



The Impact of Immigration Law Enforcement on Women & Families
Congressional Briefing
Statement of Meghan Rhoad
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Thank you all for coming today and for taking part in this discussion. My name is Meghan Rhoad and I am the US researcher for the Women's Rights Division at Human Rights Watch. I was the principal researcher and author of the March 2009 report, *Detained & Dismissed: Women's Struggles to Obtain Health Care in United States Immigration Detention*. It is a privilege to be here and to have the opportunity to share our findings and recommendations about these important issues in our nation's capital. And it is an honor to be introducing Kathleen Baldoni, who, despite the adverse consequences for herself, has come forward to speak out on behalf of the women and men she cared for as a detention center nurse.

With executive action and congressional support, a great deal can be done to improve the situation of immigrant women subject to detention, including reducing the number of women held in custody, bringing detention policies regarding women's medical care into line with the recommendations of the American Public Health Association, and establishing legally enforceable detention standards.

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It was almost a year ago exactly that I sat in the back room of a public library just across the river in Falls Church and spoke with a woman about how her attempt to seek asylum in the United States had taken her from one nightmare into another. Jameela, which is a pseudonym I will use for her privacy, told me that she fled her home in east Africa after being raped by her school teacher and enduring female genital mutilation. She told me that the attempt to circumcise her had been botched and she fled before members of her extended family could organize to have the procedure performed again. On arriving in the United States, she sought an attorney to apply for asylum, but found the ones she could afford were long on promises but short on expertise. By the time she found the conscientious attorney who introduced us, Jameela already had a final order of removal entered against her.

As a result of the order, Immigration and Customs Enforcement (ICE) took Jameela into custody, and for almost four months shuttled her between four county jails in Virginia. During this time, she battled with pain over half of her body due to a cyst on one of her ovaries that went untreated while she was in custody. At the first jail, they determined that she required treatment and began the process to make arrangements for surgery. But in the meantime ICE moved her, without her medical records, to another jail where they refused to provide treatment without the records. She started getting her period every two weeks and put in multiple requests to consult a doctor without success. Making it worse, at one place she was detained, she said they did not provide underwear. At none of the jails did they allow her to wear her hijab. At each jail she was strip searched. Her mental health suffered from the humiliation, and when she asked to speak to a psychologist they took her to be suicidal and placed her in solitary confinement.

As Jameela told me about the pain she suffered during her time in ICE custody, her story sounded all too familiar. At the time of our meeting, I had interviewed over forty women for our report, *Detained and Dismissed*, visited nine detention centers in Florida, Texas and Arizona, and spoken with detention medical care providers and ICE officials, in addition to numerous immigration attorneys and advocates. Jameela's experience reflected recurring themes from our research.

Human Rights Watch found that women in immigration detention 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 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 even when there was no security risk, 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 inappropriate treatment. Many detained women and their health care providers at other facilities were not able to obtain full medical records upon transfer or release. Women's written complaints about poor medical care through official grievance procedures went ignored. The list goes on.

We met women who required screening and treatment for breast and cervical cancer but experienced extended delays and outright denials. 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 who never got to see a doctor. We met pregnant women who did get a doctor's appointment, but who were forced to be shackled in order to get there. 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 do chores 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. We met women who sought mental health care for pre-existing conditions, including the effects of trauma, and for the stress of detention but found that the crisis orientation of services meant they could not get access to counseling, and could expect to be put in isolation if their condition deteriorated to the point of suicidality.

Particularly striking are the backgrounds of the women enduring these conditions. They included asylum seekers, victims of trafficking, survivors of sexual assault and domestic violence, pregnant women, and nursing mothers. In almost all of these cases, the women we were talking to had either committed no crimes at all or no crimes of violence. They had not been found to present a danger to the community or to be a flight risk and yet they became entangled in a system of immigration enforcement that relies disproportionately on detention, and provides immigrants with health care that is in some respects inferior to that available to imprisoned criminals.

In most cases, detention is neither necessary nor cost-effective. Studies have shown that alternatives to detention – such as supervised release programs – cost roughly one-fifth as much and are as effective in ensuring that people show up for their immigration hearings. Consequently, a major first step in addressing the gross medical failures in detention should be ensuring that fewer people are subjected to them unnecessarily, through the increased use of alternatives to detention such as humanitarian parole. But the second step is recognizing that the government cannot avoid the responsibility of providing quality health care to those it detains.

International standards and US law make clear that individuals detained by the government are entitled to at least the same standard of health care they would receive in the community. It is well within the power of the US government to meet this standard. It will require expanding the scope of care beyond emergency services and ensuring detention standards meet the American Public Health Association's standards for women's health services. It will also require improving oversight and accountability of the detention system by establishing legally enforceable detention standards through regulation or legislation so that detained persons and their advocates have recourse to the courts to address shortfalls in health care. Congress should work with the administration to reexamine the role of detention in our immigration policy and should move forward on legislation like the Immigration Oversight and Fairness Act, H.R. 1215,

which would create legally enforceable standards for immigration detention, afford detainees access to quality medical care, require facilities to be accredited by the National Commission on Correctional Health Care and the Joint Commission on the Accreditation of Healthcare Organizations, and promote the use of alternatives to detention.

In the absence of such standards, immigration detention remains a closed system that is largely hidden from public scrutiny, where abuses can go unchecked. That is why the information provided by our next speaker is so critical. Kathleen Baldoni, who worked as a nurse at Willacy Detention Center in Raymondville, Texas, for over five months has come forward at great personal cost to offer us her insight into the operation of the immigration detention medical care system.