Forced Sterilization and Coerced Contraception: Towards a Multi-National Agenda

WEB DISCUSSIONS REPORT

April 2022

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WEB DISCUSSION EXECUTIVE SUMMARY REPORT

FORCED STERILIZATION AND COERCED CONTRACEPTION: TOWARDS A MULTINATIONAL AGENDA – APRIL 2022[1]

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Non-consensual control over women's reproduction comprises a continuum of practices including Forced Sterilization and Coerced Contraception (FSCC), which refer to forcibly or coercively ensuring that women are no longer able to procreate permanently or temporarily. In Canada, recent revelations have demonstrated these practices persist,[2] while in Indonesia, the government continues to strengthen agreements with companies and migrant-receiving countries that limit the reproductive rights of migrant women workers.[3] Moreover, in Peru, after 25 years, women who underwent forced sterilization keep pursuing justice.[4]

Our project, Forced Sterilization and Coerced Contraception: Towards a Multinational Agenda, is directed by a team comprised of academics and advocates from Canada, Indonesia, and Peru, and supported by funding from the Kule Institute for Advanced Study at the University of Alberta, Canada. One of our primary objectives is to examine the contemporary history and global scope of FSCC to propose best practices for studying this topic. From October to November 2021, we hosted multilingual web-discussions with researchers and advocates, policymakers and private sector representatives, women with lived experience, and healthcare professionals from Canada, Indonesia, and Peru. The conversations revolved around the characteristics of FSCC implementation in each country; how the governments, companies, or individual health professionals were engaged with FSCC; survivors' expectations of justice; the short- and long-term effects of FSCC; and the best practices to engage women who have undergone FSCC in respectful and culturally safe research. We share highlights of the discussion here.

FSCC web-discussion: Women with lived experience: In Indonesia today, women are being coerced to use contraceptives as a requirement for work abroad and upon returning home

[1] For further information, contact Prof. Denise L. Spitzer, spitzer@ualberta.ca

[2] Collier R. (2017). Reports of coerced sterilization of Indigenous women in Canada mirrors shameful past. *CMAJ 189*(33): E1080-1081.

[3] Aryanty, R. I., & Widyantoro, N. (2019). *Sexual and Reproductive Health Services in Indonesia: An Analysis of Equality, Quality and Accountability*. Developing Alternatives with Women for New Era. https://dawnnet.org/wp-content/uploads/2021/01/Sexual-and-Reproductive-Health-Services-in-Indonesia-An-Analysis-of-Equality-Quality-and-Accountability_Discussion-paper16.pdf

[4] Amnesty International. (2021, June 11). *Perú: El derecho a la justicia de las víctimas de las esterilizaciones forzadas no prescribe* . Amnesty International . https://www.amnesty.org/download/Documents/AMR4642682021SPANISH.pdf

for holidays. Both the State and recruitment agencies collude to routinize long-term contraceptive injection practices. In Peru, women narrated how they were tricked, manipulated, and abused by healthcare professionals to undergo sterilizations. Women expressed their desire to include more voices in any FSCC research to show the diversity of the lived experiences and the urgency of working together.

> *Marala (Indonesia, woman with lived experience): I had irregular menstruation and maybe I got a little more emotional, because menstruation was already irregular and that affected my emotions. In the long run, I think some people still can't get pregnant and that brings disappointment in the couple.*

FSCC web-discussion: Researchers and advocates: FSCC in the three countries is contextualized by, and a result of, structural systems such as racism, settler colonialism, state violence, biopower, vulnerability in relation with the land, gender discrimination, and unequal access to justice. Moreover, a common theme in Canada, Indonesia, and Peru is the involvement of government and healthcare providers in the provision of FSCC. Notably, while in Canada and Peru Indigenous women or Indigenous descendant women have been the main targets of FSCC programs, currently in Indonesia women migrant workers face coerced contraception to prevent pregnancies while working in their destination countries.

> *Ana (Canada, researcher/advocate): Systematic racism, colonialism, desire for lands and resources, displacing people or keeping populations down, poverty capitalism, governments medical profession […] Alberta is a province that had openly eugenics policies in the middle of the last century.*

FSCC web-discussion: Policymakers and private sector: Participants from Indonesia connected the reproductive capacity of women with the government's plan to provide talent through human resources. They maintained that the use of contraceptive methods for migrant workers is a suggestion not a compulsory rule, even though it is a requirement to work abroad. In the case of Peru, participants highlighted the quotas implemented by the government and the use of physical and emotional force by the healthcare professionals against women. They also contextualized the FSCC's development and its nationwide implementation under a dictatorship government.

> *Esther (Peru, policymaker): Yes, many sisters have already died and continue to die. We hope for justice and that many times we have told all the governments to ask for forgiveness for all the women, but racial discrimination continues to exist. […] So, justice is very slow here in Peru.*

FSCC web-discussion: Healthcare professionals: In Indonesia, FSCC is identified as something from the past, where women in poor conditions were coerced to take a contraceptive method after childbirth to help them overcome poverty. In the case of Peru, the participant commented on how massively the implementation of the FS program was through the actions of the healthcare professionals.

Ricardo (Peru, healthcare professional): No training, no particular recruitment of certain individuals to do this. It was just you did it and the gynecologists who were going to do the procedure were going to do it in the brutal way that they did it and sort of naturally. […]

Recommendations: Recommendations focused on three areas:

(1) accountability, the importance to identify all the people involved in the implementation of the FSCC and to recognize the role they played;

2) research, continuing to conduct research that contributes to women's efforts to generate social memory and demands for justice, in a respectful way and in consultation with participants; and

(3) health care system, highlighting processes of informed consent in support of women's reproductive and sexual rights

With all this information, we hope to contribute to the survivors' claim for justice, highlighting their concerns and their requests to ground and propel further action by academics, activists, civil society, and policymakers.

STERILISASI PAKSA DAN PEMAKSAAN KONTRASEPSI: MENUJU AGENDA MULTINASIONAL – APRIL 2022[5]

Penulis : Denise L. Spitzer, Marieliv Flores Villalobos, Yuni Asriyanti, Rey Asis, Alejandra Ballón, Kristin Black, Vera Caine, Jana Grekul, Karsiwen, Jill Konkin, Susanne Luhmann, Tania Tarquí Pariona, and Budi Wahyuni

Kontrol non-konsensual atas reproduksi perempuan terdiri dari rangkaian praktik termasuk Sterilisasi Paksa dan Kontrasepsi Paksa (*Forced Sterilisation and Coerced Contraception* (FSCC) – selanjutnya menggunakan FSCC), yang mengacu pada pemaksaan atau paksaan untuk memastikan bahwa perempuan tidak dapat lagi berprokreasi baik secara permanen atau sementara. Di Kanada, baru-baru terungkap bahwa praktik FSCC ini masih bertahan.[6] Sementara di Indonesia, Pemerintah terus memperkuat Kerjasama dengan perusahaan dan negara-negara penerima pekerja migran yang membatasi hak-hak reproduksi perempuan pekerja migran.[7] Selanjutnya di Peru, setelah 25 tahun, para perempuan yang mengalami pemaksaan sterilisasi terus menuntut keadilan.[8]

Proyek kami ini, Sterilisasi Paksa dan Pemaksaan Kontrasepsi: Menuju Agenda Multinasional, dilaksanakan oleh sebuah tim yang terdiri dari akademisi dan advokat dari Kanada, Indonesia dan Peru, dan didukung pendanaannya oleh *Kule Institute for Advanced Study* di Universitas Alberta, Kanada. Salah satu tujuan dari proyek ini adalah untuk memeriksa sejarah kontemporer dan lingkup global praktik FSCC untuk menawarkan praktik terbaik untuk kajian mengenai topik ini. Dari Oktober – November 2021, kami menyelenggarakan diskusi daring multi bahasa dengan para peneliti, advokat, pembuat kebijakan, perwakilan sektor swasta, dan tentu saja para perempuan penyintas yang mengalami FSCC, serta tenaga Kesehatan dari Indonesia, Kanada dan Peru. Diskusi berkisar pada karakteristik implementasi FSCC di masing-masing negara; bagaimana pemerintah, perusahaan, atau profesional kesehatan individu terlibat dengan FSCC; harapan para penyintas akan keadilan; efek jangka pendek dan jangka panjang dari FSCC; serta praktik terbaik untuk

[5] Untuk informasi lebih lanjut, sila hubungi Prof. Denise L. Spitzer, spitzer@ualberta.ca

[6] Collier R. (2017). Reports of coerced sterilization of Indigenous women in Canada mirrors shameful past. *CMAJ 189*(33): E1080-1081.

[7] Aryanty, R. I., & Widyantoro, N. (2019). *Sexual and Reproductive Health Services in Indonesia: An Analysis of Equality, Quality and Accountability*. Developing Alternatives with Women for New Era. https://dawnnet.org/wp-content/uploads/2021/01/Sexual-and-Reproductive-Health-Services-in-Indonesia-An-Analysis-of-Equality-Quality-and-Accountability_Discussion-paper16.pdf

[8] Amnesty International. (2021, June 11). *Perú: El derecho a la justicia de las víctimas de las esterilizaciones forzadas no prescribe* . Amnesty International . https://www.amnesty.org/download/Documents/AMR4642682021SPANISH.pdf

melibatkan perempuan penyintas FSCC dalam penelitian yang secara budaya menghormati dan aman. Kami berbagi sorotan dari diskusi tersebut di sini.

Diskusi Daring FSCC: Perempuan Penyintas: Di Indonesia saat ini, perempuan dipaksa untuk menggunakan alat kontrasepsi sebagai persyaratan untuk bekerja di luar negeri dan saat mereka kembali ke rumah untuk cuti/liburan. Baik Negara maupun agen perekrutan berkolusi untuk melakukan praktik suntik kontrasepsi jangka panjang secara rutin. Di Peru, para perempuan penyintas menceritakan bagaimana mereka dijebak, dimanipulasi, dan dilecehkan oleh tenaga Kesehatan untuk menjalani sterilisasi. Para perempuan penyintas ini mengungkapkan keinginan mereka untuk melibatkan lebih banyak suara dalam penelitian FSCC untuk menunjukkan keragaman pengalaman hidup dan pentingnya bekerja sama.

> *Marala (Indonesia, perempuan penyintas FSCC): Saya mengalami menstruasi yang tidak teratur dan mungkin saya sedikit lebih emosional, karena menstruasi sudah tidak teratur dan itu mempengaruhi emosi saya. Dalam jangka panjang, saya kira beberapa orang tidak bisa hamil dan itu membawa kekecewaan pada pasangan.*

Diskusi Daring FSCC; Peneliti dan Advokat: FSCC di tiga negara dikontekstualisasikan dan sebagai akibat dari sistem struktural seperti rasisme, kolonialisme pemukim (*settler colonialism*), kekerasan negara, *biopower*, kerentanan yang terkait dengan penguasaan tanah, diskriminasi gender, dan akses terhadap keadilan yang tidak setara. Selain itu, tema umum di Kanada, Indonesia, dan Peru adalah keterlibatan pemerintah dan penyedia layanan kesehatan dalam penyelenggaraan FSCC. Khususnya, di Kanada dan Peru perempuan adat dan perempuan keturunan masyarakat adat menjadi sasaran utama program FSCC, sementara di Indonesia pekerja migran perempuan menghadapi paksaan kontrasepsi untuk mencegah kehamilan saat bekerja di negara tujuan kerja.

> *Ana (Kanada, peneliti/advokat): Rasisme sistematis, kolonialisme, hasrat untuk menguasai tanah dan sumber daya, menggusur orang atau menjaga populasi tetap rendah, kapitalisme kemiskinan, profesi medis pemerintah [...] Alberta adalah provinsi yang pernah secara terbuka memiliki kebijakan eugenika tengah-tengah abad terakhir.*

Diskusi Daring FSCC: Pembuat Kebijakan dan Sektor Swasta: Peserta dari Indonesia menghubungkan kapasitas reproduksi perempuan dengan rencana pemerintah untuk menyediakan sumber daya manusia yang berbakat. Mereka berpendapat bahwa penggunaan metode kontrasepsi bagi pekerja migran adalah anjuran bukan aturan wajib, meskipun merupakan persyaratan untuk bekerja di luar negeri. Dalam kasus Peru, peserta menyoroti kuota yang diterapkan oleh pemerintah dan penggunaan kekerasan fisik dan emosional oleh para tenaga Kesehatan terhadap perempuan penyintas FSCC. Mereka juga mengontekstualisasikan perkembangan FSCC dan implementasinya secara nasional di bawah pemerintahan diktator.

> *Esther (Peru, pembuat kebijakan): Ya, banyak saudari (penyintas) yang telah meninggal dan terus meninggal. Kami berharap keadilan dan berkali-kali kami telah*

mengatakan kepada semua pemerintahan untuk meminta maaf dan pengampunan kepada semua perempuan (penyintas), namun diskriminasi rasial terus ada. […] Jadi, keadilan sangat lambat di sini di Peru

Diskusi Daring FSS: Tenaga Medis dan Kesehatan Professional: Di Indonesia, FSCC diidentifikasi sebagai sesuatu dari masa lalu, di mana perempuan dalam kondisi miskin dipaksa untuk menggunakan metode kontrasepsi setelah melahirkan untuk membantu mereka mengatasi kemiskinan. Dalam kasus Peru, peserta mengomentari betapa masifnya implementasi program sterilisasi paksa melalui tindakan para profesional kesehatan.

Ricardo (Peru, Tenaga Kesehatan): Tidak ada pelatihan, tidak ada perekrutan khusus individu tertentu untuk melakukan hal tersebut. Itu hanya karena Anda melakukannya dan para ginekolog yang akan melakukan prosedur akan melakukannya dengan cara brutal yang mereka lakukan dan secara alami. […]

Rekomendasi: Rekomendasi fokus pada tiga area:

(1) Akuntabilitas, pentingnya mengidentifikasi semua orang yang terlibat dalam pelaksanaan FSCC dan mengenali peran yang mereka mainkan;

(2) Penelitian, terus melakukan penelitian yang berkontribusi pada upaya perempuan untuk membangkitkan memori sosial dan tuntutan keadilan, dengan cara yang terhormat dan berkonsultasi dengan penyintas; dan

(3) Sistem pelayanan kesehatan, menyoroti proses pemberian penjelasan dan persetujuan (*informed consent*) dalam rangka mendukung hak-hak reproduksi dan seksual perempuan.

Dengan semua informasi ini, kami berharap dapat berkontribusi pada tuntutan keadilan para penyintas, dengan menyoroti keprihatinan dan persoalan mereka, serta mengakomodir permintaan mereka agar penelitian lebih membumi pada pengalaman mereka langsung dan mendorong upaya lebih lanjut oleh para akademisi, aktivis, masyarakat sipil, dan pembuat kebijakan.

ESTERILIZACIÓN FORZADA Y ANTICONCEPCIÓN COACCIONADA: HACIA UNA AGENDA MULTINACIONAL – ABRIL 2022[9]

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El control no consensuado de la reproducción de las mujeres comprende una serie de prácticas que incluyen la Esterilización Forzada y la Anticoncepción Coaccionada (EFAC), que se refieren a el uso de la fuerza o de formas coercitivas para que las mujeres ya no puedan procrear de forma permanente o temporal. En Canadá, recientes revelaciones han demostrado que estas prácticas persisten[10], mientras que en Indonesia, el gobierno sigue reforzando los acuerdos con las empresas y los países receptores de migrantes que limitan los derechos reproductivos de las trabajadoras migrantes[11]. Además, en Perú, después de 25 años, las mujeres que fueron sometidas a esterilización forzada siguen reclamando justicia[12].

Nuestro proyecto, Esterilización forzada y anticoncepción coaccionada: Hacia una agenda multinacional, es liderado por un equipo compuesto por académicos y activistas de Canadá, Indonesia y Perú, y cuenta con el financiamiento del Instituto Kule de Estudios Avanzados de la Universidad de Alberta, Canadá. Uno de nuestros principales objetivos es examinar la historia contemporánea y el alcance global de la EFAC para proponer mejores prácticas para el estudio de este tema. De octubre a noviembre de 2021, organizamos debates multilingües virtuale con investigadores y defensores, responsables de políticas y representantes del sector privado, mujeres que enfrentaron estas violencias y profesionales de la saud de Canadá, Indonesia y Perú. Las conversaciones giraron en torno a las características de la implementación de la EFAC en cada país; cómo los gobiernos, las

[9] Para mayor infornación contactar a Prof. Denise L. Spitzer, spitzer@ualberta.ca

[10] Collier R. (2017). Reports of coerced sterilization of Indigenous women in Canada mirrors shameful past. *CMAJ 189*(33): E1080-1081.

[11] Aryanty, R. I., & Widyantoro, N. (2019). *Sexual and Reproductive Health Services in Indonesia: An Analysis of Equality, Quality and Accountability*. Developing Alternatives with Women for New Era. https://dawnnet.org/wp-content/uploads/2021/01/Sexual-and-Reproductive-Health-Services-in-Indonesia-An-Analysis-of-Equality-Quality-and-Accountability_Discussion-paper16.pdf

[12] Amnesty International. (2021, June 11). *Perú: El derecho a la justicia de las víctimas de las esterilizaciones forzadas no prescribe* . Amnesty International . https://www.amnesty.org/download/Documents/AMR4642682021SPANISH.pdf

empresas o los profesionales de la salud participaton en EFAC; las expectativas de justicia de las sobrevivientes; los efectos a corto y largo plazo de la EFAC; y las mejores prácticas para involucrar a las mujeres que han sufrido EFAC en una investigación respetuosa y culturalmente segura. A continuación compartimos los aspectos más destacados del debate.

Debate virutal de EFAC: Mujeres que enfrentaron estas violencias: En la actualidad, en Indonesia se obliga a las mujeres a utilizar métodos anticonceptivos como requisito para trabajar en el extranjero y al regresar a casa de vacaciones. Tanto el Estado como las agencias de contratación se confabulan para ejecutar prácticas de inyección de anticonceptivos a largo plazo. En Perú, las mujeres narraron cómo fueron engañadas, manipuladas y abusadas por profesionales de la salud para someterlas a esterilizaciones. Las mujeres expresaron su deseo de que se incluyan más voces en cualquier investigación sobre la EFAC para mostrar la diversidad de las experiencias vividas y la urgencia de trabajar juntas.

> *Marala (Indonesia, mujer que enfrentó* EFAC*): Tuve una menstruación irregular y quizá estuve muy sensible, porque la menstruación ya era irregular y eso afectó a mis emociones. A la larga, creo que algunas personas siguen sin poder quedar embarazadas y eso conlleva una decepción en la pareja.*

Debate virutal de EFAC: Investigadores y activistas: En los tres países, la EFAC está contextualizada y es resultado de sistemas estructurales como el racismo, el colonialismo, la violencia estatal, el biopoder, la vulnerabilidad en relación con la tierra, la discriminación de género y el acceso desigual a la justicia. Además, un tema común en Canadá, Indonesia y Perú es la implicación del gobierno y de los proveedores de servicios sanitarios en la prestación de servicios de salud sexual y reproductiva. En particular, mientras que en Canadá y Perú las mujeres indígenas o descendientes de indígenas han sido las principales destinatarias de los programas de EFAC, actualmente en Indonesia las trabajadoras migrantes se enfrentan a la anticoncepción forzada para evitar embarazos mientras trabajan en sus países de destino.

> *Ana (Canadá, investigadora/activista): El racismo sistemático, el colonialismo, el deseo de tierras y recursos, el desplazamiento de personas o el control de poblaciones, el capitalismo de la pobreza, la profesión médica de los gobiernos [...] Alberta es una provincia que tuvo políticas abiertamente eugenésicas a mediados del siglo pasado.*

Debate virutal de EFAC: Representantes políticos y sector privado: Los participantes de Indonesia relacionaron la capacidad reproductiva de las mujeres con el plan del gobierno de proporcionar talento a través de recursos humanos. Sostuvieron que el uso de métodos anticonceptivos para las trabajadores migrantes es una sugerencia y no una norma obligatoria, aunque sea un requisito para trabajar en el extranjero. En el caso de Perú, los participantes destacaron las cuotas implementadas por el gobierno y el uso de la fuerza física y emocional por parte de los profesionales de la salud contra las mujeres. También

contextualizaron el desarrollo de la EFAC y su implementación a nivel nacional bajo un gobierno de dictadura.

> *Esther (Perú, política): Sí, muchas hermanas ya han muerto y siguen muriendo. Esperamos que se haga justicia y muchas veces hemos dicho a todos los gobiernos que pidan perdón por todas las mujeres, pero la discriminación racial sigue existiendo. [...] Entonces, la justicia es muy lenta aquí en Perú.*

Debate virutal de EFAC: Profesionales de la salud: En Indonesia, se identificó a la EFAC como algo del pasado, donde las mujeres en condiciones de pobreza eran obligadas a tomar un método anticonceptivo después del parto para ayudarlas a superar la pobreza. En el caso de Perú, el participante comentó la masividad de la implementación del programa de esterilización forzada a través de las acciones de los profesionales de la salud.

> *Ricardo (Perú, profesional de salud): No había ningún tipo de entrenamiento, no había ningún tipo de reclutamiento de ciertas personas para hacer esto. Simplemente lo hacías tú y los ginecólogos que iban a hacer el procedimiento lo iban a hacer de la manera brutal que lo hacían y de manera natural. [...]*

Recomendaciones: Las recomendaciones se centran en tres áreas:

(1) rendición de cuentas, la importancia de identificar a todas las personas implicadas en la implementación de EFAC y de reconocer el papel que han desempeñado;

2) investigación, continuando con la realización de investigaciones que contribuyan a los esfuerzos de las mujeres para generar memoria social y demandas de justicia, de manera respetuosa y en consulta con las participantes; y

(3) sistema de salud, destacando los procesos de consentimiento informado en apoyo a los derechos sexuales y reproductivos de las mujeres.

Con toda esta información, esperamos contribuir a la reivindicación de justicia de los sobrevivientes, destacando sus preocupaciones y sus peticiones para fundamentar e impulsar nuevas acciones por parte de académicos, activistas, sociedad civil y responsables políticos.

SOMMAIRE EXÉCUTIF DISCUSSION WEB

LA STÉRILISATION ET LA CONTRACEPTION FORCÉES: VERS UN PROGRAMM MULTINATIONAL – AVRIL 2022[13]

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Le contrôle non consensuel des droits reproductifs des femmes comprend un continuum de pratiques incluant la stérilisation et la contraception forcées (SCF), ces pratiques forcent ou contraignent les femmes à ne plus pouvoir se reproduire de façon permanente ou temporarire. Au Canada, de récentes révélations indiquent que ces pratiques persistent,[2] tandis qu'en Indonésie, le gouvernement continue de renforcer des ententes avec des entreprises et des pays receveurs de migrants qui limitent les droits reproductifs des travailleuses migrantes. [3] De plus, au Pérou, après 25 années, des femmes qui ont été stérilisées forcément essaient toujours d'obtenir justice. [4]

Notre projet, La Stérilisation et la contraception forcées: Vers un programme multinational, est composé de chercheurs.euses et de défenseurs.euses du Canada, de l'Indonésie et du Pérou appuyé par des fonds du Kule Institute for Advanced Study de l'Université de l'Alberta, Canada. Un de nos buts principaux est d'observer l'histoire contemporaine et l'envergure globale de la SCF et de proposer de meilleures pratiques pour étudier ce sujet. En octobre et novembre 2021, nous avons tenu des discussions internet multilingues avec chercheurs.euses et défenseurs.es, décideurs.euses politiques et représentants du secteur public, des femmes qui ont vécu ces pratiques et des fournisseurs de soins du Canada, de l'Indonésie et du Pérou. Les conversations portaient sur les caractéristiques de la mise en application de la SCF dans chaque pays, comment les gouvernements, les entreprises ou les fournisseurs de santé individuels s'engageaient avec la SCF, les attentes en justice des survivantes; les effets à court et à long terme de la SCF, les meilleures pratiques pour la mobilisation des femmes qui ont subi la SCF de façon respectueuse et culturellement sécuritaire.

Nous partageons certains points saillants de ces discussions içi.

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[13] Pour plus de renseignements, contactez Prof. Denise L. Spitzer, spitzer@ualberta.ca

[13]Collier R. (2017). Reports of coerced sterilization of Indigenous women in Canada mirrors shameful past. *CMAJ 189*(33): E1080-1081.

[13] Aryanty, R. I., & Widyantoro, N. (2019). *Sexual and Reproductive Health Services in Indonesia: An Analysis of Equality, Quality and Accountability*. Developing Alternatives with Women for New Era. https://dawnnet.org/wp-content/uploads/2021/01/Sexual-and-Reproductive-Health-Services-in-Indonesia-An-Analysis-of-Equality-Quality-and-Accountability_Discussion-paper16.pdf

[13] Amnesty International. (2021, June 11). *Perú: El derecho a la justicia de las víctimas de las esterilizaciones forzadas no prescribe* . Amnesty International . https://www.amnesty.org/download/Documents/AMR4642682021SPANISH.pdf

SCF discussion-Web: femmes qui ont vécu l'expérience: En Indonésie aujourd'hui les femmes sont contraintes d'utiliser des contraceptifs comme condition de travail à l'étranger et en retournant chez elles en vacances. L'état et les agences de recrutement agissent en collusion pour rendre les pratiques de contraception à long-terme routiniers. Au Pérou, les femmes disaient comment ells étaient truquées, manipulées at abusées par les fournisseurs de santé pour être stérilisées. Les femmes exprimaient le désir d'inclure plus de voix dans les recherches de la SCF pour montrer la diversité des experiences vécues et l'urgence de travailler ensemble.

> *Marala (Indonésie, femme qui a vécu l'expérience): J'avais des mentruations irrégulières et j'étais peut-être un peu plus émotionnelle, parce que mes menstruations étaient déjà irrégulières et ça affectait mes émotions. À la longue, je crois que certaines personnes ne peuvent pas devenir enceinte ça apporte un désapointement dans le couple*

SCF discussion-Web: chercheurs et défenseurs: La SFPC dans trois pays est contextualisé par et est le résultat de systèmes structurels tels que le racisme, le colonialisme, la violence de l'état, le biopouvoir, la vulnérabilité par rapport avec la terre, la discrimination sexuelle, l'accès inégal à la justice. De plus, un thème commun au Canada, en Indonésie et au Pérou c'est la participation des gouvernements et des fournisseurs de soins dans la provision de la SCF. Notamment, tandis qu'au Canada et au Pérou les femmes autochtones et leur successeurs sont souvent victimes de la SCF, présentement en Indonésie les travailleuses migrantes sont contraintes à la contraception afin de prévenir la grossesse lorsqu'elles travaillent en pays étrangers.

> *Ana (Canada, chercheur/défenseur): Le racisme systémique, le colonialisme, le désir pour le (contrôle du) terrain et des ressources, le déplacement des peoples et leur subjugation, le capitalisme, la pauvreté, le gouvernement, les professions médicales […] l'Alberta est une province qui avait des politiques eugéniques au milieu du dernier siècle.*

SCF discussion-Web: Décideurs politiques et secteur public: Les participants de l'Indonésie liaient le contrôle des capacités reproductives des femmes avec le plan du gouvernement d'exporter les ressources humaines. Ils soutiennent que l'utilisation des méthodes contraceptives pour les travailleuses migrantes est suggéré et non une règle obligatoire, malgré que c'est obligatoire pour travailler hors du pays. Au Pérou, les participants soulignaient les quotas mis en place par le gouvernement et l'utilisation de la force physique et émotionelle par les fournisseurs de santé contre les femmes. Ils contextualisaient le dévelopement et le déploiment national des SCF sous un gouvernement dictatorial.

> *Esther (Pérou, décideuse politique): Oui, plusieurs soeurs sont déjà mortes et continuent de mourir. On espère pour la justice et nous avons souvent demandé aux gouvernements de demander d'être pardonnés pour toutes les femmes, mais la discrimination raciale continue d'exister. […] Donc, la justice est très lente içi au Pérou.*

SCF discussion-Web: fournisseurs de soins: en Indonésie, on identifie la SCF comme une chose du passé, où les femmes en pauvreté étaient forcées à prendre des méthodes contraceptives après l'accouchement pour leur aider à surmonter la pauvreté. Dans le cas du Pérou, le participant commentait combien la mise en application du programme de la SCF était dûe aux actions des fournisseurs de soins.

> *Ricardo (Pérou, fournisseur de soins de santé): Aucune formation, aucun recrutement particulier de certains individus pour le faire. C'est juste qu'on le faisait et les gynécologues qui allaient faire la procedure allaient le faire de la facon brutale qu'ils avaient comme si c'était naturel. […]*

Recommandations: les recommandations ciblent trois thèmes:

(1) la responsabilisation, l'importance de reconnaître tous les gens impliqués à l'exécution du SCF et de reconnaître le rôle qu'ils ont joué;

2) la recherche, de continuer d'effectuer des recherches qui contribuent aux efforts des femmes à établir une mémoire sociale et des demandes de justice, de façon respectueuse et en consultant les participants et

(3) le système de soins de santé, de souligner les processus de consentement libre et éclairé en appuyant les droits reproductifs des femmes

Avec toute cette information, nous espérons contribuer aux demandes de justice des survivantes et de mettre en évidence leurs préoccupations et leurs demandes de fonder et propulser les actions futures des chercheurs.euses, des militants.tes, de la société civile et des décideurs.euses politiques.

FORCED STERILIZATION AND COERCED CONTRACEPTION: TOWARDS A MULTI-NATIONAL AGENDA

KĀ-NAKINAMIHK AYĀWĀWASOWIN ĒKWA KĀ-SIHKIMĒCIK KĪKWAY KĀ-ĀPACIHTĀCIK NAMŌYA KĀ-OCAWĀSIMISICIK: ISI KAHKIYAW KA-PIMITISAHIKĀTĒK - APRIL 2022

namōya wiyawāw iskwēwak ka-pimipahtahkik ka-ocawāsimisicik kiyāpic ispayin tapiskōc kā-nakinamāhcik ayāwāwasowin ēkwa kā-sihkimihcik kīkway kā-āpacihtācik ka-nakinamihk ayāwāwasowin (FSCC),ēkoma itwēmakan iskwēwak ē-nakinamāhcik āhpō ē-sihkimihcik namōya ayiwāk kā-ocāsimisicik aciyaw āhpō nayistaw. pihcāyihk Canada, ācimikātēw namōya kayās kiyāpic omisi ē-itōtamihk, ēkwa pihcāyihk Indonesia, okimāwak kiyāpic wihtahpisomēwak companies kā-itamihk ēkwa askihk ita kā-nakinahkik ayāwāwasowin. ēkwa pihcāyihk Peru ispīhk 25 askiya aniki iskwēwak kā-nakinimāhcik ayāwāwasowin kiyāpic nitonamwak kwayask ta-itōtāhcik

nitatoskēwinān , Forced Sterilization and Coerced Contraception: Towards a Multinational Agenda,wīcihtāsowak oskiskinwahamākēwak ēkwa ayisiyiniwak ōhci Canada, Indonesia ēkwa Peru ēkwa tipahamwak Kule Institute for Advanced Study at the University of Alberta, Canada. pēyak kīkway ka-nohtē-kiskēyohtamāhk ōma FSCC tānsi misiwē ē-ispayik ēkwa tānsi ta-isi-pimitamihk. October iskōhk November 2021 , nikī-astānān web-discussions nikī-nitomānānik oksikinwahamākēwak, okimāwak, iskwēwak kā-kiskēyihtahkik ēkwa maskihkīwiyiniwak Canada, Indonesia ēkwa Peru ōhci. Nimāmiskotēnān tānisi ta-sipwēpitamihk FSCC tahto askīhk; tānisi okimāwak , companies, ēkwa maskihkiwiyiniwak ē-isi-paminācik FSCC kāhkī-itōtāhcik tānisi kwayask kā-ispayik, aciyaw ēkwa kinwēs kā-tākoskākocik FSCC, ēkwa tānisi kwaysk ka-isi-paminihcik iskwēwak kā-tākoskākocik FSCC. nimiyinkinān ātiht kā-pīkiskwēwin ōta.

FSCC web-pīkiskwēwin iskwēwak kā-tākoskākocik. pihcayihk Indonesia anōhc , iskwēwak ē-sihkimihcik kā-āpacihtācik kīkway namōya ka-ocawāsimisicik piyisk kā-atoskēcik kotakihk askihk āhpo kā-pē-kiwēcik. Okimāwak ēkwa aniki kā-miskawācik atoskēwa wītahpismitowak ka-cistahowācik iskwēwa namōya ka-ocāwisimisiyit. Pihcayihk Peru wihtamwak iskwēwak tānisi ē-isi-wihtamākocik maskihkikiwiyiniwa ta-otinahkik kīkway namōya ka-ocasimisicik. Iskwēwak wihtamawēwak FSCC ayiwāk ka-nitonahkik pīkiskwēwina ta-wāpacikātēk misiwē ē-ispayik ēkwa ka-wīcatoskēmitohk.

> Marala (Indonesia iskwēw ē-kiskēyihtahk) namōya kwayask menstration nitayan ēkwa niwahki-māton. Kinwēs ātiht namōya kī-ocawāsimisiwak ēkwa pakwātamwak nāpēw ēkwa iskwēw.

FSCC web-pīkiskwēwin: kiskinwahamākanak ēkwa wīcihtāsowak: FSCC pihcayihk 3 askiya ispayin pihtaw tānisi ē-isi-pakwātēhcik ayisiyiniwak, kotakak ē-miwīskākēcik ayisiyiniwak, ēkwa namōya kwayask wiyasowēwin ē-itastēk. Ēkwa pihcayihk Canada, Indonesia ēkwa Peru okimāwak ēkwa maskihkiwiyiniwak ē-pimipitahkik FSCC. Ēkwa pihcāyihk Canada ēkwa Peru iyinito-iskwēwak wiyawāw tākoskākowak FSCC. Mēkwāc pihcāyihk Indonesia iskwēwak kā-atoskēcik ē-sihkimihcik kā-āpacihtācik kīkway namōya kā-ocawāsimisicik itē akāmaskīhk kā-atoskēcik.

> Ana (Canada, kiskinwahamākan, wīcihitāsow) pakwātowin, kotakak kā-pē-mīwēskākīcik, askiy kā-nitawēyhtamihk, namōya ka-mihceticik ayisiyiniwak, okimāwak, maskihkiwiyiniwak [..] Alberta ki-ayāwak namōya ka-mihcitēyit ayisiyiniwa kā-nitawēyinmācik middle of last century.

FSCC web-pīkiskwēwin: okimāwak ēkwa atēkwa kwanta ayisiyinīnāhk: Indonesia ōhci ayisiyiniwak itwēwak iskwēwak namōya ka-ocāwsimisicik ēkwa ka-atoskēcik okimāwak kī-wiyasowēwak. Kī-itwēwak kīkway ka-āpacihtāhk namōya ka-ocawāsimisihk ē-mosci-itwēcik māka piko ēkosi ta-itōtamihk akāmaskīhk kā-wī-ātoskēhk. Pihcāyihk Peru wihtamwak tānīkōhk okimāwak ē-itastācik kā-ocāwāsimisihk ēkwa tanisi ē-isi-kitimahihcik iskwēwak ē-paminihcik āhpō ē-kitimākimihcik. Mīna wihtamwak FSCC tānsi ē-isi-osihtāhk ēkwa misiwē kā-āpacihtāhk peyak ayisiyiniw kā-okimāwiwit.

> Esther (Peru, owiyasowēw) mihcet iskwēwak pōni-waskawēwak. Nitawēyihtēnān kwayask kīkway ka-ispayik mihcētwāw nikakwēcimānik okimāwak ka-pakitēyimācik kahkiyaw iskwēwa, māka kiyāpic pakwātowin ispayin. […} nansihkāc kwayask ta-ispayik ispayin pihcayihk Peru.

FSCC Web-pīkiskwēwin: maskihkiwiyiniwak: pihcāyihk Indonesia FSCC ayimōcikātēw tāpiskōc kayās, iskwēwak kā-kitimākisicik ē-sihkimihcik kīkway ka-otinahkik namōya ka-ocawāsimisicik kā-kīsi-ocāwasimisicik namōya ka-kitimākisicik. Pihcāyihk Peru itwēw pēyak tānisi misiwē FS itōtamowin ē-ispayik osām maskihkiyiwiyiniwak ē-pimitisahkik.

> Ricardo (Peru, maskihkiwiyiniw); namōya ē-kiskinwahamāhk, namōya ayisiyiniw ē-nitonawiht ōmisi ka-itōtahk. Sōskwāc kiya ēkwa iskwēw maskihkiwiyiniw kā-wī-itōtahkik ē-mayi-itōtahkik sōskwāc. [..]

wihtamākēwin: wihtamākēwin nisto kīkwaya:

(1) kahkiyaw ka-wīhihcik aniki kā-pimipitahkik FSCC ēkwa tānisi ē-isi-wīcihtāsocik

(2) kiskēyihtamowin ka-astēk ka-kiskēyihtamihk tānisi ē-kī-ispayik ēkwa kwayask ka-paminihcik aniki ka-tākoskākocik ēkwa

(3) ahkosiwikamikōhk tānisi iskwēw ē-isi-wihtamāht wiya ē-tipēyihtahk ka-ocawāsimisit. Ēkoma kahkiyaw wihtamākēwin nipakosēyihtēnān kwaysk ka-ispayik. Opīkiskwēwiniwāw ka-āpacihtācik okiskinwahamākanak, ayisiyiniwak ēkwa okimāwak

I PROJECT DESCRIPTION

Non-consensual control over women's reproduction comprises a continuum of practices including Forced Sterilization and Coerced Contraception (FSCC), which refer to forcibly or coercively ensuring that women are no longer able to permanently or temporarily procreate.[1] Whether state-sanctioned, part of a public health intervention, or supported by diffusely circulating dominant discourses, FSCC is an enactment of the societal belief that only certain people are worthy of reproducing.[2] Most groups targeted by these measures experience multiple forms of marginalization and discrimination including Indigenous Peoples, migrants, rural, poor, transgender and intersex people, and persons living with HIV/AIDS or disabilities.[2,3,4]

The impact of FSCC on survivors, their communities, and families opens discussion of these practices as acts of torture and genocide, especially when considering the role of governments in these actions.[5] While Canadians may have thought that state-sanctioned involuntary sterilization ended with the repeal of legislation in Alberta in 1972, recent revelations have demonstrated these practices persist in Canada as elsewhere.[6,7] In Indonesia, the government continues to strengthen agreements with companies and migrant-receiving countries that limit the reproductive rights of migrant women workers.[8] In Peru, after 25 years, women who underwent forced sterilization are claiming justice within a system and a society that does not understand the severity of their rights' violations.[9] The global scope of FSCC, the impact on survivors, their families, and communities, and the roles of health care practitioners, and the nation-state, in promoting and carrying out these measures have yet to be fully explored.

A. TEAM AND OBJECTIVES

This initiative emerges from Ms. Marieliv Flores Villalobos' Master's research (University of Ottawa, Feminist and Gender Studies, 2018) with Indigenous descendant women in Peru with lived experience of forced sterilization who posed both a question "Has this happened to other women?" and a request, "We would like to share our stories with people in other countries, so we can help each other to get justice." In response, we drew on existing and emerging partnerships with colleagues in Canada, Peru, and Indonesia to form a team that could create a space for their query and their entreaty to be addressed. Additionally, we

are working to uncover commonalities and specificities of the contexts, experiences, and implications of FSCC for individuals, families, and communities to develop a global perspective rooted in the lived experience of survivors, families, and impacted communities in order to formulate a survivor-centred research agenda. The team includes academic researchers, community advocates, health practitioners, and artists from Canada, Peru, Hong Kong, and Indonesia, whose overlapping and complementary backgrounds enable us to address all aspects of our initiative. The partnership integrates Public Health, Sociology, Nursing, Gender Studies, Medicine, Anthropology, Visual Art, and Policy Studies, with expertise in advocacy with Indigenous and migrant women around issues of reproductive health and social justice.

B. FUNDING

This project, *Forced Sterilization and Coerced Contraception: Towards a Multi-National Agenda*, is funded by a Kule Institute for Advance Study (KIAS) Research Cluster Grant that supports sustained activities of an interdisciplinary research team in the social sciences, humanities and arts at the University of Alberta that have the potential to be recognized as excellent at the national or international level.

II WEB-DISCUSSIONS

One of the objectives of this study is to examine the contemporary history and global scope of FSCC to propose best practices for studying this topic by hosting multilingual web-discussions with survivors, advocates, researchers, policymakers, private sector representatives, and health care practitioners. From October to November 2021, we conducted four web-discussions with researchers and advocates, policymakers and private sector representatives, women with lived experience, and healthcare professionals.

A. METHODOLOGY AND PARTICIPANTS

The research team developed specific questions for each web-discussion based on the multi-lingual integrative literature review and researcher experiences. We invited potential participants to be part of the discussions through each country's network. Ethics approval was obtained from the University of Alberta (PRO 00011985).

In the invitation we detailed the possibility to participate in a focus group or interview of 90-120 minutes meeting in four separate groups; (1) women who have undergone FSCC, (2)

policymakers and private sector representatives, (3) advocates and researchers, and (4) health care professionals. Moreover, we highlighted that all persons involved with the project have signed oaths of confidentiality, committing themselves to protecting anonymity and confidentiality.

In the next pages we will summarize the main commonalities and differences in each country regarding the FSCC, while using quotes to prioritize participants' voices and experiences. Pseudonyms are used to protect participants' identities. With this information, we hope to contribute to the survivor's claim for justice, highlighting their concerns and requests to ground and propel further action by academics, activists, and civil society.

B. TRIGGER WARMING

Some of the information might be trigger trauma for the reader, please take any necessary precautions to be safe while reading this document.

III FSCC WEB-DISCUSSION: RESEARCHERS AND ADVOCATES

The first meeting was held with representatives from Canada, Indonesia, and Peru. The participants were interested in learning about the history of FSCC in each other's country and sharing their experiences of working on this issue. Furthermore, participants expressed appreciation for the opportunity to connect with other people from different contexts, and to share their lessons learned while conducting research and / or advocating for reproductive justice in their respective countries.

We discussed three main subjects: Firstly, we asked them to explain how FSCC was carried out in their countries in order to understand the details of its implementation. Secondly, we probed the drivers of FSCC in their country. Thirdly, the conversation centered on best practices to engage women who have undergone FSCC in a respectful and culturally safe research.

A. FINDINGS: FSCC IMPLEMENTATION IN CANADA, INDONESIA, AND PERU

The discussion highlighted the similarities between these three countries and the context of FSCC. A common theme was involvement of government and healthcare providers in the provision of FSCC, perpetuating genocidal policies and false ideas of development that

encapsulate the argument for population control's tactics like the FSCC was also present in all countries.

The time of the implementation is different for each represented country. In Canada, there are current reports of coerced sterilization and coerced contraception, which demonstrates that while the government policies may be abandoned, individual healthcare practitioners (and social service people) perpetuate it.

> *Ana (Canada, researcher/advocate): There is a significant history in Canada, particularly the western provinces, of coerced sterilization often under the rubric of family planning, but not just that. There's a history of Indigenous hospitals called "Indian hospitals" at the time, and clearly it was a part of the sort of colonial and genocidal policies of governments. More, there's evidence of some coerced contraception and there was a case in British Columbia, one of our provinces, that a 14 year old in foster care, a social worker had insisted an IUD be placed in that young woman, [...] And there's currently a case in the courts in Saskatchewan around the issue of forced sterilization in Indigenous women, so while a lot of people will think in Canada that this was a problem in the past, it has certainly carried out much more much more quietly in the present.*

In Peru, FS was connected to a dictatorial government between 1995 and 2000 that received international monetary assistance and developed a national network to implement it; and in Indonesia, FSCC has been linked to two events: a) in 1970 a family planning program was carried out with the aim of population control, where people were forced to use a particular contraceptive method and /or underwent sterilizations, and b) currently Indonesian migrant workers are forced to use contraceptive method to work abroad or for jobs at home.

FSCC in Indonesia and Peru share three similarities: (1) international agencies presented themselves as key stakeholders to help with population control as a way to escape from poverty; (2) authoritarian governments were in charge of the programs' implementation, and (3) the military was involved in contacting and coercing women into FSCC. In Canada, internal state interests have underpinned FSCC.

> *Fiorella (Peru, researcher/advocate): It was a state policy that occurred in the 1990s, under the autocratic government of Alberto Fujimori. It was implemented between 1996 and year 2000, it was presented as a birth control and sexual and reproductive rights control. Most of the victims were descendants of Indigenous people in rural areas living in conditions of poverty. International organizations were part of this, like: USAID, international cooperation, the Nippon Foundation, and others Peruvian*

organizations that carry this out were the Ministry of Health (MINSA), the arm forces and Peruvian Institute of Social Security – (IPSS). It was a genocide case that also carried out ethnic genocide, eugenics and crimes of war.

Daya (Indonesia, advocate): In early 1970 started the family planning program [...] to control the population. […]. Even at that time the military force involved to put a sign in each house in the villages for the family who hasn't or who had the contraceptive at that time. So, this program is also supported by the World Bank, at the time they called it aid but it actually was debt. So, at the beginning the purpose of this contraceptives was for the woman's health and reproductive health issue, but it was abused with the government at that time, the authoritarian government to control the population. It was in the past during the authoritarian regime, but currently the current issue is for women, it's not easy it's difficult to access the contraceptive as it requires the marriage certificate if you want to access the contraceptives. Even if you are (sexually) active but if you don't have the marriage certificate you cannot access the contraceptives.

In Indonesia, Canada, and Peru, women in poor conditions, and women with disabilities have been the target of these policies and programs. While in Canada and Peru Indigenous women or Indigenous descendant women were the main targets, nowadays, in Indonesia women migrant workers face coerced contraception as to prevent pregnancies while working in their destination countries.

Maria (Peru, researcher/advocate): it is a consequence of the colonization, and the wish for them to destroy all the Indigenous community and Indigenous people in general.

Angela (Indonesia, researcher/advocate): So, that's a perspective to control a woman, coming from the Indonesian state but also at the destination country of migrant workers. [...] So, woman migrant workers are vulnerable to experience various sexual violence. So, they say this forced contraception is part of the prevention to avoid particularly the foreign in the destination country, so this is also the control the state to the body of the women migrant workers. And for the woman with the disability, as they prone to experience the sexual violence, so the force contraception is part of the prevention to avoid the risk of the sexual violence experienced by the woman with disabilities.

B. FINDINGS: MAIN MOTIVES TO CARRY OUT FSCC

FSCC in the three countries are a result of structural systems such as racism, settler colonialism, state violence, biopower, vulnerability in relation with the land, gender discrimination, and access to justice. In that sense, the health, justice, and economic systems are more prepared to serve forced and coerced ways to control population growth, than to give access to

reproductive information, sexual education, value women's and Indigenous women bodies and their connection to the land or develop reparation when sexual and reproductive rights are violated. On the other hand, the relationship between the woman and the physician (who perform the FSCC) reflects the predominant status of the preconceived ideas of health professionals about who can make the decisions regarding women's bodies.

In the specific case of Indonesia there is a specific relation between the state and the private sector in order to implement contraceptive methods without the proper consent. This raises the question of how lucrative it is and how the power dynamics fluctuate with the government, the destination countries, and the private sector.

> *Maija (Canada, advocate): So there's this vulnerability about how we perceive a certain body, right? So there's this vulnerability Indigenous women about how their bodies are perceived and how they are thought about, and therefore this claim or this permission of violence over women's bodies, which connects with exploitation of land.*
>
> *Ana (Canada, researcher/advocate): Structural racism, systemic racism, colonialism, desire for lands and resources, displacing people or keeping populations down, poverty capitalism, governments medical profession, planned parenthood, Federation of Canada, Alberta is a province that had openly eugenics policies in the middle of the last century.*
>
> *Rosa (Peru, researcher): The reason that enforce this forced sterilization in Peru is: the violence, discrimination, structural violence, certain groups of the population maybe Indigenous women, also demographic control, and clinic violence. The new policies of contingency to avoid or prevent new births, and an economic unit. Also, this is cheaper than other conception method, discrimination structural violence.*

C. FINDINGS: WOMEN'S ENGAGEMENT IN RESEARCH

In order to engage women in our research, advocates suggested connecting with survivors in a transparent and respectful way. They highlighted the need to identify and understand their physical and emotional struggles, their efforts and how they are claiming for justice. It is also important to reflect on the purposes of doing research and ask ourselves how we want to establish relations with participants, keeping in mind that building relationships is a slow process.

A central component—and one that was repeated in the interventions—is how researchers can show that we care about survivors, that is how we will support an ethics of care. Participants suggested the work be healing oriented and that we need to be very clear

about what we are going to do with the data collected, and that we ensure that reciprocity is incorporated in our process with women with lived experience as co-creators of knowledge.

Indonesian interlocutors emphasized that there needed to be more dissemination of information regarding forced contraception as a human right violation and that we need to provide psychological help for the survivors.

> *Ella (Canada, advocate): [...] As a participant, I would want to know what is going to come from this. If I open up about this harmful and traumatic thing, what is it going to be? just a report or am I going to see something, will change happen, so this doesn't keep happening to other women? I think I would want to know how this is going to have a positive impact, before I would even open up.*
>
> *Maria (Peru, researcher/advocate): That the culture is respected. The ceremonies are really important. it's like to open a door with the ceremonies and especially for the healing process. Because it's not only why they can bring for research, but how we can help them in the healing process.*

IV FSCC WEB-DISCUSSION: POLICYMAKERS AND PRIVATE SECTOR

The second meeting was held with policymakers[14] and private sector representatives from Indonesia and Peru. There were no participants from Canada, despite invitations disseminated to relevant policymakers. In this opportunity, there was a clear distinction between the representatives of the two countries, while Peruvian participants also had experience in advocating for women who underwent FSCC; the Indonesia participants had politically correct discourse regarding reproductive rights, but were not aware of the women migrants' struggles.

During this meeting we discussed three main subjects: the main characteristic of the FSCC implementation according to their contexts, then we talked about how the governments, companies, or individual health professionals were engaged with FSCC, and finally the on the expectation of justice and the role of all people involved in the FSCC.

[14] The policymakers that participated in the discussion were former congresswomen/men and people that at the time were working or used to work for different offices of the Government.

A. FINDINGS: FSCC CHARACTERISTICS IN INDONESIA, AND PERU

Participants from Indonesia explained that, in general, when women have any condition that does not qualify as having *good health,* then healthcare professionals provide counseling to present options to avoid pregnancy. Other participants connected the reproductive capacity of women with the government's plan to provide talent through human resources (migrant workers). Participants maintained that the use of contraceptive methods for migrant workers is a suggestion not a compulsory rule, even though it is a requirement to work abroad.

> *Cahaya (Indonesia, policymaker): [...] from the perspective of the Ministry of Labor we also want to prepare human resources who are capable, that is to say that the rights of children can be fulfilled, especially the right to education. We have a future plan as a government of Indonesia to provide talent in the future to be able to prepare human resources who are able to develop in their field. I also want to add regarding the migrant workers from Indonesia, in their destination countries, we have some requirements and one of them is about their health. So, for the migrant worker who wants to work outside the country they cannot be pregnant during this process. The process of being positioned in their country of destination because it is a maintained labour agreement, and it is a requirement that also the user or employer stipulates. So, we have prepared some medical tests for the potential migrant worker*

In the case of Peru, participants highlighted the quotas implemented by the government and the use of physical and emotional force by the healthcare professionals against women. They also contextualized the FSCC's development and its nationwide implementation under a dictatorship government.

> *Carmen (Peru, policymaker): Well, forced sterilizations in Peru took place during the 1990s to 2000 during the period of Alberto Fujimori's government. In this period what we experienced in the country, in addition to the forced sterilizations, was a context of dictatorship, but also a process of internal armed conflict that exacerbated the situation particularly for women in the Andean and Amazonian areas of our country. These forced sterilizations were part of the national population policy that the government implemented with the argument of fighting against poverty, lowering the birth rate; however, this policy was imposed in an arbitrary way and was also implemented without prior, free, and informed consent of the women. Nurses and health personnel were hired, numerically speaking, to respond to a national campaign and sterilize women, especially in Indigenous and rural areas. The women were also deceived, they were taken to the health centers telling them that they were going to have their health checked, according to the testimonies expressed by*

the women they were anesthetized without their consent and they woke up when they had already undergone the surgery.

Esther (Peru, policymaker): The health personnel went from house to house, coercing the women, deceiving them, telling them that the cut was going to be very small and that they were going to work harder than they were. Some women were convinced, and others were not […].

B. FINDINGS: ABOUT THE INVOLVEMENT OF HEALTHCARE PROFESSIONALS

Participants from Indonesia explained that there is no instruction from the government or private sector to coerce women to accept contraceptives, and one of the arguments is that the government is not interested in decreasing the birth rate. They specified, however, that the government is very concerned about providing migrant workers to host countries in 'optimal condition', which includes controlling the possibility of becoming pregnant.

Cahaya (Indonesia, policymaker: What we do is we give notice to all candidates who want to enter or go abroad, as migrant workers, that they should not be pregnant during the process. So, for anyone who want to work outside the country and if they wanted to have sexual activity with their husbands, then they would have to have the idea that they should not be pregnant and that's basically what the campaign is about for migrant workers to be prepared physically and mentally before they leave the country.

Raja (Indonesia, private sector): The goal is to make sure that the women are ready and in optimal conditions to work as migrants, especially when they go through the process of waiting at home because if their departure date is close, then of course they have to be educated about how to have safe sexual activities to prevent pregnancy.

In the case of Peru, participants presented a scenario of a chain of power and coercion: the government implemented quotas for tubal ligations. Healthcare professionals were asked to meet them, if not they could lose their jobs, which contributed to coercive processes. Peruvian participants also reflected on former President Fujimori as an international figure, who portrayed himself as an ally of women's reproductive health, and how that connected to the possibility of obtaining international loans that implemented indicator frameworks to evaluate the results.

Carmen (Peru, policymaker): In the Peruvian case, goals were imposed on the health personnel, including doctors, nurses, and technicians. There was even a monetary

incentive as soon as the goals were achieved, for each sterilization there was an economic valuation. On the other hand, there was also a kind of conditioning in case, for example, the personnel did not meet the goal, they could be fired from their jobs. So much so that nurses in the health centres were looking for people to meet the goal [...]. However, there were also actors such as members of the armed forces to implement the operating rooms for the transfer of the stretchers and even the transfer of the people who were being coerced, in any case, on the way to the health center. So, there were people who were also pressured by these demands for goals and who put their jobs, their work, and so on at stake.

Esther (Peru, policymaker): Fujimori travelled to China, to Beijing, and at the conference he said that poor women were going to end their poverty because family planning was going to be implemented, I remember now, everyone applauded him. But at that time when we already had the federation, there were already complaints that they were forcing the IUDs and the women were already feeling the pain. So, I spoke with Fujimori, because there was a meeting with Peruvian women, I told him that for anything that the government wants to implement, first there should be an analysis or a study [...].

C. FINDINGS: WHAT IS JUSTICE?

Peruvian participants mentioned that they find really important that the government acknowledge its responsibility and ask for forgiveness, especially because racial discrimination against Indigenous peoples continues to exist. They also reflected on the law and the judicial system. In the case of Peru, FS is a case against humanity and the law recognizes the victims of sterilizations as subjects of reparation, taking into consideration that this violence is a form of sexual violence. Finally, they shared their concerns regarding the consequences of the FS for the Peruvian society and the national movement of reproductive rights. They also asked to identify the consequences further from the women affected, for example with the relations with their children and how their children are doing if they were breastfed when their mothers were grieving.

Esther (Peru, policymaker): Yes, many sisters have already died and continue to die. We hope for justice and that many times we have told all the governments to ask for forgiveness for all the women, but racial discrimination continues to exist. If they had sterilized women who live in Lima, who are from the city, who have money, surely justice would have acted immediately for them, not like the poor and peasant women who are not literate, not many women and most of the women are Quechua speakers, they are Aymara and Amazonian. So, justice is very slow here in Peru. We hope that the justice system will act and that the government, the State will ask for forgiveness but also that it will look at their health because right now the health of all

the women who have been sterilized and abandoned is very precarious; and it is even worse because when they go to a doctor, they are told that they have nothing []. Many children who have breastfed when the women have been sterilized and have breastfed that milk are traumatized, and this is not being seen either, there are many children who have been traumatized and today they are young people who cannot even do anything, who have not reached higher education. This is a concern for us when we talk, when we get together, we worry and we feel helpless not to find a remedy for these young people, not to find a remedy for these mothers who have been trampled on in their lives and in their right to health as women, in their right to production as women.

V FSCC WEB-DISCUSSION: WOMEN WITH LIVED EXPERIENCE

The third meeting was with women with lived experience from Indonesia and Peru. The participants were interested in meeting each other and sharing their experiences of struggle, health, care, and fight for justice.

We discussed the FSCC's implementation and the short- and long-term effects, from their own experiences. Then, we talked about how we might engage women who have undergone FSCC in research. Finally, we asked how they perceived the accountability of government, private sector, or health professionals regarding their participation in FSCC.

A. FINDINGS: FSCC CONTEXT IN INDONESIA AND PERU

In Indonesia nowadays, women are being coerced to use contraceptives as a requirement to not only work abroad but also when they return home for holidays. Both, the State and the recruitment agencies who broker their employment contracts collude to implement long-term contraceptive injections and to return migrant workers who are pregnant, forcing women to pay for all the arrangements. The migrant worker's age, marital status, or sexual orientation does not matter. Women are not informed about the name, duration, and / or any secondary effects of the contraceptive injection.

Kerani (Indonesia, women with lived experience): Well, based on my experience, forced sterilization is seen as coercion, which brings harm to us women, especially for those who are not married. For example, for us who are not married yet, it can bring negativity, but for other people it can be an option. I remember in the company I asked for permission to go home, and before I could go home at that time, I had forced sterilizations or coerced contraception, which was imposed by the company. That was in 2006 and the company was in Jakarta, the procedure was that they took us to the clinic and we were hospitalized. There were almost 10 people in each group, I was the first person who had that procedure done and then the next ones came in.

Latika (Indonesia, women with lived experience): In 2005, when I was going through the process to work abroad in Singapore, at that time it was about holidays, everyone had the option to go home again but we were asked to use company-provided contraception. If we didn't want to take that contraception, they were not going to allow us to go home. So, it felt pretty forced the way they did it. They took us to the clinic anyway. The contraceptive was in the form of injections that you had to take for many months, and it was for both married and unmarried people. And yes, it was the collaboration of the company and the state, because Indonesia was sending back migrant workers who were pregnant.

In Peru, women narrated how they were tricked, manipulated, and abused by healthcare professionals as a way to undergo sterilizations. At the moment, it was very complicated to talk about this, because there was a stigma that women who had a tubal ligation were unfaithful. In addition, it took years for women to realize that what happened to them was not an isolated case, and that is how the movement of survivors started.

Martha (Peru, women with lived experience): I am going to tell you about my experiences of forced sterilization. I live in the community xxx, in my province of Chumbivilcas. I was in poor health so I gave birth to my daughter in October 1994. A lady came to visit me, the next day she came to my house again and asked me if I wanted to go [to the hospital], I said yes. I felt bad, so let's see if they see what I have. I arrived in Cusco at night, they were traveling all day and I went to the regional hospital. Then, at 8 o'clock in the morning, arriving at the regional hospital, I thought that they were going to do blood tests, heart tests, temperature tests— but no. They made me go upstairs. I went into a room, there were a lot of women who were hospitalized, they were in pain, they were screaming ahhh! on the floors, on the beds. I said what happened here, then the nurse came. She called me "mamita" or I don't remember, but it was a nice word, she told me: "Take off your clothes, we are going to see you" and they took off all my clothes and changed me. So, I have never gone to the hospital. There were a lot of [people] inside, with their light blue clothes, covered up, with gloves. Then I got scared first when the women were screaming, I almost ran away but the nurse came. Suddenly something was happening, then they called me and pushed me and asked me: "Daughter, now we are going to cure you, lie down, what is your full name?" I spoke: "My name is always Martha," I haven't even finished and I got lost, I didn't realize what I was talking about. I could no longer speak because I seemed to fall asleep. So, from 8:30 I must have been admitted and that same day, at 3 o'clock in the afternoon, because it was still sunny, they took me out. I was in the same room where they took me first. Then my belly hurt, they cut me. There comes the nurse again and the doctor was also inside. Sure enough, when they ligated me, when I was reacting from the anesthesia, what they put in me. Then they told me, "Daughter, you are not going to have children anymore, now you are going to be young, now not even your husband is going to leave you. Now you're

going to be younger than what you were young, that's how you're going to be now […]."

Luisa (Peru, women with lived experience): I am Luisa, I am from the north of Peru. In 1996, I heard about family planning. I thought, well, it's very good for people who have many children to decide […]. In 1996, I was pregnant at 32 weeks' gestation, I had a doctor who was particularly attentive to me, but at 32 weeks I had some discomfort, my son was still premature. I had discomfort like contractions and my doctor wanted to send me to a clinic, but I said no, I have social security, I can go to a hospital and my doctor also worked there, so he transferred me to the hospital in the city of Piura. So, when you are transferred, you go in through the emergency room, I went in through the emergency room, but I remember it was 7 o'clock at night but at 8 or 8:10 I was already having a caesarean section. The moment my baby was born I heard him cry, he cried, but soon everyone was running out, I knew there were problems with the baby, but one always hoped that it was something minor, there was no pediatrician at that time. The next day, after 17 hours, I was getting ready to get up to breastfeed my baby because my breasts were already full of milk. I was sitting up when they gave me the news that my little boy had died. For me it was a tremendous shock and then the visit began that day, I asked for a very voluntary discharge, I told her that I wanted to leave because for me it was very painful to see the mothers who were breastfeeding their children, I was with my milk exploding, my breasts were full of milk. I wanted to go home. That baby was planned, I was a woman who wanted to have the baby, I had just gotten married, it was my second child I was going to have. I told the doctor that I wanted to go home, they told me why and the other doctor who was on the side told him that your baby had died; and he said to me, but you are young, you can still have another baby, and this same doctor, on the side as if he was just talking to him, said: no, she has already been sterilized. I stayed there, I said absolutely nothing, I was in pain because of the loss of my son, at the time that news. I kept quiet at that moment, but I asked to see if it was true and when they read the medical history, it was truly sterilized and the medical history did not show sterilization. When this happened, a month after I recovered from the operation, I was in a tremendous depression because I had the desire to be a mother […]

B. FINDINGS: SHORT- AND LONG-TERM EFFECTS DUE TO FORCED STERILIZATIONS OR COERCED CONTRACEPTION

For the participants of Indonesia, the effects were mainly: not having menstruation for certain periods of months, feeling pain in the body, weakness, fertility problems, changes in their emotional state or physiological health, and social discrimination.

Marala (Indonesia, women with lived experience): I had irregular menstruation and maybe I got a little more emotional, because menstruation was already irregular and

that affected my emotions. In the long run I think some people still can't get pregnant and that brings disappointment in the couple. Thank you very much

Latika (Indonesia, women with lived experience): What I experienced as a good long-term effect was that I didn't have menstruation for many months. It's not really that long term.

In the case of Peru, women explained that they live in a status of sadness because they don't feel they are the same. They also had problems with their husbands because they found it difficult to have sexual relations after the tubal ligation. Women also struggled to walk long distances or work in agriculture, because they did not have the strength. In addition, they highlighted that the psychological damage has been very profound for survivors, taking into consideration that they have been assaulted by the State and the society.

Luisa (Peru, women with lived experience): I think that all of us, plus all the damage we are feeling right now in the long term, the psychological damage. That is something that we all have until now, the aggression that we have suffered has marked our lives tremendously, in every sense, both personally and socially. Physically, in my case, I stopped menstruating for a few days, that is to say, I didn't menstruate regularly, and since then there has been a lot of inflammation. But what is hurting us the most so far is the psychological damage, we are carrying it so much more, after the operation that is physical and so much more with all the things we have had to endure. So much in the operation that we have been assaulted and so much that we are still being assaulted by all the systems and by society as well.

Martha (Peru, women with lived experience): For me it is a sadness what we live, what I live personally because we are no longer the same as we were before, even with our partners. Why do we have a ligation, so that we don't have children? Why also in relationships with our partners is no longer normal because this demand to have a relationship is a difficulty that we are experiencing. Of course, we have heard that there was family planning since 1990, it says that they take care of themselves with pills, with injectables, but I always heard that other women who did not know how to read or write, they became ill, as they did not know how to use like those who know how to read, so there were those with mental disorders [...]. Before, before I worked hard, I also walked far away, but after that [sterilization] in the short term the hemorrhage came a lot too, more than before I had hemorrhage for three or four days, that's how it came to me and they couldn't even take the wipes I had. In the long term, I have lived because I have become seriously ill with my health, my children were studying at the academy and I have never found health care because I said suddenly the ligature is making me more ill, why am I going to be ill. So I went to the hospitals, I ended up going to all the hospitals, I even went to Arequipa. What happened to me because when I had my menopause, my hemorrhage came for a week or two weeks, I was in bed, I could not walk, I had no strength. I could not work

normally on the farm, I am a farmer, I like to work on my farm, I like to work on my farm. I can't do things normally anymore; I can't help my husband as I should.

C. FINDINGS: WOMEN'S ENGAGEMENT IN RESEARCH

Women expressed their desire to include more voices that can show the diversity of the lived experiences and the urgency of working together. They also shared the importance of understanding knowledge being produced at the community level, therefore active collaboration between researchers and community has the potential to advance this work further. On the other hand, they specified that a good engagement should also educate people about what they can do if their rights are violated, especially in FSCC cases, as people are not always aware that this is a violation of their rights. In addition, the research should guarantee a safe space and be constructed as part of a healing process.

Researchers must be willing to really listen, which means to be aware of the different contexts and cultures. Women believe that research is an important tool that can help them in their search for justice, however they expect researchers to disseminate their findings in a way that can be directly associated with their needs. That is why they also want research in their original languages.

Leya (Indonesia, women with lived experience): In my opinion I would say that at the neighborhood level there are activities where people can share through the neighborhood, share their knowledge in terms of women who have experienced forced sterilizations or coerced contraception, maybe they can share at the community level, at the neighborhood level.

Mira (Indonesia, women with lived experience): In my opinion I think we have to do counseling for the victims to help their recovery to lessen the trauma, because I'm sure there is trauma. So, we have to find a way to have understanding and to be able to alleviate the trauma. And also provide a way for them to feel safe to share their experience and maybe that can be used to be able to educate other people on what actions can be taken when someone is faced with a situation like this, to prevent it from happening.

Marala (Indonesia, women with lived experience): Well, I think we must involve ourselves as good listeners, to listen to those who have experienced these things. Remembering also that women are not objects but women have to be respected. In the case of Indonesia, we are a multicultural country, this is a very sensitive issue for some women, we have to have an agreement between the researcher and the woman part of the research. I think that is something that has to be done before starting the research and the researcher has to understand the limitations of the research. I would also suggest to the researcher to have an individual approach

because it is quite a sensitive issue within the community. We also have to see what the psychological impact is, we have to give space for them to communicate their feelings and share their experiences. Finally give clear instructions, which are accepted by women who have gone through these externalizations.

Martha (Peru, women with lived experience): [..] The investigation also, the interviews should not remain in one place, but rather these investigations should be seen well and what are the things that are affecting these women, what may be their need to recover their physical or emotional health, that is what we want, in these interviews or intercultural rights that the government and society have affected us as well. We ourselves, in order to recover our health, our emotions, we want these investigations […]. So we want these changes to be seen by those who are going to get involved, who are going to work on them, always respecting interculturality and also the original uses of the languages of each department because this is not being respected until now. The original languages of Quechua, Aimara, everyone in every country that we are living in, that hurts us also because the professionals should be prepared in that language, where they are going to work, in what places we are going to work, what language, what origin of language they have.

Luisa (Peru, women with lived experience): I would just like to emphasize that respecting the individuality of the communities, the cultural issues is the most important thing. Here in Peru, we have had some excellent researchers. [...]. It is very important that research can reach every human being, that there is a personal encounter. That is what I wanted to add about what is happening here, because there are many who, as my colleagues said, have not respected and some investigations have not respected what is happening in each community and we also have some very false investigations that are the counterpart of the real investigations.

D. FINDINGS: RESPONSIBILITIES OF THE GOVERNMENT, PRIVATE SECTOR, AND HEALTH PROFESSIONALS

In both cases, women mentioned that the government should better monitor health professionals' compliance with standards of care and how they treat patients. In addition, the government should inform women about their reproductive rights and contraceptive methods.

In the case of Indonesia, there is a perception that the government is not aware of how companies coerce women to get the injections (Depo-Provera), so for them it is necessary that women can share their stories through different channels. In that way, the government can protect them.

Kerani (Indonesia, women with lived experience): I think the government should make regulations because as far as we know, I think the companies should have a contract. There should be an agreement and also on the part of the government and also on the part of the doctors there should be a sanction in case these violations occur.

In Peru, women demand a thorough investigation about the physical and psychological consequences of FSCC, so the government can implement the correct assistance. They also commented on the hearings that are currently underway. They hope that the trial will be opened, that the process will be fair and that an exemplary punishment will be given to those responsible.

Luisa (Peru, women with lived experience): The case of us in Peru, we are behind the government - well in our case it was different, it was the government who violated our rights - and for 25 years we have been in that struggle for the government to take charge of everything, for example we had the REVIESFO which was a unique registry of sterilized women, where it entered the health sector, ministry and justice and the ministry of women, which has annulled it and that which we want to be reimplemented again [...]. The government has to give us additional help, psychological help, a total follow-up in our case of sterilizations. In addition, we are also behind and the government should give us multisectoral compensation, that is to say that it should take care of everything that we are fighting for and that is what the government should do, both the executive as well as the Congress should work together in our case for integral reparations, which is what we are demanding and what that should be.

Martha (Peru, women with lived experience): I am going to speak now about all the women that I represent at the provincial level, as president. For us it is a story of our life that we live, we have no right to justice from Peru, 25 years waiting as Mrs. Luisa says, continuing to resist for our rights, seeking truth and justice, but we continue to face problems of emotional health, mental health, reproductive health, physical health, and we continue to suffer for not having education and not knowing and they did not know in those years our rights to defend and so much it hurts us the education because in these years the education, those who are mostly linked to the peasant communities are a discrimination that the government made not to those who cannot read, to those who cannot write to that to that more, it has affected in their health in everything is forced sterilization. In those years if they can't read, if they don't know their rights, they are also afraid to question, afraid to demand, afraid to decide their rights. That it is customary for the government of Peru was also not a right, it was not respected or protected by the governments of Peru in that year of our rights that we have lived.

VI FSSCC WEB-DISCUSSION: HEALTHCARE PROFESSIONALS

The last meeting was on November 05, 2021, with representatives from Indonesia and Peru who had direct experience on the FSCC implementation and expertise in the reproductive or health system of their country. We discussed how the FSCC were carried out, the involvement of health professionals, and the impact of FSCC on the healthcare system.

A. FINDINGS: COMMENTS ON THE FSCC IN INDONESIA AND PERU

In Indonesia, FSCC is identified as something from the past, implemented during the contraceptive 'safaris' campaign between 1979 and 1984, and the Jampersal program from 2011 to 2014. These programs targeted women in poor conditions, who were coerced to take a contraceptive method after childbirth to help them overcome poverty. There was no connection to the women migrant workers and the requirement to use contraceptive to travel abroad.

> *Uma (Indonesia, healthcare professional): At the moment I rarely see or experience cases of forced contraception, but maybe 40 years ago, when I was still in medical school, I did see some women in the slums who were invited to the hospital. There was a contraceptive safari program that was run in a village, they would call women in that village and the program would invite women to join contraceptive use. […]. Since I became a doctor myself 30 to 35 years ago, I don't see it anymore. The experience I can say is that there is some coercion, not strong coercion, but there is some coercion, let's put it this way, in the childbirth program of a commission or for free delivery of babies and certain women could join this commission and women had to get contraception immediately after delivery. But this program seems to me that it is no longer in force, it is a program that is called Jampersal, it happened in 2012, 2013 approximately, it was not a long-lasting program by 2014 there was already another program that replaced it.*

In the case of Peru, the participant commented on how impressive the implementation of the FS program was through the actions of the healthcare professionals. It was massive how they interacted in order to accomplish the quotas, which was something ordinary within the healthcare system.

> *Ricardo (Peru, healthcare professional): There was a program called the National Family Planning Program that was basically a program of forced sterilizations in the Andean population, from the Andes, poor Andean women and also from Amazonian groups, Indigenous Amazonian groups and this happened over a period of about 45 years, at the end of the 20th century between 1995 and 1998 more or less. This was a state program, a little bit to answer the title of the program, it was a national family planning program, it was also a particular moment in the history of Peru, we had a dictatorial government, the President then even went to the Beijing conference to present this program and present it as a program in favour of women's*

rights and it was a program that was based on many notions, while the purpose was access to contraception, it was clearly a program targeted at certain groups and based on a number of elements that over time have been seen to be well documented in documents from military groups or let's say from those close to certain kinds of very conservative thinking that limiting the fertility rate in these populations could enhance economic progress. This program was a very, very, large program, it involved many health professionals, it was very massive, it was impressively massive, and it was stopped basically by the action of institutions like the Ombudsman's Office and civil society. Since then it is difficult to say that there has been anything else, I do not participate much, but it is very sporadic that this happens, I would say and this is more because of my experience in other areas I have continued to collaborate with the Ombudsman's Office at that time and I would say that many of the elements that are, and we could talk about this then, that made health professionals get involved in this and that they do not see any contradiction in doing so are still present in society and perhaps many elements come to light frequently

B. FINDINGS: THE INVOLVEMENT OF THE HEALTHCARE PROFESSIONALS IN THE FSCC CASES / PROGRAMS

The participants from Indonesia focused their comments on the Jampersal program, saying that healthcare professionals were doing their job, but nowadays their actions related to the use of contraceptives are based on women's rights—although they cannot freely decide what contraceptives to take because that is something to discuss with their families. On the other hand, their comments related to migrant workers were focused on recalling the limits of the State, the healthcare professionals, and the companies. Identifying that the requirement of not getting pregnant and the coerced use of contraceptive must be a practice established by the companies.

Sashi (Indonesia, healthcare professional): Yes, personally I have never heard about it, what I know is that they are not allowed to get pregnant during the contract, but the coercion to accept contraception is something I have not seen before. Actually, there is research done by many companies that shows that there is a difficulty for them to access contraceptive methods, so women who are not married and ask for contraception at the clinic designated by the company, usually do not get it because the Indonesian law only allows the use of contraception for married couples. So logically if they are going to work abroad, they are going to be separated from their husbands so that's really what begs the question: Why would they need contraception? Maybe because they are going to work as sex workers or is there a specific country that has a high birth rate? Or well as far as the law is concerned, even the Ministry of Labour, there is no law that mentions that, I think just a rule set by the company.

In the case of Peru, the participant mentioned that now the State monitoring is more rigorous about what can be done and what is not right to do in the health system. The health education system remains the same, valuing coerced training and emphasising a hierarchical relationship between doctor and patient. In addition, he explained that coercion is normally used by the healthcare professionals, it is something that they have learned from the medical school reflecting the power dynamic relations between patients and healthcare professionals that leads to discriminatory practices. He emphasized that the system that validated the use of coercion is still very alive today.

> *Ricardo (Peru, healthcare professional): Coercion was part of being a doctor, I have no doubt about that, that's what they taught you in medical school. That has changed, yes, but it hasn't changed much and there are still some elements of that. There was no special recruitment, no training, no particular recruitment of certain individuals to do this. It was just you did it and the gynecologists who were going to do the procedure were going to do it in the brutal way that they did it and sort of naturally. […] We've never had doctors come out and say that they participated or that they regret doing it. Off the record they always tend to defend (what they did).*

C. FINDINGS: THE IMPACT OF FSCC ON THE HEALTHCARE SYSTEM

In the case of Indonesia, participants mentioned that the Jampersal program had a positive impact on women considering how difficult it is for women to access contraceptive methods. Plus, they mentioned that myths influence people from choosing long term methods, that is why counseling is important, so women can be informed before making any decision. Consent, does not appear to be a requirement, but as something complementary and not mandatory.

> *Uma (Indonesia, healthcare professional): for the Jampersal program like what I commented before the woman doesn't have benefits that's why in reality (the program) helps them to access those methods, according to what I have observed I think that the majority did not opt for sterilizations, well, in the Jampersal, I think it was not for a specific type of contraception, I think what they were asking them was to take a long term type of conception but not permanent. Now, if the client prefers a permanent method, then they are going to provide it to them, but it seems to me that they were offering options based on need and what the patient wanted and the contraceptive method that women chose the most was the IUD and that was the one that was preferred. I don't see it's impact as a negative impact, actually it seems to me more of a positive impact. Thank you. Maybe at the beginning they were forced because they had to take the contraceptive, but at the same time they anticipated and kept in mind the lack of access or the lack of ability to access that women had.*

A participant from Peru focused on how forced sterilization led to distrust of professionals by the population and of the free health services provided by the state, to the point that the surgical sterilization has been reduced. At the same time, there is a growth of conservatism that questions the use of any contraceptives.

> *Ricardo (Peru, healthcare professional): Yes, the people who suffered the sterilization policies are a group of people who have been scarred, not only physically but also emotionally. I think it is clear that this generated mistrust in the services, especially in rural areas, in poor areas, in free services provided by the State, and it was clearly seen in a marked withdrawal of certain types of contraception, that is to say, surgical sterilization, which was very much reduced as part of the offer after this campaign […]. In Peru, there is no regulation that prevents someone from obtaining a contraceptive method and if it is cheap or available through a non-governmental organization, a person is going to be able to obtain it. So, there is a gap between rural and urban areas, when there is a population that moves around a lot for work, and there are many more people in rural areas who go to the coast and satisfy their demand. So, there is a generational gap there, there is an improvement in terms of access, because there is also no impediment to obtaining it. And at the level of professionals, again, I think that what happened was a setback in the offer, but basically due to stigma rather than reflection.*

VII CONCLUSION AND RECOMMENDATIONS

Each country has very particular contexts that allowed the creation and development of FSCC plans and programs; however, in all three cases there are cross-cutting structures that were the foundation for the FSCC implementation, including settler colonialism, state violence, biopower, vulnerability in relation with the land, and gender discrimination. Moreover, these plans also target minoritized women (Indigenous, migrant, rural, and in poor conditions).

In all three cases, physical and psychological force, threats and/or coercion were used by the State and healthcare professionals to perform FSCC. This violates women's reproductive rights to make free and informed decisions about their own bodies, generating negative consequences for their health, families, economy, and life plans. Moreover, there is a blurred notion about what consent means. Even though participants identified that the context where healthcare professionals asked women to take a contraceptive method did not reflect a context of freedom to decide, some also argued that the purpose of doing it was acceptable because they were helping women.

It is important to identify all the people involved in the implementation of the FSCC and to recognize the role they played. In this way, it is possible to generate research that includes the experiences of key actors, in order to have a more comprehensive understanding that serves survivors' paths to justice.

As researchers we must ask ourselves why we want to research this topic, so that we can share our positionality, reflexivity, and accountability from the onset of the project. At the same time, we must reflect on the type of relationship we want to establish with the participants, in order to be clear with the invitation to participate in the research and respect their response of interest or refusal. We must plan the research, which should include time and resources to get to know the place, culture, and language of the women with lived experiences. We should ensure we have sufficient resources to disseminate the research results and develop a dissemination plan with and for participants' needs. We must collect and process the data in a respectful way, and in consultation with participants. Moreover, we must develop research methodologies that value the care and healing processes we can provide to participants, which will change according to their personal stories and their culture.

Through all the development of the web-discussions we were not able to ensure Canadian participants, although we reach specific networks. As researchers, we understand that it is important to acknowledge the current contexts, social perspectives, and feelings regarding the FSCC in each country. In this way, we can work on building trusting relationships.

Women with lived experiences considered the research relevant, as it contributes to their struggle to generate social memory and demands for justice, which is why it is important that any research plan be consulted with the participants. To this end, researchers must also do the preliminary work of identifying what research has already been carried out in the community, in order to take advantage of these resources and avoid implementing research methods that reopen wounds.

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