

The forced sterilisation of Indigenous and racialised Peoples: Origins, nature of abuses, impacts and responses

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Abstract

Purpose – This paper aims to draw attention to the global infringement of reproductive rights of Indigenous and racialised Peoples.

Design/methodology/approach – Narrative literature review. Description and comparative analysis of examples of forced sterilisation.

Findings – Large-scale sterilisation campaigns were identified in three different regions of the world: North America, Latin America and Europe. Within these, hundreds of thousands of Indigenous and racialised Peoples have been forcibly sterilised as part of state-sponsored procedures, predominantly aimed at women and gestating people. These abuses are continuing in the 21st century and have origins in “racial science” theory. The exact nature of the abuses is identified alongside the long-term health and wellbeing implications. Professional attitudes and behaviours that condoned such practices within healthcare settings are identified. The psychological, social and cultural impact of such practices, including on Indigenous body sovereignty and self-determination, are demonstrated.

Practical implications – These are twofold: firstly to eradicate any future practice of forced sterilisation and secondly to provide reparations to those affected.

Originality/value – The analysis brings together scholarship from Indigenous studies alongside that of health and social sciences.

Keywords Colonial, Fertility, Forced, Genocide, Indigenous Peoples, Impacts, Prevention, “Racial science”, Racialised, Romani Peoples, Reproductive rights, Sterilisation

Paper type General review

Introduction

This paper focuses on the phenomenon of forced sterilisation of Indigenous and racialised Peoples. The communities affected share a common experience of being considered “subhuman” by socially dominant groups (Rutherford, 2020) and “in need of” having

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their fertility rates reduced. “Racial science” and eugenics have been used to support and perpetuate white supremacy rhetoric (Rutherford, 2020). In most cases, colonial-era relations of possession, exploitation and exclusion have shaped the policies and methods related to these communities’ reproductive matters (Carranza Ko, 2019). Indigenous body sovereignty is a central theme in anti-colonial and pro-Indigenous movements. Power systems inscribe Indigenous bodies with “re-presentations” and expectations that are racialised, sexualised and body sizeist, which prohibits access to health services (Gillon, 2020). Recognising Indigenous sovereignty at the body level is one way to resist colonial subjugation of Indigenous Peoples.

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Words have political meanings; they define and redefine power relations (Freeman, 2011). As unwilling subjects of (neo)colonial practices, Indigenous Peoples have claimed English to exercise linguistic sovereignty (Neuhaus, 1999). The language in this paper is used cautiously acknowledging the dynamic and evolving landscape, anti-colonial theory and practice and Indigenous health and rights. We have adopted the term “Indigenous Peoples” as this term is identified by Indigenous Peoples for Indigenous Peoples and used by the United Nations (UN). There is no official definition of Indigenous, rather the UN identifies a number of characteristics (characteristics of Indigenous Peoples):

- Self-identification as Indigenous Peoples at the individual level and accepted by the community as their member.
- Historical continuity with pre-colonial and/or pre-settler societies.
- Strong link to territories and surrounding natural resources.
- Distinct social, economic or political systems.
- Distinct language, culture and beliefs.
- Form non-dominant groups of society.
- Resolve to maintain and reproduce their ancestral environments and systems as distinctive Peoples and communities.

We also include Roma communities alongside Indigenous Peoples because they meet many of the UN characteristics of Indigenous Peoples, certainly the fourth, fifth and sixth bullet points above (Permanent Forum on Indigenous Issues, 2018). Both Indigenous and Romani Peoples have experienced state disenfranchisement and colonial dispossession of land and place resulting in poorer health equity.

Forced sterilisation is the involuntary or coerced removal of a person’s ability to reproduce, usually through a surgical tubal occlusion procedure. While forced sterilisation has been carried out against Indigenous men (Sanchez-Rivera, 2022), and members of many other oppressed communities (Rowlands & Amy, 2018), the majority of such abuses have been against Indigenous and other racialised women and gestating people [1]. When a particular racial or religious subset of the population is targeted and measures intended to prevent births within the group are imposed, this is legally defined as an act of genocide (UN, 1948).

While Taiwan remains the only jurisdiction with active eugenic laws (Chou & Lu, 2011), there are several countries with ongoing population control policies and forced sterilisation practices (Rowlands & Amy, 2018). Given the persistent and pervasive nature of these practices, we have focused this paper on events of the last 50 years. We have adopted a historical lens only when required to contextualise contemporary practices. Documented cases have come to public attention only because of complaints

or litigation from survivors (Carranza Ko, 2019; Stejskalová & Szilvási, 2016; SSCHR, 2021). For individuals who have been sterilised, often the only way to pursue future pregnancy is by surgery to reverse sterilisation or assisted reproductive technology (ART) such as *in vitro* fertilisation (Tamblyn & Jeve, 2022). In some cases, hysterectomy (removal of the womb) has been performed without medical indications (Carpio, 2004) and pregnancy can only be achieved with the assistance of ART and a gestational carrier (DHSC, 2024). These options may be inaccessible to many people due to financial, geographical, or political barriers.

The overarching aim of this paper is to name and understand the shared perspectives and power structures which contribute to forced sterilisation globally. We hope that our analysis provides readers with an appreciation of the impact of such programmes, the tools to reflect upon local practices and policies and the will to protect against the continued use of sterilisation as an act of genocide. We also hope that survivors will receive acknowledgements, apologies and reparations.

Methodology and findings

This study was conducted using narrative literature review methodology. Subsequently, comparative analysis was undertaken, using an interdisciplinary approach, of affected communities in the regions where there was convincing evidence of forced sterilisation. Search terms used were forced or coerced sterilisation and Indigenous or racialised or Roma Peoples. Ethics committee approval was not required as the communities that are the subject of the review were not interviewed directly; their voices are heard through existing published studies. All evidence drawn upon is in the public domain. Definitive evidence of forced sterilisation of distinctions-based Indigenous and racialised Peoples was found in three continents only: North America, Latin America and Europe.

“Racial science” theory and eugenic practice as rationale for forced sterilisation

The origins of “racial science” can be traced back to Gregor Mendel and his principles of inheritance, founded on the effects of crossbreeding flowers of colour. The idea of influencing the inheritance of traits was further developed by 19th and 20th-century geneticists and physical anthropologists such as Charles Darwin. During the period of “exploration and discovery”, phenotyping was a well-established practice, guided by the Doctrine of Discovery (Tomchuk, 2022) which asserted that European Judeo-Christian cultures were superior.

“Racial science” was borne from the physical and social phenotyping of the Indigenous Peoples encountered during this time. Francis Galton, known for coining “nature vs nurture”, authored two manuscripts proposing a hierarchy of races ranked according to their level of “civilization”. He introduced the term “eugenics”: improving the human race through selective breeding. Nineteenth-century “scientists” fabricated a classification of the human species: race. They based this classification on social constructs but labelled it as science. Non-white races were then pathologised as a potential congenital disease of the human species: “savagery”. The proposed curative intervention was eugenics. In this paper, racialisation is defined as the intention to systematically construct ethnic or racial identity in a society and the processes through which that happens.

In 1950, after World War II and the passage of the 1948 Universal Declaration of Human Rights, the United Nations Educational, Scientific and Cultural Organization (UNESCO) produced a statement to clarify the scientific basis of race (Gil-Riaño, 2018). This statement

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post-dated the establishment of the convention on the prevention and punishment of the crime of genocide as a response to the Holocaust (UN, 1948). Despite UNESCO's efforts to show that race was socially constructed, biological racial categories continue to be positioned as "true science" (Arvin, 2019). The arguments in the UNESCO statement can now be dismissed as racist pseudoscience (Arvin, 2019). Contemporary ideas about race continue to be influenced by that "science" even though the study and practice of science itself is socially constructed (Rutherford, 2020). Regrettably, these racial categories, including Indigenous Peoples, continue to inform contemporary medical science and public policy. Race and Indigenous status, in particular, until only recently were listed as risk factors for disease in frameworks such as that of the World Health Organization (WHO, 2008) and continue to be present in the Government of Canada's social determinants of health (Public Health Agency of Canada, 2024).

According to eugenics practice, women are viewed as responsible for "reproducing the race", both in a biological sense and in their role as reformers and child raisers (Stote, 2015). For this reason, at the intersection of race and gender, it is Indigenous women who were, and are, disproportionately targeted for forced sterilisation, most often by way of tubal occlusion.

The magnitude to which forced sterilisation has occurred globally is unknown. Cases of forced sterilisation are likely under-reported for reasons that stem from the ongoing oppression and marginalisation of targeted groups (Boyer & Bartlett, 2017).

Antecedents to large-scale forced sterilisation

Forced sterilisation continues to be orchestrated at state level (Carranza Ko, 2023). Colonial sociopolitical constructs such as states create and implement policies at a macro level. Population control policies target, and further oppress communities deemed to have higher than desired fertility rates and are often purported to have beneficial effects (Rowlands, 2022). For example, the Fujimori regime in Peru maintained that sterilising Indigenous women would alleviate their poverty (Rousseau, 2007) and state social services directives incentivising sterilisation in the former Czechoslovakia were promoted as "socio-prophylactic" measures (Stejskalová & Szilvási, 2016). In settler Canada, there are vestiges of the eugenic laws repealed in the early 1970s and of colonial thinking among clinicians (Stote, 2015). While there are no eugenic policies remaining, practices of intimidation, harassment and psychological pressure resulting in forced sterilisation continue (Boyer & Bartlett, 2017).

Turtle Island (settler North America)

Many thousands of Indigenous and racialised women across Turtle Island have been forcibly sterilised (Stote, 2015; Carpio, 2004; SSCHR, 2021). These abuses are set within a context of widespread sterilisation of people with intellectual disability, the poor, racialised communities and prisoners from the early 20th century onwards (Amy & Rowlands, 2018a). Thousands of Puerto Rican, African-American, Chicana/o (Tajima-Peña, 2016) and Native American Peoples were sterilised in the USA in the 1960s and 1970s. Here we provide an overview of the settler US cases and dive deeper into events in settler Canada.

South Turtle Island (settler United States)

Turtle Island was home to many Indigenous Peoples for thousands of years before the arrival of the Europeans in 1492. Violence against Indigenous women became a

central element in the colonial strategy for conquest and genocide (Green, 2017). The ongoing legacy of forced sterilisation of Indigenous women and gestating people within settler USA was founded on the unethical “scientific” experimentation on black enslaved people and their descendants. Black enslavement survivorship of ongoing white supremacy is well articulated elsewhere by those with lived and living experience (Washington, 2006). Briefly, dangerous involuntary and nontherapeutic experimentation upon African–Americans have been documented at least since the 18th century (Cooper Owens, 2018). Indeed, the first Women’s Hospital in the USA was on a slave farm in Mt. Meigs, AL (Cooper Owens, 2018). From 1844 to 1849, about 12 enslaved women and girls lived and worked in this establishment founded by Dr James Marion Sims, later dubbed the “Father of American Gynecology” (Cooper Owens, 2018).

This theory and practice of “racial science”, racial experimentation and forced sterilisation made the settler USA an international leader in eugenics. Harry Laughlin’s “Model Eugenical Sterilization Law” (Laughlin, 1922) was adopted by 33 US states and provided the foundation for the Third Reich’s 1933 “Law for the Prevention of Offspring with Hereditary Diseases”. Under this law, the Nazis sterilised approximately 400,000 children and adults, mostly Jews, Romani Peoples and other “undesirables”, labelled “defective” (Amy & Rowlands, 2018b). All this resulted from the practice on and research into racialised, enslaved bodies.

Within 21st-century settler USA, Indigenous women still have higher rates of sterilisation than other racial groups (Shreffler et al., 2015) – a telling case of how colonial policies continue to exist. Control over Indigenous women’s bodies and reproduction was “central to European objectives from the first days of conquest” (Theobald, 2019) and closely associated with policies of assimilation, shrinking of tribal lands, restriction of movement and the subjugation of Native American Peoples. These “unique cultural and social realities” associated with colonial policies rendered Native American women “easier targets than other minorities” (Torpy, 2000).

North Turtle Island (settler Canada)

In settler Canada, federal colonial policies and provincial eugenic laws provided the foundation for historical and ongoing practices of forced sterilisation (Stote, 2015). The only two provinces to pass legislation on sterilisation were Alberta and British Columbia (BC). Both of these Sexual Sterilization Acts cited “mental deficiency” as the key diagnosis and justification for forced sterilisation (Amy & Rowlands, 2018a). The Charles Camsell Indian Hospital, a racially-segregated, federally funded hospital specifically for Indigenous patients, was a disproportionately active site for sterilisation. Between 1928 and 1972 when the Alberta Act was in effect, over 1,500 women were sterilised, with Indigenous women disproportionately targeted (Grekul et al., 2004; Stote, 2015; Black, Rich, & Felske-Durksen, 2021). A 1937 amendment to the Act removed the need for consent from the patient or their family, and effectively gave the Eugenics Board complete power over such decisions (Stote, 2015; Grekul, Krahn, & Odynak, 2004). The BC Sexual Sterilization Act also cited industrial, now termed residential schools (federally funded, segregated schools for Indigenous children which are now known to be sites of genocide), as qualified locations for the assessment of intellectual disability, one of the diagnoses considered to be an indication for sterilisation under the Act. There is also evidence that sterilisation was carried out on Indigenous women from 32 different northern settlements in the 1970s (Stote, 2012). It is estimated that in 1976, 26% of all Inuit women between the ages of

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30 and 50 in Igloodik, Nunavut, were sterilised (Boyer & Bartlett, 2017). The consent forms used in Northern Canada at that time were inadequate to convey proper information about sterilisation to Indigenous women who had no experience with Western medicine (Stote, 2015).

Between 2005 and 2010, many Indigenous women and gestating people in the province of Saskatchewan reported they were forced into sterilisation around the time of childbirth (Rowlands & Wale, 2019). An independent review ordered into the circumstances of these sterilisations (Collier, 2017) identified themes of healthcare provider abuse of power, feelings of patient powerlessness and experiences of discrimination (Boyer & Bartlett, 2017).

The Canadian Senate Committee on Human Rights began hearings from experts and advocates on forced sterilisation in 2019 and released two reports (SSCHR, 2021; SSCHR, 2022). Evidence from these hearings demonstrates that forced sterilisation was continuing as recently as 2018 in six settler provinces and two territories. The Senate Committee made 13 recommendations, including the criminalisation of forced sterilisation, a governmental apology to survivors, creation of a compensation framework, development of professional standards to respond to complaints of forced sterilisation, and the production of a research agenda to fully understand the extent of forced sterilisation. A report from Quebec indicates forced sterilisation has been happening there as recently as 2019 (Basile & Bouchard, 2022).

Abya Yala (settler Latin America)

Violence directed against Indigenous Peoples became a recurrent theme after the arrival of Spanish colonists (Carranza Ko, 2019). There have been sterilisations targeting Indigenous women in many parts of Latin America (Carranza Ko, 2021), most recently in Peru following the governmental campaign to forcibly sterilise Indigenous Peoples (Carranza Ko, 2020). In the midst of the internal armed conflict, thousands of Peruvians, mostly poor Indigenous Peoples living in remote Andean or Amazonian areas, underwent compulsory sterilisation in the context of the *Programa de Salud Reproductiva y Planificación Familiar* or Programme of Reproductive Health and Family Planning (PSRPF) set up by the regime of President Alberto Fujimori in 1995. The government noted that fertility rates in rural areas were twice those in urban areas (Boesten, 2007). The rationale of the PSRPF was the pretext of achieving the goals of promoting reproductive health to a “higher quality” for all inhabitants (Ministerio de Salud, 1996), with the broader underlying objectives of social development and the eradication of poverty through lower birth rates (Mooney, 2010; Rousseau, 2007). Fujimori’s speech during the 1995 Beijing Conference on Women expounded these ideas about providing access to obstetric services and information on family planning (UN Women, 1995). The underlying objective, however, was to decrease birth rates of women and gestating people who were considered “undesirable” by the government (Carranza Ko, 2020).

The enormous scale of the sterilisations over a six-year period is difficult to comprehend. Between 1996 and 2001, 272,028 female sterilisations were performed (DDP, 2015); of these, the majority were forced on Indigenous Peoples. Those affected were mainly Quechua-speaking Indigenous Peoples, followed by the Aymaras, Shipibos and Ashaninkas, many of whom are illiterate and speak their Indigenous languages rather than Spanish (DDP, 2015). Government-led “Health and Fertility Festivals”, aimed at promoting sterilisation as the optimal family planning choice, were held across poor rural communities where most inhabitants were Indigenous.

In the first year of the programme, misinformation, coercion and entrapment were rife (Carranza Ko, 2020). Ministry of Health officials issued sterilisation quotas to doctors in

rural areas, with financial incentives to meet the quotas; the numbers were monitored by the central government. An independent report described 243 cases and concluded that most of the operations violated human rights (CLADEM, 1999). The operations were often performed on stressed individuals, sometimes while they were pregnant, without valid consent and with the promise of a reward, such as food or future medical care (Onamiap, 2017).

Oftentimes, the anaesthesia administered was inadequate (Kovarik, 2019), either because of poor practice or deficient supply chains. The operations were frequently performed in unsanitary conditions (Serra, 2017) without postoperative follow-up. Indigenous Peoples were locked inside waiting rooms until they submitted to surgery (Theidon, 2015). Sometimes women were told, falsely, that the operation was reversible; in some cases, husbands who feared vasectomies signed consent for their wives' tubal ligation (CLADEM, 1999, Quipu Project, 2022). People were threatened that if they declined surgery, their children would be denied access to healthcare, their newborns would not be registered and they would be fined (CLADEM, 1999). At times, they were also threatened using misinformation, with healthcare professionals falsely claiming that having more than five children was illegal (IACHR, 2003).

Europe and Central Asia

Romani Peoples have lived in Europe and Central Asia since at least the 14th century. During the Holocaust, the Nazi regime conducted a genocidal campaign against Romani and Sinti Peoples called the *Samudaripen* – this Romani term meaning “mass murder” was coined in the 1970s (Fings, 2024). The forced sterilisation of Romani Peoples is set in the context of eugenic population control policies practised from the beginning of the 20th century in Germany, Austria, Sweden, Switzerland and Norway (Curran, 2016; Stejskalová & Szilvási, 2016). In some Central and Eastern European countries, the practice still continues: countries involved since 1970 include the former Czechoslovakia and the subsequently formed Czech and Slovak Republics (Kovac & Hajnal, 2004; Zampas & Lamačková, 2011; Albert & Szilvasi, 2017) and Hungary.

From 1972, when the country was still part of the Soviet bloc, the former Czechoslovakia carried out a programme of state-supported sterilisation, targeting predominantly Romani women and gestating people (Albert, 2023). The strict consent requirements of the 1971 Sterilisation Directive, which included examination of cases by a commission, were frequently breached (Stejskalová & Szilvási, 2016). In 1973, internal guidelines were introduced that allowed a one-off payment for “certain medical treatments in the interest of a healthy population”, which included sterilisation (Stejskalová & Szilvási, 2016). These guidelines were used by welfare officials and healthcare professionals to target Romani Peoples.

Payments were offered as a reward for becoming a sterilisation candidate (Braun et al., 2014); in 1988, under a new Sterilisation Incentive Decree, these payments were increased fivefold. Affected individuals were also threatened with potential loss of employment, withdrawal of welfare benefits (for the individual and their partner) and institutionalisation of any children for declining sterilisation (Stejskalová & Szilvási, 2016). Although Romani women were not always defined in official documents as a target group in ethnic terms, they were targeted by proxy, due to living in poverty and having more than three or four children. Furthermore, the local instructions given to health and social care workers made it implicitly clear that these state-backed policies were primarily aimed at Romani women (Albert & Szilvasi, 2017).

During the two decades following the issuing of the directive, 37% of the sterilisations performed were on Romani women who comprised less than 2% of the general population (Albert & Szilvasi, 2017). In 1989, of 803 people who were financially rewarded for undergoing sterilisation, 419 were Romani women (Motejl, 2005). The benefit programme was suspended in 1991. Nevertheless, forced sterilisations continued through the Velvet Revolution of 1989 and after the 1993 division into the Czech and Slovak Republics (Albert, 2023).

Czech obstetricians “automatically” sterilised women and gestating people having a second caesarean section without proper discussion in advance (Stejskalová & Szilvási, 2016). Romani women were also sterilised immediately after their first and only caesarean section, or after normal delivery, or on the pretext of allegedly needing a “tumour” removed (Health Ministry, 2024). Romani women were sometimes misinformed that sterilisation is a “temporary measure”. There are also reports of medical staff forging patients’ signatures on consent forms and coerced consent (Motejl, 2005).

In most cases, it has only been because of survivors’ courage and assistance from advocates and allies that there has been any public or judicial recognition of these consent abuses (Albert, 2023). In Slovakia, since the fall of communism in 1989, at least 110 cases of forced sterilisation have been documented; similar testimonies to those of Czech Romani women have been obtained (Zampas et al., 2003). Several Slovak and Czech court cases had to be taken to the European Court of Human Rights to secure justice (Stejskalová & Szilvási, 2016). The last known case in Slovakia was in 2002 (OSCE, 2016). The last alleged case in the Czech Republic dates to 2018 (Centre for the Victims of Involuntary Sterilization in the Czech Republic, 2022).

Comparative analysis and discussion

Medical providers’ agency within eugenics

We include here the agency of individuals in the medical profession and the collective agency of bodies such as regulators and universities. The campaigns mentioned above have a number of factors in common including the identification of individuals/groups as “inferior”, lack of respect for those targeted, incentivisation of potential candidates and/or health and social care professionals, threats of repercussions if the procedure was not agreed to, deficient consent processes, lack of capacity for language interpretation/translation, misinformation/disinformation and poor/unethical standards of healthcare and medical facilities. In extreme cases, operations were carried out under false pretences.

Slovak doctors and nurses are known to have negative, stereotypical attitudes about Romani women including notions of hyperfertility, hypersexuality and inability to care for children (Zampas et al., 2003). Peruvian healthcare professionals have similarly negative attitudes towards Indigenous women, influenced by colonial perspectives about ethnicity, namely the hierarchical understanding of ethnic groups that were non-European as being of lower status, intersected with views about class and gender (Carranza Ko, 2019). Medical follow-up care following sterilisation was rare. Peruvian nurses and doctors disregarded complaints from Indigenous women about their pain, seeing them as the “producers of poverty” whose ethnic and gender identity rendered them “unequal” to non-Indigenous Peruvians (Carranza Ko, 2019). While the settler Canada provinces other than Alberta and BC did not write their eugenics practices into legislation, it is known that anti-Indigenous bias exists among Canadian physicians (Roach et al., 2023) and that eugenics programmes across the country were sanctioned by the Colleges of Physicians and Surgeons, Ministries of Health and local Faculties of Medicine (SSHRC, 2023).

Slovak obstetricians performed a disproportionate number of caesarean sections on Romani women, providing surgeons easy access to their fallopian tubes (Zampas et al., 2003). Some of these operations were performed with a classical (vertical) incision which results in a higher risk of uterine rupture during a future pregnancy (Zampas et al., 2003). This lent weight to the often-used argument that a sterilisation was “necessary” because of the high risk associated with a future pregnancy and labour.

Many of these processes operating at structural and cultural levels influenced individual practices. For example, structural-level practices were apparent in Peru, where the PSRPF required health officials to meet obligatory sterilisation quotas (Carranza Ko, 2020). When these quotas were achieved, there were monetary rewards for the officials; when not, there were threats of sanctions and denials of promotion. On occasion, to meet quotas, fellow health workers recruited each other to undergo sterilisation (Carranza Ko, 2020). Medical facilities that achieved their quotas were rewarded with medical equipment. In former Czechoslovakia, social workers’ performance in recruiting candidates for sterilisation was measured by the number of women from whom they managed to obtain “consent” (Marks, 2017).

Bias within medical institutions contributed to the practice of forced sterilisation in settler Canada (Black et al., 2021), and we argue that this cultural-level bias was likely operating in all the countries involved. Furthermore, differing worldviews on reproduction and family size are other likely sources of bias, as all the communities targeted value “large” family sizes. In the former Czechoslovakia, different communist-era discourses constructed images of Romani Peoples as “abnormal” to exert social control not just over them, but over society as a whole; these images then facilitated discriminatory treatment of the Czechoslovak Roma under the guise of caring for their social welfare, including their forced sterilisation (Sokolova, 2008). Whether these cultural-level biases are a result of true cultural ideological approaches as opposed to a masked colonial agenda of maximising access to land, resources and economy by way of minimising competing populations is difficult to say.

The uncomfortable truth is that health and social care professionals have been active or complicit in translating oppressive government policies into action at local level (Rutecki, 2011). We question whether the incentivisation of professionals can be considered a valid reason for carrying out sterilisation in the absence of free and informed consent. Certainly, threats of sanctions and denials of promotion put such professionals in an invidious position. However, this does not justify them acting unethically and failing to follow professional guidance on consent. It certainly does not justify professionals becoming international leaders in the development and delivery of such oppressive government policies (Whitman, 2017).

Indigenous access to informed consent and informed refusal

Healthcare professionals have ethical obligations towards their patients, including respect for their autonomy, non-maleficence, beneficence and justice (Beauchamp & Childress, 2019). Decisions with permanent, life-changing and acutely personal outcomes require health and social care professionals to take special care. Sterilisation not only removes a person’s reproductive potential, but may also create a stigma, or create or perpetuate a value judgement on their worth within society.

We have found evidence of healthcare professionals abusing their power, railroading the consent process, using coercion and threats and ignoring language barriers (Carpio, 2004; Stejskalová & Szilvási, 2016; Serra, 2017; Rowlands & Wale, 2019; SSCHR, 2022). In some respects, it seems that health and social care professionals used lower standards when treating Indigenous and racialised people. Yet, they have a professional and moral

responsibility to promote health and wellbeing; they should avoid misusing their power for personal financial gain, knowledge or social authority (Goodyear-Smith & Buetow, 2001) and should not promote political doctrines or ideologies. Within settler Canada, important components of the consent process still lack content and relevance for Indigenous Peoples (Boivin & Machlachlan, 2019). Guidelines on how health is defined, what constitutes consent and how it should be executed are all written from the perspective of a Western worldview (McGrath & Phillips, 2008). In addition to redressing the recurring features outlined above, informed consent must reflect Indigenous ways of sharing knowledge and decision-making: inherently relational as opposed to transactional (Boivin & Machlachlan, 2019). It must be trauma-informed and include a mechanism and process of informed refusal. This recognises Indigenous body sovereignty and capacity for what Michi Sasgiig Nishnaabeg Leane Betasamosake Simpson refers to as “generative refusal” which refuses settler-colonial knowledge and practices and insists on re-generating Indigenous knowledge and practice in its place (Betasamosake Simpson, 2021).

The meaning of fertility and family to Indigenous and Romani Peoples

In many Indigenous cultures, women have long held a position of equal authority within the community, and in some they guide the community, reflecting the knowledge and experience of creating life and this connection to the land. Coloniality, patriarchy and gender violence were (and are) used to subjugate and disempower women – ubiquitously removing half the knowledge and skillset required for diplomatic proceedings during contact and treaty signing. This served the colonial agenda, which was bolstered further by eugenics programmes once the nation-state established segregated healthcare for Indigenous Peoples (Green, 2017).

Common Indigenous reproductive knowledge and practice within settler Canada centres around linking creation, water, land, air and the concepts of connection, continuity and perpetuity. Children are fundamental to the Native American kinship system (Killsback, 2019). Among the Navajo, the largest Native American group, a girl’s first menstruation is a time for public rejoicing; women are powerful symbols of life, growth and rejuvenation (Stone, 2018). A Mohawk woman reports that “women are the base of the generations. Our reproductive power is sacred to us” (Lawrence, 2000). A Lakota woman described her urge to procreate “as if driven by a feeling that I, personally, had to make up for the genocide suffered by our people in the past” (Lawrence, 2000). Family is also central in Romani communities; often there are traditional family roles with women having children and looking after the family home (Heaslip et al., 2016). If women become deprived of the ability to perform this role, it can have long-term mental health outcomes (Stejskalová & Szilvási, 2016).

The importance of female fertility has been described in the following way:

See, my people say that we are all one song. We are born of the same spiritual energy. We are created in its image and we carry it within us. As we walk upon the Earth we move with the same eternal rhythm that beats within it. The heartbeat. The Earth is a drum, a spiritual being, and the beat of it is the first sound we hear in the darkness of our mother’s belly. The drum of her. The heartbeat (Wagamese, 2019).

Consequently, forced sterilisation adversely affects mental and spiritual health and family life.

Psycho-sociocultural impact

Forced sterilisation can have a significant impact on individuals, families and communities. However, caution in reporting this is required; placing too much emphasis on adverse effects can perpetuate existing colonial deficit-based rhetoric present in health literature around

Indigenous Peoples. Nevertheless, we cannot minimise or ignore the violence and gross injustices that have been committed and their significant sequelae. While we, as scholars, will never be able to fully understand the meaning and depth of these atrocities to the people concerned, we have carefully noted the impact on those affected. Peruvian Indigenous women noted a loss of “*ánimo*” or the energy to live both physically and emotionally, resulting in loss of appetite, anxiety, headaches, insomnia and shocks throughout the body (Cuba Corimaita, 2014; Carranza Ko, 2023). Within settler Canada, one forcibly sterilised Indigenous woman reported olfactory flashbacks following her fallopian tubes being diathermied (Boyer & Bartlett, 2017); another reported suicidal thoughts and post-traumatic stress disorder (SSCHR, 2022). Twenty-one Romani women reported loss of sex drive (Stejskalová & Szilvási, 2016) and one Romani woman even had to be admitted to a psychiatric hospital (Stejskalová & Szilvási, 2016). Furthermore, interviews with survivors of forced sterilisation revealed specific changes in accessing healthcare, including avoidance of health services, such as routine health screening, because of mistrust in professionals (Boyer & Bartlett, 2017; Stejskalová & Szilvási, 2016; Lawrence, 2000; Basile & Bouchard, 2022).

Within Indigenous communities, health and illness are related to the collective, referring to the community of Peoples and nature. Thus, postoperative effects of forced sterilisation on the women had a ripple effect in the community. Many Peruvian Indigenous women reported stigmatisation, feeling “marginalised”, equating it to becoming “like disabled people” (Quipu Project, 2022). Some were thrown out of their homes by partners who misinterpreted what had happened to them, arguing that inability to conceive was due to the woman’s promiscuity (Onamiap, 2017). They felt they had been left alone to fend for themselves, without any help (Quipu Project, 2022). Other Indigenous women in established relationships reported a deterioration in those relationships once they knew about the sterilisation (Basile & Bouchard, 2022). Intimate partner violence, separation and divorce were common sequelae (Quipu Project, 2022).

The health, psychological and social implications of forced sterilisation are significant; not only is it a violation of bodily integrity at the point of intervention, but it permanently removes individuals’ reproductive potential. Women are deprived of the possibility of motherhood, which is in itself stigmatising (Gerodetti, 2016) and can result in survivors being isolated and ostracised in society (Rowlands & Amy, 2018). Under some circumstances, women who are unable to conceive have less chance of marrying and so may suffer economic hardship (von Joeden-Forgey, 2010; Ralstin-Lewis, 2005). Forced sterilisation also leads to people feeling traumatised, isolated, helpless and humiliated (Carranza Ko, 2019; Rowlands & Amy, 2018). When the trauma of forced sterilisation is superimposed upon intergenerational trauma suffered by Indigenous Peoples (Fast & Collin-Vézina, 2010), the impact is yet more devastating to individuals and communities.

Intergenerational trauma has been identified within settler Canada Indigenous Peoples (Bombay et al., 2014), Lakota tribes in settler USA (Evans-Campbell, 2008), Holocaust survivors (Danieli, 1985) and the Māori of New Zealand (Pihama et al., 2014). Intergenerational trauma can compound silencing of experiences. Survivors of both remote trauma suffered by their family/community *and* their own personal trauma results in people avoiding talking about their experiences and the related feelings arising from a continuity of trauma. Distress arising from their forced sterilisation exists over and above the well-documented health disparities resulting from ongoing and historical colonial legacies such as problematic substance use, mental health disorders and suicide (Gone, 2013).

In light of these widespread psycho-sociocultural impacts on the women and their families, it is imperative that ongoing professional care and support be provided to survivors.

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However, many of the communities affected have a lower social status, which is why these forced sterilisations were able to occur, and as such we are concerned that systematic, long-term support for the women and their communities may not be forthcoming.

Indigenous body sovereignty and self-determination

12

Assertive actions for sovereignty do not always immediately signal a connection to forced sterilisation resistance, however they are deeply rooted in resistance to the Doctrine of Discovery, its assumption of white supremacy, “racial science” and eugenics. They address the intersections of social determinants of health, which in this context include gender, colonialism, poverty and, social exclusion. These acts of resistance are guided by Indigenous knowledge systems, which often centre on creation and continuity in all its forms. Within settler Canada, such actions and national agents of change against racialised gender violence include marches for Missing and Murdered Indigenous Women, Girls and Gender Diverse and the growing number of Indigenous cis/trans-female-led organisations such as Idle No More and Land Back that recognise the connection between gestation, creation, land and water (Green, 2017). In response to Atikamekw Joyce Echequan’s death, Joyce’s Principle was established by the Indigenous communities; this demands that, at political, social and healthcare levels, Indigenous Peoples’ traditional and living knowledge of health be not only recognised but respected (Shaheen-Hussain et al., 2023).

The ultimate expression of sovereignty is the production of general norms by a body (the *demos*) comprising free and equal individuals who are posited as free subjects capable of self-understanding, self-consciousness and self-representation (Mbembe, 2019). Body sovereignty involves an intersection of identities, power and agency (Gillon, 2020). Often the ways bodies and people are re-presented and gazed upon are dictated by societal and colonial discourses and norms. Indigenous body sovereignty is not a novel concept but one that has been in existence for as long as Indigenous cultures have (Gillon, 2020). It should not be confused with body positivity and autonomy, nor should it be considered to be about individuals’ bodies alone. Body sovereignty is re-asserting and re-presenting original ownership in both rhetorical and literal form. It requires a concerted act of anti-oppression to disempower the colonial structures, attitudes and behaviours to allow space for Indigenous women to reclaim themselves and their Peoples. Indigenous Peoples are creating new political and social spaces of self-determination and collective sovereignty – a fundamental right within the UN Declaration on the Rights of Indigenous Peoples (UN, 2007).

Survivors of forced sterilisation each have their own way of resisting and coping and have demonstrated fortitude, solidarity and resilience in their communities; for example, one woman living in settler USA responded by becoming a family lawyer (Lawrence, 2000). Peruvian women and Czech Romani women have responded to sterilisation abuses by forming nongovernmental organisations and victims’ groups (i.e. the Association of Peruvian Women Affected by Forced Sterilization (AMPAEF), and the Group of Women Harmed by Forced Sterilization) which are active agents of change (Mooney, 2010; Albert & Szilvasi, 2017).

Proposals for prevention and reparation

The International Federation of Gynecology and Obstetrics (FIGO) has drawn attention to the ethical aspects of female sterilisation (FIGO, 2015). WHO and several other UN agencies have also jointly issued recommendations on how non-consensual sterilisation can be eliminated (WHO, 2014). Legal, regulatory, policy and medical measures need to be continued and strengthened (Rowlands & Wale, 2019). The UN Committee against Torture has more than once issued recommendations on how to redress forced sterilisations to

the states reviewed in this paper (UN, 2018b; UN, 2018a). Recurrent themes of recommendations from four Canadian sources available in 2019 have been grouped together (Ryan et al., 2021).

We support policy recommendations with the goals of both redressing past forced sterilisations and preventing them from reoccurring. Firstly, redressing forced sterilisations at a systems level must include regulatory, judicial and legislative actions. We believe settler society must hold health and social care professionals accountable if they are involved in performing forced sterilisations. The cooperation of professional bodies will be crucial in operationalising this recommendation. Abuses must be reported to the relevant professional regulators and appropriate disciplinary measures taken. We back the Canadian Senate proposals that forced sterilisation be criminalised, that professional standards be developed to respond to complaints of forced sterilisation, and that a research agenda be developed to fully understand the scale and extent of forced sterilisation (SSCHR, 2022). Forced sterilisation is defined as a crime against humanity in the Rome statute (ICC, 2002) and criminalisation of forced sterilisation is recommended in the Istanbul convention (COE, 2011). An example of a Bill on forced sterilisation undergoing Parliamentary scrutiny is one that was introduced in the Senate of Canada (LEGISINFO, 2023). Reparations laws have been passed in Peru (Carranza Ko, 2023) and the Czech Republic (Albert, 2023) but survivors without certain documents have been excluded from the compensatory payment schemes. Affected individuals, families and communities should be offered restorative justice, re-imagined and co-created by them, as an act of body sovereignty reclamation and self-determination (Chartrand & Horn, 2016).

Secondly, at community level, given the living legacies of “racial science” in modern medicine, actively dismantling forced sterilisation and preventing its recurrence is critical. It is vital that health and social care professionals, and the systems they work in, participate in ongoing education and reflective practice to provide culturally safe care to Indigenous and racialised patients, (Black et al., 2021). Any training programmes for healthcare professionals must embed transformational learning opportunities, enabling individuals to critically reflect upon their personal values and beliefs about a variety of oppressed communities to enable them to practise in a respectful, culturally sensitive way (Heaslip et al., 2019). All medical and nursing schools should include information on working with Indigenous and racialised health issues, including skills-based training in intercultural competency, conflict resolution, human rights and anti-racism (SSCHR, 2022; Basile & Bouchard, 2022). This training should be developed through community-informed and, ideally, community-driven strategies and instruction around local language and culture to re-centre the Indigenous voice: “Nothing about us without us”.

Conclusions

The forced sterilisation of Indigenous and racialised Peoples, based on the concepts of “racial science” and eugenics, continues to the present day. State-level colonial programmes and indoctrinated bias among clinicians have driven and perpetuated this practice in many regions around the globe. Both candidates for sterilisation and clinicians have been incentivised. Consent processes have been contravened by health and social care professionals and policymakers. The adverse psychosocial and cultural impact of forced sterilisation on individuals, families and communities has been and continues to be profound. Mechanisms of professional, civil and criminal accountability and restorative justice must exist to provide reparations to those affected and to disincentivise future abuses. Also, it is essential that the training of health and social care professionals includes competencies in cultural safety, human rights and antiracism.

Note

1. Individuals whose gender identity does not align with the sex they were assigned at birth can also experience pregnancy and give birth. For this reason, we refer to both “women” and the gender-neutral term “gestating people”.

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