



UNITED STATES

Detained and Dismissed

Women's Struggles to Obtain Health Care
in United States Immigration Detention

HUMAN
RIGHTS
WATCH



Detained and Dismissed

Women's Struggles to Obtain Health Care in United States Immigration Detention

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I. Summary

In January 2008, women in the custody of US Immigration and Customs Enforcement (ICE) in a county jail in Arizona wrote a letter. Addressed to an immigration attorney and copied to Human Rights Watch, the letter detailed conditions at the jail, including obstacles to medical care, and summarized some of the responses the women received when they pressed for needed care:

Medical care that is provided to us is very minimal and general.... If you do not speak English, you cannot fuss, the only thing you can do is go to bed & suffer.... We have no privacy when our health record is being discussed.... When we've complained to the nurses, we get ridiculed with replies like: "You should have made better choices ... ICE is not here to make you feel comfortable ... our hands are [tied] ... Well, we can't do much you're getting deported anyway ... learn English before you cross the border ... Mi casa no es su casa.".... Our living situation is degrading and inhuman.¹

These women are not alone. Most immigration detainees in the United States are held as a result of administrative, rather than criminal, infractions, but the medical treatment they receive can be worse than that of convicted criminals in the US prison system. The inspector general's office at the Department of Homeland Security (DHS) has issued two reports in the past three years criticizing medical treatment at immigration detention facilities. Deaths in custody attributed to egregious failures of medical care have received prominent media attention and a University of Arizona study in January 2009 described failures of medical care for women detained at facilities in that state.

Underlying the individual stories of abuse and mistreatment is a system badly in need of repair, recent reforms notwithstanding. This report, based on interviews with women detainees, immigration officials, and visits to nine different facilities in three states, addresses one important component of the needed change: the medical care available to women detainees. As detailed below, we found that ICE policies unduly deprive women of basic health services. And even services that are provided are often unconscionably delayed or otherwise seriously substandard.

¹ Letter from "The Female Detainees," Pinal County Jail, Florence, Arizona, to Christina Powers, Attorney, Florence Immigrant and Refugee Rights Project, January 2008.

Abuses documented in this report range from delays in medical treatment and testing in cases where symptoms indicate that women's lives and well-being could be at risk, to the shackling of pregnant women during transport, to systematic failures in provision of routine care. As the letter from the women immigration detainees in Arizona concluded, ICE healthcare standards are "not in line with international standards to ensure that detainee rights are protected." We join in the women's appeal for change.

* * *

The number of individuals held in administrative detention while their immigration cases are determined has skyrocketed in recent years. The detained population on any given day is now over 29,000 nationwide, up almost 50 percent from 2005. ICE holds the majority of them in state and county jails contracted to provide bed space and other basic custodial services, including medical care. As civil—not criminal—detainees, these individuals have no right to be provided an attorney by the government while it holds them for an uncertain period pending the outcome of their immigration case.

Every one of these individuals has health care rights and needs. Unfortunately, the system for providing health care to detained immigrants is perilously flawed, putting the lives and well-being of more and more people at risk each year. While the immigration detention system's flawed medical care affects both men and women, this report focuses on the situation of women detainees, roughly 10 percent of the overall immigration detainee population at any given time. These women include refugees fleeing persecution, survivors of sexual assault, pregnant women, nursing mothers separated from their children, patients detained amidst treatment for cancer, and many more women who have needs for basic medical care.

Many women in the United States continue to struggle with finding ways to access basic medical care. But for the thousands of women in immigration detention, there is only one way to get a Pap smear to detect cervical cancer, undergo a mammogram, receive pregnancy care, access care and counseling after sexual violence, or simply obtain a sufficient supply of sanitary pads: through ICE. In custody without other options, women receive care through ICE or are forced to go without.

In interviews with detained and recently detained immigrant women, Human Rights Watch documented dozens of instances where women's health concerns went unaddressed by facility medical staff, or were addressed only after considerable delays.

- We met women who were denied gynecological care or obtained it only after many requests, including a woman who entered detention shortly after receiving news of an abnormal Pap smear. She told detention authorities that her doctor instructed her to get Pap smears every six months, but after 16 months in detention and many requests, she had still not gotten a Pap smear.
- We met women who were refused hormonal contraceptives during detention, including one who had inflamed ovaries and endured excruciating, heavy periods when the detention facility refused to provide her the birth control pills prescribed to manage her condition.
- We met women who, according to standards of medical practice in the United States, should have received mammograms, including one woman who had breast cancer surgery before detention and was instructed to get mammograms every six months. Due for her six-month check-up when she was detained, she waited four months for her first mammogram during detention, and did not receive another in her remaining 12 months there.
- We met women who complained of inadequate care during pregnancy, including one diagnosed with an ovarian cyst threatening her five-month pregnancy shortly before she was detained. Her doctor said the cyst should be monitored every two to three weeks, but during her stay in detention of more than four weeks, she was never able to see a doctor. The medical staff's response to her last sick call request read, "be patient."
- We met mothers who were nursing their babies prior to detention and were then denied breast pumps in the facilities, resulting in fever, pain, mastitis, and the inability to continue breastfeeding upon release.
- We met women who had to beg, plead, and in some cases work within the facility just to get enough sanitary pads not to bleed through their clothes, and one woman who sat on a toilet for hours when the facility would not give her the pads she needed.

Certain themes arose again and again in our interviews and demand attention. Detained women did not have accurate information about available health services. Care and treatment were often delayed and sometimes denied. Confidentiality of medical information was often breached. Women had trouble directly accessing facility health clinics and persuading security guards that they needed medical attention. Interpreters were not always available during exams. Security guards were sometimes inside exam rooms, invading privacy and encroaching on the patient-provider relationship. Some women feared retaliation or negative consequences to their immigration cases if they sought care. A few were not given the option to refuse medication or received other inappropriate treatment.

Full medical records were not available when the detained women were transferred or released. Written complaints about medical care through facility grievance procedures went ignored. The list goes on.

Official ICE policy, which focuses on emergency care and keeping the individuals in its custody in deportable condition, effectively discourages the routine provision of some basic women's health services. ICE's Division of Immigration Health Services (DIHS) has chief responsibility for the medical care provided to detained immigrants, whether it provides those services directly or through a contractor at a local facility. The DIHS Medical Dental Detainee Covered Services Package, which governs access to off-site specialists, says that requests for non-emergency care will be considered if going without treatment in custody would "cause deterioration of the detainee's health or uncontrolled suffering affecting his/her deportation status." Although, on occasion, officials have offered generous interpretations of this policy in its defense, the message about the scope of care provided remains clear. "We are in the deportation business.... Obviously, our goal is to remove individuals ordered removed from our country," ICE spokesperson Kelly Nantel told a reporter in June 2008. "We address their health care issues to make sure they are medically able to travel and medically able to return to their country."²

The Covered Services Package operates in tandem with ICE's national standards for its detention facilities, which include a medical care standard that was revised in September 2008 (the new medical care standard will not take full effect until 2010). While the new medical care standard provides that "detainees will have access to a continuum of health care services," there is no detention standard specific to women or their health needs. The new standard mentions women's health care only briefly, specifying merely that women will have access to prenatal and postnatal care and that detained individuals will have access to "gender-appropriate examinations."

When the US government chooses to take thousands of immigrants into its custody—which is itself a highly contentious and costly course of action—it necessarily assumes responsibility for providing adequate health care to those individuals. This may pose challenges, but they are not insurmountable. Guidance on health care in custodial situations, including care for women, is readily available from a range of US and international sources, including the American Public Health Association's *Standards for Health Services in Correctional Institutions* and the National Commission on Correctional Health Care's

² Caitlin Weber, "ICE Officials' Testimony on Detainee Medical Care Called into Question," *CQ Politics*, June 16, 2008, <http://www.cqpolitics.com/wmspage.cfm?docID=hsnews-000002898081> (accessed February 25, 2009).

Standards for Health Services in Jails. As this report details, ICE practice falls short of many of these standards.

The revised ICE medical standard contains important improvements, but much more remains to be done to develop adequate policies, ensure their proper implementation, and open up the detention system to effective oversight.

As a start, the government should take immediate steps to address the fundamental policy flaws that limit access to medical care for all immigration detainees. We recommend:

- To DIHS: Amend the Covered Services Package to remove inappropriate consideration of an individual's deportation prospects in determining eligibility for medical procedures and harmonize the package with the revised ICE medical standard so that detained individuals can access a full continuum of health services, whether available inside or outside the detention facility.
- To ICE: Require all facilities holding individuals on behalf of ICE to maintain accreditation with the National Commission on Correctional Health Care.
- To DHS: Convert the ICE detention standards, including the ICE medical standard, into federal administrative regulations so that they have the force of law and detained individuals and their advocates have recourse to courts to redress shortfalls in health care.

Further, to address the glaring gaps in ICE policy regarding women's health concerns, we recommend:

- To ICE: Implement the recommendations of the UN special rapporteur on the human rights of migrants, including in particular the recommendations that ICE develop gender-specific detention standards with attention to the medical and mental health needs of women survivors of violence and refrain from detaining women who are suffering the effects of persecution or abuse, or who are pregnant or nursing infants.
- To ICE: Incorporate into the ICE medical standard the American Public Health Association's standards on women's health care in correctional institutions and the recommendations of the National Commission on Correctional Health Care's policy statement on women's health care.
- To ICE and DIHS: Establish a formal process for ICE officers charged with case management to coordinate with health services personnel to ensure that nursing mothers, pregnant women, and other women with significant health concerns are immediately identified and considered for parole.

Finally, to meet its obligations and make real improvements in medical care for women in immigration detention, the government should aggressively pursue better implementation and oversight of its policies, beginning with the following steps:

- To ICE and DIHS: Conduct intensive outreach to facilities to ensure that both health professionals and security personnel are aware that the men and women in their custody are entitled to the same level of medical care as individuals who are not detained and assure health professionals that ICE and DIHS policies are intended to support and not inhibit their delivery of care consistent with standards of medical practice in the United States.
- To ICE: Improve the current system for receiving and tracking complaints made by individuals in ICE custody. Ensure that all individuals receive notice of complaint procedures in their native languages and that they are informed of the availability of these mechanisms for addressing medical care complaints.
- To DHS: Require detention facilities to provide regular reports to the DHS Office of Inspector General detailing the number of grievances received regarding medical care and their disposition at the facility level.

II. Methodology

This report is based primarily on interviews conducted by Human Rights Watch in the United States in 2008 with individuals possessing direct knowledge of the medical care provided to women in immigration detention. Our research included consultations with legal and health service providers and immigration policy experts, and a review of relevant published materials. The research also included interviews with 48 women detained by Immigration and Customs Enforcement (ICE) (34 of whom were in detention when we interviewed them and 14 who had been detained for some period of time since the formation of ICE in 2003); 17 detention officials and health services administrators; and two off-site specialists contracted to provide prenatal and gynecological services to women in ICE custody.

In these interviews and visits to nine detention facilities, Human Rights Watch investigated care for a range of women's health concerns and collected information regarding each type of facility where ICE policies govern health care: service processing centers operated directly by ICE, contract detention facilities managed by private companies, and state and county jails contracted through intergovernmental service agreements. On October 30, 2008, we met with officials at ICE headquarters to share our preliminary findings, clarify a number of medical care policies, and discuss ICE's plans for health services going forward.

Human Rights Watch informed ICE of our intent to carry out this and two other research projects in February 2008 and entered into discussions with ICE officials regarding the parameters of our access to detention facilities.³ ICE asked Human Rights Watch to propose a schedule of facility visits that were to include a tour and private interviews with detained individuals identified by Human Rights Watch in advance of the visit. In selecting the facilities for this research project, Human Rights Watch sought to identify states with a high concentration of women in detention, examples of each of the types of facility referenced above, and local legal service providers and other partners able to identify women willing to talk about their detention experience. On the basis of these criteria, we identified ten facilities in Florida, Texas, and Arizona.⁴ With the exception of one facility visit, ICE

³ In addition to this project, Human Rights Watch undertook research on two other topics related to immigration detention in the US: transfers within immigration detention and parole of asylum seekers under a policy directive introduced in November 2007. Research into the other subjects was conducted by other researchers, and included visits to certain facilities identified for this project as well as other facilities.

⁴ The ten facilities were Broward Transitional Center, Pompano Beach, Florida; West Palm Beach County Jail, West Palm Beach, Florida; Glades County Jail, Moore Haven, Florida; Monroe County Detention Center, Key West, Florida; South Texas Detention Complex, Pearsall, Texas; Willacy Detention Center, Raymondville, Texas; Port Isabel Service Processing Center, Los Fresnos, Texas; Eloy Detention Center, Eloy, Arizona; Pinal County Jail, Florence, Arizona; and Central Arizona Detention Center,

accommodated the requests for visits to these facilities and arranged for them on the dates we specified.⁵ It should be noted that Human Rights Watch adopted this methodology to enhance the breadth and depth of the research but we did not conduct a scientific sampling and we do not contend that generalized conclusions about conditions at ICE facilities nationwide can be drawn on the basis of our findings.

While the bulk of the interviews for this report were conducted at detention centers between April 7 and May 2, 2008, in accordance with the schedule of announced facility visits negotiated with ICE, Human Rights Watch arranged further interviews with women released from detention, community service providers, and local activists during the same period. In addition, in June, July, and August 2008, we interviewed six formerly detained women in the Washington, DC and New York metropolitan areas. Follow-up research continued through February 2009 and included meeting with ICE and DIHS and examining materials obtained through a request submitted to ICE under the Freedom of Information Act.

Our main method for reaching women willing to speak with us, whether currently or formerly detained, was through legal service providers, who discussed our project with women they identified as possibly having information relevant to our research. However, with more than 80 percent of individuals in detention unrepresented, many women were simply beyond our reach. Also, fear among women that speaking with us about detention conditions could adversely affect their immigration status led some to decline an interview.

ICE had no input in identifying which women would be interviewed for this research. However, an ambiguous limitation imposed by ICE regarding the number of interviews and shifting requirements for documentation of the individuals' consent to be interviewed proved obstructive. Shortly before the start of the first trip, ICE introduced a limit of 12 on the number of individuals in custody who could be interviewed, without indicating whether this limit applied per facility, per day, per state, or per Human Rights Watch project. Despite efforts to clarify this issue, the limit became a major impediment, as each ICE field office varied in its application of the limit set by headquarters, and none permitted us to interview more than 12 detained individuals per facility for all three projects. Further, the field offices

Florence, Arizona. We also visited and talked with health care providers at Krome Service Processing Center in Miami, Florida. Krome, which does not hold women, provided a point of comparison for our visits to the other facilities. In later research conducted separately from the agreement with ICE, we visited an additional county jail in New Jersey that holds women in ICE custody.

⁵ ICE informed Human Rights Watch that West Palm Beach County Jail in Florida declined the visit. No explanation for the refusal was given. Because the jail is designated by ICE to hold individuals for less than 72 hours, it is not subject to the detention standards. However, Human Rights Watch had requested the visit upon hearing that individuals in ICE custody did in fact spend more than 72 hours at the jail and that conditions there were especially poor.

imposed different requirements regarding the form in which the individuals, and sometimes their lawyers, were to demonstrate their consent to the interviews. They also required up to five business days notice for the list of interviewees, a particularly impractical demand given the transience of the immigration detention population.

As noted above, of the 48 women who spoke with Human Rights Watch about their experience with medical care in immigration detention, 34 were in ICE custody at the time of their interview; the other 14, all of whom had been detained for some period of time since the formation of ICE in 2003, had been released from custody and were living in the US. The length of time the women had spent in ICE custody varied considerably, from less than 24 hours to over two-and-a-half years. The backgrounds of the women interviewed also varied in terms of the length of time they had spent in the US, the manner in which they had come to be in ICE custody, and their countries of origin, although 29 of the 48 came from Latin America and the Caribbean. No one below the age of 18 was interviewed for this report, and the majority of the women were in their 20s or 30s.

Human Rights Watch conducted an individual interview with each woman. With the exception of two, the interviews at detention centers took place in a room in which only the woman, the Human Rights Watch interviewers, and any interpreters were present. In two cases, the interviews were conducted in a corner of a large room in which other detained women were present but out of earshot. In a single instance, one woman we interviewed interpreted for another woman in a subsequent interview with the second woman's express consent. Human Rights Watch met with women who had been released from detention in a variety of locations selected for their comfort and privacy. In four cases, family members of the women were present at the request of the interviewee for all or a portion of the interview and in one case a woman's lawyer participated in the interview. The primary interviewers for this project were women; however, due to logistical constraints, a male colleague pursuing a separate line of research was present for several of the interviews.

The interviews ranged in length from 15 minutes to almost four hours; most lasted approximately one hour. Interviews were conducted in English or in Spanish, and, in one case, in French. They began with a discussion of the purpose of the interview and an explanation that participation was entirely voluntary and could be stopped at any time. Where appropriate, Human Rights Watch attempted to provide contact information for other organizations offering legal, counseling, or social services. No one received or was promised any material compensation for their participation. To protect their privacy and alleviate concerns regarding retaliation, Human Rights Watch assured women that their real names and the potentially identifying details of their interview would not appear in this report. For

this reason, the names of all women interviewed for this report have been replaced with pseudonyms (in the form of names and initials which do not reflect real names) and the exact date and precise location of the interviews have been withheld.

III. Background

The women whose accounts appear in this report are among a growing number whose physical and mental health are at risk as a result of the US government's increasing reliance on detention as a means of immigration law enforcement. Between December 2005 and May 2008, the number of individuals in the custody of Immigration and Customs Enforcement on any given day shot up almost 50 percent, from 19,562 to 29,340,⁶ giving ICE the distinction of overseeing the fastest growing form of incarceration in the US.⁷ For the fiscal year that ended on September 31, 2007, ICE reported that it had held more than 320,000 people in its custody for various lengths of time over the course of that single year.⁸

As the number of people detained has increased, the number of women detained has risen as well. In fact, the proportion of the detention population made up by women increased from approximately 7 percent in 2001 to 10 percent in 2008.⁹ Detained for alleged violations of US immigration law, these women include asylum seekers,¹⁰ undocumented immigrants,¹¹ legal permanent residents convicted of certain crimes,¹² refugees resettled by the US who

⁶ US Department of Justice, "Prisoners in 2006," *Bureau of Justice Statistics Bulletin*, December 2007, p.9; Email communication from Kendra Wallace, national outreach coordinator, Office of Policy, Immigration and Customs Enforcement (ICE), to Tara Magner, director of policy, National Immigrant Justice Center, and co-chair, ICE-NGO Working Group, May 14, 2008.

⁷ Margaret Talbot, "The Lost Children," *The New Yorker*, March 3, 2008, p. 58.

⁸ This figure from the 2007 fiscal year was the most recent available. Testimony of Gary Mead, deputy director, Office of Detention and Removal Operations, ICE, before the US House of Representatives Judiciary Committee, Subcommittee on Immigration, Citizenship, Refugees, Border Security and International Law, February 13, 2008, <http://judiciary.house.gov/hearings/pdf/Mead080213.pdf> (accessed October 2, 2008), p. 2.

⁹ Wendy Young, director of government relations, Women's Commission for Refugee Women and Children, testimony before the House Judiciary Committee, Subcommittee on Immigration, May 3, 2001, <http://www.loc.gov/law/find/hearings/pdf/00092836976.pdf> (accessed October 6, 2008), p. 26; email communication from Kendra Wallace, May 14, 2008.

¹⁰ In the 2006 fiscal year, 5,761 asylum seekers were detained. Alison Siskin, Congressional Research Service (CRS), "Health Care for Noncitizens in Immigration Detention," June 27, 2008, http://assets.opencrs.com/rpts/RL34556_20080627.pdf (accessed October 2, 2008), p. 19.

¹¹ Mere presence in the US without documents is an administrative violation, not a criminal offense. Entering without proper documentation can be a criminal offense. See CRS, "Health Care for Noncitizens in Immigration Detention," p. 3, n. 9.

¹² As of December 31, 2006, approximately 42 percent of the individuals in immigration detention were facing deportation proceedings due to past criminal convictions. US Government Accountability Office (GAO), "Alien Detention Standards: Telephone Access Problems Were Pervasive at Detention Facilities; Other Deficiencies Did Not Show a Pattern of Noncompliance," GAO-07-875, July 2007, <http://www.gao.gov/new.items/do7875.pdf> (accessed October 2, 2008), p. 48. Human Rights Watch has documented the harmful impact on families and communities in the US of the policy of mandatory deportation for non-citizens with criminal convictions, including minor, non-violent offenses. See Human Rights Watch, *United States - Forced Apart: Families Separated and Immigrants Harmed by United States Deportation Policy*, vol. 19, no. 3(G), July 2007, <http://hrw.org/reports/2007/us0707/>.

did not apply for permanent residency,¹³ and even US citizens whose citizenship the government disputes.¹⁴

The dramatic increase in the detention of immigrants can be traced back to several policy developments of the past 13 years. These include the passage in 1996 of the Illegal Immigration Reform and Immigrant Responsibility Act, which expanded mandatory detention during removal¹⁵ proceedings for individuals convicted of certain crimes;¹⁶ the events of September 11, 2001, and the subsequent emphasis on border security and immigration law enforcement; the broader detention powers ushered in by the USA PATRIOT Act;¹⁷ and an expansion in the use of expedited removal for undocumented individuals apprehended at a port of entry or within a certain distance of the border.

The Immigration Detention System

ICE detains individuals at over 500 facilities nationwide.¹⁸ The facilities fall into four categories: service processing centers operated directly by ICE; contract detention facilities managed by private companies such as the GEO Group and Corrections Corporation of America; state and county jails that ICE has contracted with through intergovernmental service agreements; and facilities run by the federal Bureau of Prisons. Eight of the facilities used by ICE are service processing centers, 7 are contract detention facilities, and more than 500 are state and county jails.¹⁹ This report does not address conditions at the few Bureau of Prisons facilities used because they are separately regulated.

¹³ Memorandum from Bo Cooper, general counsel, Immigration and Naturalization Services (INS), US Department of Justice, to Michael Pearson, executive associate commissioner for field operations, INS, and Jeffery Weiss, director, Office of International Affairs, INS, November 9, 2001 (outlining the government's authority to detain refugees who do not adjust status).

¹⁴ An unpublished 2006 report by the Vera Institute of Justice identified 125 people in immigration detention whose lawyers believed they had valid citizenship claims. Marisa Taylor, "Immigration officials detaining, deporting American citizens," *McClatchy Newspapers*, January 24, 2008, <http://www.mcclatchydc.com/227/story/25392.html> (accessed October 2, 2008). But see, Congressional testimony of Gary Mead, February 13, 2008, p.9 (asserting that ICE has never knowingly or intentionally detained a US citizen).

¹⁵ In the immigration law context, "removal" is synonymous with deportation.

¹⁶ Illegal Immigration Reform and Individual Responsibility Act, Pub.L. 104-208, Div. C, Title III, §§ 303(a), 371(b)(5), 110 Stat. 3009-585, 3009-645 (1996), 8 U.S.C.A. § 1226 (West 2008).

¹⁷ USA PATRIOT Act, Pub.L. 107-56, Title IV, § 412(a), 115 Stat. 350 (2001), 8 U.S.C.A. § 1226a (West 2008).

¹⁸ US Government Accountability Office (GAO), "DHS: Organizational Structure and Resources for Providing Health Care to Immigration Detainees," GAO-09-308R, February 23, 2009, <http://www.gao.gov/new.items/d09308r.pdf> (accessed March 9, 2009), p. 14.

¹⁹ Ibid; "First semiannual report on compliance with ICE national detention standards released," ICE news release, May 9, 2008, <http://www.ice.gov/pi/news/newsreleases/articles/o80509washington.htm> (accessed October 6, 2008).

To be eligible to hold women, ICE facilities need only establish that they can maintain physical and visual separation of the sexes. Even though they constitute only 10 percent of the immigration detention population, women are spread out over 300 plus facilities. However, 50 percent of the women detained by ICE are held in ten facilities, half of which are located in Texas.²⁰ ICE holds 68 percent of the women in its custody in state and county jails, 25 percent in contract detention facilities, and just 7 percent in the service processing centers run by ICE.²¹ State and county jails have greater latitude to stray from compliance with certain provisions of the ICE detention standards.²² In addition, the remoteness of some of these facilities may be detrimental to individuals' access to counsel and family members.

While "enforcement" stands out as the preeminent watchword of the current political discourse on immigration, detention is often not a proportional, necessary, or cost-effective response to immigration violations, most of which are administrative, not criminal, infractions.²³ Under US and international law, the government's infringement of fundamental rights, such as the right to liberty, for punitive purposes must be proportional to the acts punished.²⁴ Although the US considers immigration detention to be administrative rather than punitive, its effects—confinement, separation from family, loss of livelihood, among others—may serve in fact to punish harshly those detained, particularly those held for extended periods of time. Further, alternative methods for ensuring that individuals appear for their immigration hearings and comply with the final rulings in their cases have proven successful, with supervised release programs reporting upwards of 90 percent of participants appearing for their hearings.²⁵

²⁰ The ten facilities housing 50 percent of the women detained by ICE are: South Texas Detention Complex, Pearsall, Texas; Broward Transitional Center, Pompano Beach, Florida; Willacy Detention Center, Raymondville, Texas; Pinal County Jail, Florence, Arizona; T. Don Hutto Family Residential Facility, Taylor, Texas; Etowah County Jail, Gadsden, Alabama; San Diego Detention Facility, San Diego, California; Houston Contract Detention Facility, Houston, Texas; Northwest Detention Center, Tacoma, Washington; and Port Isabel Service Processing Center, Los Fresnos, Texas. Email communication from Kendra Wallace, May 14, 2008.

²¹ Email communication from Kendra Wallace, May 14, 2008.

²² The new ICE medical standard reads: "*Procedures in italics are specifically required for SPCs and CDFs.* IGSA's must conform to these procedures or adopt, adapt or establish alternatives, provided they meet or exceed the intent represented by these procedures." ICE/DRO [Detention and Removal Operations] Detention Standard No. 22, "Medical Care," December 2, 2008, http://www.ice.gov/doclib/PBNDs/pdf/medical_care.pdf (accessed February 23, 2009), p. 1. Similar language appears in the old standard. INS Detention Standard, "Medical Care," September 20, 2000, <http://www.ice.gov/doclib/pi/dro/opsmanual/medical.pdf> (accessed February 26, 2009).

²³ As stated in footnote 11, mere presence in the US without documents is an administrative violation, not a criminal offense.

²⁴ For a full discussion of the principle of proportionality, see Human Rights Watch, *United States - Forced Apart: Families Separated and Immigrants Harmed by United States Deportation Policy*, vol. 19, no. 3(G), July 2007, <http://hrw.org/reports/2007/us0707/>, pp. 52-56.

²⁵ For example, from 1997 to 2000 the Vera Institute of Justice cooperated with the Immigration and Naturalization Service, a predecessor to ICE, to pilot an alternative to detention model called the Appearance Assistance Program. Through the AAP, individuals in immigration proceedings participated in a supervised release system wherein they regularly reported to a case

Supervised release programs also offer an alternative to the ballooning costs of detention. In 2008 ICE spent an average \$119.28 per day for each person it holds in a service processing center and can pay upwards of \$100 per day to the state and county jails to which it entrusts the care of individuals in its custody.²⁶ In contrast, a study funded by the government from 1997 to 2000 showed that a supervised release program can be both effective and cost efficient, costing an estimated \$12 per person per day as compared with \$61, then the average daily cost of detention per person.²⁷

Medical Care in Detention

Chief responsibility for the medical care provided to individuals in ICE custody resides with the Division of Immigration Health Services (DIHS). Formerly a component of the Public Health Service within the Department of Health and Human Services, DIHS was detailed indefinitely to ICE in October 2007.²⁸ DIHS retains a commissioned corps of health professionals, including physicians, physician assistants, pharmacists, psychiatrists, and clinical social workers. The division is headquartered in Washington, DC, where the national office sets policy for the detention medical care system. However, of the more than 500 facilities, DIHS personnel provide the on-site medical services at only 21, eight of which are service processing centers run by ICE.²⁹ Investigations conducted in 2007 revealed that staffing at even these 15 facilities poses a challenge, with a 36 percent vacancy rate for medical staff at DIHS facilities nationwide.³⁰ At other facilities, medical care is contracted out

manager and were provided with information on their legal rights and referrals to community resources. The Vera Institute reported that 91 percent of participants in the intensive supervision program appeared for all of their required hearings. Eileen Sullivan, et al., Vera Institute of Justice, "Testing Community Supervision for the INS: An Evaluation of the Appearance Assistance Program," August 1, 2000, http://www.vera.org/publication_pdf/aapfinal.pdf (accessed October 5, 2008), p. ii. A similar undertaking by Lutheran Immigration and Refugee Service focusing on asylum seekers and working with community shelters reported a 96 percent success rate. Esther Ebrahimian, "The Ullin 22: Shelters and Legal Service Providers Offer Viable Alternatives to Detention," Detention Watch Network News, August/September 2000, p.8., quoted in "Statement from Faith Representatives Following April 30 Tour of the Wackenhut Detention Center," House Judiciary Committee, Subcommittee on Immigration, May 3, 2001, <http://www.loc.gov/law/find/hearings/pdf/00092836976.pdf> (accessed October 6, 2008), p.85.

²⁶ Leslie Berestein, "Detention Dollars," *San Diego Tribune*, May 4, 2008, http://www.signonsandiego.com/uniontrib/20080504/news_lz1b4dollars.html; (accessed October 6, 2008); Josh White and Nick Miroff, "The Profit of Detention," *Washington Post*, October 5, 2006, <http://www.washingtonpost.com/wp-dyn/content/article/2008/10/04/AR2008100402434.html?nav=emailpage> (accessed October 6, 2008).

²⁷ Eileen Sullivan, et al., Vera Institute of Justice, "Testing Community Supervision for the INS: An Evaluation of the Appearance Assistance Program," p. 65.

²⁸ Memorandum of Agreement between the Department of Homeland Security and the US Department of Health and Human Services, US Public Health Service, August 23, 2007 [effective on October 1, 2007], cited in CRS, "Health Care for Noncitizens in Immigration Detention," p. 10.

²⁹ CRS, "Health Care for Noncitizens in Immigration Detention," p.8; GAO, "DHS: Organizational Structure and Resources for Providing Health Care to Immigration Detainees," p. 20.

³⁰ "Nationally, contract detention facilities and service processing centers using Public Health Service clinicians had a 36% vacancy rate in October 2007. The contract detention facility in Pearsall, Texas, which housed more than 1,500 detainees the day we visited, had 22 medical staff vacancies. Given its rural location and the nation's high demand for nurses, staff in

along with other detention functions, and may actually be further subcontracted if the facility operator has enlisted the services of a private healthcare company.

DIHS nonetheless regulates the medical care available at all facilities through an ICE detention standard on medical care (ICE medical standard) and the DIHS Medical Dental Detainee Covered Services Package (Covered Services Package). Under this regime, individuals detained by ICE should have access to the same level of care regardless of where they are held. In state and county jails, for example, the individuals held on behalf of ICE should have access to services necessary for meeting the ICE medical standard, regardless of the services available to the criminal population at the jail. Since the services available within individual facilities may vary, ensuring uniform access to services requires providing coverage for services in the community (i.e., outside the jail or other detention facility) where necessary. The Covered Services Package, like an insurance company's statement of covered benefits, governs which services may be provided to individuals in custody at the expense of ICE that are beyond "the contracted minimum scope of services provided by a detention facility."³¹ Pursuant to this arrangement, DIHS must pre-approve any medical care provided outside of the facility, except for emergency services. Where the on-site clinic is small, this may encompass almost all medical services. In order to obtain this pre-approval, the facility's medical providers must submit a Treatment Authorization Request (TAR) to DIHS headquarters.

The TAR process is currently a major weakness in the system that can result in major delays or denials of necessary health care. Both governmental and nongovernmental bodies have criticized DIHS for tracking cost savings from TAR denials and employing only three or four nurses to evaluate TAR submissions from around the country.³² In a 2007 report, the Government Accountability Office (GAO) documented several cases in which facilities encountered difficulties obtaining approval for off-site treatment through this process.³³ A recent Congressional Research Service report found that "between FY2005 and FY2007, expenditures on medical claims [services rendered by an off-site healthcare provider]

Pearsall said that they will endure medical staff shortages indefinitely." Department of Homeland Security Office of the Inspector General (DHS OIG), "ICE Policies Related to Detainee Deaths and the Oversight of Immigration Detention Facilities," June 2008, http://www.dhs.gov/xoig/assets/mgmttrpts/OIG_o8-52_Juno8.pdf (accessed October 8, 2008), p. 33.

³¹ Division of Immigration Health Services, ICE, "DIHS Medical Dental Detainee Covered Services Package," 2005, <http://www.icehealth.org/ManagedCare/Combined%20Benefit%20Package%202005.doc> (accessed October 6, 2008).

³² Amy Goldstein and Dana Priest, "In Custody, In Pain," *Washington Post*, May 12, 2008, http://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc_d2p3.html (accessed October 8, 2008); CRS, "Health Care for Noncitizens in Immigration Detention," pp. 11-12, n. 70.

³³ GAO, "Alien Detention Standards," p.18.

remained almost constant. During the same time, the funded amount of bed space increased by 49%.”³⁴

Healthcare Standards

As mentioned above, health care provided to individuals in ICE custody must meet a national standard for medical care set by ICE. The ICE medical standard is one of a number of standards developed by ICE to govern the operation of the detention system (ICE detention standards).³⁵ In 2008 ICE revised the ICE medical standard as part of a process to update the ICE detention standards and convert them into a “performance-based” format. The new ICE medical standard was issued on September 12, 2008, with limited revisions made on December 2, 2008, but will not be binding on facilities until January 2010. Until then, the old ICE medical standard remains binding. This report refers to the revised standard as “the new ICE medical standard” and the old standard as “the currently binding ICE medical standard.”³⁶

Facility health clinics receive differing messages about the scope of care they should provide or arrange for individuals in ICE custody. The new ICE medical standard provides that “detainees will have access to a continuum of health care services, including prevention, health education, diagnosis and treatment.”³⁷ This builds on the currently binding ICE medical standard, which states that individuals in custody will have access to medical services that promote health and general well-being.³⁸ In marked contrast, however, the Covered Services Package, which regulates the care that ICE will pay for outside the facility, emphasizes only emergency care and treatment to prevent the deterioration of a health condition during the period of custody.³⁹ Given the restricted scope of services available on-

³⁴ CRS, “Health Care for Noncitizens in Immigration Detention,” p. 18.

³⁵ The revised set of ICE detention standards issued in 2008 consists of 41 standards. Prior to the revision, there were 38 ICE detention standards. The revised set includes new standards addressing staff training, sexual assault prevention and intervention, and news media interviews and tours.

³⁶ Currently binding ICE medical standard: INS Detention Standard, “Medical Care,” September 20, 2000; new ICE medical standard: ICE/DRO Detention Standard No. 22, “Medical Care,” December 2, 2008. The title for the currently binding ICE medical standard refers to the INS (Immigration and Naturalization Service), the predecessor to ICE, because the standard was developed prior to the creation of ICE in 2003.

³⁷ ICE/DRO Detention Standard No. 22, “Medical Care,” December 2, 2008, p. 1.

³⁸ INS Detention Standard, “Medical Care,” September 20, 2000, p.1.

³⁹ “The DIHS Medical Dental Detainee Covered Services Package primarily provides health care services for emergency care. Emergency care is defined as ‘a condition that is threatening to life, limb, hearing, or sight’... Other medical conditions which the physician believes, if left untreated during the period of ICE/BP custody, would cause deterioration of the detainee’s health or uncontrolled suffering affecting his/her deportation status will be assessed and evaluated for care.” DIHS Covered Services Package, 2005, p. 1.

site at some facilities, the limitation on off-site care has meant that some individuals have not had access to the continuum of services referenced in the new ICE medical standard.

The focus on emergency care is premised on the assumption that an individual's stay in detention will be brief, despite the fact that individuals may and do spend months or even years in detention. A recent Congressional Research Service report noted that, according to ICE statistics for fiscal year 2006, ICE held 7,000 people for over 6 months during that year.⁴⁰ Asylum seekers, in particular, may spend an extended period of time in custody,⁴¹ and may also be a group with particular medical needs exacerbated by detention.⁴² Access to comprehensive health services is essential for all individuals in custody, and particularly relevant for those detained over a long period.

ICE has no detention standard specific to women or their health needs, and women's health barely receives a mention in the currently binding ICE medical standard, a mere instruction that officers in charge be notified if any woman in custody is pregnant. The new ICE medical standard shows improvements in its requirement of care for prenatal and postnatal women, and its indication that "[d]etainees shall have access to age and gender-appropriate examinations,"⁴³ but without further detail these provisions provide limited assurance that women can expect the care they need. As detailed below, the Covered Services Package likewise reflects a narrow view of women's health care, restricting access to essential cancer screenings and basic components of care such as hormonal contraception.

Monitoring and Enforcement of the Standards

ICE has internal enforcement mechanisms for its detention standards, but since the standards do not constitute formal federal administrative regulations, they are not legally enforceable. Although the standards require ICE officials to visit the facilities on a regular basis, ICE evaluates most detention facilities' compliance with the detention standards with only a single official inspection each year. If the inspection shows the facility is deficient in implementation of one of the standards, the facility must devise a plan of action to remedy

⁴⁰ As of April 30, 2007, ICE reported that 25 percent of all detained aliens were removed/deported within four days, 50 percent within 18 days, 75 percent within 44 days, 90 percent within 85 days, 95 percent within 126 days, and 98 percent within 210 days. GAO, "Alien Detention Standards," p. 48.

⁴¹ Of the 5,761 asylum seekers who were detained in the 2006 fiscal year, 1,559 (27 percent) were detained for more than 180 days. CRS, "Health Care for Noncitizens in Immigration Detention," p. 19.

⁴² See Physicians for Human Rights and the Bellevue/NYU Program for Survivors of Torture, "From Persecution to Prison: the Health Consequences of Detention for Asylum Seekers," June 2003, <http://physiciansforhumanrights.org/library/documents/reports/report-perstoprison-2003.pdf> (accessed October 6, 2008).

⁴³ ICE/DRO Detention Standard No. 22, "Medical Care," December 2, 2008, pp. 16, 18.

the deficiency. Should the facility fail or refuse to fix the problem, ICE may impose penalties as outlined in its contract with the facility or discontinue using the facility.⁴⁴

ICE has undertaken new measures to improve accountability through the use of private inspectors, hiring the Nakamoto Group in 2007 to provide on-site quality control inspectors at the 40 facilities holding the highest number of individuals in ICE custody. Also in 2007, ICE hired the Creative Corrections Corporation to conduct the annual facility inspections. These private companies report their findings directly to ICE, the agency financing their work. ICE also created a new subsection within its Office of Professional Responsibility, called the Detention Facilities Inspection Group, to oversee the annual inspections process.

The quality of ICE inspections is disputed. In 2008, ICE released its first semiannual report on detention standards compliance, which indicates that 98 percent of the 176 facilities evaluated received a rating of acceptable or above for compliance with the medical care standard.⁴⁵ However, an audit conducted by the DHS Office of the Inspector General (OIG) noted discrepancies between reviews of the same facility conducted by ICE and by the Office of the Federal Detention Trustee (OFDT) of the Department of Justice. Where ICE had rated the facility “acceptable,” an OFDT review within six weeks deemed the facility “at risk,” which is the lowest possible rating, two levels below “acceptable.”⁴⁶ Further, the OIG audit found “staff conducting routine oversight of facilities has not been effective in identifying certain serious problems at facilities.”⁴⁷

Since March 2003 at least 85 individuals have died in or shortly after leaving ICE custody.⁴⁸ ICE contentions that the death rate for individuals in its custody has declined and compares favorably to that of the US prison population have been assailed by critics for failing to adjust for the comparatively short, and shrinking, period of time that the average person

⁴⁴ ICE/DRO, “Semiannual Report on Compliance with ICE National Detention Standards: January-June 2007,” May 9, 2008, http://www.ice.gov/doclib/pi/news/newsreleases/articles/semi_annual_dmd.pdf (accessed October 6, 2008), p. 4.

⁴⁵ *Ibid.*, p. 12.

⁴⁶ DHS OIG, “ICE Policies Related to Detainee Deaths and the Oversight of Immigration Detention Facilities,” pp. 12-13.

⁴⁷ *Ibid.*, p. 19.

⁴⁸ Dana Priest and Amy Goldstein, “System of Neglect,” *Washington Post*, May 11, 2008, http://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc_d1p1.html (accessed October 6, 2008); Nina Bernstein, “Ill and in Pain, Detainee Dies in U.S. Hands,” *New York Times*, August 12, 2008, http://www.nytimes.com/2008/08/13/nyregion/13detain.html?_r=1 (accessed February 16, 2009); Nick Miroff, “ICE Facility Detainee’s Death Stirs Questions,” *Washington Post*, February 1, 2009, <http://www.washingtonpost.com/wp-dyn/content/story/2009/01/31/ST2009013101877.html> (accessed February 16, 2009).

spends in immigration detention.⁴⁹ The DHS Office of Civil Rights and Civil Liberties is responsible for investigating deaths of individuals in ICE custody. The DHS Office of the Inspector General (OIG) has recommended to ICE that it send the OIG reports of all deaths in order to determine the appropriate review process.⁵⁰ This recommendation resulted from the audit mentioned above.

ICE has severely limited its commitments with respect to meeting standards set by professional accreditation bodies. Under the new and currently binding ICE medical standards, state and county jails contracted by ICE are not required to maintain any professional medical accreditation. Service processing centers and contract detention facilities must currently be accredited with the National Commission on Correctional Health Care (NCCHC); however the new ICE medical standard does not include that requirement.⁵¹ The NCCHC is a body with representatives from the Academy of Correctional Health Professionals, the American Psychiatric Association, the American Bar Association, and other professional organizations from the fields of corrections, health care, and law. Maintaining NCCHC accreditation requires an on-site survey of the facility by NCCHC staff health professionals every three years, including a review of medical policies and procedures, as well as interviews with health staff, security personnel, and individuals detained at the facility. The currently binding ICE medical care standard also states that facilities will “strive” for accreditation with the Joint Commission on the Accreditation of Health Care Organizations (JCAHO); however, the new ICE medical standard lacks this provision.⁵²

A Mounting Critique of Immigration Detention Health Care

Stories of women suffering because of delayed or denied health care have emerged amidst a mounting critique of the ICE detention medical system as a whole. Congressional hearings, international inquiries, lawsuits, nongovernmental organization reports, and media coverage have unearthed instances of facilities ignoring sick call requests, not delivering medication, losing medical records, failing to provide translation services, impeding access to specialist care, and outright denying needed treatment.

⁴⁹ Homer D. Venters, M.D., Testimony before the House Judiciary Committee’s Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law, June 4, 2008, <http://judiciary.house.gov/hearings/pdf/Venterso8o6o4.pdf> (accessed October 6, 2008), pp. 2-3.

⁵⁰ DHS OIG, “ICE Policies Related to Detainee Deaths and the Oversight of Immigration Detention Facilities,” p. 5, 14.

⁵¹ INS Detention Standard, “Medical Care,” September 20, 2000, p.1; ICE/DRO Detention Standard No. 22, “Medical Care,” December 2, 2008.

⁵² *Ibid.*

The House Judiciary Committee's Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law held multiple oversight hearings on ICE's detention and removal operations in 2007 and 2008, including two addressing problems in the medical care system. At those hearings, members of Congress heard testimony about instances of delayed and denied care and their consequences from individuals formerly in ICE custody, immigration attorneys, and medical experts. Several bills were introduced in the 110th Congress that, if adopted, would specifically address certain aspects of medical care for individuals detained by ICE.⁵³

Within the Department of Homeland Security itself, the Office of Inspector General has conducted two audits in the last two years that highlighted deficiencies in medical care. The first, published in December 2006, found instances of non-compliance with health care standards at four out of five facilities surveyed. The one facility in full compliance, Krome Service Processing Center in Miami, does not hold women.⁵⁴ More recently, in June 2008, the OIG investigated the handling of deaths in ICE custody and again found various instances of non-compliance with the medical standard, while noting compliance with "important portions" of the standard on deaths in the two individual cases reviewed.⁵⁵ In addition, a 2007 study by the US Government Accountability Office noted weaknesses in ICE's internal monitoring processes.⁵⁶

US immigration detention practices have drawn the attention of the Inter-American Commission on Human Rights and United Nations (UN) human rights experts. In October 2007, the Inter-American Commission held a hearing on detention conditions and, in October 2008, began a fact-finding mission to investigate the treatment of immigrants in detention centers.⁵⁷ The UN Human Rights Committee encouraged the US "to adopt all measures necessary for [the detention standards'] effective enforcement" in its 2006 concluding observations to the US report on its compliance with the International Covenant on Civil and Political Rights.⁵⁸ Further, the UN special rapporteur on the human rights of

⁵³ Detainee Basic Medical Care Act of 2008, H.R. 5950, 110th Cong. (2008); Secure and Safe Detention and Asylum Act, S. 3114, 110th Cong. (2008); Immigration Oversight and Fairness Act, H.R. 7255, 110th Cong. (2008).

⁵⁴ DHS OIG, "Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities," December 2006, http://www.dhs.gov/xoig/assets/mgmttrpts/OIG_07-01_Deco6.pdf (accessed October 10, 2008), p. 1.

⁵⁵ DHS OIG, "ICE Policies Related to Detainee Deaths and the Oversight of Immigration Detention Facilities," p.1.

⁵⁶ GAO, "Alien Detention Standards," p. 39.

⁵⁷ Juan Castillo, "Rights group investigates T. Don Hutto immigrant detention center," *Austin American Statesman*, October 2, 2008, <http://www.statesman.com/news/content/news/stories/local/10/02/1002rights.html> (accessed October 6, 2008).

⁵⁸ United Nations Human Rights Committee, "Consideration of Reports Submitted by States Parties under Article 40 of the Covenant, Conclusions of the Human Rights Committee, United States of America," CCPR/C/USA/CO/3/Rev.1, December 18,

migrants recommended that the US develop gender-specific detention standards with attention to the medical and mental health needs of women survivors of violence and refrain from detaining women who are suffering the effects of persecution or abuse, or who are pregnant or nursing infants. In addition, the rapporteur recommended that mandatory detention be eliminated and that the government issue legally binding standards governing the treatment of individuals in all types of immigration detention facilities, finding the current non-binding standards insufficient.⁵⁹

In a series of legal challenges, immigrants' rights advocates have called for accountability for the shortcomings of the detention medical care system. In June 2007, the ACLU filed suit challenging the constitutionality of delays and other serious shortcomings in critical health services provided at a San Diego contract detention facility.⁶⁰ The suit's plaintiffs included three women, two of whom experienced problems in requesting care for gynecological or breast health issues. Addressing the lack of enforceable standards, Families for Freedom sued in federal court in April 2008 to press its petition for rule-making which requested that the Department of Homeland Security issue formal administrative regulations governing the conditions for individuals in ICE custody.⁶¹ Both lawsuits are currently pending. April 2008 also saw the US government admit liability for medical negligence in the death of Francisco Castaneda, who died of cancer following months of being denied a biopsy in ICE custody.⁶²

Reporting by nongovernmental organizations and the media has brought forward more facts, adding to the picture of a medical system in trouble. Human Rights Watch issued a report in December 2007 documenting the failure of immigration authorities to care for the health needs of detained individuals living with HIV/AIDS. Human Rights Watch found that ICE fails to consistently deliver medication, conduct lab tests on time, prevent infections, provide access to specialty care, and ensure the confidentiality of medical care.⁶³ In addition, public

2006, <http://daccessdds.un.org/doc/UNDOC/GEN/Go6/459/61/PDF/Go645961.pdf?OpenElement> (accessed October 10, 2008), para. 8.

⁵⁹ UN Human Rights Council, Report of the special rapporteur on the human rights of migrants, Jorge Bustamante, Mission to the United States of America, A/HRC/7/12/Add.2, March 5, 2008, <http://www2.ohchr.org/english/bodies/hrcouncil/docs/7session/A-HRC-7-12-Add2.doc> (accessed October 10, 2008), paras. 110, 113.

⁶⁰ Complaint, *Woods v. Myers*, No. 3:07-CV-01078 (S.D. Cal. June 13, 2007), http://www.aclu.org/pdfs/immigrants/woods_v_myers_complaint.pdf (accessed October 6, 2008).

⁶¹ Complaint, *Families for Freedom v. Chertoff*, No. 1:08-cv-4056 (S.D.N.Y. April 30, 2008), <http://www.aifl.org/lac/chdocs/FFF-complaint.pdf> (accessed October 6, 2008).

⁶² United States of America's Notice of Admission of Liability for Medical Negligence, *Castaneda v. United States*, No. CV07-07241 (C.D. Cal. April 24, 2008).

⁶³ Human Rights Watch, *United States - Chronic Indifference: HIV/AIDS Services for Immigrants Detained by the United States*, Volume 19, No. 5(G), December 2007, <http://hrw.org/reports/2007/us1207/>.

outrage followed a May 2008 investigative report on immigration detention medical care by the *Washington Post*, which described a dysfunctional system plagued by staffing shortages, bureaucratic hurdles to providing care, and dangerous cost-cutting measures.⁶⁴

By the beginning of 2008, reports from advocates working in immigration detention were pointing to serious problems in the care provided to women. Cheryl Little, executive director of the Florida Immigrant Advocacy Center, testified before Congress in October 2007 that women often do not receive regular obstetrical and gynecological care and cited incidents including an ignored ectopic pregnancy, a uterine surgery inexplicably canceled at the last minute, a miscarriage following pleas for help, and an effort by detention personnel to prevent an asylum seeker who had survived rape from obtaining an abortion.⁶⁵ In a briefing paper compiled for the visit of the UN special rapporteur on the human rights of migrants, the National Immigrant Justice Center drew on advocates' knowledge of such incidents and outlined several areas of major concern for women in ICE custody: medical and mental health conditions for victims of violence; medical conditions for pregnant and postnatal women; sexual assault; family separation; and access to counsel.⁶⁶

As research for this report was underway, the treatment of pregnant women in ICE custody came under particular scrutiny. In early July 2008, The *Tahoma Organizer* published a letter alleging mistreatment of pregnant women at the Northwest Detention Center including malnutrition, inadequate bedding, insufficient medical care, shackling during transportation for medical care, and lack of privacy during off-site medical examinations.⁶⁷ A recent study by the University of Arizona's Southwest Institute for Research on Women noted medical care for pregnant women among numerous problem areas documented at facilities in Arizona.⁶⁸

⁶⁴ Dana Priest and Amy Goldstein, "System of Neglect," *Washington Post*, May 11, 2008.

⁶⁵ Cheryl Little, executive director, Florida Immigrant Advocacy Center, Testimony before the House Judiciary Committee, Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law, October 4, 2007, <http://judiciary.house.gov/hearings/pdf/Little071004.pdf> (accessed October 6, 2008), pp. 6-9.

⁶⁶ Briefing paper from the National Immigrant Justice Center to the UN special rapporteur on the human rights of migrants, "The Situation of Immigrant Women Detained in the United States," April 16, 2007, http://www.immigrantjustice.org/component/option,com_docman/Itemid,0/task,doc_download/gid,48/ (accessed October 10, 2008).

⁶⁷ Andrew Bacon, "Pregnant Women Mistreated at the Northwest Detention Center," *Tahoma Organizer*, July 7, 2008, <http://www.tahomaorganizer.org/pregnant-women-mistreated-at-the-northwest-detention-center/> (accessed October 10, 2008).

⁶⁸ University of Arizona Southwest Institute for Research on Women, "Unseen Prisoners: A Report on Women in Immigration Detention Facilities in Arizona," January 2009, <http://sirow.arizona.edu/files/UnseenPrisoners.pdf> (accessed February 25, 2009).

With a growing body of documentation pointing to dangerous flaws in the immigration detention medical care system, calls for reform of the system have multiplied in number and strength. Immigration detention medical care is now a live policy debate. As efforts around reform gather momentum, women's medical needs must be addressed. This report identifies existing gaps in policy and practice and outlines an agenda for the way forward.

IV. Findings: Overarching Problems in the Medical System Affecting Women's Care

In our interviews with currently or recently detained women, Human Rights Watch found that some issues arose repeatedly as impediments to proper care: delays in getting requested medical attention, compromised doctor-patient relationships, unnecessary use of restraints and strip searches, interruptions in care, unwarranted denials of testing and treatment, and ineffective complaint mechanisms. The following section outlines the difficulties women faced at each stage of their attempts to obtain appropriate care.

Delays & Denials of Testing and Treatment

I was starting to go blind. I had complained for 15 days about the blindness. I sent many sick calls. In June 2007 the officers called medical. I could only see shades of people. I couldn't see numbers or letters. An officer asked me, "How come you are always sleeping? You're not like that." They called to inform the doctors (the doctors tell them whether to send us). The officer called and said I was diabetic and needed to be seen. Then the nurse saw me. I told her, "I can't see. I'm blind. It has been 15 days." They checked my sugars. They were 549. The nurse asked, "Why didn't you tell us?" I was about to go into a diabetic coma or have a heart attack because my blood sugar was so high.

—Mary T., Texas, April 2008

Half of the women Human Rights Watch interviewed said they had experienced delays in receiving requested medical care and nearly as many were forced to make repeated appeals to obtain an appropriate response to their medical concerns. Official statements regarding the average response time for sick call requests at individual facilities bore little resemblance to the extended wait times women who spoke with us reported.⁶⁹ The length of the delays ranged from a few days to dispense ibuprofen for a headache to five-and-a-half months to follow up on an abnormal Pap smear. Some requests remained unfilled at the time of the woman's release, including requests for prenatal care that never arrived in a woman's month-and-a-half stay in detention. Giselle M., who could not remember the

⁶⁹ For example, officials at the South Texas Detention Complex said that the longest wait time for sick call was three days. Human Rights Watch interview with Jay Sparks, ICE officer-in-charge, South Texas Detention Complex, Pearsall, Texas, April 21, 2008. In contrast, one woman who was detained there told us she had waited 10 or 11 days to see a doctor regarding painful urination.

number of times she requested a sonogram to monitor a cyst that threatened her pregnancy, said the delay could not be justified: “I know everything is a process but to me there are some things they should be on top of.”⁷⁰

Delays occurred at various points from the initial request to the scheduling of specialist visits to the arrival of medication, and affected treatment for problems of varying severity and complexity. Likewise, the delays resulted in a range of consequences, some of which were not manifest until after the period of detention. In several cases, the delays deterred use of the medical system by people who needed it. After waiting 10 days for an appointment to address burning urination and 15 days to see someone about a growing rash on her face, Meron A. gave up on the sick call procedure: ‘If I have a problem today, I need help today.... That makes me mad, I don’t like to write, I’m not going to say anything.’⁷¹ Similarly, Raquel B. stopped trying to get the facility to dispense the anti-anxiety medication she took outside of detention, even though taking the substitute the facility provided caused her to tremble and prevented her from sleeping. “I’m already tired of asking [to change the medication]. Many times I’ve requested sick call.”⁷²

While less common than delays, outright denials of requested care arose in circumstances of varying gravity, including in the case of a woman with an incapacitating spinal injury that ICE diagnosed as requiring surgery that it refused to provide.⁷³ None of the health service providers we spoke with reported difficulty working within the DIHS managed care system, which requires prior authorization for off-site, non-emergency treatment. However, at least two women were told explicitly by on-site providers that they believed they should receive a certain course of treatment but were prevented from providing it by authorization denials from the managed care unit at headquarters. “[The physician’s assistant] said, ‘We can’t do anything for you. Requests for care are denied by Washington.’ If it was up to him, ‘we would have approved it right away.’ They especially don’t want to provide care if you are awaiting deportation. They probably put my file aside. I can read between the lines.”⁷⁴

Many more women complained about receiving inappropriate or inadequate care for their health concerns. These cases included a woman with gallstones whose symptoms nurses

⁷⁰ Human Rights Watch interview with Giselle M., Arizona, May 2008.

⁷¹ Human Rights Watch interview with Meron A., Texas, April 2008.

⁷² Human Rights Watch interview with Raquel B., New Jersey, May 2008.

⁷³ Human Rights Watch interview with Antoinette L., Arizona, May 2008.

⁷⁴ Ibid.

diagnosed and treated as related to depression until she collapsed,⁷⁵ as well as numerous women who were instructed to drink water for an assortment of maladies, such as intense menstrual cramps. “We call it the magic water,” said Elisa G.⁷⁶

Obstacles to Obtaining Medical Care

In order to bring their health concerns to the attention of an appropriate medical provider, women described having to overcome numerous obstacles, including lack of awareness of available services and the sometimes obstructive role of security personnel and frontline medical staff.

Information

The ability to access information on health services is an obvious prerequisite to obtaining the services themselves, but proves to be far from a simple matter in the detention context. National Commission on Correctional Health Services standards stipulate that information on the availability of health services should be provided orally and in writing to detained individuals on their arrival at a facility, with care taken to ensure it is communicated in a form and language they understand.⁷⁷ The new ICE medical standard and the standard on the admission and release of individuals from detention describe an orientation process where the facility should inform individuals about the available services, including medical care.⁷⁸ As part of the orientation, a “detainee handbook” outlining facility procedures should be provided to each individual who enters custody. In addition, the Division of Immigration Health Services (DIHS) standard intake form contains a check box for the intake examiner to indicate that the patient has been informed how to request medical care. The women who spoke with Human Rights Watch were by and large familiar with the general procedures for requesting care, although a few had received the information from other detained women and did not recall any official guidelines on how to seek care.

More commonly the information gap pertained to the nature and scope of the services available. Giselle M. spent several weeks in discomfort when she was detained during her pregnancy before one of the other women in her unit told her that she should have received

⁷⁵ Human Rights Watch interview with Mary T., Texas, April 2008.

⁷⁶ Human Rights Watch interview with Elisa G., Arizona, May 2008.

⁷⁷ National Commission on Correctional Health Care (NCHC), *Standards for Health Services in Jails 2008* (Chicago: NCHC, 2008), Std. J-E-01, p. 59.

⁷⁸ ICE/DRO Detention Standard No. 22, “Medical Care,” December 2, 2008, p.9; ICE/DRO Detention Standard No. 4, “Admission and Release,” December 2, 2008, http://www.ice.gov/doclib/PBND/standard/admission_and_release.pdf (accessed February 23, 2009), pp.3, 8.

an extra mattress pad for her bed, according to the facility's standard practice. "You don't know your rights," she told Human Rights Watch.⁷⁹ This problem arose even more frequently in relation to services that were not routinely provided. In discussing various health concerns, including abortion, lactation, hormonal contraception, and services for survivors of recent sexual assault, health providers frequently stated that an issue had not come up at their facility, or that a procedure was not standard but could be made available if requested. Women we spoke with who had been released from detention, on the other hand, frequently said that they would have wanted the services had they known they could be obtained in detention.

At Eloy Detention Center in Arizona, for example, Health Services Administrator Lieutenant Commander Melissa George indicated that Tylenol and massage would normally be recommended to nursing mothers but that a breast pump also could be made available.⁸⁰ However, Ashley J., who was detained at Eloy while nursing, told Human Rights Watch that she was not told she could have access to a breast pump and so assumed it was not available. Unable to express her breast milk manually, Ashley experienced great pain when the ducts in her breast clogged. Speaking about the pump and other services, Ashley J. explained, "Sometimes we don't ask. We don't even know these things exist. You believe in part—you almost feel like you are a criminal and the crime is to be illegal."⁸¹

This combination of ignorance of available services and inhibition inspired by detention dynamics points to why the legal onus is on the detention authorities to raise awareness and offer services to the individuals in their custody. Certainly, some individuals will come into detention with a ready knowledge of the services they are entitled to and will not shy away from asking for them, but others—especially those who have never experienced detention before and who may be traumatized or face linguistic or cultural barriers—may not be equipped to do so. Further, relying on the detention grapevine to inform women does not represent a satisfactory substitute for proactive education by facility staff and, in fact, may undermine efforts to provide care.

A key component to making individuals aware of services they need is identifying their medical concerns. DIHS officials told Human Rights Watch that their ability to respond to

⁷⁹ Human Rights Watch interview with Giselle M., Arizona, May 2008.

⁸⁰ Human Rights Watch interview with Lieutenant Commander Melissa George, health services administrator, Eloy Detention Center, Eloy, Arizona, April 30, 2008.

⁸¹ Human Rights Watch interview with Ashley J., Arizona, May 2008. As noted above, individuals in ICE custody are held pending the resolution of their immigration case, which is an administrative, not a criminal, matter.

health concerns depends in large part on what information is conveyed during an individual's initial medical screening and follow up appraisal. However, the new and currently binding ICE medical standards state that that non-medical detention staff can conduct the initial medical and mental health screening.⁸² Even though staff members receive training to perform this function, they will not be as well-equipped as certified medical professionals to identify and respond to pressing health concerns.

Gatekeepers

Limitations on their movement and a series of intermediaries between themselves and the appropriate health professionals may also impair women's access to care. In most facilities women do not have the freedom of movement to present themselves at the facility medical unit when they feel the need. Rather, health services are accessed in two ways, through submission of a "sick call" slip or "kite" or by bringing the situation to the attention of the security personnel in the housing unit.⁸³ The health services personnel triage the sick call requests and nurses conduct initial patient evaluations, provide appropriate treatment within their range of expertise, and refer patients to a physician's assistant or doctor when they deem it necessary. Although one health services administrator indicated that referral to a doctor becomes automatic after a patient has been seen a certain number of times,⁸⁴ some women told Human Rights Watch that they had difficulty reaching a doctor.⁸⁵

In between sick calls, security personnel assume the frontline in receiving the health concerns of the women in their custody. This can prove problematic for two reasons. First, staff without advanced medical training are put in the position of evaluating a patient's need for care, including in the event of an emergency. American Public Health Association standards require that "prisoners who complain of or display acute or emergency health problems must be referred to medical staff immediately."⁸⁶ One health services

⁸² ICE/DRO Detention Standard No. 22, "Medical Care," December 2, 2008, p.11; INS Detention Standard, "Medical Care," September 20, 2000, p. 3.

⁸³ At one facility Human Rights Watch visited, Willacy Detention Center, we were told that phones installed in the housing units allowed women to speak directly with medical personnel. Human Rights Watch interview with Commander Dawn Anderson-Gary, health services administrator, DIHS, Willacy Detention Center, Raymondville, Texas, April 22, 2008. However, Human Rights Watch was unable to interview any women detained at Willacy and so cannot comment on the effectiveness of this mechanism in practice.

⁸⁴ Human Rights Watch interview with Tracey McKelton, health services administrator, GEO Group, Broward Transitional Center, Pompano Beach, Florida, April 7, 2008.

⁸⁵ Human Rights Watch interview with Elisa G., Arizona, May 2008; Human Rights Watch interview with Nana B., Arizona, May 2008; Human Rights Watch interview with Dominique L., Florida, April 2008.

⁸⁶ American Public Health Association (APHA) Task Force on Correctional Health Care Standards, *Standards for Health Services in Correctional Institutions*, 3rd ed. (Washington, DC: APHA, 2003), p. 3, para. 8.

administrator insisted that officers have an obligation to call if they are notified of an emergency because they are not qualified to make medical decisions.⁸⁷ This approach is reflected in the new and currently binding medical standards' instruction that employees who are unsure whether emergency care is required should immediately notify medical personnel who can make the determination.⁸⁸ However, Rhonda U. told Human Rights Watch of her difficulties in appealing to security personnel for access to care in urgent circumstances:

Only one officer will advocate for women for medical; others will tell you to put in a request. When I say, "I'm sick, please let someone with medical knowledge check on me," the officer, Mrs. [Name], says "Out there you wouldn't get any better." But I say, "You have alternatives. Our back is against the wall. [In here] you can't do for yourself. Don't make me feel this small. Like I just want to get into a medical facility. Please help me because I can't help myself. That's all I ask."⁸⁹

Indeed, determining the existence of an emergency may entail a medical judgment in itself and according to one woman at an Arizona facility, "there is no such thing as an emergency for them unless you are bleeding."⁹⁰

Secondly, testimony provided to Human Rights Watch suggests that the relationship of security personnel to the individuals in their custody may seriously undermine access to health care. In the most benign instances, some women said that they did not feel comfortable sharing private health information with the individuals with whom they interacted day in and day out. In other cases women alleged mistreatment by security staff in the course of requesting medical care or being transported for treatment. This included guards placing a woman on lockdown in response to repeated sick call requests during a protracted struggle between her lawyers and ICE over her medical care, and, in another case described below, guards saying that they could do whatever they wanted to a woman who they knew to have been on suicide watch because no one would believe her.⁹¹

⁸⁷ Human Rights Watch Interview with Lieutenant James B. Carr, staff physician assistant, DIHS, Pinal County Jail, Florence, Arizona, May 1, 2008.

⁸⁸ ICE/DRO Detention Standard No. 22, "Medical Care," December 2, 2008, p. 17; INS Detention Standard, "Medical Care," September 20, 2000, p.6.

⁸⁹ Human Rights Watch interview with Rhonda U., Arizona, May 2008.

⁹⁰ Human Rights Watch interview with Elisa G., Arizona, May 2008.

⁹¹ Human Rights Watch interview with Rose V., Arizona, May 2008; Human Rights Watch interview with Itzya N., Arizona, May 2008.

Itzya N. described the way the guards' knowledge of her mental health issues allowed them to frighten her to the point that she wanted to leave the facility to which she had been transported for better medical care:

The guards know about medical problems.... Nothing is a secret around here. In the past, I used to get very depressed and I thought about it and here you are laughing at me and I'm just trying to go forward. They [the guards] talk poorly about the women who are here. Instead of taking care of you they pretty much screw you over verbally. I don't want to generalize but it happens with more than one. I do remember [one time] and it was at [the service processing center]. It was a woman and four men. They referred to me as the one who tried to kill herself. They said they could do anything they wanted to me because no one was going to believe me because I had done something stupid. I don't want to remember the exact words they said. All I know that is that night I told the doctor I didn't want to be there for one more minute. All I remember is that that night I couldn't sleep fearing what would happen to me. If I close my eyes I can see their faces. The first time it happened I lowered my head. But now every time I see them I raise my head because I see them and I know what they did.⁹²

Distortions in the Doctor-Patient Relationship

The immigration detention healthcare system's focus on crisis management compromised the doctor-patient relationship in multiple ways for women who spoke with Human Rights Watch. While some women spoke favorably of the medical staff, a number felt that the staff did not take their complaints seriously or lacked a genuine interest in helping them. Further, language interpretation deficiencies prevented some women from participating fully in their care, and we received four reports of health service providers insisting on medication against the express wishes of the patient.

Providers' Narrow Approach to Care

While variation in the aptitude and zeal of individual providers may be hard to avoid, the government bears responsibility for the extent to which the detention system's emphasis on stop-gap, deportation-oriented care at the policy level has influenced the outlook of its caregivers. The first rule of the Principles of Medical Ethics Relevant to the Protection of

⁹² Human Rights Watch interview with Itzya N., Arizona, May 2008.

Prisoners Against Torture, adopted by the UN General Assembly in 1983, holds that “Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.”⁹³

However, some statements by health services personnel to Human Rights Watch reflected the Covered Service Package’s more narrow view of care. One service provider articulated the medical unit’s mission as “to maintain health and keep [the detained individuals] in a deportable state.”⁹⁴ This view is consistent not only with the declared intent of the Covered Services Package, but the package’s requirement that certain basic services, such as Pap smears and annual dental examinations, only be provided to individuals “with no indication of imminent removal.”⁹⁵ Another health service provider noted that “most people are here voluntarily because they are fighting their deportation case” when explaining the limitations in available services.⁹⁶ This assertion is only true in the barest technical sense since individuals face a choice of enduring detention or giving up their claims for legal status in the US, which would likely come at great personal cost and possibly great personal peril for individuals fleeing persecution.

Women had high praise for certain medical providers and strong criticism for others. Mercedes O. told Human Rights Watch how moved she had been when a provider took a personal interest in her situation: “That doctor was a good person and helped: I’m a Christian and she prayed with me and said she was going to do everything to help me get out of [the detention center].”⁹⁷ But others felt that the providers were indifferent to their concerns, did not take them seriously, or viewed their requests as bothersome.⁹⁸ One health services administrator who spoke with Human Rights Watch gave little cause to doubt these reports. Speaking about the prevalence of anxiety among the women in custody, she said,

⁹³ UN Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted December 18, 1982, G.A. Res. 37/194, <http://www.un.org/documents/ga/res/37/a37r194.htm> (accessed October 10, 2008), principle 1.

⁹⁴ Human Rights Watch Interview with Lieutenant James B. Carr, staff physician assistant, DIHS, Pinal County Jail, Florence, Arizona, May 1, 2008.

⁹⁵ DIHS Covered Services Package, 2005, pp. 4, 26.

⁹⁶ Human Rights Watch interview with Lieutenant Commander Melissa George, health services administrator, Eloy Detention Center, Eloy, Arizona, April 30, 2008.

⁹⁷ Human Rights Watch interview with Mercedes O., Arizona, May 2008.

⁹⁸ Human Rights Watch interview with Raquel B., New Jersey, May 2008; Human Rights Watch interview with Mary T., Texas, April 2008; Human Rights Watch interview with Lucia C., New Jersey, May 2008.

“You know us girls, we just want to go home, we want to look pretty,” and later commented, “I don’t spend a whole lot of time down there with [the women in custody] because they are difficult.”⁹⁹

Some women recounted confronting a lack of compassion at a moment of intense vulnerability. Alicia Y. had to be hospitalized for kidney stones and an acute pancreatic infection that caused her to faint. At the hospital, she remembered a nurse bruising her with a needle, leaving her to bleed and letting the blood remain soaking through her sheets overnight. She overheard a nurse who thought she did not understand English comment to a colleague that, “She doesn’t have any options. She’s just a detainee.”¹⁰⁰ Beatriz R., whose physical and mental health had markedly deteriorated over the period of her detention, recalled, “I was talking to the nurse about how I feel and she interrupted, ‘You can’t be talking about your problems, you’re just here for a check-up.’”¹⁰¹ Looking up from her hands in her lap as she recounted this incident, Beatriz R. appeared both hurt and puzzled. “They treat us like we don’t have a life out there, like we don’t have a family, like if we didn’t exist in the world.”¹⁰²

Confidentiality & Privacy

Breaches of confidentiality in the handling of medical information and intrusions into the privacy of the exam room concerned several women who spoke with Human Rights Watch and led at least one woman to decline to seek care. According to the currently binding ICE medical standard, healthcare providers are expected to protect the confidentiality of medical information to the degree possible “while permitting the exchange of health information required to fulfill program responsibilities and to provide for the well being of detainees.”¹⁰³ The new ICE medical standard states that privacy of medical information will be protected in accordance with “established guidelines and applicable laws.”¹⁰⁴ Three women reported that guards, some male and some female, commonly have knowledge of the women’s health concerns, while two health services administrators explained that although they did try to limit security personnel’s exposure to individual medical information, the guards would also be bound by medical privacy laws. Nonetheless, Maya Z. insisted, “They talk about other

⁹⁹ Human Rights Watch interview with health services administrator (name and location withheld), May 2008.

¹⁰⁰ Human Rights Watch interview with Alicia Y., Texas, April 2008.

¹⁰¹ Human Rights Watch interview with Beatriz R., Arizona, April 2008.

¹⁰² Ibid.

¹⁰³ INS Detention Standard, “Medical Care,” September 20, 2000, p. 9.

¹⁰⁴ ICE/DRO Detention Standard No. 22, “Medical Care,” December 2, 2008, p. 20.

patients. Everyone always knows why you went to the doctor.”¹⁰⁵ Women may find their confidential medical information exposed to other detained women as well, including in the communication of pregnancy test results which is not always done individually.

According to the new ICE medical standard, detention facility medical units should have sufficient space to allow patients to be seen in private while ensuring safety.¹⁰⁶ However, on visits to off-site providers, security measures vary between facilities and by the security classification of the woman detained. In some cases these measures can include having a guard stationed inside the exam room. This practice, as implemented in cases described to Human Rights Watch, is inconsistent with standards issued by the National Commission on Correctional Health Care which maintain that all clinical visits should be conducted in private “without being observed or overheard.”¹⁰⁷ The NCCHC recognizes exceptions for the presence of security personnel only where a patient poses a probable safety risk to a health care provider or others. In the instances described to Human Rights Watch, the women whose care was observed had no history of violent behavior.

One woman confessed that she had multiple issues she had not raised after hearing that another woman received a Pap smear in the presence of a guard. “The doctors outside treated me okay but it was uncomfortable for me because the guard has to be in the room. If I have to show where I have pain, the guard has to see it too. The CO [corrections officer] was there when they did the Pap smear on [other woman in custody]. I haven’t told them [that I am due for a Pap smear] because I don’t want to go through what she went through... I have breast implants, I didn’t tell them. By the end of last year I was supposed to get them checked. I haven’t told them about the breast implants because I don’t want the officers to see me naked.”¹⁰⁸

Language & Consent

Under the American Public Health Association’s standards, “It is the institution’s responsibility to maintain communication with the prisoners; therefore, personnel must be available to communicate with prisoners with language barriers.”¹⁰⁹ Each facility Human Rights Watch visited insisted that language differences did not impede access to care,

¹⁰⁵ Human Rights Watch interview with Maya Z., Florida, April 2008.

¹⁰⁶ ICE/DRO Detention Standard No. 22, “Medical Care,” December 2, 2008, p. 9.

¹⁰⁷ NCCHC, *Standards for Health Services in Jails 2008*, Std. J-A-09, pp. 15-16.

¹⁰⁸ Human Rights Watch interview with Beatriz R., Arizona, April 2008.

¹⁰⁹ APHA, *Standards for Health Services in Correctional Institutions*, p. 27, para. 27.

generally because the staff spoke multiple languages and interpretation for less commonly encountered languages could be obtained by phone. However, inconsistencies in the use of interpretation services compromised care for several women Human Rights Watch interviewed. Meron A. said that she informed the facility health providers that her English “was not good” only to have them dismiss her concern, saying they understood her, neglecting to consider that she in fact did not understand them.¹¹⁰ Medical records for Nana B., whose interview with Human Rights Watch required French interpretation, indicate that facility personnel repeatedly conducted her medical visits in English, perhaps contributing to the fact that the date of birth in her records was off by 18 years.¹¹¹ Suana Michel Q., hospitalized during her time in ICE custody, reported being asked to sign consent forms for treatment without the opportunity to consult with a translator.¹¹²

Informed consent arose as an issue on several different occasions.¹¹³ The new and currently binding ICE medical standards state that “as a rule, medical treatment shall not be administered against a detainee’s will.”¹¹⁴ However, some women reported that they did not have the option to refuse medication when the staff came through to distribute it at “pill call.” Itzya N. recalled, “I started to stick the pills under my tongue ... because I didn’t want to take the pills. But some nurses look under your tongue.”¹¹⁵ Serafina D. reported that the facility would not permit her to stop taking anti-seizure medication, even after tests confirmed her ailments were not seizure-related: “They just kept giving it to me.... They said since I was under their rules, if didn’t want to take it, I still have to take it.... Medicine would make me tired and drowsy. My body was feeling heavy, my eyes were heavy. I felt drugged up.”¹¹⁶

Detrimental and Unnecessary Use of Restraints and Strip Searches

ICE detention standards impose few definitive limits on the measures available to security personnel to control the individuals in their custody, with the result that women find their

¹¹⁰ Human Rights Watch interview with Meron A., Texas, April 2008.

¹¹¹ Human Rights Watch interview with Nana B., Arizona, May 2008; medical records from detention facility for Nana B., on file with Human Rights Watch.

¹¹² Human Rights Watch interview with Suana Michel Q., New York, July 2008.

¹¹³ Human Rights Watch interview with Itzya N., Arizona, May 2008; Human Rights Watch interview with Serafina D., Texas, April 2008; Human Rights Watch interview with Mary T., Texas, April 2008; Human Rights Watch interview with Isabel F., Florida, April 2008.

¹¹⁴ ICE/DRO Detention Standard No. 22, “Medical Care,” December 2, 2008, p. 19; INS Detention Standard, “Medical Care,” September 20, 2000, p. 8.

¹¹⁵ Human Rights Watch interview with Itzya N., Arizona, May 2008.

¹¹⁶ Human Rights Watch interview with Serafina D., Texas, April 2008.

safety and their dignity subject to the inclinations of those charged with their supervision. Women interviewed by Human Rights Watch said this undermined their physical and psychological health.

The failure to categorically prohibit the shackling of pregnant women in ICE custody has drawn considerable criticism, as it is a practice condemned by health professionals and international bodies.¹¹⁷ Under ICE policy, security staff may use restraints on pregnant women with the consultation of a medical provider.¹¹⁸ Officials from the American College of Obstetricians and Gynecologists have declared their disagreement with the practice of shackling pregnant women, stating that “physical restraints have interfered with the ability of physicians to safely practice medicine by reducing their ability to assess and evaluate the physical condition of the mother and the fetus ... thus, overall putting the lives of women and unborn children at risk.”¹¹⁹ In July 2008 a coalition of over one hundred women’s rights and immigrants’ rights groups wrote to ICE to request that the agency’s policy be changed to prohibit the routine restraint of pregnant women during medical appointments, transport to appointments, labor, delivery, and post-delivery.¹²⁰ ICE declined to make any revisions to the existing policy, stating in a response that it “properly balances the safety of the public, detainees and ICE personnel.”¹²¹

Women who were pregnant while in ICE custody told Human Rights Watch that they were not shackled during medical examinations, but that the use of restraints was typical during transportation between detention facilities and to and from off-site medical providers.¹²² Both the new and currently binding ICE detention standards on land transportation indicate that as a rule women should not be restrained, but in addressing the shackling of pregnant

¹¹⁷ See HRC, “Consideration of Reports Submitted by States Parties under Article 40 of the Convention, Conclusions and Recommendations of the Human Rights Committee, United States of America,” CCPR/C/USA/CO/3/Rev.1, December 18, 2006, <http://daccessdds.un.org/doc/UNDOC/GEN/Go6/459/61/PDF/Go645961.pdf?OpenElement> (accessed October 10, 2008), para. 33.

¹¹⁸ INS Detention Standard, “Use of Force,” September 20, 2000, <http://www.ice.gov/doclib/pi/dro/opsmanual/useoffor.pdf> (accessed February 26, 2009), pp. 8-9; ICE/DRO Detention Standard No. 18, “Use of Force and Restraints,” December 2, 2008, http://www.ice.gov/doclib/PBNDs/pdf/use_of_force_and_restraints.pdf (accessed February 23, 2009), p.6.

¹¹⁹ Letter from Ralph Hale, MD, executive vice president, American College of Obstetricians and Gynecologists (ACOG), to Malika Saada Saar, executive director, The Rebecca Project for Human Rights, June 12, 2007 (citing ACOG District X testimony supporting a legislative prohibition on shackling in California).

¹²⁰ Letter from Maalika Saada Saar, executive director, The Rebecca Project for Human rights [on behalf of 111 organizations], to Julie L. Myers, assistant secretary of homeland security, ICE, July 17, 2008.

¹²¹ Letter from Susan M. Cullen, director of policy, ICE, to Maalika Saada Saar, executive director, The Rebecca Project for Human Rights, September 10, 2008.

¹²² While most officials and providers told Human Right Watch that women are almost always paroled or deported before they reach full term, two did recall women giving birth in custody.

women ICE has stated that “[its] policy is clear that any individual who has demonstrated violent behavior, criminal activity, or a strong likelihood of escape shall be restrained during transit.”¹²³ Giselle M., who was shackled while en route from one detention center to another, questioned the necessity of putting her pregnancy at risk: “What if I had fallen? How fast is a pregnant girl going to run?”¹²⁴ Recalling her experience with shackling, Katherine I. said, “When we went to the clinic in [city name], we were in a van without a way to hold on. There was a bench around and no way I could get myself so I couldn’t fall; I was pregnant and she was driving too fast. And I told the security who took us and they said they couldn’t do nothing about it.”¹²⁵

Women who were shackled in the course of requesting medical care, whether pregnant or seeking care for other concerns, reported that the restraints took a psychological toll and presented a disincentive to seek care. Itzya N. said, “They only use shackles in transportation, but that is a trauma that lasts for three days. It’s just that on top of being chained you are being treated like an animal. It is more about the way they treat you, how they yell at you, how it’s like being caged.”¹²⁶

Human Rights Watch spoke with women detained at facilities that also held criminal populations who were subjected to the facilities’ standard strip search procedures. The searches, which were imposed without apparent cause, constituted debilitating affronts to their dignity. Nora S. shook her head and closed her eyes as she recalled, “When the women from California first arrived, we were asked to strip down naked and walk around in circles in front of the women guards... I didn’t file a request for two whole weeks. All I could do was cry. I was in shock.”¹²⁷ Jameela E. was required to strip at each of the four county jails she was transferred between in Virginia. She described herself as devastated at the immodesty of being unable to wear her hijab, to say nothing of the requirement that she disrobe for inspection on multiple occasions.¹²⁸

¹²³ INS Detention Standard, “Transportation (Land Transportation),” September 20, 2000, <http://www.ice.gov/doclib/pi/dro/opsmanual/transp.pdf> (accessed January 20, 2009 p. 14; ICE/DRO Detention Standard No. 3, “Transportation (By Land),” December 2, 2008, http://www.ice.gov/doclib/PBNDs/pdf/transportation_by_land.pdf (accessed February 23, 2009), p.12; Letter from Cullen, September 10, 2008.

¹²⁴ Human Rights Watch interview with Giselle M., Arizona, May 2008.

¹²⁵ Human Rights Watch interview with Katherine I., Texas, April 2008.

¹²⁶ Human Rights Watch interview with Itzya N., Arizona, May 2008.

¹²⁷ Human Rights Watch interview with Nora S., Arizona, May 2008.

¹²⁸ Human Rights Watch interview with Jameela E., Virginia, June 2008.

Discontinuity of Care

Women and healthcare providers alike identified lack of continuity of care as one of the greatest obstacles in the detention medical system.¹²⁹ Given the number of transfers between facilities and the short time that some individuals spend in the detention system, disruptions in care are an expected part of the detention system, as currently operated. Human Rights Watch interviews indicate that DIHS is failing to take sufficient steps to address this reality.

Records

Having a complete medical history available and transferring it with the patient can help considerably in bridging the gaps in care between a facility in the community and one in the detention system, as well between different facilities within the detention system. Yet exchanging comprehensive records does not register as a priority in ICE policy. Although not required by the ICE detention standards, some health service providers who spoke with Human Rights Watch said that they would try to get a patient's prior medical records from a community provider where necessary and feasible.¹³⁰ But several women reported that they had to resort to getting those records on their own in order to substantiate their healthcare needs.¹³¹ Receiving no help from the facility to obtain her records, Lily F. tried repeatedly to reach the doctor in California who had originally put in her breast implants, which ruptured while she was in prison and remained deflated in her chest when she reached ICE custody. But Lily F. found the doctor had moved offices. She tried to follow up but had no money for phone calls and, not being literate, could not write letters. To get more money for the calls she worked in the detention center for the nominal wage (one or two dollars) the facility provided: "I worked for five-and-a-half months but I had to quit because I was not feeling good."¹³²

¹²⁹ Human Rights Watch interview with Martha Burke, midwife, Su Clinica Familiar, Harlingen, Texas, April 25, 2008; Human Rights Watch interview with Dr. F. Javier del Castillo, Brownsville, Texas, April 25, 2008; Human Rights Watch Interview with Lieutenant James B. Carr, staff physician assistant, DIHS, Pinal County Jail, Florence, Arizona, May 1, 2008.

¹³⁰ Human Rights Watch interview with Captain Marian Moe, health services administrator, DIHS, Port Isabel Service Processing Center, April 23, 2008; Human Rights Watch Interview with Lieutenant James B. Carr, staff physician assistant, DIHS, Pinal County Jail, Florence, Arizona, May 1, 2008; Human Rights Watch interview with Carol R. Bobay, health services administrator, Armor Correctional Health Services/Glades County Jail, Moore Haven, Florida, April 10, 2008.

¹³¹ Human Rights Watch interview with Lily F., Arizona, April 2008; Human Rights Watch interview with Lucia C., New Jersey, May 2008; Human Rights Watch interview with Jameela E., Virginia, June 2008; Human Rights Watch interview with Mary T., Texas, April 2008.

¹³² Human Rights Watch interview with Lily F., Arizona, April 2008.

Individuals transferred from one ICE detention facility to another can encounter the same difficulties and experience disruptions in care, even though they remain in the custody and care of the same authority. American Public Health Association standards stipulate that a full medical record should accompany an individual transferred within the same correctional system, and a summary should only be used for transfers into another system.¹³³ Under ICE policy, a summary is used whenever ICE transfers someone to a facility where DIHS does not directly provide care.¹³⁴ The new non-DIHS facility does not receive the full medical record as a matter of course. This is problematic because, unlike transfers between correctional systems, transfers between DIHS and non-DIHS facilities happen frequently within the ICE system. ICE moved Antoinette L., who had a complicated medical history, from one facility to another located just across the street and still provided only an incomplete transfer sheet that did not include her list of medications, an omission that could further compound difficulties that can arise due to DIHS and non-DIHS facilities maintaining different formularies.¹³⁵

For Jameela E., whom ICE shuttled between four county jails in Virginia, the impact of the policy on transferring records was palpable. “I had pain over half my body,” she said in describing what it was like to contend with an ovarian cyst without her pre-detention painkillers.¹³⁶ At the first detention center, the health authorities referred her to a specialist at a local hospital where it was determined that the cyst required surgery. Before the scheduled surgical appointment two weeks later, ICE transferred her to another jail. Not having received any records from the first facility, the health provider demanded, “Do you have any proof you have a cyst?” Jameela E. had records from prior to detention with her belongings: “I said I have it in my property but they won’t let me have it.... Finally I got it.”¹³⁷ But the jail kept saying it had to wait for records from the first facility, and before long ICE transferred Jameela E. again. She did not receive surgery for her cyst during her time in ICE custody.

¹³³ APHA, *Standards for Health Services in Correctional Institutions*, p. 40, paras. 2, 3.

¹³⁴ ICE Detention Standard: Detainee Transfer, June 16, 2004, pp. 6-7. The new ICE medical standard requires that the medical provider ensure that all relevant medical records accompany an individual who is transferred or released. ICE/DRO Detention Standard: Medical Care, December 2, 2008, p. 19. However, the new ICE transfer standard differentiates transfers to facilities not operated by DIHS (state and county jails and some contract detention facilities) from those to facilities within the DIHS system, stating that a transfer summary will accompany an individual transferred to facilities not operated by DIHS, while a transfer summary and “the official health records” will accompany an individual transferred within the DIHS system. ICE/DRO Detention Standard: Transfer of Detainees, December 2, 2008, http://www.ice.gov/doclib/PBNDs/pdf/transfer_of_detainees.pdf (accessed February 23, 2009), pp. 7-8.

¹³⁵ Human Rights Watch interview with Antoinette L., Arizona, May 2008.

¹³⁶ Human Rights Watch interview with Jameela E., Virginia, June 2008.

¹³⁷ Ibid.

The new and currently binding ICE medical standards do not provide for individuals to automatically receive their full medical record on release, but they are entitled to request it from the detention center.¹³⁸ Nonetheless, detained women and their lawyers report problems accessing medical records, with requests going unanswered or yielding only partial files. Serafina D. reported that the off-site specialists she saw refused to give her paper records because they said the tests had been ordered by ICE.¹³⁹ Despite provisions in federal law and the detention standards intended to ensure individuals' access to their records, lawyers report that facilities often impose obstructive requirements.¹⁴⁰ Kelleen Corrigan of the Florida Immigrant Advocacy Center told Human Rights Watch that one facility she deals with regularly accepts record requests only from lawyers, effectively prohibiting unrepresented individuals from accessing their own medical information.¹⁴¹

Referrals and Discharge Planning

The Division of Immigration Health Service prides itself on its tuberculosis program, which includes not only screening and treatment at the detention facilities, but referral for continued treatment after detention, even in those cases in which the individual is being deported. Health services administrators told Human Rights Watch that they will provide individuals with a supply of medication and a referral to their nearest available clinic to receive follow up care. Although this level of continuity of care may be impracticable for all health concerns, the success with tuberculosis has shown that it is possible to provide useful medical advice and assistance to individuals leaving detention. Indeed, in standards issued by the American Public Health Association, it is expected that "correctional health care providers should work with government and non-government health care agencies to develop referral criteria and programs to ensure continuity of care for discharged prisoners with significant health care needs including medications and supportive care."¹⁴²

¹³⁸ As noted in footnote 134 above, the new ICE medical standard requires that the medical provider ensure that all relevant medical records accompany an individual who is transferred or released. However, the standard also indicates that these records need only include a transfer summary when the individual is moving to a non-DIHS facility, including when the individual is "being transferred into or out of ICE custody." ICE/DRO Detention Standard: Medical Care, December 2, 2008, pp. 19-21.

¹³⁹ Human Rights Watch interview with Serafina D., Texas, April 2008.

¹⁴⁰ An individual's rights to with respect to access to his or her health information are recognized in multiple statutory and regulatory instruments. Freedom of Information Act, 5 U.S.C.A. § 552 (West 2008); Privacy Act, 5 U.S.C. § 552a (West 2008); Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 29 U.S.C. and 42 U.S.C.); ICE/DRO Detention Standard: Medical Care, September 12, 2008, pp. 20-21; INS Detention Standard, "Medical Care," September 20, 2000, p. 9.

¹⁴¹ Human Rights Watch telephone interview with Kelleen Corrigan, August 5, 2008.

¹⁴² APHA, *Standards for Health Services in Correctional Institutions*, p. 40, para. 5.

The issue of continuity of care arose most frequently in our research in relation to pregnancy, in part because women are likely to be released from detention through parole or another mechanism the further they progress into the pregnancy. Two officials Human Rights Watch spoke with described their commitment to identifying quality programs in the community to provide alternatives to detention for pregnant women: “Just because she’s out of detention doesn’t mean she is out of our responsibility.”¹⁴³ At another facility, however, Human Rights Watch asked whether the detention center would assist pregnant women who were about to be released with identifying appropriate health care providers in the community, and was told that those arrangements would be up to the women themselves.¹⁴⁴

Lack of Effective Remedies

I filled out a grievance a long time ago and didn’t get a response so I didn’t bother to grieve any more. The officers told me to put in a grievance because I was feeling bad. This was around September of 2007. I didn’t get a response until this January [2008]. They said it had gotten mixed in with a bunch of papers and they just found it. I don’t think so. I put a grievance against the medical treatment and they said, “Are you better now?” I told them, “You took so long to answer I could have been dead by now.”

—Mary T., Texas, April 2008

In the past year ICE has instituted a number of new oversight measures to assess facility compliance with detention standards; however, few include effective mechanisms for seeking feedback from or providing redress to detained individuals. The main mechanism for individuals in custody to register complaints about their care remains the local facility grievance systems, which to-date have had limited input into ICE oversight programs.

Standard setting bodies such as the National Commission on Correctional Health Care state that a grievance process must be available to address complaints about health services.¹⁴⁵ Currently binding ICE detention standards require detention facilities to institute a grievance system whereby the individuals detained can file complaints that are reviewed and may be

¹⁴³ Human Rights Watch interview with Jay Sparks, ICE officer-in-charge, South Texas Detention Complex, Pearsall, Texas, April 21, 2008.

¹⁴⁴ Human Rights Watch interview with Diana Perez, ICE officer-in-charge, Willacy Detention Center, Raymondville, Texas, April 22, 2008.

¹⁴⁵ NCCHC, *Standards for Health Services in Jails 2008*, Std. J-A-11, p. 18.

appealed up the chain of command to the officer-in-charge of the facility.¹⁴⁶ In addition, facilities must post the telephone number for the Office of the Inspector General's (OIG) toll-free hotline where individuals can bypass the facility grievance process and report violations of their civil rights directly to the national-level authorities.¹⁴⁷ The new ICE standard on grievances, which will become binding on facilities in 2010, includes a separate process for addressing medical grievances in which ICE must be notified of appeals of medical grievances.¹⁴⁸ Also, ICE informed Human Rights Watch that it has begun screening correspondence to its field offices to identify communications raising pressing medical issues.¹⁴⁹

These policy changes are positive signs, but their implementation will be essential to realizing actual progress. In interviews about the operation of the current grievance system, women indicated to Human Rights Watch that it was at the facility level of implementation that the process often failed them. Women interviewed for this report rarely found the available complaint mechanisms to be effective tools for obtaining redress. Even though information on the grievance system should be provided in an individual's orientation upon arrival at the detention facility, some women never heard about the grievance system or seemed unclear on the availability of the grievance system for medical issues.¹⁵⁰ "When the doctor says no, it's no. I don't know about grievance,"¹⁵¹ said Teresa W. Others said using the grievance system carried a risk of retaliation. "When you become such an advocate, you become a target. To them I'm threatening their job,"¹⁵² said Nadine I. Serafina D., who said she did not shy away from advocating for herself or others, admitted, "One time I was going to file a complaint [about a non-medical issue] but then I was told if I file a complaint that they would do something to me and I never filed it."¹⁵³ Facility procedures for the submission of complaints in some facilities amplified those fears. In one county jail, to file a grievance

¹⁴⁶ INS Detention Standard, "Detainee Grievance Procedures," September 20, 2000, <http://www.ice.gov/doclib/pi/dro/opsmanual/griev.pdf> (accessed February 26, 2009).

¹⁴⁷ It should be noted that the Government Accountability Office reported that it encountered significant problems in trying to connect to the DHS OIG hotline during their study of telephone access and other detention standards at multiple detention facilities in 2007. GAO, "Alien Detention Standards," p.11.

¹⁴⁸ ICE/DRO Detention Standard No. 35, "Grievance System," December 2, 2008, http://www.ice.gov/doclib/PBNDs/pdf/grievance_system.pdf (accessed February 26, 2009), p. 6

¹⁴⁹ Human Rights Watch interview with Joseph Greene, Jay Sparks, Andrew Strait, Philip Jarres, and Jeffrey Sherman, ICE headquarters, Washington, DC, October 30, 2008.

¹⁵⁰ Human Rights Watch interview with Jameela E., Virginia, June 2008; Human Rights Watch interview with Rosario H., Virginia, June 2008; Human Rights Watch interview with Teresa W., Florida, April 2008.

¹⁵¹ Human Rights Watch interview with Teresa W., Florida, April 2008.

¹⁵² Human Rights Watch interview with Nadine I., Florida, April 2008.

¹⁵³ Human Rights Watch interview with Serafina D., Texas, April 2008.

women needed to ask the guards for the form and return it directly to them after completing it.¹⁵⁴ Even the option of calling the OIG hotline was not perceived by women as being without risk, as women feared their calls would be monitored and their anonymity would be compromised.

For many of the women who spoke with Human Rights Watch, behind the decision to opt out of the grievance system or drop a complaint lay not fear but exhaustion and resignation. Having attempted to engage the system without success in other forms—filing sick call requests, asking guards for help, mentioning their concerns to deportation officers—women looked dimly upon the prospect of satisfaction through yet another bureaucratic process.

The women who did pursue the grievance process or another complaint mechanism reported mixed results. One woman reported that she convinced the facility to purchase new shower curtains for the women’s unit,¹⁵⁵ while another noticed a change for the better in the demeanor of a nurse after filing a complaint about her behavior toward patients.¹⁵⁶ Fewer appreciable results followed complaints about courses of treatment or the availability of particular medical services. One woman tried to call the Texas Health Department because a notice posted at the facility said that the Department accepted complaints, but could not get her call to connect.¹⁵⁷ Women who had the support of lawyers and family members who filed supporting letters and made follow up phone calls had more success, but it was inconsistent and delayed. Even with the backing of a team of zealous lawyers and attentive family members, Rose V. faced intimidation in pursuing her complaints regarding medical care. After advocacy efforts on her behalf graduated into a full-fledged campaign, Rose V. said that a senior official from the medical staff visited her and warned her, “I’m going to tell you right now, if your lawyers don’t stop it’s going to hurt your case. It’s going to make your judge mad; it’s going to make ICE mad... Call your lawyer.”¹⁵⁸

¹⁵⁴ The facility whose grievance process is described is Monroe County Detention Center, Key West, Florida.

¹⁵⁵ Human Rights Watch interview with Antoinette L., Arizona, May 2008.

¹⁵⁶ Human Rights Watch interview with Rose V., Arizona, May 2008.

¹⁵⁷ Human Rights Watch interview with Serafina D., Texas, April 2008.

¹⁵⁸ Human Rights Watch interview with Rose V., Arizona, May 2008.

V. Findings: Specific Women's Health Concerns

Human Rights Watch interviewed women about their ability to access medical care for the full range of their health concerns while in detention. To gauge the system's preparedness in policy and in practice to address the particular needs of women, the interviews included in-depth discussions of women-specific health concerns. This chapter presents our findings on those issues, as well as findings on care for survivors of violence and on mental health care, both of which emerged in our research as priority issues for women in detention.

Routine Gynecological Care

As a group for whom routine, but consequential and potentially painful reproductive healthcare issues arise frequently, women stand to suffer considerably within a medical system that emphasizes emergency care and treating conditions that “would cause deterioration of the detainee’s health or uncontrolled suffering affecting his/her deportation status.”¹⁵⁹ Although individual providers may conceive of their role more broadly, policies set at the national level establish a framework that is startlingly inadequate in addressing common gynecological concerns. The Covered Services Package warns providers that non-emergency gynecological services are usually not a covered benefit, though requests may be approved on a case by case basis, effectively limiting care to whatever minor interventions may be available at the facility clinic or, if the woman is lucky, through Division of Immigration Health Services (DIHS) approval of outside care.¹⁶⁰ This overall approach, as well as specific restrictions on Pap smears, hormonal contraception, and access to specialist care, undermined the health of a number of women who spoke with Human Rights Watch.

Pap Smears

Cervical cancer represents the second leading cause of cancer deaths among women worldwide.¹⁶¹ However, the Pap smear, a simple and inexpensive screening test, is capable of detecting 90 percent of early cellular changes in the cervix that signal an increased risk of

¹⁵⁹ “The DIHS Medical Dental Detainee Covered Services Package primarily provides health care services for emergency care ... Other medical conditions which the physician believes, if left untreated during the period of ICE/BP custody, would cause deterioration of the detainee’s health or uncontrolled suffering affecting his/her deportation status will be assessed and evaluated for care.” DIHS Covered Services Package, 2005, p.1. As noted in the summary, some officials have argued this language is broadly interpreted, but other official statements and accounts of the policy in practice indicate that this policy does significantly limit the scope of care.

¹⁶⁰ “Scheduled, non-emergency services are usually not a covered benefit. Requests will be reviewed on a case by case basis.” DIHS Covered Services Package, 2005, p.26.

¹⁶¹ Kimberly B. Fortner et al., eds., *The Johns Hopkins Manual of Gynecology and Obstetrics* (Philadelphia: Lippincott Williams & Wilkins, 2007), p. 473.

cancer, allowing for life-saving interventions.¹⁶² Accordingly, Pap smears have become a mainstay of routine preventive health care for women in the US. The American College of Obstetricians and Gynecologists and the American Cancer Society recommend that beginning within three years of sexual activity or after the age of 21, women receive a Pap smear annually until they reach the age of 30. After age 30, women who have had three negative Pap smears can be screened every two to three years. Women who have reached the age of 65 with no abnormal results in the last 10 years may be safe to discontinue screenings.¹⁶³ As Dr. Homer Venters testified before Congress during a hearing on problems with medical care in immigration detention, Pap smears represent one of “the most beneficial and cost-effective measures of modern medicine.”¹⁶⁴

Women in ICE custody cannot count on accessing this essential screening with the frequency recommended above. According to ICE Policy, women must generally spend a year in ICE custody before becoming eligible for a Pap smear screening.¹⁶⁵ Pap smears may be considered before that time if “medically indicated”¹⁶⁶ or if a specific problem is brought to the attention of the medical providers.¹⁶⁷ On its face, this policy does not correspond to the community standard because it does not account for when a woman may have last had a screening before entering detention. Several women told Human Rights Watch that they had plans for an annual exam right around the time they were detained, while others had not had the opportunity for a screening in years. Standard setting bodies for correctional institutions such as the National Commission on Correctional Health Care and the American Public Health Association avoid this problem by recommending that Pap smears form part of jails’

¹⁶² Shannon E. Perry, Kitty Cashion, and Deitra Leonard Lowdermilk, eds., *Maternity & Women’s Health Care* (St. Louis: Mosby Elsevier, 2007), p. 451.

¹⁶³ American College of Obstetricians and Gynecologists (ACOG), “The Pap Test,” ACOG Education Pamphlet APo85, 2003, http://www.acog.org/publications/patient_education/bpo85.cfm (accessed October 6, 2008); American Cancer Society (ACS), “American Cancer Society Guidelines for the Early Detection of Cancer,” March 5, 2008, http://www.cancer.org/docroot/PED/content/PED_2_3X_ACS_Cancer_Detection_Guidelines_36.asp?sitearea=PED (accessed October 6, 2008) (ACS recommends 70 as the age for discontinuing screenings).

¹⁶⁴ Homer D. Venters, M.D., Testimony before the House Judiciary Committee’s Subcommittee on Immigration, June 4, 2008, p.6.

¹⁶⁵ The requirement that women must generally spend a year in custody before receiving a Pap smear screening is reflected in the Covered Services Package as well as the DIHS Policies and Procedures Manual, which provides instructions for staff at DIHS-operated facilities regarding how to approach specific health issues. DIHS Covered Services Package, 2005, p. 26; Division of Immigration Health Services, ICE, “DIHS Policies and Procedures Manual,” unpublished document provided by ICE to Human Rights Watch on January 5, 2009, sec. 8.2.4.

¹⁶⁶ According to the DIHS Policies and Procedures Manual, DIHS staff shall perform a Pap smear as part of the initial screening if medically indicated. The manual states that “Indications can be based on the detainee’s past history, family history, current medical conditions, or reported lifestyle. Local operating procedures provide specific indications for performing pelvic examination.” DIHS Policies and Procedures Manual, sec. 8.2.4.

¹⁶⁷ Human Rights Watch interview with Joseph Greene, Jay Sparks, Andrew Strait, Philip Jarres, and Jeffrey Sherman, ICE headquarters, Washington, DC, October 30, 2008.

initial health screening for women, to then be followed up with periodic screening according to community standards.¹⁶⁸

Interviews conducted by Human Rights Watch confirm that women are indeed being denied this critical screening. Of eight women interviewed who had been detained for more than a year, six women had not received a Pap smear,¹⁶⁹ one had been screened once in two years of detention,¹⁷⁰ and another had received the test when she was receiving attention for other medical concerns.¹⁷¹ In some cases the women actively pursued the screening; in others they were unaware of their potential eligibility because medical personnel had not mentioned it.

Cecile A., detained for 18 months at the time she spoke with Human Rights Watch, said she had stopped trying to get the test after multiple attempts: “In Texas I asked. I submitted a request and they said yes but they never called. In Texas I asked many times but here [at a Florida detention center] I don’t think they do it.”¹⁷² Cecile A. and the other five women we spoke with whom ICE detained for over a year without a Pap smear were in detention at the time we interviewed them, making it impossible to assess the impact of the missed screenings on their physical health. However, the understandable impact of this uncertainty on their mental health was readily apparent. Expressing distress over the number of Pap smears and other cancer screenings she had not received over the course of two years in detention, Nana B. said, “I think because I have been here a long time they need to do all the tests ... I don’t know if I’m sick or not. I’m scared.”¹⁷³

Improvements in the eligibility criteria for Pap smears at the national policy level likely constitute only the first step toward ensuring access to screenings at the facility level. If the experience of Lucia C., who met all of the current requirements for Pap smears, provides any indication, implementation poses its own challenges. Prior to her detention by ICE, Lucia C. had obtained a Pap smear and learned that the result was abnormal. Her doctor instructed her that she should follow up with Pap smears every six months to check for signs that

¹⁶⁸ This approach has proven feasible at the New York City jail on Riker’s Island where it is standard practice. See Homer D. Venters, M.D., Testimony before the House Judiciary Committee’s Subcommittee on Immigration, June 4, 2008, p.6.

¹⁶⁹ Human Rights Watch interview with Cecile A., Florida, April 2008; Human Rights Watch interview with Nana B., Arizona, May 2008; Human Rights Watch interview with Lucia C., New Jersey, May 2008; Human Rights Watch interview with Mary T., Texas, April 2008; Human Rights Watch interview with Rhonda U., Arizona, May 2008; Human Rights Watch interview with Nuene D., Arizona, April 2008.

¹⁷⁰ Human Rights Watch interview with Serafina D., Texas, April 2008.

¹⁷¹ Human Rights Watch interview with Rose V., Arizona, May 2008.

¹⁷² Human Rights Watch interview with Cecile A., Florida, April 2008.

¹⁷³ Human Rights Watch interview with Nana B., Arizona, May 2008.

cervical cancer was developing. When ICE detained her at a county jail in New Jersey, Lucia brought her situation to the attention of medical authorities. Initially rebuffed, she persisted: “I was supposed to be checked every six months. I asked my daughter to send the records. I got it and I brought it to medical so they could see I’m not lying. I have asked a lot of times.”¹⁷⁴ Speaking with Human Rights Watch after almost 16 months in detention, Lucia C. reported that the medical staff still had not provided her a Pap smear. “It’s terrible,” she said, “because you feel like you have something you can die for... and you don’t have no assistance.”¹⁷⁵

Hormonal Contraception and Gynecology Appointments

DIHS policy denies women in ICE custody access to basic family planning services including contraceptive drugs, interfering with their reproductive autonomy, and exposing them to the risk of unintended pregnancy and unnecessary hardship. Furthermore, several women reported struggling to obtain appropriate attention for menstrual irregularities and other gynecological concerns through the detention medical care system.

Out of step with American Public Health Association correctional standards mandating access to contraception, the Covered Services Package specifically disclaims coverage for family planning services of any kind and the DIHS formulary omits hormonal contraceptives.¹⁷⁶ DIHS officials told Human Rights Watch that hormonal contraceptives for birth control were not available because they constitute an elective therapy that is not without risks.¹⁷⁷ In addition to blocking access to birth control, Human Rights Watch found that this policy can also impede women from obtaining access to hormonal contraceptives as treatment for other health conditions, including painful or irregular menstruation.

Despite the limitations that a sex-segregated detention setting might seem to imply, the lack of access to contraceptives can put women at risk for unintended pregnancy. Instances of sexual contact between men and women in detention centers, while rightly forbidden given the impossibility of meaningful consent in such an environment, has occurred and women

¹⁷⁴ Human Rights Watch interview with Lucia C., New Jersey, May 2008.

¹⁷⁵ Ibid.

¹⁷⁶ DIHS Covered Services Package, 2005, p. 27; DIHS, “Commonly Used Drugs Formulary,” March 5, 2007, http://www.icehealth.org/ManagedCare/DIHS_Formulary.pdf (accessed October 6, 2008).

¹⁷⁷ Human Rights Watch interview with Joseph Greene, Jay Sparks, Andrew Strait, Philip Jarres, and Jeffrey Sherman, ICE headquarters, Washington, DC, October 30, 2008.

should not be required to report sexual abuse in order to obtain needed services.¹⁷⁸ Further, women's time in detention must be viewed in the context of their larger reproductive lives. On release from detention, women who had been forced to discontinue their use of hormonal contraceptives would not immediately be able to rely on that method due to the time it takes for hormonal contraceptives to become effective.¹⁷⁹ It is notable that the Federal Bureau of Prisons, which cares for women who will generally be out of the community for longer periods, provides women with advice and consultation about methods of birth control and will prescribe it when deemed medically appropriate.¹⁸⁰

In addition, hormonal contraceptives serve a number of important purposes beyond birth control. Among their many uses, hormonal contraceptives may be prescribed to reduce a woman's risk of developing ovarian and breast cancer, to regulate a woman's menstrual cycle, or to alleviate painful menstrual cramps.¹⁸¹ Three of the health services administrators who spoke with Human Rights Watch indicated that the exclusion of family planning services from the Covered Services Package and DIHS formulary would not prevent hormonal contraception from being prescribed for a medical issue aside from birth control.¹⁸² However, for Serafina D., that was exactly the effect it had:

I was having ovarian problems where I was bleeding very heavily and [my medical providers before I was detained] told me that that I had inflammation of ovaries and because the bleeding was so heavy they prescribed birth control ... Birth control would make it soft and light. When it was heavy it was very uncomfortable. Cramping, heavy, like I was hemorrhaging ... [In detention] they couldn't give me the medications because they don't provide birth control. "We don't [provide that] kind of

¹⁷⁸ Advocates have reported numerous instances of sexual abuse in immigration detention facilities. See, e.g., Cheryl Little, Testimony before the Prison Rape Elimination Commission, December 13, 2006, http://www.nprec.us/docs/sxvimmigrdet_d13_persaccts_CherylLittle.pdf (accessed November 1, 2008).

¹⁷⁹ Women are advised to use a back-up method of contraception for the first seven days when beginning hormonal contraception if it is not begun on the first day of her monthly menstruation. See e.g. Association of Reproductive Health Professionals, "Administration of Hormonal Contraceptive Drugs," December 2003, <http://www.arhp.org/publications-and-resources/quick-reference-guide-for-clinicians/delsys> (accessed October 6, 2008).

¹⁸⁰ Federal Bureau of Prisons, US Department of Justice, "Program Statement: Birth Control, Pregnancy, Child Placement and Abortion," No. 6070.05, August 6, 1996, sec. 551.21.

¹⁸¹ Reproductive Health Access Project, "Non-Contraceptive Indications For Hormonal Contraceptive Products," undated, http://www.reproductiveaccess.org/contraception/non_contra_indic.htm (accessed October 6, 2008).

¹⁸² Human Rights Watch interview with Diana Perez, ICE officer-in-charge, Willacy Detention Center, Raymondville, Texas, April 22, 2008; Human Rights Watch interview with Captain Marian Moe, health services administrator, DIHS, Port Isabel Service Processing Center, April 23, 2008; Human Rights Watch interview with Lieutenant James B. Carr, staff physician assistant, DIHS, Pinal County Jail, Florence, Arizona, May 1, 2008.

medication.... The only thing we can give you is ibuprofen as an anti-inflammatory.” I was glad when I didn’t have my period for two months but then when it came, ahhhh. I wouldn’t want to get up.¹⁸³

Women unable to obtain gynecological appointments reported that, in some cases, the difficulty was directly attributed to the requirement that national headquarters authorize outside appointments for specialist care. Before ICE detained her, Nadine I. had made arrangements to see a gynecologist for painful menstruation-related concerns.¹⁸⁴ She said, “A week before I got my period I would be in agony. I would pass heavy, huge clots.”¹⁸⁵ At one Florida detention center, she put in four or five requests to see a gynecologist and understood that the medical facility had sent in the required papers for DIHS authorization to make the appointment. After six months passed without a response, she was transferred to a second facility in another part of the state. There she again filed a request. It was not until more than four months later, over 10 months from her original request, that she saw a gynecologist. During her months of waiting, she said, “They wouldn’t give you anything.”¹⁸⁶

Several other women repeated similar stories of difficulty obtaining attention for gynecological concerns but never received an explanation for the delay. In two instances, the requests simply went unanswered. After she was detained, Jameela E. started getting her period every two weeks. She put in multiple requests to consult a doctor without success.¹⁸⁷ Lily F., who arrived at a detention center in Arizona and immediately sought follow up for an abnormal Pap smear, waited months to be sent for treatment. Transferred from a prison in California, she had the good fortune of having her medical records follow her to ICE detention, including the abnormal Pap results, but it still took six months for the facility to arrange for her to go off-site for a biopsy.¹⁸⁸

Sanitary Pads

They only give two pads. In the morning they come and give you two. If you need more than that you have to go to the nurse. “Why do you need more pads?” You have to tell her, “Because I bleed so much.” But it has to be an

¹⁸³ Human Rights Watch interview with Serafina D., Texas, April 2008.

¹⁸⁴ Human Rights Watch interview with Nadine I., Florida, April 2008.

¹⁸⁵ Ibid.

¹⁸⁶ Ibid.

¹⁸⁷ Human Rights Watch interview with Jameela E., Virginia, June 2008.

¹⁸⁸ Human Rights Watch interview with Lily F., Arizona, April 2008.

extraordinary reason. If it's normal for you to have a heavy period—nothing. I bleed through three pairs of pants. Well yes, if the officers see this, then it's a reason.

—Nana B., Arizona, May 2008

Women at several facilities described arbitrary and humiliating limitations on access to sanitary pads. ICE standards state that facilities will issue feminine-hygiene items on an as-needed basis.¹⁸⁹ However, as implemented in several detention centers, this policy has failed to meet the UN Standard Minimum Rules on the Treatment of Prisoners requirement that authorities provide individuals in custody with “water and with such toilet articles as are necessary for health and cleanliness.”¹⁹⁰ A number of women told Human Rights Watch that officers would distribute a certain quantity of pads (two to six), and obtaining more “as needed” posed a challenge. Nadine I. recalled that after you used your allowance of four pads, the officers would hand them out one at a time. “I needed three pads. It would just gush. It would end up soaking my clothes. If my clothing got soaked, I could go through a shift change without a change of clothing ... We were shaken down every night. If you had hoarded they would take [away] the extra pads.”¹⁹¹

Such restrictions put women in the place of having to justify to staff—and often not the medical professionals—the needs occasioned by a private bodily function. Elisa G. had her period when the detention center decided to lock down her entire housing unit for three days. The circumstances forced her to appeal to the ICE officer visiting the unit: “I had to ask [for pads] again. ‘I have my period. I have a lot of pain. I need to shower. It’s not for [my benefit], it’s for my roommate.’ [ICE officer:] ‘Give this lady two pads.’ I said, ‘Sir, you’re not understanding what I am saying. I need more than two pads,’ ... I had to just sit on the toilet for hours because I had nothing else [I could] do.”¹⁹²

Several women at one facility expressed anger over a recently instituted rule at that particular facility that required women to work to receive any sanitary pads beyond their

¹⁸⁹ INS Detention Standard, “Admission and Release,” September 20, 2000, <http://www.ice.gov/doclib/pi/dro/opsmanual/admiss.pdf> (accessed February 26, 2009), p.4; ICE/DRO Detention Standard No. 23, “Personal Hygiene,” December 2, 2008, http://www.ice.gov/doclib/PBNDs/pdf/personal_hygiene.pdf (accessed February 23, 2008), p.3.

¹⁹⁰ United Nations Standard Minimum Rules for the Treatment of Prisoners (Standard Minimum Rules), adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolution 663 C (XXIV) of July 31, 1957, and 2076 (LXII) of May 13, 1977, para. 15.

¹⁹¹ Human Rights Watch interview with Nadine I., Florida, April 2008.

¹⁹² Human Rights Watch interview with Elisa G., Arizona, May 2008.

initial allotment.¹⁹³ “I don’t have any problem with working, but I don’t feel that it is right that you have to do that to get what you need,” said one woman.¹⁹⁴ Upon learning of this rule, the ICE field office said this rule was against policy and would be taken up with the facility immediately.

Mammography and Breast Health

I worry about my breast a lot. I told my family, “Don’t ask me to [appeal my immigration case].” I’m not well and I would have to stay without medical care. I don’t know from month to month ... things can get worse in my breast. It’s hurting me. What was I supposed to do, die of cancer here? With adequate care, yes, I would stay until the end. Because 22 years of my life [have been in the US]. My kids are 12 and the United States is all they know. Depression, inadequate food, detention? Yes, still I would have fought it indefinitely.

—Antoinette L., Arizona, May 2008¹⁹⁵

Topping even cervical cancer, breast cancer ranks as the leading cause of cancer deaths among women. Calling mammograms “the gold standard” for early detection of the disease, the American Cancer Society recommends that women age 40 and over receive the screening yearly along with a clinical breast exam from their health care provider, and that younger women undergo the clinical exam every two to three years. The American Cancer Society also counsels providers to tell women in their 20s and older about the benefits and limitations of breast self-examinations.¹⁹⁶

The DIHS approach to breast health is deficient in how it addresses all three modes of breast cancer screening. National policy limits access to mammograms and is completely silent on manual breast exams and self-exams. The DIHS benefit package provides that mammography requests will be considered for asymptomatic cases only after an individual has been in custody for one year and only if that the individual is not facing imminent

¹⁹³ Some women indicated to us that the rule required women to work to receive any pads whatsoever; others said that a first distribution was given without requirements.

¹⁹⁴ Human Rights Watch interview with Flor H., Florida, April 2008.

¹⁹⁵ Human Rights Watch interview with Antoinette L., Arizona, May 2008.

¹⁹⁶ American Cancer Society, “Updated Breast Cancer Screening Guidelines Released,” May 15, 2003, http://www.cancer.org/docroot/NWS/content/NWS_1_1x_Updated_Breast_Cancer_Screening_Guidelines_Released.asp (October 6, 2008).

deportation.¹⁹⁷ As discussed in regard to Pap smears, the one-year requirement contradicts advice that these tests be administered annually, since it does not take into account when the woman last obtained a screening prior to detention.

Four women who spoke with Human Rights Watch who had been in custody over one year had not received either a mammogram or a manual breast exam.¹⁹⁸ Another woman had recently had surgery on her breast before being detained and was instructed to get a mammogram every six months. Due for her six-month mammogram at the time she was detained, she had to wait four months before the detention authorities arranged for a mammogram, and did not receive another one during her remaining 12 months in detention.¹⁹⁹

Those women who have breast health concerns that require examination and follow up care find the uncertainty around their health compounded by uncertainty around the procedure for obtaining appropriate medical attention. The Covered Services Package does not set out separate rules on eligibility for diagnostic mammograms. However, presumably they would fall under the rubric of procedures that might be authorized if supported by clinical findings.²⁰⁰ Two women felt their lives were in jeopardy due to ICE's failure to follow up on concerns related to breast cancer. Antoinette L., quoted above, waited months for a mammogram. When one was finally performed, and it was determined that at least one of two lumps required further investigation, no plan of action was formed; rather, she was told that this was something she should pursue after leaving detention, whenever that might be.²⁰¹ During Lily F.'s months-long wait for a mammogram she felt increasing discomfort—"It's like something bite[s] me"—and worried with thoughts of her mother's death from breast cancer: "I have kids," she said, "I don't want to die here away from my family."²⁰²

¹⁹⁷ DIHS Covered Services Package, 2005, p. 26.

¹⁹⁸ Human Rights Watch interview with Cecile A., Florida, April 2008; Human Rights Watch interview with Nana B., Arizona, May 2008; Human Rights Watch interview with Mary T., Texas, April 2008; Human Rights Watch interview with Rhonda U., Arizona, May 2008.

¹⁹⁹ Human Rights Watch interview with Lucia C., New Jersey, May 2008.

²⁰⁰ DIHS Summary of Changes to the Detainee Covered Services Package, August 25, 2005.

²⁰¹ Human Rights Watch interview with Antoinette L., Arizona, May 2008.

²⁰² Human Rights Watch interview with Lily F., Arizona, April 2008.

Pregnancy

Prenatal and Postnatal Care

Pregnancy is one of the few women's health concerns ICE leadership has begun to address with appropriate gravity in policy, but this improvement is limited by uneven implementation. It is ICE policy that medical personnel immediately inform ICE when they discover a woman in custody is pregnant in order that those responsible for case management can monitor her progress and assess whether alternatives to detention might be available. For the duration that prenatal and postnatal women are in custody, the ICE benefit package states that prenatal exams are covered services and the new ICE medical standard will provide that "[f]emale detainees shall have access to pregnancy testing and pregnancy management services that include routine prenatal care, addiction management, comprehensive counseling and assistance, nutrition, and postpartum follow up."²⁰³ As it stands, however, access to these services appears to vary considerably.

ICE contends that all pregnant women in detention receive care from off-site obstetrical specialists, two of whom we spoke with and confirmed that they provide the detained women with care commensurate with community standards. Martha Burke, midwife at Su Clinica Familiar in Harlingen, Texas, sees pregnant women detained at Willacy County Detention Center and told Human Rights Watch that "What's available to them is what's available to everyone."²⁰⁴ Restrictions in the DIHS health coverage or in the logistics of transporting women for services do not pose a problem according to Dr. F. Javier del Castillo, who provides care at his practice in Brownsville, Texas, for women detained at Port Isabel Service Processing Center: "If I say the lady needs an ultrasound on Sunday, she'll get it on Sunday."²⁰⁵ Three women who visited off-site providers expressed satisfaction with the services.²⁰⁶ Speaking of the Brownsville practice, Katherine I. said, "They [ICE] sent me to the doctor three or four times, a women's clinic in Brownsville.... They did a sonogram twice, checking everything. They treated me well. There's nothing that needs to be changed about Brownsville."²⁰⁷

²⁰³ ICE/DRO Detention Standard No. 22, "Medical Care," December 2, 2008, p. 18.

²⁰⁴ Human Rights Watch interview with Martha Burke, midwife, Su Clinica Familiar, Harlingen, Texas, April 25, 2008.

²⁰⁵ Human Rights Watch interview with Dr. F. Javier del Castillo, Brownsville, Texas, April 25, 2008.

²⁰⁶ Human Rights Watch interview with Katherine I., Texas, April 2008; Human Rights Watch interview with Shania E., Texas, April 2008; Human Rights Watch interview with Isabel F., Florida, April 2008.

²⁰⁷ Human Rights Watch interview with Katherine I., Texas, April 2008.

However, we spoke with three women in Arizona who never reached an outside provider and for whom these services never materialized. In two of those cases, the women told the medical staff of their pregnancy but tested negative on the urine test the DHS facilities use to detect pregnancy in all detained women who are of child-bearing age. While accurate most of the time, urine tests cannot predict pregnancy as early as blood tests.²⁰⁸

Failure to schedule necessary tests in a timely manner can also delay or effectively deny access to prenatal care. Giselle M., pregnant for the first time, entered ICE custody after her doctor identified an ovarian cyst that threatened her five-month pregnancy and her health but, despite bringing her need for frequent sonograms to the attention of ICE, never obtained a prenatal exam of any kind during a month and a half in detention:

When I went to get a sonogram [before being detained] the doctor found a cyst and wanted to monitor every two to three weeks because it kept growing, growing to the size of a golf ball. It could erupt and hurt me or the baby. I was a first time mom, I didn't know what to expect. I told them [at the detention center] this is what is going on and I need to see a doctor. I would go every time with my little paper. They would say, "Go ahead, put [in] a request." But they never took me once. They never got back to me.²⁰⁹

Giselle M.'s medical record indicates that the health unit planned to include her the next time they arranged a visit with the prenatal care provider, but did not make any accommodation for her to see a specialist more quickly given her circumstances. After almost a month had passed from when she was supposed to have had a sonogram according to the schedule set by her doctor, Giselle filed another sick call request asking about when she would have an appointment. The response from the medical staff read, "You are scheduled to see PA soon, within 2 wks. Be patient."²¹⁰

Abortion

The Division of Immigration Health Services lists "elective abortions" as an example of "commonly requested procedures" that are generally not authorized under the Covered Services Package. Several of the health service providers we questioned about the

²⁰⁸ US Department of Health and Human Services, "Pregnancy Tests," March 2006, <http://www.womenshealth.gov/faq/pregtest.htm#d> (accessed October 6, 2008).

²⁰⁹ Human Rights Watch interview with Giselle M., Arizona, May 2008.

²¹⁰ Medical records from detention facility for Giselle M., on file with Human Rights Watch.

accessibility of abortions indicated that ICE would not provide or fund an abortion for a woman in custody, but could arrange transportation to an appointment paid for by the woman herself or a third party. For many women who arrive in detention without significant personal funds or connections to resources in the immediate area, arranging to pay for the procedure, which can cost hundreds of dollars, may be impossible. Detention health care providers emphasized that abortion rarely comes up and some could not remember it ever arising at all. In contrast, legal and social service providers noted the frequency of sexual assault along the border and recalled clients seeking access to abortion following incidents of rape. By comparison, unlike women in ICE custody, women in the custody of the Bureau of Prisons may receive an elective abortion at Bureau expense if the pregnancy is the result of rape.²¹¹

The reference to abortion not “coming up” underscored the apparent omission of options counseling for women who test positive on the pregnancy tests all women receive at intake.²¹² The DIHS Policies and Procedures Manual, which provides instructions to staff at DIHS-operated facilities, requires providers to screen all women between the ages of 10 and 55 for pregnancy, and to follow up on positive results with notification to ICE and initiation of prenatal care. But there is no recognition of the possibility that a woman might not wish to continue the pregnancy.²¹³ Indeed, one provider confirmed that unless the woman articulates a desire to terminate the pregnancy, it is “care as usual.”²¹⁴ Three women confirmed that they received no such counseling and one indicated that she had planned to seek an abortion before being detained and would have requested one in detention if that option had been explained to her:

You know when you find out you’re pregnant you feel excited. That’s normal. But I didn’t feel that way. I was indifferent. I had been thinking about abortion ... But the doctors [at the detention center] were going to want me to tell them why I am thinking about that. In that moment, if I had the option I would have done it [abortion] ... I didn’t know that there were those kind of services available.²¹⁵

²¹¹ Federal Bureau of Prisons, US Department of Justice, “Program Statement: Birth Control, Pregnancy, Child Placement and Abortion,” No. 6070.05, August 6, 1996, sec. 551.23.

²¹² Options counseling refers to unbiased and medically accurate information provided by a healthcare provider to a pregnant woman regarding her options for continuing the pregnancy toward parenting or adoption, or terminating the pregnancy.

²¹³ DIHS Policies and Procedures Manual, sec. 8.2.5.

²¹⁴ Human Rights Watch interview with Donna McGill, health services administrator, Corrections Corporation of America (CCA), Central Arizona Detention Center, Florence, Arizona, May 2, 2008.

²¹⁵ Human Rights Watch interview with Katherine I., Texas, April 2008.

According to standards issued by the National Commission on Correctional Health Care, “pregnant inmates [should be] given comprehensive counseling and assistance in accordance with their expressed desires regarding their pregnancy, whether they elect to keep the child, use adoption services, or have an abortion.”²¹⁶ The Federal Bureau of Prisons requires wardens to “offer to provide each pregnant inmate with medical, religious, and social counseling to aid her in making the decision whether to carry the pregnancy to full term or to have an elective abortion.”²¹⁷ The new ICE medical standard states that pregnant women will have access to “comprehensive counseling and assistance” as part of “pregnancy management services” but does not elaborate on what this entails, whether it covers information on abortion, how it will be made available or who will be responsible for providing it.²¹⁸

The duty to provide options counseling as a component of pregnancy testing is especially important in the immigration detention context, where desires to terminate a pregnancy may not be expressed because women are unaware of the options that are legally available in this country. It is incumbent on facilities to provide each pregnant woman with, at the very least, a statement of the law and referrals to trained counselors for more information as desired.

Nursing Mothers

Recent policy changes limiting the detention of nursing mothers should prevent many women from having to contend with the detention health services’ deficient approach to lactation. However, gaps in implementation of the new policy raise concerns that women and children will continue to suffer the short- and long-term effects of the scant medical attention offered to nursing mothers in custody.

In a November 2007 directive, then Assistant Secretary Julie Myers instructed ICE Field Offices to consider paroling all nursing mothers who did not meet the criteria for mandatory detention²¹⁹ and who did not present a national security risk.²²⁰ Nonetheless, two of the five

²¹⁶ NCCHC, *Standards for Health Services in Jails 2008*, Std. J-G-09, p. 108.

²¹⁷ Federal Bureau of Prisons, US Department of Justice, “Program Statement: Birth Control, Pregnancy, Child Placement and Abortion,” No. 6070.05, August 6, 1996, sec. 551.23.

²¹⁸ ICE/DRO Detention Standard No. 22, “Medical Care,” December 2, 2008, p. 18.

²¹⁹ “The law requires the detention of: criminal aliens; national security risks; asylum seekers, without proper documentation, until they can demonstrate a ‘credible fear of persecution’; arriving aliens subject to expedited removal ...; arriving aliens who appear inadmissible for other than document related reasons; and persons under final orders of removal who have committed aggravated felonies, are terrorist aliens, or have been illegally present in the country.” Alison Siskin, Congressional Research

nursing mothers who spoke with Human Rights Watch had entered detention since the directive despite being eligible for parole under its guidelines. In both cases, it appeared that there had been a breakdown in communication between health services personnel and the case management authorities in charge of parole decisions. The directive instructs field offices to update ICE headquarters regarding decisions to detain nursing mothers; however, there does not seem to be a functioning system for health services staff to alert immediately field offices of the presence of nursing mothers, as they must with pregnant women. In fact, when Human Rights Watch queried health services administrators about their approach to lactation, none made reference to the directive.

Women entering detention as nursing mothers, whether because they meet the criteria for mandatory detention or because they have been overlooked for parole, face considerable hardship, much of which could be avoided with the most basic and inexpensive of interventions: a breast pump. Officials at DHS headquarters informed Human Rights Watch that breast pumps should be made available to nursing mothers.²²¹ However, of the five women who spoke with us about their experience of being detained while lactating, none were offered the option of using a breast pump when they presented for medical intake.²²² The absence of this option caused intense physical discomfort including fever, chills, and pain. Jennifer L., detained at two facilities in Texas, recounted, “I told them at [the first detention center], and they called me after two-three days. They gave me a little bit of pills for fever but the breasts were full. And the fever was permanently in my body. No pump, no compress, no ice.”²²³ Similarly, Ashley J., detained in Arizona, said, “The ducts clogged. I felt very bad. [My breasts] were so full my arms hurt. I couldn’t move my arms.”²²⁴ In at least one case, mastitis resulted when these concerns went unaddressed.²²⁵

In addition to causing severe discomfort, the abrupt halt to lactation has significant long-term implications for the woman and her child. The women who spoke with Human Rights

Service (CRS), “Immigration-Related Detention: Current Legislative Issues,” April 28, 2004, <http://www.fas.org/irp/crs/RL32369.pdf> (accessed January 20, 2009), p. 7.

²²⁰ Memorandum from Julie L. Myers, assistant secretary, ICE, to all field office directors and all special agents in charge, ICE, November 7, 2007.

²²¹ Human Rights Watch interview with Joseph Greene, Jay Sparks, Andrew Strait, Philip Jarres, and Jeffrey Sherman, ICE headquarters, Washington, DC, October 30, 2008.

²²² Human Rights Watch interview with Linda G., Florida, April 2008; Human Rights Watch interview with Jennifer L., Texas, April 2008; Human Rights Watch interview with Dita K., Arizona, April 2008; Human Rights Watch interview with Mercedes O., Arizona, May 2008; Human Rights Watch interview with Ashley J., Arizona, May 2008.

²²³ Human Rights Watch interview with Jennifer L., Texas, April 2008.

²²⁴ Human Rights Watch interview with Ashley J., Arizona, May 2008.

²²⁵ Human Rights Watch interview with Mercedes O., Arizona, May 2008.

Watch had intended to continue breastfeeding their children, in some cases, for years beyond the point of their detention, as is typical in some cultures. Women who breastfeed benefit from a reduced risk of breast and ovarian cancer, and their children are less likely to suffer from pneumonia, viral infections, and, research suggests, possibly obesity and diabetes.²²⁶ Despite one health services administrator's contention that they had the option of manually expressing milk, none of the women who went without a pump were able to breastfeed after their release. Apart from depriving mother and child of the physical benefits of continued breastfeeding, this carried with it mental anguish for several women. "My focus was that I couldn't nurse my child. I could not go back to nursing,"²²⁷ said Ashley J. Mercedes O. remembered, "When I was thinking that my daughter would look for me to nurse and I couldn't, I felt useless."²²⁸

Services for Survivors of Sexual and Gender-Based Violence

While it is impossible to say what percentage of the women detained by immigration authorities have survived sexual or gender-based violence, observers' estimates and the risks associated with migration suggest it is high, and possibly climbing.²²⁹ Even though this violence does not affect women exclusively, Human Rights Watch considers it an important topic to address in assessing the detention medical care system's response to women's health needs. One health services administrator told Human Rights Watch that she thought almost all the women in her care were touched by domestic violence;²³⁰ at another facility a health official said that women reporting rape during border crossing "is not surprising for us. Routinely we see it."²³¹

Among the women who spoke with Human Rights Watch, many reported some form of sexual or gender-based violence in one or more stages of the migratory process. For some, violence created the impetus for leaving their country of origin: "I was afraid of my husband because

²²⁶ American Academy of Pediatrics, "Parenting Corner Q & A: Breastfeeding," March 2007, http://www.aap.org/publiced/BR_BFBenefits.htm (accessed October 6, 2008).

²²⁷ Human Rights Watch interview with Ashley J., Arizona, May 2008.

²²⁸ Human Rights Watch interview with Mercedes O., Arizona, May 2008.

²²⁹ The vulnerability of migrant women to violence is well documented. See, e.g., UN Commission on Human Rights, Report of the special rapporteur on violence against women, Radhika Coomaraswamy, Report on trafficking in women, women's migration and violence against women, E/CN.4/2000/68, February 29, 2000, [http://www.unhcr.ch/Huridocda/Huridoca.nsf/o/e29d45a105cd8143802568be0051fcfb/\\$FILE/Goo11334.pdf](http://www.unhcr.ch/Huridocda/Huridoca.nsf/o/e29d45a105cd8143802568be0051fcfb/$FILE/Goo11334.pdf) (accessed November 10, 2008).

²³⁰ Human Rights Watch interview with Lieutenant Commander Melissa George, health services administrator, Eloy Detention Center, Eloy, Arizona, April 30, 2008.

²³¹ Human Rights Watch Interview with Lieutenant James B. Carr, staff physician assistant, DIHS, Pinal County Jail, Florence, Arizona, May 1, 2008.

he was abusing me and if I go back he may do something to me,” said Yesenia P.²³² For others, it transpired over the journey: “There was no lock on the door to the bathroom [at the house where the coyotes kept us]. I had my back turned in the shower when they came in ... afterwards I saw the condoms on the floor,” said Suana Michel Q.²³³ For still others, it formed part of their experience in the US: “Little by little I came to be in a relationship where [my husband] had the biggest control over me because of my being illegal. He had total control over me,” said Ashley J.²³⁴ For almost all, the violence had repercussions that persisted at the time of their detention, such as severe mental distress.

In addressing the needs of survivors of sexual and gender-based violence, inconsistency among detention centers’ approaches means that some women benefit from a comprehensive approach to their mental and physical health, but many go without any recognition of their needs. Both the American Public Health Association and the National Commission on Correctional Health Care recommend that women in custody receive services to address those needs.²³⁵ The APHA standard states that, “Health care for incarcerated women should include services that address the consequences of abusive relationships. The safety of women should be ensured and care should be provided for the physical and emotional sequela of abuse.”²³⁶

ICE policy fails to comprehensively address the needs of survivors of violence. During the recent revision of the detention standards, ICE added a standard on preventing and responding to sexual assault. While this is an important improvement, the standard focuses on sexual assault that takes place in ICE custody, and does not specifically address the needs of survivors whose assault predates their detention. Discussions with facility health services administrators and women currently or formerly detained by ICE highlighted some existing positive practices but also weaknesses in several areas: the identification of survivors, the range of services available to address the short- and long-term consequences of violence, and the cultivation of partnerships with community service providers.

²³² Human Rights Watch interview with Yesenia P., Florida, April 2008.

²³³ Human Rights Watch interview with Suana Michel Q., New York, July 2008.

²³⁴ Human Rights Watch interview with Ashley J., Arizona, April 2008.

²³⁵ APHA, *Standards for Health Services in Correctional Institutions*, p. 108, para. 12; National Commission on Correctional Health Care, Position Statement: Women’s Health (Adopted by the National Commission on Correctional Health Care Board of Directors, September 25, 1994; Revised: October 9, 2005), <http://www.ncchc.org/resources/statements/womenshealth2005.html> (accessed November 10, 2008), para. 4(B).

²³⁶ APHA, *Standards for Health Services in Correctional Institutions*, p. 108, para. 12.

Providing clear opportunities and safe spaces for women to disclose their experience with violence is essential for ensuring the well-being of women in custody, both because they may have urgent medical needs and because the experience of detention may retraumatize them. The new ICE medical standard directs facilities to question all detained persons at their initial medical screening about past or recent sexual victimization, but only advises questioning about other forms of physical abuse for individuals referred for mental health evaluations.²³⁷ Despite assertions by facility providers that they ask about violence during medical intake, a number of the women who spoke with Human Rights Watch did not recall ever being asked. In cases where abuse or assault formed the basis for the woman's claim for immigration relief and would likely have been known to her deportation officer, these issues still went unaddressed on the medical side. Nora S. said that this subject did not come up with the detention staff: "I only spoke about this in court."²³⁸

Failure to identify survivors of violence during initial screenings may be linked to the phrasing of the question and the person by whom it is asked. On one intake form, the question is asked, "Have you ever been the victim of a sex crime?"²³⁹ In addition to leaving out the most common form of gender-based violence—domestic violence—the question may fail to elicit information because of confusion over what constitutes a crime. National and international standards on such screening typically advise a series of questions about specific behaviors or incidents given the varying ways in which individuals, especially those from diverse cultural backgrounds, may define violence or crimes.²⁴⁰ In addition, in many cases, women may only be willing or comfortable disclosing violence to a healthcare provider of the same gender. As noted above, the initial medical screening at ICE facilities may be conducted by personnel who are not medical professionals. Further, detainees are not necessarily screened by someone of the same gender.

An early opportunity for an effective discussion of these issues is particularly important for women who have suffered sexual violence immediately preceding their detention. Otherwise,

²³⁷ ICE/DRO Detention Standard No. 22, "Medical Care," December 2, 2008, pp.12, 14.

²³⁸ Human Rights Watch interview with Nora S., Arizona, May 2008.

²³⁹ Facility intake form, on file with Human Rights Watch.

²⁴⁰ See Kathleen C. Basile, Maci F. Hertz, and Sudie E. Back, *Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings: Version 1.0*, (Atlanta: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2007), <http://www.cdc.gov/NCIPC/pub-res/images/IPVandSVscreening.pdf> (accessed January 21, 2009). See also Carole Warshaw and Anne L. Ganley, *Improving the Health Care Response to Domestic Violence: A Resource Manual for Health Care Providers*, (San Francisco: Family Violence Prevention Fund, 1996), http://www.endabuse.org/section/programs/health_care/_resource_manual (accessed January 21, 2009); World Health Organization, "Violence against women: What health workers can do," July 1997, <http://www.who.int/gender/violence/v9.pdf> (accessed October 19, 2008).

they may miss the window for time-sensitive interventions such as emergency contraception (EC) and prophylaxis for sexually transmitted infections (STIs), as well as the collection of physical evidence of the attack. Health services administrators told Human Rights Watch that while most women would have passed the time period for EC to be effective at the point they reached the detention center, the medication could be made available when appropriate, as could treatment for STIs, crisis counseling, and referral to a local hospital for forensic evidence collection. Despite the administrators' statements regarding the availability of EC, the medicine is not on the detention center formulary and, unlike STI prophylaxis, it is omitted from the list of interventions to be made available to rape survivors in the new standard on sexual abuse and assault prevention and intervention.²⁴¹ Officials from DIHS headquarters insisted that as an "emergency" intervention, EC would be obtained in one manner or another to ensure a woman would have timely access to it.²⁴²

Women in abusive relationships may also have immediate needs and concerns for their safety. Ashley J. recounted the continuing torment her abusive husband inflicted on her while she was in detention: "He would tell me that he knew deportation officers and that he could see the videos of how I was behaving. I believed that he could reach me inside, in detention."²⁴³ Ashley J. informed her deportation officer of the situation so that he would not provide her husband with information on her case, but she was not referred by the officer for services nor was the subject broached by health care providers.

For women whose experience with violence dates back further, the needs for medical attention may still be acute. Human Rights Watch spoke with two women, Nana B. and Jameela E., who suffered gynecological problems while in detention that they attributed to female genital mutilation performed in their country of origin. Regarding mental health care, Nora S., a survivor of domestic violence, stated affirmatively, "I would definitely have wanted help with this, the opportunity to talk about this. I was a victim of domestic violence for 13 years."²⁴⁴

Finally, a hallmark feature of one facility's successful response to one survivor's assault was the detention facility's partnership with a local service provider. According to Suana Michel

²⁴¹ ICE/DRO Detention Standard No. 14, "Sexual Abuse and Assault Prevention and Intervention," December 2, 2008, http://www.ice.gov/doclib/PBNDs/pdf/sexual_abuse_and_assault_prevention_and_intervention.pdf (accessed February 26, 2009), pp. 8-9.

²⁴² Human Rights Watch interview with Joseph Greene, Jay Sparks, Andrew Strait, Philip Jarres, and Jeffrey Sherman, ICE headquarters, Washington, DC, October 30, 2008.

²⁴³ Human Rights Watch interview with Ashley J., Arizona, May 2008.

²⁴⁴ Human Rights Watch interview with Nora S., Arizona, May 2008.

Q., the health providers at Port Isabel Service Processing Center referred her to the Family Crisis Center in Harlingen, Texas, who provided her with counseling during her stay in detention and afterwards when she was released into an alternative to detention program.²⁴⁵ Moreover, when she moved out of state, the facility provided her with a referral to a similar organization at her destination. Unfortunately, not all detention centers coordinate so closely with local resources. An advocate for sexual assault survivors in Arizona told Human Rights Watch that she had repeatedly sought to engage her local ICE field office in a dialogue on ways they could cooperate to serve the needs of survivors but found them uninterested.²⁴⁶

Mental Health Care

Human Rights Watch decided to probe further on care for mental health issues because it emerged in interviews as a priority issue for many women in detention. When asked about the health concerns women frequently presented, several health services administrators noted that women would commonly seek care for depression or anxiety.²⁴⁷ This held true in Human Rights Watch's interviews with women who were or had been in detention.

According to the women we spoke with, the facilities' response to mental health concerns ranked as one of the greatest deficiencies in the detention health care system. In part, this failing represents one more manifestation of the detention standard and benefit package's emphasis on acute care. The currently binding ICE medical standard provides for a mental health screening, but does not elaborate on what treatment is available.²⁴⁸ The new ICE medical standard shows improvement in that it stipulates that every facility shall provide mental health care to the individuals in its custody and that a treatment plan will be devised for individuals with mental health needs.²⁴⁹ However, the extent to which an effective treatment plan can be implemented may be limited by the off-site services authorized under the DIHS Covered Services Package, which states that non-emergency services are generally not covered and that counseling and psychotherapy are not covered unless approved by the medical director.²⁵⁰ DIHS officials assured Human Rights Watch that counseling is available

²⁴⁵ Human Rights Watch interview with Suana Michel Q., New York, July 2008.

²⁴⁶ Human Rights Watch interview with sexual assault advocate (name withheld), Arizona, May 2008.

²⁴⁷ Human Rights Watch interview with Donna McGill, health services administrator, CCA, Central Arizona Detention Center, Florence, Arizona, May 2, 2008.

²⁴⁸ INS Detention Standard, "Medical Care," September 20, 2000, p. 3.

²⁴⁹ ICE/DRO Detention Standard No. 22, "Medical Care," December 2, 2008, pp.13- 14.

²⁵⁰ DIHS Covered Services Package, 2005, p. 33.

and that medication would not be prescribed alone but as part of a comprehensive treatment plan, as is contemplated in relevant health standards.²⁵¹

However, a number of women cited difficulty obtaining counseling or accessing other options for treating mental health concerns beyond medication alone: “I’ve never been offered therapy but I have asked for information to try to get something done but I’ve never received any replies . . . [The clinic manager] keeps telling me that there is nothing that the institution can do with us because we are not going to be here for a very long time,” said Itzya N., who at the time had already been detained for more than four months.²⁵² Her severe depression led the facility to twice place her on suicide watch and to prescribe her increasingly strong doses of medication, but without a complementary course of therapy, as she requested. Beatriz R., on the other hand, said she had been told that counseling was available but was never able to avail herself of it: “They say, ‘Oh, you can speak to a counselor anytime you want.’ But they’re not there or they’re busy. Before they said they would call me. I don’t know who the counselor is. They never called me to talk with the counselor.”²⁵³

Several women who had suffered from depression or anxiety told Human Rights Watch that they were dissuaded from even seeking help by the knowledge that, at best, they would get medication but no counseling or therapy.²⁵⁴ Others delayed or decided against reporting their mental health concerns out of fear that they would face negative consequences.²⁵⁵ Maya Z. said that facility staff as well as other women detained at the facility advised her to cope with her anxiety problems by herself because bringing it to the attention of medical staff might result in a transfer to a less desirable facility.²⁵⁶ Another woman found that the medical staff immediately interpreted a request to speak with a psychologist as an indication of suicidal ideation. After her request, the staff asked her if she wanted to kill herself, to which she responded that she would rather be dead than have been taken into detention, but that she had no intention of harming herself. She was immediately put on

²⁵¹ Human Rights Watch interview with Joseph Greene, Jay Sparks, Andrew Strait, Philip Jarres, and Jeffrey Sherman, ICE headquarters, Washington, DC, October 30, 2008. APHA standards state that psychotropic medication should only be prescribed as one element of a treatment plan. APHA, *Standards for Health Services in Correctional Institutions*, p. 59, para. 1(b)(3).

²⁵² Human Rights Watch interview with Itzya N., Arizona, May 2008.

²⁵³ Human Rights Watch interview with Beatriz R., Arizona, April 2008.

²⁵⁴ Human Rights Watch interview with Nora S., Arizona, May 2008; Human Rights Watch interview with Ashley J., Arizona, May 2008.

²⁵⁵ Human Rights Watch interview with Raquel B., New Jersey, May 2008.

²⁵⁶ Human Rights Watch interview with Maya Z., Florida, April 2008.

lockdown for several days, which only compounded her distress and dissuaded her from raising the issue again.²⁵⁷

The medical system's focus on crisis intervention also serves to exclude preventive care for individuals who develop depression and anxiety in response to the experience of being detained. Women, both those who have pre-existing mental health concerns and those who do not, face a host of stressors brought on by detention. These may include separation from children and family members who depend on them, uncertainty about whether they will be allowed to remain in the country, trauma from their arrest, and the deprivation of their liberty inside the facility. One DIHS healthcare provider acknowledged to Human Rights Watch that detention does take a toll on mental well-being but added that the medical staff has limited options for alleviating these stressors before the situation degrades to the point where intervention by mental health professionals is necessary.²⁵⁸

These needs might be met through the assistance of a social worker who could, for example, make inquiries into the well-being of separated family members or contact deportation officers to discuss the case management of individuals having a particularly negative response to detention. But the women we spoke with pointed to even smaller interventions that, where available, helped a great deal. Comparing two facilities, Nora S. said that at the first one, a service processing center, they "had the heart to help." This, she explained, meant that "they would give us paper, pens to write our families every day," and offered her opportunities to call her family, as opposed to the second facility, a contract detention center, where she was unable to call her family for four weeks. "I mean the fact that they were allowing people to communicate with families is emotional support because it is very hard to be locked up," Nora S. said. The facility's enabling them to reach family members meant that they "were not abandoned."²⁵⁹

²⁵⁷ Human Rights Watch interview with Jameela E., Virginia, June 2008.

²⁵⁸ Human Rights Watch Interview with Lieutenant James B. Carr, staff physician assistant, DIHS, Pinal County Jail, Florence, Arizona, May 1, 2008.

²⁵⁹ Human Rights Watch interview with Nora S., Arizona, May 2008.

VI. Legal Standards

International Legal Standards

Failures in the detention medical care system's response to women's health concerns implicate fundamental human rights, including international legal protections for the right to health, the right to non-discrimination, and the rights of detained persons. A number of these protections are enshrined in the International Covenant on Civil and Political Rights, the Convention against Torture, and the Convention on the Elimination of All Forms of Racial Discrimination, treaties which the US has ratified. The right to health itself is articulated in the International Covenant on Economic, Social and Cultural Rights (ICESCR), which the US has signed but not yet ratified.

The Right to Health

By restricting coverage of basic women's health services, failing to ensure that appropriate care is delivered in a timely way, and paying insufficient attention to the manner in which services are delivered, ICE undermines the right to health of the women in its custody. The International Covenant on Economic, Social and Cultural Rights (ICESCR) recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."²⁶⁰ The US, as a signatory, has an obligation not to undermine the object and purpose of the treaty.²⁶¹ The US is additionally committed to protecting the right to health as a member of the United Nations under the Universal Declaration of Human Rights. The right to health is inseparable from provisions on the right to life and the right to freedom from degrading treatment that are included in the International Covenant on Civil and Political Rights and the Convention against Torture, both of which the US has ratified.²⁶²

²⁶⁰ International Covenant on Economic, Social and Cultural Rights (ICESCR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force January 3, 1976, art. 12(1). While the Covenant recognizes that developing countries are under a duty of "progressive realization" of the right, this is not true for developed countries, such as the United States, which are responsible for ensuring the Covenant rights in full.

²⁶¹ Vienna Convention on the Law of Treaties, adopted May 29, 1969, UN Doc. A/Conf.39/27, 1155 UNTS 331, entered into force January 27, 1980, art. 18(1).

²⁶² International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, ratified by the United States on June 8, 1992, art. 10. The Convention against Torture obligates governments to take measures to prevent acts of degrading treatment committed by or with the consent or acquiescence of a public official, with particular attention to preventing such acts in the context of detention. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention against Torture), adopted December 10, 1984, G.A. res. 39/46, annex, 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984), entered into force June 26, 1987, ratified by the United States on October 21, 1994, art. 10, 11, 16(1).

The Committee on Economic, Social and Cultural rights, the body charged with interpreting and monitoring the implementation of the ICESCR, has identified four essential components to the right to health: availability, accessibility, acceptability and quality.²⁶³ The health care provided in US immigration detention is deficient in each of these areas. Availability refers to the existence of health services, personnel, and materials of a “sufficient quantity.”²⁶⁴ ICE fails in this respect when women in custody seek professional services, such as therapy for mental health issues or other specialist care, and experience delays or denials due to medical staff shortages. In addition, the Committee’s assessment of availability looks at essential drugs as defined by the World Health Organization Action Programme on Essential Drugs. This list includes hormonal contraception, which is not part of the DIHS formulary. Moreover, the limitation on access to contraception infringes on what the Committee has identified as a freedom encompassed in the right to health: “the right to control one’s health and body, including sexual and reproductive freedom.”²⁶⁵

Accessibility as an element of the right to health breaks down into four sub-parts: non-discrimination in access, physical accessibility, economic accessibility, and information accessibility. The Committee on Economic, Social and Cultural Rights has noted that the governmental obligation to respect the right to health includes “refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services.”²⁶⁶ The restricted scope of care available under the Covered Services package limits access to a range of such services for individuals in ICE custody. With respect to information accessibility, which includes the right to “seek, receive and impart information and ideas concerning health issues,”²⁶⁷ ICE falls short when it impedes women’s access to their health records either by failing to transfer medical information between facilities or stonewalling records requests. Also, by omitting options counseling in its handling of pregnancy, ICE denies women access to information about the range of health services that are legally available to them.

²⁶³ UN Committee on Economic, Social and Cultural Rights (CESCR), “Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights,” General Comment No. 14, The Right to the Highest Attainable Standard of Health, E/C.12/2000/4 (2000), [http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/40d009901358boe2c1256915005090be?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/40d009901358boe2c1256915005090be?Opendocument) (accessed October 10, 2008), para. 12.

²⁶⁴ *Ibid.*, para. 12(a).

²⁶⁵ *Ibid.*, para. 8.

²⁶⁶ *Ibid.*, para. 34.

²⁶⁷ *Ibid.*, para. 12(b).

Regarding the acceptability of health services, ICE has an obligation to ensure that the services it provides are “respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.”²⁶⁸ In the interviews Human Rights Watch conducted, the issue of acceptability emerged with inconsistencies in the use of translators for non-English speakers, in the sophistication of the assessment of women’s experience with violence, and in providers’ sensitivity to the impact of the detention environment on individuals. Further, breaches of confidentiality in the course of medication distribution and the use of security precautions that intruded on the privacy of exams and treatment raised questions around the observance of medical ethics.

ICE health care is also unsatisfactory in terms of quality. Under the Committee’s analysis, quality refers to the appropriateness of care by medical and scientific standards.²⁶⁹ ICE policy diverges from standards of medical practice in the United States in its approach to certain basic women’s health services, including Pap smears and mammograms. In other areas, including services for nursing mothers, failures at the level of policy implementation prevent women from accessing care consistent with prevailing medical standards. In addition, by imposing few requirements for professional accreditation on its facilities, ICE removes itself from rigorous external evaluation of its operations that would help to monitor the appropriateness of the care available.

In addition to falling short on benchmarks of availability, accessibility, acceptability and quality, ICE’s performance on safeguarding women’s health is also problematic under other international legal standards. For example, the inconsistent care provided to pregnant women in ICE custody raises issues under article 12 of the Convention on the Elimination of All Forms of Discrimination against Women, a treaty the US has signed but not ratified. Article 12 obligates governments to “ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.”²⁷⁰ Similar

²⁶⁸ Ibid., para. 12(c).

²⁶⁹ Ibid., para. 12(d).

²⁷⁰ Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted December 18, 1979, G.A. res. 34/180, 34 U.N. GAOR Supp. (No. 46) at 193, U.N. Doc. A/34/46, entered into force September 3, 1981, art. 12(2).

provisions regarding prenatal and postnatal care and support for breastfeeding appear in the Convention on the Rights of the Child, which the US has also signed but not ratified.²⁷¹

Further, the Committee on the Elimination of Discrimination against Women recommends, as one step toward assuring women equal access to health care, that governments “establish or support services for victims of family violence, rape, sex assault and other forms of gender-based violence, including refuges, specially trained health workers, rehabilitation and counselling.”²⁷²

The Right to Non-Discrimination

Non-discrimination represents a central principle of international human rights law.²⁷³ As a party to the International Covenant on Civil and Political Rights (ICCPR), the US is obligated to guarantee effective protection against discrimination.²⁷⁴ The Convention on the Elimination of All Forms of Discrimination against Women, specifically mandates that states take action to “eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to healthcare services, including those related to family planning.”²⁷⁵ While both men and women may experience deficiencies in the medical care provided by ICE, certain deficiencies are discriminatory due to the disproportionate impact they have on women. The lack of coverage for family planning methods affects both sexes, but women are particularly affected because the lack of services places them at risk of unintended pregnancy, along with its accompanying health risks and many other profound consequences. Further, women may be disproportionately affected by the limitations on preventive and routine reproductive health care, for which women generally have greater needs.²⁷⁶

²⁷¹ Convention on the Rights of the Child (CRC), adopted November 20, 1989, G.A. Res. 44/25, annex, 44 U.N. GAOR Supp. (No. 49) at 167, U.N. Doc. A/44/49 (1989), entered into force September 2, 1990, art. 24(d), (e).

²⁷² UN Committee on the Elimination of Discrimination against Women, “Violence against Women,” General Recommendation No. 19, UN Doc. A/47/38 (1992), <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm#recom19> (accessed October 10, 2008), para. 24(k).

²⁷³ International protections for the right to non-discrimination include: ICCPR, arts. 2, 4, 26; ICESCR art.2(2); CEDAW, art. 2; International Convention on the Elimination of All Forms of Racial Discrimination (ICERD), adopted December 21, 1965, G.A. Res. 2106 (XX), annex, 20 U.N. GAOR Supp. (No. 14) at 47, U.N. Doc. A/6014 (1966), 660 U.N.T.S. 195, entered into force January 4, 1969, ratified by the United States on October 21, 1994, art. 5; International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (Migrant Workers Convention), adopted December 18, 1990, G.A. Res. 45/158, annex, 45 U.N. GAOR Supp. (No. 49A) at 262, U.N. Doc. A/45/49 (1990), entered into force July 1, 2003., art. 1(1), art. 7.

²⁷⁴ ICCPR, art. 26.

²⁷⁵ CEDAW, art. 12.

²⁷⁶ In certain societal contexts, men may have equivalent or greater needs for reproductive health care than women. However, in most, women have greater needs. See Priya Nanda, “Gender Dimensions of User Fees: Implications for Women’s Utilization

The Rights of Individuals Deprived of their Liberty

Women taken into the custody of immigration authorities do not lose their fundamental rights. The International Covenant on Civil and Political Rights obligates states to ensure that “all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.”²⁷⁷ This, the UN Human Rights Committee has explained, entails a positive obligation to see that those individuals suffer no “hardship or constraint other than that resulting from the deprivation of liberty; respect for the dignity of such persons must be guaranteed under the same conditions as for that of free persons. Persons deprived of their liberty enjoy all the rights set forth in the Covenant, subject to the restrictions that are unavoidable in a closed environment.”²⁷⁸

There is no doubt that both the humiliating treatment of women in ICE custody, and the lack of access to routine health services is far from unavoidable, and can be traced to policy choices well within the power of the government to change. Human Rights Watch’s investigation revealed that the treatment of women in ICE custody is often humiliating and at times crosses the line into cruel, inhuman, and degrading treatment. Unnecessary use of restraints and strip searches, arbitrary restrictions on sanitary supplies, and insufficient privacy during medical examinations undermine the dignity of women in detention. The right to a basic level of healthcare in detention is fundamental to maintaining human dignity and too often is not afforded to women in ICE custody.

Addressing a concern specific to women in detention, the Human Rights Committee has advised states that “Pregnant women who are deprived of their liberty should receive humane treatment and respect for their inherent dignity at all times, and in particular during the birth and while caring for their newborn children; States parties should report on facilities to ensure this and on medical and health care for such mothers and their babies.”²⁷⁹ In this respect, ICE’s policy permitting shackling of pregnant women is at odds with a growing international consensus against the use physical restraints on women during

of Health Care,” *Reproductive Health Matters*, 2002, p. 128; SH Ebrahim, MT McKenna, and JS Marks, “Sexual behaviour: related adverse health burden in the United States,” *Sexually Transmitted Infections*, 2005, p. 39.

²⁷⁷ ICCPR, art. 10(1).

²⁷⁸ UN Human Rights Committee (HRC), “Replaces general comment 9 concerning humane treatment of persons deprived of liberty,” General Comment No. 21, U.N. Doc. A/47/40 (1992), [http://www.unhchr.ch/tbs/doc.nsf/\(Symbol\)/3327552b9511fb98c12563ed004cbe59?Opendocument](http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/3327552b9511fb98c12563ed004cbe59?Opendocument) (accessed October 10, 2008), para. 3.

²⁷⁹ HRC, “Equality of rights between men and women (article 3),” General Comment No. 28, U.N. Doc. CCPR/C/21/Rev.1/Add.10 (2000), [http://www.unhchr.ch/tbs/doc.nsf/\(Symbol\)/13b02776122d4838802568b900360e80?Opendocument](http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/13b02776122d4838802568b900360e80?Opendocument) (accessed October 10, 2008), para. 15.

pregnancy, delivery, and the immediate postnatal period. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment has described pregnant women being shackled or otherwise restrained as “completely unacceptable, and could certainly be qualified as inhuman and degrading treatment.”²⁸⁰ The Human Rights Committee commented on the continuation of this practice in the United States in its concluding observations to the country’s second and third periodic reports in June of 2006 and recommended that the government “prohibit the shackling of detained women during childbirth.”²⁸¹

Finally, ineffective grievance procedures and the Department of Homeland Security’s failure to convert the ICE detention standards into enforceable regulations impede detainees in enforcing their rights. The ICCPR, article 2.1, requires that states parties undertake to “ensure” the Covenant’s rights to all persons within their territory. Without an effective remedy for the violation of the right to dignity, the enjoyment of the right cannot be guaranteed. The Human Rights Committee, which interprets the ICCPR and evaluates state compliance, has urged states to specify in their reports whether individuals in detention “have access to such information and have effective legal means enabling them to ensure that those rules are respected, to complain if the rules are ignored and to obtain adequate compensation in the event of a violation.”²⁸²

Defining a standard of care

The basic international healthcare standard for individuals in state custody is that such persons are entitled to at least comparable services and care as those who are at liberty. The principle of equivalence, articulated in the Basic Principles for the Treatment of Prisoners, adopted by the UN General Assembly in 1990, holds that:

Except for those limitations that are demonstrably necessitated by the fact of incarceration, all prisoners shall retain the human rights and fundamental freedoms set out in the Universal Declaration of Human Rights, and where the State concerned is a party, the International Covenant on Economic,

²⁸⁰ European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, “The CPT Standards, Substantive Sections of the CPT’s General Reports” CPT/Inf/E (2002) 1, Rev. 2006, <http://www.cpt.coe.int/en/documents/eng-standards-scr.pdf> (accessed October 10, 2008), p. 78, para. 27.

²⁸¹ HRC, “Consideration of Reports Submitted by States Parties under Article 40 of the Convention, Conclusions and Recommendations of the Human Rights Committee, United States of America,” CCPR/C/USA/CO/3/Rev.1, December 18, 2006, <http://daccessdds.un.org/doc/UNDOC/GEN/Go6/459/61/PDF/Go645961.pdf?OpenElement> (accessed October 10, 2008), para. 33.

²⁸² HRC, General Comment No. 21, para. 7.

Social and Cultural Rights, and the International Covenant on Civil and Political Rights and the Optional Protocol thereto, as well as such other rights as are set out in other United Nations covenants... Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.²⁸³

According to the UN principles on the ethical responsibilities of healthcare providers, health professionals should provide individuals imprisoned or detained with the same quality and standard of care as those who are not imprisoned or detained.²⁸⁴ This suggests that the appropriate standard for DIHS should be a level of physical and mental health care equivalent to that available in the community, a bar much higher than the standard embodied in the Covered Services Package or even the new ICE medical standard.²⁸⁵

Domestic Legal Standards

The US Constitution establishes a right to medical care for individuals in government custody. The eighth amendment prohibition on cruel and unusual punishments entitles individuals convicted of crimes to medical care. However, since immigration detention is not punitive, the right to medical care for individuals held by ICE derives from the fifth amendment, which states that no person shall “be deprived of life, liberty, or property, without due process of law.”²⁸⁶ Despite the difference in constitutional origin, the rationale behind both protections lies in the custodial responsibility assumed by the state when it deprives the individual of liberty:

[W]hen the State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being. The rationale for this principle is simple enough: when the State by the affirmative exercise of

²⁸³ Basic Principles for the Treatment of Prisoners, adopted December 14, 1990, G.A. Res. 45/111, annex, 45 U.N. GAOR Supp. (No. 49A) at 200, U.N. Doc. A/45/49 (1990), art. 9.

²⁸⁴ See UN Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, adopted December 18, 1982, G.A. Res. 37/194, art. 1.

²⁸⁵ Some have argued that states may in fact have an elevated responsibility to ensure medical care for individuals in detention based upon the custodial relationship the state assumes when it deprives them of their liberty and their options to provide for their own health care. The duty to ensure a higher level of care for detained persons than that available in the community may apply with particular force to conditions created or exacerbated by detention conditions, such as mental health concerns. See Rick Lines, “From equivalence of standards to equivalence of objectives: the entitlement of prisoners to standards of health higher than those outside prisons,” *International Journal of Prisoner Health*, vol. 2 (2006), p. 269.

²⁸⁶ US Const., amend. V.

its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs—*e.g.*, food, clothing, shelter, medical care, and reasonable safety—it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause.²⁸⁷

The government does not escape this duty when it engages a contractor to provide detention services. The US Supreme Court has held that “Contracting out prison medical care does not relieve the State of its constitutional duty to provide adequate medical treatment to those in its custody, and it does not deprive the State's prisoners of the means to vindicate their Eighth Amendment rights.”²⁸⁸

In addition, the scope of the protection for individuals held by ICE in civil custody may exceed that afforded to convicted individuals. The Ninth Circuit Court of Appeals has held that an individual confined awaiting adjudication under civil process cannot be punished and that punishment occurs where “the individual is detained under conditions identical to, similar to, or more restrictive than those under which pretrial criminal detainees are held.”²⁸⁹ Thus, as another court held, “persons in non-punitive detention have a right to ‘reasonable medical care,’ a standard demonstrably higher than the Eighth Amendment standard.”²⁹⁰ However, in the absence of case law specific to immigration, applications of the eighth amendment protection provide guidance on at least the very minimum that the constitution requires ICE to provide.

In *Estelle v. Gamble*, the landmark case defining custodial responsibility for medical care, the US Supreme Court held that the eighth amendment prohibits “deliberate indifference” on the part of detention authorities to a “serious medical need” of a prisoner in their custody.²⁹¹ Federal courts have had several occasions to apply the *Estelle* standard to specific women’s rights concerns and, in some cases, reached differing results. The entire US Court of Appeals for the Eighth Circuit has granted a rehearing to determine the constitutionality of shackling a woman during labor, after a three-judge panel of that court held that the practice did not constitute deliberate indifference to her serious medical

²⁸⁷ *DeShaney v. Winnebago County Dept. of Social Services*, 489 U.S. 189, 200 (1989).

²⁸⁸ *West v. Atkins*, 487 U.S. 42, 56 (1988).

²⁸⁹ *Jones v. Blanas*, 393 F.3d 918, 931–934 (9th Cir. 2004). See also *Hydrick v. Hunter*, 500 F.3d 978, 994 (9th Cir. 2007) (finding that “the Eighth Amendment provides too *little* protection for those whom the state cannot punish”).

²⁹⁰ *Haitian Centers Council, Inc. v. Sale*, 823 F. Supp. 1028 (EDNY 1993).

²⁹¹ *Estelle v. Gamble*, 429 U.S. 97, 104 (1976).

need.²⁹² The US District Court for the District of Columbia has already banned the practice, holding that shackling during labor and shortly thereafter is “inhumane” and constitutionally impermissible.²⁹³ In the area of abortion rights, the US Court of Appeals for the Third Circuit has recognized access to elective, non-therapeutic abortions as a serious medical need.²⁹⁴ While disagreeing with the finding of a serious medical need, the Eighth Circuit nonetheless invalidated a ban on transporting incarcerated women for abortion on the basis of its unreasonable restriction on a woman’s right to abortion under the fourteenth amendment.²⁹⁵ The obligation to ensure that incarceration does not force a woman to forfeit her constitutional right to abortion has also been interpreted to include ensuring access to funding for the procedure.²⁹⁶

In a notable 1994 case, the US District Court in the District of Columbia found that inadequate obstetrical and gynecological care at a correctional treatment facility violated the division of the DC Code governing the treatment of prisoners, which the court described as a codification of the common law rule that prison officials have a duty of reasonable care in the protection and safekeeping of individuals who are imprisoned. Stating that “in the area of medical care, physicians owe the same standard of care to prisoners as physicians owe to private patients generally,” the court found that inadequate gynecological examination and testing, STD testing, follow up care, health education, and prenatal care violated the law.²⁹⁷

²⁹² *Nelson v. Correctional Medical Services*, 533 F.3d 958, (8th Cir. 2008) (vacated pending hearing en banc).

²⁹³ *Women Prisoners of District of Columbia Dept. of Corrections v. District of Columbia*, 877 F.Supp. 634, 668 (DDC 1994).

²⁹⁴ *Monmouth County Correctional Institutional Inmates v. Lanzaro*, 834 F.2d 326, 351 (3d Cir. 1987).

²⁹⁵ *Roe v. Crawford*, 514 F.3d 789 (8th Cir. 2008) (holding that elective, nontherapeutic abortion is not a serious medical need under the eighth amendment, but banning transportation for prisoners seeking abortions constituted an unreasonable restriction on the fourteenth amendment right to seek an abortion). See also *Doe v. Arpaio*, 150 P.3d 1258 (Ariz. 2007) (cert denied, 128 S.Ct. 1704, March 24, 2008) (holding that requiring court order for transportation to abortion procedure was impermissible because it constrained the incarcerated woman’s constitutional right to terminate her pregnancy without a reasonable connection to a legitimate penological interest). But see *Victoria W. v. Larpenter*, 369 F.3d 475 (5th Cir. 2004) (finding the requirement of a court order was reasonable where it was required for all elective procedures and the asserted state interest was inmate security and avoidance of liability).

²⁹⁶ *Monmouth County*, 834 F. 3d at 352.

²⁹⁷ *Women Prisoners of District of Columbia Dept. of Corrections v. District of Columbia*, 877 F.Supp. at 667-68 . On appeal, the court’s determination with regard to obstetrical and gynecological care was vacated on jurisdictional grounds. *Women Prisoners of District of Columbia Dept. of Corrections v. District of Columbia*, 93 F.3d 910 (DC Cir. 1996).

VII. Recommendations

To the Division of Immigration Health Services

General Policy Recommendations

- Amend the Covered Services Package to remove inappropriate consideration of an individual's deportation prospects in determining eligibility for medical procedures and harmonize the package with the revised ICE medical standard so that detained individuals can access a full continuum of health services, whether available inside or outside the detention facility.
- Create mechanisms to improve the timeliness of response to the health care needs of individuals in ICE custody and to their submission of complaints.
- Recruit qualified health professionals to maintain a sufficient number of medical staff at facilities to address the nationwide shortages.
- Ensure that individuals in custody can request translation during their medical visits and are advised of their right to do so.
- Increase the number of qualified staff reviewing Treatment Authorization Requests to remove bottlenecks that cause delays in treatment.
- Ensure that the pursuit of cost savings does not override the medical needs of the patients in the consideration of Treatment Authorization Requests.
- Improve the screening for sexual and gender-based violence according to Family Violence Prevention Fund and WHO guidance.²⁹⁸
- Encourage facilities to establish partnerships with community organizations that provide services to survivors of sexual and gender-based violence to increase women's access to services during and following their period of detention.
- Encourage facilities to establish partnerships with community organizations to ensure that detainees receive referrals for medical care after detention.

²⁹⁸ See Family Violence Prevention Fund, "Preventing Domestic Violence: Clinical Guidelines on Routine Screening," October 1999, <http://endabuse.org/programs/healthcare/files/screpol.pdf> (accessed October 19, 2008), pp. 18-21; World Health Organization, "Violence against women: What health workers can do," July 1997, <http://www.who.int/gender/violence/v9.pdf> (accessed October 19, 2008).

Women's Health Policy Recommendations

- Amend the Covered Services Package to ensure coverage for Pap smears and mammograms for screening purposes according to community standards.
- Amend the Covered Services Package to provide coverage for family planning services and ensure that detention center formularies stock contraceptives, including emergency contraceptive pills.
- Expand mental healthcare options for individuals detained to include scheduled, non-emergency counseling visits with a mental health professional.

Implementation and Training Recommendations

- Conduct intensive outreach to facilities to ensure that both health professionals and security personnel are aware that the men and women in their custody are entitled to the same level of medical care as individuals who are not detained and assure health professionals that ICE and DHS policies are intended to support and not inhibit their delivery of care consistent with standards of medical practice in the United States.
- Ensure that all facility medical staff conducting intake examinations are aware of the jurisdiction's legal standards and ICE's policy on access to abortion. Require staff to apprise women testing positive for pregnancy that they have legal rights regarding the continuation or termination of their pregnancy, and refer women who have questions about access to abortion for a consultation with a licensed abortion provider.
- Ensure that facilities have ready access to breast pumps and are aware of their duty to offer them to nursing mothers who come into custody.
- Provide training to medical staff conducting intake examinations on the manifestations of trauma in women and appropriate techniques for talking about sexual and gender-based violence.

To Immigration and Customs Enforcement

General policy improvements

- Require all facilities holding individuals on behalf of ICE to maintain accreditation with the National Commission on Correctional Health Care.
- Improve precautions to protect the privacy of individuals' medical examinations, including by requiring security personnel to remain outside the exam room in the absence of extraordinary security concerns.

- Amend the detention standards to require that certified health professionals conduct medical intake screening.
- Amend the detention standards to require that individuals receive their complete medical records on release or deportation and to mandate that the full medical record accompany individuals who are transferred between facilities, regardless of whether DIHS operates the facilities.

Improvements in the treatment of women

- Implement the recommendations of the UN special rapporteur on the human rights of migrants, including in particular the recommendations that ICE develop gender-specific detention standards with attention to the medical and mental health needs of women survivors of violence and refrain from detaining women who are suffering the effects of persecution or abuse, or who are pregnant or nursing infants.
- Incorporate into the ICE medical standard the American Public Health Association's standards on women's health care in correctional institutions and the recommendations of the National Commission on Correctional Health Care's policy statement on women's health care.²⁹⁹
- Establish a formal process for ICE officers charged with case management to coordinate with health services personnel to ensure that nursing mothers, pregnant women, and other women with significant health concerns are immediately identified and considered for parole.
- Amend the ICE detention standard on the use of force to specifically prohibit the shackling of women during pregnancy, delivery, and in the immediate postnatal period.
- Consider the availability of specialist services for obstetrics and gynecology in the surrounding community when determining the suitability of facilities for the detention of women.
- Require that facilities make sanitary pads and other materials and facilities necessary for cleanliness and dignity available without restriction.

²⁹⁹ American Public Health Association (APHA) Task Force on Correctional Health Care Standards, *Standards for Health Services in Correctional Institutions*, 3rd ed. (Washington, DC: APHA, 2003), p. 108; National Commission on Correctional Health Care, Position Statement: Women's Health (Adopted by the National Commission on Correctional Health Care Board of Directors, September 25, 1994; Revised: October 9, 2005), <http://www.ncchc.org/resources/statements/womenshealth2005.html> (accessed November 10, 2008).

Implementation of existing and improved policies:

- Improve the current system for receiving and tracking complaints made by individuals in ICE custody. Ensure that all individuals receive notice of complaint procedures in their native languages and that they are informed of the availability of these mechanisms for addressing medical care complaints.
- Provide public notice of penalties imposed on facilities for violations of the detention standard.
- Insist that private contractors engaged to monitor facility compliance with detention standards include professionals with medical expertise in the review of compliance with the medical standard. Provide copies of the private contractors' findings to oversight committees in Congress.

To the US Department of Homeland Security

- Convert the ICE detention standards, including the ICE medical standard, into federal administrative regulations so that they have the strength of law and detained individuals and their advocates will be able to have recourse to courts to redress shortfalls in health care.
- Require detention facilities to provide regular reports to the DHS Office of Inspector General detailing the number of grievances received regarding medical care and their disposition at the facility level.
- Designate a focal point for the protection of the rights of women in immigration detention within the DHS's Office for Civil Rights and Civil Liberties.

To the US Congress

- Pass legislation to require that all individuals in immigration detention have access to medical care that meets standards of medical practice in the United States.
- Establish a commission of independent experts to examine the status of the ICE medical system and identify means of ensuring that immigrants in ICE custody have access to medical care that meets standards of medical practice in the United States.
- Require ICE to provide relevant congressional oversight committees with the reviews of facility compliance with ICE detention standards completed by private contractors. Require DHS to provide oversight committees with any future analyses of the cost savings generated by denying treatment authorization requests.

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Detained and Dismissed

Women's Struggles to Obtain Health Care in United States Immigration Detention

Women represent an increasing share of those caught up in the fastest growing form of incarceration in the United States: immigration detention. Human Rights Watch research in detention facilities in Florida, Arizona, and Texas found that these women, held for periods ranging from a few days to several months or even years, often have limited access to adequate basic health care.

Detained and Dismissed, based on interviews with detained and recently detained immigrant women, documents dozens of instances where women's health concerns went unaddressed by facility medical staff, or were addressed only after considerable delays. Women reported struggling to obtain important services such as Pap smears to detect cervical cancer, mammograms to check for breast cancer, pre-natal care, counseling for survivors of violence, and even basic supplies such as sanitary pads or breast pumps for nursing mothers. A host of problems obstructed access to health services, including inadequate communication about available services, unexplained delays in treatment, unwarranted denial of service, breaches of confidentiality, failure to transfer medical records, and ineffective complaint mechanisms.

Many of these problems are traceable to official policy of US Immigration and Customs Enforcement (ICE), the agency responsible for immigration detention. Although international standards maintain that individuals held in detention are entitled to the same level of medical care as individuals who are not detained, ICE policy focuses on emergency care and effectively discourages the routine provision of some core women's health services. ICE has made improvements with the recent revision of its medical care standard, but still falls short of developing adequate policies, ensuring their proper implementation, and opening up the detention system to effective oversight.

This report examines current gaps in immigration detention health care policy and implementation and provides detailed recommendations to ensure respect for detained women's rights.

Women detained by Immigration and Customs Enforcement turn their backs to the visiting media as instructed by officials inside Willacy Detention Center in Raymondville, Texas.

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