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It Never Stopped:

The Continued Violation of Forced, Coerced, and Involuntary Sterilization

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Abstract

From the Buggery laws of 1533, to the hundreds of years of medical experiments taking advantage of already historically oppressed communities throughout the world, to the current anti-Trans laws and policies that are bombarding the nation today, reproductive autonomy has long been treated as a privilege as opposed to an inalienable right. The notion of reproductive freedom should be uncompromisable but it has not been fully realized due to the fostering and the legitimizing of coercive systems that keep marginalized communities oppressed, perpetuate violations to a person's body, and that prevent individuals from asserting themselves as the experts of their lives. While self-declaration, reproductive autonomy, and clear informed consent should always be the highest standard, we continue to see that these basic human rights are simply not afforded to all. This paper explores the history of coerced, forced, and involuntary sterilization, globally and in the United States, as a means of population control through criminalized punishment, "cures" to gynecological issues, and the gatekeeping of bodily autonomy, with a call to attention on how this practice has and continues to impact persons of color, the poor, and the LGBTQIA+ community. The authors of this paper aim to shift the oppressive standards that currently exist towards self-declaration, reproductive and sexual autonomy, and self-advocacy as a means to combat the harm of coerced sterilization and its intentional practice in medicine and policies. The clinical considerations provided intend to challenge the reader to examine their own actions as a possible "conspirator" to the passive eugenic practices that lead to sterilization by default, as outlined by the authors.

Introduction

In September 2020, alarming details emerged from the Irwin County Detention Center in Georgia outlining the mistreatment of immigrant detainees under ICE custody. In a report issued by Project South, The Institute for the Elimination of Poverty & Genocide, a complaint was filed on behalf of the detained immigrants held at the Irwin County Detention Center, citing lack of proper access to language translation, medical neglect, unsanitary conditions, safety issues, and other human rights abuses and violations.[1] One of the biggest red flags brought forward by the complaint was the alarming rate of hysterectomies that were being performed of the women under ICE custody.

Project South conducted several interviews with immigrant detainees who reported undergoing medical procedures without a clear understanding as to why the procedure needed to be done.[1] Initially, the women were experiencing issues with heavy periods, cramping, or other gynecological concerns. According to detainee interviews, many women did not receive proper education and information from the doctor and the medical staff and were not able to properly consent to medical treatment. Additionally, detainees reported that there were no Spanish

speaking medical staff available to explain and clarify the doctor's orders; instead, medical staff resorted to using improper Spanish translation measures such as Google Translate to communicate with the detainees.

Horrifically, the recent ICE detention story is just a continuation of a long history of forced, coerced sterilization, intrusive gynecological practices, and "medically necessary" procedures that still exist in this country and globally.[2] Eugenics, the practice of selective reproduction, has been used since the beginning of the 1900s to control and limit certain communities deemed undesirable.[3]

History of Sterilization in the United States

The arrival of the 20th century marked the beginning of forced reproductive sterilization all over the world.[2] The main purpose of this government-imposed tactic was for population control while other governments used sterilization to prevent those considered socially unsatisfactory from reproducing.[3] Indiana became the first state to adopt involuntary sterilization statutes in 1907; from 1907-1939, 30 states followed with their own sterilization laws.[2]

In the South, sterilization was used as a means of racial control and as a way to break the dependency of residents on welfare.[4] Up until 1977, nearly 7,600 individuals were sterilized in North Carolina; the vast majority were Black.[4,5] For various reasons, Black youths as young as ten years old were deemed and declared unfit to be parents, according to state records.[4,6] In order to aggressively promote the sterilization agenda, the government used tactics such as threats of losing welfare benefits and other assistance provided by the state if sterilization consent forms were not signed.[4,5]

In the United States, sterilization was used for depopulation but it was also heavily used to prevent those considered to be "retarded and insane" from reproducing.[2] Labeled "feebleminded," individuals who were mentally and physically differently-abled were subjected to sterilization in order to remove the option of family planning.[7] Although sterilization of these communities still occurs today, new guidelines have been created by human interest groups such as The World Health Organization in order to lobby for the best interest of the person.

As an effort to reduce immigration in California, Mexican men and women were sterilized at a significantly higher rate than non-Latinos between 1920-1945.[8] According to accounts from several California eugenics programs, Mexican women were classified as "hyperfertile, inadequate mothers, criminally inclined, and more prone to feeblemindedness" therefore, sterilization was justified in order to control the spread of these undesirable qualities.

Forced sterilization was a key tactic of government funded assimilation campaigns that targeted Indigenous and Native communities throughout the 19th and 20th centuries.[9] Native women describe coercion and non-consensual surgical sterilization; chemical sterilization, such as ingestion of radioactive iodine, was often administered on a daily basis. Between 1970 and 1976 alone, it is estimated that over 3,400 Native women had been sterilized, forced to abort, or received "medically necessary" hysterectomies; some reservations reported a sterilization rate of 80% or higher.[10] Additionally, the creation of residential schools in the 1800s saw the forcible removal of Native children from their families and their land, as an attempt to force children to assimilate into White society.[9] Upon reaching puberty, administrators of the residential schools were given the right to sterilize any Native student that was under their care.[9]

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Global Cases of Sterilization

All over Latin America, women and men have been reproductively violated in order to comply with their government's strategy to eliminate poverty by limiting family size.[11] As a tactic, many governments began to limit access to forms of birth control as a way to promote a more permanent solution in the way of sterilization.[11] Additionally, there is evidence that many governments developed financial incentives that were awarded to health care workers for every woman they brought in for sterilization. These types of claims have also been made in Honduras, Mexico, Guatemala, Argentina, and other Spanish-speaking countries.[12]

In recent years, the government of Peru launched an investigation based on claims that 300,000 women were subjected to forced sterilization under the ten-year reign of former president Alberto Fujimori.[11] It had been reported that poor, uneducated women were lured into medical offices with promise of free medical checkups; once the women were on the examination table, the medical staff allegedly restrained the women, anesthetized them, and then performed the tubal ligation.

For over two decades, Puerto Rico had the highest rate of coerced sterilization in the world.[13] It was determined that by 1954, 16% of the women on the island had been sterilized and that "no other country-industrialized or developing had sterilization ever achieved such popularity."[14] Research and studies have concluded that the reason sterilization was so popular on the island was due to the adamant encouragement, persistence, and coercion of the American physicians who practiced on the island.[13,14]

In parts of Africa, there have been thousands of cases of involuntary sterilization occurring with women living with HIV/AIDS.[15] Based on presumptions, miseducation, and stereotyping, the African government pursued sterilization as a method of preventing the transmission of the virus to unborn children. Without proper information and consultation, women have reported being forced to sign consent forms under coercion and duress.

Adopting American ideology on the matter, perhaps the biggest proponents of sterilization were the German Nazi leaders.[3] Known as Rassenhygiene, or racial hygiene, Nazi German doctors performed involuntary sterilization for the sake of eradicating the inferior from society. Medical documentation accounted for the sterilization of 400,000 men and women but scholars believe the numbers are much higher[3,16]; it had been argued that "as many as 10-15 percent of the population were defected and ought to be sterilized.[16] Feeling that surgical sterilization was too slow of a process for mass efforts, the Nazis experimented with medicinal methods that would allow sterilization via ingestion or injection.[16]

"Medically Necessary" Hysterectomies

The "medically necessary" hysterectomy is one of the most controversial medical procedures performed around the world, with physicians suggesting that 90% of hysterectomies are unnecessary and that other option should be explored.[17] Recently, The Guardian released an expose bringing to light that sugar cane workers in India are being coerced into having hysterectomies as a remedy to painful periods[18]; in Sweden, a case has been launched to investigate the misdiagnosis of 33 women who had unnecessary hysterectomies.[19]

According to Yale Medicine, approximately 500,000 hysterectomies are performed in the United States every year; hysterectomies are the second most common surgery for women in the US.[20]

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Medical recommendations for hysterectomies include abnormal bleeding, gynecological cancers, and unmanageable pain from fibroids, cysts, or endometriosis. The two most common types of hysterectomies are the total hysterectomy and the radical hysterectomy. Both types of procedures are considered common treatments to address gynecological concerns; the radical hysterectomy is the full removal of all reproductive organs such as the uterus, ovaries, fallopian tubes, and cervix.

Involuntary Sterilization for the LGBTQIA+ Community

Targeted as far back as the Buggery Laws of 1533 in Britain, cisgender gay men were a group within the LGBTQIA community that underwent involuntary sterilization through the criminalization of consensual homosexual sex.[21] Chemical castration has been used as a permanent punishment for those engaging in criminal same sex interactions.[22] Through the administration of hormones and medications to block testosterone, the purpose of chemical castration aims to decrease the desire of sex and cause impotence. Often resulting in infertility, chemical castration also impacts sperm production, known as azoospermia.

One of the most well-known cases of chemical castration of a gay man was that of Dr. Alan Turing, the British mathematician who in 1952 was prosecuted criminally for engaging in homosexual acts.[23] Turing was forced to choose between a prison term or chemical castration and chose the latter. The effects and impact of the chemical castration left Turing ostracized and isolated, he developed breasts due to the hormonal treatments, and he experienced severe depression. In 1954, Turing died by suicide. Homosexual activity was decriminalized in England and Wales in 1967.[21] In 2009, the British government publicly accepted wrongdoing, apologized to Dr. Alan Turing for his abhorrent mistreatment, and posthumously recognized Turing's accomplishments and contributions as a codebreaker during WWII.[23] Turing was issued a posthumous pardon in 2017 under the Disregards and Pardons Scheme, which serves to grant expungements to those convicted under laws criminalizing same sex activity.

In addition to chemical castration, jail time was also used as a means to deter and punish homosexuality.[21] Jail terms varied up to life in prison, included fines, and other consequences such as registering as a sex offender. It is estimated that 49,000 persons were found guilty under Buggery Laws in the UK, one being playwright, novelist, and poet Oscar Wilde.[21,24] After two very public trials, Wilde was found guilty of gross indecency under British law in 1895 and was sentenced to two years in prison.[24] After completing his sentence, Wilde fled to France where he lived freely as homosexuality was decriminalized there in 1791.[24,25]

Across the United States, and many parts of the world, Trans individuals are forced to undergo required reproductive procedures in order for their gender to be legally recognized.[26] Up until 1987, the American Psychological Association (APA) considered gender and sexual orientation variance a mental illness in its Diagnostic and Statistical Manual of Mental Disorders (DSM); therefore, for those who identified as LGBTQ, sterilization was justified under those criteria.[27] Currently in the US, there are nine states that actively mirror coercive sterilization against Transgender and gender non-conforming individuals by requiring sterilization as part of the medical transition process.[26] Several other states require proof of gender medical transition which includes hormone replacement therapy in order to change the sex markers on a birth certificate.

Adopting America's lead, other countries followed in enacting laws sterilizing LGBTQ-identified individuals.[28,29] Japan and Finland also required sterilization before an individual is able to legally and medically transition.[28,29] Recognizing that a person is entitled to reproductive autonomy, both countries dropped this requirement in 2023.[30] Up until 2014, Denmark required sterilization in order to change gender markers but now only requires a six month reflection period before moving forward with legal transition.[31] Worldwide, self-declaration recognition is now being called for as the ultimate standard for legally affirming one's gender.[32]

Undeniably, the intersex community has had an extensive history of medical abuse, specifically medical professionals making unilateral reproductive decisions on behalf of the patient.[33] One of the early pioneers of this practice was Dr. John Money who was considered to be the eminent expert in human sexuality and the treatment of intersex medical cases.[34] As noted in his most famous gender reassignment case of the twins referred to as John and Joan, Money believed that gender identity was malleable and that it was possible to shape gender via consistent environmental cues.[35] While this patient was not intersex, Money's extensive publication and press around the case formed the basis for what continue to be the standard medical and psychological approaches to treating intersex patients. Money's theories of malleable gender identity were disproven when fellow sexologist, Dr. Milton Diamond, published a follow up to the John/Joan case.[36] Diamond reported that Money's theories and practice were not only erroneous but absolutely damaging to the patient's emotional and psychological wellbeing. In the case of John/Joan, both patients died by suicide in 2002 and 2004.[37] It is estimated that Money attended to dozens of intersex patients, experimenting on them with his misguided theories of malleable gender identity which essentially altered the course of their lives.[36] Globally, organizations such as the World Association for Transgender Health (WPATH) and the United Nations Human Rights Council, have issued best practices guidelines for working with the intersex community, primarily focusing on the ending of non-consensual medical procedures.[35] In January 2025, the U.S. Department of Health and Human Services released the Advancing Health Equity for Intersex Individuals.[38]

Sterilization by Default

Perhaps the most pervasive form of sterilization among Transgender individuals is the surrendering of fertility based on assumption, lack of information, and lack of access to alternative options. While there is no longer a widespread culture of medical providers intentionally pushing sterilization onto Transgender patients, there are several aspects of the medical transition process that contribute to sterilization by default. Currently, there are no standardized guidelines regarding fertility preservation education or options counseling when working with Transgender patients. As so, this leaves many providers to assume the patient's wants or needs based on their own preconceived ideas around the patient's medical transition goals.[39]

In assuming that a patient is not interested in fertility preservation, or prioritizing patient education only around Hormone Replacement Therapy (HRT) instead of the full scope of medical transitioning, patients are often left learning about time sensitive fertility preservation medical options too late, if at all. In a 2023 study focusing on fertility preservation education for Transgender patients, between 37.5 and 51% of adult Transgender respondents reported that they would have been interested and opted in for fertility preservation had they been given the education and resources before starting HRT or having surgery.[40] While 58% of respondents

reported receiving adequate fertility options counseling, 42% of respondents reported receiving inadequate education or no education at all.[41] Instead, patients are often learning about preservation options after initiating HRT and fertility has been impacted, leaving them with the decision to temporarily stop their medical transition or accept the loss of their fertility.

Even in cases when proper patient education is given, patients still might feel hesitant to focus on fertility preservation if it contradicts other transition-related goals. Engaging in fertility preservation delays starting HRT and scheduling Gender Affirming Surgery, and in many states delays the ability to complete the legal transition process. Transgender men wishing to preserve their eggs typically need to engage in estrogen therapy and an intense fertility medication regimen.[41] Also taking into consideration that treatments take place at fertility clinics which often aesthetically center on motherhood, these combined factors may trigger increased feelings of dysphoria.

One of the largest barriers to autonomy in the fertility preservation process is the significant financial burden of this care. Fertility preservation is rarely covered by medical insurance plans, requiring patients to pay for the initial costs of the preservation process, as well as the long-term fees related to storage, and the costs related to initiating the conception process. When faced with the reality of paying for the costs associated with continuing medical transitioning or fertility preservation, many give up hope of becoming parents. By refusing to cover the costs associated with this process, insurance companies are effectively making the determination to sterilize Transgender individuals and that can be viewed as a form of eugenics.

Reproductive Trauma Support

There is a dearth of qualitative and quantitative studies investigating the emotional impact of post-sterilization experiences. The body of research that does exist tends to focus on medical measures of pain and healing while ignoring emotional impact of depression, loss of fertility, shifts in sexual identity, bodily agency, and sense of self.[42] In addition to the aforementioned issues, patients who have undergone a hysterectomy have reported changes in libido, weaker orgasms, loss of interest in masturbation and sex, difference in sexual sensation, and feeling disconnected from their partner.[43] We imagine the same is true of all individuals who have gone through reproductively invasive procedures.

As expected, medical practitioners are most likely strictly prioritizing the medical aspect of the procedure and not the emotional and sexual impact of the patient's new post sterilization reality.[44] Education around expectations typically stops at medical aftercare instructions, while therapy is rarely recommended or mentioned. If existent at all, most support groups, literature, discussion, or even therapeutic approaches focus on the concepts of cancer survivorship, not so much reproductive trauma.

For many clients, the experience of reproductive intrusiveness is likely to be viewed as a medical trauma, therefore, clinical treatment should be viewed through a trauma-focused lens. Clinicians should be prepared to treat clients using the lens of grief therapy to address loss of autonomy, the changing of identity, the feelings surrounding the function of their body, and their sexual identity and satisfaction. Clinicians should consider working to balance themes of empowerment and a patient's reclamation of their body and life while giving space for exploration of grief, loss, and even self-blame or doubt. Healing from the trauma of an intrusive reproductive practice may impact intimate relationships, mistrusts of medical providers, and the ability to connect with

one's own body in a healthy and fulfilling way.[43,45] Concerns regarding post-procedural sexual function and satisfaction may arise, causing feelings of inadequacy, anxiety, and depression; fears of both emotional and physical discomfort surrounding intercourse post procedure are very common.[43]

In essence, broader multidisciplinary conversations are needed between sexuality and medical providers to address the holistic impact of medical procedures on clients. Recommendations for pre and post procedure counseling should be required in order to respond to a client's non-medical questions, concerns, and expectations. Oncosexology is a discipline of sex therapy that focuses specifically on the sexual wellness and intimacy of cancer patients, which includes hysterectomies; this lens may still be helpful in helping others who are navigating a post-sterilization reality. Clinicians should become familiar with the modalities used in the branches of sexology that focus on chronic illness, oncology, and gynecological issues, as these are best suited to address the impact of medical procedures on a client's sexuality.

Finally, validating, normalizing, and encouraging a client's right to question a medical professional's opinion is a significant way of empowering a client. Recognizing the need to expand their fullest informed consent, explicitly understanding the impact on all aspects of their procedure - the medical, emotional, physical, and sexual - is crucial in establishing reproductive agency. Moreover, identifying gaps in the patient's knowledge will contribute to creating a personalized care plan that will increase their cognizance. Motivating the client to work collaboratively with their medical team to achieve the most optimum outcome for their situation is paramount.

Professional Considerations

Throughout 2025, the United States has seen a relentless attack on reproductive health and gender affirming care. Laws and policies are being introduced to criminalize those exercising their reproductive rights.[46] Medical professionals are under threat of jail time, loss of license to practice, and the withholding of federal funds if they continue to provide affirming care. The Trans community is experiencing the stripping of access to HRT and the legal transition process. The advancements made to secure reproductive autonomy, self-declaration of identity, and freedom of gender expression are all being gutted on a daily basis. In spite of these risks, professionals have an ethical and moral obligation to continue providing comprehensive gender affirming care and reproductive care.

As we broaden our understanding of experiences with intrusive reproductive procedures, a series of moral and ethical questions arise:

- Why do we continue to be denied reproductive anatomy?
- Are medical recommendations grounded in what is actually best for the patient or are drastic reproductive procedures simply being performed as the first and only intervention as opposed to a last resort?
- Historically, why do reproductive organs continue to be viewed as expendable by the medical profession and not as an extension of one's holistic identity?
- Why do we have to choose between our gender identity and our sexual identity? What further fundamental changes need to take place in order for these two distinct entities to be disentangled?

- Finally, are we contributing to eugenics by not engaging in the full disclosure of the medical consequences for all reproductive procedures, especially for procedures that have irreversible consequences?

According to renowned physician Dr. James E. Bowman, the concept of eugenics speaks to "genetic inequality" and can be viewed as two pronged: active eugenics and passive eugenics.[47] Bowman defines active eugenics as the act of encouraging or discouraging reproductive capabilities amongst certain groups, while passive eugenics is seen as policies and laws that do the same. In both cases, lack of reproductive advocacy, the lack of fully transparent informed consent in patient care, and the oppression of reproductive autonomy can all be seen as fostering eugenics.

Without exception, the reproductive potential of all individuals must be respected. The consequences of being forced or coerced into decisions that lack full information and transparency not only violate human rights but the trauma imposed upon someone who has had no informed decision over their own body is beyond negligent and the repercussions can be felt for years, impacting every part of their lives. The right to gender identity and expression, and the right to sexual reproductive autonomy, are basic human rights. Being forced to renounce one's reproductive abilities based on misinformation, lack of information, or even the assumptions of a medical provider, violates this right. Case in point, based on the statistics provided, it appears that hysterectomies have been and continue to be used as a frontline treatment to solve gynecological issues.[20] By presenting a hysterectomy as the foremost intervention, the patient is denied the agency over their own body and reproductive future. This can be viewed as a form of eugenics as medical professionals may be acting as "conspirators in health care inequality" by influencing clients to surrender their fertility abilities.[47]

Recognizing that Trangender and intersex individuals must have a say in retaining their fertility potential is of the most paramount importance. What prevents Trans individuals from fully exercising their sexual and reproductive rights are not only found in the regulation of laws and policies but also within societal expectations and norms that have been created.[48] The thought of a Trans man being pregnant or a Trans woman producing sperm appears to be beyond the scope of comprehension and acceptance by most in today's society. True sexual and reproductive freedom requires the dismantling of gender binary structures that are so ingrained in current society. Challenging the existing notion that pregnancy is only possible to cisgender women and moving towards inclusivity and acceptance that parenthood is actually gender neutral is essential in order to progressively evolve.[48]

One of the first steps in obliterating the fostering of eugenics is removing the obstacles and regulations that prevent individuals from asserting themselves as the experts of their lives. Reproductive justice cannot be fully achieved until we examine and challenge the coercive systems that keep marginalized communities oppressed, perpetuate violations to a person's body, and strip away the right to make personal reproductive decisions. In order to accomplish reproductive freedom, the recognition and prioritization of reproductive self-determination must be uncompromisable. It is a grave injustice to continue legitimizing gatekeeping agendas when self-declaration, reproductive autonomy, and clear informed consent should always be the highest standard.

Please reach out to DESexualityGenderCollective@gmail.com with any questions.

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