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# Reproductive Reparations: A Framework for Addressing Forced Sterilization in the United States

*by*

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**Abstract**

This paper introduces a novel framework, Reproductive Reparations, combining reproductive justice (RJ) and reparations, to confront the lasting impact of forced sterilization in the United States. The literature review explores the core elements of the RJ and reparations frameworks, emphasizing human rights, intersectionality, and the right to remedy reproductive injustices. This study examines the efficacy of the new Reproductive Reparations framework in addressing forced sterilization by scrutinizing case studies from North Carolina and Planned Parenthood Greater of New York (PPGNY). Key policy recommendations are proposed based on the synthesized frameworks and case analyses. The findings highlight the significance of acknowledging historical injustices, providing restitution, and fostering systemic change. The implications of this research underscore the urgency of rectifying past harms related to reproductive injustice, preventing future violations, and promoting inclusivity in sexual and reproductive health care. The Reproductive Reparations framework offers a transformative avenue for addressing forced sterilization, aligning with principles of justice, human rights, and the comprehensive well-being of affected individuals and communities.

*Keywords*: reproductive justice, reparations, sexual and reproductive health and rights, forced sterilization

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## Introduction

Throughout its history, the United States has grappled with the legacy of forced sterilization, a practice rooted in eugenics that targets marginalized communities, particularly women of color. The repercussions of this systematic violation of human rights have lasted for generations, leaving a significant impact on survivors and their communities. This study provides a comprehensive examination of forced sterilization, focusing on the intersection of reproductive justice (RJ) principles and reparations. Review of scholarly work on forced sterilization reveals a complex historical context, legal ramifications, and human rights implications. This study seeks to contribute to the ongoing discourse on the subject by addressing the pressing need to rectify past wrongs and prevent the perpetuation of systemic injustices. Moreover, connecting this issue to current discussions on reproductive rights, racial equity, and healthcare disparities enhances its relevance in contemporary socio-political landscapes. This study synthesizes existing literature, case studies, and human rights-based frameworks to address the injustice of forced sterilization, analyzes the efforts made to provide reparations, and proposes a nuanced framework for addressing historical wrongs. This paper argues for a combined framework termed "Reproductive Reparations," which integrates the principles of RJ and reparations to address the reproductive and sexual rights of marginalized individuals affected by forced sterilization. By examining case studies, such as North Carolina and Planned Parenthood of Greater New York (PPGNY), this study seeks to provide policy recommendations and broader implications that pave the way for acknowledging past injustices, providing restitution, and ensuring a more equitable and just future for all. The subsequent sections of this paper will delve into the historical context of forced sterilization, examine frameworks that partially address this injustice, review specific case studies, evaluate the effectiveness of past reparations efforts, and propose

policy recommendations. Through a nuanced understanding of RJ and reparations, this framework aims to contribute to ongoing conversations about justice, human rights, and the ethical dimensions of current sexual and reproductive healthcare practices.

## Literature Review

### Articulation of the Problem

The issue of reproductive injustice in the United States is rooted in a lack of sexual and reproductive health and rights (SRHR) stemming from a history of violence and oppression. Reproductive injustice refers to the systemic barriers that negatively impact an individual's sexual and reproductive health and rights. SRHR encompasses a state of "well-being…. [related] to sexuality and reproduction" (*Accelerate Progress*, 2018). It does not represent only the absence of reproductive injustice and sexual health but also the positive commitment to fulfilling rights and well-being.

SRHR is grounded in human rights principles that define rights to bodily autonomy, pleasure, expression, choice, and access to resources. In 1994, the International Conference on Population and Development (ICPD) in Cairo marked a significant shift in global perspectives on population and development (*International Conference on Population and Development*, n.d.). The conference outlined a transformative agenda that placed human dignity and rights at the core of sustainable development. The ICPD Programme of Action, adopted by 179 governments, emphasized the inseparability of inclusive sustainable development from the prioritization of human rights, particularly reproductive rights. This conference led various international human rights bodies to follow suit and make statements protecting SRHR. In 1998, Dr. Carmel Shalev, presented at the International Conference on Reproductive Health, highlighting the rights related to women's sexual and reproductive health, particularly examining

legal texts such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Dr. Shalev delves into health-related rights under the Women's Convention, emphasizing Articles 16(1)(e) and 12 that address the right to decide on the number and spacing of children and the obligation to eliminate discrimination in healthcare, ensuring access to services related to family planning, pregnancy, and postnatal care (Shalev, 1998). Further, the concept of autonomy is discussed in relation to women's right to make decisions about fertility and sexuality, free from coercion and violence. The importance of informed consent and confidentiality in healthcare contexts is also emphasized.

In the context of the U.S., this issue of poor SRHR, particularly for people of color and indigenous communities, is rooted in enslavement, colonialism, and other forms of oppression. This violence and control manifested through various means, such as forced breeding, predatory incentives for reproduction, and the intrusive involvement of white doctors during childbirth (Wilson, 2021). For example, during the era of slavery in the U.S., enslaved individuals were often subjected to forced breeding practices. Slave owners treated enslaved people as property and their reproductive capabilities were seen as a means of increasing the slaveowner's workforce. Enslaved women, in particular, were often forced to bear children, with little regard for their well-being or desires (Clouse, 2020). Families were torn apart as children were separated from their parents, adding a traumatic dimension to this form of reproductive injustice. This example begins to illustrate how the legacy of slavery and colonialism has deeply influenced SRHR in the U.S. It highlights systemic issues where the control over individuals' reproductive autonomy was not only a consequence of historical injustices but also a tool for maintaining oppressive structures.

This subsequent literature review outlines the history of reproductive injustice against Black, biologically female individuals in the United States. Beginning with the era of slavery, it highlights practices such as sexual assault, denial of legal protection, and exploitation of reproductive labor. The narrative extends into the post-slavery period, discussing the eugenics movement, forced sterilization, and the role of birth control organizations. This review further explores the racist ideologies behind these practices, particularly the targeting of minority groups. The focus shifts to forced sterilization, portraying it as a form of surgical genocide that disproportionately affected Black women. The review concludes by connecting historical injustices to contemporary disparities in sexual and reproductive health outcomes among Black women. It notes issues such as racial discrimination, high rates of sexually transmitted infections (STIs), maternal mortality, and limited access to quality health care. The enduring repercussions of slavery, manifested in areas such as transgenerational poverty and structural inequalities, contribute to the ongoing disparities.

**A History of Reproductive Injustice**

Looking specifically at the Black, assigned female-at-birth population in the United States, instances of reproductive injustice toward this population were common during the era of slavery. Even before America's founding in 1776, Black women (and men) were subjected to various practices that significantly negatively affected their reproductive freedom and autonomy. These practices were exacerbated during the era of slavery, which lasted from 1776 until approximately 1865, when the 13$^{th}$ Amendment abolished slavery. Estimates indicate that as many as 58% of enslaved women aged 15-30 were sexually assaulted by white men during this period (Prather et al., 2018). All the while, enslaved women were denied legal protection from such assaults due to laws defining them as property. Furthermore, acts of violence against Black

men, such as lynching and castration, disrupted relationships, and constrained reproductive choices for enslaved women.

Female slaves were exploited for their sexual and reproductive labor, as slavery depended on control over bodies and, thus, reproduction. Reproductive labor refers to the historical and systemic exploitation of Black women's bodies, sexuality, and reproductive capacity, particularly within the context of slavery (Clouse, 2020). This concept extends beyond the contemporary understanding of forced sterilization and encompasses a broader spectrum of coerced reproduction during the era of slavery in the United States. Slave owners relied on enslaved individuals to reproduce to ensure a never-ending supply of forced labor (Clouse, 2020; Prather et al., 2018). However, enslaved women displayed resilience and resistance, and found ways to assert agency in childbirth and fertility control (Wilson, 2021). Enslaved women turned to self-imposed abortions and birth control during slavery, serving as a form of resistance against labor exploitation, not wanting to bring children into a life of exploitation and abuse (Prather et al., 2018; Wilson, 2021). However, there is a lack of data on abortion practices among enslaved women, likely due to complex factors including the criminalization and taboo nature of abortion, as well as the domination of white voices in documenting these experiences (Wilson, 2021). It is clear, however, that even after the end of slavery, Black women still lacked reproductive freedom, and society shifted to trying to stop their reproduction altogether.

**Reproductive Injustice Beyond Enslavement: Forced Sterilization**

These adverse sexual and reproductive health experiences persisted throughout the Jim Crow era and beyond, marked by legal segregation, rape, forced sterilization, and unethical medical practices. One specific example of reproductive injustice is the eugenics movement. In 1883, British biologist Francis Galton coined the term "eugenics" to describe an applied science

based on genetics and selective breeding, aiming for human perfection (*Eugenics and Birth Control*, n.d.). By the 1920s and 1930s, eugenics gained popularity in the United States, with two ideologies: "positive" eugenics promoting childbearing by the "fit" and "negative" eugenics discouraging reproduction among the "unfit." Racist ideologies were intertwined, favoring middle and upper-class white people, and classifying racial minorities and immigrants as "unfit." The eugenics movement quickly began targeting groups of people who were seen as 'less than human'–those considered less intelligent, those with poor physical or mental health, criminals, immigrants, and all people of color, trying to eliminate them from the genetic pool (Clouse, 2020). The ruling elite, composed of wealthy white men and women, aimed to perpetuate control over minority groups by limiting and erasing their populations (Alonso, n.d.). The campaign for voluntary motherhood and birth control was also present during this time, but these rights were more accessible for white, upper-class women, and the leaders of this movement did not include the concerns of the working class (Clouse, 2020).

The history of birth control in the United States has revealed a complex narrative marked by both progressive strides and troubling associations with racism. The American Birth Control League, which later became Planned Parenthood, emerged in the early 20th century with the mission of increasing access to contraception (Good, 2022). However, its founder, Margaret Sanger, held eugenicist views that promoted using birth control to prevent what she deemed "undesirable" populations from having children, perpetuating racist, classist, and ableist ideas (Alonso, n.d.; Good, 2022). Furthermore, her endorsement of the 1927 Buck v. Bell decision, which contributed to forced sterilizations, raised suspicion (*The History & Impact of Planned Parenthood*, n.d.). These choices perpetuated racial injustices in reproductive rights and health care. Sanger's connection with eugenics raised suspicion, especially among Black Americans,

who believed her motive was to eliminate Black generations (*Eugenics and Birth Control*, n.d.). Sanger's relationship with eugenics and suspicions about her intentions has contributed to a legacy of distrust among some of the communities that Planned Parenthood intends to serve today.

During the campaign for voluntary motherhood and birth control, some arguments for birth control were made with racist principles. For example, some eugenicists, despite not promoting contraceptive use, viewed birth control as a tool to curb procreation among those perceived "undesirable" (*Eugenics and Birth Control*, n.d.). Gould (1984) noted the failure of the birth control movement to address issues relevant to Black women, revealing prevalent racist attitudes among birth control advocates. Accusations of Black genocide surfaced when the federal government's involvement in subsidized family planning services was linked to coercive features in the 1967 amendments to the Social Security Act (Gould, 1984).

Sterilization, often referred to as a form of "birth control," is not an inherently bad concept and procedure. Individuals also have the right to sterilization, should they no longer want to conceive. However, sterilization procedures were not always consensual or voluntary. Forced sterilization, the act of removing one's ability to reproduce without consent, was eventually made a lawful practice in the United States, with Indiana being the first state to enact legislation allowing eugenic surgery in 1907 (Alonso, n.d.). Forced sterilization became a known method of surgical genocide to eliminate and control populations of color, especially in Black women. In 1972, the Supreme Court's Buck v. Bell decision determined the forced sterilization of Carrie Buck to be legal, upholding the constitutionality of forced sterilization, and setting a precedent for such practices in the country. Subsequently, many Black women were sterilized against their will, often unknowingly, as consent was not required. By the 1930s, at least 30 to 33

states had laws that allowed the sterilization of those who were seen as the "unwanted" members of society, primarily those of Black communities and other communities of color (Kaelber, n.d.; Prather et al., 2018). Only eight have issued public apologies for their actions (Chernoguz, n.d.; Villarosa, 2022).

**Table 1**

*Sterilization Laws by State*

| States that Passed Laws Allowing Sterilization by the 1930s | States that Did Not Pass Laws Allowing Sterilization by the 1930s |
|---|---|
| Alabama, Arizona, California, Connecticut, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin | Alaska, Arkansas, Colorado, Hawaii, Illinois, Kentucky, Maryland, Massachusetts, Missouri, New Mexico, Ohio, Tennessee, Texas, Wyoming |

*Note.* Some states that did not pass laws allowing sterilization attempted to pass such laws (Kaelber, n.d.).

Black women in North Carolina were heavily targeted in the movement for forced sterilization. The state had one of the most active and long-lasting state-sponsored sterilization programs in the country, running from 1929 to 1974 (Alonso, n.d.; Collins, 2013). Around 7,600 individuals were sterilized during this period based on criteria such as being deemed "feeble-minded, promiscuous, or socially and mentally unfit" (Collins, 2013). This resulted in a significant increase in the percentage of Black American patients subjected to state-sanctioned sterilization, rising from 23% in the 1930s-1940s to 64% between 1964 and 1966.

Sterilization rates for Black women surged during the era of "desegregation," a period marked by the dismantling of racial segregation in schools and hospitals. The historical context strongly suggests that the rise in sterilization was not coincidental but rather a deliberate response to the perceived threat of breaking down Jim Crow. From 1950 to 1966, Black women were sterilized at over three times the rate of white women (Stern, 2020). This pattern reflects deeply rooted beliefs that Black women were unfit parents and that managing poverty required restricting their reproductive rights. During this time, Black American welfare recipients were disproportionately coerced into undergoing sterilization procedures (Alonso, n.d.). It is estimated that between 100,000 to 150,000 individuals from low-income backgrounds underwent sterilization through federally funded programs. Additionally, many individuals were pressured into agreeing to sterilization by doctors, who threatened to terminate their welfare benefits if they refused the procedure.

Today, the legacy of the aforementioned historical injustices continues to affect the sexual and reproductive health and rights of Black women. As the National Black Women's Reproductive Justice Agenda notes, "both historically and today, medical racism has resulted in experiments on, exploitation of, and mistrust of Black women's sexual and reproductive health" (Howell et al., 2020). There are significant recent reports on racial discrimination and disparities in reproductive health outcomes. For example, Black women face a disproportionate burden of STIs. In 2018, they were diagnosed with syphilis, gonorrhea, and chlamydia at rates 8.4, 6.9, and 5 times higher than white women, respectively (Cohn & Harrison, 2022; *Health Disparities in HIV, Viral Hepatitis, STDs, and TB*, 2021). Additionally, Black women accounted for 11% of the HIV incidence rate, which was higher than that of women of any other racial or ethnic group. Black women are also more likely to experience pelvic inflammatory disease, which, if

untreated, can lead to pregnancy complications and infertility (Prather et al., 2018). Broadly, in 2021, approximately 31% of all cases of chlamydia, gonorrhea, and syphilis occurred in Black individuals (*National Overview of STDs, 2021*, 2023). This is noteworthy because even though Black people make up only around 12% of the U.S. population, they accounted for a higher proportion of these sexually transmitted infection cases. Furthermore, in 2021, Black individuals accounted for 40% of the estimated HIV infections (CDC, 2023).

Black birthing people in the United States face unacceptably poor outcomes, including staggering rates of death related to pregnancy and childbirth. The United States has the highest maternal death rate among high-resource countries. In 2021, the maternal mortality rate for non-Hispanic Black women was 69.9 deaths for every 100,000 live births (Hoyert, 2023). This rate is 2.6 times higher than that of non-Hispanic White women, with a rate of 26.6 deaths per 100,000 live births. They also have an increased risk of pregnancy-related hypertension and chronic hypertension (Prather et al., 2018). Further, Black women have higher rates of preterm births and low birth weight infants than white women (*Black Reproductive Justice Policy Agenda*, 2021). These disparities suggest that Black women contend with multiple systemic injustices rooted in histories of oppression, such that they do not receive adequate prenatal care or preventive reproductive health care services.

The enduring repercussions of slavery manifest in a spectrum of injustices spanning transgenerational poverty, educational limitations, residential segregation, and structural inequalities in employment. These multifaceted challenges contribute to adverse outcomes that negatively impact the reproductive health of Black women. These societal inequities expose Black women to heightened vulnerabilities concerning sexual and reproductive health, for instance, the increased prevalence of HIV (Prather et al., 2018). Limited education is associated

with various sexual and reproductive health issues, including poor adherence to HIV treatment, preterm birth, infant mortality, and hysterectomies. Residential segregation by race continues to limit access to quality educational opportunities in predominantly Black neighborhoods. This segregation extends to healthcare access, with Black Americans being less likely to receive early HIV testing and treatment. Additionally, the previous lack of compensation for women's work during slavery now contributes to a wage gap and low-paying jobs with limited advancement opportunities and influences sexual behavior decisions, as individuals may engage in sex work, for example, to meet basic needs (Prather et al., 2018).

It is clear that the United States grapples with a deeply entrenched history of reproductive injustice rooted in slavery, forced sterilization, and systemic discrimination against Black women. The legacy of these injustices continues to impact the sexual and reproductive health outcomes of Black women today, leading to disparities in maternal mortality rates, STI diagnoses, and preterm births. This historical perspective underscores the urgent need for comprehensive policies, education about SRHR, and acknowledgment of past harmful actions to address the deep-seated inequalities that persist in the realm of reproductive injustice today.

## Methodology

This research project aims to develop a novel framework by combining the principles and objectives of two established frameworks: RJ and reparations. The creation of this integrated framework involved a systematic process, including an extensive literature review and an analysis of the key components of both frameworks.

### Research Focus and Scope

The primary focus of this research is to address the critical issue of forced sterilization within Black communities, specifically emphasizing the experiences of Black women. The

decision to concentrate on this demographic is grounded in an extensive research review that unequivocally demonstrates the disproportionate targeting and impact of forced sterilization on Black women. The historical context and systemic nature of these violations necessitate a dedicated examination to understand and redress the unique challenges faced by this population.

Through a comprehensive literature review, it became evident that Black women were historically and systematically targeted for forced sterilization. Instances of coerced or involuntary sterilization procedures were prevalent, reflecting a deeply rooted issue that requires specific attention and redress. The intersectionality of race and gender compounds the reproductive injustices that Black women experience. By focusing on this population, this study aims to provide nuanced insights into how systemic oppression intersects with reproductive rights, thus providing a foundation for tailored solutions.

While recognizing the broader scope of forced sterilization across various communities, including Indigenous populations, disabled individuals, and others, this research deliberately narrows its focus. This limitation is driven by the need for depth and specificity to address the unique challenges faced by Black women. It is important to acknowledge that these violations span multiple communities, and future research endeavors should comprehensively explore and address the specificities of each affected group.

This study recognizes the interconnected nature of forced sterilization issues across diverse communities and emphasizes the importance of extending research efforts to encompass these broader contexts. Indigenous populations, disabled individuals, and other marginalized groups have also been subjected to forced sterilization, and their experiences warrant further investigation. While the current research prioritizes the experiences of Black women, it is essential to emphasize that the broader context of forced sterilization demands comprehensive

exploration. Future research should expand the scope to include a thorough examination of the impact on Indigenous populations, disabled individuals, and other marginalized communities. This approach ensures a holistic understanding of the systemic nature of forced sterilization and facilitates the development of inclusive frameworks for redress and advocacy.

**Framework Exploration**

The initial phase entailed a thorough examination of the RJ framework, involving a detailed review of foundational documents such as the Black Reproductive Justice Policy Agenda. The focus was on grasping the core principles, values, and objectives of RJ, including the right to choose whether or not to have a child, access to comprehensive healthcare, and control over birthing options. Concurrently, a comprehensive exploration of the reparations framework was conducted utilizing key resources such as international legal instruments, the UN Principles on Reparation, and the International Commission of Jurists' (ICJ) guide on reparation and remedy. The emphasis was on identifying the elements within the core components of reparations: restitution, compensation, rehabilitation, satisfaction, and guarantees of non-repetition. The objective was to discern shared principles and objectives between RJ and reparations, with special attention paid to recognizing intersectionality in both frameworks, acknowledging the multifaceted nature of human rights violations and social issues.

**Framework Creation**

The subsequent analysis involved identifying the components of RJ that aligned with the main components of reparations outlined by the ICJ. Notable commonalities emerged where both frameworks addressed the economic, social, and political harms that were imperative to their core values. The integration process concentrated on aligning principles, such as the right to comprehensive healthcare in RJ, with the right to remedy and reparation in the reparations

framework. The overarching goal was to develop a cohesive and comprehensive framework addressing both the reproductive rights of marginalized individuals and the imperative need for redress for human rights violations, specifically forced sterilization. Throughout the integration, careful consideration was given to the intersectionality of human rights and social issues, ensuring that the integrated framework adequately addressed the interlocking systems of oppression highlighted by RJ and the multidimensional harm recognized by the reparations framework. The creation of the integrated framework involved a meticulous literature review, identification of commonalities, alignment of principles, and partial validation through case studies. The resulting framework aims to address the reproductive rights of marginalized individuals while providing a comprehensive approach to redress for the human rights violation for forced sterilization.

## Definitions

### *Sexual and Reproductive Health and Rights*

The Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights (SRHR) defines SRHR as a comprehensive package of essential interventions that go beyond the commonly recognized components of sexual and reproductive health (*Accelerate Progress*, 2018). It emphasizes the toll that gaps in SRHR take on individuals, communities, and economies worldwide and calls for a holistic approach that encompasses the right of all individuals to make decisions about their bodies and have access to essential sexual and reproductive health services. The commission emphasizes the impact of fulfilling the need for modern contraception and essential care for pregnant women and newborns. It further outlines the importance of evidence-driven SRHR policy and programming rooted in human rights as

well as high-priority actions to address gaps in health services and barriers preventing people from fully achieving SRHR.

### *Sexual Health*

Sexual health addresses a spectrum of issues, such as access to sexual health services, challenges encompassing contraception, natal care, unsafe abortions, STI treatment, HIV infections, cervical cancer deaths, and gender-based violence(*Accelerate Progress*, 2018; *Reproductive Rights Are Human Rights*, 2014). It underscores the advantages of investing in sexual health while emphasizing the potential for substantial returns arising from improved access to related services. Additionally, sexual health aims to enrich life and personal relationships beyond counseling and care focused solely on sexuality and sexually transmitted diseases.

### *Reproductive Health*

Reproductive health encompasses a broad range of issues, including access to essential sexual and reproductive health services; addressing gaps in health services; promoting gender equality; and reducing unintended pregnancies, newborn deaths, and maternal deaths (*Accelerate Progress*, 2018). It is a state of complete physical, mental, and social well-being in all matters related to the reproductive system and its functions (*Reproductive Rights Are Human Rights*, 2014). There is an emphasis on the rights of individuals to be informed, have access to safe family planning methods, and receive appropriate healthcare services for safe pregnancy and childbirth. The concept is linked to the ability to have a satisfying and safe sex life, the capacity to reproduce, and the freedom to make informed decisions about reproduction.

### *Sexual Rights*

Sexual rights are the rights of all individuals to make decisions about their bodies free of stigma, discrimination, and coercion. It also encompasses the need to address gender-based violence; the importance of engaging men in supporting women's health, rights, and autonomy; and the necessity of changes in laws, policies, and social norms to enable all people to understand, protect, and fulfill their rights (*Accelerate Progress*, 2018). It emphasizes the need to provide support to marginalized groups, including protecting the sexual rights of displaced and refugee populations; addressing the sexual rights needs of people with diverse sexual orientations, gender identities, and expression; and acknowledging the sexual rights needs of people with diverse sex characteristics.

### *Reproductive Rights*

Reproductive rights acknowledge the fundamental entitlement of couples and individuals to autonomously determine the desired number, spacing, and timing of their children. (*Reproductive Rights Are Human Rights,* 2014). Additionally, reproductive rights involve access to the information and resources necessary for making such decisions as well as the right to achieve optimal sexual and reproductive health. The concept extends to freedom from discrimination, coercion, and violence in reproductive decision making, as articulated in various human rights documents.

### *Forced Sterilization*

"Forced sterilization is the involuntary or coerced removal of a person's ability to reproduce…[it] is a human rights violation and can constitute an act of genocide, gender-based violence, discrimination, and torture" ("Forced Sterilization," 2019). In the context of this paper,

forced sterilization encompasses other forms of unjust sterilization, such as coerced, involuntary, and non-consensual sterilization.

### *Intersectionality*

In her 1989 paper *Demarginalizing the Intersection of Race and Sex*, Kimberlé Crenshaw coined the term intersectionality. Crenshaw provides examples of how the legal system and societal attitudes fail to recognize the unique compounding elements of discrimination against Black women, leading to their marginalization in both feminist theory and antiracist politics (Crenshaw, 1989). She highlights the limitations of antidiscrimination law's remedial scope and normative vision, which marginalize Black women by failing to recognize their unique compounded experiences of discrimination. Crenshaw critiques the dominant framework of discrimination that operates to marginalize Black women by limiting inquiry to the experiences of otherwise-privileged members of the group.

## Limitations and Biases

While this study aims to contribute to the understanding of forced sterilization, RJ, and reparations, it is crucial to acknowledge several inherent limitations and biases that may influence the interpretation and generalization of the findings. Due to the expansive nature of these topics, some nuances and specificities in certain regions or communities might not be fully explored. Furthermore, the availability and accuracy of historical data regarding forced sterilization cases may be limited. Incomplete or inaccurate records could affect the precision of the findings and hinder a comprehensive understanding of the extent of these human rights violations. Additionally, the case studies presented offer valuable insights, but their generalizability may be limited. Each case is unique and may not represent the complexities of forced sterilization across diverse geographical and sociocultural contexts. Finally, I

acknowledge my own position as a white woman, which may introduce biases into the interpretation of the data and literature. My perspective might influence the framing of issues and the analysis of the intersectionality inherent in forced sterilization cases. By acknowledging these limitations and biases, this study aims to foster transparency and encourage further investigation and dialogue on these topics. It is crucial for future researchers to build upon this foundation, considering diverse perspectives, and continuously reevaluating the complexities of these deeply ingrained issues.

## Frameworks: Reproductive Justice and Reparations

### Reproductive Justice

In 1994, a group of 12 Black women came together to discuss the healthcare system in the US and its implications for Black women (*Black Reproductive Justice Policy Agenda*, 2021). They called for a comprehensive healthcare plan that provided universal coverage, protected against discriminatory practices, and ensured the representation of Black women in the decision-making processes. The group coined the phrase "reproductive justice" to center the specific experiences of Black women and affirm their human rights values, including the right to not have a child, the right to have a child, the right to social and economic supports for parenting, and the right to sexual expression and pleasure. RJ recognizes the interlocking systems of oppression that contribute to the reproductive oppression of women of color and demands that society ensure that conditions exist for individuals to realize these values (*Black Reproductive Justice Policy Agenda*, 2021; *Reproductive Justice*, n.d.). RJ cannot be achieved until Black women and other communities of color, femmes, girls, and gender-expansive individuals can experience pregnancy and childbirth without endangering their lives.

RJ is a movement focused on achieving the complete physical, mental, spiritual, political, social, and economic well-being of women and girls based on the full protection of women's human rights (*Black Reproductive Justice Policy Agenda*, 2021; *Reproductive Justice*, n.d.). This movement fights for the right to have a child, the right to not have a child, and the right to parent children. It also addresses the social inequality that affects an individual woman's decision-making process. RJ analyzes reproductive oppression in its myriad forms, which include issues of economic justice, the environment, immigrants' rights, disability rights, discrimination based on race and sexual orientation, and a host of other community-centered concerns. RJ specifically focuses on organizing women, girls, and their communities to challenge structural power inequalities and build a more powerful and relevant grassroots movement. The key strategies for achieving this vision include supporting the leadership and power of the most excluded groups of women, girls, and individuals within a culturally relevant context, and building the social, political, and economic power of low-income women, Indigenous women, women of color, and their communities (*Black Reproductive Justice Policy Agenda*, 2021; *Reproductive Justice*, n.d.).

According to the *Black Reproductive Justice Policy Agenda* (2021), RJ is enshrined in various international human rights instruments. In other words, SRHR are considered human rights. Women's sexual and reproductive health is intricately linked to a range of human rights, including "the right to life, freedom from torture, health, privacy, education, and the prohibition of discrimination" (*Sexual and Reproductive Health and Rights*, n.d.). Both the CESCR and CEDAW affirm that women's right to health encompasses sexual and reproductive health. Consequently, states are obligated to respect, protect, and fulfill these rights. Further, the Special Rapporteur on the Right to Health asserts that women are entitled to reproductive health services

and facilities that are adequate in number, physically and economically accessible, free from discrimination, and of high quality.

There are some key instruments that experts have highlighted as evidence of the protection of reproductive rights in the international arena. Article 16 of CEDAW "guarantees women equal rights in deciding 'freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights'" (*Sexual and Reproductive Health and Rights*, n.d.). The right to education, as outlined in CEDAW Article 10, "includes 'access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning'" (*Sexual and Reproductive Health and Rights*, n.d.). The Beijing Platform for Action underscores women's human rights, stating that "'the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence'" (*Sexual and Reproductive Health and Rights*, n.d.). CEDAW's General Recommendation 24 urges states to "prioritise the 'prevention of unwanted pregnancy through family planning and sex education'" (*Sexual and Reproductive Health and Rights*, n.d.). The Committee on Economic, Social and Cultural Rights' (CESCR) General Comment 14 emphasizes "that the provision of maternal health services is comparable to a core obligation which cannot be derogated from under any circumstances, and the States have to the immediate obligation to take deliberate, concrete, and targeted steps towards fulfilling the right to health in the context of pregnancy and childbirth" (*Sexual and Reproductive Health and Rights*, n.d.). Additionally, CESCR General Comment 22 "recommends states 'to repeal or eliminate laws, policies and practices that criminalize, obstruct or undermine access by individuals or a particular group to sexual and

reproductive health facilities, services, goods and information'" (*Sexual and Reproductive Health and Rights,* n.d.). It is important to note that there are a handful of other international human rights instruments, such as the Universal Declaration of Human Rights, which includes rights that would broadly encompass human rights (e.g., the right to life). However, providing a comprehensive list and analysis of these instruments is outside the scope of this project and should be considered for future research.

**Table 2**

*The Key Elements of the Reproductive Justice Framework*

| Key Element | Description |
|---|---|
| **Founding Principles** | Comprehensive Healthcare; Universal Healthcare Coverage; Protection Against Discrimination; Representation in Decision-making; Human Rights Values; Right to Not Have a Child; Right to Have a Child; Right to Parent with Support; Right to Sexual Expression; Right to Pleasure (*Black Reproductive Justice Policy Agenda*, 2021; *Reproductive Justice*, n.d.). |
| **Address Interlocking Systems of Oppression** | Addresses Reproductive Oppression; Analyzes Economic Justice, Environment, Immigrants' Rights, Disability Rights, Discrimination based on Race and Sexual Orientation, and other Community-centered Concerns (*Black Reproductive Justice Policy Agenda*, 2021; *Reproductive Justice*, n.d.). |
| **Movement Goals** | Complete Well-being of Women and Girls; Full Protection of Human Rights; Control Over Birthing Options; Addressing Social Inequality (*Black Reproductive Justice Policy Agenda*, 2021; *Reproductive Justice*, n.d.). |
| **Strategies for Achieving Vision** | Support Leadership of Historically Excluded Groups; Culturally Relevant Context for Addressing Issues; Building Power of Low-income Women, Indigenous Women, Women of Color, and their communities; Education (*Black Reproductive Justice Policy Agenda*, 2021; *Reproductive Justice*, n.d.). |
| **Link to Human Rights** | Linked to Various Human Rights, including Right to Life, Freedom from Torture, Health, Privacy, Education, and Prohibition of Discrimination; Affirmed by CESCR and CEDAW (*Black Reproductive Justice Policy Agenda*, 2021; *Reproductive Justice*, n.d.; *Sexual and Reproductive Health and Rights*, n.d.). |

| | |
|---|---|
| **State Obligations** | Respect, Protect, and Fulfill Reproductive Rights; Reproductive Health Services and Facilities: Adequate in Number, Physically and Economically Accessible, Free from Discrimination, High Quality (*Black Reproductive Justice Policy Agenda*, 2021; *Reproductive Justice*, n.d.; *Sexual and Reproductive Health and Rights*, n.d.). |

**Reparations**

There is a well-established right to a remedy and reparation for individuals affected by human rights violations under international human rights law. While the right to a remedy and reparation is widely recognized, the specific modalities and principles governing this right can be complex and vary across international legal instruments. International legal provisions for this right are often diverse, vague, and lack uniform terminology (*The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018). However, international jurisprudence has developed and refined several principles over time. Some of these principles have been codified in treaties, nontreaty instruments, and General Comments by international bodies. In 2005, the UN General Assembly adopted the "Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law" (UN Principles on Reparation), which provide detailed rules for States' obligations regarding remedies and reparations for gross violations of international human rights law and serious violations of international humanitarian law. State's obligations to uphold human rights are multifaceted and interdependent, especially in cases of grave violations. These obligations, including investigation, prosecution, compensation, and prevention, are complementary and must be fulfilled collectively rather than as alternatives. They are unconditional and extend to all regardless of individual complaints or decisions (*The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018).

The ICJ published a guide in 2006 outlining the five components of reparations for gross human rights violations: restitution, compensation, rehabilitation, satisfaction, and cessation guarantees of non-repetition (*The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018). To achieve full and effective reparations, all five components must be included in reparative policies. Restitution involves restoring the individual to their original situation, including liberty, identity, employment, and property. Compensation is a monetary transfer based on an economic assessment of the damage done. Rehabilitation includes medical, social, and mental health, as well as legal assistance. Satisfaction includes public apologies, sanctions, and commemorations. Cessation and guarantees of non-repetition involve protection against future violations. The rights to truth, justice, and reparation are interconnected and mutually reinforced, with the right to an effective remedy encompassing access to these rights. This comprehensive approach ensures a robust response to human rights violations and helps hold perpetrators accountable, while offering redress to affected individuals (*The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018).

**Table 3**

*The Key Elements of the Reparations Framework*

| | |
|---|---|
| **Restitution** | "Restitution refers to measures that restore victims to the original situation before they suffered gross violations of inter- national human rights law and/or serious violations of international humanitarian law. For example, restoration of liberty, identity, family life and citizenship, return to one's place of residence, restoration of employment and return of property" (*The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018, p. xiii). |
| **Compensation** | "Compensation refers to a monetary quantifiable award for any economically assessable damage, whether pecuniary or non-pecuniary, as appropriate and proportional to the gravity of the violation and the circumstances of each case, such as lost opportunities, loss of earnings and moral damage" (*The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018, p. xiii). |

| | |
|---|---|
| **Rehabilitation** | "Rehabilitation refers to medical and psychological care as well as legal and social services" (*The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018, p. xiv). |
| **Satisfaction** | "Satisfaction refers to a broad category of measures, ranging from those aiming at a cessation of violations, to truth- seeking, the search for the disappeared, the recovery and re- burial of remains, public apologies, judicial and administrative sanctions, commemoration and memorialization, and human rights training" (*The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018, p. xiv). |
| **Guarantees of non-repetition** | "Guarantees of non-repetition is a broad category which includes, for example, institutional reforms establishing civilian control of military and security forces; strengthening judicial independence; the protection of human rights defenders; human rights training; the promotion of international human rights standards in public service, law enforcement, the media, and psychological and social services" (*The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018, p. xiv). |

**Table 4**

*Similarities and Differences Between Reproductive Justice and Reparations*

| **Aspect** | **Reproductive Justice** (*Black Reproductive Justice Policy Agenda*, 2021; *Reproductive Justice*, n.d.) | **Reparations** (*The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018) |
|---|---|---|
| **Human Rights Perspective** | Grounded in a human rights perspective, emphasizing individual rights. | Emphasizes the rights of individuals affected by gross human rights violations. |
| **International Legal Framework** | References international legal instruments like CEDAW, CESCR, and others. | Refers to the UN General Assembly's "Basic Principles and Guidelines on the Right to a Remedy and Reparation." |
| **Intersectionality** | Acknowledges interlocking systems of oppression affecting women of color. | Recognizes the multifaceted nature of human rights violations and addresses various components. |
| **Collective and Individual Responsibility** | Focuses on the well-being of women, transwomen, girls, | Requires states to collaboratively fulfill multifaceted obligations and |

| | | |
|---|---|---|
| | and femmes particularly reproductive rights. | acknowledges individual rights to ensure a comprehensive approach. |
| **Focus and Scope** | Focuses on the well-being of women and girls, particularly reproductive rights. | Specifically deals with remedies and reparations for gross violations of international human rights and humanitarian law. |
| **Subject Matter** | Addresses reproductive health and rights, including the right to have/not have a child. | Focuses on remedies for individuals affected by gross human rights violations. |
| **Historical Context** | Originates in the experiences of Black women within the U.S. healthcare system. | Acknowledges historical injustices but provides a broader framework applicable to various human rights violations. |
| **Components of the Frameworks** | Key strategies include supporting excluded groups and building economic power. | Components include restitution, compensation, rehabilitation, satisfaction, and guarantees of non-repetition. |

## Combining the Frameworks: Reproductive Reparations

The RJ and reparations frameworks share some common principles and objectives. They can be integrated into a combined framework titled Reproductive Reparations, which addresses both the reproductive and sexual rights of marginalized individuals and the need for redress for past related human rights violations. Both frameworks acknowledge the intersectionality between human rights and social issues. RJ recognizes the interlocking systems of oppression that impact the reproductive choices of women of color, while the reparations framework acknowledges that human rights violations often involve multiple dimensions of harm, including economic, social, and political (*Black Reproductive Justice Policy Agenda*, 2021; *Reproductive*

*Justice*, n.d.; *The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018). Furthermore, RJ is rooted in the protection of human rights, including the right to have a child, access to healthcare, and control over birthing options (*Black Reproductive Justice Policy Agenda*, 2021; *Reproductive Justice*, n.d.). Similarly, the reparations framework is based on the well-established right to a remedy and reparation for individuals affected by human rights violations under international law (*The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018).

Many components of the RJ framework overlap with the five components of reparations outlined by the ICJ. The reparations framework includes principles of restitution and compensation for affected individuals (*The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018). Restitution aims to restore individuals to their original state, which aligns with the goal of RJ to ensure that individuals can make reproductive choices without endangering their lives. Compensation, in both frameworks, involves addressing the economic and social harms suffered by individuals (*Black Reproductive Justice Policy Agenda*, 2021; *Reproductive Justice*, n.d.; *The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018). Additionally, RJ emphasizes the need for comprehensive healthcare, including medical, social, and mental health assistance (*Black Reproductive Justice Policy Agenda*, 2021; *Reproductive Justice*, n.d.). This aspect aligns with the rehabilitation component of reparations, which includes medical and social support for individuals affected by human rights violations. Further, the reparations framework includes elements of satisfaction, such as public apologies and commemoration, which acknowledge the suffering of the affected individuals (*The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018). In the context of RJ, the acknowledgment of historical injustices, such as forced sterilization, and public apologies, is an

essential step toward healing and redress (*Black Reproductive Justice Policy Agenda*, 2021; *Reproductive Justice*, n.d.). Reparations emphasize guarantees of non-repetition to prevent future human rights violations, and this can translate into policies and measures to ensure that past abuses, such as forced sterilization, are not repeated and that individuals have the right to make reproductive choices without coercion or discrimination (*The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018). Both frameworks recognize the importance of truth and justice. RJ advocates for addressing the social inequalities that affect an individual's decision-making process, which aligns with the pursuit of justice in the reparations framework (*Black Reproductive Justice Policy Agenda*, 2021; *Reproductive Justice*, n.d.; *The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018). This combined framework emphasizes the importance of acknowledging past injustices, providing restitution and compensation, ensuring access to comprehensive healthcare, and implementing policies to prevent future violations within the context of protecting and promoting human rights.

**Table 5**

*The Key Elements of the Reproductive Reparations Framework*

| **Key Elements** | **Reproductive Justice** (*Black Reproductive Justice Policy Agenda*, 2021; *Reproductive Justice*, n.d.) | **Reparations** (*The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018) | **Reproductive Reparations (Combined Framework** |
|---|---|---|---|
| **Intersectionality** | Recognizes interlocking systems of oppression affecting women of color. | Acknowledges multiple dimensions of harm in human rights violations (economic, social, political). | Integrates the understanding of intersectionality from both frameworks. |
| **Rooted in Human Rights** | Protects human rights, including the right to have or not | Based on the right to a remedy and reparation for | Establishes the foundation for the framework, |

| | | | |
|---|---|---|---|
| | have a child, access to healthcare, and control over birthing options. | individuals affected by human rights violations under international law. | emphasizing human rights principles. |
| **Restitution and Compensation** | Aims to restore individuals to their original situation and address economic and social harms. | Components within RJ and reparations addressing economic and social harms. | Recognizes the need for restitution and compensation as integral aspects of the combined framework. |
| **Comprehensive Healthcare** | Emphasizes the need for comprehensive healthcare, including medical, social, and mental health assistance. | Aligns with the rehabilitation component of reparations, involving medical and social support. | Highlights the importance of comprehensive healthcare as a shared objective in the combined framework. |
| **Acknowledgement of Historical Injustices** | Acknowledges historical injustices, such as forced sterilizations. | Includes elements of satisfaction (public apologies, commemoration) in the reparations framework. | Stresses the importance of acknowledging past injustices as a step toward healing and redress. |
| **Guarantees of Non-Repetition** | Advocates for policies to prevent future human rights violations. | Emphasizes guarantees of non-repetition in the reparations framework. | Calls for policies and measures to ensure past abuses are not repeated, safeguarding the right to make reproductive choices without coercion or discrimination. |
| **Truth and Justice** | Advocates for addressing social inequalities affecting decision-making. | Aligns with the pursuit of justice in the reparations framework. | Emphasizes the importance of truth and justice as shared values in the combined framework. |

## Previous Approaches to Reparations for Forced Sterilization

In exploring the various approaches to reparations for forced sterilization, it becomes evident that a comprehensive framework that integrates both RJ and reparations principles can offer a nuanced and effective solution. This combined approach, titled Reproductive Reparations, aligns with the broader pursuit of justice in acknowledging historical injustices, providing restitution, and addressing intersecting dimensions of harm. To better understand this new framework, it is important to delve into specific instances where reparations have been attempted, examining both the successes and challenges in achieving justice for those affected by forced sterilization.

### North Carolina

North Carolina was the first state in the United States to allocate compensation to individuals affected by its state-sponsored sterilization program (Nelson et al., 2017). The state dismantled its sterilization program in 1975. In 2002, a series of articles by a local state-level publication, the Winston-Salem Journal, brought attention to the program. This led to a public apology by the governor, but legal action was not taken for many years after that. In 2013, as a result of a bipartisan effort, the state legislature approved the budget for reparations, and disbursements were supposed to begin in 2015. This law allocated ten million dollars to provide a $50,000 compensation payment to each affected individual, recognizing the harm they had endured (Cohen, 2013; *Senate Passes Bipartisan Bill to Assist Eugenics Victims Receiving Compensation Payments*, 2015). The state also erected a commemorative marker for those affected by forced sterilization (Villarosa, 2022).

While the state established a compensation program, many affected individuals were unable to qualify for payments due to restrictive eligibility criteria. To be eligible, individuals

had to prove that they were sterilized under the state's eugenics program between 1929 and 1974, and their files had to be verified for authenticity (Mennel, 2014). However, due to incomplete records and bureaucratic challenges, many individuals struggled to meet these requirements. Even with evidence of sterilization, including court orders and procedural details, survivors' claims have been denied because of technicalities. For example, the law specifies that sterilization operations must have occurred under the state's Eugenics Board to qualify for compensation. However, many sterilizations were authorized by judges and social service workers at the local level rather than by the Eugenics Board. As a result, individuals who underwent involuntary sterilization procedures initiated at the local level are facing denial for compensation because their paperwork was not preserved in the official Eugenics Board files in Raleigh, or it may not have been there in the first place (Mennel, 2014). This technicality highlights the complexity and limitations of compensating victims of historical injustices that occurred at both the local and state levels, adding an extra layer of challenge for those seeking restitution. Advocates estimate that hundreds may be in this situation, leading to frustration and calls for revisiting the compensation criteria. Therefore, questions can be raised about the justice and fairness of the reparations program. Current emphasis is placed on the ongoing struggle for recognition and compensation for all those affected by forced sterilization (Mennel, 2014).

**Planned Parenthood of Greater New York**

In 2019, PPGNY organized an event called "Radical Repair: Building a Pathway to Transformation," bringing together communities of color (*Reviving Radical*, n.d.). The focus of this event was the adoption of a RJ lens to address reparations for eugenics and forced sterilization. As a result, PPGNY officially adopted the Reviving Radical Community mandates in 2020, acknowledging its historical role in reproductive harm within communities of color. As

part of these mandates, PPGNY committed to dismantling white-dominant organizational norms, promoting racial equity, eliminating unearned advantages, and actively tracking and addressing disparities within the organization (*Reviving Radical*, n.d.). The organization pledged to adopt practices that value people of color, provide race and gender justice training, commit to continuous learning, and be accountable for mistakes. Trusting the leadership and expertise of communities of color and centering their voices, experiences, and knowledge became a crucial aspect of this commitment. In line with these commitments, PPGNY emphasized the importance of listening, believing, and honoring the truth of communities of color while providing care and services. The mandates further highlighted the need to build accountable relationships based on trust. PPGNY also pledged to continuously improve, address community needs based on community input, and hold itself accountable for engagement with and within these communities (*Reviving Radical*, n.d.). The core goals of Reviving Radical encompass acknowledging the historical impact of PPGNY's actions on communities of color, identifying measurable steps based on community discussions, implementing, and reporting on actions taken to be accountable to communities of color in health services, programs, and organizational practices. The overall commitment is towards ongoing restoration and transformation within the communities of color served by PPGNY (*Reviving Radical*, n.d.).

## Lessons and Framework Applications

The cases mentioned above offer valuable insights into the complexities of addressing historical injustices related to forced sterilization. Subsequently, a broader analysis is needed to distill the lessons and identify potential applications of the frameworks for a comprehensive approach to reproductive reparations. The following draws on the experiences of North Carolina and PPGNY to extract key lessons and framework applications that integrate RJ principles and

reparations. This analysis will help identify a path forward that not only acknowledges past wrongs but also lays the groundwork for transformative and inclusive practices in addressing the intersecting dimensions of harm.

**Assessing North Carolina's Reparation Effort**

The case of reparations in North Carolina provides both positive and negative lessons from which to learn. The state had unique features in its reparations program, including focusing on rural young women, giving social workers (in addition to affected individuals) the authority to file sterilization petitions, and having strong support from state media promoting reparations (Nelson et al., 2017). However, although the Office of Justice for Sterilization Victims was established, only approximately 3% of individuals received compensation (Smaw, 2022). The office has limited jurisdiction, which excludes individuals sterilized in local health facilities outside of state jurisdiction, and there are arguments that the compensation offered is inadequate considering the permanent harm inflicted upon survivors. Critics of the state recognize that placing a monetary value on the harm suffered is challenging as affected individuals' experiences vary (Klein, 2012). However, simply because it is challenging does not mean that solutions cannot be found.

Some of North Carolina's efforts to compensate survivors of the state-sponsored sterilization program align with the Reproductive Reparations framework. The program acknowledges historical injustices as the state issued a public apology, erected a commemorative marker, and allocated funds for compensation, all of which align with the satisfaction component of the reparations framework. The compensation program allocating $50,000 to each survivor recognizes the economic harm and suffering that they endured (*N.C. to Compensate Victims of Sterilization in 20th Century Eugenics Program*, 2012). This aspect also aligns with the

compensation component of the reparations framework. While this case of reparations does not explicitly mention healthcare, the reparations framework includes rehabilitation, which encompasses medical assistance (*The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018). Ensuring that sterilization survivors have access to healthcare, including medical, mental health, and social support, would further fit within the Reproductive Reparations framework. However, while the eligibility criteria in North Carolina, requiring affected individuals to prove that they were sterilized under the state's eugenics program between 1929 and 1974 with verified files, align with the pursuit of truth and justice, it has proven challenging for many survivors because of incomplete records and bureaucratic hurdles. Therefore, improvements could be made to facilitate survivors' access to this component.

Gaps between the Reproductive Reparations frameworks and the case of North Carolina also exist. While the case addresses forced sterilization, it does not fully encompass the intersectional nature of RJ. This case could benefit from a more comprehensive understanding of how these intersecting factors contributed to the harm suffered by survivors. Furthermore, while the program addresses past violations, it does not adequately emphasize measures to prevent future violations of reproductive rights. A more robust program should include policies and actions aimed at ensuring that similar abuses will occur in the future. Lastly, RJ advocates for the inclusion and representation of marginalized groups. The case could benefit from ensuring that all affected individuals, especially those from marginalized communities, are adequately represented in the compensation process and decision-making.

The case of North Carolina's compensation program for individuals affected by forced sterilization demonstrates a significant effort to address historical injustices and provide financial compensation to survivors. It aligns with several components of the Reproductive Reparations

framework, particularly in terms of acknowledgment, compensation, and access to healthcare. However, there are areas where the program could be further strengthened, including a more comprehensive and intersectional approach, a focus on preventing future violations, and ensuring the inclusivity and representation of marginalized communities in the process.

**Table 6**

*Summary of North Carolina's Reparation Effort*

| Key Elements | North Carolina's Reparation Effort | Aligns with Reproductive Reparations | Gaps and Areas for Improvement |
|---|---|---|---|
| **Intersectionality** | Targets rural young women. | Somewhat | Could benefit from a more comprehensive understanding of how intersecting factors contributed to harm. |
| **Rooted in Human Rights** | No human rights instruments mentioned. | No | Base reparations in international human rights instruments to strengthen plan. |
| **Restitution and Compensation** | Public apology, commemorative marker, compensation program offers $50,000 to each survivor. | Yes | Questions raised about adequacy; challenging to place a monetary value on the harm suffered. |
| **Comprehensive Healthcare** | No mention of healthcare. | No | Take down barriers to prove sterilization has occurred. |
| **Acknowledgement of Historical Injustices** | Public apology. | Somewhat | Outline details of the injustice in public document. |
| **Guarantees of Non-Repetition** | Does not include measures to prevent future violations. | No | Include measures to prevent future violations. |

| | | | |
|---|---|---|---|
| **Truth and Justice** | No mention of truth or justice elements. | No | Establish a state commission on Forced Sterilization. |

**Assessing PPGNY's Reparation Effort**

PPGNY is experiencing a transformation both internally and externally, with a focus on equity and centering the most marginalized and impacted individuals in their engagement work. They are creating pathways for engagement and partnership, removing barriers, and providing resources to small community organizations (*Reviving Radical*, n.d.). They aim to amplify marginalized voices and perspectives by building networks and learning when to follow, partner, or lead. Their goal is to be invited into spaces rather than imposing themselves on others. The organization is engaged in internal efforts to foster racial equity, including the establishment of equity competencies and standardized practices, demonstrating a commitment to genuine transformation beyond symbolic gestures (Stewart, 2020).

Overall, organizers within PPGNY are seeing early indications of shifts and changes within the organization, but external pressure and evaluation are still necessary. The transformed leadership team, with its diverse composition, brings a different level of analysis and possibilities to the table, allowing for actions that were not previously possible (Siddiqui, 2021). For example, PPGNY has decided to remove the name of its founder, Margaret Sanger, from its Manhattan health clinic due to her "harmful connections to the eugenics movement" (McClain, 2020; Stewart, 2020). This move is part of the organization's efforts to address its historical association with reproductive harm within communities of color. This decision reflects a broader societal trend of reevaluating historical figures in light of systemic racism.

Organizers are also excited about PPGNY's new initiative, the Equity School, which has resulted in a shift in the level of analysis and the type of hires made (Siddiqui, 2021). It goes

beyond diversity and focuses on equity competencies and standardized practices. For example, the organization has embedded equity competencies in its hiring and promotion practices, ensuring a focus on candidates' understanding of structural racism. By creating spaces for disruptive conversations and rebuilding systems with a specific equity lens, PPGNY is moving beyond symbolic diversity to foster a tangible and sustained commitment to equitable practices. The organization is taking bold steps to confront internal challenges and root out systemic issues, demonstrating a commitment to acknowledging past harms and working towards a more inclusive future (McClain, 2020).

The case of PPGNY aligns with various elements of the Reproductive Reparations framework. PPGNY has taken steps to acknowledge its historical role in reproductive harm within communities of color. This acknowledgment aligns with the principles of reparations, which often begin by recognizing past injustices and their impact on marginalized communities. In addition, PPGNY's commitment to apologizing for its historical actions and taking accountability for past harm is in line with the reparations framework, as reparations often involve acknowledging wrongdoing, expressing remorse, and taking concrete steps to rectify harm (*The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018). The Reviving Radical framework adopted by PPGNY emphasizes transformative actions, such as dismantling white-dominant organizational norms, promoting race equity, and actively addressing disparities. These actions align with the goals of reparations, which seek to create meaningful changes and redress systemic injustices. Further, PPGNY's commitment to centering the voices, experiences, and knowledge of communities of color and trusting their leadership and expertise reflects the RJ framework's emphasis on ensuring that affected communities are at the forefront of decision-making processes. Both the reparations and RJ frameworks emphasize the

importance of listening, learning, and building accountable relationships based on trust in affected communities (*Black Reproductive Justice Policy Agenda*, 2021; *Reproductive Justice*, n.d.; *The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018). PPGNY's focus on these aspects demonstrates a commitment to the principles of both frameworks. Additionally, PPGNY's commitment to identifying measurable steps based on community discussions and reporting on actions taken to be accountable to communities of color aligns with the reparations framework's emphasis on concrete, measurable steps.

However, it is important to note that while PPGNY's efforts align with these frameworks in many ways, this case also presents challenges. For instance, the extent to which these efforts result in meaningful change and address the historical harm caused by the organization will require ongoing scrutiny and evaluation. Additionally, the case primarily focuses on organizational-level actions, and broader systemic issues related to RJ and reparations may require additional advocacy and policy changes beyond the scope of one organization. The PPGNY case demonstrates a commitment to addressing historical harm and promoting racial equity within the reproductive healthcare context, while the effectiveness of these efforts is measured by their tangible impact on affected communities over time.

**Table 7**

*Summary of PPGNY's Reparation Effort*

| Key Elements | PPGNY's Reparation Effort | Aligns with Reproductive Reparations | Gaps and Areas for Improvement |
|---|---|---|---|
| **Intersectionality** | Recognizes interlocking systems of oppression affecting communities of color, centering the most | Yes | Address how each type of oppression (eg., economic stability) intersects with reproductive rights specifically. |

| | | | |
|---|---|---|---|
| | marginalized, and removing barriers. | | |
| **Rooted in Human Rights** | No human rights instruments mentioned. | No | Base reparations in international human rights instruments to strengthen plan. |
| **Restitution and Compensation** | Apologized for historical actions and taking accountability for past harm. | Somewhat | No mention of possible compensation. |
| **Comprehensive Healthcare** | Commitment to centering the voices, experiences, and knowledge of communities of color to provide informed care. | Yes | Continual evaluation of clinic practices. |
| **Acknowledgement of Historical Injustices** | Acknowledges historical role in reproductive harm within communities of color and expressing remorse. | Yes | Evaluating the effectiveness of efforts to address historical harm over time is necessary. |
| **Guarantees of Non-Repetition** | Commitment to identifying measurable steps and reporting on actions taken. | Somewhat | Not an outright guarantee. |
| **Truth and Justice** | The Reviving Radical mandates are an attempt at Truth and Justice. | Somewhat | Could make an organizational level commission on Forced Sterilization. |

## Policy Recommendations and Broader Implications

To address the case of forced sterilization in the United States, considering the case studies of North Carolina and PPGNY and the combined frameworks of RJ and reparations, several policy recommendations can be considered.

1. Establish a National Commission on Forced Sterilization comprised of experts in RJ, human rights, and legal scholars.

Although only approximately 33 states had specific laws allowing forced sterilization, all states in the U.S. should investigate their history with forced sterilization and eugenics, as some have a history of wanting to implement such laws (Kaelber, n.d.). This commission should be responsible for investigating historical cases of forced sterilization, documenting stories of affected individuals, and recommending appropriate reparative measures.

2. Establish national regulations on record keeping.

Requiring healthcare institutions to maintain detailed records of all sterilization procedures with a focus on informed and voluntary consent will help in the trust-building process. Furthermore, a centralized repository for historical records related to forced sterilizations, medical, and otherwise, will ensure that documentation is preserved for future investigations and research. Progress in addressing forced sterilization cases, including the implementation of reparative measures and adjusting policies, must be continuously monitored and documented to ensure justice and accountability.

3. Enact legislation that explicitly bans all forms of non-consensual sterilization and imposes severe penalties on individuals and institutions found guilty of performing such procedures.

This would require bi-partisan support, as was the case in North Carolina. Legislation should also consider compensation, education, and reparative reproductive healthcare. It should be similar in that it targets non-institutionalized rural young women, gives social workers the authority to file sterilization petitions, and has strong support from state media promoting eugenics (Nelson et al., 2017). However, legislation should differ from North Carolina in that it has exceptions and considerations for individuals who cannot bureaucratically verify their sterilization records, as access to these records is a privilege implicated by the history of white supremacy.

4. Create a national reparations fund to compensate survivors of forced sterilization, their families, and communities.

Similar to California's plan for reparation, legislation should include compensation for more recent survivors of forced sterilization ("California Tries to Find 600 Victims of Forced Sterilization for Reparations," 2023). Money must also be allocated to the spread of information on how compensation can be acquired and who qualifies. In this pursuit, it is important to ensure that legal recourse is accessible to survivors seeking justice.

5. Enact legislation that outlines an effort to repair the damage done to the trust of Black communities in the government and reproductive healthcare institutions.

PPGNY provides an approach, as outlined above, that other reproductive healthcare providers and organizations should follow, including the national chapter of Planned Parenthood (*Reviving Radical*, n.d.). This approach includes trust-building practices and educational content that should be required for all reproductive healthcare providers.

6. Promote legislation that requires proper sexual education, including education about the history of eugenics in America.

Integrating the history of forced sterilization, eugenics, and reproductive injustice into educational curricula at all levels in an age-appropriate manner emphasizes the importance of preventing such atrocities in the future. Educational resources should promote public awareness and acknowledgment of historical injustices related to forced sterilization. This includes acknowledging the role of institutions, healthcare providers, and government agencies in perpetrating violations. Furthermore, part of this education should include programs to inform individuals about their reproductive and sexual rights.

7. Enact legislation to ensure that survivors of forced sterilization have access to comprehensive healthcare services including mental health support, sexual and reproductive health services, and specialized care related to the consequences of sterilization.

RJ training should be provided to all health care providers, emphasizing the importance of informed consent, patient autonomy, and cultural sensitivity. Community-based support programs that facilitate healing and offer resources to survivors and their families may also be beneficial. These programs should provide mental health counseling, legal assistance, and opportunities for survivors to share their stories if they wish.

## Conclusion

The historical legacy of forced sterilization in the United States has left a lasting impact on individuals, families, and communities, particularly those that are marginalized and vulnerable. Examining the intersection of the RJ and reparations frameworks to address the complex effects of forced sterilization reveals the interconnectedness of these frameworks. Thus, the intertwined principles of RJ, focusing on the holistic well-being of women and girls, and

reparations, seeking redress for past human rights violations, present a comprehensive approach called Reproductive Reparations.

The RJ framework, born out of the need to center the experiences of Black women and other communities of color in the United States, recognizes the interlocking systems of oppression that have historically constrained their reproductive choices (*Black Reproductive Justice Policy Agenda*, 2021; *Reproductive Justice*, n.d.). It affirms the right to have a child, the right not to have a child, and the right to parent with dignity. The reparations framework, grounded in international human rights law, provides a structured approach for addressing past human rights violations (*The Right to a Remedy and Reparation for Gross Human Rights Violations*, 2018). It encompasses the principles of restitution, compensation, rehabilitation, satisfaction, and guarantees of non-repetition, emphasizing the right to a remedy for affected individuals and seeking to hold perpetrators accountable while offering redress. To further contextualize RJ (and reparations) within the broader scope of international SRHR, it is essential to recognize that RJ's origins, while rooted in the experiences of Black women and marginalized communities in the United States, resonate with global struggles for reproductive autonomy. The interconnected nature of oppression and the pursuit of comprehensive well-being, as emphasized by the frameworks, aligns with international efforts to address SRHR issues on a broader scale.

By recognizing and addressing the multifaceted dimensions of reproductive oppression, both at the local and global levels, Reproductive Reparations becomes an integral part of the broader conversation to ensure sexual and reproductive rights worldwide. The interconnectedness between the goals of RJ and the goals of reparations underscores the importance of adopting a holistic approach outlined by the Reproductive Reparations Framework, which encompasses both the unique experiences of marginalized communities

within specific national contexts and the broader struggle for global SRHR equity. The Reproductive Reparations framework recognizes that individuals affected by reproductive oppression may require restitution, including the restoration of their ability to make reproductive choices. It is important to acknowledge that there are limits to choice, and overarching changes are needed to have a just system, so that everyone has the opportunity to make a choice. Some limitations to choice are inevitable, but in this case, many are systemic and unnecessary. For example, a lack of reproductive healthcare services available in rural communities.

Reproductive Reparations contains several key elements. Moreover, this combined framework underscores the importance of acknowledging past injustices, offering public apologies, and commemorating individuals' suffering. It seeks to prevent future violations by implementing policies and measures that protect individuals' rights to make reproductive choices free from coercion, discrimination, and structural barriers, such as systemic racism. Achieving RJ and seeking reparations are interconnected goals that empower communities, promote justice, and contribute to a more equitable society.

Both North Carolina's compensation program for individuals affected by forced sterilization and PPGNY's commitment to acknowledge and rectify historical harm align with the Reproductive Reparations framework, albeit with unique challenges and opportunities. North Carolina's compensation program demonstrates a significant step towards acknowledging past injustices and providing financial compensation to survivors, aligning with several components of the combined frameworks. However, the eligibility criteria and administrative challenges highlight the need for further refinement and inclusivity in the program. Additionally, PPGNY's transformation and commitment to addressing its historical role in reproductive harm within communities of color aligns with the principles of acknowledgment, accountability, and

transformative actions advocated by both frameworks. However, the effectiveness of these efforts requires ongoing evaluation to ensure that they result in meaningful changes and redress for past harm. Both cases serve as examples of organizations and states taking steps towards reparative actions, but they also underscore the complexities and challenges involved in addressing historical injustices and promoting equity in reproductive healthcare.

Drawing from the lessons of case studies, such as North Carolina and PPGNY, a set of policy recommendations emerges. These recommendations encompass the establishment of a National Commission on Forced Sterilization to investigate historical cases, the enactment of legislation banning non-consensual sterilization with severe penalties, and the creation of a national reparations fund to compensate survivors. Additionally, efforts to rebuild trust in reproductive healthcare, mandatory sexual education, and the inclusion of eugenics history in curricula, along with ensuring access to comprehensive healthcare services, are essential components. Community-based support programs, centralized repositories for historical records, and continuous monitoring mechanisms for accountability also contribute to this multifaceted strategy. By embracing these policies, the United States can confront its history of forced sterilization, provide reparative justice, and work toward a more equitable and just future for all its citizens.

Overall, this research underscores the urgent need for comprehensive policies, education, and acknowledgment of past wrongs to address the deep-seated inequalities that persist in the realm of RJ today. The Reproductive Reparations framework can be applied to various violations of sexual and reproductive rights on a national and international scale. There are current recent of international human rights instruments being used to address sexual and reproductive rights violations, such as was the case in *Manuela v. El* Salvador, decided in 2021. In this case, the

Inter-American Court of Human Rights issued a groundbreaking ruling establishing regional standards to protect women seeking reproductive healthcare, including abortion (*Manuela v. El Salvador (Inter-American Court of Human Rights)*, n.d.). The Court ordered El Salvador to make reparations to Manuela's family and reform policies criminalizing women for reproductive health care. Similarly, in the case of *Alyne da Silva Pimentel v. Brazil* the United Nations' CEDAW Committee condemned Brazil in the first-ever international human rights case on maternal mortality (*Alyne Da Silva Pimentel v. Brazil (Committee on the Elimination of Discrimination Against Women)*, n.d.). The Committee recognized that states have a human rights obligation to address and reduce maternal mortality by providing timely and non-discriminatory maternal health services. This case has global significance, establishing that governments are obligated to ensure that all women, regardless of income or racial background, have access to appropriate maternal health services. Including the Reproductive Reparations framework, which covers international human rights norms and instruments, national reproductive rights frameworks, and reparations-based ideology, will only strengthen legal arguments. This framework is a call to action to dismantle systemic discrimination and ensure that all individuals, regardless of their background, have equal access to reproductive healthcare and the ability to make informed choices about their bodies and their futures.

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