Society & Genetics

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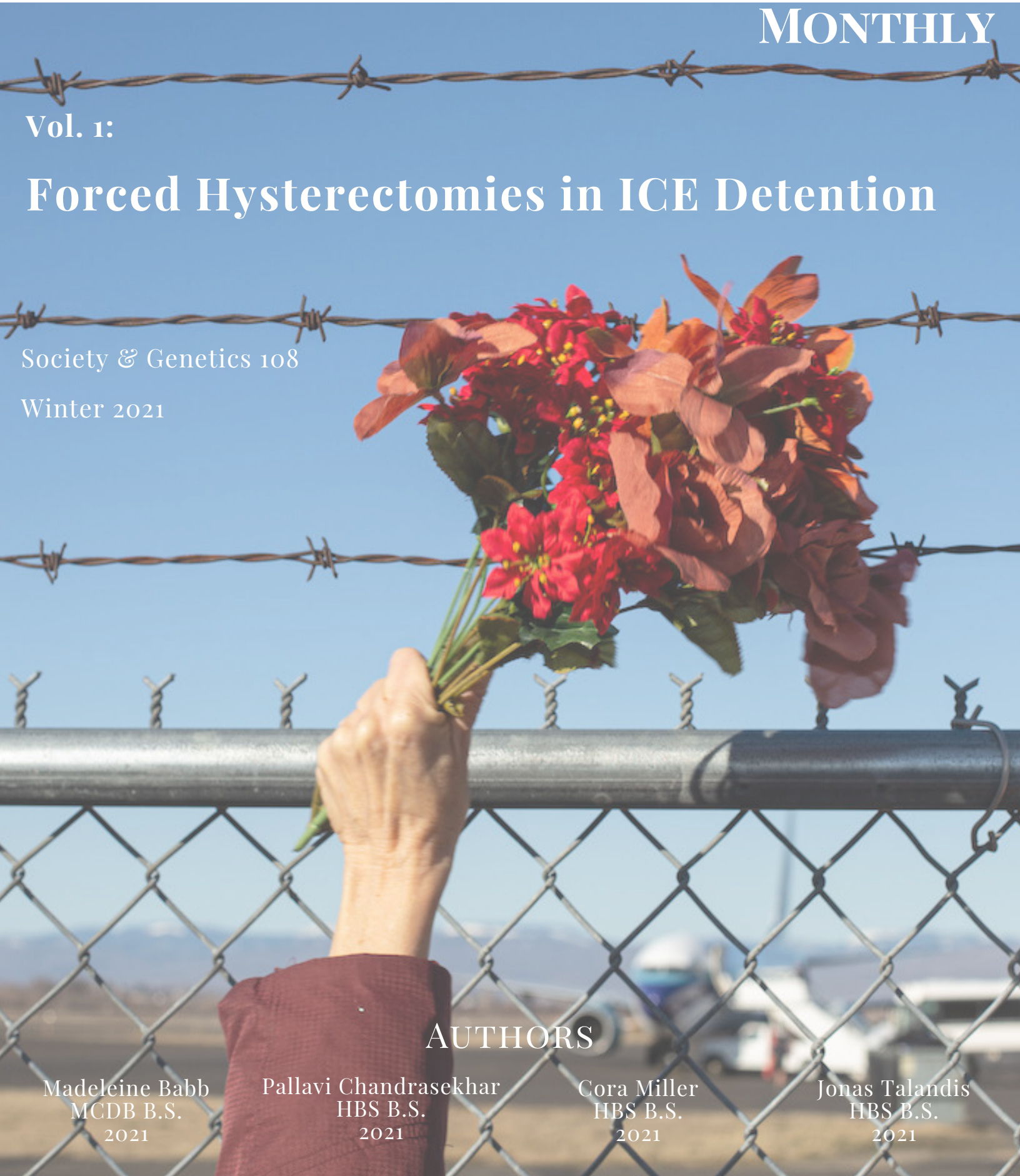
Vol. 1:

Forced Hysterectomies in ICE Detention



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FORCED

THE REPORT, THE HISTORY, THE CONSEQUENCES

BY JONAS TALANDIS [7]

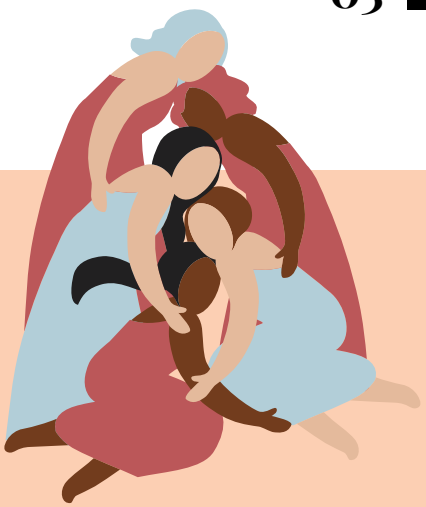
Content Warning: This magazine contains graphic accounts of sexual violence and abuse.

In southern Georgia, a little less than 200 miles down the I-75 South expressway from Atlanta, lies the rural town of Ocilla. It has everything your average small community could offer: a handful of restaurants and businesses, several churches, a golf course, a high school, etc.[1] However, one institution located in Ocilla sets it apart from other seemingly innocent small towns. Ocilla is home to the Irwin County Detention Center (ICDC): a prison used by ICE and run by the for-profit LaSalle Corporations that incarcerates undocumented immigrants under investigation prior to deportation. [2]

Further distinguishing the small town, it was at this detention center in September 2020 that Dawn Wooten, a now former nurse at the ICDC, exposed a troubling trend of extreme, allegedly unwanted and/or uninformed gynecological procedures done on detained women at the center.[3] Partnering with human rights organization Project South, she released a whistleblower report that alleged, among other human rights violations, that the ICDC was the site of inhumane living conditions, neglectful treatment of detainees, and unethical, unnecessary, and unwanted medical procedures resulting in loss of fertility for the female victims.[3]

In particular, Wooten noted "red flags regarding the rate at which hysterectomies [were] performed on immigrant women under ICE custody at ICDC."[3] While relatively common, hysterectomies are not simple or easy procedures; a hysterectomy is a surgery that removes the patient's uterus. Due to the severity of the surgery and recovery, as well as the irreversible loss of fertility, hysterectomies are typically reserved for only the most dire and necessary of medical situations. [4]

Introduction (Cont.)



The report exposes the medical mistreatment at the hands of medical and security staff, centering around the doctor and surgeon who performed the procedures, Dr. Mahendra Amin.[3]

Wooten's whistleblower complaint has engendered a massive reaction from the public and even spurred an ongoing congressional investigation into the ICDC and Dr. Amin's actions.[2] Immediately, the report raises questions of why hysterectomies and other forced sterilization procedures occurred at such a high rate at the ICDC and what Dr. Amin's rationale for these procedures was. Additionally, the ICDC has been described as "unlivable," establishing questions surrounding the quality of medical care and living conditions the detainees were subjected to, especially in comparison to medical care afforded to other Ocilla and Irwin County residents.[3] This magazine will explore these queries and share accounts of the center, the living conditions there, and the medical care provided.

Many, including the authors, are angered over the mistreatment of the detained women, especially given their multifaceted marginalized statuses, with many victims being incarcerated women of color without the guaranteed rights provided by US citizenship. This marginalization has raised many questions surrounding what rights the victims are guaranteed given their undocumented and detained status.

Perhaps more harrowing than the case itself, is the unfortunate realization that it is but one case of an entire history of forced sterilizations in the United States, particularly in the South and against poor people of color. While some may hear the victims' allegations and be shocked, many experts are sadly unsurprised by the revelations exposed by Wooten at the ICDC.[5]

From the turn of the century, eugenics practices in the US were heralded as a form of population control and "optimization" and were seen as ways to reduce criminality, feeblemindedness, and otherwise unwanted traits in the population.[6] As a result, many states, especially in the South, passed laws allowing for the compulsory sterilization of anyone not fitting the desired qualities

> **"In many instances, the medically unindicated gynecological procedures Respondent Amin performed on Petitioners amounted to sexual assault."**
>
> – Dawn Wooten [3]

[2]

of the state, targeting poor people, disabled people, and people of color in particular to not be allowed to reproduce. [6] It is unfortunately obvious that this focused example at the ICDC in Georgia exists within a larger historical framework of forced sterilization practices that persists to this day, unfairly targeting the most disenfranchised people.

This case, it is clear, is not an isolated incident, but rather a progression on the timeline of the United States' history of sterilization of Indigenous, Black, and Latina women. This magazine, to begin, will follow this history as well as concurrent histories of immigrant detention and sterilization procedures.

On September 14, 2020, these three timelines converge in the small town of Ocilla, GA, where this magazine will explore the multitude of biological and social implications that this case has on the victims, ICE, other immigrants, and US history at large. Finally, we present a call to action on what you, the reader, can do to support and defend the rights of undocumented immigrants at ICDC and across America.

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CONCURRENT TIMELINES:

HISTORY OF STERILIZATION OF MARGINALIZED WOMEN

HISTORY OF DETENTION, DEPORTATION, AND ICE MEDICAL ABUSE

HISTORY OF STERILIZATION PROCEDURES

History of Sterilization of Marginalized Women

By Pallavi Chandrasekhhar

This timeline will describe the landmark court cases and events that show the continuance of coercive sterilization on marginalized women in the United States. This includes the mentally ill, felons, poorer women, and women of color, specifically Black and Latinx women. The overarching theme you will notice is the continued allowance of legalized coercive sterilizations, often motivated by fiscal, xenophobic, and racist ideology.

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History of Detention, Deportation, and ICE Medical Abuse

By Cora Miller

This timeline will explore the history of U.S. immigration control, focusing on detention and deportation, the formation of ICE, and immigrant medical abuse. There are many ways in which the history and present of U.S. immigration policy is overtly racialized, gendered, and ableist. See if you can find these facets of systemic oppression of immigrants as you travel through the timeline.

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History of Sterilization Procedures

By Madeleine Babb

This timeline will follow the development of medical sterilization procedures such as hysterectomy, oophorectomy, and salpingectomy. We will also discuss how these invasive procedures were initially introduced as therapeutic treatments, but were later adopted to prevent pregnancy. This timeline aims to educate readers on the medical practice of sterilization so we may critique physicians' actions, rather than assume that medical professionals would only do what is best for their patients.

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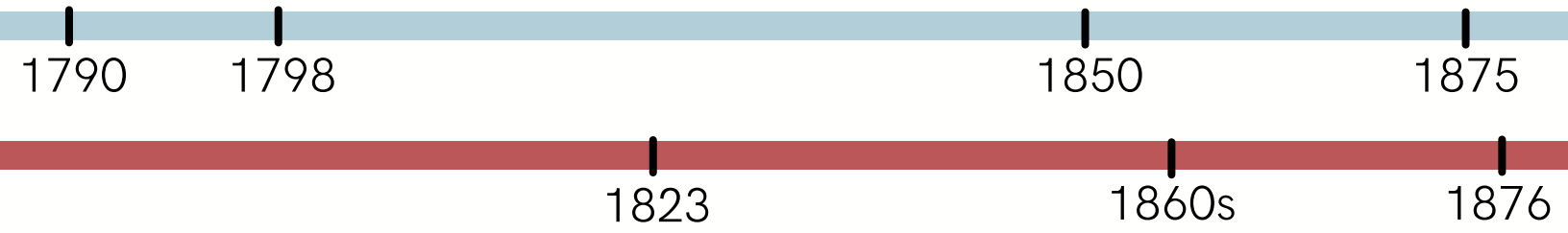
TIMELINE: 1790-1876



1790: Naturalization Act allows (only) White immigrant men to become U.S. citizens.[1]

1798: Alien and Sedition Acts establishes law for deportation of "dangerous persons."

1850: First privately-run prison is established.

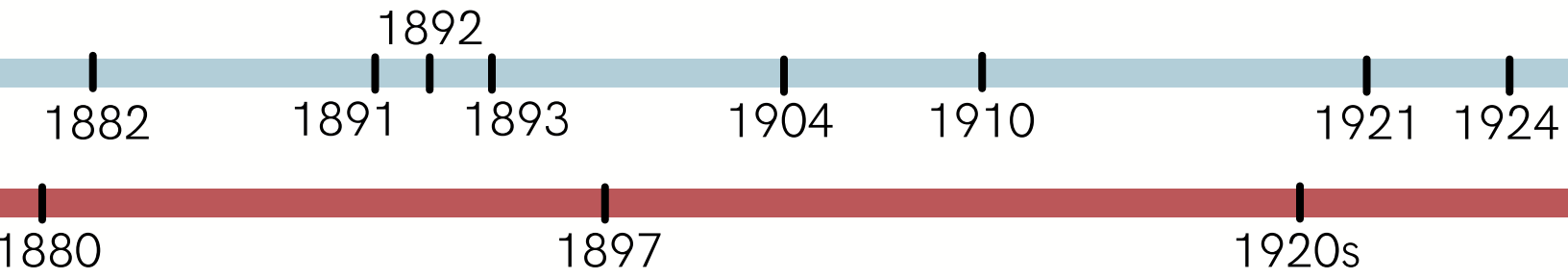
1875: Page Act Bans forced laborers and suspected sex working women from Asia.

1823: Dr. James Blundell, best known as the Father of Blood Transfusion, first suggests tubal ligation for the purposes of sterilization. "In my opinion... for if a woman in that condition in which delivery could not take place by the natural passage... I would advise that the fallopian tube on either side should be drawn up; and lastly, that a portion of the tube should be removed, an operation easily performed, when the woman would, for ever after, be sterile".[1]

1860s: Dr. James Marion Sims develops a surgical technique to treat vesicovaginal fistula, a common postpartum complication. He is credited as the "Father of Modern Gynecology"; but, we must draw attention to his racist methodology. Sims developed his surgical technique through experimentation on enslaved Black women without the use of anesthesia. Furthermore, his technique to cure vesicovaginal fistula was not to treat the discomfort of the afflicted women, but rather to increase their likelihood to reproduce and thereby profitability.[2]

1876: Dr. Eduardo Porro performs the first cesarean hysterectomy with sterilization as a secondary intent. His patient, 25 year old Julia Cavillini, has stunted growth and a deformed pelvis due to rickets. In his treatise on the procedure, Porro wrote "It was obvious that absolute disproportion existed and that cesarean section was mandatory". At the time, cesarean sections were extremely dangerous procedures with high mortality rates. Dr. Porro performed a hysterectomy after the cesarean section to prevent the risk associated with future pregnancies. Miraculously, both Julia and her child survive.[3]

TIMELINE: 1877-1925



1882: Chinese Exclusion Act
Establishes first immigration inspectors and the process of deportation.

1891: Immigration Act
Creates the first immigration department and establishes classes of excludable immigrants.

1892: First dedicated immigration detention facility opens at Ellis Island Immigration Station in NJ.

See article on page 14:
Ellis Island: Medicalized Incarceration at the "Golden Door"

1893: A law passes requiring immigrant detention. At officer discretion, (mostly white) immigrants are allowed to be let out on bond.

1904: U.S.-Mexico border patrols begin.

1910: Second dedicated detention center opens at Angel Island Immigration Station in CA.

1921: Emergency Quota Act
Allows maximum of 3% of each nation's immigrant population to newly immigrate per year, favoring Western European countries and limiting other, less desired nations of origin.

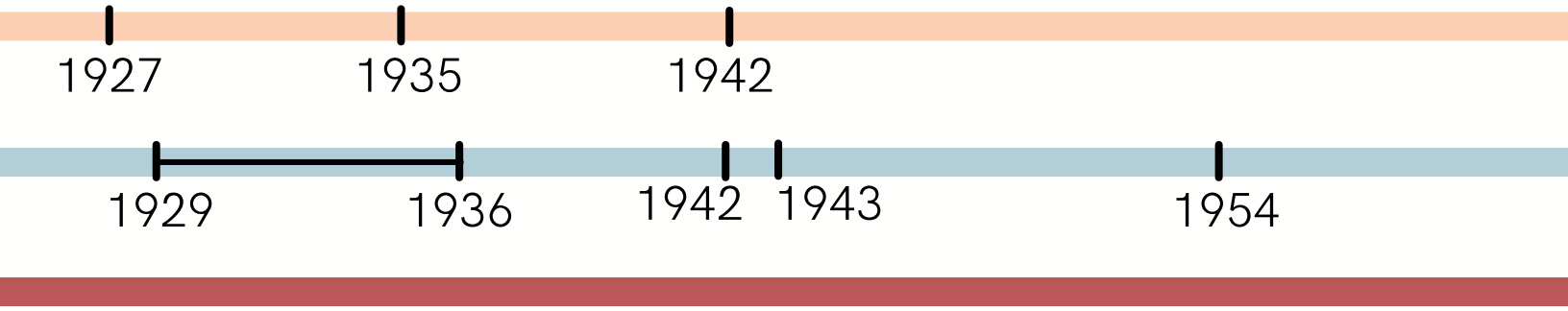
1924: Johnson-Reed Immigration Act
Lowers quota to 2%, explicitly stating purpose to "preserve American homogeneity." Labor Appropriation Act forms U.S. Border Patrol.

1880: Dr. Samuel Smith Lungren performs the first tubal ligation. After performing a second cesarean section on his patient, Lungren determined that sterilization was necessary to prevent the high risk associated with the possibility of a third cesarean section. "The fallopian tubes were tied instead with a strong silk ligature about one inch from their uterine attachment." This ligature method is relatively invasive; however, the fallopian tubes are likely to undergo recanalization (i.e. natural rejoining).

1897: Dr. Ferdinand Adolf Kehrer, a German surgeon, performs the first sterilization procedure with the intent to prevent pregnancy. He performed a hysterectomy on an unnamed woman who had given birth to seven children, some of whom were considered "feeble-minded". This surgery marks the first recorded surgical sterilization of a woman for purely eugenic reasons.

1920s: Dr. Ralph Hayward Pomeroy adopts a technique that involves ligating the Fallopian tubes into a loop and then removing a small section of the tube. This method, known as salpingectomy, prevents recanalization and allows for a possibility of reversal. Salpingectomy became the preferred method of female sterilization in the early 20th century.[4]

TIMELINE: 1926-1960



1927: Buck vs. Bell
This Supreme Court case upholds the State's rights to forcibly sterilize a person considered "unfit to reproduce". The justices rule that "[Carrie Buck] is the probable potential parent of socially inadequate offspring, likewise afflicted, that she may be sexually sterilized without detriment to her general health, and that her welfare and that of society will be promoted by her sterilization."[2]

1935: Criminal Sterilization Act
This act is passed in Oklahoma and allows the state to forcibly sterilize individuals convicted of three or more felonies. A man named Jack T. Skinner is labelled a habitual offender and ordered to undergo compulsory sterilization. His appeal goes to the Supreme Court.[3]

1942: Skinner vs. Oklahoma
This Supreme Court case sets a legal precedent that the 14th Amendment entails the "right to procreate" and forcible sterilization by the state "amount[s] to felonies involving moral turpitude." However, only some specific felonies were excluded from the act's sterilization rule. Thus, this decision did not determine that compulsory sterilization was a violation of human rights; rather it simply stated that sterilization can be mandated after careful consideration.[3]

1929: Immigration Act
Criminalizes unlawful entry, specifically targeting Mexicans and undermining previous Supreme Court rulings that unlawful entry is not criminal.

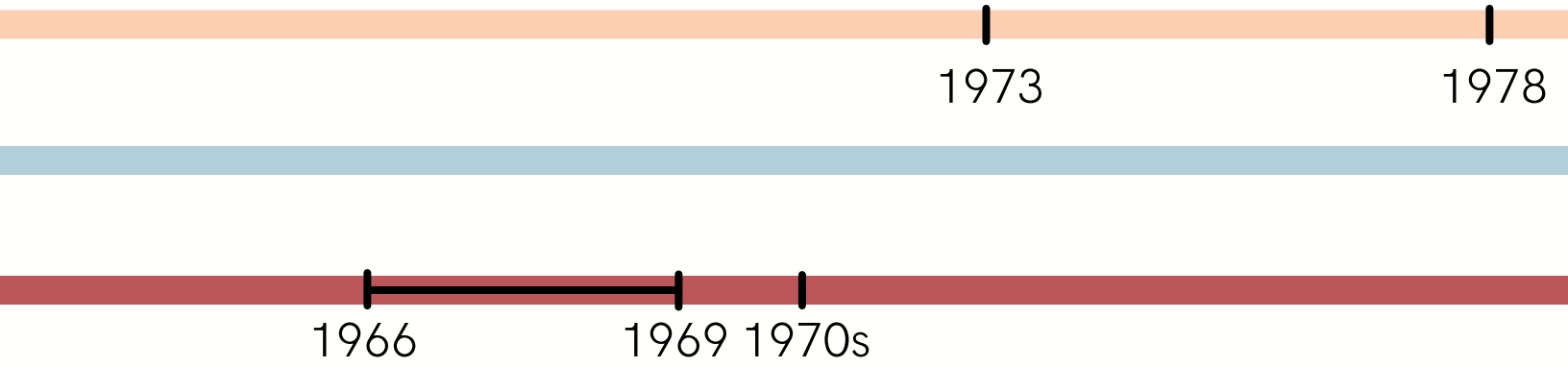
1929-1936: Mexican Repatriation
A period of mass roundups and deportations of an estimated .5-2 million Mexican and Filipinx individuals, despite an estimated 60% of deportees being U.S.-born citizens.

1942: FDR signs Executive Order 9066, leading to internment of 120,000 Japanese-Americans in addition to German-Americans and Italian-Americans. Bracero Program is created, providing temporary agricultural visas for Mexican immigrants to fill a WWII-caused shortage in U.S. farm labor.

1943: Chinese Exclusion Act is repealed and replaced with a quota.

1954: "Operation Wetback"
Anti-Mexican immigration campaign begins, under which 1 million Mexicans, many of whom arrived under the Bracero Program, are deported.

TIMELINE: 1961-1979



1973: Roe v. Wade
This is one of the most famous supreme court cases in U.S. history and set the precedent that women are granted the right to an abortion so long as the fetus is not viable (about 24-28 weeks since conception). It is often cited as a case that ensured the right to bodily autonomy, specifically for women in a reproductive sphere, but the case was won using the 9th Amendment, the right to privacy.[4] This distinction means no legal precedent was set for women to have bodily autonomy when it comes to reproductive issues.

1973: Relf v. Weinberger
This lawsuit exposes that two poor black teenagers, Mary Ann (14) and Minnie (12), were sterilized after their mother (who could not read) signed an X on a form believing that her daughters would be given birth control shots. The lawsuit exposed that 100,000-150,000 poor people in the South had been coerced into sterilization using federal funds. The judge ruled for the prohibition of federal-funds for involuntary sterilization and required doctors to obtain informed consent before performing sterilization procedures.[5]

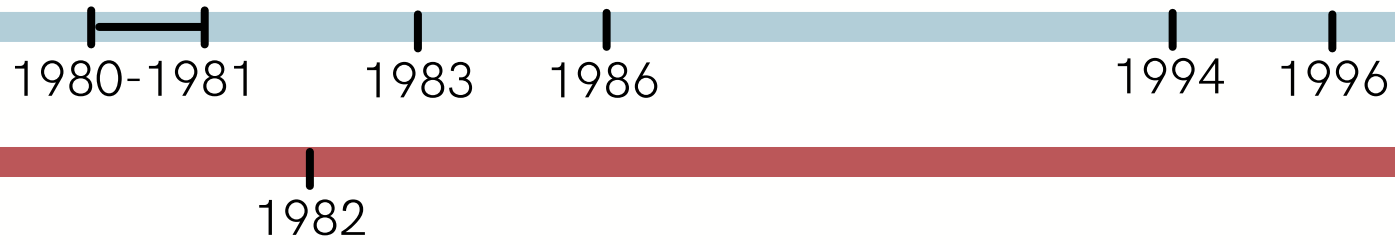
1978: Madrigal v. Quilligan
This lawsuit exposes that over a dozen women of Hispanic descent were involuntarily sterilized at USC County Hospitals. The women spoke little to no English and were systemically coerced into submitting to sterilization while in active labor. The women lost the lawsuit; however, the case served as a catalyst for stricter regulations in obtaining voluntary consent for sterilization. [6,7]

See article on Page 15: Eugenics in America

1966-1969: Minilaparotomy is first developed and used to perform tubal ligations. Prior to this point, female sterilization methods used highly invasive laparotomy surgery that required large incisions through the abdominal wall. Conversely, minilaparotomy involves small incisions less than 5cm in length [6].

1970s: Laparoscopic surgical techniques transform the field of female sterilization. This technique uses a laparoscope; that is, a tube-shaped instrument with a camera on one end. The instrument is inserted into the abdomen and surgical tools are inserted. The camera allows surgeons to visualize and perform the procedure. Female sterilization become more widely accepted as a form of birth control due to the minimal invasiveness and short recovery times associated with this technique [7].

TIMELINE: 1980-2000



1980-1981: Mass immigration detention begins in response to Cuban, Haitian, and Central American migration (fleeing dictatorships and civil war caused by U.S. imperialism). President Reagan begins a program to increase detention of asylum seekers to deter Latin American migration to the U.S. Simultaneously, Reagan's "War on Drugs" leads to border militarization and racialized conflation of drug and immigration enforcement.

1983: The world's first private prison company Corrections Corporation of America (CCA) aka CoreCivic, is formed. CCA enters into its first federal government contract for an immigration detention facility in Texas.

1986: The Immigration Reform and Control Act provides blanket amnesty for undocumented arrivals and places sanctions on employers of unauthorized workers; the latter aspect goes largely unenforced.

1994: Operation Gatekeeper
Clinton administration doubles Border Patrol officers and constructs 5-mile border wall in San Diego.

1996: The Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) and the Antiterrorism and Effective Death Penalty Act (AEDPA)
These laws expand the U.S. immigration detention system by adding to the list of "crimes of moral turpitude," including non-violent drug and other charges, for which both legal immigrants and undocumented non-citizens can be subjected to mandatory detention and deportation. The acts also establish ICE's minimum daily detention numbers.[2]

1982: Female sterilization becomes the second most widely used form of contraception in America (10.3 million women), falling just behind oral contraceptive pills (10.7 million women). Most Americans use some form of family planning; however, the demographics of which method is used varies widely. College-educated women are more likely to use non-permanent methods such as oral contraceptive pills, while less-educated women are more likely to undergo permanent sterilization procedures. Additionally, Hispanic and Black women are more likely to undergo sterilization than their white counterparts.[8]

TIMELINE: 2001-2011

2001: The attacks on 9/11 result in the USA PATRIOT Act, expanding surveillance and targeting Arab and Muslim-presenting individuals for detention.

2002: Homeland Security Act
INS is dissolved, becoming the Department of Homeland Security (DHS) with three branches: U.S. Citizenship and Immigration Services (USCIS), Customs and Border Enforcement (CBP), and Immigration and Customs Enforcement (ICE) with the detention system under ICE.[3]

2003: ICE OPERATIONS BEGIN

See article on Page 16: Medical Oversight in ICE Detention

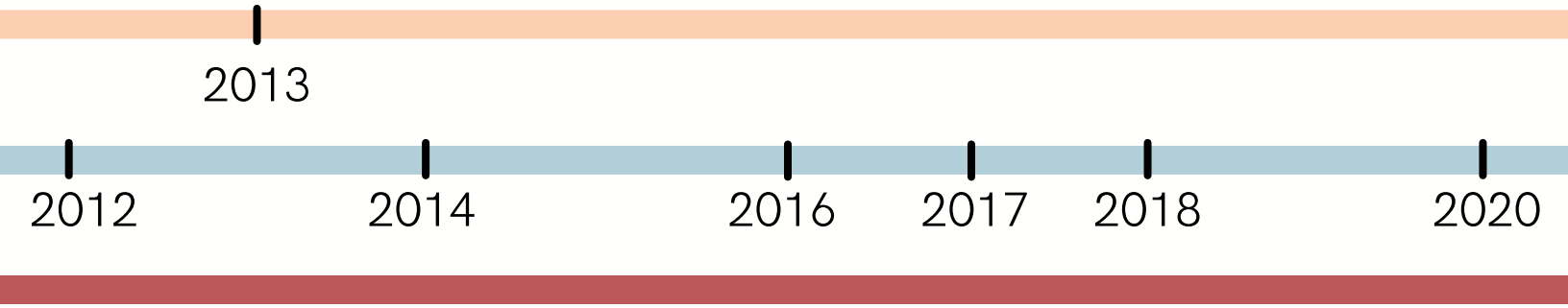
2003: National Fugitive Operations Program
Focuses on apprehending, detaining, and deporting individuals who did not comply with ICE requests for removal/deportation or did not report to ICE after being ordered to do so. This program quickly becomes one of the largest reported operations of ICE.[2]

2008: "Secure Communities Program"
Bush admin begins to increase ties and partnerships between federal immigration and local law enforcement, effectively transforming all of the U.S. into heavily patrolled borderlands carrying out ICE objectives. ICE states program was "an initiative to modernize the process used in identification and removal."[2]

2009: Irwin County Detention Center (ICDC) secures a contract with ICE after failing as a private prison.[4]

2011: The Obama administration expands the "Secure Communities" program. Additionally, ICE creates the 2011 Performance-Based National Detention Standards, intended to improve healthcare and confinement conditions in ICE detention. These standards fall short of standards for medical care in prisons and jails, and are adopted slowly, if at all, by facilities. Some detention healthcare services are centralized under the ICE Health Service Corps (IHSC), though many private health services companies remain under contract.

TIMELINE: 2012-2020



2013: Sterilizations of Female Inmates in California Prisons

An article released in 2013 revealed that between 2006 and 2010 almost 150 female inmates in California prisons were sterilized without state approval or patients' informed consent. The California Department of Corrections and Rehabilitation paid a total of about $150,000 to surgeons for these procedures, which one prison OB-GYN stated was not a large sum of money "compared to what you save in welfare paying for these unwanted children."[8] These women were pressured to agree to the procedure, often while undergoing medical care for other reasons. One former inmate described that pressure being put on her while she was "under sedation and strapped to an operating table."[8] Informed consent cannot be obtained while under duress, and situations like these certainly qualified as duress. California's prison inmates have disproportionate amounts of women of color; this overrepresentation of women of color, particularly Black and Latina women, in prisons along with the coercive sterilizations of female inmates leads to yet another example of contemporary eugenics.

2012: The Obama administration established the DACA program, providing temporary relief from deportation for some immigrant minors.

2014: The Obama administration resumes family detention in response to increased women and child immigrants from Central America.

Jan 18, 2016: Teka Gulema dies in ICE custody after being detained since 2012. Gulema was paralyzed from the neck down due to a preventable and treatable infection contracted at the Etowah County Detention Center in Alabama.[4]

2017: At the end of President Obama's term, detention numbers are at a record high of over 40,000 per day. The administration has deported over 3 million people, more than all presidents since 1890 combined.

May 25, 2018: Roxsana Hernandez, a 33-year-old transgender woman from Honduras, dies in ICE custody. She was refused medical care despite informing officials she had untreated HIV.[6]

March, 2020: A joint suit is filed to address abysmal COVID regulation compliance in ICE detention. Fourteen detention facilities in the American South are explicitly named as perpetrators, including the Irwin County Detention Center. The lawsuit was granted and resulted in orders to improve the medical treatment and COVID precautions in ICE detention.[7]

See article on Page 17: Medical Abuse in ICDC

Content Warning:

Sexual violence, medical violence

Hear Her Words

On this page, you will find first- and second-hand accounts of the horrific forced sterilizations in Irwin County Detention Center. As authors, we would not be accurately portraying this case if we did not center the real experiences of the women affected. Please read on with caution and empathy.

Believe Women.

The document was entirely in English and Jane Doe #15 could not read any of it...[she] felt that she had no choice but to sign, **despite not knowing what the surgery was for**, what they would do to her body during the surgery, or what wounds or potential side effects she might suffer after the surgery.

- Lawsuit description of anonymous Petitioner's hysterectomy [1]

When she arrived and saw that it was Respondent Amin, **she was terrified of being butchered**... The vaginal ultrasound and internal exam were done without Jane Doe #22 informed consent.

- Lawsuit description of anonymous Petitioner's medical exam [1]

She wanted a second opinion, but was not granted one and **was forced to go through with the hysterectomy.**

- Lawsuit description of Petitioner Terrazas Silas [1]

"I don't think this is okay. **We don't know what they're doing to our bodies.**"

- ICDC Detainee Elizabeth [2]

"[It felt like] **being raped again**"

- Lead Plaintiff Yanira Yesenia Oldaker [1]

"The most **medical way of being raped** you could possibly experience"

- Petitioner Jenel Haug [1]

"ICE medical professionals consistently **pressured her into undergoing a hysterectomy**."

- Petitioner Jaromy Floriano Navarro [1]

Sources
[1] Oldaker v. Giles, No. 7:20-cv-00224-WLS-MSH (District Court for the Middle District of Georgia December 21, 2020).
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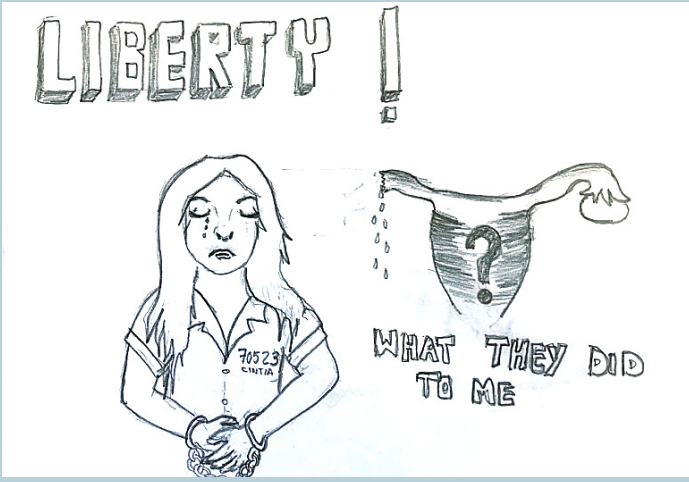
CONVERGENCE

September 14, 2020

Dawn Wooten, a nurse at the Irwin County Detention Center in Ocilla, Georgia, publishes a whistleblower report describing human rights violations occurring at the facility.[1] In this report, she alleges that the center is failing to adhere to CDC guidelines regarding the ongoing COVID-19 pandemic. Additionally, the report outlines the high rates of hysterectomies that the immigrant women are being subjected to by a particular gynecologist, Dr. Mehendra Amin. In regard to Dr. Amin, Ms. Wooten explained,

> "That's his specialty, he's the uterus collector... Everybody he sees, he's taking their uterus out or he's taken their tubes out... These immigrant women, I don't think they really, totally, all the way understand this is what's going to happen."[1]

Dawn Wooten's whistleblower report of forced sterilizations at the Irwin County Detention Center immediately garnered major media attention.[2] The concept that such inhumane cruelty was occurring on American soil was astounding to a populace that traditionally values individual rights, particularly in regards to family.[2] It is easy and satisfying to simply accuse Dr. Amin of wrongdoing and hold him accountable, and then completely move on. And while he should be held accountable, Dr. Amin is no more than a single actor part of a massive scheme of social injustice. These timelines have made clear that the injustice the detained women were subject to is not an isolated incident.



Personal artwork by a detained woman at ICDC.[1]

Powerful structures of white nationalism, de jure and de facto racial immigration policy, and reproductive control of marginalized women jointly form the violent context which created the heinous acts at the ICDC. The history of forceful sterilization procedures is entangled in these ongoing structures. Furthermore, the victims' marginalization as economically disadvantaged, undocumented, non-English speaking women-of-color led to a culmination of oppression.[2] The intersection of this discrimination enabled Dr. Amin to enact this travesty without immediate consequence.[1] We thank Ms. Dawn Wooten for her bravery in calling attention to this injustice and for giving the detained women a platform to tell their stories. We must be critically aware of historical and modern wrongdoings in order to dismantle these institutional systems of oppression, discrimination, and injustice.[2]

By Madeleine Babb

[1] Project South (2020)."Re: Lack of Medical Care, Unsafe Work Practices, and Absence of Adequate Protection Against COVID-19 for Detained Immigrants and Employees Alike at the Irwin County Detention Center," https://projectsouth.org/wp-content/uploads/2020/09/OIG-ICDC-Complaint-1.pdf.
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While impoverished, racialized, disabled and ill groups were jailed and deported at Ellis Island, the nearby Statue of Liberty plaque of Emma Lazarus's 1883 sonnet "The New Colossus" read, with bitter irony:

Give me your tired, your poor,
Your huddled masses yearning to breathe free,
The wretched refuse of your teeming shore.
Send these, the homeless, tempest-tost to me,
I lift my lamp beside the golden door!
[1]

Ellis Island: Medicalized Incarceration at the "Golden Door"

Known as the "Golden Door" to the U.S., the Ellis Island Immigration Station is a renowned symbol of the free-flowing immigration on which the United States was built.[2] However, this station was more prison than portal for many immigrants. Ellis Island was the first dedicated immigrant detention center in the United States, operating between 1892 and 1954.[3] During this time, the fate of third-class or steerage immigrants was held in the hands of U.S. Public Health Service (PHS) doctors, who swiftly assessed individuals for detectable illness or disability to determine if they were eligible for entry.[2] PHS officers were encouraged to mark the incoming individuals with chalk of the lapels of their jackets: "EX" signifying need for further examination, "C" indicating suspected eye condition, "S" for senility and "X" for insanity.[2] This process was created based on the 1891 Immigration Act, which established several excludable classes of immigrants, namely "[a]ll idiots, insane persons, paupers or persons likely to become a public charge, persons suffering from a loathsome or a dangerous contagious disease, persons who have been convicted of a felony or other infamous crime or misdemeanor involving moral turpitude, polygamists."[4] The interpretation of "persons likely to become a public charge" included unaccompanied women, especially pregnant women, an important instance of gendering and reproductive control in migration.[2] The overtly ableist and anti-mentally ill and neurodiverse policies further codified key eugenic practices of the time. Additionally, the prior Chinese Exclusion Act (1882) and Page Act (1875) had already established racialized and gendered anti-Asian immigration policies.[3] Thus, solely by who was chosen to be detained at Ellis Island, immigrant detention was established as a deeply racist, ableist, and misogynistic practice from its birth.

Thus, Ellis Island became a simultaneous location of detention and inpatient hospitalization, with approximately 20% of inspected immigrants experiencing temporary detention. The southernmost wing of the facility confined those deemed ill for weeks, months, or years. Those who were detained for treatment were held in the 300-bed General Hospital, which included a "Psychopathic Ward" and a maternity ward, or the 450-bed Contagious Disease Hospital.[5] Beginning in the mid-1910s, the island received immigrants from across the U.S., many of whom were German, Austrian, and Hungarian immigrants detained amid WWI nativist panic.[2] From the 1930s through its closure in 1954, Ellis Island mainly imprisoned immigrants for political purposes, serving as a WWII and early Cold War facility for detention, internment, and deportation.[2] Ellis Island, then, was the nation's final pre-deportation destination for undesired immigrants from across its colonized lands. Considering this history, it is important to reframe the narrative about the role Ellis Island plays in U.S. immigration mythology. The U.S. has never been a nation of free immigration for all.

"I became a jailer instead of a commissioner of immigration; a jailer not of convicted offenders but of suspected persons who had been arrested and railroaded to Ellis Island."

– Fredrick C. Howe
U.S. Immigration Service Commissioner
[6]

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EUGENICS IN AMERICA

Forced Sterilization in the Eyes of the Law

By Pallavi Chandrasekhar and Madeleine Babb

Ultimately, the actions at ICDC were eugenic. The physicians revoked the reproductive potential of women they deemed unfit, illegal, and sub-human. This is only the most recent chapter of the history of eugenics and sterilization in the Unites States. This article will explore the legacy of some landmark court cases that sought to end this horrific practice.

BUCK v. BELL

This Supreme Court case legitimized eugenic sterilization in the U.S. and set the legal precedent authorizing the State to forcibly sterilize those they deemed "unfit." Carrie Buck was an inmate at a mental institution admitted for "feeblemindedness," an outdated diagnosis that is now clinically meaningless. The term applied to those with behavior considered abnormal or those who scored low on IQ tests. Patients diagnosed with the condition would today simply be considered mildly mentally disabled, learning disabled, or underachievers. People considered feebleminded were thought to be linked to "promiscuity, criminality, and social dependency," which was especially frightening to eugenicists who feared the spread of genetic mental disorders and the resulting fiscal and social burden.[1] Both Ms. Buck and her daughter were diagnosed as feebleminded, and the Virginia mental institution in which she was housed forcefully sterilized her in order to prevent the further spread of her "feeblemindedness gene," which is now known not to exist. The case of *Buck v. Bell* was brought to the Supreme Court to determine if any constitutional rights had been violated through the Virginia statute that aimed to promote the "health of the patient and the welfare of society." They determined that the statute was constitutional and the operation could take place after the patient had been observed for many months. Disturbingly, Supreme Court Justice Holmes stated that this ruling was vital to prevent "being swamped with incompetence" and that "three generations of imbeciles [were] enough."[2]

RELF v. WEINBERGER

In this case, two Black girls (aged 12 and 14) in Alabama were permanently sterilized without informed consent as part of a campaign to sterilize poor Southerners. Mary Alice and Minnie Relf were both mentally ill and their mother, who was illiterate, signed an "X" on a piece of paper expecting her daughters to be given birth control shots. Instead, her daughters were permanently sterilized; they were just two of about 100,000 to 150,000 people who were sterilized annually through federally-funded programs in the South.[5] The majority of these victims were poor and African American, and a substantial number were minors when the procedures occurred. If patients refused to give consent, their doctors threatened to revoke their welfare benefits. The Southern Poverty Law Center filed a lawsuit to fight this practice. The District Court ended up ruling that federal money could not be used for coerced sterilizations or threatening women with the loss of their welfare benefits.[5] Unfortunately, simply revoking federal funding did not explicitly outlaw the practice. However, as a result, the U.S. Department of Health, Education, and Welfare (now the Department of Health and Human Services) changed their regulations to require that all doctors receive informed consent from patients before performing sterilization procedures.

MADRIGAL v. QUILLIGAN

In the landmark case of *Madrigal v. Quilligan*, Spanish-speaking women in LA County were coerced into tubal ligation without informed consent by their physicians while under the duress of late stage labor. In the late 1960s to early 1970s, the USC Medical Center in LA County performed coercive sterilizations on the ten women involved in the lawsuit as well as many more who remained unnamed.[6] Many of these women did not speak English and were coerced into tubal ligation, a form of permanent sterilization commonly referred to as getting one's "tubes tied", during late stage labor, a condition that puts them under duress. A young Chicana lawyer used hospital records secretly gathered by a whistleblower physician at the Medical Center to bring this civil rights violation to national attention. The prosecutors in the case argued that Roe v. Wade guarantees a woman's right to bear a child, and these coercive sterilizations violated that right.[7] Doctors were quoted taunting these Mexican-American women in labor with pain medication to get them to sign tubal ligation consent forms, as well as threatening the lives of the newborns.[5] Although no motives of race were ever proven in court, the thought process and actions of these doctors and hospitals aligns with the Neo Eugenics movement at the time and the idea of ridding the country of its social and financial burdens. The xenophobic mindset towards these women was that they immigrated to the United States to have children and then live off of taxpayer dollars. This court case exposed the continuation of a eugenics movement, often motivated by financial goals, similar to the forced sterilization of the mentally ill in the early 1900s. The USC Medical Center unfortunately won this case, as the judge decided these sterilizations were a result of miscommunication and cultural barriers rather than malicious intent, and blamed the victims instead. The only changes to come out of this case were the requirement for Spanish translations of sterilization booklets as well as the California Department of Health to create a 72 hour waiting period for sterilization procedures.[6] All other injustices remain unacknowledged to this day.

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Banner Images [clockwise from left]
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International Eugenics Logo Photograph by American Philosophical Society.
Physical Culture magazine, June 1934. Holdings Inc/Corbis via Getty Images.
Philadelphia, Pennsylvania. 1926.Wikimedia Commons

Whistleblower Dawn Wooten was demoted from her full-time position to a on-call position after advocating for improved detainee healthcare.

[1]

Medical Oversight in ICE Detention

by Cora Miller

There are far too many examples of issues with medical oversight in ICE detention.[2] The prevalence of medical abuse is deeply connected to lacking accountability and failure to uphold medical care standards in ICE detention. Abysmal accountability is endemic to the ICE medical system due to lacking systematic data reporting and fragmented regulation and oversight.[3]

U.S. immigration is overseen by the Department of Homeland Security (DHS), the Department of Health and Human Services, and the Department of Justice. The DHS oversees ICE along with several other agencies, and ICE itself contains three agencies to oversee and ensure it's own compliance with standards: Enforcement and Removal Operations (ERO), Office of Detention Oversight (ODO), and ICE Health Services Corps (IHSC).[3] While IHSC is mainly responsible for medical oversight, all three departments conduct inspections and oversight procedures, creating an extremely fragmented system of accountability. Additionally, IHSC reportedly directly staffs 20 ICE detention facilities in the U.S., imprisoning 15,300 detainees, but also performs "medical case management and oversight" for 22,600 individuals imprisoned at 112 ICE facilities who contract to external, for-profit medical services.[4] The vast majority of detention centers and detainees are served by contracted medical services companies. Additionally, detention centers often refer detained individuals to non-contracted, off-site healthcare providers. Healthcare services and healthcare service oversight are fragmented in ICE detention, resulting in a system built to perpetuate (not prevent) poor medical care and decrepit conditions. Simultaneously, this oversight is performed by those entrenched in the same system and operating under ICE, making all existing oversight partial and ineffective.

Further confusing this accountability structure, the standards and regulations underlying detention facility function are highly variable from site to site. The 2011 Performance-Based National Detention Standards are the most recent and strict, but are still far below normal prison standards. However, many facilities are within the purview of several older standards or not be contractually bound to any detention standards.[3] Without actual standardization of minimum required conditions, there is no way to effectively hold facilities accountable, and this system cannot regulate a sufficient quality of life or medical care across detention centers.

Finally, minimal recording and reporting of healthcare data further complicates ICE medical accountability. Despite the high prevalence of electronic medical records systems in the U.S., there are no regular, systematic avenues for healthcare data reporting at ICE detention centers. The U.S. Government Accountability Office has reported that ICE data collection is focused on finances and cost, with very little medical reporting infrastructure.[3] Obviously, the cost of the ICE detention operations matters more to them than do detainee health and survival. Additionally, ICE does not collect or examine data to determine overall trends in their healthcare delivery, making it impossible to systematically recognize and rectify patterns of care deficiencies across centers. Their medical records system, MedPAR, does not allow users to identify the detainee procedures or off-site medical visits that were requested, approved, or denied by ICE employees. IHSC does collect minimal data in the facilities it staffs, but this practice is absolutely insufficient, is not aggregated or compared across the 20 facilities, and does not include the 112 non-IHSC-staffed facilities.[3]

Lacking accountability is nothing more than another symptom of this system's intended function of disrupting and extinguishing immigrant life to preserve "white American" hegemony. Refusing to collect consistent healthcare data is a brutal indication of the lack of actual care our government has for the humans they imprison. However, expanding data collection alone would be insufficient to improve ICE detention healthcare. To make marginal improvement, ICE detention must also halt their expansion, create a legal minimum standard of care, end contracts with non-compliant facilities, and facilitate effective, external, community oversight.[3] Importantly, these reforms will never be sufficient to create just and humane immigrant detention, because that does not exist. Absolute abolition of immigrant detention is the only true solution, as the system was based on and was built to perpetuate racist, misogynist, unjust, anti-immigrant, anti-science policies which cannot be reformed and must be taken up from the root.

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Medical Abuse

in Irwin County Detention Center

By Cora Miller

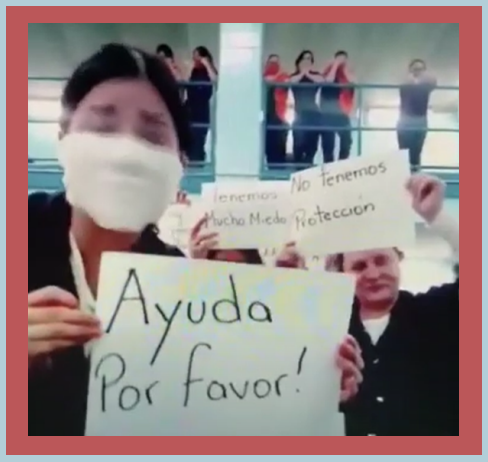
In 2016, ACLU senior staff attorney Eunice Cho contributed [1] to an extensive report by the Southern Poverty Law Center describing severe legal and medical abuses in Irwin County Detention Center (ICDC) in Ocilla, GA as well as several other Southern ICE detention centers.[2] After the 2020 whistleblower report accusing vast medical abuse in ICDC, Cho stated "[t]he allegations Ms. Wooten made in her whistleblower complaint are shocking, but unfortunately not surprising, given everything that we know about healthcare in ICE detention facilities specifically at Irwin, and nationwide."[1] So, what do we know about healthcare at ICDC that makes the whistleblower revelation so expected among scholars? To explore this question, we must understand ICDC as a facility and the state of the facility's healthcare.

The report by the Southern Poverty Law Center elucidates the foundational context of ICDC. After a long history of serving as a U.S. Marshalls Service detention center, the abandoned and aging facility was bought by a private prison investment company. The private prison owners convinced Irwin County officials to provide $55 million in bond revenue to renovate the facility without taxpayer approval in order to make the facility more attractive and profitable. However, still faltering in 2009, the owners came to ICE to secure a contract with the bargain rate of $45 per night per detainee (ICE paid $69-$90 in Georgia at the time). Despite this, the detention center was still deeply in debt, owing Irwin County $1.6 million in back taxes and penalties in 2012 and forcing the owners into bankruptcy. The facility was sold to new, private owners: CGL and LaSalle Corrections, who operate the facility today.[2]

It is well-established the for-profit detention centers and prisons prioritize lowest possible operation costs to facilitate the largest possible profit margin.[4] After years of financial faltering, it is unsurprising that ICDC owners cut back to bare minimum operational cost, severely sacrificing quality of food, medical care, and facilities. Medical malpractice is painfully evident in ICDC, as exhibited in the 2016 Southern Poverty Law Center report. This report was created based off of interviews with detainees, including 43 ICDC detainees, many of whom reported consistent patterns of medical abuse.[2] Commonly reported patterns include officials and providers ignoring detainee complaints, symptoms, and medical histories, leading to preventable complications; delays and inconsistencies in medications and reliance on ibuprofen and Tylenol instead of treatment; and other horrific conditions producing or worsening health issues.

Several individuals living under detention in ICDC indicate horrific undertreatment of communicated medical conditions, often resulting in pervasive and avoidable complications. Mark Bell, an immigrant from Jamaica, was not provided with cancer treatment despite providing proof of his diagnosis years prior and his constant request for treatment as he faced worsening symptoms. After being erroneously declared "cancer-free," Bell was deported without care in 2016. Another detainee, Saul, suffered trauma to his head and was told he did not need medical care, receiving no help until he vomited on the floor. Samuel told officials he was experiencing a severe medical condition and was not examined until he fainted. Estaban broke his clavicle while detained and did not receive treatment for five months as the infirmary insisted he did not require treatment. After a hunger strike, he was finally allowed to visit a doctor, where he was told his clavicle could have been reset if he had had earlier treatment, but now surgery was necessary to heal the fracture.[2]

Further, a disturbing video was posted in April, 2020 on YouTube by women detained ICDC.[5] In the video, a series incarcerated immigrant women speak in fearful but powerful tones of the horrific conditions and lack of proper medical care they are experiencing at the facility. Many hold cloths over their mouths as makeshift masks to protect themselves from COVID-19 while they lift signs that read "Ayuda, por favor!" or "Somos vulnerables" or "No somos criminales" and plead for freedom, healthcare and safety.[5] They tell stories of getting sick with COVID and being told by ICDC medical providers "you're fine, go back to your cell."[5] When we jointly consider these harrowing stories and those of the 2015-2016 interviewees, there is a clear pattern unreasonable and immoral refusal of treatment in ICDC which only has become more horrific in the era of COVID-19.



Click the photo above to see first-hand accounts of ICDC medical abuse. Warning: Disturbing content. [5]

Southern Poverty Law Center interviewees indicated that they experienced issues with undermedication, delays in medication, or medication to avoid actual examination and treatment. Benjamin, for example, had been waiting a month for a medication he had yet to receive at time of interview. Even those who did receive regular medication often received them at irregular times, posing extreme risk to diabetic detainees who require regular and short-notice treatment. Detainees also referenced often receiving Tylenol or ibuprofen when they reported pain or discomfort, even if this pain was likely associated with an underlying disease requiring treatment. Bernardo, an ICDC detainee, stated that he was given only Tylenol for what eventually became a severe bladder infection.[2]

The lacking medical care outlined above is compounded by non-existent mental health care and unsafe food. Multiple detainees referenced the lack of treatment for those with mental health problems, leaving detainees with mental illness to suffer alone and without familial or institutional support. Lacking healthcare is worsened by terrible food; the detainee's only meal option is rotten, expired, poor quality food supplied at rock-bottom prices by for-profit Trinity Services Group, which causes regular illness according to interviewees. One interviewee, Simon, stated: "The food is bad, and looks like dog food… One day we found cockroaches on the ham and they still served it."[2]

Thus, due to this evidence of systemic abuse, Eunice Cho considered the accusations of forced hysterectomies, COVID safety violations, and other medical mistreatment to be perfectly aligned with what the Irwin County Detention Center has proven itself to be: a torturous facility brimming with injustice and malpractice.

> "They don't attend to them, they don't ask them the necessary questions to diagnose them. We are at risk. They don't give us anything to cover ourselves, so that we can protect ourselves. I was the first person that got sick."
>
> – Unnamed Woman in ICDC [5]

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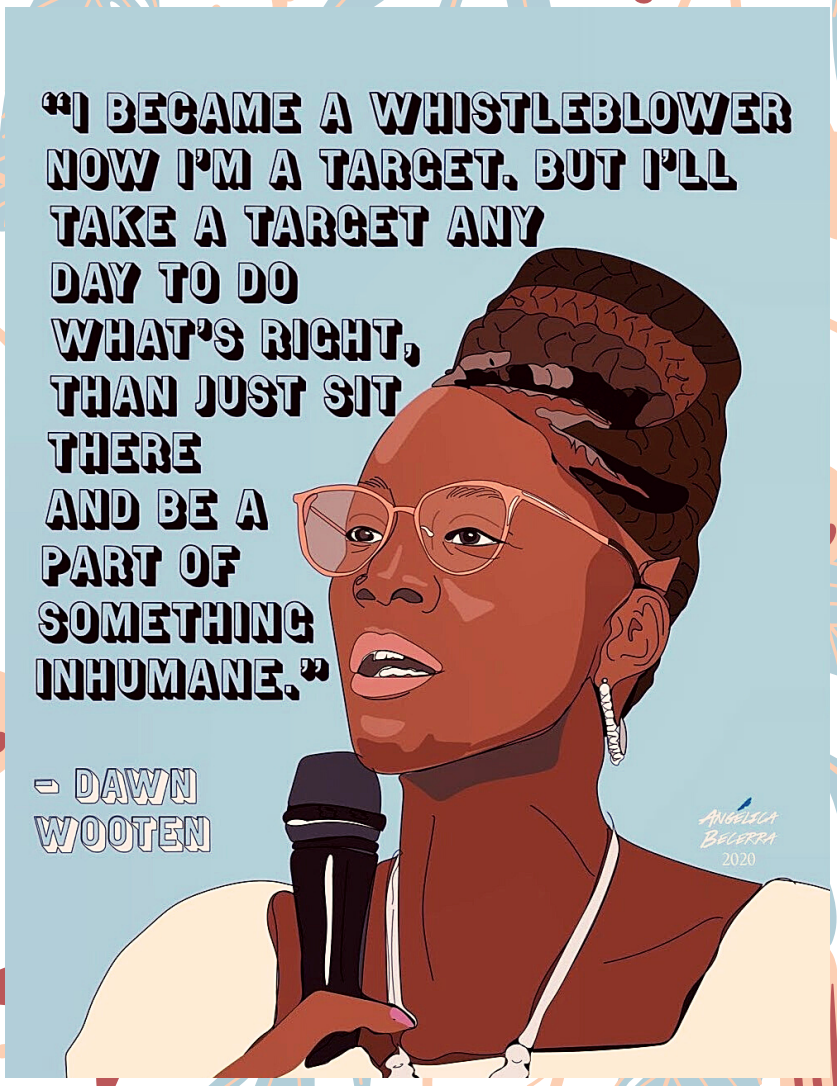

[1]

ICE Retaliation:

By Pallavi Chandrasekhar and Cora Miller

We must acknowledge Dawn Wooten and the incarcerated women who spoke out for their bravery in drawing attention to the injustices of Irwin County Detention Center. Horrifically yet unsurprisingly, ICE has retaliated against Ms. Wooten and many of the detained women who spoke out. Floriano Navarro and another, unnamed woman in ICDC were deported "within a day after they spoke out… about medical abuses at ICDC."[2] ICE has an appalling history of retaliating against whistleblowers; Ms. Wooten previously experienced retaliation for speaking up at ICDC. In a clear act of retaliation, Ms. Wooten was demoted from her full-time position to a on-call position after advocating for improved detainee healthcare in ICDC.[3] As a Black woman, Ms. Wooten is especially vulnerable to retaliation and blacklisting from this deeply racist organization, but she does not regret her actions and stated she "can close [her] eyes at night knowing [she] was a voice those [whose] voices were silenced."[4] Ms. Wooten has stated that finding employment has been increasingly difficult after the backlash from her whistleblower report.[4] To support Ms. Wooten, her family, and her courageous actions amplifying the experiences of women mistreated at ICDC, consider donating to the below GoFundMe fundraiser, which was organized to support her search for physical and financial security.

GoFundMe for Dawn Wooten

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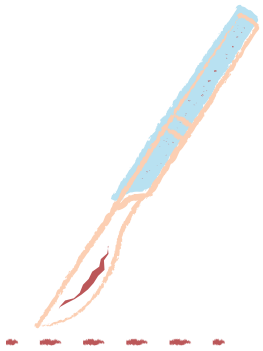
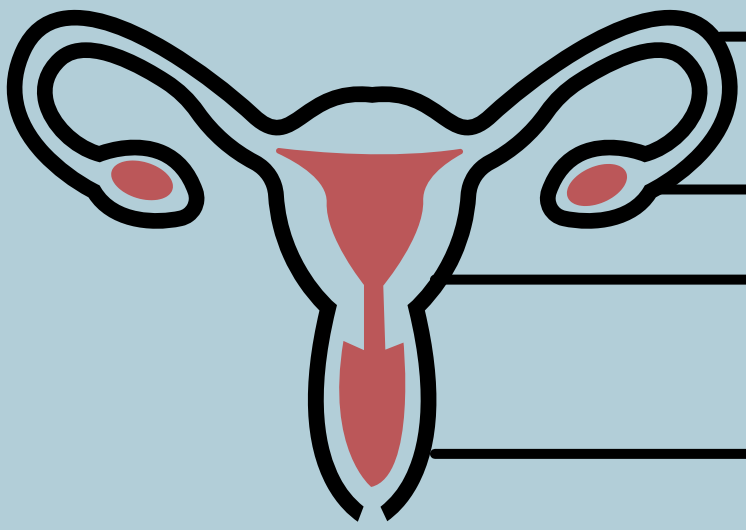
Medical Procedures

And Their Physical Effects

By Madeleine Babb



Anatomy Overview



Fallopian Tubes: Long, narrow ducts that connect the ovaries to the uterus. Site of fertilization and allows passage of fertilized egg into the uterus.

Ovaries: Site of oogenesis (egg development) and ovulation (monthly egg maturation).

Uterus: Fertilized eggs implant in this muscular organ and develop into a fetus.

Vagina: Muscular canal that connects the uterus to the outside of the body. Allows for menstruation, childbirth, and intercourse.

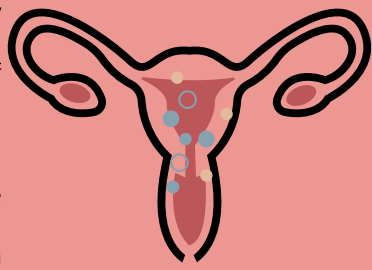
Diseases of the Female Reproductive System

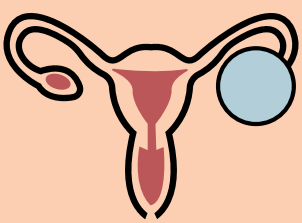
Suffered by Women at ICDC

Uterine Leiomyoma

These smooth muscle, non-cancerous tumors are also commonly known as uterine fibroids. Roughly 10 to 20% of women suffer from uterine leiomyomas at some point in their lifetime. Most women with leiomyomas are asymptomatic; however, some afflicted women may suffer from abnormal bleeding, pain, uterine enlargement, and pressure.[1] Many of the detaineed women sent to Dr. Amin were done so for uterine leiomyoma treatment.[2] Fibroids are clinically detected with pelvic examination and transabdominal ultrasound.[1] However, Dr. Amin conducted invasive transvaginal ultrasounds, which do not allow for detection of fibroids in enlarged uteri.[2]

Uterine leiomyomas are typically treated with non-surgical hormonal treatments or gonadotropin-releasing hormone agonists. These drugs work by targeting sex hormones that promote fibroid growth. Surgical methods may be used if medication-based approaches are unsuccessful. These surgeries include endometrial ablation (i.e. destruction of the inner uterine lining) and hysterectomy. Both of these options are invasive and typically used as a last resort in women nearing menopause.[1]. Despite this, Dr. Amin universally recommended surgical treatments to women without first exploring medication-based treatments.[2]





Ovarian Cysts

5 to 15% of women suffer from ovarian cysts, i.e. abnormal masses in the ovaries. Most of these cysts are classified as functional cysts that arise from disruptions in ovulation. Like uterine leiomyomas, most patients with ovarian cysts are asymptomatic. However, some patients may report severe pain and pressure, particularly if the cyst ruptures. Ovarian cysts are diagnosed with transabdominal ultrasound.[3]

Typically, functional cysts will spontaneously disappear after 6 months in pre-menopausal women. The typical course of action for these patients is to monitor their symptoms over the span of one year. Surgery is only recommended if the cyst is suspected to be cancerous.[3] Once again, Dr. Amin routinely pursued invasive surgical procedures rather than use non-invasive methods. Furthermore, Dr. Amin would recommend uterine surgical treatments such as endometrial ablation and hysterectomy for treatment of ovarian cysts.[2] These procedures involve the uterus and would have absolutely no effect on the cysts themselves. This misdiagnosis may be due to the lack of translators provided for the women.[3]

[1] Dashe, Jodi et. al. (2018). Williams Obstetrics 25e. McGraw-Hill Education Publishing. Chapter 9 "Benign Uterine Pathology".
[2] Oldaker v. Giles, No. 7:20-cv-00224-WLS-MSH (District Court for the Middle District of Georgia December 21, 2020).
[3] Dashe, Jodi et. al. (2018). Williams Obstetrics 25e. McGraw-Hill Education Publishing. Chapter 10 "Benign Adnexal Mass".

HYSTERECTOMY

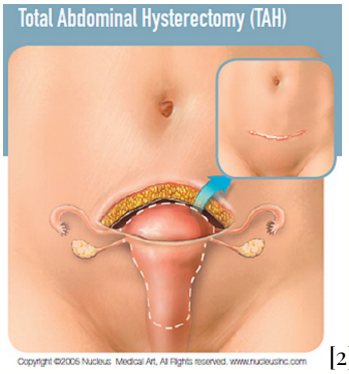
By Madeleine Babb

Some women at ICDC were subjected to **non-voluntary hysterectomies**. Hysterectomy is a major surgical procedure that involves the partial or full removal of the uterus. Women who receive hysterectomies are unable to bear children thereafter and are permanently sterilized. The main forms of hysterectomy practiced today include abdominal, vaginal, laparoscopically assisted vaginal, total laparoscopic, and subtotal hysterectomy.[1]

Sources:
[1] Lopes, T., Spirtos, N. M., Hilton, P., & Monaghan, J. M. (2018). Operations on the Uterus. In *Bonney's Gynaecological Surgery* (pp. 105-120). Hoboken, NJ: Wiley Blackwell.
[2] Nucleus Medical Art. (2005). *Hysterectomy Procedures.* www.nucleusnc.com

Total Abdominal Hysterectomy

This procedure is by far the most invasive form of hysterectomy. It requires a large incision to open both the abdominal and pelvic cavities in order to facilitate the removal of the entire uterus. The surgeon may or may not remove the fallopian tubes and ovaries depending on the patient's history. Many physicians chose to leave the ovaries intact to provide a natural source of hormones. Total abdominal hysterectomies require at least 6 weeks of recovery time post-surgically and a clean environment to prevent the risk of infection.[1]



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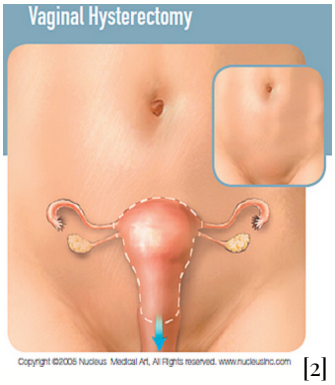


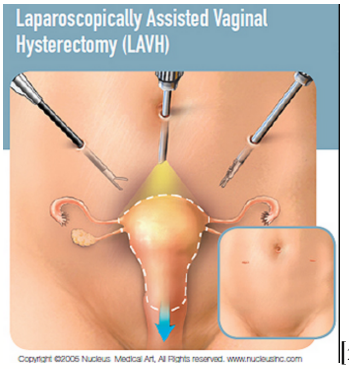
[2]

Vaginal Hysterectomy

Vaginal hysterectomies involve the removal of the entire uterus through the vaginal canal. This surgery is typically recommended to treat genital prolapse; however, it is used as an alternative for abdominal hysterectomy for other conditions like uterine leiomyoma, dysfunctional uterine bleeding, or in patients with abdominal obesity. The entire uterus and cervix are removed during the procedure; however, it is not always possible to remove the ovaries. Vaginal hysterectomy requires a shorter recovery time and entails less postoperative discomfort when compared to abdominal hysterectomy.[1]

Laparoscopic-Assisted Vaginal Hysterectomy

This technique was developed in the 1990s with the intent to create a simple procedure that could allow for removal of the ovaries, which is not always possible in a traditional vaginal hysterectomy. Laparoscopic-assisted vaginal hysterectomies (LAVH) use a laparoscopy to allow the surgeon to visualize the inside of the pelvic cavity without a large abdominal incision. The uterus and ovaries are then removed through the vagina. This procedure is relatively noninvasive and has a short recovery time.[1]



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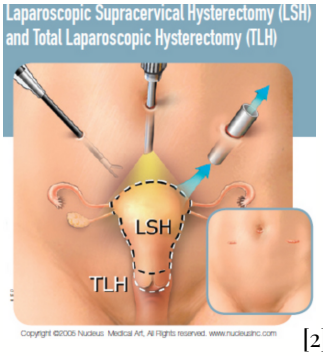


[2]

Total Laparoscopic Hysterectomy

This technique is similar to LAVH as it utilizes laparoscopy. However, the uterus is removed through abdominally inserted tubes rather than the vagina. The laparoscope allows the surgeon to visualize the interior of the pelvic cavity and section the uterus into small fractions to facilitate removal through the tube. This procedure is relatively noninvasive when compared to the total abdominal hysterectomy, and is used to treat women with large uterine leiomyoma or severe endometriosis.[1]

An Assault on Identity

THE PSYCHOLOGICAL EFFECTS OF FORCED STERILIZATION by Jonas Talandis

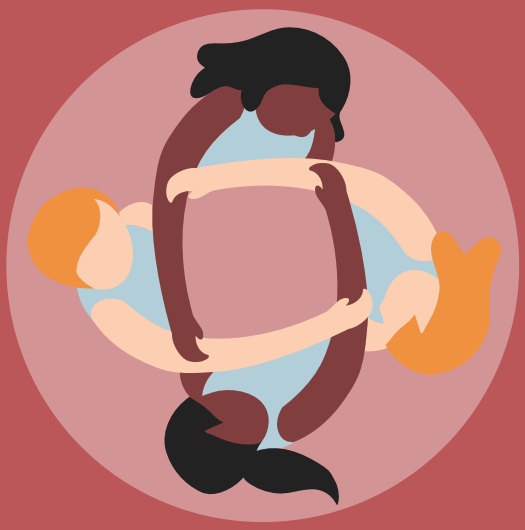
Even under normal circumstances, hysterectomies are extreme procedures with intense biological implications. Aside from the drastic physiological and hormonal effects the procedure has on the patient's body, it is equally important to consider the psychological effects the patient may experience during recovery.

According to Leppert et al., "hysterectomy is usually an elective procedure," indicating that women usually make a conscious decision to undergo the surgery and lose their childbearing abilities.[1]

In a study conducted among women who received a hysterectomy, Leppert and her partners asked 1000 premenopausal women before their scheduled hysterectomy whether they desired to have another child.[1] Using the Profile of Mood States (POMS) measurement tool, they found that those who said they did want another child had "higher scores on the POMS depression, anxiety, anger and confusion subscales" not only before the surgery but also even two years later during a follow-up.[1] From this, it is clear that there are clear detrimental effects on the mental health of women interested in having another child both pre- and post-hysterectomy.

Importantly, however, this study only examined women who were aware and consenting to the hysterectomy procedure, while the victims at the ICDC were allegedly unaware/not consenting. This indicates that for a procedure with already severe psychological effects, those who are not aware of the procedure are very likely subject to even worse trauma and mental health detriment. This is evidenced by firsthand accounts of the psychological aftermath of forced sterilizations. One such account comes from Dorothea Buck-Zerchin, a victim of forced sterilization in Nazi Germany. She discussed the dehumanization she felt from her psychologist who ordered her sterilization without so much as a conversation, saying that "he was no longer capable of seeing his patients as fellow human beings, because that is only possible by speaking with them."[2]

This account is particularly interesting, as many of the victims at the ICDC could not speak or understand English and were not given sufficient translation, indicating that they too may have experienced similar loss of humanity in favor of "the symptoms [the doctor] observed" as a result of being left out of the medical decision process. [2]



Another such account comes directly from Werner Villenger, a doctor who performed many forced sterilizations in Nazi Germany on imprisoned children, who proudly reported the psychological horrors of the procedures under the assumption that they were justified and necessary.[3] He states that his victims felt sentiments of "inadequacy" as well as feeling "no longer human," having "lost their honor," and being "no longer in control of [their] body."[3] These victims, like those at the ICDC, were also prisoners and not afforded any agency over their own bodies. This indicates that many of Dr. Amin's patients are subject to these extreme hits to their mental health, especially in connection to feelings of self-worth and womanhood.

According to Denbow, fertility, for many, is deeply tied to gender identity and feelings of "womanhood."[4] Therefore, losing one's fertility through an unnecessary, uninformed, or otherwise involuntary procedure, like those supplied by Dr. Amin, presents a shock to one's gender identity and self-evaluation to what it means to be a woman. Rowlands and Amy describe this shock and the subsequent mental health effects as "traumatic" and inflicting "irreversible harm onto the victims."[5] While the procedures and victims' experiences have only recently come to light, the mental health effects are long lasting and will likely continue to impact the victims psychologically.

Indeed, the class action lawsuit alleges that "Irwin County Respondents made conscious decisions to either act or fail to act causing Petitioners and putative class members to suffer severe emotional distress and anguish."[6] One petitioner describes Dr. Amin's "failure to obtain consent for the transvaginal ultrasound" as "particularly trauma-inducing," while another claimed that "since her [non-consensual, medically unindicated, or invasive gynecological procedures] with Dr. Amin, she has suffered from depression and is taking medications for her depression."[6] The lawsuit makes clear that the accounts of the psychological effects of involuntary sterilization and gynecological procedures are similar to and verified by what Dr. Amin's victims are feeling currently. Tragically, memories of Dr. Amin's procedures do not go away after the physical recovery, and it is clear that the mental detriment engendered by these unwanted, invasive procedures will affect the victims for years to come.

Sources

[1] Leppert, Phyllis C., Richard S. Legro, and Kristen H. Kjerulff "Hysterectomy and Loss of Fertility: Implications for Women's Mental Health." Journal of Psychosomatic Research 63, no. 3 (September 2007): 269-74. https://doi.org/10.1016/j.jpsychores.2007.03.018.

[2] Buck-Zerchin, Dorothea S. "Seventy Years of Coercion in Psychiatric Institutions, Experienced and Witnessed." In Coercive Treatment in Psychiatry, 235-43. John Wiley & Sons, Ltd. Accessed February 28, 2021. https://doi.org/10.1002/9780470978573.ch14.

[3] Wilkes, J. "Wie erlebten Jugendliche ihre Zwangssterilisierung in der Zeit des Nationalsozialismus?" Der Nervenarzt 73, no. 11 (November 1, 2002): 1055-57. https://doi.org/10.1007/s00115-002-1422-0.

[4] Denbow, Jennifer. "Sterilization as Cyborg Performance: Reproductive Freedom and the Regulation of Sterilization." Frontiers 35, no. 1 (2014): 107-131,215.

[5] Rowlands, Sam, and Jean-Jacques Amy. "Non-Consensual Sterilization of Women Living with HIV - Sam Rowlands, Jean-Jacques Amy, 2018." Accessed February 28, 2021. https://journals.sagepub.com/doi/10.1177/0956462418758116.

[6] Oldaker, Yanira Yesenia, Jane Doe, Jane Doe, and Jaromy Jazmín Floriano. "UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA," n.d., 160.

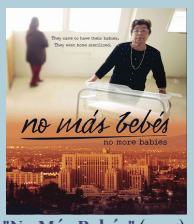
Female Bodily Autonomy

Adopting a Reproductive Justice Framework

by Pallavi Chandrasekhar

Female bodily autonomy has been a controversial topic for years, and the politically conservative view in the U.S. government has always been against abortion rights, often using the argument that fetuses having the right to a life. With this view we would expect the GOP to be furious about forced sterilization. However, they were completely silent on the matter, which is not surprising at all, as anti-abortion policies were never about birth but centered around white male supremacy denying non-white, non-wealthy women the right to decide if they wanted to become a parent.[1] A violation of bodily autonomy of all genders can be seen through the disregard for the health of ICE detainees once the COVID-19 pandemic began.[2] Institutionally, there is a lack of autonomy and an unacceptably high amount of control over the bodies of women, specifically those of Black, Brown, and Indigenous backgrounds.

Reproductive Justice Resources



"No Más Bebés" (2015)
A documentary about the Madrigal v. Quilligan case

"Belly of the Beast" (2020)
A documentary about sterilization in CA prisons.

Other Resources

- California Latinas for Reproductive Justice
  An organization committed to honoring the experiences of Latina's/x's to uphold their right to dignity, their bodies, their sexuality, and families.
- Sterilization and Social Justice Lab
  A multi-disciplinary team researching the legacy of eugenics and sterilization in 20th century America

Roe v. Wade is often cited as the Supreme Court case setting the precedent for reproductive justice and full autonomy for women; however, it was actually won using the Constitutional right to privacy (9th amendment).[3] This distinction sets the stage for why women are still fighting for the right to build families as they wish. The intersectional challenges faced by Latina women include immigration law, the inhumane conditions for their families in ICE detention centers, police brutality and murder, and forced sterilization, all caused by the societal desire to exert control over this population.[4] Reproductive Justice has been an ongoing fight from gaining the right to an abortion until now when it involves fighting for the right to prevent, terminate, or pursue pregnancy as an individual wishes.[5] It has clearly been evolving as an issue, as seen by this modern reproductive injustice of coerced sterilization.

Committee Opinion No. 695: Sterilization of Women: Ethical Issues and Considerations, published by the American College of Obstetricians and Gynecologists, offers the official lens that this regulatory committee believes sterilization should be seen through. They emphasize a "Reproductive Justice Framework" when considering sterilization. We often hear the term "reproductive rights" and assume this means access to contraception and abortion, and while this is part of the story, reproductive rights encompass much more. They include the right to have children, not have children, and to parent in a safe and humane environment.[6] The College emphasizes that having a Reproductive Justice framework when considering sterilization procedures inherently includes acknowledging a patient's gender, race, and socioeconomic status.

It's easy to not consider the ICE sterilizations as a matter of reproductive rights, because we often frame reproductive rights as more about preventing pregnancy than pursuing it. However, the concept of a Reproductive Justice framework described here explains that regardless of what medical procedure is involved, it's a woman's right to bodily autonomy that is a key concept of reproductive justice. The main factors creating barriers to bodily autonomy are access and paternalism.

Access to reproductive services spans from reversible contraception to sterilization to abortion and more. One key aspect of reproductive justice is that women cannot just have access to one form of contraception; they deserve to have all the options that are feasibly available, regardless of their insurance status. Some women undergo permanent sterilization not because it is their first choice, but because they require some form of contraception and options such as an IUD (intrauterine device) or hormonal birth control pills are not offered to them. Naturally, this leads to them consenting to something permanent that they could potentially regret, just because of a lack of complete access. Additionally, some women are only covered for reproductive services when they are already in the hospital for a birth, miscarriage, or abortion. These are all distressing circumstances during which they might not make the best decision for themselves, but since they are only given medical care at this time they have to decide right then and there. The only way to fix this issue of access is comprehensive universal healthcare. It is incredibly inequitable to have women be forced to make such important decisions under the limiting restrictions of the current Medicaid system. If this coverage were more comprehensive, it would empower women to make what is genuinely the best decision for their bodies.

This leads into the issue of physician paternalism. A Reproductive Justice framework is complicated because learning about it makes physicians more aware of historical injustice, and while this is overall a good thing because it would get rid of the issue of encouraging unnecessary sterilizations, it has the potential to have the opposite effect as well. The College describes that physicians need to remember to not allow a patient's demographics to affect their medical counseling; for example, just because a patient is part of a group that has been historically victimized does not mean the physician has the right to make decisions for them and discourage a sterilization if the patient actually desires one and has been given all the appropriate information.

Overall, a Reproductive Justice framework is a good lens for viewers to look at the ICE sterilizations because these women were robbed of their fundamental right to pursue fertility and children in the future. In our society, reproductive rights activists are often oversimplified by opposition as only fighting for abortion rights. However, what they are actually fighting for are simply a woman's most basic rights to be empowered in her choice of having or not having biological children. The Reproductive Justice framework can be important in deconstructing that misconception and garnering more support for all types of reproductive justice.

Sources
[1] Republican Silence on ICE Forced Sterilization Allegations; Penny, L. (2019)
[2] *Forced Sterilization Accusations at ICE Facility Fit with Trump's Poor Treatment of Immigrants | Brennan Center for Justice*. September 18, 2020.
[3] *Roe v. Wade, 410 U.S. 113 (1973)*
[4] *Making Waves (Poem) - California Latinas for Reproductive Justice*
[5] Planned Parenthood (2018)
[6] Committee Opinion No. 695: Sterilization of Women: Ethical Issues and Considerations. (2017). *Obstetrics and Gynecology*, *129*(4), e109-e116. https://doi.org/10.1097/AOG.0000000000002023
[7] Background Image: Stern, A. M. (2005). STERILIZED in the Name of Public Health. *American Journal of Public Health*, *95*(7), 1128-1138. https://doi.org/10.2105/AJPH.2004.041608

A Demand for Justice

The Consolidated Class Action Lawsuit against ICE & Dr. Amin

by Pallavi Chandrasekhar

A lawsuit against Dr. Amin and ICE was filed on December 21, 2020, on behalf of 14 women, but has since grown to include more than 40 women, some of whom are still being detained and some of whom have been deported. This all comes after Dawn Wooten filed the original whistleblower report on September 14, 2020. The lawsuit petitioners come from a variety of countries of origin, of which many but not all are Spanish-speaking. It charges that these women filed complaints about Dr. Amin's "painful, unnecessary, non-indicated, and/or non-consensual medical procedures" but were still sent to see him.[1] The gynecologist is also being investigated by Congress and the Department of Homeland Security, but his lawyer has so far denied any wrongdoing. A spokesman for ICE confirmed, however, that Respondent Amin would no longer be seeing any patients from the detention center, because of the ongoing investigation by the Department of Homeland Security's Inspector General.[2]

"Just because we're detainees doesn't mean that we don't feel or that we don't hurt. We're no less women than the regular people in the free world and we still deserve to have the same respect and proper medical attention."

– Lead Plaintiff Yanira Oldaker, the night before her scheduled deportation to Mexico [2]

Pictured: Whistleblower nurse Dawn Wooten (far left) and protestors at an Atlanta news conference [2]

This pattern of medical abuse at ICDC has been occurring since 2018 and the lawsuit includes many of the women's detailed accounts of the nonconsensual procedures performed on them. Together, the cases draw a very heartbreaking picture of women being denied their basic right to have a family if they desire one. The lack of proper informed consent before undergoing these procedures shows a clear civil rights violation. This is not an injustice that can be fixed by punishing one individual because it is not a unique event. Rather, it fits into the ongoing fight for informed consent, female bodily autonomy, and reproductive justice in the United States. An institutional problem requires an institutional solution rather than an individualistic one. It should also be highlighted that these women are part of marginalized groups often being institutionally discriminated against, because of their immigration status, race, socioeconomic status, and gender. The legal and advocacy director at Project South, an organization dedicated to the social, economic, and political issues in the South, and a co-counsel on the lawsuit, Azadeh Shahshahani, stated that the "consolidated action is significant because we have been able to establish a pattern of medical abuse at Irwin."[2] This provides some hope that the women involved in this lawsuit may win their case, but as historical court decisions have shown, the U.S. government unfortunately has a tendency to be lenient and never explicitly outlaw coercive sterilization.

Sources

[1] Oldaker v. Giles, No. 7:20-cv-00224-WLS-MSH (District Court for the Middle District of Georgia December 21, 2020).

[2] More Than 40 Women Provide Testimony Alleging Medical Abuse By ICE Doctor at Irwin County Detention Center. (n.d.). Time. Retrieved February 28, 2021, from https://time.com/5924021/women-lawsuit-irwin-detention-ice/

Throughout this magazine, you have learned so much about what happened to detained women in Irwin County Detention Center. You have seen the long histories of racialized immigrant detention, sterilization, and medical abuse that have lead to this moment and read about how the women are and will be affected. But now, you might be wondering...

What comes next?

Armed with your powerful knowledge, it is time to **set goals** and **act**.

Goal 1: Prevent Medical Abuses in ICE Detention

Implementing standardized data collection and reporting of medical procedures in ICE detention will improve accountability and oversight.[1] DHS must ensure more medical, dental, and medical health professionals are accessible and must develop and enforce strict compliance standards.[2] Both centralized oversight and community oversight committees must be improved and created. Additionally, contracting with corporations for medical care and detention center management creates incentive to provide the lowest possible quality of care, so detention should be fully non-for profit.[2,3,4]

Goal 2: Decreased detention

Though less revolutionary than abolition, massive decarceration is one of the most important tactics for preventing these atrocities. This can occur by releasing more individuals with medical conditions or based on other criteria, avoiding programs which increase detention, and shifting funding for detention to community-based alternatives.[2]

Goal 3: Detention abolition

Abolition of immigrant detention is the only way to truly uproot this evil system. A system created to punish Brown and Black immigrants which was created on fundamentally racist, misogynist, paternalistic, and unjust grounds cannot be truly reformed. Imprisonment of immigrants is the fundamental evil of their function, and while this evil stands, mistreatment is inherent in the system.

Sources

[1] Bowen, Allison Michelle. "The Importance of Standardized Data Collection and Reporting in Improving Medical Care for Immigration Detainees." Saint Louis University Journal of Health Law & Policy 13 (2020): 27.

2] Southern Poverty Law Center. "Shadow Prisons: Immigrant Detention in the South." Southern Poverty Law Center, November 21, 2016. https://www.splcenter.org/20161121/shadow-prisons-immigrant-detention-south.

[3] "Fatal Neglect: How ICE Ignores Death in Detention." American Civil Liberties Union, February 24, 2016. https://www.aclu.org/report/fatal-neglect-how-ice-ignores-death-detention.

[4] Freedom for Immigrants and Human Rights Watch. "Medical Neglect." Accessed February 4, 2021. https://www.freedomforimmigrants.org/medical-neglect.

By Cora Miller

MAKE IT HAPPEN!

ORGANIZE, PARTICIPATE, AND DONATE

to national and local activism that focuses on detention abolition and reproductive justice. Choose from the list below based on your personal passions, or research your local organizations!

Reproductive Justice Action Collective

is a Southern organization focused on dismantling gatekeeping and white supremacy in reproductive healthcare and ensuring communities can access the services that are important to them.

Freedom for Immigrants

is a national coalition focused on ending immigrant detention by supporting the organizing and activism of those most affected. "Nobody's free until everybody's free." - Fannie Lou Hamer

Detention Watch Network

is a national membership-based coalition connecting local anti-detention movements across the U.S. Their "Take Action" page has many toolkits for community members to become involved with detention abolition in their local areas.

Southern Poverty Law Center

began as a small civil rights firm in the 1970s, and has grown to be a massive force of legal activism. They create a wide variety of thoughtfully researched content centering around anti-racism, anti-hate and justice-seeking initiatives.

Project South

is the Atlanta, Georgia-based non-profit which filed the whistleblower report on behalf of Wooten. Rooted in the Southern Freedom Movement, Project South focuses on local, community-based, grassroots organizing to empower communities.

CREATE

art reflecting immigrant experience in detention and advocating for detention abolition.

PREVENT

the need for atrocity-driven immigration by advocating against U.S. imperialist action in Latin America, the Caribbean, Africa, and Asia.

VOTE

for candidates and policies that reflect abolitionist and anti-detention values.

FORM

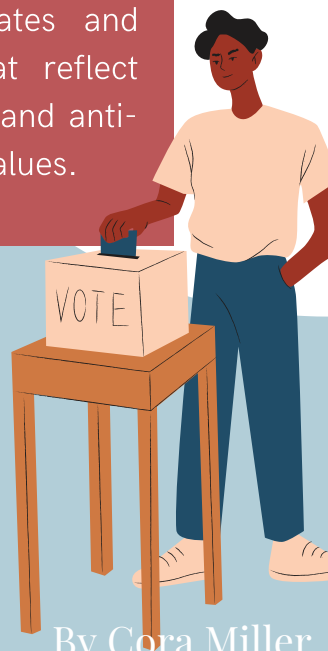
a civilian action and/or oversight committee for your local detention centers.

SPREAD

information about detention centers in your area and around the U.S.

CONTINUE

sharing incarcerated immigrant stories through your lives and careers, centering their experiences in your words and actions.



By Cora Miller