

Health practices of domination and exclusion: views of activists, professionals and researchers on the situation of forced sterilization of women and girls with disabilities in Spain

Prácticas de salud de dominación y exclusión: visiones de activistas, profesionales e investigadoras sobre situación de esterilizaciones forzadas en mujeres y niñas con discapacidad en España

Andrea Yupanqui-Concha^{a,b}

 <https://orcid.org/0000-0003-2698-6755>

E-mail: andrea.yupanqui@umag.cl

Cristian Aranda-Farias^{a,b}

 <https://orcid.org/0000-0002-0151-7744>

E-mail: cristian.aranda@umag.cl

Victoria A. Ferrer-Perez^b

 <https://orcid.org/0000-0002-8096-4031>

E-mail: victoria.ferrer@uib.es

^aUniversidad de Magallanes. Facultad de Ciencias de la Salud. Departamento de Terapia Ocupacional. Punta Arenas, Magallanes y la Antártida Chilena, Chile.

^bUniversidad de las Islas Baleares. Facultad de Psicología. Departamento de Psicología. Palma, Baleares, España.

Abstract

In 2017, the United Nations declared that 38 countries, including Spain, continued to practice forced sterilizations on women and girls with disabilities, despite it being a practice widely condemned by various international human rights organizations. This study analyzed the situation of this practice in Spain, from the perspective of activists, professionals and researchers with experiences related to this group. The methodology used was qualitative, based on Constructivist Grounded Theory. Semi-structured in-depth interviews were applied to 22 informants, representing 6 autonomous communities of the country. The participants identified a model of health practices of domination and exclusion, where the sexuality and reproduction of women with disabilities has been the object of expropriation, alienation and contempt by systems, structures and differentiated policies, with little transfer of the global framework of human rights to their reality. Sexual violence has gone unnoticed, becoming naturalized by the environment, and has promoted mechanisms of social exclusion and health inequities, depriving them of their fundamental human rights. As it is a situation that is replicated in various parts of the world, it should be considered an issue of relevance for international public health. **Keywords:** Forced Sterilization; Women with Disabilities; Human Rights; Sexual and Reproductive Health; Social Exclusion.

Correspondence

Andrea Yupanqui-Concha

Av. Presidente Manuel Bulnes, 1.855. Punta Arenas, Magallanes y la Antártida Chilena, Chile. CP 6210427.

Resumen

En 2017, las Naciones Unidas declaran que 38 países, entre ellos España, continuaban realizando esterilizaciones forzadas en mujeres y niñas con discapacidad, a pesar de tratarse de una práctica ampliamente condenada por diversos organismos internacionales de derechos humanos. Este estudio analizó la situación de esta práctica en España, desde la perspectiva de activistas, profesionales e investigadoras con experiencias vinculadas a este colectivo. La metodología empleada fue de tipo cualitativa basada en la Teoría Fundamentada Constructivista. Se aplicaron entrevistas semiestructuradas en profundidad a 22 informantes, que representaron a 6 comunidades autónomas del país. Las participantes identificaron un modelo de prácticas de salud de dominación y exclusión, donde la sexualidad y reproducción de mujeres con discapacidad ha sido objeto de expropiación, alienación y desprecio por parte de sistemas, estructuras y políticas diferenciadas, con escasa transferencia del marco global de derechos humanos a su realidad. La violencia sexual ha pasado inadvertida, naturalizándose por el entorno, han promovido mecanismos de exclusión social e inequidades en salud, al privarles de sus derechos humanos fundamentales. Al tratarse de una situación que se replica en diversos lugares del mundo, debiese considerarse un tema de relevancia para la salud pública internacional.

Palabras clave: Esterilización Forzada; Mujer con Discapacidad; Derechos Humanos; Salud Sexual y Reproductiva; Exclusión Social.

Introduction

Forced sterilization is a medical practice that has been permitted in much of the world since the second half of the 19th century and persists to the present day as one of the most widespread human rights violations in the world (OHCHR et al., 2014; Sterilization..., 2011; UN, 2017). A sterilization has been considered to be forced, coerced or involuntary if it is performed without a person's full, free and informed consent or despite being expressly refused, or without person's knowledge about the intervention, or without the opportunity to the person give the consent (Sterilization..., 2011). At the international level it has been distinguished as a form of violence against women (UN Women, 1996); crime against humanity and serious crime of sexual violence (ONU, 2003); form of torture, cruel, inhuman and degrading treatment of women (UNHRC, 2008), crime and criminal practice (Consejo de Europa, 2011). Although the rights instruments are categorical in their recognition of the practice, there is a gap between them and the legal norms of the various countries involved, as the act of forced sterilization has not yet been explicitly prohibited in many of them. Evidence supports that it has been exercised on vulnerable populations, such as people with disabilities, indigenous peoples and ethnic minorities, people with HIV, transgender or intersex people, among others. However, women and girls with disabilities have been the priority target of these procedures in the world (OHCHR et al., 2014; Rowlands; Wale, 2019; Sifris, 2016).

Europe has been no exception. Several European countries carried out this type of practice during World War II due to their eugenic policies, which remain present in many of them up to nowadays (Albert; Szilvasi, 2017; Stansfield; Holland; Clare, 2007). Particularly in Spain, this procedure has been legalized since 1989, with the approval of Organic Law 3/1989 updating the Criminal Code (España, 1989), which established the power to sterilize a person subject to guardianship in a non-punishable manner. This measure was modified in the new Criminal Code, through Organic Law 10/1995 (España, 1995), which in its Article 156 incorporated the concept of "greater interest" of

the 'incapacitated' person. However, the monitoring mechanisms of the Convention on the Rights of Persons with Disabilities in Spain (ONU, 2019b) and CEDAW (ONU, 2019a), recently requested the Spanish State to repeal Article 156, with the purpose of abolishing this practice.

Some national figures partially demonstrate this reality, indicating that, as of 2016, 100 persons with disabilities would have been applied annually for the last 10 years, despite the fact that these data are not disaggregated by sex, and there are no data from 2016 onwards (Cermi; EDF, 2017).

A recent study reveals that this practice continues to be a topic insufficiently studied and reported in the literature worldwide (Yupanqui; Ferrer, 2019) and that, in Spain, this practice has been denounced as a priority by disability activists (Arnau, 2014; Cermi; EDF, 2017). This activism describes the practice as a form of subtle eugenics, although they affirm that a large part of society is unaware of its existence. They agree on the need to promote research to disseminate the reality of sterilization of people with disabilities in the country.

In short, Spain recognizes the existence of a controversial medical procedure, which is endorsed by its legislation, rejected by activist and human rights organizations, with little exploration in the scientific literature. As part of this analysis, and in accordance with the particular scenario existing in the country, it was proposed to describe and analyze the current situation of the practice of forced sterilization in women and girls with disabilities in Spain, from the perspective of representative women, the fundamental aim of this article.

Method

This study adopted a qualitative methodology, of the descriptive-relational type of speeches. The collective case study was selected, focusing on different representative populations, with common processes and situations, in order to favor a comprehensive understanding of the phenomenon under study (Stake, 1999). This study was considered appropriate because of the interest in the variation of informants, with the purpose of capturing diverse characteristics of human reality, different

experiences and contexts. For this purpose, the inclusion criteria for the study were to be a woman, over 18 years old, with at least 1 year of experience working with women and/or girls with disabilities (with deficiencies in their physical, mental, intellectual, sensory or multiple health conditions) and to be part of one of the representative women's groups: (1) activist representing women's groups or people with disabilities, (2) professional with experience working with women with disabilities, (3) researcher in disability issues.

Regarding the concept of disability, this study adopts the nomenclature proposed by the United Nations (UN, 2007), which defines disability as the result of the interaction between people with deficiencies in their health conditions (physical, mental, intellectual, sensory or multiple) and the contextual, attitudinal and environmental barriers that prevent their full and effective participation in society on equality with others.

Convenience and snowball sampling was used in order to privilege informants with experience in the practice studied and because of the difficulty of accessing informants with knowledge of the subject and interest in participating in the study. The sample consisted of 22 participants. They represented 6 of the 17 autonomous communities in the country and their ages ranged from 25 to 55 years, with an average of 12 years of experience working with women with disabilities (Table 1). The selection of female participants is based on previous findings showing that those who have spread the existence of this practice worldwide have been mainly women (Yupanqui; Ferrer, 2019) and, as it is a socially feminized problem (Cermi; EDF, 2017; OHCHR et al., 2014; UN, 2017), the production of scientific knowledge situated from the experience of women involved in the problem studied is needed, because it is a key element to know this reality (Biglia; Vergés-Bosch, 2016).

By telephone and/or e-mail communication between the main investigator and each one of them, the general characteristics of the study were explained. In the process, the high resistance to provide information on the subject in a research context stood out, since 49 women were invited to participate, of which 22 agreed to participate.

The majority who declined to participate in the study stated that they did not have sufficient information, did not have time for the interview, or they just did not continue the initial contact established. The interviewees were not previously known, which reduced bias in the process. Fieldwork was conducted between March 2017 and February 2018.

Table 1 – Informants characteristics

Information	Participants (n=22)
Age range	
25-34	6
35-44	5
45-54	9
55+	2
Years of experience with women with disabilities	
<5	3
5-9	8
10-15	4
15-19	2
20+	5
Autonomous community of experience (*)	
Madrid	5
Catalonia	4
Balearic Islands	8
Castile and Leon	4
Andalusia	1
Aragon	2
Representative	
Activist	5
Professional	9
Researcher	8

* The data show cases with multiple representation, so it does not add up to the total number of participants.

Twenty-two individual semi-structured in-depth interviews were conducted face-to-face and through online communication platforms, in order to allow interaction with people from different geographic

locations. All of them were administered by the main researcher, trained in the technique and with 11 years of experience in qualitative research. The audios were recorded and transcribed. Their average duration was 75 minutes. An episodic interview was used as an instrument to collect information, through a thematic script with narrative elements, with the purpose of promoting the narration of the informant about her own experiences related to the detection of practices that violate the sexual and reproductive rights of women and/or girls with disabilities; practices of forced sterilization of the group; personal and institutional positions regarding these practices; procedures for its execution.

The analysis followed the strategies of the Constructivist Grounded Theory (Charmaz, 2006), starting with the collection of categories, ending with their integration and generation of the integrating theory, a relational explanatory model of the discourses. The choice of this strategy is due to its relevance in research on social processes that have been studied insufficiently or with little depth and, in turn, allows for a theoretical understanding of a situated process (Charmaz, 2006). For this purpose, two researchers independently analyzed the material separately, using the program ATLAS.ti version 8.4.4 (Friese, 2019). With the support of a third researcher, interjudge reliability was ensured. The number of participants was determined by data saturation criteria, reached with 18 interviews and 4 more interviews were applied to corroborate findings.

Credibility, originality, resonance and usefulness were used as criteria of rigor (Charmaz, 2006). Credibility was achieved with theoretical triangulation (review and discussion of previous studies), coding (3 analysts) and researchers (3 persons). In the description of results, confrontation of findings is reported, which endorse the structural and content coherence. Originality is in offering an original treatise in an area with little development and by a deep analysis of the phenomenon studied. Resonance was established through the detailed description of categories and inclusion of direct quotations from the interviews to illustrate elements for decision-making, achieved

after consensus meetings of the research team. Finally, the usefulness is linked to the fact that this analysis can generate more research in substantive areas, such as in the area of sexual and reproductive rights of this group and by contributing to the development of knowledge in the area of violence against women. In order to guarantee its quality and transparency, the standards of the Consolidated Criteria for Qualitative Research Reports were followed (Tong; Sainsbury; Craig, 2007).

Ethical aspects were safeguarded according to the principles of the Declaration of Helsinki (WMA, 2013). The informed consent procedure was followed with each participant, who received information about the project, its objectives, guarantees of respect for autonomy, anonymity and confidentiality. The project was evaluated and approved by the Ethics Committee of the University where the study was conducted.

Results

Current forced sterilization

Most of the informants agree in distinguishing forced sterilization as a health practice administered specifically to women and girls with disabilities, whose decision is made by the environment of the woman or girl, alluding to the reason for their protection against a possible pregnancy and fear of reproducing the disability. They emphasize the limited visibility of the practice in Spanish society, due to its concealment by the agents involved in the practice, and the lack of statistics and studies that make transparent the validity of the procedure at the national level: It has always happened, there are many more than we think. As always, the world of disability was invisible until a few years ago. This specific issue has been hidden (E20, professional).

A minority of professionals differed from the rest of the informants about the current existence of the practice, either because they said they were unaware of any history of the practice or because they did not consider it a “forced” issue. This is how one of them relates it: It is not forced, but it is recommended for people affected by mental illness to take contraceptive methods (E18, professional).

Activists and researchers point out that this practice can be hidden behind gynecological interventions aimed at solving disorders such as endometriosis, pain related to menstruation or hormonal changes. They mention that they are often carried out by giving false information about the procedure performed or by coercing the affected women:

Many women who find themselves in that situation of having been forcibly sterilized, really do not know that they were sterilized, and, on the other hand, nobody has explained to them what it means that they are sterilized... the cases I know are people who do not know that they were sterilized and who were told that they were surgically removed for appendicitis or some other nonsense thing, and do not know what sterilization means [...] the numbers are very necessary, because it is not something punctual, it is something quite generalized. (E1, activist)

Most of the participants identified circumstances that put the woman or girl at greater risk of being subjected to this practice, such as being of reproductive age, having intellectual and psychosocial disabilities, however, it applies to women with all types of disabilities (physical, intellectual, mental, sensory, autism spectrum) with any level of functional compromise (from low to high), with high levels of dependency and need for assistance, with a mostly medium-low educational level. They do not see any difference in the place of residence (in an institution or with their nuclear family). The judicial incapacitation applied to the woman is a determining factor, but the most decisive element visualized is the confluence of these characteristics mentioned in the same woman:

I have not encountered an age pattern. It makes no difference whether they live with a family or are institutionalized. The number of institutionalized women, although higher than men, is relatively low. Women who are institutionalized are usually because the disability already has a very high degree of affectation and the cases of

incapacitation are due to very concrete cases of abuse. But there is no pattern. Moreover, the more freedom of movement the woman has, the more fear the families have of a pregnancy... In the end, what the practices do is to hide a lot of aspects for which we are not prepared to provide inclusion. (E15, researcher)

Other related forced sexual and reproductive regulation practices

Forced temporary contraceptive methods

Most of the reports agree on the existence of these methods in a more generalized form nowadays towards the collective. According to this view, they are also applied in a forced manner. Institutions, professionals and family members do not problematize these practices; on the contrary, they justify them based on the temporary aspect of these methods and the judicial incapacitation process established. Some professionals express that this practice does not give importance to the infection of sexually transmitted diseases or HIV and that it favors the concealment of abusers. Many agree in recognizing families as one of the main agents that promote these practices:

I know of many girls who use the IUD, or some method of contraception, that lasts a long time, and they don't even have to worry, knowing that not all the risks are pregnancy. It seems that the only risk that families care about is pregnancy, and it is not the only risk. There are other infections that are also quite risky, but above all, the greatest risk is the psychological risk, that this girl may be mistreated or that this girl may be emotionally hurt, raped, impaired by men with or without disabilities, and this is a risk that is not assumed. (E9, professional)

Once again, there is a minority and transversal group among the groups of informants who state that they are unaware about the existence of this type of procedure.

Other associated violence practices

Informants from all the groups consulted identified that the above practices often coexist with

other types of violence, many of which are deeply rooted in the institutions, such as the removal of custody of children; the exposure and concealment of repeated rape and abuse; the lack of social recognition of gender violence against these women and the lack of care for such victims. In particular, activists describe that these forced practices and associated violence affect in greater proportion women who live with more elements of inequality, although those with disabilities and undocumented immigrants are perceived as one of the most vulnerable groups:

There is a great lack of protection and a lot of institutional mistreatment. For example, in 2010 I became pregnant and they dismissed me from my job. I arrived at the [social assistance institution] and they demanded that I be sterilized. They wanted to take my children away from me to give them up for adoption because I was an immigrant, undocumented, unemployed and separated from an abuser who was in prison. The institutions, instead of helping, frighten us [...] I met a Brazilian woman in a similar situation to mine, who was abused and persecuted by the institutions to such an extent that she even attempted suicide and, after that, they threatened to take her children away. (E21, activist)

Forced abortions, deprivation of accessible gynecological care, medical care limited by beliefs and stereotypes of medical and health professionals, maternity wards without official support such as personal assistance or funding, deprivation of accessible sexual and reproductive health information, failure to validate women by requiring them to provide personal information to others, and lack of protection due to increased exposure to sexually transmitted infections and HIV/AIDS are added to the list of abuses:

I know of many more coercive abortions. This is a common practice, either forced by incapacitation, or forced by pressure from the environment, by doctors, family [...] On the one hand, women are denied the right to exercise their sexuality, and on the other, they are unprotected from possible abusers, making them vulnerable. Stigma and lack of information mark their life stories. (E15, researcher)

As in the previous practice, a minority and transversal group among the groups of informants denies their existence or states that they do not know of any antecedents about these associated forms of violence.

Contextual conditions

For the informants, the context in Spain as related to the period 2017-2018, is characterized by the predominance of models that have permeated the structure of associations and of persons with disabilities, allowing practices of violation and control of these women.

Patriarchal-capitalist-ableist model

This model arises mainly from the accounts of activists and researchers. From their point of view, this model fosters an ideology against women, which is intensified in the case of women with disabilities. They observe that this alliance of models criminalizes their desire for motherhood, rejecting the reproduction of bodies considered not perfect; it defends the dominion and control of their bodies with interventions such as sterilizations, behind which lies the belief of their inferiority, annulment of their sexuality, showing rejection of human diversity for an ideal of perfection:

For me there are 3 key axes: ableism, which is what censures these diverse bodies, and also in a certain way capitalism, which is afraid of this reproduction of bodies that are not perfect. On the other hand, patriarchy, because this is deposited in women's bodies, because there is no systematic forced sterilization of men with functional diversity. In other words, on the one hand, they are considered sexual, but on the other hand, an anti-gender ideology still prevails, which places the responsibility on the woman's body, which is the one that must be protected, while men are not. So it is this triple alliance; an ableist, capitalist and patriarchal society. (E13, researcher)

Medical-rehabilitative model

A model distinguished by the 3 groups consulted. They explain that its current presence is more

predominant than the social models of disability. They said that it promotes the pathologization, devaluation and exclusion of these women, that it sustains the belief in treatment as a means to obtain normality, and it promotes the culture of assistance and charity. They add that it determines the annulment of sexuality in this group, as it is not considered as a necessity:

Because they consider that this people have less capacity, because their life has less value, this value is restricted to the possible cure and, if this cure does not happen, they have to remain more isolated, hidden. This is the history of the conception of disability, the medical-rehabilitative model [...] The basis is the same of any type of discrimination, it is that there are people inferior to others, there are people with less value than others, therefore, it is necessary to 'protected' them, but it is a false sense of protection. (E22, activist)

Facilitating conditions

Instrumentalization of judicial incapacitation

The informants distinguish, transversally, that it is a determining condition of this practice in the country. This element is recognized as a gateway to the sterilization procedure and the civil death of these women. It is seen as a generalized and normalized reality in the field of disability, with the aim of controlling the decisions of these women:

The parents also reported how their daughters were sterilized. It was as if we came face to face with a very generalized reality and the criticism of the families was more in line with judicial pitfalls, that they had to find a judge who would not give them any difficulty to validate the procedure... these practices greatly support the exclusion of the group, because, in the end, to desexualize is to dehumanize. (E11, researcher)

They report that this legal procedure is based on hierarchical relationships, with asymmetry of power, where the abuse is allowed, without recognizing it as

such. It occurs between these women and the agents involved in the decision to carry out the procedure: State, institutions, associations, judges, health and socio-educational professionals, families and/or legal representatives:

The ultimate decision must be made by the legal guardian. The State allows it, the professionals promote it and the family gives the approval. They are also defenseless in front of the professionals and the State. It is the method to solve these problems. (E6, professional)

Especially activists and researchers report that judicial incapacitation in the country has been a way to exercise other types of violence against these women, such as sexual violence (protection of abusers and exposure of women), psychological violence (coercion, blackmail, subjugation, removal of custody of children, threats, annulment of self-determination), economic violence (removal of patrimony, generating economic dependence), institutional violence (civil death, removal of the right to vote), among other forms of violence:

There are families that use incapacitation with other interests, for economic reasons, a way to control the person, there are cases of marriages in the process of divorce and husbands threatening their wives to incapacitate them in order to take away their children or their patrimony. We have found that the family continues to be the main protector, but also the main focus of violence. (E2, activist)

National and international legal frameworks

They emphasize the existence of an insufficient international framework on disability and sexual and reproductive rights. In addition, they point out the existence of national laws without awareness, with low prioritization and budget at the national level, which hinders their implementation. In the country, they recognize the presence of a Criminal Code that denies rights by modifying the legal capacity of these women, endorsing the forced sterilization procedure:

Honestly, I would like to think that there has been a before and an after [on the creation of legal instruments on disability], but I think that they have not had so much relevance, that still, especially in the case of legally incapacitated persons, the family makes the decisions for them. And there is no one to watch over those decisions whether they are consensual or not. (E14, researcher)

Sexual violence

The 3 groups of informants emphasize the presence of sexual violence against women and girls with disabilities, pointing out its high frequency, despite the lack of official statistics. They recognize them as crimes that have no visible consequences, occasionally only demonstrated by sexually transmitted diseases, with a low rate of denunciation. It is a violence that goes undetected and unpunished for abusers. They recognize that institutionalization often tolerates this type of abuse:

Well, this has happened in [name of institution] [...] it makes my hair stand on end, because I lived it, I was in a judgment of an auxiliary who had sexual relations with a woman with intellectual disability, with behavioral problems. (E10, professional)

Educational deficit in the sexual and reproductive rights of women with disabilities

They identify that the State has not assumed responsibility for covering this need and that the approach to the issue is unequal for the Spanish population, because decision-making is carried out in isolation by each autonomous community, and each association linked to disability does the same. These women and girls are more exposed to the risk of contracting sexually transmitted diseases, unwanted pregnancies, abuses and rights violations in general, as they do not have the educational tools to face sterilizations:

In the absence of good training you put the girls in the firing line, you make them very vulnerable to all kinds of abuses. It affects us because we are not doing prevention of these abuses, and more so for women with disabilities... So without a doubt, that's not

going to change their vulnerability and maybe it will increase it, they are a very easy target. Only the most immediate consequence is prevented. (E17, researcher)

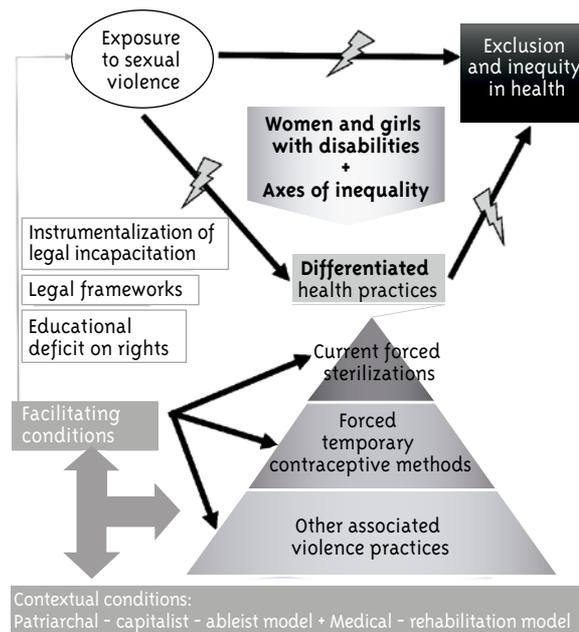
They warn that professionals involved in the care of this group are also unaware about these issues, as can be seen in the following excerpt:

In this [occupational] center there are users with legal incapacitation, but I don't know how this issue is handled. It is a topic that I have not touched on, because many women see their sexual options restricted. This is a topic that is not mentioned because our users do not have sexual relations. (E8, professional)

Explanatory-relational model of speeches

As a final stage of the analysis, the model of health practices of domination and exclusion of women and girls with disabilities emerges (Figure 1). This model suggests that the central phenomenon of forced sterilization in current Spanish society, carried out alongside measures of forced temporary contraception and other associated practices of violence, is distinguished by the informants as differentiated health practices, directed at people considered socially different. Given the exposure of the entire population to a social problem such as sexual violence, this type of intervention is exclusive to the group of women and girls with disabilities and, to a greater extent, to those in whom various axes of inequality converge, as was observed in women with disabilities, migrants and undocumented women. Interventions based on the problems revealed in relation to their sexual and reproductive health have been implemented, but instead of solving them, they have aggravated and deepened them. The measures implemented, through processes of medicalization and control of their inferiorized bodies, have controlled and conditioned their sexual and reproductive health, have left women exposed to a greater risk of this and other forms of violence, and have promoted mechanisms of social exclusion and inequities in health and well-being, by depriving them of their fundamental human rights.

Figure 1 – Model of health practices of domination and exclusion of women and girls with disabilities



Discussion

The general objective of this study was to present an analysis of the situation of the practice of forced sterilization in women and girls with disabilities in Spain, based on the speeches of representative women linked to this group. According to their vision, the sexuality and reproduction of women with disabilities in the country has been expropriated, alienated and disregarded by systems, structures and policies, with little transfer of the global framework of human rights to the daily reality of the group. Meanwhile, sexual violence has gone unnoticed, becoming naturalized by the environment with the use of interventions that have not focused on those who commit and continue to exercise sexual violence and still remain unpunished, but on the contrary, focusing on the attacked women and girls, by limiting their reproductive capacity. This is consistent with those who argue that public health has focused on changing behaviors rather than changing the environments in which the behaviors are necessary for survival, and intervention approaches often demonstrate a tendency to blame the victims (Castle et al., 2019).

These findings allow us to visualize the presence of exclusion dynamics that operate in different areas (health, education, social, legal, judicial) demonstrating the existence of rationalities based on the hierarchization of different forms of inequality (gender, disability and age in interaction with social determinants such as belonging to an ethnic group, limited access to information, poverty, immigration, marginality, among others), which justify the generation of policies that reproduce inequality, materializing in the health practices of domination and exclusion studied. It is observed that these constitute the last link in a web of antagonistic logics that underlie their contextual and facilitating conditions. This dichotomous understanding of practices is seen through multiple dimensions of the discourses: recognition vs. non-recognition, varying from a recognition of the application of forced procedures to their non-recognition or use of the connotation 'forced', as accepted health care benefits; destruction vs. preservation, the destruction of sexual and reproductive capacity is justified for the purpose of preserving the integrity of the person and her family; dimension of abandonment vs. protection, where the exposure of these women and girls to sexual violence is protected by institutional solutions that abandon them completely. However, according to the situation analyzed, these contradictions tend to favor non-recognition, destruction, abandonment and, therefore, social exclusion. According to the approach of Santos (2007) and Oliveira (2018), this situation fits what is defined as a manifestation of racism, an element that, when used as a biopolitical device, collaborates in the understanding of differentiated policies according to various economic, social, ethnic, gender, and other divisions. In other words, racism as a social determinant of health, acting through discriminatory practices in a marginalized population (Castle et al., 2019). These findings are consistent with the literature that denounces inequity in access to health services by the population with disabilities in Spain, mostly perceived by women (Hernández; Jiménez, 2011); and with studies that suggest that those who are socially excluded are attributed little social value and are denied the enjoyment of opportunities available

to others, including the enjoyment of good health (Tamayo; Besoain; Rebolledo, 2018).

The limitations of this study point to its difficulties for the generalization of its results, according to its qualitative characteristics and the high rate of rejection of the invited participants, which implies continuing to investigate the issues discussed here, such as the sexual and reproductive rights of this group and contribute to the development of knowledge in the field of violence against women. However, as this is a situation that is replicated in other parts of the world, it should be considered an issue of international public health relevance. Its strength lies in its contribution to cover the existing research gap on the subject, and disseminating this knowledge helps to raise awareness of a health practice considered to be a type of violence against women and girls that is scarcely visible and occurs worldwide. The importance of these findings involves health professionals, institutions and decision makers from different places, who have the obligation to move towards the eradication of health practices of violence against women and the promotion of more equitable and socially fair practices.

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Authors' contribution

Yupanqui-Concha and Ferrer-Perez were responsible for the conception and design of the study. Data collection was carried out by Yupanqui-Concha. All of the author team contributed to the data analysis, the theoretical discussion of the results and the production of the final manuscript.

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