Forced/Coerced Sterilization of HIV-positive Women in the Southern African Region in the context of Reproductive Justice and Intersectional Gender-Based Violence

by

Ogechukwu Chinenye Chukwudozie

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Approved: Dr. Tatjana Takseva
Supervisor

Approved: Dr. Maki Motapanyane
Second Reader

Approved: Dr. KellyAnne Malinen
External Examiner

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Abstract

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Abstract: HIV-positive women have been targets of forced and coerced sterilization which persists despite research showing that if managed correctly the risk of mother-to-child transmission of HIV can be reduced to less than 1%. This study draws on reproductive justice, the intersectionality framework, and feminist content analysis to examine how different identities such as poverty, age, lower educational level and racism intersect to make the HIV+ women who are victims of forced and coerced sterilization additionally vulnerable to that form of oppression. My research amplifies the voices of the HIV+ women who are victims of forced sterilization and contributes to feminist scholarship by expanding the use of the intersectionality framework in Africa and how other less researched identities such as poverty, level of education, and age intersect in HIV+ women who are targeted for sterilization.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
EU	European Union
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
HIV+	HIV positive
IPV	Intimate Partner Violence
PEPFAR	President's Emergency Plan for AIDS Relief
SVRI	Sexual Violence Research Initiative
US	United States of America
USAID	US Agency for International Development

Chapter 1: Introduction/Background

Sterilization is a process or act that renders an individual incapable of sexual reproduction (OHCHR et al., 2014). It involves a surgical procedure and is a permanent method of birth control. When sterilization is a choice and performed with consent, it is liberating and promotes reproductive justice. My thesis, however, is focused on involuntary sterilization, wherein the patient is either forced or coerced to undergo the procedure. The geographical focus of this research is the Southern African region where forced and coerced sterilization against HIV-positive (HIV+) women has been recorded. I argue that forced or coerced sterilization of HIV+ women is a violation of their reproductive justice and also a form of gender-based violence. My research is aimed at specifically highlighting the HIV+ women who are most at risk of and vulnerable to forced and coerced sterilization. I apply an intersectionality framework in analysis of secondary data to highlight who is primarily targeted for such sterilization outside of gender markers and HIV status.

Forced sterilization occurs when a person is sterilized after expressly refusing the procedure, is sterilized without her knowledge, or is not given an opportunity to provide consent (Human Rights Watch, 2011). Coerced sterilization occurs when financial or other incentives, misinformation, or intimidation tactics are used to compel an individual to undergo the procedure (Human Rights Watch, 2011). Historically, the practice of forced and/or coerced sterilization has been primarily carried out against marginalized and vulnerable populations, including persons with mental or physical disabilities, racial minorities, and poor women as promoted during the height of Eugenics.

Sir Francis Galton, a 20th century English scientist and researcher promoted the so-called ‘science’ of eugenics, a Greek word that means ‘good in birth’. He proposed

that man be more active in the process of natural selection to improve the quality of humans through selective breeding, rather than waiting on nature to weed out the unfit, he described the natural selection process to be slow and blind (Roberts, 1997, p.59). Eugenics encouraged improving the race of a nation by increasing the reproduction of the best stock, those who were perceived to be better by the dominant class. The premise was that intelligence and character were genetically transmitted, thus society should take steps to encourage the procreation of people of superior stock (Roberts, 1997,p. 60). Positive eugenics supports and encourages those who are deemed fit by society to continue to procreate even when they do not want to, while negative eugenics enforces and ensures that the less desirable population does not procreate. To enforce negative eugenics, laws were enacted in 1913 in the United States forbidding marriage by people considered genetically defective, including epileptics, paupers, drunkards, criminals and the feebleminded (Roberts 1997; 65). American birth control activist Margaret Sanger promoted birth control using negative eugenics; birth control thus became a tool to regulate the poor, immigrants, and Black Americans (Roberts, 1997). The history of eugenics is heavily characterized by subjective elements that favour the privileged over the marginalized, thus making eugenics unethical. As espoused by Roberts (1997):

> Race completely changes the significance of birth control to the story of women's reproductive freedom. For privileged white women in America, birth control has been an emblem of reproductive liberty….but the movement to expand women's reproductive options was marked by racism from its very inception….while slave masters sought to force Black women to bear children for profit, more recent policies have sought to reduce Black women's fertility.

> Both share a common theme: that Black women's childbearing should be regulated to achieve social objectives. (p. 56)

The targeting of the oppressed using eugenics tools persists. In the United States of America, a whistleblower reported mass hysterectomies carried out on migrants in US detention centers during the COVID-19 pandemic. One detainee at the Irwin Center said she knew of five women who had been subjected to hysterectomies, and who appeared confused about what had been done to them or why the operations were performed. She said, "When I met all these women who had had surgeries, I thought this was like an experimental concentration camp" (Lenzer, 2020, 1). Hysterectomy is a surgery that removes the uterus (womb).

Forced/coerced sterilization of HIV+ women fall under negative eugenics. HIV+ women are amongst the most neglected at the margins of society and are often deemed inappropriate to reproduce, thus resulting in the forced and coerced sterilization these women are disproportionately exposed to. Durojaye (2017) posits that vulnerable and marginalized women, particularly those living with HIV or disabilities tend to be targets of involuntary sterilization. Her Rights Initiative, a feminist advocacy group in South Africa, opines that forced and coerced sterilization is enforced as a result of the colonial and apartheid policies related to ending and controlling the fertility of Black poor women to meet political ends (Mthembu, 2022). From a colonialist perspective, Black female bodies, and in this instance, Black female HIV+ bodies, reproduce undesirable children, and as such, Black women's bodies have remained a site of racial oppression, control, governability, and politicized population management strategies (Mthembu, 2022). Similarly, bodies of other historically marginalized groups have been a site of oppression. Coerced and forced sterilization of HIV+ women has been reported in Latin America (Center for

Reproductive Rights, 2010; Kendal, 2009, Kendall et al., 2015), Asia (Women of Asia Pacific Network, 2012), and Africa (Ahmed et al., 2012; Mallet et al., 2008; Strode et al., 2012). Kendall et al.'s 2015 study of El Salvador, Honduras, Mexico and Nicaragua revealed that in all four countries, women were told by healthcare providers that their HIV status meant that they could not have more children and that they had to accept sterilization. Sterilization was also presented to HIV+ women implicitly or explicitly as a condition for receiving medical services and benefits, including caesarean delivery and breast milk substitution used to prevent vertical HIV transmission. Women were pressured into signing consent for sterilization just prior to entering the operating room for a caesarean section (Kendal et al 2015).

Human Immunodeficiency Virus (HIV) is a virus that affects the immune system and predisposes an individual to several infections. There is much stigma and discrimination against people living with HIV, and this is reported as one of the major barriers to effective HIV response (UNAIDS 2010 Roseman et al., 2013).

Forced and coerced sterilization of HIV+ women was first documented in South Africa in the late 1990s. In 2008, 230 women living with HIV were interviewed in Namibia about sterilization. Forty of the women (17%) stated that they had been coerced or forced into sterilization (International Community of Women Living with HIV/AIDS, 2009). The issue of forced sterilization continues to happen to date. There is a documented case of a young HIV+ woman who was sterilized in 2021 in South Africa (Mthembu 2022). In November 2023, four women who were forcefully sterilized in Kenya won a nine-year court case in which the Honorable Justice of the High Court of Kenya ruled that the sterilization was a violation of their human rights. Research has shown that if managed correctly, the risk of mother-to-child transmission of HIV can be reduced to less than 1% (CDC, 2023; WHO, 2007;); yet the sterilization of HIV+

women persists. In their report “Against Her Will Forced/coerced Sterilization of Women across the Globe”, Open Society Foundation identified HIV+ women and poor women amongst other classes of women that face sterilization. According to the report, despite advances in effective and affordable treatment, healthcare workers regularly coerce HIV+ women into being sterilized (2011).

Forced/coerced sterilization of HIV+ women represent a violation of their reproductive rights, is against reproductive justice, and is also a form of gender-based violence. The intersection of HIV and Gender Based Violence (GBV) has not been explored fully. As reported by Hale et al. (2006) in Toronto, Canada, GBV and HIV are viewed as largely separate and distinct areas of work: “To bring these together and at the same time, to add in human rights, feminism, sexuality or any of the other frameworks has been found to be challenging” (Hale et al., 2011, p. 14). Forced/coerced sterilization is violence against HIV+ women. Hale et al. (2011) define violence against HIV+ women as any act, structure or process in which power is exerted in such a way as to cause physical, sexual, psychological, financial or legal harm to women living with HIV (2011).

Reproductive justice is a social movement that brings together reproductive rights and social justice (Ross et al., 2017). Black women activists coined the reproductive justice framework in the US to encompass human rights, reproductive health, and social and racial justice. When applied to Africa, the reproductive justice framework can help in understanding how health inequalities may be eradicated in Africa through decolonization and interrogation of structural inequalities. Reproductive rights refer to individuals having the right to control their bodies, including having the right to decide when to have children and when to terminate a pregnancy. Reproductive rights focus on the individual and their decision while reproductive

justice looks beyond the individual to other factors that may impede the ability to make choices. Achieving a reproductive goal requires a safe and dignified context which can only be possible with resources such as quality health care, housing, education, a living wage and a healthy environment. Reproductive justice therefore promotes the provision of these essential resources, without which reproductive rights cannot be achieved. Touting only individuals' choice for reproductive rights is not practical and promotes an illusion of choice. The illusion of choice and social determinants of health are discussed in more detail in Chapter 2.

Forced/coerced sterilization acts against the right to have a child, which is one of the three tenets of reproductive justice. The other two tenets are the right not to have a child and the right to parent a child. Through a reproductive justice framework, forced and coerced sterilization of HIV+ women in Southern Africa is linked to African women's economic, social, and political power and resources to make decisions about their bodies, sexuality, and reproduction.

Scope of study

The two main countries of focus in this research are The Republic of Namibia and South Africa.

The Republic of Namibia

The Republic of Namibia is a Southern African country. The country has been inhabited since pre-historic times by the Khoi, San, Damara and Nama people. The Germans established rule in the territory in 1884, forming a colony known as German Southwest Africa. Between 1904 and 1908, the German colonial government perpetrated a genocide against the indigenous tribes became the first genocide of the 20th

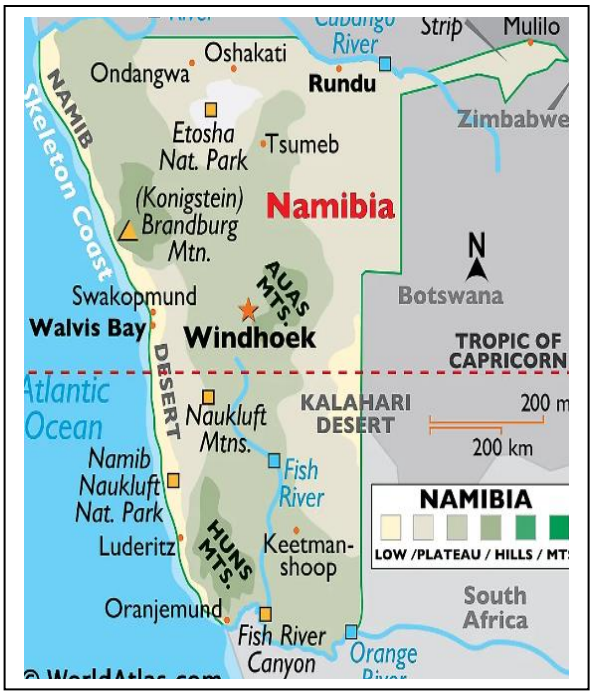

Figure 1: Map of Namibia

century. German rule ended in 1915 with a defeat by South African forces. In 1948, the National Party, whose focus was on the interest of the White minority, was elected into power and was responsible for the implementation of apartheid policy. Most Africans were confined to native territories, and development was focused on areas with White population.

Namibia obtained independence in 1990 following continued guerrilla warfare. Since independence, the country has completed the transition from White minority apartheid rule to parliamentary democracy.

South Africa

South Africa is a country in the Southern African region and is the southernmost country in Africa. South Africa was colonized first by the Dutch and then by the British.

In 1948, the National Party was elected to power. The party strengthened racial segregation in the country. Taking Canada's Indian Act as a framework, the nationalist government classified all peoples into three races (Whites, Blacks, and Indians and developed rights and limitations for each. The White minority (less than 20%) controlled the vastly larger Black majority. The legally institutionalized segregation became known as apartheid.

Figure 2: Map of South Africa

While Whites enjoyed the highest standard of living, the Black majority remained disadvantaged by almost every standard, including income, education, housing, and life expectancy (Britannica, 2022).

Sub-Saharan Africa was identified as the epicenter of the HIV epidemic. South Africa was the country with the largest population of HIV+ people in the world, with 7.1 million people living with HIV in South Africa in 2016 at an adult prevalence of 19%, which dropped to 17.8% by 2022 (UNAIDS, 2022). In a nationwide survey of 10,473 South African people living with HIV, 498 out of 6719 women living with HIV (7%) reported that they had been forcibly sterilized because of their infection (South African AIDS Council, 2014).

Three Namibian women who were sterilized by bilateral tubal ligation between 2005 and 2007 took legal action against the Government of Namibia in the High Court, seeking financial damages for having been unlawfully sterilized. The women argued that the non-consensual procedures violated their constitutional rights to dignity,

liberty, and the right to found a family. The women also argued that the acts were discriminatory because they were performed on the basis that they were HIV+ (Chingore-Munazvo et al., 2015). In November 2014, the Namibian High Court delivered a landmark judgment in the women's favor, upholding that they had been sterilized without their consent, thus rendering the procedures unlawful. The judge, however, concluded that there was insufficient evidence that the women's HIV status motivated the forced sterilizations (Chingore-Munazvo et al., 2015; Kendall et al., 2015). In 2020, UNAIDS issued a press statement condemning forced or coerced sterilization of HIV+ women, calling this a violation of their human and reproductive rights. None of these articles, however, are explicit about the prejudice, discrimination, and otherization that HIV+ women experience. My thesis foregrounds this perspective, highlighting the otherization and alienation that HIV+ women experience, which makes them vulnerable to forced sterilization.

There has been a feminization of the HIV/AIDS epidemic in sub-Saharan Africa, with HIV being more prevalent in women than in men. This has been attributed to women's greater physiological vulnerability to HIV, as well as to systemic factors such as gender inequities, poverty, cultural, sexual, and gender norms, a lack of education, and violence against women (Harris et al., 2014; Quinn & Overbaugh, 2005). The experience of HIV+ women who are forced and coerced to undergo sterilization is a continuation of patriarchal domination. HIV+ men are not targeted for sterilization (Mthembu, 2022). Women, and in this case, HIV+ women, experience oppression because of their gender. Gender identity thus majorly contributes to making women victims of forced or coerced sterilization. In the patriarchal societal ladder, women are considered lower than men. As posited by Curran et al. (1994), "that which is

considered masculine is typically more highly valued than that which is feminine" (p. 272).

My thesis project recognizes that different individuals face oppression because of varying forms of identities that are associated with them. In a patriarchal society, women are more disadvantaged even when faced with similar barriers to men, for example HIV status. The Namibian and South African case studies exemplify a broader and seemingly ongoing pattern in the Southern African region where women living with HIV have reported being sterilized without their informed consent.

I am drawn to focusing my thesis on this region as a result of the Namibian women court case, as well as the prevalence and the impact of HIV in Southern Africa. The apartheid in South Africa and other countries in the region also provides a unique experience for the region. Apartheid in South Africa and Namibia has had an impact on the health care system. According to Coovadia et al. (2009), racial and gender discrimination, the migrant labor system, the destruction of family life, vast income inequalities, and extreme violence are part of South Africa's troubled past, and have all inexorably affected health and health services. A notable feature of the history of health services in South Africa has been fragmentation, both within the public health sector and between the public and private sectors. Medical training and care were racially segregated during apartheid. The first faculty of medicine was established at the University of Cape Town in 1920 for training White doctors; Black doctors in any numbers were only trained after the University of Natal Medical School was opened in 1951. As a result, in the 1930s there were still fewer than ten Black doctors in the whole of the Union of South Africa (Schapiro, 1981; South African Medical Trust, 1981). Between 1968 and 1977, only 3% of graduating doctors were Black (International Defence Aid Fund, 1983). Despite expanding the training of Black

doctors in the 1980s, in 1994 they remained a small minority of all medical professionals (Scrubb, 2011). Black nurses also experienced racial discrimination in the workplace as well as in wider society. Until the 1970s, they could not nurse White patients or have White subordinates and, until 1986, had lower salaries than White nurses (Marks, 1994; Scrubb, 2011). The repercussions of these historical legacies of oppression continue into present-day South Africa, where the confluence of gender, race and professional hierarchy still influences the nature of leadership and management in today's health system (Shung-King et al., 2018). The intersection of racist and patriarchal domination is evident in the health care system and leadership structure. White men are more likely to train as doctors than Black men who are more likely to train as doctors than Black women. Race and gender intersect to consequently, help men to progress faster and further into management positions (Shung-King et al. 2018).

Thesis Statement and Research Question

HIV+ women who experience sterilization are not only marginalized as a result of their HIV status but are generally further oppressed as a result of other intersecting identities that make them additionally vulnerable. Through the application of feminist content analysis, this thesis seeks to answer the question, what are the additional factors that additionally make HIV+ women vulnerable to forced and coerced sterilization?

Forced or coerced sterilization against HIV+ women deny them the right and choice to have a child, representing a violation reproductive justice. I also argue that this violation represents a distinct form of gender-based violence. I applied an intersectionality framework and feminist content analysis as a research tool in studying and analyzing the materials about HIV+ women who experienced forced sterilization.

The early eugenicists opposed social programs which were designed to improve the living conditions of the poor, with the argument that programs such as adequate medical care, minimum wages and better working conditions harmed society by enabling the less desirable population with inferior inherited traits to live longer and continue to have children (Roberts, 1997). This applies to the issue of forced/coerced sterilization, because instead of implementing Prevention of Mother-to-child Transmission (PMTCT) programs which allow an HIV+ mother to have HIV-negative children, those in authority with higher power seeks, without consent, to stop vulnerable women from having children. Health professionals resort to manipulation and misinformation to coerce HIV+ women into sterilization. One participant in a focus group discussion conducted by the International Human Rights Clinic at Havard Law School (IHRC) and the Namibian Women's Health Network (NWHN) shared, "I was told that if I got another child I would die" (Strode et al., 2012, p. 64). This treatment is contrary to the Government of Namibia's National HIV/AIDS policy, which pledged to "provide free access to safe obstetric care and antiretroviral treatment to all HIV+ pregnant women to prevent vertical HIV transmission from mother to child" (Roseman, 2013, p. 16). In Kendal et al.'s 2015 study, 285 women living with HIV in Nicaragua, Honduras, Mexico and El Salvador reported similar experiences. The study indicated that in all four countries, HIV+ women were pressured to be sterilized as a means of preventing vertical transmission of HIV, despite the fact that Latin American facilities' rates of vertical (mother-to-child) HIV transmission have been reduced to below 2% and that antiretroviral therapy to prevent vertical transmission is available (Kendal et al., 2015, p. 3). Similar to the South African context, health professionals also resorted to manipulation and death threats to coerce women living with HIV into sterilization.

Purpose of this research; aims and objectives

The purpose of this research is to critically analyze and understand additional factors that contribute to HIV+ women's vulnerability to forced and coerced sterilization. The thesis aims to highlight the voices and experiences of HIV+ women who were forced or coerced into sterilization, applying an intersectional lens and feminist content analysis, to provide nuanced insights into specific characteristics and identities of the victims.

During my coursework in the Women and Gender Studies Master's program, I had the opportunity to deeply explore theories of intersectionality. I developed the understanding that groups are made up of individuals with different identities, thus there are no completely homogenous or monolithic groups. Groups have characteristics that privilege or oppress their members. The different identities of individuals intersect, making them part of different groups. The further these identities and groups are from the dominant culture, or what is considered the norm, the more oppressed the individuals are. On the other hand, the more the identities of individuals are aligned with the dominant group or norm, the more privileged the individuals are. Intersectional understanding of identity therefore starts from the premise that rather than being static and immutable or based on a single marker or category, identity is fluid and multiple, with different aspects becoming or being perceived as more or less relevant depending on the context/setting in which the identity is situated, received, and enacted (Takseva 2022). Applying an intersectional lens in health care helps provide a nuanced understanding of the experiences, challenges and barriers to health care that different categories of people face. As Young et al., (2020) posit, failure to use an intersectional lens can result in a superficial analysis of inequity in health

outcomes, focused on the outcomes rather than the entrenched and root causes of the inequity.

In this thesis project, I applied an intersectional lens in data study and analysis. This meant that in reading and studying the materials, I was mindful of the intersection and interaction of race, class, age, and educational level in the data that characterize the women who were forced or coerced into sterilization. This provided a framework for developing a more nuanced understanding of the characteristics of these women. Applying an intersectionality framework, I analyzed academic articles, media reports and reports from nonprofit sectors (listed in Appendix 1) for the characteristics and demographics of women in the Southern African region who are living with HIV and are victims of forced and coerced sterilization. The aim is to explore further and highlight the importance of analyzing multiple parameters of multilevel vulnerability in women living with HIV who have been forced or coerced into sterilization. Several forms of oppression make HIV+ women additionally vulnerable. These forms of oppression are a result of level of education, level of income, age, and even race. My research focuses on how these factors intersect in HIV+ women who have been sterilized to increase their vulnerability.

My interest in this research is driven by personal experiences. I worked on HIV prevention for many years during my career in international development. My international development career has majorly focused on how gender dynamics privilege the male gender over the female gender. Irrespective of the thematic sector (e.g. HIV), gender affects the experiences of males and females resulting in different outcomes. In addition to gender, other socioeconomic factors impact people's experiences, and understanding these experiences and identities will contribute to developing social programs to meet the needs of those who face the risk of being

invisible. My thesis critically analyzes the characteristics of HIV+ women who are victims of forced and coerced sterilization, and I identify that the victims are women who are additionally vulnerable and risk being invisible as they are at the bottom of the social economic ladder. The contribution of this research is providing insight into the importance of nuanced analysis with an intersectional lens to support the design and implementation of social justice programs that meet the needs of the most marginalized and vulnerable. I analyzed different reports, articles and media in my research to answer my research question and unpack the characteristics of the HIV+ women who are the targets of forced and coerced sterilization. These sources are listed in Appendix 1. The data collection and analysis are discussed in detail in Chapter 3.

The key findings of my research are that HIV+ women who are poor, with lower educational status, lower socioeconomic status, and Blacks are more likely to be victims of forced or coerced sterilization in the Southern African context. The HIV+ women who are privileged such as those with higher socioeconomic status are more likely to use their resources to access private health care where they are treated with more respect and their choices valued. My research suggests that forced or coerced sterilization against HIV+ women constitute a form of gender-based violence and it identified that Gender-based violence and HIV have largely been seen as separate and distinct areas of work resulting in violence against HIV+ women not considered in mainstream GBV discourse. This non-intersection is evident in international instruments such as the 1993 Declaration of Elimination of Violence against Women not mentioning forced sterilization as a form of violence against women and the 1995 Beijing Platform of Action not identifying HIV+ women as part of minority women who are most vulnerable to violence.

This research contributes to the field of Reproductive Justice and supports that an individual's ability to make decisions about reproduction and reproductive rights is linked to other conditions such as educational level, race, housing, and factors in the community. Deciding about reproductive rights is not simply a matter of individual choice. This is evident in the HIV+ women who experienced forced or coerced sterilization. External factors such as poverty level, lower educational status, race and younger age additionally make them vulnerable to forced or coerced sterilization depriving them of the opportunity to make choices.

This research will also contribute to the discourse of intersectionality theory and will bridge the gap in the application of the theory in the African continent. Intersectionality theory has two major limitations in its current usage; one is the location, which is majorly focused on the global north. The second limitation is the centrality of the trinity of race, gender and class, which will be discussed in detail in Chapter 2. I contribute to the Women and Gender Studies body of knowledge through this research by exploring the utilization of intersectionality theory more widely, outside of the major factors of race, gender and class. My research will contribute to bridging these gaps. My thesis additionally will provide insight into the intersection between HIV and Gender Based Violence, which have for the most part remained separate areas of work.

Positionality

I was introduced to the concept of eugenics during my Reproductive Justice course in the Women and Gender Studies program. It caught my interest, and I wanted to explore applications of eugenics in the African context. That research led me to the issue of forced/coerced sterilization of women living with HIV in some parts of Africa.

I started my career in the non-profit sector in 2003 after graduating with my bachelor's degree in Abuja, Nigeria during the HIV/AIDS epidemic. My work included facilitating training sessions on how HIV can be contracted, the means of prevention, and some common myths about HIV. The training was geared towards preventing the further spread of the virus, as well as reducing the stigmatization of those who are already infected. The projects then were largely funded by the US Government under the President Emergency Plan for AIDS Relief (PEPFAR). While working on that, I was exposed to different ways that HIV+ women can prevent mother-to-child transmission. Sterilization was not an option that I was aware of. It therefore came as a rude shock to me when I learned that HIV+ women in some parts of Africa have been subjected to sterilization.

As a student of feminist scholarship and feminist research, I understand the importance of engaging and interrogating power relations. Intersectionality theory, stemming from the experiences of Blacks and women of colour, offers a tool for such interrogation and analysis. Though originating from Black women's experiences, intersectionality has largely been American-centric in its application and has been less frequently applied to the African continent. The aim of this thesis project is to explore factors that further increase the vulnerability of women living with HIV to forced/coerced sterilization. This provides a lens through which power and marginalization can be viewed in the African context as a Nigerian, I situate myself as an outsider(within) (Collins,1999) in this research. Existing studies on researchers' positionality highlight the concept of an outsider and an insider (Berger, 2013; Dwyer & Buckle, 2009). The outsider is depicted as a stranger who is detached, emotionally distant and objective during the research (Buscatto, 2016; Chawla-Duggan, 2007). This makes it difficult for the researcher to have easy access to sites and research

participants. The insider, on the other hand, is often at an advantage, as they access and engage with research participants more easily due to shared experiences or qualities (Dwyer & Buckle, 2009). In this research, I do not completely feel like an insider, even though I am an African, because of the unique characteristics of different African countries. Africa is not monolith but varies from region to region, country to country, containing many different cultures and linguistic characteristics. There are fifty-four countries in Africa, with 1.2 billion people speaking different languages outside the major official languages of English, French, Arabic, and Portuguese. On the other hand, I do not feel alienated, because I am from the African continent and I also feel connected because of my career in the HIV sector. I recognize that the population that is the focus of my research may not consider me an insider. I therefore resorted to using the concept of outsider-within to define my positionality. The outsider-within positionality describes social locations or border spaces occupied by groups of unequal power (Collins, 1999). The outsider-within highlights how systems of power and authority exclude others who are not of the dominant race, gender, and social class or who do not hold the dominant ideology even when they are within the same space. An example would be Black women domestic workers in White families. Despite their perceived privileged insider position in the lives of white families, these Black women understood they would never be equal to or have the same power as a white family member (Bailey, 2023). Though an insider by the position of being an African and my understanding of HIV as a result of my work, I remain somewhat an outsider to the research target population.

As an outsider-within in this context, I also recognize my position of power as a researcher from a Canadian institution. As posited by Makana (2018), this power pushes the researcher to ask pertinent questions: Whose story am I documenting, and

why does this story matter to the community and the outside world? The story of the women living with HIV who have been forced or coerced into sterilization is a story that I believe is worth looking into and highlighting. Using this as an anchor, this research will contribute to an increase in the body of knowledge by aiming to understand how intersectionality and different intersecting identities in an African context marginalize individuals, thus bridging a gap in the application of intersectionality theory in the African context. I committed to openness in the process of data collection, analysis and representation of information. As a feminist researcher, I approached this research with a feminist lens, to shed light on the intersecting issues of gender, class, race, and socioeconomic status to better understand the experiences and characteristics of HIV+ women that experienced forced or coerced sterilization. Drawing from reproductive justice and intersectionality frameworks, which are concepts that were derived from the lived experiences and voices of marginalized Black women, I am committed to amplifying the voices of the HIV+ women in Africa who experienced forced or coerced sterilization. As an African feminist researcher, I situated myself within the research, and I intend to write, representing vulnerable HIV+ women while also engaging with African feminist scholars, to co-produce knowledge that serves the interest of African women. My relational accountability to the research and the people is because I am an African woman and although I am in a somewhat privileged position as a researcher located in the Global North, I understand what it is to be on the margin of society where one is not seen or heard. I am invested in this research as an African woman who has worked in the HIV/AIDS sector and wants to highlight the nuanced experiences of those with additional layers of vulnerability.

There are research benefits for the HIV+ women who are the target group of my research. As described in the Canadian Tri-Council Policy on Ethical Research (TCPS), including a group in research provides potential research benefits. The inclusion of women (as well as other marginalized groups) in research advances the commitment to justice (2022). Although my research is based on secondary data analysis and does not directly engage with participants, it still highlights the voices of HIV+ women who experienced forced or coerced sterilization, foregrounding their distinct characteristics and experiences. It will thus contribute to advancing knowledge and reducing potential harm that may arise when inappropriate general assumptions are made as a result of limited research applying intersectionality to the experience of forced sterilization among HIV+ women and other groups who are victims of this procedure.

As a feminist researcher, these research benefits are essential to me, as the women I engaged with and their stories are real, and behind each story is an actual complex human. I am aware of how research can be extractive and exploitative. I am also aware of my inherent power as a researcher in a Canadian institution researching experiences in African countries. I understand I hold an asymmetrical power position in relation to the women I write about, many of whom have minimal levels of education, live in poverty, and deal with multiple health issues. With this knowledge, my relational accountability lies with my target group, whom I have respect for; I aim to present their experiences and tell their stories to throw more light on how their different vulnerable identities intersect, making them victims of forced or coerced sterilization. This will contribute to reducing the gap in knowledge in factors that make HIV+ women additionally vulnerable to forced and coerced sterilization. It will also reduce the potential harm of overgeneralizing without attention to differing identities, experiences

and relationships. To minimize the harm of extraction of data, I decided to focus on secondary data. This is discussed in the Data Collection section of Chapter 3.

Thesis Structure

This thesis is structured into five chapters. Chapter 1 serves as an introduction to the topic, providing a contextual framework for the sterilization of HIV+ women. It includes a historical overview and background of eugenics practices, while also establishing the interconnectedness of my topic to the field of Women and Gender Studies and the reproductive justice framework, as well as my positionality as the researcher. Chapter 2 encompasses the literature review, and a definition of the concepts of reproductive justice and gender-based violence. I discuss the strengths and gaps of different international instruments on violence against women in mitigating forced sterilization as a form of violence against women. I also explore how intersectionality theory provides an opportunity for a nuanced analysis and how it applies to HIV+ women who are victims of forced and coerced sterilization. The third chapter focuses on the method of data inquiry employed in this study. I used secondary data for this study and analyzed it through the lens of feminist content analysis and an intersectionality framework. Through the lens of feminist content analysis, I reviewed data and studies about women who are forcefully sterilized in Southern Africa to identify specific factors that make the victims particularly vulnerable. Calling attention to intersecting identities is a way of making visible the most vulnerable, who usually live in obscurity. In Chapter 4, the analysis of the research findings is presented and discussed. This revealed that HIV+ women who are victims of forced or coerced sterilization are younger women, unemployed, with lower socioeconomic status, or with lower levels of education. Finally, Chapter 5 serves as the conclusion, offering recommendations for various stakeholders.

Chapter 2: Literature Review

Reproductive justice

My thesis statement highlights that forced or coerced sterilization against HIV+ women represent a violation of the victims' reproductive justice as it denies them the right and choice to have a child if desired. The term reproductive justice was conceived to conceptualize reproductive rights struggles embedded in social justice which challenges racism and classism, among other oppressions (Luna et al., 2013). Reproductive justice is a framework through which reproduction is viewed not as a standalone issue, but one affected by factors such as race and class. The term considers the complete physical, mental, spiritual, political, social and economic well-being of women and girls, based on the full achievement and protection of women's human rights. It offers a different perspective on reproductive advocacy, pointing out that for Indigenous women and women of colour it is important to fight equally for (1) the right to have a child under circumstances of one's own choosing; (2) the right not to have a child and freedom to use the legitimate means available for it; and (3) the right to parent the children in a safe and healthy environment which is free from individual and state violence (Ross, 2016). The HIV+ women who are victims of forced and coerced sterilization are denied the right to have children. My research also suggests that these women are on the lowest rung of socioeconomic ladder, made additionally vulnerable by low educational levels, poverty, young age, and race.

Reproductive justice applies a broader lens through which to view the issues of reproductive rights, beyond abortion and pro-life advocacies. Research has shown that the reproductive health of women and girls is intricately tied to their cultural, social, economic, and political locations (Afable-Munsuz & Brindis, 2006; Chrisler, 2012; Tornello et al., 2014). It is therefore important to acknowledge women's health

decisions, processes, and outcomes as extensions of their interactions with others and systems rather than as individual phenomena. Reproductive justice recognizes that the ability of women and girls to make meaningful choices about their reproductive lives is shaped by intersecting systemic oppressions such as racism, sexism, classism, and heterosexism (Eaton et al., 2020). This illustrates the illusion of choice and the reason why it is not enough to discuss these issues in the context of reproductive rights only. This illusion of choice also applies to HIV+ women who were forced or coerced into sterilization. Their intersecting identities marginalize them and make it impossible for the women to make decisions about sterilization.

Choice is the preserve of the privileged (Tiew et al., 2022). Chiweshe et al. (2017) define reproductive justice as locating reproduction within the social power relations of a particular context. They reject the more commonly touted “reproductive choice” framework as Western-centric and less relevant to African contexts (p. 18). Applying the Reproductive Justice framework, Ross and Solinger (2017) also argue that the concept of choice does not apply to people in the same way and that different factors affect the ability to choose. They reveal ways that laws, policies and public officials differently punish or reward the childbearing of different groups of women as well as the different degrees of access women have to healthcare and other resources necessary to manage sex, fertility, and maternity. Ross et al in their study found that historically the experiences of White women and women of colour were different. In the 1970s sterilization became the fastest growing method of birth control in the US disproportionately affecting women of colour. While White women had a hard time getting their doctors to perform tubal ligation (because the children produced by Whites are considered of superior value), Black women, on the other hand, were fighting for the right to refuse sterilization and against the political culture that defined

them as illegitimate and 'bad mothers' and their babies as unwanted. As described by Ross et al. (2017), the war on motherhood in 1960s and 1970s in the US excluded several categories of women from legitimate motherhood, including the poor, unwed women, and women of colour. Unwed White women were made to secretly give up their babies for adoption; this was the only way to 'redeem' themselves. The unwed woman of colour, however, had no choice but to keep her child and suffer official punishment for having given birth out of wedlock (Ross et al., 2017). White women who were single, poor, and deemed feebleminded were also at an increased risk of sterilization. Thus, sterilization was inflicted on women who departed from the norm of White, married/monogamous, and wealthy, which became the 'norm' of legitimacy and became associated with Western colonial ideologies of good motherhood.

Achieving the three principles of reproductive justice - the right *to* have a child, the right *not* to have a child, and the right to *parent* children in safe and healthy environments depends on access to specific resources, including high-quality health care, housing, education, a living wage and a healthy environment (Ross et al., 2017). Reproductive justice centers the experience of those facing the greatest barriers to reproductive freedom. This essentially means that marginalized groups who owe their marginalization to multiple layers of structural oppression need to be placed at the forefront of any discussion on reproductive justice. This foregrounds largely under-discussed or ignored reproductive vulnerabilities. Utilizing the human rights framework, reproductive justice draws attention to (and resists) laws and policies based on racial, gender, and class prejudices. The reproductive justice framework is appropriate for exploring connections between reproductive health and gendered/racialized sociopolitical complexities that impact reproductive rights. It provides a means for understanding the varied, intersecting, systemic inequities that

shape reproductive health outcomes. Reproductive justice provides a critical lens by exposing oppression and power dynamics in an attempt to address the reproductive challenges that diverse marginalized women face. Integrating the principles of reproductive justice in practice within a health care plan for African Americans and other marginalized populations should integrate various areas of needs such as coverage for abortions, contraceptives, pre and postnatal care, fibroids, infertility, cervical and breast cancer, infant and maternal morbidity and mortality, intimate partner violence (IPV), HIV/AIDS, and other sexually transmitted infections (Ross et al 2017).

Any individual's ability to make decisions about reproduction and reproductive rights is directly linked to other conditions in their community, which are referred to as social determinants of health. Reproductive decision-making is not simply a matter of individual choice and access. For example, a woman cannot individually make decisions about her body if she is part of a community whose human rights as a group are violated, such as women of colour and other historically marginalized women with insufficient quality health care living in largely White societies with a colonial history (Ross et al., 2001). The same applies to HIV+ women who cannot make a decision about their reproductive rights, especially those made additionally vulnerable due to poverty, lower education levels, age, and race.

Social determinants of health refer to the historical, political, social, physical and economic conditions in society that impact health, indicating the links between racism and other forms of discrimination and health outcomes (WHO, 2020). They are contexts which are beyond individual behaviours, linked to historical injustices such as the apartheid experienced by Southern Africa and its linkage to a high prevalence of HIV and inequitable health systems in the region. As Ross et al. (2017) aptly state:

"When we apply a social-determinants-of-health model to analyze reproductive politics, we can see how social and economic resources create advantages and disadvantages for parenthood based on income, education, social class, gender, and gender identity" (p. 173).

At the core of reproductive justice are three interconnected principles:

Intersectionality: this recognizes that people experience reproductive oppression differently based on their race, class, immigration status, gender identity and other social factors.

Human rights: this affirms that access to comprehensive reproductive health is a fundamental human right.

Social Justice: this addresses systemic inequalities that limit individuals' reproductive choices such as poverty, discrimination, and lack of access to healthcare.

Violence against women

I argue that forced and coerced sterilization is not only a violation of reproductive justice and the right to parent, but also a form of gender-based violence. In this section, I situate forced and coerced sterilization of HIV+ women as a form of violence against women which is exacerbated by other compounding factors. Violence against women is a well-recognized human rights issue globally. Several international instruments on violence against women have sought to progressively expand definitions of violence against women as understanding and acknowledgment of the issue has grown. Women's experience of violence cuts across different cultures, countries, and continents and is presented in different forms. Some of the instruments that aim to bring the issue of violence against women to the fore include the 1979 Convention on Elimination of all Forms of Discrimination against Women (which came

into force in 1981), the 1993 landmark Declaration on Elimination of Violence against Women, and the 1995 Beijing Platform for Action, which also identified specific areas of action for governments to take in prevention and response to violence against women and girls.

Decades of advocacy efforts led by the women's movement and grassroots organizations around the world have led to the recognition that violence against women and girls is a manifestation of systemic gender discrimination and inequality, a violation of human rights, and is detrimental to development (UN Women, 2010). Systemic discrimination persists as a result of socialization which favours some groups based on gender, race, or ethnic group over others. Such socialization promotes that where there are differences, one group must be better or more important than the other. In a patriarchal society, men are viewed as superior and more important than women. As a result of this socialization and gender discrimination, women face different forms of violence. The various international instruments on violence against women, such as the 1993 Declaration of Elimination of Violence against Women and the 1995 Beijing Platform for Action, have defined the concept of violence against women differently.

The 1993 Declaration of Elimination of Violence against Women provides the following definition of violence against women :

Declaration of Elimination of Violence against Women

> Violence against women shall be understood to encompass, but not be limited to, the following
>
> a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;
>
> b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;
>
> c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.' (United Nations General Assembly, 1993).

This definition focuses on three levels of potential violence– family, community/place of work, and State. Examples of types of violence are cited at the family and community levels, but there is no example provided at the State level. I propose that forced/coerced sterilization is a type of violence enacted at the State level, because forced/coerced sterilizations are performed in health facilities that are under the regulation of the State.

The failure of the 1993 Declaration of Violence against women to identify forced or coerced sterilization poses a major limitation of this instrument in addressing this form of violence against women. Forced and coerced sterilization has been reported in different countries across the globe and has been used as a form of population control, and a tool to maintain racial integrity and prevent those considered feebleminded and retarded from reproducing (Diekema, 2003; Open Society Foundation, 2011; Vasquez del Aguila, 2006). Most victims of forced and coerced

sterilization are women, especially the marginalized and vulnerable. Thus, the Declaration leaves a vacuum in omitting forced and coerced sterilization as a form of violence.

The Beijing Platform for Action expanded the definition of violence against women as follows:

1995 Beijing Platform for Action

Violence against women includes: violations of the rights of women in situations of armed conflict, including systematic rape, sexual slavery and forced pregnancy; forced sterilization, forced abortion, coerced or forced use of contraceptives; prenatal sex selection and female infanticide.
The Beijing Platform for Action recognizes the particular vulnerabilities of women belonging to minorities: the elderly and the displaced; indigenous, refugee and migrant communities; disabled; women living in impoverished rural or remote areas, or in detention.'

The 1995 Beijing Platform for Action specifically highlights forced sterilization and coerced or forced use of contraceptives as forms of violence against women. It goes further to highlight that women belonging to minority groups are most vulnerable to different forms of violence. HIV+ women, though not mentioned explicitly, are one of the most marginalized groups of women and are highly vulnerable to violence. The identification of forced sterilization as a form of violence in the 1995 Beijing Platform of Action is essential. Naming this form of violence gives it credence. It provides an anchor on which victims, advocates and supporters of action against forced sterilization can rely. However, the omission of HIV+ women as a minority group in the definition emphasizes the othering and alienation this group of women experiences. It also mirrors the exclusion of HIV+ women from the general discourse and study of

violence against women and works on gender-based violence. Violence against HIV+ women and gender-based violence are rather seen as separate areas of work, which relegates the experience of HIV+ women to the background,

Violence against women and girls is prevalent in almost all countries and is widely acknowledged as a major public health and human rights concern (Devries et al., 2013; Nambi et al., 2022). Gender-based violence (GBV) is extensive around the world. While both men and women can be victims of gender-based violence, women and girls are disproportionately affected (Pandey, 2023). The World Health Organization (2021) reports that one in three women has experienced physical or sexual abuse. Further statistics from UN Women (2021) show that globally, 35 percent of women have experienced physical and/or sexual intimate partner violence or sexual violence by a non-partner. This figure does not include sexual harassment. When it comes to adolescent girls aged 15–19, 15 million worldwide have experienced forced sex (UN Women, 2021). A European report on gender-based violence highlights that one in three women in the European Union (EU) have experienced physical and/or sexual violence since the age of 15, while one in ten has experienced sexual harassment or stalking via new technologies (European Parliament, 2016). The gap in these data and statistics is the absence of data on gender-based violence perpetuated by systems and structures, as in the case of forced sterilization of HIV+ women. The non-inclusion of violence specifically experienced by HIV+ women in the data on violence against women portrays the invisibility of the experience of this category of women, which further marginalizes this group.

Afrobarometer survey findings (2024) show that across Africa, GBV ranks as the women's rights issue that citizens most want the government and society to address; 38% of the respondents reported that GBV is "somewhat common" or "very

common" in their community. In nine countries, at least half of respondents claimed that violence against women is a common occurrence, led by Angola (62%) and Namibia (57%). Poor citizens are more likely to report that GBV happens frequently (M'Cormack-Hale et al., 2023). In a bid to address GBV, African states have taken some important steps, such as the ratification of the Convention on the Elimination of All Forms of Discrimination against Women. Fifty-two out of fifty-four states have ratified the Convention, which is widely regarded as a global bill of women's rights and formally acknowledges the importance of addressing violence against women as part of advancing these rights. African countries have also spearheaded regional efforts. 44 states have ratified the Maputo Protocol, which commits states to addressing violence against women, including harmful traditional practices such as child marriage and female genital cutting (African Union, 2003). To curb GBV, the South African government has introduced new laws to protect women and children from abuse and violence. President Cyril Ramaphosa has described GBV as the country's second pandemic. The National Council on Gender-Based Violence and Femicide Bill was signed into law on 24 May 2024 (Republic of South Africa State of the Nation, 2024).

Pandey (2023) argues that gender-based violence occurs in a continuum of violence. At one end of the continuum are behaviours that are generally considered sexually violent in our society, such as rape. These acts are recognized as serious crimes in most cultures and societies and are judged more harshly and carry legal ramifications and punishments (Stout, 1991). At the other end of the continuum are behaviours that are more commonly accepted such as, traditional gender norms, sexually degrading language against women, molestation and harassment (McMahon et al., 2011). The behaviours at this end of the continuum are often normalized as a part of culture, and their connection to sexual violence is not widely recognized nor

judged as harmful (Stout, 1991). Forced and coerced sterilization of HIV+ women fit at the latter end of the continuum; it is not recognized as a form of violence against these vulnerable women, who are discriminated against and whose issues do not make it into the general discourse on women's rights. As a result of additional layers of vulnerability, HIV+ women who are forcefully sterilized risk being invisible and may be viewed by other women as deserving of sterilization.

Intersectionality as a theory

Intersectionality within feminism is a theoretical concept emphasizing the differences among women, challenging the binary positioning of men versus women that assumes all women are the same. The term has alluded to Black women's oppression among other subjugations. As a concept, intersectionality historically has been adopted by Black, Indigenous, Latinx, and women of colour to demonstrate their experiences of omission and exclusion within social justice movements in primarily western, Anglo-American contexts (Bowman Williams, 2021). Intersectionality was initially introduced as a concept that centred on women of colour, but the concept has evolved and is now applied to a wider range of groups and used in different contexts, such as (a) as an academic tool (e.g., theory and/or research paradigm) and (b) as a way to engage in critical praxis or as an approach for "remedying complex social inequalities" (Cho et al., 2013; Collins, 2015; 3; Hancock, 2013). Intersectionality provides an inclusive paradigm for promoting social justice. Non-application of the intersectionality framework may compound the marginalization of women of colour and other marginalized populations. An example is the Marriage Fraud Amendments to the 1986 Immigration Act in the U.S., which required that a couple remain married for two years before the immigrant spouse becomes eligible to apply for permanent resident status. Applying an intersectional lens in analyzing this policy highlights how

immigrant women who are facing intimate partner violence may be exposed to prolonged harm as they would not want to leave or report the abusive spouse to legal authorities for fear of facing deportation (Crenshaw 1991). Eventually recognizing this challenge, Congress implemented a domestic violence waiver to the Marriage Fraud Amendments.

Intersectionality theory provides an opportunity for nuanced analyses of programs, services and laws, knowing that people are not homogenous but face different forms of oppression (and privilege) based on their identities, including race, class, colonialization, sexuality, dis(ability), and others. The word intersectionality was coined by Kimberle Crenshaw in the 1990s She opines that women have different experiences determined not only by their gender but also other aspects of their being such as race, ethnicity, and social class. She argued that these intersecting identities pose different forms of oppression which may not be identified when focusing on only aspect of identity. Even before the term was coined in the 1990s, Black women understood how the various parts of their identities have been sources of oppression. An example would be the 1977 Combahee River Collective Statement, which identified the specific challenges faced by Black women in the U.S. at the time of the women's liberation and civil rights movements in North America:

> We believe that sexual politics under patriarchy is as pervasive in Black women's lives as are the politics of class and race. We also often find it difficult to separate race from class from sex oppression because in our lives they are most often experienced simultaneously. We know that there is such a thing as racial-sexual oppression which is neither solely racial nor solely sexual, e.g., the history of rape of Black women by white men as a weapon of political repression (p. 4)

Since these early beginnings, intersectionality has been used to study and expose the exclusion inherent in a hegemonic single-axis framework by considering multiple axes of power and difference (Brah & Phoenix, 2004; Dhamoon, 2011). Dhamoon (2011) espoused that focus on *either* race or sex failed to consider how marginalized women are vulnerable to *both* grounds of discrimination; thus, even a combination of studies about women and studies about race often erase the experiences of Black women. A Black woman is at the intersection of gender and race, and her experience totally differs from that of a White woman. The discrimination and oppression at the intersection of gender and race make her more vulnerable than a White woman. The same applies when other intersections of disability, socioeconomic status, sexuality, etc. come into play. The more a person intersects with less dominant factors, the farther away they are from power and privilege and the more vulnerable they are. This applies to my target population for this thesis, HIV+ women who are victims of forced sterilization. In the course of my research, it became evident that the identities of being HIV+, gender, age, level of education, and socioeconomic status intersect to keep the victims at the margins of society, making them vulnerable to the violence and harm of forced and coerced sterilization. In line with intersectionality theory, those who are closer to the dominant group and do not present the additional oppressed identities are better off and can be considered more privileged. For example, men who are HIV+ are not targeted for sterilization. In Chapter 4, I delve further into a discussion about power, privilege, and inequalities in the Southern African context.

Forced and coerced sterilization has been documented in countries in North and South America, Europe, Asia, and Africa (Open Society Foundation, 2011). The most recent cases of forced and coerced sterilization target women living with HIV, women who are ethnic and racial minorities, women with disabilities, and poor women,

among others (Open Society Foundation, 2011). When these characteristics intersect in an individual, they further marginalize such person(s), placing them in a tangled web from which there may be no escape. In the metaphorical social ladder, certain women are placed over other women (Sifris, 2016). Consequently, certain groups of women are more likely to be subjected to forced or coerced sterilization than others. Women who are living with HIV, have a lower level of education, are poor, or are of lower socioeconomic class are more vulnerable to being sterilized as they are most likely to be targeted. As Sifris (2016) posits, involuntary sterilization is not only a form of discrimination (and violence) against women but is a form of intersectional discrimination. In Roseman et al.'s (2013) research, an HIV+ Namibian woman attested that a physician told her: "You have enough kids, you are unemployed, and have no money, you have to get sterilized" (p. 28). This statement attests that women who live with HIV and are poor are at higher risk of forced/coerced sterilization because they are considered 'unworthy' of bearing and rearing children.

As noted by Phoenix et al. (2006), intersectionality foregrounds a richer ontology than approaches that attempt to reduce people to one normative category at a time. It makes visible the multiple positionings that constitute everyday life and the power relations that are central to it, bringing fresh nuanced perspectives and insights. Grounded in Black feminist theory, intersectionality can be applied to the promotion of social justice by illuminating, analyzing, and working to change multiple interacting systems of power and oppression connected to mutually constructed social positionalities; it is a distinctive knowledge that is generated by experiences of previously excluded communities and oppressed groups (Dill & Zambrana, 2009; Reed et al., 2021). Intersectionality promotes social justice by considering the interaction of different structures of society and how this interaction affects different

individuals, recognizing that these key components influence political access, equality, and the potential for any form of justice (Hancook, 2007; Rice et al., 2019). As my research reveals, reviewing studies of HIV+ women who are forced or coerced to undergo sterilization through the prism of intersectionality provides more nuanced information that highlights additional specific characteristics of those who are sterilized.

Researchers and authors of articles on the experience of HIV+ women who experienced forced or coerced sterilization focus for the most part on the axis of HIV status and the axis of gender (Durojaye, 2018; Essack et al., 2012; Mthembu, 2022; Roseman et al., 2013). Roseman et al. (2013) report that several studies suggest that women experience HIV-related stigma and discrimination more than men, and are more likely to experience the harshest and most damaging forms of stigma and have fewer resources for coping with it.

Highlighting the gendered oppression faced by HIV+ women is not wrong; it reveals the gendered dimension of forced sterilization experienced by HIV+ women. HIV+ men do not have the experience of forced or coerced sterilization. There is, however, a need to study how other axes of oppression – lower educational level, lower social/economic status, age and other factors intersect and intertwine to create the tangled mesh that captures victims. In Dhamoon's (2011) work on discrimination against Black women, she argues that a single-axis framework maintains a focus on either race or sex and subsequently fails to consider how marginalized women are vulnerable to both grounds of discrimination. The intersectionality road metaphor highlights that where the roads intersect, there is a double, triple, multiple, and many-layered blanket of oppression (Dhamoon, 2011). Applying this theory to my research group, HIV+ women in Southern Africa, the multiple layers of HIV status, gender,

educational level, social status, and race create a web that keeps the victims in bondage and exposed to several levels and forms of oppression, such as forced/coerced sterilization. Chi et al. (2011) reveal that socioeconomic conditions play a key role in HIV+ Vietnamese women's decisions to keep a pregnancy or not. According to the authors, women are more likely to comply with the opinions of others when they are in a situation of economic dependency in which they find it difficult to insist on their own wishes. This reveals that socioeconomic situation is a major factor for HIV+ women either in making decisions for themselves or in being forced or coerced. My thesis examines whether socioeconomic factors also play a role in the Southern African context when it comes to forced sterilization.

Domains of oppression

The intersectionality framework helps us understand how domains and dynamics of power apply in society in general. Power is a major focus in the experience of HIV+ women who were forced or coerced into sterilization in Southern Africa. The victims of this sterilization are mostly vulnerable individuals at the lowest rung of the societal ladder. Intersectional analysis explores and unpacks relations of domination and subordination of privilege and agency.

Patricia Hill Collins (2000) uses intersectionality to refer to particular forms of oppression that are expressed at the individual or micro level, for example, the intersections of race and gender, or sexuality. There is also oppression at the systemic or macro level, such as racism, class, and gender. Collins argues that these processes of micro (intersectional) and macro (interlocking) work together to shape oppression. Thus, for Collins, the forms of oppression at individual and systemic levels are complementary.

The intersectionality framework offers insights and understanding of processes and systems because of the multidimensional analysis of how power operates and its effects on different levels of life. Dill and Zambrana (2009) identify individual and structural domains as two domains of power or oppression that can be experienced. The individual domain of power is focused on ways that individuals are either privileged or oppressed based on their intersecting identities. The structural or systemic domain of power explores how institutions or systems can further oppress persons who are marginalized in society. The powerful position of health authorities and government in South Africa is revealed in the BBC News report indicating that health authorities had yet to contact and apologize to victims of sterilization, even after the Commission for Gender Equality report on forced sterilization by Her Rights Initiative was made public (BBC News, 2021). During a parliamentary meeting in November 2020, South African Minister of Health Dr. Mkhize confirmed that there is no policy allowing any woman to be forcefully sterilized; however, he claimed that there is no adequate evidence to substantiate the allegations and reports of forced sterilization, as many of the health professionals who were in service at the time the sterilizations took place may have died, retired, or may not remember the incidents. This statement is devoid of empathy for the victims and takes on a supremacist and patriarchal standpoint in that victims' testimony is not considered as evidence. This reaffirms the marginalization of the vulnerable by powerful institutions that powerful individuals represent.

Individual and social group domain of oppression

The intersectionality framework offers insight into the identities of an individual or set of individuals or social groups that are marked as different (e.g., a Muslim woman, Black woman, poor woman, woman in a rural area, lesser educated or HIV+

woman). Individuals' various identities position them for either oppression or privilege. People living with HIV are positioned as different from the norm, creating the distinction of 'us' versus 'them'; that is, those who are not living with HIV versus those who are HIV+. This is reflected in the stigma and discrimination that people living with HIV experience, however, the experience of stigmatization is not the same for everyone; as described earlier, it is divided along gender lines, with women bearing the brunt of the worst kinds of discrimination. Women living with HIV/AIDS are frequently referred to as "vectors," "diseased," and "prostitutes," but these terms are seldom used for infected men (Ndinda et al., 2007, p. 93). This 'otherization' is evidenced in the stigma that persons living with HIV experience. Specifically, the HIV+ women who are forced to undergo sterilization are a highly marginalized group. Stemming from the experiences of Black women and women of colour, intersectionality acknowledges and brings in lived experiences and voices of the marginalized. The HIV+ women in my research are a marginalized population because their community, family and even health professionals consider people living with HIV as outside of the margin, outside of the norm. This is worse for women, as they are usually the first to test positive in their family, as testing is a requirement during pregnancy. Focusing on individual or group identity provides an in-depth insight into the uniqueness of specific individual or group experiences and knowledge, and this embodied knowledge serves to contextualize oppression and discrimination (Dhamoon, 2011).

Structural domain of oppression

Dill and Zambrana (2009) describe how institutions are organized to reproduce subordination over time. Dhamoon (2011) discusses this as systems of domination such as racism, colonialism, sexism, patriarchy. Understanding how systems of power are implicated in the development, organization, and maintenance of inequalities and

social injustice is essential. Hancock (2007) posits that policy problems are more than the sum of mutually exclusive parts, creating an interlocking prison from which there is little escape. The structural domain of oppression is highlighted by Dill and Zambrana (2009) using the experience of persons of colour in the United States and how they have been controlled by policies in every institution by racial segregation, exclusion acts, forced relocation, denial to own property and denial of the right to marry and form stable families.

The impact of structural oppression on reproductive justice has been studied. This is evident in the history of eugenics in the 19th century which sought to eliminate and end reproduction of those who are not considered a good fit for the society. Eugenics is a form of structural oppression as laws and policies were enacted to keep those referred to as 'feeble-minded' from procreating. These included all Blacks and those whom Stubblefield referred to as 'Tainted Whites' – making a distinction between pure White and tainted Whites (2007; 169). The concept of feeble-mindedness is racialized and deployed to eliminate the Blacks and the 'tainted whites' who are poor and considered impure and lacking civilization-building skills. As revealed by Ross (2017), sterilization during the Depression was not merely allowable by law but was actively pursued as a public health measure. This law and its implementation were a source of terror for poor people; houses were raided and people on welfare were specifically targeted. Such terror is currently being experienced by HIV+ women who are specifically targeted for sterilization. The experience of coerced sterilization by HIV+ women in Southern Africa mirrors the Depression era in the U.S. The targeted group remains the marginalized and vulnerable people, such as poor people. In present-day Southern Africa, poverty and

other factors that further reduce the socioeconomic status intersect with HIV to HIV+ women a target for sterilization.

In August 1994, the CDC issued a drug recommendation as part of a regimen for the prevention of mother-to-child transmission of HIV, and since then more advancements have been made (CDC, 2006). The treatment, and therefore the epidemiology of HIV has changed over the years. Several drugs have been developed belonging to different classes of antiretroviral therapy (ART). This has led to the more appropriate treatment of pregnant women living with HIV (Rowlands, 2018). Regardless, HIV+ women (not men) with lower socioeconomic status are marked for reproductive management, with thousands of HIV+ women estimated to have been subjected to forced sterilization in South Africa (Mthembu, 2022). 7.6% of 4 million HIV+ women in South Africa reported that they were forced into sterilization (Mthembu 2022). Although transmission of HIV from mother to child can be as low as 1% with adequate treatment, forced and coerced sterilization of HIV+ women persist; as mentioned, a case of sterilization was recorded in South Africa in 2021 (Kendall et al 2015; Mthembu 2022). This shows how the vulnerable and those lower in the societal ladder remain oppressed by structures maintained by the powerful and privileged.

Forced sterilization has also been applied as a method of population control between 1920 and 1990 in Canada and some parts of Asia, Europe and Latin America without regard to human rights (Brown, 1984; Petchesky et al., 1998; Strange et al., 2010). Coercive measures such as the promise of money, food, land, and housing, or threats, fines, and punishments, together with misleading information, were employed to secure the sterilization of some members of the population (OHCHR et al., 2014). The forced sterilization policy was targeted at vulnerable groups, such as people living in poverty, persons with disabilities, Indigenous peoples, and ethnic minorities. In recent

times, transgender people, people living with HIV, and intersex people have become targets of forced sterilization (OHCHR et al., 2014). In 1928, the Legislative Assembly of Alberta, Canada enacted the Sexual Sterilization Act. In British Columbia between 1933 and 1973, the Sterilization Act attempted to limit the reproduction of “unfit” persons and increasingly targeted Indigenous women. Between 1968 and 1982, about 42% of Indigenous women of childbearing age were sterilized compared to 15% of White women (McCavitt, 2013). This was a continuation of the larger eugenics’ movement in Canada. Coerced sterilization of Indigenous women took place both within and outside existing legislation, and in federally operated Indian hospitals (Senate Committee on Human Rights Report, 2021). The Act was meant to maintain the desirable genetics of the White middle class. The vast majority of people sterilized through the Canadian programs had been institutionalized in psychiatric hospitals or homes for people considered feebleminded, mentally deficient, or intellectually disabled. In 1942, however, Alberta changed its law to move the eugenics program beyond the confines of institutions. As a result, more children and Indigenous people were identified in the community, at schools, and through public health visits (McCavitt, 2013). Though the Act was repealed in the 1970s, the Senate Committee on Human Rights report (2021) revealed that forced or coerced sterilization continued to be reported as recently as 2018. Forced sterilization continues today despite the absence of formal laws supporting it because of entrenched patriarchal and white supremacist norms. The majority of health professionals in leadership positions are male and they continue to perpetuate male dominance and supremacist standpoint. This reinforces unequal power dynamics. This also applies to the Southern African context with the impact of apartheid. During the period of apartheid from 1948 – 1994, racial discrimination and segregation in Southern Africa were entrenched and this continue

to have an impact, especially on vulnerable populations such as HIV+ women. Apartheid entrenched inequality through distinct segregation and the creation of systems that favour and make the white minority more powerful. This inequity persists post-apartheid and the privileged remains powerful to the detriment of the poor. Post apartheid the percentage of Black doctors in South Africa is 25.85% in 2016 (Top Empowerment, 2023). The segregation and racialized policies of apartheid affected the medical education of Blacks. For example, there was a limited range of clinical material and patterns of diseases that black medical students were exposed to. They were only allowed to see black patients and also only allowed to work solely on black bodies in anatomy and pathology, denying them the opportunity to learn from the diversity of races. The range and frequency of pathologies varied according to race, as a black student stated, 'keeping the black students away from white patients, took a chunk out of their development and self-confidence' (Digby 2013 p. 277). Black women doctors experienced the double axe of race and gender. Gender stereotyping remains deeply entrenched and the expectation is for women to become teachers and nurses, but not to assume authority as doctors. Early gendered restrictions in who can and cannot take science lessons lead to low recruitment to medical school. Young medical women discovered male power to be entrenched and institutionalized, and the majority of the women encountered gender discrimination and career difficulties. Unfortunately, the South African Society of Medical Women – a professional organization set up to advance and improve medical women's position through confronting professional discrimination and inequality – was perceived by black female doctors to be 'white, elitist and apolitical and consequently unable to meet the needs of black women (Digby 2013).

Roseman et al highlight the issue of affordability and access to health care in Namibia where there are user fees and patients have to pay out of pocket for health care services. This puts a burden on the poor Namibian population and for an individual woman living with HIV, her entire household budget could be absorbed by such costs and be a barrier to accessing health services and medication (2013). This barrier in accessing health care also impacts their reproductive justice and their ability to truly make decisions about their reproduction.

Globally, forced and coerced sterilization has been practiced for several decades. In the U.S., Indiana became the first state to adopt involuntary sterilization statutes in 1907; from 1907-1939, 30 states followed with sterilization laws, with the vast majority of victims of being Black (Gartner et al., 2020; Klutchen, 2009). Coercive methods used included threats of losing welfare benefits and other assistance provided by the state if sterilization consent forms were not signed (Gartner et al., 2020; Klutchen, 2009). To reduce immigration in California, Mexican men and women were sterilized at a significantly higher rate than non-Latinos between 1920 and 1945 (Novak et al., 2018). Still promoting eugenics ideology, Mexican women were classified as hyper fertile, inadequate mothers, criminally inclined, and more prone to feeblemindedness, therefore justifying their sterilization to control the spread of these undesirable qualities (Novak et.al., 2018).

In different parts of Latin America, women and men have been reproductively violated to comply with their government's strategy of eliminating poverty by limiting family size (Vasquez del Aguila, 2006). As a tactic, many governments in Latin America restricted access to other forms of birth control as a way to promote sterilization as a more permanent solution (Vasquez del Aguila, 2006). Vasquez del Aguila (2006) reported evidence that many governments developed financial

incentives that were awarded to healthcare workers for every woman they sterilized. 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 (Vasquez del Aguila, 2006). Poor, uneducated women were lured into medical offices with the 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 tubal ligation (Vasquez del Aguila, 2006).

Most recently, in 2020, there was a report of mass hysterectomies on migrants in Georgia, USA during the global pandemic (Ghandakly et al., 2021). This report is evidence that forced sterilization is not just part of history, but a violence that continues to be perpetrated by structural institutions against poor, vulnerable, racially marginalized populations, most specifically targeted at women.

The system's ability to punish the most vulnerable and reward the privileged is evident in the experience of Blacks during the slave era, where the procreation of slaves was promoted for the benefit of the slave masters, as this provided them with a constant supply of slaves to work for them or for sale. In the 1930s debates raged among Black people about the pros and cons of birth control. It was feared that the over-use of birth control in the Black community could lead to ‘race suicide’. Gregory, a Black advocate against birth control, was wary of White people’s motives underlying the promotion of family planning. Gregory, as cited in Roberts (2017), provides an insight into the context and experiences of the Black population as it relates to reproduction:

> "For years they told us where to sit, where to eat, and where to live. Now they want to dictate our bedroom habits. First, the white man tells us where to sit on the bus. Now it looks like he wants me to sleep under the bed. Back in the days of slavery, black folks couldn't grow kids enough for white folks to harvest. Now that we've got a little taste of power, white folks want us to call a moratorium on having children". (p. 98).

The structural inequalities against the marginalized still persist. On the PBS News Hour (2018), a panel discussed why Black mothers and infants are three to four times as likely to die in the United States of America from pregnancy-related causes than their White counterparts. Linda Villarosa, one of the panellists, revealed unconscious bias and racism against Black women in the healthcare system as a major contributing factor to the poor maternal health statistics. Monica Simpson, another panellist, affirmed that it does not matter what the Black women's socioeconomic status is or what their education level is, drawing from the experience of Serena Williams. Serena herself had this to say about her reproduction experience: "Giving birth to my baby was a test for how loud and how often I would have to call out before I was finally heard" (Coady, 2022). Racism is a major form of oppression used against the less dominant Black community groups in the United States.

Colonialism works hand in hand with racism to continue to relegate Africans to a prison of subjugation and a perpetual position of subordination to White colonizers, even in the African continent. This is exemplified by Strode et al. (2012), who relate how an HIV+ woman in South Africa who experienced forced sterilization was treated by health workers: "He was shouting at me while all were listening. He said all black people are careless. I was embarrassed and I just signed without getting time to read

the form" (p. 65). In Chapter 4, I discuss the impact of apartheid and racist policies in Southern Africa and their influence on inequality and HIV.

Identified gaps in the intersectionality framework

a. Location of intersectionality

One major limitation of the study of intersectionality is that the concept is located mainly in the global north. As Patil (2013) espouses, the focus of intersectionality theory is currently on the global north in general and the United States in particular, leading to an American-centric conception of intersectionality. This results in limited research and study in other parts of the globe on how the operation/impact of intersectional structures influences individuals, systems, and structures. My thesis will contribute to bridging this knowledge gap. Future research should engage in the application of intersectionality theory outside of the Global North, which will facilitate an understanding of differences and synergies within the application of intersectionality in the Global South and the Global North.

b. Scope of intersectionality

The race–class–gender trinity, as described by Monture (2007), has been a major focus in applying intersectionality and how different individuals with different identities are impacted. This focus privileges the components of the trinity as identities that are researched and studied. There is, however, a need for the study of other domains of oppression that further under-privilege individuals, placing them in a position of disadvantage and further oppression. This is essential for societies that may be considered homogenous in terms of race. Examples of such other identities outside of the trinity include nationality, education, language, age, sexual orientation, and disability (Fogg-Davis, 2006; Garland-Thomson, 2002; Kliewer & Fitzgerald, 2001). Future studies should research intersectionality theory as it relates to other

forms of identities. My research will focus on how identities such as education level and socioeconomic status contribute to disempowering HIV+ women, recognizing that HIV+ women are not a homogenous group.

Chapter 3: Method

Data collection

My thesis primarily focuses on secondary data sources. Secondary use of data refers to the use in research of information or human biological materials originally collected for a purpose other than the current research purpose (Government of Canada, 2022). I applied secondary data analysis to assess the characteristics of HIV+ women who experienced forced and coerced sterilization. I researched reports and articles that highlighted the characteristics and experiences of my target population. I did not collect raw data but collected data from already published reports. The core materials that I analyzed had a total of forty four (44) research participants who had experienced forced sterilization between 1996 and 2010. The title, authors, number of participants and recruitment pool and method are represented in the table below.

Title, Author(s)	**Year**	**# participants**	**Recruitment pool**	**Recruitment method**
Experiences of forced sterilization and coercion to sterilize among women living with HIV (WLHIV) in Namibia: an analysis of the psychological and socio-cultural effects Bakare K, & Gentz S	2020	7	40 women (22 from the Khomas Region and 18 from the northern regions) who experienced forced and coerced sterilization in Namibia, and whose cases were documented	Based on availability and proximity to the researcher
"She made up a choice for me": 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces	2012	22 (15 in Kwazulu Natal; 7 in Gauteng)	A purposive sample of HIV+ women who believe they have been forcefully	Recruited from support group meetings and are victims of forced sterilization

Strode A, Mthembu S, & Essack Z			sterilized. Aged 18 or older in KwaZulu-Natal and Gauteng provinces of South Africa	with interest to be part of the research
The power of the small group: from crisis to disclosure Sewpaul V & Mahlalela	1998	15	HIV+ women who are members of a support group in Kwazulu Natal province of South Africa	Interest in participating in the research
	Total	44		

Secondary analysis is the analysis and use of data collected by another researcher for a different purpose (Wickham 2019). The use of secondary data analysis in this thesis provided an opportunity to analyze a wide range of data, which may not have been possible using primary data collection given the specificity of the target group. My decision to focus on secondary data sources is supported by the Murad Code, which is a UN-formulated, international Code of Conduct that provides minimum standards for the safe, effective, and ethical gathering and use of data on victims or survivors of sexual and gender-based violence. Forced and coerced sterilization against HIV+ women, as posited in my thesis statement, is a form of gender-based violence. Section 4.3 of the Murad Code promotes the use of alternative sources of data collection in research regarding victims or survivors of gender-based violence. It proposes that using alternative sources rather than engaging directly with victims or survivors through interviews removes potential risks to survivors, those around them, and researchers (Murad Code, 2022). The Murad Code supports the use of existing data to answer new questions. Data collected for different purposes can be beneficial in answering new questions and should be encouraged and supported as

it offers benefits such as reduction in research fatigue and retraumatization. Therefore, in accordance with Section 4.3 of the Murad Code, I opted for the use of secondary data collection as an alternative source of data collection for my thesis.

The other benefits of secondary data analysis are savings not limited to finances but also in terms of time, and labour. It also prevents data collection challenges such as in the recruitment of study participants, study drop out and completing data collection within a reasonable time (Wickham 2019). Given that this is a Master's thesis which has a limited time frame working within reasonable time is important to me. Wickham defines secondary data analysis as where a researcher addresses new questions from a dataset previously gathered for a different primary study. He affirms that the researcher must have access to source data, as opposed to secondary source data (e.g., a medical record review), and that original qualitative data sources could be videotaped or transcribed (2019). For my thesis, the materials I analyzed are articles and reports of data previously analyzed by the researchers. The data is mostly qualitative, and to keep to the original account as much as possible, I focused primarily on the quotations of the actors who are largely HIV+ women and also health practitioners. In this instance, my thesis differs from Wickham's in that it was not direct data source that I analyzed, however, because I focused majorly on the quotations I was as close as possible to the original data source.

The recurring themes from the stories and experiences of the HIV+ women who participated in past research provided insight into the characteristics and underlying factors that made the victims additionally vulnerable to sterilization. The data sources I analyzed also helped me identify the tension between gender-based violence for the general female population versus the HIV+ female population. The

segregation of violence against HIV+ women from works on mainstream violence against women leads each to be seen as separate areas of work.

To locate literature on the topic, I used the Saint Mary's University Patrick Power Online Library and Google Scholar and collaborated with the Women and Gender Studies Librarian at Saint Mary's University and colleagues in Nigeria, South Africa, Malawi and the UK. I also identified additional relevant sources by following references cited in the works I studied. The colleagues I reached out to initially also introduced me to additional contacts. I decided to focus on secondary sources because of the particularly vulnerable population on which my thesis is focused. Glaser was among the first to highlight the benefit of reanalyzing data in 1963 (Kelly et al., 2024). Since then, scholars have appreciated the wealth of valuable information available in existing datasets and have used existing data to answer new research questions (Kelly et al., 2024). The benefits of secondary data analysis include limiting repeated "exposure" of participants to interviews, questionnaires, treatments, or other interventions (Smith, 2008). This is especially relevant for participants with unique conditions or who may be challenging to access, for example HIV+ women who have experienced forced or coerced sterilization. For over-researched or difficult to reach populations, as well as the exploration of sensitive topics, secondary data analysis extends access to data already collected and avoids research fatigue (O'Connor, 2020; Wickham, 2019).

Women living with HIV are affected by trauma, and conducting primary data collection (such as interviewing) on this population could be re-traumatizing. Brezing et al. (2015) argue that "although both women and men living with HIV are affected by trauma, women living with the virus are mostly affected" (p. 178). According to Brown et al. (2022), people living with HIV tend to have higher prevalence estimates of trauma

and post-traumatic stress disorder (PTSD) compared to the general population. Some of the identified factors that lead to PTSD among this group include revictimization and the diagnosis of HIV. This is confirmed in a recent study by Silima et al. (2024), which found that an HIV+ diagnosis often triggers mental health symptoms linked to depression and anxiety among participants. The participants in the study reported initial feelings of overwhelming fear of death and denialism. Their findings also show that internalized stigma intensifies overall mental health challenges faced by people living with HIV.

Minority stress theory explains that health disparities among minority populations are caused in large part by stressors induced by a hostile, stigma-inducing culture, often resulting in experiences of external prejudice, expectations of rejection, and internalized rejection, which may impact behaviour and access to care (Marshal et al., 2008; Meyer, 2003). Minority stress theory distinguishes the excess stress that individuals from stigmatized social categories are exposed to because of their social, often minority, position (Meyer, 2003). The alienation from social structures, norms, and institutions that minority groups (such as women living with HIV) endure results in a traumatic experience which may lead to self-rejection and may negatively affect access to care and involvement in research. Meyer (2003) posits that theoretical perspectives based on social interaction and comparison with others suggest that receiving negative evaluations—such as stereotypes and prejudice directed at minority persons in society—may lead to adverse psychological outcomes. In line with this, the target group for this thesis may self-reject, which would affect their interest and availability to participate in research. In addition, I opted not to engage directly with my target research population to avoid retraumatization. I reflected on minority stress theory during my data collection and analysis, understanding that HIV+ women

who are forced or coerced into sterilization are a minority group with high stressors and discrimination both real and perceived.

For the analysis of the experiences of my target population, I collected data from a combination of global, regional, and national studies. The available data revealed that while it has been identified that poverty, HIV status, ethnic minority, and disability have been targets of forced sterilization, the intersection of these characteristics in individuals has not been adequately studied. This exclusion further creates an invisible group of these highly vulnerable women. In my analysis, I systematically reviewed the available data for the voices and stories of the victims. The women's narratives provide direct insight into their experience and existence and create an opportunity to share part of that existence. Stories immerse us into the experiences of people, and we should learn to listen and not only to hear, applying a feminist ear as described by Ahmed (2021). Experiences are an intimate and intrinsic part of people's ontology and epistemology and are the core of people's identity; they are unique to a person or group of people. My positionality as an African who has worked in the HIV thematic area helped me to connect with and be sensitive to the experiences of HIV+ women who are victims of forced and coerced sterilization.

As part of my method of collecting secondary data, I reached out to colleagues in different countries for reports or studies they may have undertaken on the topic. The colleagues I contacted referred me to other sources such as Gender Based Violence (GBV) Community of Practice (GBV CoP), Sexual Violence Research Initiative (SVRI) and Network of Women Living with HIV/AIDS in Nigeria. I applied and became a member of the GBV CoP, which is a network of GBV professionals in the nonprofit sector around the world. I posted a question in the group forum asking for any

materials or research on the topic of forced/coerced sterilization of HIV+ women. I got a reply with links to materials and information.

My search for materials exposed me to the lack of awareness and silence that surrounds this topic. The criteria I used to identify which colleagues to contact included those who have worked in the fields of HIV/AIDS or Gender-Based Violence, or who are medical practitioners in the Southern African region. I was troubled when most of these people told me that they had not heard about this issue. When I contacted a former colleague from a Nigerian non-profit organization who is currently practicing medicine in Southern Africa, he told me that he was not aware of the practice of forced sterilization. Another colleague who used to work in the HIV/AIDS department of USAID PEPFAR in Southern Africa reached out to his former colleagues but received no promising information. I also reached out to a contact with the Association of Women Living with HIV/AIDS in Nigeria, which also did not yield results. The data I received came from GBV CoP, SVRI, and university professors in South Africa.

The lack of awareness that surrounds this topic is disturbing. In addition to a lack of awareness, I believe that there is an unwillingness to share information, which may be associated with the extractive logic of data capitalism (Sadowski, 2019). Data capitalism is linked to paternalistic relationships, where the authority figure or governing body assumes a position of superiority over those targeted as the object of development. Paternalism is problematic because it undermines the agency of individuals and/or autonomy of communities and perpetuates or even reinforces existing power asymmetries between countries in the Global South and the Global North (Helm et al., 20233). By the latter generating knowledge about the former and then using that knowledge to tell the former what is best for them, historically grown relationships of dependency are likely to be maintained (Helm et al., 2023). My

positionality as a researcher associated with an institution in the Global North may trigger experiences associated with data capitalism and the exploitative use of data.

To address the challenge of extractive data practices and paternalism, real collaborative relationship is essential. The relationship between the Global South and the Global North has been of unequal collaboration, which undermines the agency of individuals and/or autonomy of communities in the Global South. Data sets that promote diversity are essential, such as in creating richer data sets that enable better/fairer performance of collaborative filtering (Helm et al., 2023). Helm et al. (2023) claim that local adaptation is necessary to make participation more attractive to people living in very different sociocultural contexts. To do this, local teams must be involved, not only in the implementation phase of the research, but also as much as possible should be part of project planning and design. The goal should not be just to take data, but to foster and build community. This approach aligns with feminist research principles, which seek to respect, understand, and empower women (Campbell et al, 2000). The feminist method of inquiry involves a heightened concern for research ethics and care for participants, and an attempt to address the hierarchical nature of relationships between the researcher and the researched (Mauthner et al., 2005; Montell, 1999).

Recommended strategies to overcome these challenges include constant awareness and acknowledgment of power dynamics between the researcher and research participants and between the Global North and South. Interpersonal relationships are shaped by historically established and normalized inequalities, and therefore respecting the values of the participants and acknowledging that they are the masters of their stories is crucial to building trust and rapport, reducing power inequalities, and encouraging the research participants to feel relaxed. As I did not

engage in primary data collection, I lacked the forum to build trust with research participants, instead relying on my previous relationships and trust that I have built over several years with my colleagues across different countries. I relied on my networks to reach out to their networks for data.

All the resources I received were already in the public domain and accessible via the Internet. Studying and analyzing the reports, articles and resources on the topic of forced and coerced sterilization, I identified that various variables such as educational level, poverty, age, race and employment status are discussed independently and in silos. There was no specific discussion of how intersecting identities further make people more vulnerable. Individuals are not one indivisible part but are made up of various identities that may intersect to make a person more privileged or more oppressed. When such intersecting identities are applied to HIV+ women who have been forcefully sterilized, it exposes how other factors make these women extremely vulnerable.

Limitations

While there are benefits and justifications for using secondary data, doing so also comes with some limitations. The non-involvement of my target population in primary research may have resulted in omitting some specific details and additional insight that direct engagement fosters. Consequently, the voices and experiences of the women who are victims may not have been fully captured or comprehensively represented.

Engaging in primary data collection would have offered me the opportunity for the researcher to frame my own interview questions. I would have developed specific questions not only for the victims but for other actors such as health professionals in Southern Africa. This would have added more information about racism which was

subtly identified in this research. I would also have targeted HIV+ women who were not sterilized. This would have allowed me to further understand how classism and socioeconomic privilege plays a role in this discourse and the Southern African context.

The data I analyzed came from people who participated in the various studies conducted by the researchers and was shaped by the authors of the texts. This was intentional as I did not want to be exploitative with data collection thereby causing more harm to women who are HIV+, who have experienced gender-based violence, and who have already been interviewed, possibly multiple times for other projects. Such data collection would go against the tenets of the Murad code that promote safe, effective, and ethical gathering and use of data on victims or survivors of sexual and gender-based violence. The code supports the use of existing data to answer new questions with the intention to limit research fatigue and increased harm to survivors of gender-based violence. Women of higher socioeconomic status in terms of education and income may not have had an interest in participating in such studies. This may be due to confidentiality concerns, or they may have adequate resources and capacity to steer away from the research gaze. The intersection of other identities, such as disability, was not identified in the literature I studied. However, various articles report that persons with disability are part of the category of persons vulnerable to forced sterilization (Open Society Foundation, 2011).

Despite these limitations, this thesis provides valuable insights and serves as a foundation for further research on the topic of forced and coerced sterilization of HIV+ women. Future research could consider incorporating additional methods, such as semi-structured interviews with all actors, not only the HIV+ women but also health practitioners for a more nuanced understanding of the topic.

Feminist content analysis

I applied feminist content analysis to study the materials available on this topic and used it to analyze the data available about HIV+ women who experienced forced sterilization. The materials studied include academic literature, media reports, and reports from nonprofit sectors. According to Reinharz et al. (2007), feminist content analysis focuses on both the interpretation of the content and on its juxtaposition in the larger sociopolitical context. Feminist content analysis also examines processes that prevent or disadvantage the experiences of particular groups of women or women in general from being documented. It is a study of both texts that exist and texts that do not exist (Karon, 1992; Reinharz, 1988). A common practice in feminist content analysis is to examine how gender and other interlocking social forces are embedded in mainstream texts. Feminist content analysis also involves categorization and operationalization of the 'woman' and avoids of taking a hegemonic view of women, instead helping to pay attention to multiple social forces among women of various races and classes. Knowledge and production of knowledge are gendered and inherently based on power.

The materials and articles I read were research conducted for other purposes. Although they were focused on my target population they did not answer my research question of the factors that make the victims vulnerable to the violence of forced sterilization. Most of the conclusion of the study were not helpful in the answer to my research question. I had to critically study and identify themes that are relevant to my research. The essential overlap with my study and the materials I studied were the target population. The materials I read has as the research population HIV+ women who have experienced forced or coerced sterilization. However, the materials focused

on understanding the impact of this violence on the victims. Such impact included psychological, physical and financial. Some of the materials are focused on the benefits of having a support group for HIV+ women especially those who have experienced forced sterilization. I read the articles and reports using my laptop and as I studied the materials, I copied and pasted on Microsoft Word any quotation that provides the characteristics of my target population. I was interested in the voices of my target population, I wanted to know their experience, their lives, and their stories. I was drawn to any information that provided insight about my target population and their experiences in navigating health care. Upon completion of the readings, I went through what I copied out and noticed they can be grouped into different categories. I categorized the data into themes and patterns to arrive at a more nuanced representation of the experiences of different groups of HIV+ women. While reading, I identified quotations that hint at the characteristics, social status, or other demographics that provide more information on the victims of forced or coerced sterilization. These stories and quotations were then grouped into categories- poverty, age, education, and race, which represented the characteristics of the HIV+ women who are victims of coerced or forced sterilization in Southern Africa. I discuss these characteristics further in Chapter 4.

Understanding the power and privilege of those who study, document, or report on issues, I was sensitive to what was reported or documented, keeping in mind that the voices of the marginalized are most often silenced. I was continuously conscious of my power as a researcher and continually practiced self-reflection. Utilizing my power, I committed to highlighting the intersecting identities of HIV+ women who are highly vulnerable and often invisible, because their specific intersecting identities are not named or studied. This is represented by the 44 people who were research

participants in the data I analyzed. Calling attention to intersecting identities is a way of making visible the most vulnerable, who are usually in obscurity. In my research, I give voice to the struggles of the victims by naming the intersecting identities that make them additionally vulnerable to forced sterilization, including race, age, poverty, employment status, educational status, and overall socio-economic status. The data I studied did not pay attention to the interlocking identities of the participants; rather, the HIV+ women were lumped together and discussed as a homogenous or monolithic group. I was intentional in my analysis to bring out the fact that HIV+ women are not a homogenous group and have intersecting identities that make some additionally vulnerable to forced and coerced sterilization. My thesis, therefore, contributes to calling attention and making visible the intersecting identities such as age, level of education, and socioeconomic status that further marginalize HIV+ women who are victims of forced and coerced sterilization.

Thus, applying feminist content analysis, I reviewed data and studies conducted about women who have been forcefully sterilized in Southern Africa as a way of identifying specific factors that particularly make the victims vulnerable. Such an analysis has not been conducted; thus, this research adds to the body of knowledge and provides more insight into the groups of HIV+ women who face forced/coerced sterilization. It will further expose the vulnerability faced by different intersections of HIV+ women, highlighting that HIV+ women are not a homogenous group.

Intersectionality as a research tool

Intersectionality has been examined as a theoretical, analytical, and epistemological framework, but it has been under-examined as a methodologic approach or process, that is, as a set of governing principles, methods, practices, procedures, and techniques used to collect and analyze data (Rice, 2011).

Intersectionality can be used as a form of disciplinary self-reflexivity and as an analytic strategy, which includes how questions are formulated and studied with attention to power and complexity. It serves not simply to describe and explain complex dynamics of power in specific contexts and at different levels of social life, but also to critique or deconstruct, and disrupt the forces of power to offer alternative worldviews (Dhamoon, 2011; Reed et al., 2021). Intersectionality can be applied as a critical analytical tool to dig deep into understanding human experiences outside the hegemonic and dominant lens.

Applying intersectionality in research allows us to study the various levels of oppression and marginalization which result from a combination of factors. Intersectionality theory formed the basis of my questioning; I wanted to find out other factors that make HIV+ women who are forcefully sterilized in Southern Africa vulnerable. The studies I analyzed presented two axes for the violence committed against these women: HIV status and gender. However, I wanted to go deeper into that analysis to identify other intersecting identities that may be applicable. Therefore, when studying the materials and data, I was conscious of demographics and specific experiences which provide insight into the various identities of the victims.

In some instances, researchers employ additive approaches to consider the characteristics of two or more social markers without considering complexities that emerge at these junctures, and without acknowledging the broader social context in which identities and differences are considered and constructed (Rice et al., 2019). My thesis is not at risk of this pitfall, as it reviews holistically the identities of individuals in the target population from the data available. The experience of the 44 HIV+ women in the study population revealed that the violence of forced sterilization emerges at the juncture of younger age, poverty, lower educational status, race, HIV+, and female

gender. Applying an intersectionality framework in analyzing the data meant that I was conscious of the factors that made my target population more vulnerable. To identify these factors, I critically studied the data for any quotation or sentence that revealed other identities of the victims. I aimed to review the data with a critical lens to examine how power dynamics impact those who hold some of the lowest positions in society, and I achieved this by focusing on the voices of the victims. Applying intersectionality as a research paradigm requires gathering data from different sources, not only the voices that are represented as dominant. I tried to diversify my data collection approach by not only searching online for resources, but also reaching out to various colleagues for research materials. I reached out to the Association of Women with HIV in Nigeria intending to get connected to a similar association in Southern Africa, and although they did not have the contact I was looking for, I received resources and connections through other contacts. Intersectional empiricists cannot rely on the same old data, or more precisely, data collected in the same old unitary way. In studying my target population, I applied intersectionality in my analysis by moving beyond the mainstream dominant and most visible structures of oppression (gender and HIV status) to other forms of oppression that further harm the victims. The focus on the impacts of HIV status and gender is not bad, as it has revealed the gendered nature of forced sterilization. However, applying intersectionality as a research paradigm reveals other variables that further oppress the victims.

The gendered nature of HIV discrimination has been highlighted in various studies as the primary factor that puts women at risk of forced sterilization. However, this violation of the reproductive rights of HIV+ women in Namibia, South Africa and other affected countries is a result of various factors. Mthembu (2022) posits that HIV+

women are targeted because they are females, and that HIV+ men are not targeted for forced sterilizations. This positions the oppression on a gender level only.

I do not accept that this violation of the reproductive rights of HIV+ women is based on gender alone. There are several forms of oppression people face which can be a result of race, class, colonialization, sexuality, dis(ability), and others. Studies in South Africa on forced and coerced sterilization of women living with HIV have reported stigma and discrimination as a result of HIV status, ineffective legal frameworks, lack of policies to protect individuals, and negative attitudes of health professionals towards these women as factors that promote forced sterilization (Essack et al., 2012; Roseman et al., 2013). These factors are mainly external, paying less attention to internal factors, such as the identities of the individuals, and how these intertwine with external factors to reduce the humanness of the victims, making them invisible and undesirable. The oppression that forcefully sterilized HIV+ women face is not limited to gender alone, but also relates to social determinants of health. How different factors such as education, social status, and employment intersect in HIV+ women who have been targeted for sterilization needs to be further analyzed and studied.

Young et al. (2020) argue that what is measured reflects what is implicitly valued or perceived to be the biggest priorities in a health system. Datasets (e.g. Demographic Health Surveys) are for the most part disaggregated by variables such as sex, age, location or wealth quintile. While this allows us to see variation between groups, it does not show us how groups may be disadvantaged as a result of the intersection of stratifiers (Young et al., 2020). Such data gaps can mask health inequities and needs experienced by specific groups, often characterized by multiple, intersecting social stratifiers, rendering them invisible (Bauer, 2014). ‘Invisible

populations' may be more likely to be subjected to non-desirable services such as sterilization. Applying an intersectional lens to health systems can provide a more nuanced and robust way to examine health inequities (Young et al., 2020). Failing to use an intersectional lens in analysis can result in a superficial analysis of inequity without focusing on the root causes of the inequity.

Chapter 4: Data Analysis and Discussion

Researching and analyzing data on HIV+ women who are victims of forced and coerced sterilization in Southern Africa using feminist content analysis and an intersectional lens indicates that these women tend to be racialized, poor, and young, with lower levels of education and lower socioeconomic class. It also highlights the illusion of choice, the incorrect perception promoted by reproductive rights that every woman can pursue their reproductive liberty. Applying the reproductive justice framework to the data analysis, my research supports that different factors affect reproductive choice, such as accessibility and affordability, which intersect with race, status and power (Ross et al., 2017). HIV+ women who are forced or coerced into sterilization do not have the support and adequate information to make an informed choice. Their HIV status, gender, socioeconomic status, and level of education, as well as power differentials between the women and health professionals, are major influences that impact the women's lack of choice. This is supported by a soulful outcry from one participant: "She made up a choice. She made up a choice for me" (Strode et al., 2012, p. 63). The lowest on the socioeconomic ladder are often the most marginalized and have very limited choices. My study supports the power imbalance between health practitioners and patients, as rather than seeking informed consent, health practitioners impose their decision on the HIV+ women. The following comment made by a medical professional emphasizes the fact that the women do not have a choice: "We were told by our boss that we must sterilise all women who are positive…" (Bakare et al., 2020, p. 339).

The sources I analyzed suggest that women bear the brunt of stigmatization and the worst kinds of discrimination experienced by persons who are HIV+. The 44 research participants' experiences suggest that other identities such as age, level of

education, socioeconomic status, and race intersect and further oppress them by putting them in the category of the 'other'. This highlights the need for the study of other domains of oppression that further under-privilege an individual, putting them in a positionality of disadvantage and further oppression. In my analysis, I also highlight how apartheid, segregation and racist policies in the Southern African region created deep inequalities which still impact the health sector and health experience.

Violence against HIV+ women in the health sector: a form of systemic oppression

The health sector plays a key role in identifying women and girls experiencing violence, providing care, or referring them to specialized services (Bell, 2019). Healthcare professionals play a unique role in supporting women who have experienced violence at the family or community level. However, healthcare professionals also perpetrate gender-based violence in health settings, as is seen in forced sterilization. Women on the margins of society, including HIV+ women, face systems of oppression that are further enhanced by intersecting identities such as class, educational level, and economic status. HIV+ women are not considered desirable enough to procreate, thus measures are put in place to prevent reproduction, with health practitioners being the gatekeepers of such unwritten laws. Bell (2019) recognizes the need for the health sector to address the high levels of violence that take place within health services. When a system that is meant to protect turns out to be causing harm, such systemic violence and oppression create a web of tangled mesh from which the victim has no means of escape. By applying feminist content analysis, I identify that the decision to sterilize does not rest only with the attending physician but rather with a higher authority, indicating that the women would not find any means of escape even when they go to another health facility or meet another

physician. For example, one victim reported that her doctor informed her that the instruction to sterilize HIV+ women comes from higher authorities, and that failure to accept sterilization would result in denial of health care (Bakare et al., 2020). This substantiates the structural or systemic domain of oppression and how it is evoked in the health system in the Southern African context against HIV+ women. The (health) institutional or systemic power is brought to bear on the oppressed individuals who come in contact with the institution, for example, HIV+ women who are young and poor with lower levels of education and socioeconomic status. This systemic form of oppression occurs globally, as discussed earlier using examples of eugenics, the high maternal and infant mortality amongst Black communities in the U.S., and the recent incident of hysterectomy performed on migrants in US detention camps. Stigmatization and othering of HIV+ women accessing antenatal services has been widely documented and was exacerbated during the COVID-19 response; Najmah's (2021) Indonesian study suggests that from HIV+ women's experience, it is less stigmatizing to be treated for COVID-19 than for HIV (2021). The HIV+ woman is always in the category of the other. Such stigmatization and otherization put the HIV+ women in the dilemma of whether or not to reveal their HIV status. However, a pregnant woman with HIV has no choice but to reveal her status to be able to access healthcare required to minimize the risk of HIV transmission to her baby.

The health system operates within a hierarchical structure with a power imbalance between health providers and patients. The power differential increases when the patient is not formally educated or is in a lower socioeconomic class. This power imbalance is disempowering for the patients, resulting in an oppressive structure. Though the constitutional laws and HIV/AIDS policies in Southern African Countries such as South Africa and Namibia respect the rights of patients to make

autonomous health choices (Republic of South African Constitution, 1996; Sterilization Act, 1998), HIV+ women who were sterilized did not feel they were properly informed of the procedure and did not provide their informed consent (Durojaye, 2018; Essack et al., 2012; Mthembu, 2022; Roseman et al., 2013). One participant revealed how health professionals made the decision for her: “You know what, she [the nurse] snatched something that I wanted, you know? She made up a choice. She made up a choice for me” (Strode et al., 2012, p. 63).

The victims of forced or coerced sterilization were fearful of questioning health professionals because of the inherently unequal power dynamics between the health professional and patient relationship: “I wouldn’t have asked anything because the doctor said nothing must be requested of her [the doctor]... she [the nurse] has epaulettes so she was an important somebody and she’d say she doesn’t want to be questioned” (Strode et al., 2012, p. 64).

Another victim told a similar story about speaking up against authority ‘‘In those days[1] we did not know much about our rights. One was simply told, and to say to a doctor, ‘I do not want’ was unheard of. You were just told to do this or else you had to leave the clinic or hospital” (Strode et al., 2012, p. 64).

The health professionals resorted to manipulation and provision of wrong information to coerce the women. They brought to bear their full powerful positions of authority to hand-tie and coerce these vulnerable marginalized women into sterilization. The health practitioners did not inform the patients of their rights to refuse sterilization, nor were the victims informed that sterilization was simply one of a range of birth control options (Mthembu, 2022; Strode et al., 2012). A participant shared: “I

[1] This was between the period of 1996 and 2010, during which time the women involved in the study were sterilized

was told that if I get another child I would die" (Strode et al., 2012, p. 64). Part of the coercive method was to trivialize and/or withhold crucial information, as evidenced by the following statement from a victim: I was told to be sterilized. They said it was a simple procedure. Only when I went to the theater (operating room) did I begin to realize the seriousness of my situation. They had not told me that I would be taken to a theater (p. 64)

Providing deceitful information is another way health providers deceive their victims to consent to sterilization. One victim shared, "that's what she said. When you want a baby, you'll decide then... to go and get it opened and get another baby"; another was told that "they said they would sterilize me and I would be able to reverse it one day" (Strode et al., 2012 p. 64).

Sterilization is a permanent, non-reversible procedure; however, this information was withheld and misrepresented to the victims. The powerful position of health authorities and how this is leveraged to marginalize vulnerable patients is evident in how medical professionals withhold or misrepresent valuable information, reaffirming the power imbalance between health professionals and clients.

Health services also exacerbate violence against women during HIV testing, which is done during pregnancy as a way to prevent transmission to children. HIV testing during pregnancy is also generally used to establish HIV prevalence at a national level. As important and life changing as HIV testing is during pregnancy, women are often not given the support to make an informed decision to take the HIV test and to deal with a positive diagnosis (Webb, 2013). Conducting HIV tests during pregnancy means that women can be the first to test positive in the family, leaving them vulnerable to accusations of bringing HIV into the family and potentially escalating violence, abuse, and abandonment at the family and community level.

Involving male partners and offering couple-friendly services in PMTCT programs (which start with HIV testing) are potential ways to reduce the stigmatization of and improve the PMTCT program (Lyatuu et al., 2018; Morfaw et al., 2013).

In health facilities, health professionals continue violence against women by criticizing the women who organize and demand their rights: “When you go there in the consulting rooms, the nurses will say those are the people that have been marching against us in the streets saying that they want their wombs back, therefore you won’t be treated as you were supposed to anymore” (Bakare, 2020, p. 343). These attitudes of dominance by health institutions reiterate the idea that the world may seem just for the powerful but is unjust for the weak and vulnerable. It highlights the hierarchal structure of the health provider-patient relationship which is marked with physical, social and personal barriers and is disempowering for the patient.

The dominant and powerful groups in society are privileged, however the vulnerable, marginalized, and less powerful are not so. In the context of my research, the health facilities and medical practitioners form a powerful system that oppresses the vulnerable and marginalized HIV+ women in the Southern Africa region who are less educated and have low socioeconomic status. According to Roseman et al. (2013), medical personnel are dismissive of HIV+ women’s concerns and are unwilling to explain procedures and processes to women living with HIV. In Southern Africa, healthcare professionals have resorted to manipulation and threats to discourage HIV+ women from getting pregnant and compel them to agree to sterilization (Durojaye, 2018; Mthembu, 2022; Strode et al., 2012). Health workers should not make decisions for their patients; however, this is not the experience of HIV+ women who have undergone forced sterilization. The experience of these victims is an

indication that health workers not only make decisions, but they impose their decisions on their patients.

Though informed consent is required for a medical procedure such as sterilization, the means through which healthcare professionals gain 'consent' is often questionable. The goal of the informed consent process is to provide sufficient information to a person in language that is easily understood by them so that they can make the voluntary decision regarding "to" or "not to" participate in the medical intervention (Nijhawan et al., 2013, p. 134). The process requires physicians, as a professional duty, to notify their patients of the nature of the intervention, the condition and its expected course, the benefits and risks of any proposed treatment, and the choice of alternative treatment or non-treatment (Jonsen, 1998). To address the power differential between health providers and patients and to improve the experience of patients, alternative methods to improve participatory decision-making and empower patients have been suggested. Andrist (1997) recommends a feminist-centric model where the provider-patient relationship is one of mutual reciprocity, and the clinician decreases traditional physical, social and personal barriers. Akpa-Inyang and Chima (2021) argue that the concept of informed consent is based on the Western-European concept of autonomy, which advocates respect for individual rights and may conflict with African cultural values and norms that focus on communitarianism. They thus recommend an Afrocentricist method of informed consent, which should consider the socio-economic status, literacy level, environment, spirituality, and culture of local peoples when dealing with African communities. Such an Afrocentricist informed consent method should recognize that Africans act as a group, and thus group survival and interests may supersede individual rights (Akpa-Inyang et al., 2021). Feminist-centric and Afrocentricist models of interaction between health workers and patients

are worth applying to improve health worker/patient relationships. These models are discussed further in Chapter 5 under the recommendation section.

Gender-Based Violence and violence against women living with HIV; the (non) intersection

Forced and coerced sterilization against women living with HIV is a distinct form of gender-based violence (GBV), however, the intersection between HIV and GBV has not been fully explored. Gender-based violence and HIV have largely been seen as separate and distinct areas of work. Hale et al. (2011) recognize that bringing these two areas together and at the same time considering human rights, feminism, sexuality is challenging. The framework through which work on HIV, which is largely focused on prevention and treatment, has primarily been viewed is the impact of intimate partner violence and its association with HIV spread, stigma and discrimination, and its effect on access to services such as sexual and reproductive rights. The focus of stigma and discrimination has centered on how it prevents HIV treatment and is a barrier to the goal of ending the HIV epidemic by 2030. The feminization of women in HIV infection, where women are seen as vectors that transmit the virus to their partners and children (failing to recognize that they were infected by their male partners) contributes to the worst kinds of stigma and discrimination faced by women living with HIV. This includes association with different labels, alienation, and othering in society. Women may be labelled as unworthy mothers who cannot procreate desirable children. Many HIV+ women felt that they had been branded as unfit mothers who would not live long and productive lives (Bakare, 2020). The distinction between ‘us’ (people living without HIV) vs ‘them’ (women living with HIV) creates a hostile, stigma-inducing culture that is traumatic and can result in post-traumatic stress disorder (PTSD), supporting minority stress theory. Continued stigmatization regularly re-traumatizes the victims.

Stigma and other forms of violence such as forced and coerced sterilization experienced by HIV+ women are also violence against women. Sterilization remains a badge that these women continue to wear throughout their lives in addition to their HIV status and other badges of shame such as poverty, low socioeconomic class and poor educational level.

I also argue that stigma and discrimination associated with HIV is a major contributor to HIV+ women's experiences not being taken up by the women's movement as examples of violence against women (Hale et al., 2011). Much of the work done to date on HIV+ women's sexual and reproductive health and rights has not been framed as 'violence against women', even when it falls squarely into the definitions proposed by the UN Declaration on Violence against Women, or the Beijing Platform for Action. This otherization and alienation continue to impact HIV+ women by making them invisible in the discourse of women's issues. Their vulnerability is increased because their specific intersecting identities are not named or studied. This aligns with Young's (2020) claim that what is measured reflects what is implicitly valued or perceived to be the biggest priorities. HIV+ women are not valued in the general experience of women's issues; they are thus excluded from programs or specific interventions targeting GBV and are less likely to have services designed to meet their specific needs.

Women experience structural oppression, which is now considered a form of gender-based violence, from the power differential between health professionals and patients. The HIV+ women's experience of othering and oppression in society is also mirrored in health facilities, thus increasing their vulnerability. Recorded experiences of this include forced and coerced sterilization of HIV+ women and pinching and punching of HIV+ women by health workers because of their HIV status (ICW, 2009).

Sewpaul et al. (1998) reported discrimination against HIV+ women by medical and nursing personnel, which was exhibited in the form of negative attitudes resulting in a lack of care toward persons with HIV. This was reflected both verbally and non-verbally; some personnel openly displayed anger and insensitively informed patients that they were going to die because there was no cure for the illness. Instead of being a source of comfort and providing adequate medical care to HIV+ individuals, health professionals can harbour as much prejudice and stigma as the general public does (Sewpaul, 1998).

Violence against women living with HIV is commonplace to the extent that it is not even recognized as the violence that it is. The work on violence against women in relation to HIV/AIDS has mainly focused on how violence against women increases women's vulnerability to HIV and negatively impacts HIV prevention and treatment. However, the lived experiences of HIV+ women, their organizations, and allies have shown that violence remains (and/or becomes) a major issue for women after an HIV+ diagnosis (Hale et al., 2011). There is still much to be done to address the linkages between violence against women and HIV and to ensure that this connection is not seen only in terms of prevention of HIV transmission. My research highlights the non-intersection between violence against HIV+ women and mainstream GBV. Activists against GBV tend not to recognize the violence and harm against HIV+ women as a GBV issue. It also affirms the othering that HIV+ women experience and recognizes that when they experience violence, it is not seen as an issue that should be integrated with the experiences of other women who face various forms of violence. This is similar to the experience of Black women and other people of colour during the first wave of feminism in the 19th century and the suffrage movement when White middle-class women fought for women's right to vote. This right, however, did not include non-White

women. hooks (2015) criticizes the emergence of feminism in the United States, which did not recognize the most victimized and oppressed women who have less power to change their conditions of life. This otherization is mirrored in this discourse, where the violence that HIV+ women experience is not integrated into the mainstream discussion of gender-based violence. This is exemplified by the gaps identified in international instruments against GBV where HIV+ women were not mentioned as minority groups in the 1995 Beijing Platform of Action.

To bridge this gap GBV professionals need to begin to include the violence of HIV+ women in the discourse. HIV+ women are women, the violence they face is also violence against women and should be reflected as such. Research articles need to include specific variables of HIV+ women which are distinct. This naming will provide more education and awareness of the violence and oppression HIV+ women face. It is essential that international instruments that promote awareness of GBV and women's rights intentionally include the distinct experiences and violence HIV+ women face. Intentional collaboration between GBV professionals and HIV professionals and activists will enhance knowledge sharing and identification of specific vulnerabilities and violence HIV+ women are exposed to. It will also contribute to breaking the barrier of otherization and being at the margin that HIV+ individuals face. I will contribute to the naming of violence HIV+ women experience by sharing findings from my thesis in conferences and journals. I hope this knowledge sharing will contribute to debunking some of the stigma and otherization HIV+ women face.

Apartheid: a contributory factor to inequality and violence against women in Southern Africa

South Africa is labeled as the rape capital of the world, where a woman is sexually assaulted every 17 seconds and 10,818 rape cases were reported in the first

quarter of 2022 (Gouws, 2022; SABC, 2012). Inequality in Southern African countries provides a platform for violence against women to persist. Such inequality is evident in levels of income that translate into and result from vast wealth gaps between the rich and the rest of the population. According to a World Bank Report, the Southern African Customs Union (SACU) member countries of Botswana, Eswatini, Lesotho, Namibia, and South Africa represent the world's most unequal region in terms of wealth distribution. Although there are differences across countries, Namibia and South Africa have distinctly higher inequality than the others (World Bank, 2022). The story of inequality and HIV in the Southern African region cannot be complete without a reflection on the impact of its apartheid history. Racist segregation policies and disproportionate access to health care are a part of South Africa's troubled past that still impacts the present, especially regarding the HIV prevalence rate and violence against women. Racist policies such as the migrant labour system, which ensured a supply of Black South Africans as cheap labour in mines while prohibiting them from permanently settling in 'Whites only' areas are an example. Such policies resulted in "circular or oscillating migration where men leave their partners and families at home to go and work in the mines and cities while periodically returning home and if infected while they were away from home would infect their wives or partners upon return" (Lurie, 2006, p. 650). Access to health care and HIV treatment was also made difficult (if not impossible) within the racist system in place during apartheid, where the Whites were disproportionally cared for because the doctors were Whites; in a country where over 70% of the population was Black, over 88% of doctors were White, and only 1.3% were Black (Baker, 2010).

Consequences of segregation and racist policies resulting in material deprivation of Blacks constitute key structural factors that facilitated the spread of HIV

and established a widespread, generalized epidemic in Black areas (Coovadia et al., 2009; Kon et al., 2008; Scrubb, 2011). There was clear discrimination against the Black population, including limits on where they could work and the type of work they could engage in; however, this discrimination did not extend to buying things from White-owned shops. This sent a message that "your money is valued but not you", fuelling an aggressive form of capitalist social values with an increased drive for profiteering and wealth acquisition:

> Black men do all the physical labor in our country because no white man wants to dig a road or load a truck. But for every kind of work a white man wants to do, there are sanctions and job reservations to shut the black man out. In the building trade, and in industry, the Africans are the unskilled and semi-skilled workers, and they cannot, by law, become anything else. They cannot serve behind the counters in the shops and cannot be employed alongside white clerks. Wherever they work, they cannot share the washroom or the canteens of the white workers. **But they may buy in the shops** [emphasis mine].(Gordimer, 1999, p. 107)

This still impacts the post-apartheid Southern African context, where the powerful groups remain privileged. The economy has continued to grow in a direction that is unfriendly to the poor (Seekings, 2011). As Azania (2014) points out, the political breakthrough of 1994 deracialized governance; however, privilege and poverty continue to have a race in South Africa: the former is White, while the latter is Black. In the 1996 national census, 21% of Black South Africans (6 million people) lived in informal housing, versus 0.1% of White South Africans. 7 (seven) million Black South Africans had no access to pipe-borne water. while 97% of White South Africans had access; 59% of Black South Africans (18 million people) had no access to regular

refuse removal, while 92% of the White population did. 56% of Black South Africans (17 million people) had no access to electricity, but 99.6% of White South Africans did.

The South African apartheid experience affirms that colonial and apartheid governments created massive inequality by taking on a supremacist standpoint, enforcing segregation, patriarchy, capitalism, and racism. The inequality was achieved by creating favourable policies to benefit White South Africans while suppressing and making servitude of Black South Africans for several decades. Where such inequality persists, those on the lowest rungs of the societal ladder, such as HIV+ women who are poor and have limited education, become more oppressed. Occupying such a position, they bear the brunt of classist and sexist oppression, and the burden of being the 'other', facing victimization and exploitation. Gender inequality and HIV-related stigma intersect to leave HIV+ women in a vulnerable position in all areas of their lives (Hale and Vazquez, 2011).

To address the negative impact of the legacy of apartheid, the African National Congress (ANC) has pursued an ambitious and far-reaching set of policies that are meant to eliminate racial and gender inequality and reduce poverty, particularly among Blacks (Fernandez, 2020). The policy reforms have been aimed at promoting employment equity and expanding opportunities for the historically disadvantaged. These policies are focused on different aspects of public service, namely social assistance programs, employment, education and health.

From 1994 to 2010, the number of recipients of pensions and social grants increased from about 2.6 million to almost 14 million, and by 2014, the number had grown to about 16 million (Marais, 2011; Seekings & Nattrass, 2016). More than one-third of adult women are reliant on them (South African Social Security Agency, 2013).

The child support grant has experienced the highest growth in terms of recipients, from less than 1 million recipients in 1998 to over 10 million in 2011 (Seekings & Nattrass, 2016). These changes may be as a result of both the growing population and poverty levels. The main beneficiaries of this grant are poor African mothers, particularly those living in rural areas (Lund, 2008). In terms of education, a racially integrated curriculum with inclusionary textbooks was developed for primary, secondary, and tertiary education by 2000 (Marais, 2011). Gains in literacy, however, have been small, and racial and class inequalities in education persist, with funding levels and matriculation and pass rates in predominantly Black schools lagging behind those of other schools (Marais 2011).The health sector has also experienced policy changes that aim to favour the poor by eliminating the fees for primary care; however, disparities still persist when it comes to access to health care and the quality of services rendered between those living in rural and urban areas and between rich and poor (Rispel et al., 2013). To address employment gaps, a series of affirmative action policies have been implemented to protect and advance persons belonging to groups that have been historically disadvantaged by unfair discrimination. Such policies include the 1998 Employment Equity Act, an affirmative action law that promotes equity in the workplace, and the Black Economic Empowerment (BEE).

In addition to policies promoting racial equality and poverty alleviation, the ANC in power has formulated a series of policies designed to promote gender equality. The 1998 Domestic Violence Act and the 2007 Criminal Law Act are designed to protect women against any form of violence, including sexual offenses. The 2014 Women Empowerment and Gender Equality Act was passed to consolidate ongoing efforts to promote gender equality by calling for at least 50% female representation in decision-making bodies, improving women's access to education, training and development,

safeguarding women's reproductive health rights, and eliminating gender discrimination and violence against women (Fernandez, 2020). More recently, the National Council on Gender-Based Violence and Femicide Bill was signed into law in 2024 to curtail GBV, which is described as the country's second pandemic. While these legislative accomplishments are noteworthy, patriarchal norms, values, and practices that subordinate women have proved to be resilient to policy interventions and continue to permeate South African society (Fernandez, 2020).

The work of Mbali and Mthembu (2012) describes how the AIDS epidemic disproportionately affects women, and how women in South Africa cannot routinely implement their sexual and reproductive decisions in a safe manner, even when they attend state health facilities. Badul and Strode (2013) highlight the three factors that characterize the epidemic in sub-Saharan Africa: its feminization, the implications it poses for sexual and reproductive health services (particularly those provided to women), and the pervasive discrimination following those who are infected. Women remain at the bottom rung of the inequality ladder in South Africa and other countries in the region. In a patriarchal society where women have been socialized to be lower than males in all aspects, including economically, women bear the brunt of sexist and classist oppression. This is further compounded for women who are living with HIV. This results in the policing of the HIV+ woman's body, which is deemed unfit and therefore should be punished. Ross et al. (2017) espouse that certain people such as the poor, immigrants and others are marked for reproductive management, resulting in the denial of reproductive dignity. Different people are marked differently for reproductive management: some fertile people are disciplined for pregnancies or for exercising reproductive autonomy, while others are honoured for doing the same thing (Ross et al., 2017). HIV+ women who are poor, young, and have lower levels of

education and lower socioeconomic status are forced or coerced into sterilization because they are not deemed desirable to reproduce. The women have a perceived notion that they are not contributing to nation-building if they are not bearing children. This is linked to the essentialist understanding of womanhood and reproduction. While this may differ for different women, reproduction was paramount for the target population of my research, who are cis African women. Their right to parent a child(ren) forms part of their gender expression and is a reproductive that should not be invalidated. The burden of the denial of childbearing is evident in these comments: "It makes me feel incomplete that I am not a proper woman, first that I'm HIV positive and secondly I cannot bear children' (Essack & Strode, 2012, p. 28); "I was still very young when this happened and I had hoped to have more children" (Bakare et al., 2020, p. 342).

Digging deeper: who experiences forced sterilization amongst HIV+ women?

According to Open Society Foundations (2011), documenting the practice of coerced and forced sterilization is difficult, especially given that its primary targets are already marginalized persons. This applies to Namibia, South Africa, Bostwana, and Lesotho, as the targets of coerced sterilization in these countries are women living with HIV who are poor and have lower levels of education and lower socioecomonic status. Women's experiences are already less likely to be documented or analyzed. This is additionally so when the factor of HIV is added to the mix (Open Society Foundations, 2011). Apart from the ICW-Southern Africa, most HIV organizations in the region are focused broadly on people living with HIV and not on the particular realities and experiences of women living with the virus. On the other hand, women's rights organizations in the region focus on the realities of women's lives but do not

necessarily look specifically at the experiences of women living with HIV. Furthermore, many organizations working with women living with HIV focus more on providing care and less on the rights of these women (Patel, 2008).

Based on my analysis of the resources on the topic, I identify that various variables such as age, level of education, socioeconomic status, and employment status are discussed independently with no specific discussion of how the intersection of the identities makes people more vulnerable. For example, Open Society Foundation (2011) and Bell (2019) both assess that people belonging to certain population groups, including people living with HIV, poor people, persons with disabilities, Indigenous peoples and ethnic minorities, transgender and intersex persons, and other marginalized women are targets of forced and coerced sterilization without full, free and informed consent of the victims. However, neither discuss the experience of individuals living with more than one of these identities.

I argue that HIV+ women who experience sterilization are not only marginalized as a result of their HIV status, but are generally further oppressed as a result of other intersecting identities that make them additionally vulnerable. Below, I discuss different identities and how they intersect to further marginalize victims. Applying feminist content analysis and an intersectionality framework, I identify salient themes from my study materials. I pull out quotations that highlight specific demographic descriptions, positionality, and experiences of HIV+ women who are victims of forced/coerced sterilization. The themes and factors that emerge suggest that poverty, younger age, lower level of education and racism are intersecting identities that make the HIV+ women who are victims of forced or coerced sterilization in Southern Africa additionally vulnerable to the oppression of sterilization. 29 out of the 44 research participants were explicitly reported as unemployed or in the lowest wage category; details of the

employment status of the rest were not provided. The majority of the 44 research participants were young (below the age of 33) at the time of sterilization. Of the 44 research participants, none had received a college education; Grade 12 was the highest recorded educational level. I present and discuss these themes in detail below.

Poverty

My research shows that class, income, or poverty level presents a level of oppression that intersects with HIV status and gender. This intersection is evident in an excerpt from Bosch's (2009) study: "My rights were violated and someone needs to be held accountable,' says 38-year-old Shikongo in her iron corrugated house in Okahandja Park, **a poverty-stricken** township of Namibia's capital" [emphasis mine] (p. 1). Sewpaul et al. (1998) report that out of their 15 participants (HIV+ women), the majority (87%) "were unemployed, single mothers, producing major financial burdens" (p. 35). According to the study, the majority of single mothers lived in extended family households and relied on the pensions of their mothers or grandmothers for financial support. An exception was a woman who received monthly upkeep of R250 (equivalent to about $70CAD in 1998, the year of the study) from her ex-husband, on which she supported three children.

Taylor-Brown (1993) contends that for HIV+ women, economic dependence is another diagnosis with which they must cope. HIV+ status contributes to economic dependence for women because of stigmatization and the feminization of HIV. Women's economic dependence on men renders them subordinate and therefore places them in awkward positions when trying to negotiate safer sex practices. This is supported by this quote: "What must I do if he does not want to use a condom? He gives me money. How will I feed my child if he does not give me money?" (Sewpaul

et al., 1998, p. 40). This statement reveal the living conditions of HIV+ individuals portraying their economic status *"…People aged between 15 and 49 years who live in* ***informal settlements*** *have the highest HIV prevalence of all people in South Africa based on residential type" [emphasis mine] (O'Reilly et al 2012; 127)*

Bakare et al.'s (2020) study to documenting the experiences of HIV+ women who have experienced forced or coerced sterilization in Namibia reported low socio-economic levels of the study participants. The study involved an in-person interview of victims of forced and coerced sterilization. According to the report, all participants were either **unemployed** or working in traditionally **low-paying jobs** [emphasis mine].

In a BBC News video (2021), Dr. Tlaleng Mofokeng, the UN Special Rapporteur on the Right to Health suggested that the victims of forced sterilization are Black women who primarily live in rural areas. Residence in rural areas and informal settlements can be linked to poverty, as most African rural areas are characterized by fewer employment prospects, as well as poorly equipped social amenities such as health facilities and schools. In reviewing materials on this topic through the lens of feminist content analysis, terms such as unemployed, poverty-stricken, low-paying jobs, informal settlements, rural areas run as threads through the fabric of HIV+ women's experience. This highlights that poverty is a contributory factor to the experiences of HIV+ women who are victims of coerced or forced sterilization. This is similar to the eugenics movement and continues to be experienced. Poverty is a major factor that leaves women vulnerable to sterilization, not only for HIV+ women, and not only in Southern Africa. In 2009, Tessa Savicki, an American woman receiving social assistance filed a lawsuit against a hospital after she was sterilized without her consent while undergoing a caesarean section (Diaz-Duran, 2017). The Open Society Foundation (2011) posits that stigma around poverty is deeper when women engage

in criminalized behaviours. I also argue that HIV-related stigma is deeper for poor women when the two undesirable attributes intersect in a woman.

In 2010, Project Prevention, a US based nonprofit organization expanded to Kenya where the project founder offers women living with HIV $40 USD as a coercive measure to have an intrauterine birth control device (IUD) implanted. In its fundraising materials, Project Prevention erroneously claims that this is the only way to reduce the number of babies born with HIV. Government-run population control programs target all women, but poorer women—often the most marginalized members of society—are more vulnerable to coercion (Open Society Foundation, 2011).

My analysis of poverty as a thematic factor aligns with the argument that the majority of HIV+ women who are victims of forced sterilization are poor. Poverty does not only make women vulnerable to the risk of HIV infection but continues to serve as an oppressive tool in a capitalist society. Applying feminist principles which promote equity can play a role in mitigating the vulnerability imposed by poverty for HIV+ women. Lack of engagement with complex inequalities and intersecting identities invalidates the efforts for meeting the real needs of the most oppressed and underserved population. The intersection of poverty, gender, HIV, and violence needs to be considered not only in the prevention of HIV transmission but also in how it contributes to increased violence and structural oppression for those in the tangled mesh of interlocking identities.

Age

Age is another factor that makes HIV+ women vulnerable. Younger women are more at risk of forced sterilization. Bakare (2020) reports that their study participants were sterilized when they were in their twenties to early thirties. One participant

explained: “I was still **very young** when this happened, and I had hoped to have more children” [emphasis mine] (p. 342). A participant in a different study told a similar story: “I was **young**. I did not get… options.” [emphasis mine] (Strode et al., 2012, p. 64). In a BBC News video (2021) on forced sterilization in South Africa, Zanele (a pseudonym) shared that she was sterilized in her 20s without her consent. She was just asked to sign a document; in her words, “he(doctor) said he was going to sterilize me and he wasn’t asking for my permission...I had to sign”. Crying and begging the doctor not to sterilize her as she was still young did not change his decision. The doctor confirmed he would sterilize her because of her HIV status. This is also corroborated by Kendall et al.’s (2015) study on forced sterilization of HIV+ women in four countries in Latin America; they reported that according to their multivariate analysis, being in the youngest age group is one of the statistically significant predictors of being pressured to be sterilized. Women in older age groups (25-34 years of age and 45 or older) were less likely to report experiencing pressure to be sterilized than women 24 years of age or younger.

The experience of facing sterilization at a young age resonates with Sethembiso Promise Mthembu’s experience. Mthembu is a victim of forced sterilization, which inspired her Ph.D. thesis. Mthembu was forcefully sterilized in her twenties when she found out she was HIV+. She became pregnant when she was 16 and had the baby but it was in her first year as a university student in 1995 that she knew of her HIV status. When she found out about her status, her parents refused to pay her university fees on the assumption that she was going to die (Sobuwa, 2022; Wikipedia 2023). She thus dropped out of school, however, she was able to navigate through the challenges of teenage pregnancy, living with HIV, and mothering a

severely disabled child, and is proud of her achievement and of being a role model to young girls (Sobuwa, 2022). Mthembu's works, which are focused on forced sterilization of HIV+ women, are cited throughout my thesis.

When sterilization requests are made by young people, they are frequently denied by doctors, with the reason that the patient will later regret their decision (McQueen, 2016). However, when it comes to forced sterilization, younger women are more at risk. This resonates with eugenics history, where the victims were primarily young women. One such example is Leilani Muir, a victim of Alberta's eugenics policy. A 1995 CTV interview with Muir revealed that in 1959, Muir was deemed feeble-minded and was sterilized without her permission or knowledge at the age of fourteen. Muir explained she was taken to the eugenics board before she turned fourteen, where the board decided that she had an IQ of 64 and was a mentally defective moron. When she went for the surgery, she was told it was to take out an appendix. She only found out that her tubes were not intact at the age of twenty-five, after she got married and could not have children (CTV, 1995). In their examination of Alberta's sterilization victim case files, Park et al. (1998) also identified that very young women were marked for sterilization. Women and men ranging from 14 – 35 years who were labelled as morons, vagrants, critical, and aggressive were approved by the eugenics board to undergo the procedure without consent. My research corroborates the account that age has continued to be a major contributory factor to sterilization, with younger females being more at risk of this violence.

Education

Lower levels of formal education serve as an additional category for the victimization of women who are targeted for sterilization. Women who are not able to

read are pressed to sign a written consent form that is in English and contains medical terminologies. As McLaughlin et al. (2014) explain: “the power imbalance between provider and patient, disproportionately affect[s] **illiterate** women, who are preyed upon to obtain signed consent” [emphasis mine] (p. 77).

This excerpt supports my argument that HIV+ women with lower levels of formal education are disproportionately affected by the sterilization knife. Women who are not formally educated are less likely to know about their human and reproductive rights. They also may naively believe everything that health professionals offer, and may not be able to engage and ask for specific clarifications. The gulf of power imbalance is wide and deep; while a woman believes that the health provider is there to provide her with the best care, the health provider, on the other hand, may be focused on victimizing her. The patient is an ‘other’, and the health professional may not see them as anything more than a nuisance to society, a misfit that must be prevented from continuing their kind.

The table below highlights the socio-demographic characteristics of HIV+ women who were forcefully sterilized in Namibia (Bakare et al., 2020). This data aligns with the themes being discussed indicating that younger women with lower education levels who are unemployed and poor are the main targets of the violence of forced and coerced sterilization. The researchers engaged with seven participants for the study.

Table 1. Socio-demographic characteristics of participants

Participant Code	Age	Highest education level obtained	Employment	Marital status	Sterilisation date	No. of biological children	Age at sterilisation
P001	43	Grade 10	Unemployed	Previously married – separated	2007	4	33
P002	44	Grade 10	Volunteer	In a relationship – 6 years	2004	4	31
P003	43	Grade 12	Employed – night supervisor in catering	In a relationship – 2 years	2007	3	33
P004	41	Grade 12	Unemployed	Married – 5 years	2007	3	31
P005	39	Grade 9	Employed – security guard	Single	2006	2	28
P006	41	Grade 9	Employed – cleaner	Married – less than 12 months	2007	2	31
P007	38	Grade 6	Unemployed	Divorced	2005	3	26

Table 1: Socio-demographic characteristics of study participants (Bakare et al., 2020).

The table highlights the participant's age at the time of the study and age of sterilization, the highest level of education attained, employment status, marital status, and number of children for the seven women who participated in the study. I focused my analysis on the age at sterilization, level of education and employment status.

Out of the seven women who participated in the study, only two reached Grade 12, and one left school at Grade 6. The highest level of education for the rest was evenly distributed between Grades 9 and 10. This supports my argument that HIV+ women with lower levels of education are more at risk of forced and coerced sterilization. As mentioned earlier, an Afrocentrist model can be applied to empower Africans, especially women with lower levels of education. Health communication with individuals should consider their literacy level and should be in a language they understand, and the use of images and pictures should be utilized to enhance

understanding. This is further discussed in the recommendations section of Chapter 5.

Three out of the seven participants were unemployed, and one was a volunteer, which may also be categorized as unemployed. The other three were employed in low-income jobs, as a security guard, a cleaner, and a night supervisor in a catering facility. The seven participants in this study who underwent involuntary sterilization were of low socioeconomic status and were on the lowest rungs of the metaphorical social and economic ladder. This is linked to the theme of poverty and economic dependence. Those who are poor and do not have adequate financial capacity are more vulnerable to coerced and forced sterilization.

The category of age at sterilization indicates that all the participants were sterilized in their 20s and 30s. The oldest age was 33 and the youngest was 26. This is the peak reproductive age for women. This resonates with my discussion earlier that younger women are more vulnerable to the harm of forced or coerced sterilization. Younger women are targeted for sterilization at the peak of reproductive age to ensure that they do not continue to procreate.

Racism

In addition to age, economic status and educational level, the issue of race emerges subtly in the research on this topic. Racism from a health professional is evident in this quote from a victim of forced sterilization: “He was shouting at me while all were listening… He said all **black people** are careless. I was embarrassed and I just signed without getting time to read the form” [emphasis mine] (Strode et al., 2012, p. 65). I assume that this health professional is not Black as a Black is unlikely to speak about Black people in such a manner. “**All of them are blacks**, all of them from a

rural area", said Dr. Tlaleng Mofokeng in describing the characteristics of the women who have been forcefully sterilized. It may be difficult to understand how racism can be an issue for an African in an African country. However, recalling the history of apartheid and the marginalization of the Black majority by the White minority highlights how racism was invoked and continues to play a role in Southern Africa. As a result of apartheid, there was very limited training of Blacks in the medical field and other more intellectual professions. Blacks were reserved only for positions of servitude. As a result of this, in 2006 there were 33,506 registered medical practitioners in South Africa, and of these only 12.74% were Black. In 2016, there were 43,892 registered medical practitioners in South Africa, with 25.85 % being Black (Top Empowerment, 2023). This is different from a country like Nigeria, where over 90% of the health professionals are Blacks and Nigerians. Such statistics suggest that in South Africa, Blacks are still marginalized and targeted for being Black in the health sector.

According to Christopher et al. (2023), racism is endemic and a central, permanent, and "normal" part of U.S. society and, I add, the world. This is embedded in White supremacy and Whiteness being the yardstick through which everything and everyone is measured. The trajectory of global White supremacy is deeply historical and contemporary and it is a global, transnational, and imperial phenomenon (Taylor, 2006). Taylor (2006) asserts that assumptions of White superiority are so ingrained in political, legal, and educational structures that they are almost unrecognizable; because it is all-encompassing and omnipresent, it cannot be easily recognized by its beneficiaries. Racism is how White supremacy is evoked, and the apartheid in the Southern Africa region is how it was experienced. This has continued to affect the Black population, especially the poor, women, and my target population for this thesis – HIV+ women who are forced or coerced to undergo sterilization. My thesis confirms

the impact of racism and anti-blackness on HIV+ women who are victims of forced sterilization. These women are also victims of racism at the hands of health professionals who, statistically, are primarily non-Blacks.

Chapter 5: Conclusion

Forced and coerced sterilization of HIV+ women is a violation of their reproductive justice and is also a distinct form of GBV. This form of violence disproportionately affects poor, younger, Black women with lower levels of education in the Southern African context. My research demonstrates the connections between the present moment and what was experienced during the eugenics movement in the 19th century, which sought to prevent those who were deemed unfit from continuing their kind. HIV+ women are deemed as the 'other', and with additional levels of oppression such as poverty, lower educational level, and low socioeconomic status they are pushed further away from the centre of power and privilege, thus adding to the complexity of their vulnerability. These less desired identities intersect and intertwine in the individuals to create a web of undesirability that does not align with the supremacist standpoint and view of a valuable human, which are the categories of male, healthy (ableist), middle-class, and college-educated. Sterilization is performed by medical professionals who are respected and may even believe that they are doing it for the women's good. However, the patient is the person who has the right to determine if she needs sterilization or not.

Unlike the eugenics movement, which was supported by law, contemporary sterilization of HIV+ women is not backed by any written law. Illegal sterilization has been recorded in different parts of the world; for example, even after the Alberta Sterilization Act was repealed, some sterilizations continued to happen, with a case reported in 2018. The case of migrants undergoing hysterectomy without their knowledge in U.S. detention camps is also another example where such practice is not backed by law. Though this practice is not legal, it does not negate or dispel the fact that such actions occur and cause both physical and emotional harm to the victims

and are against the victims' rights. Laws fail to protect the most vulnerable women living with HIV and law reforms alone cannot guarantee women's rights to access reproductive health services (ICW, 2009; Mbali, 2012;). Feminists and practitioners against gender-based violence therefore must research and advocate on issues of policy implementation after legislation.

My research findings suggest that poverty, younger age, lower level of education, and racism intersect in some HIV+ women to make them additionally vulnerable to forced or coerced sterilization. My research supports the finding that social determinants of health such as education, housing, social status, and employment all intrinsically play a role in the health outcomes of individuals. These determinants of health create disadvantages and an illusion of choice for HIV+ women who undergo forced or coerced sterilization. It may seem that forcefully sterilized HIV+ women consent to procedures before they are carried out, but my research suggests that this is too often not the case. Many HIV+ women have additional levels of vulnerability, such as lower levels of education, poverty, and unemployment/low employment that serve as barriers to consent and widen the power imbalance between them and health professionals. These factors have been shown to influence people's general health experience and reproductive justice. This is evidenced by the experience of forced or coerced sterilization of HIV+ women.

Recommendations

a. Feminist-centric approach

Feminist-centric values or principles are rooted in giving voice to non-dominant groups and promoting a system where everyone is recognized and supported. Feminism is negotiating power relations where the more powerful share power with the least powerful. Core concepts of feminist principles applicable to women's health

are acknowledging the agency of the woman from the standpoint of women as actors, and challenging existing structural power relations in society (Andrist, 1997). The principles of the feminist-centric approach are focused on empowering non-dominant and marginalized groups, such as patients in the health provider-patient situation. This approach has been utilized in promoting collaboration, community building, and validating knowledge based on experience (Kishimoto, 2009; Walters, 2020).

The more dominant feminism has been Western feminism with the first wave in the 19th century during the suffrage movement with a fight for (white) women's right to vote. The second wave from 1960s – 1980s focused on the inequality of laws and the promotion of women's rights in a patriarchal society and was also largely about middle-class white women. The feminist struggles of other races such as Black women have been for the most part not included in Western feminism. In African contexts, feminism is largely seen as a Western invention, and as a result of this bias of the concept of feminism as a Western construct, feminism may be seen as something that should not apply in the local African context. Therefore, to apply a feminist-centric approach, health practitioners must be sensitized and trained on the underlying principles of feminism which is to promote the voices and agency of the marginalized and non-dominant groups. Health practitioners should be sensitized and trained on these principles, which provide a model for dismantling the supremacy and power gap between health providers and patients. Health practitioners need to build the trust of their patients by ensuring that female patients who are lower on the societal ladder, such as HIV+, poor, and lesser educated women, have adequate time to express themselves and ask questions. Trust would be earned when the health practitioners remain humble and even keen to learn from their patients. Ahmed (2021) describes what she terms a 'feminist ear', which involves hearing what is not heard or who is not

heard (p. 3). Applying a feminist-centric approach to health care would create an empowering structure for patients and ultimately improve the health care experience of marginalized groups of patients. Feminist-centric principles acknowledge the agency of the oppressed, therefore avoiding situations where health practitioners make decisions for patients. Rather, the patient is provided with all the information about their health care plan in a language they understand, and is given adequate time and space and other support needed to make a decision.

b. Afrocentric approach

Applying an Afrocentric approach and principles to African patients would provide an empowering and improved health experience for Africans. The Afrocentric approach provides a frame of reference wherein phenomena are viewed from the perspective of the African people, concepts and history (Asante, 1991). Akpa-Inyang et al (2021) promote an Afrocentric model in health provider interactions with African patients. This is because the model places African ideals at the center of any analysis that involves African culture and behaviour and applies the standpoint of Africans as the key players rather than victims. Applying this in health care would mean that health professionals provide patients the opportunity to interact from an African worldview; for example, the use of stories, which is in line with the oral culture of Africans, can be used to gain the medical history of a patient. The use of visuals depicting Black bodies in local languages that are understood by patients for health education and promotion will provide the opportunity for real learning. Most health educational and teaching materials locate Whites at the centre of visual representation; Black, uneducated, poor women thus cannot relate to the situation. Creating opportunities for representation would empower patients, especially the most marginalized, to not see themselves as an ‘other’ but as an integral participant in their health and well-being. Afrocentric

approach would be empowering for my target population; HIV+ women in Southern Africa to be better educated, aware of their choices and supported to make decisions. More study on the application of Afrocentric approaches in health care is needed.

Contributions

This research contributes to expanding the use of the intersectionality framework in Africa. The framework has been primarily applied to Blacks in the diaspora, but the application in the African context has been limited. My research has contributed to highlighting how other less researched identities such as poverty, level of education, and age intersect in women who are targeted for sterilization based on their positive HIV status.

Methodologically, the application of intersectionality as a research framework and the application of feminist content analysis has been enriched through processes undertaken by this study. I recommend continued use of feminist content analysis and intersectionality frameworks in Women and Gender studies, as they provide platforms to examine underlying socio-political contexts which are essential in the implementation of social policies that directly and indirectly impact women within nation-states and globally.

The dominant strength of this research is its contribution to the study of reproductive justice and gender-based violence. This research contributes significantly to existing knowledge, conceptualizing major discourses and critiques, and unravelling the impact of apartheid in maintaining a supremacist standpoint. It also provides recommendations for reducing the power imbalance and barriers between health providers and patients by offering feminist-centric and Afrocentric models.

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Appendix

Appendix 1: List of core articles analyzed

1. Addressing VAWG in the Health Sector, Helpdesk Research Report No. 266. London, UK: VAWG Helpdesk by Bell 2019
2. Against her will: Forced and coerced sterilization of women worldwide by Open Society Foundations 2011
3. "At the Hospital There are No Human Rights": Reproductive and Sexual Rights Violations of Women Living with HIV in Namibia by Roseman et al 2013
4. BBC News (2021) South Africa: Forced to face sterilization YouTube https://www.youtube.com/watch?v=gjGHTZ_gRZg accessed March 13, 2024
5. Experiences of forced sterilization and coercion to sterilize among women living with HIV (WLHIV) in Namibia: an analysis of the psychological and socio-cultural effects by Bakare et al 2020
6. Experiences of coercion to sterilize and forced sterilization among women living with HIV in Latin America by Kendall et al 2015
7. I feel like half a woman all the time: The Impacts of Coerced and Forced Sterilization on HIV-positive Women in South Africa by Essack, et al, 2012
8. Reproductive Health Coercion, Helpdesk Research Report No. 253. London, UK: VAWG Helpdesk by Bell 2019
9. “She made up a choice for me”: 22 HIV-positive women’s experiences of involuntary sterilization in two South African provinces by Strode et al 2012
10. The power of the small group: from crisis to disclosure by Sewpaul et al 1998