s motivation to harm on account of a protected ground.

A procedure is “forced” within the meaning of the Immigration and Nationality Act 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.²⁹ The threats need not be just physical harm, as “persecution” is not limited to only physical harm.³⁰ “Forced” is a much broader concept that includes being compelled, obliged or constrained by mental, moral or circumstantial means, in addition to possible physical restraint or harm.³¹ However, just using pressure or persuasion to submit to an unwanted action is not “force” unless the harm suffered or feared rises to the level of persecution.³² Thus, if a woman was just given inaccurate or faulty information and then agreed to sterilization, the case might not rise to the level of persecution. However, if she were coerced under abusive circumstances and suffered mental harm, the case may rise to the level of persecution. *Thus, documenting extensive details in a case of involuntary sterilization is paramount in establishing persecution and building a strong case for asylum.*

On history, the evaluator should probe for details about what the applicant, if HIV positive, was told when initially diagnosed with HIV infection. What did healthcare providers tell her about her condition and the availability of HIV care? What did doctors and nurses explain about sequelae, treatments options, and, importantly, were any threats issued? What was the applicant told during prenatal care visits? And what transpired during labor and delivery? Was she required to sign a document, and what was she told would happen to her or her infant if she refused? It is also very important to document any emotional distress suffered by the applicant and any symptomatology she may have had or continues to experience. Evaluators can utilize the Hopkins 25 Symptom Checklist to screen for symptoms of depression and anxiety. In our two cases, both women had evidence of anxiety and depression, although displayed different symptomatology. This highlights that, while anxiety and depression may be present, specific symptoms may vary between individuals and specific symptom patterns are not related to credibility.

If the history suggests the applicant underwent sterilization, the evaluator should consider obtaining a hysterosalpingogram (HSG)² to document it. In both these cases, an HSG was obtained on a *pro bono*

² Hysterosalpingogram (HSG) is a radiologic procedure utilized to investigate the shape of the uterine cavity and the shape and patency of the fallopian tubes. It entails a radiologist injecting radio-opaque dye into the cervical canal and using fluoroscopy with image intensification to create x-ray images of the female reproductive tract.

basis and confirmed bilateral tubal blockages. Images of the radiographic studies can be included as appendices in the medical affidavit, as they were in these two cases.

4. Conclusion

Clinicians conducting asylum evaluations for women seeking asylum need to be alert to the possible history of involuntary sterilization, particularly in HIV-positive women from marginalized and oppressed ethnic groups. Suspicion of sterilization should be documented with a hysterosalpingogram if at all possible; the events surrounding the involuntary sterilization, particularly the interactions with the healthcare provider(s), should be explored in detail during the history taking; and the psychological harm suffered by the asylee should be accessed and clearly recorded in the affidavit. Attorneys should be attuned to the history of involuntary sterilization as well, and communicate any suspicion of such to medical evaluators. Given that involuntary sterilization has been established in US law as grounds for asylum based on political opinion, documentation of such an experience may strengthen both affirmative and defensive cases of individuals seeking immigration relief in the United States.

Declarations of interest

None.

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