MAASTRICHT UNIVERSITY

European Master's Programme in Human Rights and Democratisation

A.Y. 2022/2023

The Fundamental Conflict Between Immigration Detention and The Right to Health: An Exploration of Gender and Vulnerability

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Word Count Declaration: 27624

Acknowledgements

Firstly, I would like to say thank you to Dr. Jennifer Sellin. I appreciate the guidance and the reassuring advice throughout the development of this thesis.

Secondly, to my family. Thank you for helping me when I was stressed (which was always), and for encouraging me to quit my job and do this Masters.

To my friends from Venice: thank you for making the time there so fun, and for all your support afterwards.

To my friends from home: thank you for visiting, for always making me laugh, and for being the best.

Finally, to those held in immigration detention, I wish you health and liberty.

Abstract

Immigration detention is a global practice, fraught with human rights abuse and subject to much criticism. Punitive in nature, the detention of migrants for administrative purposes has dire consequences, primarily the failure to respect the right to health of detainees. Constructed through an androcentric lens and largely housing male migrants, the structures of immigration detention fail to consider the unique health needs of women. The pervasive themes of vulnerability, indignity, and lack of autonomy for female detainees will be explored, and the barriers to the realisation of mental, physical, and social health will be discussed. Parallels will be drawn between panopticism, biopolitics, and the legal and normative frameworks that govern immigration detention structures, and emphasis on the importance of an intersectional approach will be addressed. Ultimately, the inherently contradictory nature of immigration detention in terms of realising the right to health will be discussed, and alternatives to detention will be examined.

Introduction

'As a global community, we face a choice. Do we want migration to be a source of prosperity and international solidarity, or a byword for inhumanity and social friction?'

- *António Guterres, Secretary-General of the United Nations, 2018*[1]

History has been characterised by cross-border movement, and it is undeniable that our future will be defined by it.[2] Not only does migration power economic growth, reduce inequality, and promote a diverse society, it is also a great source of political contention.[3] During his tenure as Secretary-General of the United Nations, Guterres highlighted that we stand at a political crossroads in contemporary society.[4] Facing a future of climate induced mass migration,[5] we have the option to produce migration policies of acceptance and integration, or maintain systems of exclusion and marginalisation.

Statistics show that approximately 2.3% of the world's population live outside of their country of origin.[6] This equates to around 184 million migrants, of which 37 million are refugees.[7] In terms of gender division within these numbers, migrant workers consisted of 58.5% men, 41.5% women,[8] whereas the gender divide was more evenly split for asylum seekers.[9] The term 'migrant' refers to someone who has moved across an international border, away from their usual country of residence.[10] A 'refugee' is someone who 'is unable or unwilling to return to their country of origin' owing to a well-founded fear of persecution.[11] Far too often, States will impose draconian border control measures in an attempt to deter

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[1] Guterres, António. 2018. "Towards a new global compact migration." *United Nations: Secretary General.* January 11. Accessed July 11, 2023. https://www.un.org/sg/en/content/sg/articles/2018-01-11/towards-new-global-compact-migration.

[2] World Bank. 2023. *World Development Report 2023: Migrants, Refugee, and Societies.* Flagship Report, Washington, DC: World Bank. Page 1

[3] (Guterres 2018)
[4] *Ibid.*
[5] *Ibid.*
[6] (World Bank 2023) Page 1

[7] *Ibid.* Page 1
[8] Mcauliffe, M, A Triandafyllidou, (Eds.). 2021. *World Migration Report 2022.* Geneva: International Organisation for Migration (IOM). Page 27

[9] UNHCR. 2022. *Figures at a glance.* Accessed July 11, 2023. https://www.unhcr.org/about-unhcr/who-we-are/figures-glance.

[10] IOM UN Migration. 2023. *IOM Definition of "Migrant".* Accessed July 12, 2023. https://www.iom.int/about-migration.

[11] UN General Assembly, *Convention Relating to the Status of Refugees*, 28 July 1951, United Nations, Treaty Series, vol. 189, p. 137, Article 1 A (2)

migrants and asylum seekers, leading to a vicious cycle of irregular migration and increasing restrictions.[12] One such example is the detention of migrants.

Immigration detention is the deprivation of liberty for non-citizens, and one of the most controversial methods of border control. State implementation of such practices has gradually increased over recent years,[13] despite international requirements that it only be used as a last resort.[14] Generally, refugees are not held in immigration detention, with the majority of the detained population consisting of migrants. In some circumstances, asylum seekers may be detained whilst a State determines the validity of their claim.[15] Under international human rights law, any form of detention or arrest must not be arbitrary.[16] To be deemed legally justified under such frameworks, States must prove that detention of migrants is necessary, reasonable, and proportionate for the intended aim.[17] The cited aim of immigration detention in most circumstances is to prepare migrants for deportation and avoid the risk of absconding, or to hold migrants whilst their right to stay in the country is determined.[18] Most States implement these practices under administrative structures, but a few have criminalised irregular migration, and detention is thus used as a criminal sanction.[19] Regardless of the governing structure of immigration detention, there are undeniable parallels with the criminal justice system, and therefore an inherent message of criminalising people who cross borders.[20] International human rights bodies generally consider the criminalisation of irregular migration to be disproportionate,[21] and combined with the deprivation of liberty, harmful to those detained.[22]

One of the most detrimental consequences of immigration detention is the deterioration of migrants' health. Confirmed by the World Health Organisation, conditions of immigration detention can result in

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[12] (Guterres 2018)
[13] The World Health Organisation. 2022. *Addressing the health challenges in immigration detention, and alternative to detention: A Country Implementation Guide.* Copenhagen: WHO Regional Office for Europe. Page vi

[14] Global Compact for Migration. 2018. "Global Compact for Safe, Orderly and Regular Migration: 23 Objectives." *Intergovernmental Conference on the Global Compact for Migration.* United Nations. Objective 13

[15] (The World Health Organisation 2022) Page vi
[16] UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III) Article 9
[17] UN Human Rights Committee (HRC), *General comment no. 35, Article 9 (Liberty and security of person)*, 16 December 2014, CCPR/C/GC/35 Para 18
[18] International Organisation for Migration. 2017. *Immigration Detention and Alternatives to Detention.* Global Compact Thematic Paper, IOM: The UN Migration Agency. Page 1

[19] *Ibid.* Page 1
[20] *Ibid.* Page 1
[21] *Ibid.* Page 1
[22] (The World Health Organisation 2022) Page 2

harm to the physical, mental and social health of detained migrants.[23] The extent of this harm is difficult to ascertain due to limited data provisions and a lack of transparency by States on their detention practices.[24] Of particular concern, and the focus of this thesis, is the health of female migrants held in immigration detention centres. The rate of detention for women is much lower than that of their male counterparts,[25] and so there is limited available data or research on the specific gendered experience of immigration detention. This is a gap that needs to be addressed.

Immigration detention is constructed through the lens of 'male as the norm' and as such, current analysis on the harms of detention is typically amalgamated into a singular framework of the masculine experience, rather than considering the unique experiences of women. Socio-economic status, gender, race, and sexual identity have long been acknowledged as indicators of marginalisation, creating a nexus of systemic harm that migrant women may be exposed to. A combination of these factors with the lack of disaggregated date on race, ethnicity, and sex, results in the experiences of migrant women being obscured and inadequately addressed.[26]

To illustrate this point, migrant women are at a significantly higher risk of gender-based violence.[27] They may have experienced trauma specific to women, such as female genital mutilation, and require expert and compassionate care which is not provided for within immigration detention.[28] Moreover, pregnant women have unique health needs that require particular care and attention. The inconsistency of care in immigration detention can be detrimental to both mother and foetus.[29] Considering these factors, it is evident that the equitable realisation of health within immigration detention requires an acknowledgement of migrant women's vulnerability, and the essentiality of gender-sensitivity within the immigration detention complex.

Aim

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[23] *Ibid.*
[24] *Ibid.* Page 2
[25] *Ibid.* Page 22
[26] Hamilton-Jiang, Sarah. 2022. *Racially Marginalized Migrant Women: Human Rights Abuses At The Intersection of Race, Gender and Migration.* Policy Brief, UN Women. Page 1

[27] UN Women. 2021. *From Evidence to Action: Tackling Gender-Based Violence Against Migrant Women and Girls.* Policy Brief, New York: UN Women. Page 1

[28] British Medical Association. 2017. *Locked up, locked out: health and human rights in immigration detention.* British Medical Association Medical Ethics Committee. Page 20

[29] (The World Health Organisation 2022) Page 23

The aim of this thesis is to shed light on the health experiences of migrant women held in immigration detention. Practicing a rights-based approach and drawing on concepts of underlying determinants of health, gender-sensitivity, and medical ethics, this thesis will analyse the particular vulnerability of women in immigration detention, and the resulting impact on their physical, mental and social wellbeing. Considering the construction of immigration detention as a State mechanism to deprive and deport, this thesis will examine the complex relationship with health through policies that reduce harm.

Echoing a similar sentiment to that of António Guterres, this thesis will advocate for a compassionate and rights-centred approach to border control.

Research Question

What are the key barriers and challenges faced by women in immigration detention regarding their right to health? To what extent is the inherent nature of immigration detention incompatible with the equitable realisation of migrant women's right to health?

Methodology

The research methodology for this thesis consists of legal and doctrinal analysis, with the US, Australia, and Sweden as case studies.

International human rights law, regional treaties, and state obligations will first be considered in order to develop a comprehensive understanding of the current frameworks that govern health, immigration detention, and women's rights respectively, as well as together. The Vienna Convention on the Law of Treaties[30] interpretative techniques are utilised as a guiding framework, requiring the analysis of treaty content, such as Articles and the Preamble, as well as authoritative sources of interpretation. General Comment No.14 and 22 from the Committee for Economic, Social and Cultural Rights will be utilised in this context.

Existing research and academic scholarship will be examined using a doctrinal approach, focusing on women's health barriers in immigration detention. Sources for this include qualitative and quantitative research, conducted by a variety of academics, institutions, and organisations. Theoretical frameworks such as medical ethics and intersectionality are employed to present a well-rounded examination of the research questions.

[30] United Nations, *Vienna Convention on the Law of Treaties*, 23 May 1969, United Nations, Treaty Series, vol. 1155, p. 331

The United States, Australia, and Sweden were selected for case studies to demonstrate practical realisation of immigration detention policies, how health is governed within such structures, and the lived experiences of migrants in detention based on such policies. Particular attention is paid to women's health outcomes. The rationale behind choosing these states was primarily practical. Existing data on immigration detention and gender specificity is limited. A significant amount of existing and accessible research originates within these three States. Sweden in particular was selected as it is famed for its soft approach to immigration detention, this provides a useful baseline to consider whether the 'best' approach has sufficient safeguards for women's health. The UK is the centre of much research in this area, but was not included in the case study so as to allow for more detailed analysis of the other States within the confines of the thesis. A critical analysis of alternatives to detention will also be conducted.

A rights-based approach will be employed throughout, maintaining an intersectional gender perspective to appropriately address and critique the current invisible nature of women's experiences in immigration detention, and the existing health barriers.

Scope

Women's migration processes are fraught with health implications and barriers; however, this thesis will solely focus on immigration detention so as to develop a nuanced perspective. Focusing on the immigration detention practices of a single region or State may limit understanding of the overall impact of immigration detention on women's health, or the range of frameworks that may be employed to comply with international human rights obligations. Furthermore, the limited data on women's health experiences necessitates a compilation of numerous research studies from a variety of sources. The scope of this thesis will therefore cover global practices of women's experiences of immigration detention.

Limitations

Empirical, primary research will not be conducted in the production of this thesis, primarily due to ethical considerations. Women who are held in immigration detention centres are particularly vulnerable, as this thesis will discuss, and initiating contact with past or present detainees without a trauma-informed care approach and resources for follow-up support would risk causing further harm.

Whilst the thesis intends to cover a wide range of sources and discuss the global immigration detention complex, there is a limited focus on women's health within immigration detention. Moreover, language

barriers will limit a complete examination of research conducted internationally. Only sources available in English will be used. Geographic bias may therefore be present, with a significant proportion of literature originating from Europe, the US, or Australia.

Thesis Outline

Chapter 1

This chapter will set the stage for later analysis, providing the groundwork for the right to health, immigration detention, and an intersectional gender-sensitive approach. Providing the majority of legal analysis, this section will be largely explanatory, detailing the content of international human rights law and normative frameworks.

Chapter 2

Building on the concept of health as established in the previous chapter, this section of the thesis will provide a detailed insight into the barriers that women face to their health in immigration detention. This will utilise existing frameworks from the Committee on Economic, Social and Cultural Rights, alongside a variety of academic literature, in order to produce a comprehensive understanding of the current nature of immigration detention in the context of women's health.

Chapter 3

Examination of domestic practices will be conducted in this chapter, focusing on the US, Australia, and Sweden. This will help to illustrate the issues raised in the previous chapter by exemplifying them through national frameworks. Recurrent themes will be addressed, including mental health, reproductive health, and human dignity.

Chapter 4

Drawing on all of the information provided, and analysis conducted throughout the thesis, this chapter will discuss the benefits of detention alternatives. A rights-based approach will be maintained, and existing cases of alternatives to detention will be reviewed. Recommendations for improving health for female migrants in immigration will be discussed, with a critical perspective for the longevity of such practices.

Conclusion

Final remarks about the analysis conducted and the research question will be presented here. The aim of this chapter will be consideration of whether immigration detention can be compatible with women's health, as well as principle of necessity, reasonableness, and proportionality will be discussed.

Chapter 1: A Rights-Based Perspective on Health for Women in Immigration Detention

1.0 Introduction

The practice of detaining migrants for administrative purposes is a growing phenomenon. Unfortunately, those detained have reported State neglect and health deterioration that has lasting consequences. The conceptualisation of health is not straightforward, as there are a variety of definitions and underlying factors that determine the extent to which someone is 'healthy'. We will address the existing legal and normative structures that govern health on an international and regional scale. This will help to develop a general consensus on the definition of the right to health, from which we can discuss the applicability to immigration detention. A rights-based approach will be applied throughout, with specific focus on provisions for the standard of healthcare and support within detention facilities.

1.0.1 Understanding Health Through a Rights-Based Perspective: Legal Frameworks

Health was acknowledged as a right inherent to all people by the Universal Declaration of Human Rights (UDHR) in 1948, in which it was declared that '[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family,' including access to food, housing, medical care, and necessary social services.[31] Article 2 of the UDHR reaffirms the universal, declaring that '[e]veryone is entitled to all the rights and freedoms set forth in this Declaration,' and distinction should not be made for any reason, including gender or race. Important to note is that an adequate standard of living is not just associated with medical care, but with other factors such as food and housing. This is indicative that medical care is indivisible with an adequate standard of living, but it must also be considered in association with other factors.

This is expanded upon within later treaties. The International Covenant on Economic, Social and Cultural Rights (ICESCR) has been formative in the shaping of health governance and understanding. Article 12 dictates the 'right of everyone to the highest attainable standard of physical and mental health.'[32] With a vast scope of 171 State ratifications, [33] ICESCR requires that States take sufficient steps to realise the right to health. Examples of such steps includes minimising the rate of still-birth and infant mortality, improving environmental hygiene, and creating conditions for which medical service would be assured

[31] UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III) Article 25
[32] UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3, Article 12
[33] United Nations. 2023. *United Nations Treaty Collection.* Accessed June 22, 2023. https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-3&chapter=4.

in the event of sickness.[34] This non-exhaustive list demonstrates the multi-faceted character of the right to health.

In the interests of gender equality and women's rights, the Convention for the Elimination of Discrimination Against Women (CEDAW)[35] acknowledges the importance of a gender-sensitive approach to human rights obligations. Article 12 dictates that States must 'take all appropriate measures to eliminate discrimination against women in the field of health care'.[36] Reproductive health is emphasised, for which Article 16(e) requires that women have the right to decide freely the number and spacing of their children, with the appropriate health education to facilitate such decisions.[37] Particular attention is paid to women in rural settings, and those living in poverty who have limited access to health services.[38] This is an embodiment of the principle of intersectionality and gender-sensitivity; there are a variety of internal and external factors that influence a person's attainment of the right to health, and specific provisions for this is essential to creating substantive equality in health. As of July 2023, 189 States have ratified CEDAW and are committed to achieving gender equality.

Whilst not directly related to the rights of women, The Convention on the Rights of the Child (CRC), [39] reflects the ICESCR perspective of health realisation, stating that children are entitled to 'the highest attainable standard'.[40] This reiterates the idea of differential standards of health and the necessity of an adaptive framework. Of particular interest to the context of immigration detention is the obligation on State Parties to 'take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation, or abuse; torture, or any other form of cruel, inhuman or degrading treatment or punishment.'[41] Whilst States tend to avoid detention of children unless in exceptional circumstances, this is an important development in the acknowledgement of the importance of mental health support within international frameworks. Moreover, 41% of the world's refugees were children in the year 2022,[42] and protection seeking girls are likely to have

[34] *Ibid,* Article 12 (a),(b) and (d)
[35] UN General Assembly, *Convention on the Elimination of All Forms of Discrimination Against Women*, 18 December 1979, United Nations, Treaty Series, vol. 1249, p. 13
[36] *Ibid,* Article 12
[37] *Ibid,* Article 16(e)
[38] *Ibid.* Article 14 (b), and Preamble.
[39] UN General Assembly*, Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3
[40] *Ibid.* Article 24
[41] *Ibid. (CRC)*, Article 39
[42] UNICEF. 2023. "Child Displacement." *UNICEF Data.* June. Accessed July 7, 2023. https://data.unicef.org/topic/child-migration-and-

experienced some form of gender-based violence, such as Female Genital Mutilation (FGM).[43] Legal frameworks that can be adapted to support gender specific health needs are essential when adapted a rights-based approach to immigration detention.

As we discussed earlier, an intersectional perspective is essential to the equitable realisation of the right to health. The Convention on the Rights of Persons with Disabilities (CRPD)[44] and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (CMRW)[45] embody this principle. The CRPD focuses on the delivery of the '[h]ighest attainable standard of health' without discrimination on the basis of disability. Approximately 16% of the global population are persons with disabilities,[46] and a study by the United Nations Populations Fund discovered that women and girls with disabilities are at a significantly higher likelihood of experiencing gender-based violence, sometimes even 40% higher.[47] Sufficient healthcare provisions, including physical and psychological support, are essential to minimise the harm to women. Non-discrimination is embodied within the CMRW through the provision that all migrant workers and their families are provided with urgent medical care for the preservation of life or the avoidance of irreparable harm to their health,[48] as well as equal treatment with nationals in relation to access to social and health services.[49] Intersectionality is embodied here with the crossover between race, nationality, and health. However, some argue that this is an 'ambivalent document',[50] as it is predicated on the migrant workers meeting the 'requirements for participation in the respective schemes',[51] and so is not a true reflection of equitable healthcare. 58 States

displacement/displacement/#:~:text=Children%20make%20up%20less%20than,the%20world's%20refugees%20in%202022.

[43] UNHCR. 2018. *Female Genital Mutilation & Asylum in the European Union: A Statistical Update (August 2018).* The UN Refugee Agency.

[44] UN General Assembly, *Convention on the Rights of Persons with Disabilities : resolution / adopted by the General Assembly,* 24 January 2007, A/RES/61/106, Article 25

[45] UN General Assembly, *International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families*, 18 December 1990, A/RES/45/158

[46] The World Health Organisation. 2023. *Disability: Key Facts.* March 7. Accessed July 7, 2023. https://www.who.int/news-room/fact-sheets/detail/disability-and-health#:~:text=Key%20facts,earlier%20than%20those%20without%20disabilities.

[47] UNFPA. 2018. *Young Persons With Disabilities: Global Study on Ending Gender-Based Violence, And Realising Sexual and Reproductive Health and Rights.* New York: United Nations Population Fund.

[48] CMRW, Article 28

[49] *Ibid.* Article 43(e)

[50] Krennerich, Michael. 2017. *The Human Right to Health: Fundamentals of a Complex Right.* Vol. 4, in *Healthcare as a Human Rights Issue: Normative Profile, Conflicts and Implementation*, by Sabine Klotz, Heiner Bielefeldt, Martina Schmidhuber and Andreas Frewer. transcript Verlag. Page 29

[51] CMRW, Article 43(e)

are currently party to the Convention,[52] an illustration of the lack of international consensus on migrant protections.

Recurrent and important factors to note from the discussed treaties is the mention of the 'highest attainable standard of health', which has been essential in the development of normative frameworks. Additionally, the combination of different factors such as food, medical care, housing, psychological support, and rehabilitative programmes such be noted. This will be expanded upon but is a useful indication of the multifaceted essence of international legal frameworks for the right to health.

1.0.2 Regional Treaties on Health: A Gendered Perspective

Human rights treaties on the regional level allow States to adopt a more nuanced approach to health and women's rights, permitting for variations within that specific demographic. Treaties from the European, Inter-American and African region will be examined, to understand the range of possible approaches, and the common themes amongst them.

The European Union Charter of Fundamental Rights emphasises the importance of non-discrimination in the delivery of healthcare. Article 35 requires that 'everyone has the right of access to preventative health care and the right to benefit from medical treatment' according to national law and practices.[53] Similarly, the European Social Charter, which falls within the remit of the Council of Europe, states that Parties should undertake appropriate measures to remove as far as possible the causes of ill health, to provide health-related education, and to prevent epidemics, endemics, and accidents, as much as possible.[54] Both are very broad statements, but can have particular relevance in the face of migrant women's health needs. Preventative action against epidemics and endemics is especially significant; in certain countries, there is a 50% increased risk of women and girls contracting HIV if they have been subject to gender-based violence. [55] By agreeing to tackle the spread of communicable diseases, the

[52] United Nations. 2023. "Status of Ratification Interactive Dashboard." *United Nations Human Rights Office of the High Commissioner.* Accessed June 23, 2023. https://indicators.ohchr.org/.

[53] European Union, *Charter of Fundamental Rights of the European Union*, 26 October 2012, 2012/C 326/02, Article 35

[54] Council of Europe, *European Social Charter*, 18 October 1961, ETS 35, Article 11

[55] UNAIDS. 2023. *Gender based violence.* June 29. Accessed July 7, 2023. https://www.unaids.org/en/keywords/gender-based-violence#:~:text=In%20countries%20with%20high%20HIV,or%20stay%20on%20HIV%20treatment.

Council of Europe has inexorably committed to address the causes of such harm, including the 'shadow pandemic' of gender-based violence.[56]

The Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights (The Protocol of San Salvador)[57] advocates for the 'highest level of physical, mental and social well-being.'[58] Health is perceived within the Inter-American region as a 'public good'[59] that should be extended to all individuals that are subject to the States jurisdiction,[60] and particular attention paid to the 'highest risk groups and of those who poverty makes them the most vulnerable'. The concept of vulnerability will be explored in greater detail in a later chapter,[61] but it must be acknowledged that vulnerability is inherent to migration, particularly women's experiences of migration. Therefore, achieving the highest level of physical, mental and social well-being requires particular consideration of women's needs outside of the lens of male as the norm.

A pertinent example of regional frameworks addressing health rights that are specific to women can be found within the Maputo Protocol, otherwise known as the African Charter on Human and People's Rights on the Rights of Women in Africa. [62] Article II advocates for the elimination of discrimination against women, including the prohibition of any harmful practice or discrimination that endangers the health and general well-being of women.[63] We could make several connections here, including the eradication of practices such as Female Genital Mutilation, or the elimination of immigration detention regimes that are harmful to the well-being of detainees, including women. Expansion upon women's health rights can be found in Article XIV, in which States are required to ensure that women's sexual and reproductive health is respected and promoted.[64] This involves taking appropriate measures to guarantee adequate, affordable and accessible health services,' including pre- and post-natal health

[56] UN Women. 2021. *Measuring the shadow pandemic: Violence against women during covid-19.* Survey Report, UN Women.

[57] Organization of American States (OAS), *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights ("Protocol of San Salvador"),* 16 November 1999, A-52

[58] *Ibid.* Article 10(1)
[59] *Ibid.* Article 10(2)
[60] *Ibid.* Article 10(2)(b)
[61] Chapter 2 – 2.1 Unveiling Vulnerability
[62] African Union, *Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa*, 11 July 2003

[63] *Ibid.* The Maputo Protocol, Article II 1 (b)
[64] *Ibid.* The Maputo Protocol Article XIV 1

care.[65] Perhaps most notably, abortion is explicitly authorised 'in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health' of the mother or foetus.[66] This was particularly revolutionary, as prior to the Maputo Protocol, abortion was not directly referred to within international legal frameworks. [67]

Building upon the explored concepts within international human rights frameworks, the regional treaties demonstrate similar priorities. Non-discrimination is an evident priority, as well as reproductive health, representing the need to adopt gender-specific health policies. An implicit acknowledgement of the harm of gender-based violence is also apparent, which will be relevant throughout this thesis when considering female migrants right to health.

1.1.Normative Frameworks for the Right to Health

Normative frameworks can be understood as an accumulation of authoritative guidance on human rights, and they are essential for understanding how the right to health is realised on a practical basis.[68] This helps us to conceptualise human rights beyond that of what is contained within treaty documents; UN bodies and regional committees are some of the influential actors in the development of normative frameworks. Described as a 'patchwork' of hard and soft law, legally binding frameworks for the right to health and non-binding guidelines should be seen as 'mutually supportive,'[69] thus helping us to develop a complete understanding of how the right to health functions.

1.1.1 The Committee for Economic, Social and Cultural Rights

The Committee for Economic, Social and Cultural Rights (CESCR) is a primary source for guiding the implementation of the right to health. Established in 1985, it monitors State compliance with ICESCR obligations, and provides recommendations for improvement. [70] 'Concluding Observations' are the

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[65] *Ibid.* The Maputo Protocol XIV 2 (a) and (b)
[66] *Ibid.* The Maputo Protocol, Article XIV 2 (c)
[67] Ferroni, Giacomo. 2022. "The Status of Women's Reproductive Rights in Africa: Symposium, Women in International Law Vol.1." *Völkerrechtsblog: International Law & International Legal Thought.* March 9. Accessed July 7, 2023. https://voelkerrechtsblog.org/the-status-of-womens-reproductive-rights-in-africa/.

[68] Kähler, Lena, Marie Villumsen, Mads Holst Jensen, and Pia Falk Paarup. 2017. *AAAQ & Sexual and Reproductive Health and Rights.* Cophenhagen: The Danish Institute for Human Rights. Page 5

[69] Toebes, Brigit, and Meaghan Beyer. 2021. "The origins and scope of global health law." In *Global Health Law Disrupted: Covid-19 and the Climate Crisis*, by Prof. B.C.A Toebes, M.A. Beyer, Dr. S.K. Perehudoff, Dr. J.A. Sellin, M.M.E. Hesselman and Dr. P.A. Villarreal, 1-30. Royal Netherlands Society of International Law. Page 9

[70] United Nations: Office of the High Commissioner. n.d. *Introduction to the Committee: Committee on Economic, Social and Cultural Rights.* Accessed June 22, 2023. https://www.ohchr.org/en/treaty-bodies/cescr/introduction-committee#:~:text=The%20Committee%20on%20Economic%2C%20Social,Rights%20by%20its%20States%20parties.

primary mechanisms for country specific advice, whereas 'General Comments' provide a broad overview of issues pertinent to economic, social and cultural rights. [71] Guidance produced by CESCR is not legally binding, however it is an authoritative and States are expected to follow it as much as is feasible.

General Comment No.14 from CESCR is fundamental for understanding the normative frameworks to the right to health. [72] ICESCR drafting history was utilised to understand that a variety of socio-economic factors influence the right to health. Two key components were identified in successful realisation: 'underlying determinants of health',[73] and the provision of 'timely and appropriate healthcare'.[74] Underlying determinants of health consist of factors such as food, nutrition, housing, safe and potable water, adequate sanitation, healthy working conditions, and a healthy environment.[75] As we can see, this shows the connection between legal and normative frameworks, as these principles are echoing some of the recurrent themes we explored above.

CESCR not only identifying defining characteristics of the realisation of health, but also developed a four-pronged approach to ensure that States could realise the 'highest attainable standard', as emphasised within ICESCR. This framework consists of 'availability', 'accessibility', 'adequacy' and 'quality' of healthcare.[76] Otherwise known as the AAAQ framework, these standards have been vital in transforming the realisation of the right to health into a tangible concept. They allow for State parties to understand the connection between the idea, and the real-life implementation of the right to health.[77]

Understanding exactly what these concepts refer to is useful in determining how the right to health will be applied in immigration detention centres. Availability of the right to health refers to a functioning public health service and facilities, with programmes, goods and services that are provided in sufficient quantity to be available to everyone.[78] In the context of women's health, CESCR General Comment No.22 requires that States have trained medical personnel who are available to perform a full range of sexual and reproductive health-care services.[79] This includes the provision of essential medicines for

[71] *Ibid.*
[72] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant),* 11 August 2000, E/C.12/2000/4, Paragraph 4
[73] *Ibid.* Para 4
[74] *Ibid.* Para 11
[75] *Ibid*, Para 4
[76] *Ibid.* Para 12(a)
[77] (Kähler, et al. 2017) Page 5

[78] CESCR General Comment No.14, Para 12 (a)
[79] UN Committee on Economic, Social and Cultural Rights, *General Comment No.22: the Right to sexual and reproductive health (Art. 12 of the Covenant),* 2 May 2016, E/C.12/GC/22, Para 12

abortion and post-abortion care, as well as a range of contraceptive methods, and treatment for HIV.[80] Availability is contingent upon the unique needs and capacities of the state in question, with economic resources factored into consideration.[81]

Non-discrimination, physical accessibility, economic accessibility, and information accessibility are the four dimensions of the 'accessibility' requirement.[82] There is particular focus by CESCR on the access of vulnerable and marginalised groups to health. Ensuring that health facilities, goods and services are within physical reach for all is essential, this also refers to the underlying determinants of health, such as safe and potable water, or sanitation facilities.[83] Affordability is a key aspect of accessibility,[84] and is especially pertinent to migrant women, who often suffer the most from the gender pay gap.[85]

'Acceptability' confers a responsibility of health facilities, goods and services to comply with medical ethics and be culturally appropriate.[86] This also requires an element of gender-sensitivity,[87] and in the context of women's health can include provision of abortion care, allowing for the choice between surgical or medical abortion where appropriate.[88]

Quality of healthcare as part of the normative framework utilises several different factors; cultural acceptability, goods and services that are scientifically and medically appropriate, as well as skilled medical personnel, safe drugs, water, equipment, and adequate sanitation.[89] All of these factors are applicable to the circumstance of detention, particularly that of cultural acceptability, and reflect the importance of underlying determinants of health.

The Committee for the Elimination of Discrimination Against Women (CEDAW Committee) describes how quality healthcare in the context of gender equality would require services delivered in a way that ensures a woman can, and does, give her fully informed consent.[90] Respect for human dignity is essential

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[80] *Ibid*. Para 12
[81] CESCR General Comment No.14 Paragraph 12(a)
[82] *Ibid* Para 12 (b)
[83] *Ibid.* Para 12 (b)
[84] *Ibid,* Para 12(b)
[85] ILO. 2020. *The migrant pay gap: Understanding wage differences between migrants and nationals.* Executive Summary, International Labour Organisation. Page 1

[86] CESCR General Comment No.14 Paragraph 12(c)
[87] *Ibid.* Para 12(c)
[88] (Kähler, et al. 2017) Page 30
[89] CESCR General Comment No.14 Para 12(d)
[90] UN Committee on the Elimination of Discrimination Against Women (CEDAW*), CEDAW General Recommendation No. 24: Article 12 of the Convention (Women and Health),* 1999, A/54/38/Rev.1, chap. I, Para 22

and any form of coercion is unacceptable, including mandatory testing for sexually transmitted diseases or pregnancy.[91] General Comment No.26 from the CEDAW Committee addresses the discriminatory nature of mandatory pregnancy tests in places of employment for migrant workers, often resulting in deportation.[92] Pre-departure gender-sensitive training programmes are recommended in order to minimise women's risk of exploitation and to ensure they are aware of their health rights.[93] If we consider this in light of migrant women held in immigration detention, there is a responsibility of States to ensure that any sort of medical screening or tests conducted within detention, is done so with fully informed consent.

1.1.2 The World Health Organisation

Alongside treaty monitoring bodies, the World Health Organisation (WHO) has been a significant influencer in the development of normative frameworks for health. Founded in 1948 by the United Nations, the WHO aims to promote universal and equitable healthcare.[94] Currently, there are 194 State Parties, all of whom must ratify the WHO constitution prior to acceding to the organisation. [95] The preamble to the Constitution states that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.'[96] This reflects the principles of universality, interdependency and indivisibility. A key distinction between the WHO and the ICESCR, is that the WHO acknowledges the importance not only of physical and mental health, but also the interconnectedness of social and moral health.[97] Health is defined as 'not merely the absence of disease or infirmity', but a 'state of complete physical, mental, and social well- being.'[98] This demonstrates a separation from the 'purely biomedical understanding' of health, widening the scope of consideration for human rights protection.[99]

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[91] *Ibid.* Para 22
[92] UN Committee on the Elimination of Discrimination Against Women (CEDAW), *General Recommendation No. 26 on women migrant workers*, 5 December 2008, CEDAW/C/2009/WP.1/R, Para 18

[93] *Ibid,* para 24 (b) (i)
[94] World Health Organisation. 2023. *Who we are.* Accessed July 11, 2023. https://www.who.int/about.

[95] The World Health Organisation. 2023. *World Health Organisation: Countries.* Accessed June 25, 2023. https://www.who.int/countries.

[96] World Health Organisation. 1948. "Constitution of the World Health Organisation." Geneva. Preamble
[97] (Krennerich 2017) Page 26
[98] CESCR General Comment No.14 Paragraph 4
[99] (Krennerich 2017) Page 24

Examination of the above frameworks demonstrates the variety of factors that must be considered in the realisation of the right to health. However, this should not be confused with the right to be *healthy*.[100] Instead, it is an obligation on States to ensure that they are doing as much as reasonably possible to comply with their international obligations, as will be discussed in the next section.

1.2 Exploring State Obligations in Realising the Right to Health

The realisation of economic, social and cultural rights is determined by the principle of 'progressive realisation,' found in Article 2(1) of ICESCR.[101] This is inclusive of the right to health, and State Parties must employ their 'maximum available resources' to realise such rights. The intent behind this syntax was to allow for poorer or less developed States to employ some discretion as to what extent they realise the right to health, dependant on their financial capabilities.[102] However, the conditionality of this clause was subject to some concern that States would use it to minimise or shirk their obligations.[103] CESCR General Comment No.14 addressed this, stating that progressive realisation 'should not be interpreted as depriving the State parties' obligations of all meaningful content.'[104] Therefore, there is still an expectation that States will make genuine efforts to realise the right to health. CESCR General Comment No.3 advised that 'minimum core obligations'[105] should be adhered to in order to ensure satisfactory protection. States have immediate legal obligations they must comply with.[106] Non-discrimination is one, and deliberate, concrete, targeted steps towards the full realisation of Article 12 ICESCR is another.[107]

At the time of drafting ICESCR, there was little consensus as to what the concept of minimum core obligations would entail.[108] General Comment No.3 appoints every State Party with the minimum core obligation to 'ensure the satisfaction of, at the very least, minimum essential levels of each right,'[109] whilst General Comment No.14 requires at least access to health facilities, goods and services without

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[100] CESCR, General Comment No.14, Paragraph 8
[101] ICESCR Article 2(1)
[102] ICESCR Article 2(1)
[103] Klotz, Sabine, Heiner Bielefeldt, Martina Schmidhuber, and Andreas Frewer. 2017. *Healthcare as a Human Rights Issue: Normative Profile, Conflicts and Implementation.* Vol. 4. Page 10

[104] CESCR General Comment No.14 Para 31
[105] UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant),* 14 December 1990, E/1991/23, Paragraph 10
[106] CESCR General Comment No.14. Paragraph 30
[107] *Ibid.* Paragraph 30
[108] Forman, Lisa, Claudia Beiersmann, Claire E. Brolan, Martin Mckee, Rachel Hammonds, and Gorik Ooms. 2016. "What Do Core Obligations under the Right to Health Bring to Universal Health Coverage?" *Health and Human Rights Journal* 18 (2): 23-34. Page 29

[109] CESCR General Comment No.3 Para 1 and 10

discrimination, access to minimum essential foods, basic shelter, housing and sanitation, and essential drugs. [110] However, there was limited expansion on what primary healthcare consisted of, beyond essential drugs, which leaves room for much interpretation.[111]

Considering this in the context of women's rights, we could ask to what extent States are expected to provide specific health measures? However, in doing so, we perpetuate the concept of 'male as the norm' and obstruct progress towards an equitable realisation of health. In order to ensure that women, particularly migrant woman, are protected, there is an argument to be made that States should adhere to at least a minimum core standard of health that encompasses not only unique gender needs, but also considering the intersection of race, sexuality, and socio-economic circumstances.

When examining any State obligations under human rights discourse, it is essential to consider the principles of 'respect, protect, and fulfil'. In the context of the right to health, 'respect' requires that a State refrains from any direct or indirect interference with the right to health.[112] This also requires a non-discrimination framework, and the right to health for all persons must be respected, including detainees, minorities, asylum seekers, and illegal immigrants.[113] Access to contraceptives and other means of sexual health should be ensured, and States should make sure they do not impede upon a persons' participation in health-related matters.[114] Particular reference is made to women's health status and needs, acknowledging the unique considerations a State must make so as to respect their right to health.[115]

Protecting the right to health means that States must take appropriate measures to prevent any third-party interference with Article 12.[116] The increasing privatisation of immigration detention marks the importance of such a concept, [117] as States still have an obligation to protect the health rights of detainees, even if they are not directly managing the facilities. This can be embodied by preventing any infringement on the availability, accessibility, acceptability or quality of healthcare, as well as ensuring that any

[110] *Ibid.* Paragraph 43
[111] (Forman, et al. 2016) Page 29
[112] CESCR General Comment No.14 Para 33
[113] *Ibid,* Para 34
[114] *Ibid,* Para 34
[115] *Ibid.* Para 34
[116] *Ibid.* Para 33
[117] Brooker, Stephen, Steve Albert, Peter Young, and Zachary Steel. 2017. "Mental health care in an invalidating environment: the case of immigration detention in Australia." In *Challenging Immigration Detention: Academics, Activists and Policy-Makers*, by Michael J.Flynn and Matthew B.Flynn, 195- 221. page 198

cultural or traditional practices do not cause any harm, particularly to women.[118] Protecting the right to health may also include protecting against gender-based violence,[119] reiterating the points raised above.

Fulfilling the right to health carries three individual obligations; facilitate, provide, and promote.[120] This can be done through legislative, administrative, judicial and budgetary means.[121] Women's right to health in this context can be done through consideration of reproductive health and safe motherhood as a priority in public health infrastructure.[122] If we compare this to the provision for abortion rights within the Maputo Protocol,[123] whilst not within the remit of CESCR, it is a perfect embodiment of utilising legislature to fulfil women's right to health, particularly in the context of reproductive health.

1.2 Analysing the Legal Basis of Immigration Detention under International Law

In order to understand the concept of health and how it is realised within immigration detention, we must first gain an understanding of the legal frameworks that govern the detention of migrants. Under international human rights law, the right to liberty is essential. Found within the International Covenant on Civil and Political Rights (ICCPR), Article 9(1) states that '[e]veryone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention."[124] Any restriction upon a persons must be in accordance with established legal precedent.[125] Arbitrary detention was discussed in Saadi v the United Kingdom,[126] in which it was determined that all detention for immigration purposes must be carried out in good faith, with close connection to the purpose of preventing unauthorised entry, appropriate detention conditions, and with consideration that those detained are often migrants who have fled their country.[127] Additionally, the length of detention should not exceed what is reasonably required.[128] The UN Working Group on Arbitrary Detention found that holding an undocumented immigrant or an asylum seeker within detention for a unspecified or excessive period of time can be considered arbitrary if the facilities are improper and there is not sufficient justification for the

[118] CESCR General Comment No.14. Para 35
[119] *Ibid.* Para 35
[120] *Ibid.* Para 33
[121] *Ibid.* Para 33
[122] *Ibid.* Para 36
[123] The Maputo Protocol, Article XIV 2 (c)
[124] UN General Assembly, *International Covenant on Civil and Political Rights*, 16 December 1966, United Nations, Treaty Series, vol. 999, p. 171 Article 9(1)
[125] *Ibid.* Article 9(1)
[126] *Saadi v United Kingdom.* 2008. 13229/03 (ECtHR, January 29).
[127] *Ibid* para 74
[128] *Ibid.* para 74

detention.[129] Moreover, the European Court of Human Rights ruled that detention, combined with sickness, and a lack of appropriate medical treatment may result in a violation of Article 3 of the European Convention of Human Rights,[130] the right to be free from inhuman or degrading treatment.[131]

According to the Human Rights Committee, any form of detention needs to be 'reasonable, necessary and proportionate'.[132] The European Data Protection Supervisor describes proportionality as the requirement to 'strike balance between the means used and the intended aim.'[133] In order to be proportionate, immigration detention would have to be the most efficient means of achieving the States' objective. The Parliamentary Assembly of the Council of Europe requires that immigration detention be for the specific purpose of preventing unauthorised entry into a State, or with the intention to deport.[134] This is echoed by the UN International Organisation for Migration, who state that immigration detention is an administrative procedure, intended to identify persons and determine nationalities, prevent unauthorised entry, and to ensure deportation is enforced.[135] However, evidence suggests that this is generally not achieved. For instance, the UK detained 25,282 people in the year leading up to March 2022, but only 14% were removed, meaning that 85% of detainees were released back into the community.[136] This indicates that proportionality is not always prioritised in immigration detention practices.

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[129] S.Weissbrodt, David, and Brittany Mitchell. 2016. "The United Nations Working Group on Arbitrary Detention: Procedures and Summary of Jurisprudence." *Human Rights Quarterly* 38 (3): 655-705

[130] Council of Europe, *European Convention for the Protection of Human Rights and Fundamental Freedoms, as amended by Protocols Nos. 11 and 14*, 4 November 1950, ETS 5, Article 3

[131] *Aswat v the United Kingdom.* 2013. 17299/12 (ECHR, April 16).

[132] UN Human Rights Committee (HRC), *General comment no. 35, Article 9 (Liberty and security of person)*, 16 December 2014, CCPR/C/GC/35 Para 18

[133]European Data Protection Supervisor. n.d. *Necessity & Proportionality.* Accessed June 26, 2023. https://edps.europa.eu/data-protection/our-work/subjects/necessity-proportionality_en#:~:text=Proportionality%20is%20a%20general%20principle,used%20and%20the%20intended%20aim.

[134] Parliamentary Assembly. 2010. *Detention of asylum seekers and irregular migrants in Europe.* Resolution 1707 (2010) Final Version, Council of Europe. Para 9.1

[135] International Organisation for Migration. 2017. *Immigration Detention and Alternatives to Detention.* Global Compact Thematic Paper, IOM: The UN Migration Agency. Page 1

[136] Association of Visitors to Immigration Detainees. 2022. "Immigration detention Statistics: Year ending March 2022." *AVID.* Accessed June 26, 2023. https://aviddetention.org.uk/immigration-detention-statistics-year-ending-march-2022.

Detention centres are often modelled around prisons,[137] and represent a precarious balance between state sovereignty and individual rights.[138] In circumstances of criminal incarceration, whilst still harmful, there is argued proportionality in the sense of justice and legitimacy, which is not present in the context of immigration detention.[139] As the UN Special Rapporteur for the Human Rights of Migrants so aptly explained, 'detention is a tool that characterises criminal law as opposed to administrative law.'[140] It takes a punitive stance, despite the lack of criminality. Some have even argued that there are fewer protections for migrants in detention than prisoners in the criminal justice system.[141] Criminal defendants are rightfully offered due process and the chance to appeal their detention, whereas immigration systems often demonstrate procedural unfairness, with disparity in access to legal representation or remedy.[142] The Committee for the Prevention of Torture has indicated that a prison is 'fundamentally flawed' for housing migrants,[143] demonstrating the inherent lack of justification in current immigration systems that embody criminal practices for administrative procedures.

Considering the above information, it would not be unreasonable to conclude that there was an inherent dichotomy between the deprivation of liberty for migrants, and the realisation of their health. In the interests of adapting a rights-based approach to immigration detention, treaties and guidelines have been created to minimise the harm caused. These will be explored below in the context of women's right to health.

1.3 Promoting Women's Health in the Context of Immigration Detention: Guidelines for Action

[137] Flynn, Michael. 2012. "Who must be detained? Proportionality as a tool for critiquing immigration detention policy." *Refugee Survey Quarterly* (Oxford University Press) 31 (3): 40-68. page 40

[138] *Ibid.* Page 40

[139] Gerlach, Alice. 2022. "Women's experiences of indignity in immigration detention and beyond." *Incarceration* (Sage Journals) 3 (2): 1-18. Page 14

[140] UN General Assembly. *Report of the Special Rapporteur on the human rights of migrants: Note by the Secretary-General* 3 August 2010. A/65/222, Para 27

[141] Esposito, Francesca, Salvatore Di Martino, Erica Briozzo, Caterina Arcidiacono, and Jose Ornelas. 2022. "Women's Experiences of Immigration Detention in Italy: Examining Immigration Procedural Fairness, Human Dignity, and Health." *Frontiers in Psychology* 13. Page 2

[142] *Ibid.* Page 2

[143] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. 2010. *CPT Standards.* Council of Europe. page 54, para 28

The Standard Minimum Rules (SMR) for the Treatment of Prisoners provided the original guidelines for conditions within detention,[144] and they called for equitable care between prisoners and those in the outside community.[145] The Bangkok Rules were subsequently developed when the UN General Assembly determined that sufficient attention was not paid to women and their unique health needs and vulnerability to harm within detention.[146] It is important to note that these guidelines were created to focus on women incarcerated within prisons, but as Faiver et al explain, regardless of the reason for detention, inhumane conditions are inexcusable.[147] Therefore, recommendations for health in prison are applicable to immigration detention.[148]

The Bangkok Rules dictate that upon admission to detention, due consideration must be paid to women's particular vulnerability.[149] This includes their experiences prior to detention, such as gender-based violence,[150] but also the risk of harm and abuse within detention.[151] The CEDAW Committee echoed a similar sentiment, arguing that in order to achieve *de facto* equality, health policies need to consider biological as well as socially and culturally constructed differences between women and men.[152] In circumstances where detention of female asylum seekers is unavoidable, specific policies should be implemented to ensure women's needs are met, such as staff training, female guards, and provisions for women's hygiene.[153] Especially pertinent is the reminder that seeking asylum is not a crime, and migrants should be not penalised for this, including by punitive methods of detention.[154]

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[144] UN General Assembly, *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) : resolution / adopted by the General Assembly*, 8 January 2016, A/RES/70/175
[145] *Ibid.* Rule 24.1
[146] United Nations General Assembly. 2011. "United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules)." Sixty-fifth session. Preliminary Observations, para 1

[147] Faiver, Kenneth L. 2020. *Correctional health care delivery: unimpeded access to care.* Springfield;Illinois: Charles C Thomas Publisher Ltd. Page 7

[148] *Ibid.* Page 7
[149] The Bangkok Rules Page 8
[150] Hout, MC Van. 2021. "Human rights violations, detention conditions and the invisible nature of women in European immigration detention: A legal realist account." *International Journal of Prisoner Health.* Page 1 and 3

[151] IOM: Immigration Detention and Alternatives to Detention 2017 Page 5
[152] UN Committee on the Elimination of Discrimination Against Women (CEDAW), *General recommendation No. 25, on article 4, paragraph 1, of the Convention on the Elimination of All Forms of Discrimination against Women, on temporary special measures*, 2004, Para 8
[153] UN Committee on the Elimination of Discrimination Against Women (CEDAW), *General recommendation No.32 on the gender related dimensions of refugee status, asylum, nationality and statelessness of women,* 2014, CEDAW/C/GC/32, Para 34
[154] *Ibid.* Para 49

Sexual and reproductive health is essential for women and girls to lead a dignified life.[155] In the context of immigration detention, this may require acknowledgment of, and adaption to, the sexually transmitted diseases that migrant women face a higher risk of exposure to.[156] The CEDAW Committee advocates for the right to sexual health for all women and girls, including those who have been trafficked and are not legally resident in the country.[157] Moreover, CESCR General Comment No.22 has declared sexual and reproductive health essential for women's rights.[158] In immigration detention, this has implications for civil and political rights such as autonomy, liberty, or freedom from torture and other inhuman or degrading treatment.[159] Consequences, any delivery of healthcare to women in immigration detention needs to embody these principles.

A principle that runs parallel to autonomy is informed consent. The International Covenant on Civil and Political Rights requires that '[n]o one shall be subjected without his free consent to medical or scientific experimentation.'[160] This is reaffirmed by the Committee for the Elimination of Discrimination against Women, who state that acceptable services are delivered in a way that ensures informed consent, respect for dignity, guarantees confidentiality, and adopts a sensitive approach to any unique health needs or challenges.[161] Emblematic of this is the guarantee that no form of coercion is present in healthcare for women, particularly non-consensual sterilisation, or mandatory testing for sexually transmitted diseases.[162] Informed consent requires sufficient available information, in language understood by the prospective patient, about any medical care. This enables female migrants to make informed decisions about their health, and thus exercise proper autonomy.[163] For instance, a full medical screening is recommended to ensure the health of detainees upon entry to the detention centre,[164] but it must be conducted in a respectful manner that observes the fundamental principles of autonomy, consent, confidentiality, and choice.[165]

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[155] (Kähler, et al. 2017) Page 7
[156] UN Committee on the Elimination of Discrimination against Women, *Report of the Committee on the Elimination of Discrimination against Women, 20th and 21st Sessions,* 1999, A/54/38/Rev.1 Para 12 (a)
[157] *Ibid. Para 18*
[158] CESCR General Comment No.22, Para 1
[159] *Ibid.* Para 10
[160] ICCPR Article 7
[161] *Report of the Committee on the Elimination of Discrimination against Women, 20th and 21st Sessions,* Para 22
[162] *Ibid* Para 22
[163] (Klotz, et al. 2017) Page 15
[164] United Nations Office on Drugs and Crime. 2009. *Women's health in prison: Correcting gender inequity in prison health.* Europe: World Health Organisation. Section 4.3 Page 6

[165] *Report of the Committee on the Elimination of Discrimination against Women, 20th and 21st Sessions,* Para 31(e)

1.4. Conclusion

In light of the above examination of legal and normative frameworks surrounding the right to health, we can conclude that there are several recurring themes within the right to health, particularly for women. Firstly, the right to health is to the 'highest attainable standard', which varies between individuals and population demographics. Secondly, health can be physical, mental, social, moral, and reproductive. Indicators of such health can stem from 'underlying determinants of health', which consist of a variety of external factors. The practical realisation of health is reliant on the AAAQ framework, and this can be adapted based on gender specific needs. An important take away, is that there is a requirement to remove any barriers to the realisation of women's health.[166] The barriers to women's health in immigration detention will be explored in the next chapter, and the above definitions of health will be an underlying consideration throughout.

[166] CESCR General Comment No.14 para 21

Chapter 2 – Exploring Barriers to Women's Health in the Context of Immigration Detention.

2.0 Introduction

The intersection between immigration detention and women's health is fraught with difficulty, often resulting in the deterioration of physical and mental well-being, with long-lasting consequences. This chapter will explore the myriad of barriers that impede the realisation of the right to health for women in immigration detention. By developing an understanding of vulnerability and its baseline within the migration process, we can understand how women's health is influenced within detention. This will then help us to consider women's mental, physical and reproductive health, as well as the influence of environmental factors.

2.1 Unveiling vulnerability: Intrinsic Factors to Migrant Women's Health

Vulnerability manifests in a variety of forms; it can be physical or mental, temporary or permanent, and individual or collective. One guarantee is that it is inherent to the experience of immigration, particularly that of being detained.[167] Anyone can be vulnerable, but there are particular individuals and groups that may be more likely to experience vulnerability.[168]

In an independent report to the UK Home Office, Shaw (2016) explains that vulnerability does not solely derive from ongoing or current suffering.[169] It can arise from the likelihood of future physical or mental harm.[170] He depicts the categorisation of vulnerability as an ever-changing concept,[171] and the extent to which someone can be considered vulnerable may increase or decrease over time. This depends on many internal and external factors.[172] The Jesuit Refugee Service conceptualises vulnerability as a 'concentric circle',[173] featuring personal, social, and environmental factors.[174] This demonstrates a marked similarity

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[167] Shaw, Stephen. 2016. *Review into the Welfare in Detention of Vulnerable Persons: A report to the Home Office by Stephen Shaw.* Independent Report, Home Office. page 83

[168] Flegar, Veronika. 2016. "Groningen Centre for Health Law." *University of Groningen.* April 01. Accessed July 8, 2023. https://www.rug.nl/rechten/onderzoek/expertisecentra/gchl/blog/towards-individualized-vulnerability-in-migration-policies?lang=en.

[169] (Shaw 2016) Page 82
[170] *Ibid.* Page 82
[171] *Ibid.* Page 81
[172] *Ibid.* Page 81
[173] Jesuit Refugee Service Europe. 2010. *Becoming Vulnerable in Detention.* Civil Society Report, The DEVAS Project. page 11

[174] *Ibid.* Page 91

with the underlying determinants of health,[175] and provides an insightful demonstration of the interplay between health, vulnerability, and detention.

Personal factors that contribute to a sense of vulnerability could refer to an individuals' sense of agency within detention.[176] Agency, which also falls under the scope of autonomy, can be restricted by a number of variables. Language competency, understanding of the legal process of immigration or asylum, and level of mental or physical health are all key indicators of the sense of control a detainee has.[177] Language barriers are considered a significant stressor in detention;[178] not only due to the feelings of powerlessness and isolation, but also because it minimises the potential effectiveness of any mental health care within detention.[179] Reporting mistreatment becomes more difficult, particularly when migrants are reluctant to speak out against the system they are reliant on.[180] This is especially influential on women's health experiences within immigration detention as they regularly face abuse from detention guards and officials,[181] and the lack of appropriate translation services only makes accountability mechanisms harder to access. Language barriers can also hinder informed consent, exacerbating vulnerability and derailing progress towards highest attainable standard of health.[182] Informed consent requires a professional medical explanation in a patient's native or preferred language, failure to provide adequate translation services ultimately prevents morally acceptable medical treatment.[183] Restriction of autonomy is an unavoidable consequence of deprivation of liberty, and ultimately a contributing factor to the vulnerability of women in immigration detention.

Social factors of vulnerability are the 'sum of the individual's existing social network, and available means of communicating with that network.'[184] Components that seem to have the largest impact on an individual's social vulnerability is the continued connection with family and friends outside of detention,

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[175] CESCR General Comment No.14 Para 4
[176] (Jesuit Refugee Service Europe 2010) page 12
[177] *Ibid.* page 12
[178] (The World Health Organisation 2022) Page 14

[179] *Ibid.* Page 31
[180] *Ibid.* Page 32
[181] Ellmann, Nora. 2019. *Immigration Detention is Dangerous for Women's Health and Rights.* October 21. Accessed June 2023. https://www.americanprogress.org/article/immigration-detention-dangerous-womens-health-rights/.

[182] Sullivan, Margaret M., Margareta Matache, Samuel Peisch, and Jacqueline Bhabha. 2022. "Reproductive healthcare in immigration detention: The imperative of informed consent." *The Lancet Regional Health - Americas* 10. Page 3

[183] *Ibid.* Page 3

[184] (Jesuit Refugee Service Europe 2010) page 12

but may also include a social network within the detention centre itself.[185] Implementing barriers to visitation, such as remote locations, is likely to have a negative impact on women's health, who suffer separation anxiety from family and children more acutely than their male counterparts.[186] Detention has been described as an 'affective mode' of discipline,[187]in which migrants are forced into a state of docility and self-imposed exile,[188] thus suffering even greater impacts of social exclusion and vulnerability.

Environmental factors of vulnerability are aspects that the detainee has not control over, but will likely still impact them and pose a risk of harm. .[189] This can include elements such as the architecture and structure of the detention centre, living conditions, and the duration of detention.[190] Lungu-Byrne et al (2021) found that even if an individual was in good health prior to detention, their unique support needs are unlikely to be met and they will be particularly vulnerable to environmental stressors within detention.[191] Moreover, detention settings in all forms are often construed through the lens of male as the norm.[192] Women are living in an environment that was not designed for them,[193] therefore exacerbating their health difficulties.[194] The detrimental impact of the environment of detention on migrant women's health will be examined in more detail later in this chapter.

In combination, the above factors make the realisation of health within detention a precarious goal for women. According to Thomasma, there is a moral obligation for those in positions of power to protect the vulnerable, not to create a system of exploitation.[195] This is translated into a legal obligation by international human rights law, and thus dictates that the dynamic nature of vulnerability is considered within domestic frameworks surrounding health in immigration detention. For instance, relying on pre-established categories of vulnerability to determine who should be exempt from detention does not allow

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[185] *Ibid.* page 12
[186] (Faiver 2020) page 87
[187] Carney, Megan A. 2013. "Border Meals: Detention Center Feeding Practices, Migrants Subjectivity, and Questions on Trauma." *Gastronomica* (University of California Press) 13 (4): 32-46. Page 42

[188] *Ibid.* Page 42
[189] (Jesuit Refugee Service Europe 2010) page 12
[190] *Ibid.* page 12
[191] Lungu-Byrne, Cassie, Jennifer Germain, Emma Plugge, and Marie Claire Van Hout. 2021. "Contemporary Migrant Health Experience and Unique Health Care Needs in European Prisons and Immigration Detention Settings." *International Journal of Forensic Mental Health* (Taylor and Francis Group) 20 (1): 80-99. page 80

[192] (Faiver 2020) page 87
[193] *Ibid.* page 90
[194] Brooker, Stephen, Steve Albert, Peter Young, and Zachary Steel. 2017. "Mental health care in an invalidating environment: the case of immigration detention in Australia." In *Challenging Immigration Detention: Academics, Activists and Policy-Makers*, by Michael J.Flynn and Matthew B.Flynn, 195- 221. Edward Elgar Publishing Limited. page 197

[195] Thomasma, David. 2000. "The vulnerability of the sick." *Bioethics Forum* 16 (2): 5-12. Page 7

for individual circumstances, putting vulnerable people at risk of being detained.[196] This is a direct contradiction of the duty to create healthcare system that prioritises non-discrimination, autonomy and well-being,[197] as well as a denial of sufficient protection for women and their increased chances of vulnerability.[198]

Evidently, vulnerability in the context of immigration detention and women's health is multi-faceted. It is a concept that underlies all health experiences within immigration detention, and sets the base line for understanding how immigration detention can constitute a barrier to women's health. One notable issue faced by female migrants is the deterioration of mental health within immigration detention, which can often be attributed to a lack of respect for human dignity.

2.2 Insufficient Mental Health Care and Indignity in Immigration Detention

The growing body of literature surrounding immigration detention demonstrates the detrimental impact it has on the mental health of detainees.[199] Women in particular have a higher chance of developing a psychiatric disorder in immigration detention when compared to men.[200] One of the primary reasons for this is the statistical likelihood of sexual or gender-based violence prior to immigration detention.[201] The Royal College of Psychiatrists reports that people with pre-existing trauma, such as survivors of torture, are pre-disposed to harm and mental health deterioration when detained.[202] Detention compounds the previous emotional, physical and psychological abuse, resulting in disproportionate symptoms of Post-Traumatic Stress Disorder.[203] To minimise the degradation of mental health, continuous social and professional support is essential and immigration detention poses barriers to this.[204] Health care professionals are often not trained to cater for the unique needs of those within immigration detention,

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[196] (Shaw 2016) page 81
[197] Clark, Beth, and Nina Preto. 2019. "Exploring the concept of vulnerability in health care." *Canadian Medical Association Journal* 190 (11): E308-E309. page E309

[198] (Ellmann, Immigration Detention is Dangerous for Women's Health and Rights 2019)
[199] (Gerlach 2022) Page 3-4
[200] (The World Health Organisation 2022) Page 30
[201] (Ellmann, Immigration Detention is Dangerous for Women's Health and Rights 2019)
[202] Royal College of Psychiatrists. 2021. *Detention of people with mental disorders in immigration removal centres (IRCs).* Position Statement, Royal College of Psychiatrists. Page 7

[203] Canning, Victoria. 2019. "Degradation by design: women and asylum in northern Europe." *Race & Class* (Institute of Race Relations) 61 (1): 46-63. Page 48

[204] (Royal College of Psychiatrists 2021) Page 3

particularly women's prior trauma,[205] and medical records are poorly maintained or lost.[206] This prevents any form of care continuity.

Feelings of vilification and injustice as a result of the carceral nature of immigration detention, combined with the uncertainty of the experience, are also reported as detrimental to women's mental health.[207] Several factors contribute to this, including isolation, lack of privacy, stress,[208] anda lack of respect for autonomy or human dignity.[209] Esposito et al (2022) found a strong correlation between undignified treatment, procedural unfairness, and self-rated poor physical and mental health of detained women.[210]

'Observantia' has been identified by Jones (2015) to be the understanding that respect for human dignity is essential in observing all human rights, including economic, social and cultural rights such as the right to health.[211] Mann (1998) establishes that environments that promote severe, and sustained violations of individual and collective dignity are likely to have a substantial impact on the mental health of people living there.[212] Medical treatment that does not embody human dignity can result in feelings of low self-worth and motivation, as well as long term negative social, physical and mental health consequences.[213] Numerous studies reveal that inconsistent, inadequate healthcare is a regular occurrence within immigration detention; indifferent officials, understaffed medical teams, and irregular policies are all obstacles to sufficient mental healthcare for women in immigration detention.[214] Ways in which dignity is repeatedly violated can be through a lack of respect for privacy. The World Health Organisations reports that intrusive medical care or inappropriate behaviour from guards is a global phenomenon.[215] Occasions where staff attended medical appointments with detainees and entered the room when 'delicate

[205] (The World Health Organisation 2022) Page 42
[206] *Ibid.* Page 35
[207] (Gerlach 2022) Page 8
[208] Arshad, Forzia, Melanie Haith-Cooper, and Pheobe Palloti. 2018. "The experiences of pregnant migrant women in detention: A qualitative study." *British Journal of Midwifery* 26 (9): 559-622. Page 593

[209] (Gerlach 2022) Page 13
[210] (Esposito, et al. 2022) Page 1
[211] Jones, David Albert. 2015. "Human Dignity in Healthcare: A Virtue Ethics Approach." *The New Bioethics* 21 (1): 87-97. Page 91

[212] Mann, Jonathan. 1998. "Dignity and Health; The UDHR's Revolutionary First Article." *Health and Human Rights* 3 (2): 30-38. Page 30

[213] (Gerlach 2022) Page 3
[214] (Ellmann, Immigration Detention is Dangerous for Women's Health and Rights 2019)
[215] (The World Health Organisation 2022) Page 32

procedures' were taking place, including consultations surrounding female genital mutilation, illustrated such an issue.[216]

Evidently, there are systemic obstacles to the appropriate delivery of mental health care within immigration detention. An overarching feature of this is the lack of respect for human dignity, and the actions of detention staff have connotations of gendered abuse by infringing upon women's privacy and making them feel unsafe in their body and space. Van Hout highlights that EU policy, jurisprudence and literature is incomplete when considering the unique protections that women require.[217] Continued gender dominance and unequal protections for women in detention position them as 'deportable', ultimately constituting degrading treatment, and failing to appropriately treat mental health in detention.[218]

As we have established, a key indicator into the realisation of the highest attainable standard of health is the respect for underlying determinants such as food, hygiene, and a healthy environment. The provision of inadequate food in immigration detention has severe physical and mental health repercussions for women and will be discussed below.

2.3 Deprivation and Detention: Limited Access to Food and Nutrition for Women in Immigration Detention

Women's bodies have been subject to patriarchal, paternalistic control for centuries, and restricting access to nutritious, culturally appropriate food epitomises this discourse.[219] Food deprivation induces physical and psychological distress and may lead to disordered eating later on in life.[220] Not only does it cause direct harm to the health and wellbeing of detained women, but it is also another means in which the State seeks to exert control, and to penalise migrants.[221] It reinforces the notion of illegality by constraining access to something that all human beings require, creating a sense of non-belonging and discomfort, and representing a tool of exclusion within the framework of biopolitics.[222]

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[216] *Ibid.* Page 32
[217] (Van Hout 2021) Page 1
[218] *Ibid.* Page 6
[219] (Carney 2013)Page 34
[220] *Ibid.* Page 34
[221] *Ibid.* Page 34
[222] *Ibid.* Page 35

Biopolitics is a term coined by Foucault,[223] which he described as 'a power that exerts a positive influence on life', whilst 'subjecting it to precise controls and comprehensive regulations.'[224] He identified a new form of governance that centred around 'the basic biological features of the human species,' essentially, it is political power that relates directly to biological functioning and characteristics.[225] State racism has been labelled as a contemporary form of biopolitics,[226] and the weaponization of food within immigration detention can be considered a form of structural violence.[227] Targeted primarily against 'racialised people from low-income countries,'[228] food deprivation is both psychologically and physically harmful.

Removing the element of choice around food and eating is an unnecessary exertion of power by a State, and a concealed means to eliminate a sense of autonomy. The parallels with criminality compound the overall sense of degradation in immigration detention for women. Examples of such forms of structural abuse can be found within the strict daily routines of immigration detention centres,[229] wherein mealtimes are regimented and do not take individual needs into consideration.[230] Within a Swedish immigration detention centre, one migrant reported only being able to eat at mealtimes and having to wait until the next day if they missed something. However, another detainee reported access to snacks if requested.[231] This suggests arbitrary and inconsistent policies around food. In the UK, women have reported that they are not permitted to store food in their room, despite getting hungry overnight.[232] This is unnecessarily punitive, and the impact this has on the health of pregnant women can be severe.

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[223] Foucault, Michel. 1976. *History of Sexuality (The Will to Knowledge: History of Sexuality Volume 1).* Éditions Gallimard.

[224] *Ibid.* Page 137

[225] Foucault, Michel. 2007. *Security, territory, population: lectures are the Collège de France 1977-1978.* New York: Palgrave Macmillan. Page 1

[226] Adams, Rachel. 2017. "Michel Foucault: Biopolitics and Biopower." *Critical Legal Thinking.* May 10. Accessed June 19, 2023. https://criticallegalthinking.com/2017/05/10/michel-foucault-biopolitics-biopower/.

[227] (Carney 2013) Page 44

[228] (Esposito, et al. 2022) Page 9

[229] McLoughlin, Pauline, and Megan Warin. 2008. "Corrosive places, inhuman spaces: Mental health in Australian immigration detention." *Health & Place* 14: 253-264. Page 259

[230] (Lungu-Byrne, et al. 2021) page 93

[231] Puthoopparambil, Soorej Jose, Beth Maina Ahlberg, and Magdalena Bjerneld. 2015. ""A prison with extra flavours": experiences of immigrants in Swedish immigration detention centres." *International Journal of Migration, Health and Social Care* 11 (2): 73-85. Page 78

[232] (Lungu-Byrne, et al. 2021) page 93

Lungu-Byrne et al (2021) discussed the experience of a Pakistani woman held in detention in the UK who was suffering from severe morning sickness.[233] She would often only eat one orange a day, because she was unable to enter the dining room without experiencing nausea. She describes crying for plain rice, but her request was never met.[234] Unfortunately, this is not a unique experience. Another study conducted in the UK found that the food provided was 'unpalatable,' insufficient and did not deliver adequate nutrition.[235] One pregnant detainee explains that she only ate to ensure the survival of her baby, but the food was too spicy.[236] Studies have shown than hunger or food insecurity in pregnant women can result in gestational weight gain, disordered eating, and pregnancy complications.[237] Key nutrients such as iodine, iron, folate, calcium and zinc are essential to a healthy pregnancy.[238] Without which, there can fatal consequences for both mother and foetus.[239] The evident neglect of States to prioritise the health via simple policy adjustments such as food provision is a gross violation of the right to health, and a direct contravention of the observance of underlying principles of health.

2.3.1 Hunger Strikes: Reclaiming Bodily Autonomy and the Health Costs

In an attempt to reclaim a sense of control and autonomy in an environment of fear and degradation, immigration detainees sometimes engage in hunger strikes.[240] A political act with a long history of resistance,[241] British suffragettes employed this tactic in their fight for women's liberation.[242] It is reticent of State oppression and discrimination that this method of political resistance is deemed necessary by

[233] *Ibid.* page 93
[234] *Ibid.* page 93
[235] (Arshad, Haith-Cooper and Palloti 2018) Page 594

[236] *Ibid.* page 594
[237] Bastian, Amber, Courtney Parks, Amy Yaroch, Fiona H. McKay, Katie Stern, Paige van der Pligt, Sarah A. McNaughton, and Rebecca Lindberg. 2022. "Factors Associated with Food Insecurity among Pregnant Women and Caregivers of Children Aged 0-6 Years: A Scoping Review." *Nutrients* 14 (12). Page 2

[238] UNICEF. n.d. *Maternal nutrition: Preventing malnutrition in pregnant and breastfeeding women.* Accessed July 08, 2023. https://www.unicef.org/nutrition/maternal#:~:text=During%20pregnancy%2C%20poor%20diets%20lacking,and%20developmental%20delays%20for%20children.

[239] *Ibid.*
[240] (Carney 2013) Page 38
[241] Machin, Amanda. 2016. "Hunger Power: The embodied protest of the political hunger strike." *Interface: a journal for and about social movements* 8 (1): 157-180.

[242] *Ibid.* Page 166

women once again.[243] A hunger strike is a way to usurp the violence of the state towards the imprisoned migrant and invoke a 'disruption of the dominant order.'[244] Whilst this form of protest is voluntary and thus not an explicit State barrier to health within detention, it evidences the extent of undignified and inhumane treatment to induce such protest behaviour. Sometimes described as a way to 'gain attention',[245] individuals are utilising the suffering of their own bodies to draw attention to the mistreatment that they are experiencing.[246] In February 2018, over 100 detainees in a women's only detention centre in the UK went on hunger strike. The motivating factor behind this was to protest the inhuman treatment within detention.[247] Staff responses to this behaviour is far from sympathetic and only serves to compound the trauma of migrants and asylum seekers.[248] Women were subsequently threatened with accelerated deportation if they did not end their hunger strike.[249]

The refusal to eat is belied by its contradictory nature.[250] It can be a form of self-harm, and an indicator of a secondary stage of depression,[251] whilst also an empowering act to regain control and fight for liberation. The health consequences of hunger strikes are long-lasting, and in extreme circumstances fatal. Organs are weakened, there is increased risk of infection, and muscle mass can severely deteriorate.[252] If the protestor does not eat, they may die from malnutrition after six to eight weeks.[253] Degradation of physical health is not the only consequence, as there is reported evidence of psychological harm as well. Some patients on 'crash diets' that mimic starvation have developed auditory

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[243] Dart, Tom. 2015. "More than 20 women detained in Texas immigration facility begin hunger strike." *The Guardian.* October 29. Accessed June 20, 2023. https://www.theguardian.com/us-news/2015/oct/29/texas-immigration-detention-center-women-hunger-strike.

[244] (Machin 2016) Page 157
[245] World Medical Association. 2006. "WMA declaration of malta: A background paper on the ethical management of hunger strikes." *World Medical Journal* 52 (2): 36-43. Page 36

[246] (Machin 2016) Page 159
[247] Bulman, May. 2018. "More than 100 women in Yarl's Wood detention centre go on hunger strike over 'inhumane' conditions." *The Independent.* February 22. Accessed July 08, 2023. https://www.independent.co.uk/news/uk/home-news/yarls-wood-women-immigration-detention-centre-hunger-strike-home-office-a8223886.html.

[248] (McLoughlin and Warin 2008) Page 262
[249] Travis, Alan. 2018. "Minister defends threats over Yarl's Wood hunger strike." *The Guardian.* March 06. Accessed July 08, 2023. https://www.theguardian.com/uk-news/2018/mar/06/minister-defends-deportation-threats-over-yarls-wood-hunger-strike.

[250] (Machin 2016) Page 157
[251] (McLoughlin and Warin 2008) Page 262
[252] Foltynova, Kristyna. 2021. "Anatomy of a Hunger Strike: Why Is It Done And What Does It Do To The Human Body?" *Radio Free Europe/ Radio Liberty.* May 21. Accessed July 08, 2023. https://www.rferl.org/a/hunger-strikes-russia/31266830.html.

[253] *Ibid.*

hallucinations, dissociation, and even suicidal tendencies.[254] This demonstrates the interrelated nature of food, nutrition, women's health, and the conditions of immigration detention. Consequently, the State is indirectly harming women by failing to implement policies that provide sufficient access to nutritious, culturally appropriate food.

2.4 Autonomy and Reproductive Justice: A Disservice to Women's Health in Detention

Reproductive justice is a human rights framework that advocates for the right to decide if, or when, to have children, as well as the ability to decide on the environment to raise them in.[255] Failure to observe such concepts is a violation of international human rights law such as Article 16(e) of the Convention for the Elimination of Discrimination against Women, or authoritative sources such as CESCR General Recommendation No.22.[256] The detention of migrant women regularly consists of reproductive rights violations, parents are separated from their children; pregnant women are denied access to sufficient health care; women encounter significant barriers to abortion facilities, and sexual health services are significantly limited.[257] States are consequently denying access to reproductive health care and justice,[258] and failing to fulfil the AAAQ framework for health care.

Limited attention has been paid to this human rights infringement, particularly within immigration detention. The WHO produced an authoritative report, 'Addressing the Health Challenges in Immigration Detention',[259] and yet no reference is made to 'menstrual justice', 'periods', or 'reproductive health'. Instead, any focus on women's health within immigration detention is when compared to the health of men or focused on pregnant women. This reinforces Van Hout's legal realist account that women's health is prioritised when fulfilling their societally expected role as a mother and reproducing the normative order of patriarchal society.[260]

Vulnerability is inherent to reproductive justice in immigration detention. Women are reliant on immigration officials, for instance, when requesting menstrual products.[261] However, studies of detention

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[254] Fessler, D M T. 2003. "The implications of starvation induced psychological changes for the ethical treatment of hunger strikers." *Journal of Medical Ethics* 29: 243-247. Page 243

[255] (Ellmann, Immigration Detention is Dangerous for Women's Health and Rights 2019)
[256] CESCR General Recommendation No.22
[257] (Ellmann, Immigration Detention is Dangerous for Women's Health and Rights 2019)
[258] (Ellmann, Immigration Detention is Dangerous for Women's Health and Rights 2019)
[259] (The World Health Organisation 2022)
[260] (Van Hout 2021) Page 6
[261] Gomez, Valeria, and Marcy L. Karin. 2021. "Menstrual Justice in Immigration Detention." *Columbia Journal of Gender and Law* 123-32. Page 128

practices in the US indicate that detention guards often withhold or restrict access to adequate products in an abusive display of power.[262] When products are available, they can be of poor quality, without adhesion, or with limited option as to the type of product available e.g., tampon or a sanitary pad.[263] This form of control is metaphorical in its representation of the immigration detention system: an unnecessarily punitive act that could be performed in a much more humane manner. Furthermore, it reinforces the stigma surrounding menstruation[264] and perpetuates the commodification of women's bodies by infringing upon autonomy.[265] Menstrual health and justice is an importance facet of immigration detention and requires an intersectional approach. Not only are menstruating women affected, but also transgender men and boys, as well as non-binary detainees.[266] This should all be considered when reviewing the inherent harm of immigration detention, and the barriers to the realisation of health.

Exerting control over the reproductive health of women is not a new phenomenon. As Ellmann (2019) aptly explains, 'forced sterilisation and forced birth are instruments of the same goal – to exert power and control over immigrant women.'[267] Non-consensual medical procedures have been occurring throughout history and forced hysterectomies have been an unfortunate presence in immigration detention records.[268]

Pregnant women in immigration detention have unique health needs, with approximately half of them likely to have claimed asylum at some point in the immigration process.[269] Providing healthcare that is of sufficient quality for pregnant detainees requires several components; patient-centred care that is culturally appropriate and in a language that the patient understands, routine assessments, examination of the normal progress of pregnancy, psychosocial support, and education surrounding childbirth.[270] This is not an exhaustive list, however it does identify the ongoing, specialist care that is required within the environment of detention. Without this, there is a higher risk of maternal and perinatal complications. One case review found that high-risk pregnancies were seven times more likely for women in detention

[262] *Ibid.* Page 123
[263] *Ibid.* page 127
[264] *Ibid.* Page 127
[265] *Ibid.* Page 129
[266] *Ibid.* Page 127
[267] (Ellmann, Immigration Detention is Dangerous for Women's Health and Rights 2019)
[268] *Ibid.*
[269] (Arshad, Haith-Cooper and Palloti 2018) Page 591
[270] (Ellmann, Immigration Detention is Dangerous for Women's Health and Rights 2019)

than the average woman in the UK.[271] The stress of detention can often lead to perinatal mood disorders such as maternal depression, which has been linked to hypertension, pre-eclampsia and diabetes. All of which are indicators of a risk of maternal mortality.[272] Detention practices in the U.S. have seen occasions in which pregnant women are shackled; the traumatic experience can have lifelong implications.[273] Medical ethics dictate that health professionals do no harm, and act in the best interests of their patients.[274] Yet participating in such practices inevitably contravenes these ethics.

As we have seen, the pervasive theme of immigration detention in relation to reproductive and menstrual health is one of degradation and dismissal. The unique vulnerability of women to have their rights violated in this manner is one that all States should directly address within immigration detention policies. Achieving the highest attainable standard of health for women requires direct addressal of these issues. Moreover, it requires consideration of the attitudes of detention officials with regards to women's health, and this will be explored within the concept of environmental health in the below section.

2.5 Embodied Environments: The Impact of Place and Space on Health

Geographical exclusion is a formative example of the harm of immigration detention on women's health. Detention centres are often located in a remote area, [275] creating a symbolic divide and inflicting social marginalisation. The WHO identified isolation and separation from family members as a significant contributor to psychosocial stress[276] and the effect on women in detention is severe, usually resulting in separation anxiety.[277] This is reflective of the social aspect of the Jesuit concentric circles of vulnerability,[278] exacerbating the likelihood of harm and health deterioration women experience.

The delivery of sufficient psychological services becomes increasingly difficult if medical professionals cannot easily travel to the detention centres.[279] Martin argued that the spatiality of detention is a strategy of deterrence and criminality within the US immigration complex,[280] intended to undermine all things

[271] (Arshad, Haith-Cooper and Palloti 2018) Page 591
[272] (Ellmann, Immigration Detention is Dangerous for Women's Health and Rights 2019)
[273] *Ibid.*
[274] (Faiver 2020) Page 9
[275] (McLoughlin and Warin 2008) Page 256
[276] (The World Health Organisation 2022) Page 32
[277] Chapter 3: Unveiling Vulnerability
[278] (Jesuit Refugee Service Europe 2010) Page 12
[279] (Brooker, et al. 2017) Page 198

[280] Martin, Lauren. 2015. "Noncitizen Detention: Spatial Strategies of Migrant Precarity in US Immigration and Border Control." *Annales De Géographie* 231-247. Page 233

that make undocumented life possible.[281] This includes work, education, family life, health care, and a sense of home,[282] all of which can influence a detainees mental health. The exclusionary geographic design of detention[283] could therefore be responsible for the failure to sufficiently realise women's right to health.

As the number of detained migrants increases, so does the risk of overcrowding. This increases psychosocial stress, and risks re-traumatisation or exacerbation of existing mental health issues.[284] The WHO established that the environment of immigration detention not only poses a risk to detainees' mental health, but also to their physical health, placing them at risk of communicable diseases, violence, and further trauma.[285] Failure to develop detention structures that can appropriately house detainees is an inexcusable barrier to health. The Covid-19 Pandemic was an unwelcome but revealing example of how the physical structure of detention can be detrimental, with migrants being held in close quarter and limited chances to self-isolate if necessary. It became near impossible for any deportation order to take effect due to closed borders, thus delegitimising the purpose of detention, yet this harmful practice continued across the European Continent despite the European Commissioner for Human Rights asking that migrants be released 'to the maximum extent possible'.[286]

Carceral architecture is a significant source of stress and harm for women detained within immigration detention.[287] Some detention centres characterise this through the mimicking of criminal structures, such as barbed wire, [288] or even the use of prisons. The Committee for the Prevention of Torture has indicated that a prison is 'fundamentally flawed' for housing migrants,[289] and this is evidenced via the mental and physical degradation of migrants. This punitive nature of such a practice is degrading, and emblematic of societal rejection of migrants.

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[281] *Ibid.* Page 243
[282] *Ibid*. Page 243
[283] *Ibid.* Page 235
[284] (The World Health Organisation 2022) Page 32
[285] *Ibid.* Page vi
[286] Aal, Monty, Sophia Fehrenbach, Grace Linczer, and Mohammad Abu Hawash. 2021. "'Locked up like animals' - immigrant detention centers in the time of the coronavirus." *Politico.* August 04. Accessed July 09, 2023. https://www.politico.eu/article/inside-immigrant-detention-centers-coronavirus-times-covid-19-europe/.

[287] (Gerlach 2022) Page 8
[288] (Gerlach 2022) Page 8
[289] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. 2010. *CPT Standards.* Council of Europe. page 54, para 28

Environmental sources of harm are not strictly physical. As the Jesuit refugee services explained, it is an external factor that is outside of the realm of control of the vulnerable individual in question.[290] The socio-political climate of a State could also be considered a determinate of health in this sense. Friedrich Engels wrote that the socioeconomic structure of British society in 1845 was 'social murder' due to the poor standard of living.[291] Responsibility towards health should be collective, and the structures that determine health are macrosocial.[292] Therefore, the environment of deprivation and poverty was a significant contributor towards ill health, and something that the most vulnerable i.e., those living in poverty, had minimal control over. If we equate this to the health of women in immigration detention, it requires consideration of the political influences governing such structures.

2.5.1 The Adverse Effects of a Hostile Environment on Health

There is a growing global perception that migration is increasingly out-of-control and unregulated. Political narratives have created misguided fear about increasing crime rates, job insecurity, and degradation of cultural heritage.[293] A hostile approach to migrants has therefore been adopted across multiple borders, despite many countries being founded on migrants. The US, Canada, and Australia are prime examples of this.[294] They have become 'increasingly restrictive' in areas of immigration regulation, such as border control.[295] Flynn[296] attributes this paradox to a history of colonialist influence over government policies. He further states that deportation and detention are symbolic acts to satisfy the electorate, when in reality they are ineffective and a form of structural harm.[297]

Goldberg explores the theory of 'law as a social determinant of health',[298] which reflects the socio-political elements of healthcare throughout the international landscape, but also demonstrates that any

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[290] (Jesuit Refugee Service Europe 2010) page 12

[291] S.Goldberg, Daniel. 2013. "Global Health Care Is Not Global Health: Populations, Inequities, and Law as a Social Determinant of Health." In *The globalization of health care: legal and ethical issues*, by I.Glenn Gohen. Oxford;New York: Oxford University Press. Page 404

[292] *Ibid.* Page 414

[293] Sampson, Robyn, and Grant Mitchell. 2013. "Global Trends in Immigration Detention and Alternatives to Detention: Practical, Political and Symbolic Rationales." *Journal on Migration and Human Security* 1 (3): 97-121. Page 99

[294] Flynn, Matthew B. 2017. "Capitalism and immigration control: what political economy reveals about the global spread of detention." In *Challenging immigration detention: academics, activists and policy-makers*, by Michael J Flynn, 171-194. Cheltenham,UK: Edward Elgar Publishing. Page 176

[295] *Ibid.* Page 177

[296] *Ibid.* Page 177

[297] *Ibid.* Page 177

[298] (S.Goldberg 2013)

aspect of legislative systems can be applicable to public health.[299] Evidence of this can be found in domestic detention policies. The United Kingdom introduced a policy of a 'hostile environment' under the former Home Secretary Theresa May. The rationale behind this was to create such an antagonistic and unfriendly atmosphere that migrants would leave voluntarily.[300] This was enacted by maintaining an immigration system that was procedurally difficult to navigate, whilst ensuring that limited support was available. Similarly, the Danish Minister for Immigration advocated for making life 'intolerable' for migrants.[301] The combination of this with restricted access to healthcare within immigration detention, is a recipe for health deterioration.

Hostility towards migrants is not exclusive to domestic legislature and policy. It is often found in the behaviour and prejudice of detention centre staff. An exposé of the UK's harmful immigration detention centre 'Yarl's Wood' found that the attitudes of detention centre guards and officials had a significant effect on the health offemale migrants.[302] Gender and race were shown to intersect in the prejudice of immigration detention staff, who allowed their preconceived notions of different nationalities to influence how they divided 'residents'.[303] Jamaican detainees were generalised to be 'assertive' whilst Pakistani women were labelled as 'passive' when guards were deciding how to group detainees within the accommodation.[304] Detention officials may initially demonstrate an empathetic approach but over time this is eroded and guards participate in systems of persecution, illustrating the pervasive prejudicial sentiments that govern immigration detention centres..[305] When conducting her research in the UK, Turnbull found no evidence that detention centres had implemented any form of gender sensitivity or responsive training.[306] This evidences the failure of States to mitigate the risk of discriminatory attitudes, and thus an indirect failure to protect the realisation of the right to health.

The overall harmful environment within immigration detention is perpetuated by the growing privatisation of these practices. Separating the State from the responsibility to care for migrants inevitably

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[299] *Ibid.* Abstract

[300] (Canning 2019)Page 48

[301] *Ibid.*

[302] (Turnbull 2015)

[303] Turnbull, Sarah. 2015. "Gender, Race and Immigration Detention." *Border Criminologies.* April 17. Accessed June 20, 2023. https://blogs.law.ox.ac.uk/research-subject-groups/centre-criminology/centreborder-criminologies/blog/2015/04/gender-race-and.

[304] *Ibid.*

[305] (The World Health Organisation 2022) Page 44

[306] (Turnbull 2015)

creates a distance in accountability for any human rights infringement, Brooker at al (2017) label this as 'distancing office from infractions.'[307] The growing 'immigration detention complex'[308] reflects the economic interests that draw on anti-migrant sentiment, utilising this discourse to generate a profit.[309] Unfortunately, this results in a prioritisation of profit before people, and the implementation of gender-sensitive healthcare practices is disregarded as an unnecessary expense. This is exemplified by the UK Home Office refusing to disclose whether a woman in Yarl's Wood immigration detention centre had been raped in case it damaged 'the commercial interests of companies.'[310] Not only do they prioritise economic gain, but they are dismissive over the potential perpetuation of gender-based violence in an environment where women are likely to have prior traumatic experiences of such.

Political forces combined with economic actors are perpetuating the practice of 'crimmigration.'[311] This instils a culture of degradation,[312] failing to respect human dignity, and punishing those for crossing borders. Detention driven by profit is unlikely to consider proportionality, necessity or reasonableness. Instead, private companies with endeavour to maintain a system of incarceration, regardless of potential human rights violations. If we liken this comparison to Faiver's analysis of the privatisation of correctional facilities, once a detention centre is monetised by a private contractor, the only way to ensure continued profit is by guaranteeing that migrants continue to be detained.[313] Therefore, enabling a neoliberal approach to immigration detention is a fundamental barrier to women's health.

Immigration detention centres and the carceral nature of the space have been described as a locus of criminalisation, and a display of State sovereignty.[314] Constant monitoring and control is a pervasive embodiment of Foucault's' 'panopticon'[315] and a clear example of how the environment of detention can be destructive. McLoughlin and Warin (2008) draw on this to analyse the intrinsic ties between space,

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[307] (Brooker, et al. 2017) page 198
[308] (Flynn 2017) page 183
[309] *Ibid.* page 183
[310] Fenton, Siobhan. 2016. "Home Office refuses to reveal whether women in Yarl's Wood have been raped in case it 'damages the commercial interests' of companies." *The Independent.* June 13. Accessed July 09, 2023. https://www.independent.co.uk/news/uk/politics/home-office-refusing-to-reveal-whether-women-in-yarl-s-wood-have-been-raped-to-protect-the-commercial-interests-of-companies-operating-it-a7077736.html.

[311] Abji, Salina, and Lindsay Larios. 2021. "Migrant justice as reproductive justice: birthright citizenship and the politics of immigration detention for pregnant women in Canada." *Citizenship Studies* 25 (2): 253-272.

[312] (Flynn 2017) page 187
[313] (Faiver 2020) page 60
[314] *Ibid.* Page 235
[315] (McLoughlin and Warin 2008)Page 259

place and mental health, reaching the conclusion that detention centres exacerbate poor health, expose vulnerability to mental health struggles, and create an environment that is 'psychosocially destructive.'[316] Not only does it restrict the autonomy of detainees,[317] but it also renders them without personhood, forcing them to remain in a frozen liminal state whilst they await release.[318] Ultimately, these oppressive conditions worsen the physical and mental health of detainees by creating a sense of de-personalisation.[319] The impact that this has on female migrants is severe. Within circumstances of imprisonment, the body is often all the detainee has.[320] By creating an environment that is predicated on control and subservience, women are left without a sense of personhood or sense of power, which many female asylum seekers may have experienced prior to detention. The complexity of achieving 'safe womanhood'[321] is fraught with many challenges, environmental conditions that are defined by patriarchal powers, such as immigration detention, is one of them. We could argue that this is a form of state violence that imposes manifold restrictions of women's autonomy, thus causing deterioration of health and wellbeing.

The Public Health Lancet has established that the ideas that shape and inform the policies for immigration detention need to be radically transformed, starting with health institutions;[322] the prioritisation of economic growth and profitability over the welfare of people results in a lack of oversight and a failure to respect the right to health.[323] Inevitably, women's health is effected more severely by these policies due to their invisibility in immigration detention policies, jurisprudence, and national legislature.[324] Health care providers are in an increasingly difficult position, attempting to balance their obligation to their employer, to the legal rules of border control and immigration, and their duty to their patient.

2.6 Balancing conflicting duties: Ethical Dilemmas for Health Professionals in Immigration Detention

[316] *Ibid.* page 255
[317] *Ibid.* page 259
[318] *Ibid.* page 260
[319] *Ibid.* page 261
[320] Stoller, Nancy. 2003. "Space, place and movement as aspects of health care in three women's prisons." *Social Science & Medicine* 56 (11): 2263-2275. Page 2264

[321] Dyck, Isabel. 2006. "Travelling tales and migratory meanings: South Asian migrant women talk of place, health and healing." *Social & Cultural Geography* (Routledge: Taylor & Francis) 7 (1). Page 1

[322] The Lancet Public Health. 2020. "Living in detention: a matter of health justice." *Lancet Public Health* 5: 71

[323] (The World Health Organisation 2022) Page 47
[324] (Van Hout 2021) Page 1

The four pillars of ethical healthcare were developed by Beauchamp and Childress, who identified beneficence, non-maleficence, autonomy and justice, as integral to moral delivery of patient care. Beneficence and non-maleficence bear the strongest resemblance to the famous Hippocratic oath, requiring that healthcare professionals 'do good' and 'do no harm', respectively.[325] Autonomy and Justice were developed as ethical concepts later. International human rights law addresses the importance of autonomy, as we have discussed, but it also has a philosophical underpinning. Similar to the concept of dignity developed by Immanuel Kant, autonomy is inherent to all persons as everyone has unconditional worth and should therefore have the power to exercise self-determination.[326] Underlying principles of autonomy are informed consent, truth-telling, and confidentiality.[327] Justice, and consequently 'distributive justice', is interpreted to be the fair, equitable, and appropriate treatment of persons.[328] These are intended to be the guiding principles for all medical professionals in the delivery of healthcare treatment.

The concept of medical ethics in border control is a complex one. The World Medical Association Declaration of Geneva includes a promise to refrain from using medical knowledge 'to violate human rights and civil liberties, even under threat'.[329] The British Medical Association raises the concept of 'dual loyalties', in which Doctors have to balance their professional obligations with the migration related issues.[330] The primary concern of immigration detention is to 'detain and secure', whereas that of the health care sector is to 'protect and promote health and wellbeing'.[331] Therefore, a Doctor may attempt to act in the best interests of their patient but have to contend with interference from detention staff, security issues, or reporting confidential information to the State.[332] For instance, Doctors will often assess the age of a detainee so as to determine whether they are an adult, and whether their detention may continue. If they are to disclose that a migrant is above the age of 18, this will likely result in extended detention, and subsequent health deterioration. However, they are under an obligation to perform this

[325] Varkey, Basil. 2020. "Principles of Clinical Ethics and Their Application to Practice." *Medical Principles and Practice* 17-28. Page 18

[326] *Ibid*. Page 19
[327] *Ibid.* Page 19 and 20
[328] *Ibid.* Page 20
[329] World Medical Association. 2018. *WMA Declaration of Geneva.* July 09. Accessed July 09, 2023. https://www.wma.net/policies-post/wma-declaration-of-geneva/#:~:text=I%20WILL%20ATTEND%20TO%20my,freely%2C%20and%20upon%20my%20honour.

[330] (British Medical Association 2017) Page 5

[331] *Ibid*. Page 5
[332] *Ibid.* Page 5

assessment when hired by the detention centre, and so must comply.[333] The reason that this may be detrimental to women's health in detention, is because of the breakdown of medical ethics, and the deterioration of clinical independence. Clinical Independence is important to medical care as it ensures that doctors can exercise their professional judgement without coercion or undue influence.[334] Situations in which this is violated can have serious impacts on women's health.

Australia implemented the 'Border Force Act' that criminalises employee disclosure of 'entrusted information' that could include the clinical environment within offshore processing centres.[335] Not only does this imply a layer of secrecy to the practices within detention, it is also a means to avoid accountability. Medical professionals have to conduct a form of 'ethical calculus'[336] in which they balance their obligations to their patients, with that of their employer. This is a clear infringement upon the principle of clinical independence. Additional ethical conflict can arise from the pressure exerted by other detention staff. Brooker et al report that advocacy for detainees' health status by clinicians within immigration detention was seen as an inappropriate political statement and treated with suspicion.[337] As the United Nations Office on Drugs and Crime states, it is a challenge to maintain the balance between dignity and respect, with that of surveillance and security for those in prison.[338]

Clinical transparency and communication are essential to health care, particularly mental health care, within immigration detention.[339] However, it is difficult to establish appropriate communication with detainees. Distrust of the system and staff is inevitable, with medical professionals to be perceived as a cog in the machine of oppression.[340] As we have already established, female migrants can be particularly vulnerable in immigration detention. If healthcare professionals are unable to abide by medical ethics in a sufficient capacity, it risks human rights abuse disguised in the form of medical treatment. Moreover, release from immigration detention could be contingent on the opinion of a medical professional.[341] This

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[333] *Ibid*. Page 5
[334] *Ibid.* Page 30
[335] (Brooker, et al. 2017) page 196

[336] (Faiver 2020) page 9
[337] (Brooker, et al. 2017) page 201
[338] United Nations Office on Drugs and Crime. 2009. *Women's health in prison: Correcting gender inequity in prison health.* Europe: World Health Organisation. Page 4

[339] (Brooker, et al. 2017) page 196
[340] (Lungu-Byrne, et al. 2021) Page 84

[341] Sahraoui, Nina. 2020. "Challenges to medical ethics in the context of detention and deportation: Insight from a French postcolonial department in the Indian Ocean." *Social Science & Medicine.* Page 3

implies that a doctor conducts a role in border control.[342] If we are to view this from a deontological perspective, it is morally wrong for a doctor to engage in such treatment that may result in extended detention or deportation and therefore health deterioration, but also morally wrong for a doctor to refuse to treat a patient.

2.7 Conclusion

Delivery of care in the environment of immigration detention is fundamentally contradictory. Adherence to the AAAQ framework is impossible if a medical professional is unable to comply with their ethical duties. A consequence of this is the failure to deliver an equitable standard of care with the outside community, violating principles of non-discrimination. Moreover, the oppressive environment, inconsistent healthcare delivery, violation of migrants' privacy, autonomy, and dignity, all accumulate to prevent the realisation of the highest attainable standard of health for women.

State specific examples of health violations have been provided within this chapter to contextualise the nature of harm and the specific consequences that immigration detention poses. The next chapter will expand this analysis, by examining the State practices of the UK, US, Australia, and Sweden, a detailed understanding of how different State policies can impact migrants' health will be developed.

[342] *Ibid.* (Sahraoui 2020) Page 3

Chapter 3 - Implementing the Right to Health for Women in Immigration Detention: An Examination of Existing Domestic Practices

In this chapter, the focus is shifted towards the domestic landscape of women's health in immigration detention. The US, Australia, and Sweden were selected on the basis of available research, but also due to the detailed insight these States can provide over the differing approaches to immigration detention, and the consequent health impacts.

The US and Australia show some parallels in their immigration detention regimes due to the fact that they have refrained from implementing a time limit on immigration detention and are considered to have some of the world's harshest forms of border control. However, a disparity between them is the failure of the US to ratify ICESCR and CEDAW. As we established, these two treaties are essential to the international protection of women's rights, and the right to health. Examination of the two domestic practices allows insight as to whether the safeguards within said treaties provide any real benefit to the health of migrant women who have been detained.

Sweden adopts a more humane approach, as we shall examine, than the US and Australia. It has also ratified ICESCR and CEDAW, so should theoretically have a higher success rate for the realisation of health within detention than the US. This will be examined by reviewing domestic legislature, policies, and extant literature surrounding experiences of immigration detention within the respective States.

3.1 The Legal Landscape of Immigration Detention in Australia

According to the Migration Act 1958, any non-citizen who arrives or resides in Australia without a valid or correct visa must be detained.[343] Release cannot be arranged until an unlawful non-citizen has been approved for a visa, if they are removed, or if they voluntarily leave the country.[344] There is no time limit to the length of detention, and lengthy legal processes often results in prolonged confinement. Australia historically implemented a policy of offshore detention in which refugees, asylum seekers, and non-citizens were held.[345] Nauru and Papua New Guinea were contracted to house the detainees, arguably a remnant of Australia's colonial ties with the Island States.[346] Whilst these centres have been closed, and the last refugee flown from Nauru to Brisbane in June 2023, the legacy of harm for these centres remain.

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[343] *Australia: Act No. 62 of 1958, Migration Act 1958 - Volume 1* [Australia], 8 October 1958 Section 189 (1)

[344] *Australia: Act No. 62 of 1958, Migration Act 1958 - Volume 1* [Australia], 8 October 1958 Section 191

[345] Dehm, Dr. Sara. n.d. "Australia's 'offshore' detention regime." *Future Learn.* Accessed June 28, 2023. https://www.futurelearn.com/info/courses/migration-facts/0/steps/244548

[346] *Ibid.*

Australian is maintaining an 'enduring' offshore detention contract with the relevant islands, as a precautionary measure to be used in future if deemed necessary.[347] This illustrates the failure to acknowledge the inhumanity of such practices, holding it as a form of leverage to reinstate at any point they deem necessary in the future.

As mentioned, Australia is a party to the ICESCR, CEDAW, and to the ICCPR. As such, it has obligations under international human rights law to ensure that immigration detention meets the requisite standards of any site in which an individual is deprived of their liberty. The UN Human Rights Committee detailed how Australia's maintenance of arbitrary, indefinite detention inflicts serious, irreversible psychological harm in direct contravention of Article 7 and 10 of the International Covenant on Civil and Political Rights.[348] There is no legal mechanism in which a migrant may challenge their detention.[349] In fact, the only exception to indefinite detention is if the Minister for Home Affairs exercises their discretion to release an individual into the community whilst they await their visa decision.[350]

3.1.2 Statistical Data Regarding Australian Immigration Detention Practices

As of April 2023, 1128 people were detained, 73.5% of which had been for longer than 91 days, and the average length of detention was 735 days. [351] Of the 1128 people detained, 50 of these were women.[352] The Australian Border Force report the average length of detention with vague language, such as '26.5 per cent had been detained for 91 days or less.'[353] We can understand this as a veiled attempt to minimise the severity of their practices. For context, in 2020 the average length of time someone spent at an immigration detention facility in Australia was 545 days, whilst in contrast Canada's average time was

[347] Doherty, Ben, and Eden Gillespie. 2023. "Australia to move last refugee from offshore processing on Nauru - but its cruelty and cost are not over." *The Guardian.* June 23. Accessed July 10, 2023. https://www.theguardian.com/australia-news/2023/jun/24/australia-to-move-last-refugee-from-offshore-processing-on-nauru-but-its-cruelty-and-cost-is-not-over.

[348] UN Human Rights Committee. August 2013. "Communication No.2094/2011: Views adopted by the Committee at its 108th session (8-26 July 2013 Para 3.12

[349] Joint Standing Committee on Migration. 2022. *Submission to the inquiry on the ending indefinite and arbitrary immigration detention bill 2021.* Refugee Council of Australia. Para 1.3

[350] *Australia Act No.62*

[351] Australian Border Force. 2023. *Immigration Detention and Community Statistics Summary: April 2023.* Australian Government Department of Home Affairs. Page 12

[352] Refugee Council of Australia. 2023. *Statistics on people in detention in Australia.* May 13. Accessed July 10, 2023. https://www.refugeecouncil.org.au/detention-australia-statistics/2/.

[353] (Australian Border Force 2023) Page 12

14 days, and the US was 55.[354] The lack of temporal certainty for detainees, combined with the dehumanising isolation on another island, has inevitable detrimental impacts for the health of detainees.

3.2.2 Healthcare Approaches: A focus on Women's Health Provisions

The Royal Australian College of General Practitioners (RACGP) developed the 'Standards for health services in Australian immigration detention facilities' with Government funding.[355] The intention of which is to enable the provision of health-quality healthcare to people detained under immigration regulations.[356] The RAGCP advocate for the consideration of biomedical, psychological, social and environmental factors in the delivery of health services, as well as the patient's language, culture, beliefs, and values in their understandings of health.[357] These principles are fundamental in the ethical and consensual realisation of health. It is also important to note that these Standards are not legally binding, and therefore do not constitute a direct legal obligation.

When considering gender sensitive care, the RACGP Standards emphasise the importance of gathering data on a detainees' sex and gender identity so as to maintain accurate records, whilst also delivering tailored, appropriate care.[358] It is also acknowledged that comprehensive care should be gender appropriate,[359] and that communities 'benefit considerably from having localised health services', including women's health,[360] but there is little expansion upon what this would entail. The health needs of pregnant women are also mentioned, with a requirement for tailored health care, and even discussion of how best to handle 'ethical dilemmas' such as pregnancy termination.[361] This is a nod to the importance of observing reproductive health rights within immigration detention.

There is extensive discussion around ethical healthcare, including the observance of informed consent. The RACGP require consideration of linguistic and cultural backgrounds, health literacy, and cognitive capacities that may impact understanding.[362] The previous chapter explored how failing to accommodate for these different components can have a detrimental impact on women's health, so it is important that

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[354] Public Interest Advocacy Centre. 2020. "Facts & Figures." *Public Interest Advocact Centre.* June 2. Accessed June 28, 2023. https://piac.asn.au/project-highlight/facts-figures/.
[355] RACGP. 2022. *Standards for health services in Australian immigration detention facilities.* 2nd edition, The Royal Australian College of General Practitioners.

[356] *Ibid* Page iv
[357] *Ibid* Page iv
[358] *Ibid* Page 82
[359] *Ibid* Page 131
[360] *Ibid* Page 130
[361] *Ibid* Page 27
[362] *Ibid* Page 17

this is recognised in governmentally approved standards. There is also a discussion surrounding the permissibility of third parties being present during a consultation, and requirements for consent.[363] This could minimise the privacy infringements experienced by detainees and, if we compare this to women's experiences in UK detention facilities, reduce the feelings of degradation and indignity. For women with prior traumatic experience, such as human trafficking, it is essential that medical standards respect privacy, autonomy, and dignity. Ensuring confidentiality and consent during medical procedures is an essential facet of this.

As we have observed, there is sufficient coverage of how to deliver ethical, comprehensive care within immigration detention in Australia. However, based on accounts from detainees and existing research, it is apparent that these guidelines are not sufficient, or not adequately followed. The health experiences of migrants within immigration detention will be discussed below, particularly that of female migrants.

3.2.3 Australian Immigration Detention: Examining the Health Consequences for Female Migrants

A significant amount of literature surrounding the health impacts of indefinite immigration detention on migrants originates from Australian practices. The harsh nature of indefinite detention understandably attracts international attention, and as such there are recurrent themes that can be identified as common occurrences of harm to women's health, specifically, mental health deterioration.

Australia's framework of mandatory detention means that even the most vulnerable can be detained. .[364] The recurrent feelings of women in detention were described as social isolation, loneliness, frustration, anger, hopelessness, and demoralisation in a study conducted by Rivas et al.[365] This was heightened by the physical, verbal, and sexual abuse prevalent in immigration detention centres.[366]

A comprehensive analysis in 2015 found that mental health problems were the most common form of ailment affecting women in immigration detention, with 88.9% of the sample suffering from at least one

[363] *Ibid* Page 32

[364] Amnesty International. 2021. *The impact of indefinite detention: the case to change Australia's mandatory detention regime.* Amnesty International, 1-74. Page 23

[365] Rivas, Lorena, and Melissa Bull. 2018. "Gender and Risk: An Empirical Examination of the Experiences of Women Health in long-Term Immigration Detention in Australia." *Refugee Survey Quarterly* 307-327. Page 320

[366] *Ibid.* Page 319

form of mental health disorder.[367] 55.6% of the women surveyed had suicidal ideation, and some had engaged in self harm.[368] Research suggests that a key stress factor distinctive to women is their exposure to rape and sexual assault.[369] Female asylum seekers are often survivors of human rights abuse such as torture, or serious forms of discrimination like gender-based violence, but are regularly confined within Australian immigration detention.[370]

Amnesty International reiterated the harm to the mental health of asylum seekers who were kept in prolonged detention; chronic depression, self-harm, and attempted suicide were all likely consequences.[371] The rate of self-harm within Australian immigration detention is reportedly 200 times higher than the comparative Australian community hospital rate.[372] Moreover, 88% of refugees and asylum seekers on Manus Island (an offshore detention facility) were found to be suffering from depression, anxiety, and/or post-traumatic stress disorder.[373] Statistics from Manus island were produced in a 2018 prior to the reduction in use of offshore detention, but it a pertinent indicator of the legacy of such harsh and ostracising practices.

Food and nutrition, as underlying determinants of health, are essential to a successful realisation of the right. Described as 'substandard, unappetising and sometimes off,'[374] the provided food in Australian detention centres contravenes any expectation of an appropriate diet. A recent report provided damning evidence of the substandard food when maggots were found. Indicating not only a failure to maintain adequate hygiene standards, but also a complete disregard for the nutritional health of those in detention.[375]

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[367] *Ibid.* Page 316

[368] *Ibid.* Page 317

[369] Kurth, E., F.N. Jaeger, E. Zemp, S. Tschudin, and A Bischoff. 2010. "Reproductive Health Care for Asylum Seeking Women - A Challenge for Health Professionals." *BMC Public Health* (BMC Public Health) 10 (659): 1-11. Page 5

[370] (Amnesty International 2021, The Impact of Immigration Detention) Page 28

[371] (Amnesty International 2021, The impact of indefinite detention) Page 23

[372] (Joint Standing Committee on Migration 2022) Para 3.3

[373] *Ibid.* Para 3.4

[374] Select Committee on the Recent allegations relating to conditions and circumstances at the Regional Processing Centre in Nauru. 2015. *Final Report on Taking Responsibility: Conditions and Circumstances at Australia's Regional Processing Centre in Nauru.* The Senate. Page 74

[375] ASRC. 2023. "Damning report on Australia's immigration detention regime finds maggots in food, use of force and spithoods." *Asylum Seeker Resource Centre.* January 24. Accessed June 28, 2023. https://asrc.org.au/2023/01/24/opcat-detention/#:~:text=The%20most%20recent%20statistics%20show,applied%20for%20a%20protection%20visa.

Physical and emotional environments are particularly influential over the health of pregnant women and women who have recently given birth. This is likely to be exacerbated for women who have fled their country of origin due to traumatic experiences, and immigration detention centres should be particularly sensitive to this.[376]

The journey to reach Australia can often be traumatic. In a 2014 inquiry, one women reported losing her child at sea, whilst another had experienced a history of political persecution including rape, kidnapping of relatives, and death threats.[377] For a State to receive people who have survived such traumatic experiences and place them in a detention environment of degradation and harm, is morally contemptuous. This inquiry found signs of severe post-natal depression in new mothers, which could be attributable to the feeling of 'parental disempowerment,' a consequence of being unable to protect their baby from the harms of detention.[378] There was also a 'pattern of fear' experienced by pregnant women who were detained on Nauru (the offshore processing island), stemming from the constant sense of degradation, such as having to queue up to use a shower whilst pregnant and living in a tent.[379] These sanitary arrangements also impact on the menstrual hygiene of women, making it difficult to appropriately manage their periods.[380] Whilst this centre is not currently in use, the threat of reopening hangs over the heads of present and future migrants to Australia. It is also damning evidence of the extent to which immigration detention can be used to harm migrants.

Despite existing international human rights that is supposed to protect individuals against arbitrary deprivation of liberty, and promote a society of integration and support, it appears the women's health in immigration detention has fallen to the wayside. Immigration detention practices without the influence of ICESCR or CEDAW will be examined below via the United States.

3.3 Legal Frameworks Governing Immigration Detention in the United States

[376] Australian Human Rights Commission. 2014. *6 Mothers and babies in detention.* July. Accessed July 10, 2023. https://humanrights.gov.au/our-work/projects/6-mothers-and-babies-detention.

[377] *Ibid.*
[378] *Ibid.*
[379] *Ibid*
[380] The Royal Australasian College of Physicians. 2016. *RACP Submission: Conditions and treatment of asylum seekers and refugees at the regional processing centres in the Republic of Nauru and Papua New Guinea.* Submission 5 - Attachment 1, RACP. Page 5

The United States is famed for cruel immigration detention practices, particularly during Donald Trump's presidency,[381] but he unfortunately was not the exception. Cruel detention practices have a long history in the United States and are maintained in contemporary society. It is important to remember in this examination of US immigration detention policies, the United States is not party to the ICESCR, or to CEDAW, therefore international accountability is minimised, and female migrants in immigration detention centres are reliant on domestic legislature for protection.

The Immigration and Nationality Act (INA) provides authority in certain circumstances for the Department of Homeland Security to detain non-nationals.[382] Four provisions of key importance are INA s236(a), authorising the detention of 'aliens' pending a decision on deportation, INA s236(c) requires the detention of those who are removable due to criminal activity or terrorism related grounds, INA 235(b) requires detention of applicants who are subject to deportation, including those who have not be admitted or paroled into the IS, and INA 241(a) generally requires detention to be within 90 days whilst the removal is arranged, but this may be extended depending on the circumstances.[383] A 2022 Supreme Court ruling found that there is no automatic entitlement of those in immigration detention to a bond hearing, thus meaning that those being held can continue to do so indefinitely.[384] If a detainee wants to challenge their deprivation of liberty, they must do so on an individual basis, despite no guarantee of legal advice whilst held in detention.[385]

3.3.1 Statistics for US Immigration Detention Practices: A Lack of Transparency

There is limited reliable data on the characteristics of people held in immigration detention in the United States,[386] and so it is difficult to discern how many women are detained by Immigration and Customs Enforcement (ICE). However, what we can distinguish is that as of 18th June 2023, 29,613 people were

[381] (Ellmann, Immigration Detention is Dangerous for Women's Health and Rights 2019)
[382] *United States: Immigration and Nationality Act (last amended March 2004)* [United States of America], 27 June 1952
[383] Smith, Hillel R. 2022. *The Law of Immigration Detention: A Brief Introduction.* Congressional Research Service. Page 1

[384] Carlise, Madeline, and Jasmine Aguilera. 2022. "Supreme Court Rules Thousands of Immigrants Can Be Detained Indefinitely." *TIME.* June 12. Accessed June 29, 2023. https://time.com/6187133/supreme-court-immigrants-bond-hearings/.

[385] *Ibid.*
[386] Freedom For Immigrants. 2018. *Detention by the number.* Accessed July 10, 2023. https://www.freedomforimmigrants.org/detention-statistics.

held in Immigration Detention across the U.S. 63.1% of whom did not have a criminal record, but those that did were generally only minor offences.[387]

Accountability in immigration detention practices is often reliant on reliable data and a clear insight into who is affected by detention practices. The failure by the US to provide regular and reliable updates on detention statistics not only shows an administrative failure, but also a disregard for human rights, and a lack of respect for the thousands of people detained each year who may get lost in the system.

3.3.2 Healthcare frameworks in US Immigration Detention Policies

US Immigration and Customs Enforcement have implemented detention standards so as to demonstrate an ongoing effort to maintain humane and safe conditions. Specific provisions are available for women, centring access to 'appropriate and necessary medical and mental health care.'[388] This includes routine, age-appropriate care, including gynaecological and obstetric, in line with community guidelines for women's health.[389] Pregnant women should not be restrained unless absolutely necessary in extraordinary circumstances, and adequate pregnancy healthcare services should be available throughout time in custody.[390] Whilst the US has not ratified ICESCR, this demonstrates similar values in terms of non-discrimination and the removal of barriers to women's health. Despite the efforts to protect women's health in national policies, it is not necessarily embodied in practice.

3.3.3 Women's Experiences in US Immigration Detention, and the Subsequent Health Consequences

Discrimination, racialisation, and criminalisation are all ubiquitous to the US immigration detention system.[391] There were 33,126 complaints of sexual and physical abuse within the space of 6 years.[392] Women are particularly vulnerable to abuse within immigration detention. In an El Paso detention centre,

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[387] TRAC Immigration. 2023. "Immigration Detention Quick Facts." *TRAC Immigration.* Accessed June 29, 2023. https://trac.syr.edu/immigration/quickfacts/#:~:text=Immigration%20and%20Customs%20Enforcement%20held,as%20of%20June%2018%2C%202023.&text=18%2C686%20out%20of%2029%2C613%E2%80%94or,minor%20offenses%2C%20including%20traffic%20violations.

[388] U.S. Immigration and Customs Enforcement. 2011 (Rev.2016). "2011 Operations Manual ICE Performance-Based National Detention Standards, Rev. 2016." Page 322

[389] *Ibid.* Page 322

[390] *Ibid.* Page 322

[391] Saadi, Altaf, Maria-Elena De Trinidad Young, Caitlin Patler, Jeremias Leonel Estrada, and Homer Venters. 2020. "Understanding US Immigration Detention." *Health and Human Rights Journal* 22 (1): 187-197.Page 189

[392] *Ibid.* Page 189

it was reported that a guard told one female detainee he would prevent her deportation if she 'behaved.'[393] This was a veiled threat to enable him to assault with her no repercussions. Allegations of systemic rape and sexual assault were raised in 2020, with three complainants describing how guards would make sure they only did this out of view of any CCTV, so as to avoid repercussions.[394] One officer said that no one would believe their reports of abuse.[395] A legal case was brought forward but has subsequently been dismissed.[396]

In February 2018, Human Rights Watch published an exposé on the conditions within US Customs and Border Protection Cells.[397] Whilst these are generally only short-term holding facilities, the degradation suffered is severe. It was rare that detainees were permitted to shower during their time there, despite it lasting up to 4 days.[398] Holding facilities were described as freezers, and a small aluminium blanket is typically provided for warmth, but detainees have to sleep on the floor.[399] One 2015 mental health assessment determined that the time spent in these holding cells was the most traumatic period of detention.[400] Another form of abuse within U.S. detention centres appears to be the withholding of adequate meals, nutrition, and even access to water.[401] Some short-term detainees report not receiving a meal despite being held for over 48 hours, whilst others recall being told to eat off the floor like animals.[402]

A study of Arizona long-term detention facilities detailed frustration at the use of security measures to justify excessive force towards women; with complaints raised about the use of shackles and strip

[393] Wilson, Laura. 2020. "Violence Against Women and Girls in ICE Custody." *Global Rights for Women.* September 21. Accessed June 29, 2023. https://globalrightsforwomen.org/violence-against-women-and-girls-ice-custody/.

[394] Kriel, Lomi. 2020. "ICE guards "systematically" sexually assault detainees in an El Paso detention center, lawyers say." *The Texas Tribune.* August 14. Accessed June 29, 2023. https://www.texastribune.org/2020/08/14/texas-immigrant-detention-ice-el-paso-sexual-abuse/.

[395] *Ibid.*
[396] *Ibid.*
[397] Human Rights Watch. 2018. "In the Freezer: Abusive Conditions for Women and Children in US Immigration Holding Cells." *Human Rights Watch.* February 28. Accessed June 29, 2023. https://www.hrw.org/report/2018/02/28/freezer/abusive-conditions-women-and-children-us-immigration-holding-cells.

[398] *Ibid.*
[399] *Ibid.*
[400] *Ibid.*
[401] (Carney 2013) Page 37
[402] *Ibid.* Page 37

searches despite minimal security risk.[403] Often this would take place in groups, with one detainee recounting a time that she was menstruating and force to strip in front of others.[404] Not only does this contravene her right to privacy,[405] it disregards the fundamental human rights principle of autonomy. In Georgia, women were forced to undergo unnecessary medical treatment whilst in immigration detention.[406] This included removal of benign ovarian cysts that would typically resolve without surgery, or the performance of a Pap smear to test for cervical cancer without any explanation of the procedure.[407] Informed consent is essential for fulfilment of bodily autonomy and failure to ensure that detainees understand and agree to all medical treatment is arguably a form of medical abuse.[408]

Gender-based abuse does not exist in a singular form; it can be mental, physical, sexual, or even medical. Immigration Detention in the US evidently does not implement sufficient safeguards to prevent harm. The failure to ratify ICESCR and CEDAW reduces US accountability on the global stage in comparison to other countries. However, as this thesis explores, human rights abuse within immigration detention is not unique to the US, nor is deterioration of women's health.

3.4 Swedish Immigration Detention Legal Frameworks

Sweden's immigration detention practices have been proclaimed as relatively 'benign,'[409] and therefore a useful comparator for understanding the extent to which harm can be reduced in immigration detention. The implementation of a time limit for detention is a key example of this. According to the Aliens Act,[410] a migrant should only be held in immigration detention for two weeks. This may be extended, but only in exceptional circumstances. For instance, if they are issued with an order of expulsion. If this is the case, they may be detained for up to 2 months. Once again, any extension to this must be exceptional, and immigration detention cannot be extended beyond 12 months for any reason (other than criminal

[403] Southwest Institute for Research on Women, College of Social and Behavioural Sciences Bacom Immigration Law and Policy Program, James E. Rogers College of Law. 2009. *Unseen Prisoners: A Report on Women in Immigration Detention Facilities in Arizona.* The University of Arizona. Page 27

[404] *Ibid.* Page 27
[405] UDHR Article 12
[406] Montoya-Galvez, Camilo. 2022. "Investigation finds women detained by ICE underwent "unnecessary gynecological procedures" at Georgia facility." *CBS News.* November 15. Accessed June 29, 2023. https://www.cbsnews.com/news/women-detained-ice-unnecessary-gynecological-procedures-georgia-facility-investigation/.

[407] *Ibid.*
[408] *Ibid.*
[409] von Werthern, M., K. Robjant, Z. Chui, R. Schon, L. Ottisova, C. Mason, and C. Katona. 2018. "The impact of immigration detention on mental health: a systematic review." *BMC Psychiatry*, December 06. Page 14

[410] *Sweden: Aliens Act (2005:716)* [Sweden], 31 March 2006, Chapter 10, Section 4

prosecution).[411] If a migrant is detained whilst Sweden investigates their right to reside there, this cannot exceed 48 hours.[412] This is a stark contrast to the harsh regimes we explored in the US, and Australia. It demonstrates that not only is a time limit to immigration detention feasible, but it has already been realised. This is the case for most States.

Asylum seekers and refugees may both be detained under Swedish law. If the identity of a non-citizen is unclear upon entry to the country, and the individual cannot prove that the identity provided is correct, then they may be detained.[413] Uuthorities may also detain a non-citizen if it is necessary to carry out an investigation of their right to remain in Sweden; if it is probable they will be refused entry or removed; and for the purpose of carrying out a deportation order.[414]

3.4.1 Immigration Detention Statistics in Sweden

Despite the imposed time limits, the average length of time migrants spent in detention was 52 days in 2022.[415] For men, it was an average of 53 days, and for women it was 37.[416] Of the 3022 adults detained, 286 were women.[417] Once again, this represents the disparity in gender within detention, but also reinforces the point that immigration detention centres are built for men.

3.4.2 Swedish Healthcare Policies in Immigration Detention

The Aliens Act (2005) is a proviso for the conditions of immigration detention, particularly medical care. According to Chapter 11, human dignity must be respected at all times, and humane treatment made a priority.[418] Humane treatment refers to a good relationship between the detainee and staff, a feeling of safety within the detention centre, and detention staff must be sensitive to the needs of the detainee.[419]

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[411] *Ibid.* Chapter 10, Section 4
[412] *Ibid.* Chapter 10, Section 4
[413] *Ibid.* Chapter 10, Section 1(1)
[414] *Ibid.* Chapter 10, Section 1(2)
[415] Asylum Information Database. 2023. *Duration of Detention: Sweden.* April 19. Accessed July 13, 2023. https://asylumineurope.org/reports/country/sweden/detention-asylum-seekers/legal-framework-detention/duration-detention/#:~:text=%5B1%5D%20Persons%20who%20are%20issued,that%20the%20execution%20will%20take.

[416] *Ibid.*
[417] Asylum Information Database. 2022. *Country Report: Sweden.* European Council on Refugees and Exiles. Page 93

[418] *Aliens Act 2005*, Chapter 11, Section 1
[419] Asylum Information Database. 2022. *Country Report: Sweden. Page 99*

Premises should be specifically designed for the purpose of immigration detention,[420] and anyone held in detention should have the opportunity for recreation and time outdoors.[421] So long as it does not interfere with the purposes of detention, contact with the outside world must be permissible and facilitated. This includes visitation, which can be supervised if necessary due to security concerns.[422] The level of available healthcare must be the same as someone who has applied for a residence permit; this includes hospital care during the course of detention if the migrant requires it.[423]

3.4.3 Women's health experience in Swedish Immigration Detention Centres

In a 2021 visit to Sweden, the Committee for the Prevention of Torture (CPT) highlighted some success, and some failures, of the immigration detention centres. Reported to be of good standard were the 'material conditions', and the possibility of 'activities' within the two centres examined.[424] This is in contrast to reports from other countries such as the UK, and implies a good standard of environmental health, as well as increased sense of agency. Access to adapted clothing and personal hygiene items was also reportedly easily accessible, emblematic of the AAAQ framework and cultural appropriateness.[425] Food was reportedly varied, available at regular times throughout the day, with a snack at 10pm, and tea or coffee provided constantly.[426] This illustrates respect for the underlying determinants of health as per CESCR requirements.[427]

Canning addressed the nature of immigration detention in Sweden with particular regard to the environment. She details the availability of recreational activities such as ping pong and gym equipment, describing them as means to 'pass time' and 'pacify' detainees.[428] On the surface, this appears to be a step forward for the elimination of a carceral atmosphere. But in reality, the 'nexus' between the 'soft' environment and the 'hard' detention are two irreconcilable concepts.[429] There is an inherent loneliness

[420] *Aliens Act 2005*, Chapter 11, Section 2
[421] *Ibid,* Chapter 11, Section 3
[422] *Ibid.* Chapter 11, Section 4
[423] *Ibid.* Chapter 11, Section 5
[424] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment. 2021. "Report to the Swedish Government on the visit to Sweden carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment from 18 to 29 January 2021." Council of Europe.

[425] *Ibid.* Para 21
[426] *Ibid.* Para 21
[427] CESCR General Comment No.14
[428] Canning, Victoria. 2019. "Keeping up with the kladdkaka: Kindness and coercion in Swedish immigration detention centres." *European Journal of Criminology* (Sage) 17 (6): 723-743. Page 728

[429] *Ibid.* page 728

to immigration detention, and this is present even with the constant availability of internet to contact family, regular visits, and the encouraged socialisation with other detainees.[430] Social health is irrevocably damaged whilst in immigration detention, and attempts to remedy this will not be effective until the State eradicates its 'othering' of migrants through carceral structures for the purpose of removal.[431] Women are particularly impacted by this, especially women with children. There is no future predictability, and this uncertainty takes its toll. Psychologists have reported cases of trauma that developed as a direct result of immigration detention, even that of the 'benign' Swedish detention.[432]

Whilst CPT was relatively satisfied with the environment of Swedish immigration detention, concerns were raised regarding the provision of healthcare (or, more accurately, the lack of). Firstly, healthcare staff were not available on site. Instead, a nurse visited from a local centre at regularly scheduled times throughout the week.[433] This posed a risk if any medical emergencies occurred that required first aid when the nurse was not present. Any health concerns that required specialist treatment, such as a dentist or general practitioner, necessitated a written request for support from the detainee.[434] This request would then be passed to a medical professional by detention staff, after the detainee had explained the source of their ailment. The CPT expressed particular concern over this. Not only was there a delay in appropriate medical care, but also an infringement upon the detainees right to medical confidentiality and privacy.[435]

Similar concerns about privacy were raised in an existing study on the experience of Swedish immigration detention. There are circumstances within Swedish immigration detention centres that isolation may be imposed.[436] This is generally when the detainee poses a risk of harm to themselves or to others. If the harm is to themselves, they must be examined by a doctor as soon as possible.[437] Reports indicate that isolation rooms have constant camera surveillance, making it almost impossible to take care of personal hygiene without an infringement on privacy.[438] Furthermore, there is no time limit to such isolation, it is decided by a senior staff member within the detention centre, and there are no procedural

[430] *Ibid.* Page 728
[431] *Ibid.*
[432] *Ibid.* Page 728
[433] CPT, Report to the Swedish Government, para 23
[434] *Ibid.* Para 23
[435] *Ibid.* Para 23
[436] *Aliens Act 2005*, Chapter 11, Section 7
[437] *Ibid.* Chapter 11, Section 7 (2)
[438] Asylum Information Database. 2022. *Country Report: Sweden.* Page 101

safeguards for detainees to challenge this treatment.[439] Some detainees were held in isolation rooms for up to 3 weeks, despite CPT guidance recommending this is limited to several hours rather than days.[440] The harmful impact of isolation on mental health is well documented, and for someone who is already in a state of distress, this is undeniably cruel.

It is not clear how many women are subject to this treatment, but such practices are likely to leave detainees feeling degraded, and without agency. Considering Foucault's concept of the panopticon, this is a distressing embodiment of such analysis. Not only does it confer a sense of securitisation and constant monitoring, but it also creates a sense of criminality and danger. This replication of surveillance tactics found in the criminal justice system has carceral undertones, and described as 'a prison with extra flavours',[441] immigration detention practices are inherently harmful in this sense. The consequences of such treatment would arguably violate Sweden's self-imposed obligation to maintain respect for dignity and humane treatment at all times.

Another concern raised by the CPT is the lack of psychiatric and psychological care available to migrants held in immigration detention.[442] When requested, it would only be made available after considerable difficulty. Cases of emergency were the exception,[443] but allowing mental health deterioration to go so far infers a form of State neglect towards detainees. Considering the increased vulnerability to post-traumatic stress and exacerbation of such symptoms, refusing access to consistent therapeutic care is risking the deterioration of detainees' mental health, with potentially severe consequences.

In terms of gender-sensitive policies, of which there is little mention, a particular health concern is the permissibility of women being held in the same detention centres as men. Whilst there are some areas that men are not permitted to enter,[444] it remains that women who may have suffered gender-based violence or sexual trauma are held in close confinement with male detainees. The risk of re-traumatisation within immigration detention is one which States should take all reasonable steps to prevent.

3.5 Concluding Remarks on Domestic Practices of Immigration Detention: Recurring Themes and a Need for Change

[439] CPT, Report to the Swedish Government, Para 27
[440] *Ibid. Para 27*
[441] (Puthoopparambil, Ahlberg and Bjerneld 2015) Page 73
[442] CPT, Report to the Swedish Government, Para 24
[443] *Ibid.* Para 24
[444] Asylum Information Database. 2022. *Country Report: Sweden.*Page 97

The World Health Organisation determined that regardless of country context, health policy, or legislative framework, immigration detention resulted in health deterioration.[445] We can see this echoed above; the US, Australia and Sweden have all enacted different legislative frameworks for the immigration detention process, with varying degrees of provision for health within detention. Despite this, it is evidenced that mental health deteriorates, physical health worsens, and fundamental concepts of autonomy, dignity, privacy, and informed consent are dismissed.. The consequences for female migrants are severe when we factor in their unique health needs, existing vulnerabilities, and the lack of appropriate redress.

Another recurrent factor is the failure for many States to provide up to date and accurate statistics regarding the immigration detention complex within their country. For the Asia-Pacific region, this is a common occurrence. According to the International Detention Coalition (IDC), Australia is the only country to regularly release data on immigration detention.[446] When information is released, States are unlikely to disaggregate data by sex, age, or migration status,[447] preventing public scrutiny or an understanding of how many vulnerable detainees are held. The Global Detention Project contacted 33 countries across Europe and North America to inquire about detention practices. Over half did not disclose the locations of detention centres, 12 provided no data on total number of migrants held, and 17 failed to show how many asylum seekers were detained.[448]

Accountability needs to be increased on a global scale, but removing the need for provision of this data would be preferable. By phasing out and replacing methods of immigration detention, States would demonstrate a rights-based approach to immigration, in opposition to the current priority of state sovereignty and border securitisation. The benefits of such policies will be examined in the next chapter, as well as temporary provisos for improving immigration detention practices in light of female migrants' health.

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[445] (The World Health Organisation 2022) Page vi

[446] Immigration Detention Coalition. 2022. *Immigration Detention and Alternatives to Detention in the Asia-Pacific Region.* International Detention Coalition. Page 5

[447] *Ibid.* Page 6

[448] Global Detention Project and Access Info Europe. 2015. "The Uncounted: Detention of Migrants and Asylum Seekers in Europe." Special Report & Working Papers. Page 2

Chapter 4: Gender-Sensitive Alternatives to Immigration Detention

4.0 Introduction

Immigration detention is a site of deprivation; it takes time from migrants' lives, it separates them from family and friends, it causes health deterioration, and limits the opportunity to receive community-based holistic medical care. For female migrants, it is a painful reminder of the androcentric nature of healthcare, rife with patriarchal and paternalistic influences. The nexus of misogyny and racism lead to an experience of 'crimmigration'[449] that has lasting health consequences. Considering the principles of human rights law and frameworks, alongside ethical obligations in the medical sector, it is vital that immigration detention is eliminated. The path to doing so is complex and will require full State cooperation, as we will explore below, but for the sake of health, morals, and finances, it is essential.

4.1 A Paradigm Shift: What are 'Alternatives to Detention' and How Are They Beneficial from a Rights-Based Perspective?

Existing human rights discourse emphasises the need to consider alternatives to detention on an individual basis prior to detaining migrants. This should be done through vulnerability screenings, as well as an assessment of whether the chance of deportation is imminent.[450] However, in spite of this, the immigration detention complex is still a popular means of border control on the international stage.

There is no universal consensus on the definition of alternatives to detention (ATD), because of the variety of forms that it can take.[451] The UNHCR clarified that ATD must be governed by laws and regulations to ensure that there is no arbitrary deprivation of liberty, and that human rights standards are maintained.[452] As we have established, immigration detention is an embodiment of securitisation, criminalisation, and harm. Alternatives to detention must ensure that they do not replicate this practice in the interests of human rights discourse and obligations.

ATD can follow two different branches: enforcement, or engagement-based approaches.[453] Practices of enforcement would entail strict rule following and adherence to the legal immigration processes in the

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[449] (Abji and Larios. 2021)

[450] (The World Health Organisation 2022) Page 29

[451] *Ibid.* Page 42

[452] UN High Commission for Refugees. 2012. "Guidelines on the Applicable Criteria and Standards relating to the Detention of Asylum-Seekers and Alternatives to Detention." Guideline 4.3

[453] (The World Health Organisation 2022) Page 42

country in question. Engagement-based practices utilise a more holistic approach, prioritising engagement and support whilst still working towards a legal resolution of any visa processes. There may be a tendency for States to prefer an enforcement-based approach due to concerns of migrants absconding, or 'loosely defined' security risks.[454]

Practical examples of the forms that ATD can take include reporting regimes, NGO supervision, restricted movements, private accommodation, open and semi-open centres, directed residence, case management techniques, monetary bonds, or community placement.[455] This is not an exhaustive list, but gives a brief example of the variety of options a State may choose from. Restricted movements and reporting regimes are more representative of the enforcement approach to ATD, whereas community placement or case-management techniques are less restrictive and more focused on societal inclusion. The Global Compact for Safe, Orderly and Regular Migration advocates for countries to 'prioritise non-custodial alternatives to detention.'[456] The reasons for this are manifold when considered from a rights-based perspective.

Deprivation of liberty is an inevitable consequence of immigration detention, and the consequences of such manifest in physical and mental health deterioration. By enabling migrants to integrate into the community whilst they await their visa decisions, the health benefits would be undeniable. Continuity of care would be feasible, with increased agency in medical decision making, and contact with family and friends would be easily maintained. These are all components in improving a person's standard of health, and vital to a 'multi-modal therapeutic model.'[457] Engaging with ATD demonstrates willingness to apply all available resources towards the realisation of health, as per requirements under ICESCR. States that are not party to this convention should still aim to pursue a humane approach to migration control, so as to respect the inviolable nature of human dignity in human rights discourse. Moreover, by following the IDC recommendations to ensure that all basic needs are met, the underlying determinants of health as

[454] Global Compact for Migration. 2018. "Global Compact for Safe, Orderly and Regular Migration: 23 Objectives." *Intergovernmental Conference on the Global Compact for Migration.* United Nations. Objective 13 (a)

[455] (The World Health Organisation 2022) Page 43

[456] Global Compact for Migration. 2018. "Global Compact for Safe, Orderly and Regular Migration: 23 Objectives." *Intergovernmental Conference on the Global Compact for Migration.* United Nations. Objective 13 (a)

[457] (Royal College of Psychiatrists 2021) Page 3

determined by CESCR should be observed.[458] Housing, food, and sanitation are key components, and sufficient provision of such would be instrumental in improving migrant's health.

The impact of ATD on the realisation of female migrant's human rights would be a dramatic improvement and the realisation of the right to health would be a much more realistic prospect. Pregnant women are likely to receive more appropriate care, reducing chances of labour and maternity complications. Treatment for pre-detention trauma such as gender-based violence or sexual assault would be more effective and ethically permissible when in a community-based setting, and the uncertainty of detention would no longer be a significant source of mental health deterioration for migrant women.

Despite the numerous advantages to ATD, implementation is still relatively limited.[459] The IDC introduced the 'CAP Model', otherwise known as 'Community Assessment and Placement,' as a way to facilitate governmental implementation of ATD.[460] There are two main principles that guide this framework; the first dictates that the right to liberty is maintained.[461] The second principle is that a minimum standard must be applied across all decision making; this includes the respect for fundamental rights, observance of basic needs, provision of formal status and documentation, legal advice and interpretation, fair and timely case resolution, as well as a regular review of the placement decision.[462] Vulnerability is emphasised by the IDC as a fundamental motivation for alternatives to detention; they advocate for individualised assessments to be conducted in order to determine the most appropriate placement of alternative to detention.[463] Age, gender, sexual orientation, health, and protection needs are all identified as characteristics that may indicate vulnerability and should encourage State consideration of ATD.[464]

The CAP Model can be used by States to analyse existing laws, policies, and practices and determine the most efficient way to implement ATD, as well as identifying the biggest gaps in protection in order to prioritise remedying this.[465] Border security is one of the primary reasons for detention, the IDC emphasise that whilst security checks remain permissible and justifiable, States should conduct this

[458] CESCR General Comment No.14 Para 4
[459] (The World Health Organisation 2022) Page 46
[460] Sampson, R, V Chew, G Mitchell, and L Bowring. 2015. *There Are Alternatives: A Handbook for Preventing Unnecessary Immigration Detention (Revised).* Melbourne: International Detention Coalition. Page 16

[461] *Ibid.* Page 18
[462] *Ibid.* Page 27
[463] *Ibid.* Page 40
[464] *Ibid.* page 40
[465] *Ibid.* Page 17

within a reasonable time frame and ensure that those who are cooperating with such checks are not placed in prolonged detention unnecessarily.[466] The IDC also advocate for health to be a key consideration when practicing alternatives to detention.[467] States should understand that regular reporting requirements may be difficult for those with mental or physical health disabilities, and so any ATD procedures that practice such methods should be accessible, and considerate of unique requirements.[468] A gender-perspective should be included in this policy development. Pregnant women may require additional support in attending reporting check-ins or have to balance immigration processes with medical check-ups. States should be considerate and understanding of such factors. Women are more likely than men to be single parents, and so familial obligations should also be included in ATD policies. This minimises stress for migrants whilst allowing for States to operate their sovereign right to border security and control over the migration flow.

4.2 Real Life Implementation of Alternatives to Detention

Human Rights Watch conducted a systematic analysis of existing ATD practices, examining the benefits and drawbacks of such schemes in relation to human rights obligations.[469] This report included Bulgaria, Canada, the Republic of Cyprus, Spain, the United Kingdom, and the United States. There was a variety of approaches between the different States, with a contrast between holistic, rights-based methods, and those that continued to prioritise securitisation and surveillance.[470] The results of this study demonstrate that caution must be exercised to ensure that it is not another mechanism of harm for migrants.

The United States chose to implement a policy that is a chilling embodiment of the criminal justice system through ankle monitors, or Electric Monitoring Devices (EMDs). Migrants have described them to be embarrassing, disruptive, and painful.[471] The physical and psychological side effects are evidently detrimental, and the racialised aspect is undeniable. EMDs were disproportionately used on Black migrants, a perpetuation of the surveillance state rooted in racism,[472] as well as a violation of the universal human rights principle of non-discrimination. In terms of the health consequences, 12% of those being monitored experienced suicidal ideation, and 88% described experiencing mental health issues, with

[466] *Ibid.* Page 39
[467] *Ibid.* Page 41
[468] *Ibid.* Page 40
[469] (Human Rights Watch 2021)
[470] *Ibid.*
[471] *Ibid.*
[472] *Ibid.*

sleep consequences and migraines.[473] Physical consequences included cramps, numbness, discomfort due to heat from the battery, and swelling.[474] One in five participants reported electric shocks, and one migrant had to go to the hospital as a result.[475]

The intersection between gender and race for Black female migrants in the US can be a troubling one. The use of facial recognition as another form of ATD is an embodiment of such. SmartLINK is a phone application that is used to monitor migrants and ensure that they are complying with the terms of their immigration process. Regular check-ins are required at times dictated by the State, with concerning implications for the right to privacy. [476] In addition to the concern for over-surveillance, false negatives are common with this application, disproportionately affecting 'African born subjects',[477] and women,[478] thus resulting in migrants being questioned for non-compliance. Not only would this be detrimental for the legal resolution of the immigration process, but it perpetuates an environment of fear and panopticism that is detrimental to health and emblematic of immigration detention centres. The disproportionate impact on women of colour violates the principle of non-discrimination.

In contrast, the ATD programmes piloted in Bulgaria, Cyprus, and Poland saw more success from a rights-based perspective. Migrants were assigned a case worker who was often the first point of contact for any issues, legal or not.[479] Some even reported that caseworkers were the only source of support they received upon entering the country, providing emotional support and helping with housing concerns.[480] Families were reunited by caseworkers under this scheme, not only improving the environmental and mental health of migrants, but also the social health. The case-management program operates 'under the assumption that an individual's legal needs cannot be met unless their other needs are also addressed.'[481] This is comparable to Sen's Capability Approach[482] in which 'real freedom' is not fulfilled unless a

[473] Betancourt, Sarah. 2021. "'Traumatizing and abusive': Immigrants reveal personal toll of ankle monitors." *The Guardian.* July 12. Accessed July 11, 2023. https://www.theguardian.com/us-news/2021/jul/12/immigrants-report-physical-emotional-harms-electronic-ankle-monitors.

[474] *Ibid.*
[475] *Ibid.*
[476] (Human Rights Watch 2021)
[477] Grother, Patrick, Mei Ngan, and Kayee Hanaoka. 2019. *Facial Recognition Vendor Test.* National Institute of Standards and Technology: U.S. Department of Commerce. Page 54

[478] (Human Rights Watch 2021)
[479] *Ibid.*
[480] *Ibid.*
[481] *Ibid.*
[482] Alkire, Sabina, Mazaffar Qizilbash, and Flavio Comim. 2008. *The capability approach: concepts, measures and applications.* Cambridge University Press. Page 1

person's 'functioning's' are fulfilled, such as being adequately nourished, in good health, or being happy.[483] Immigration detention is evidently contradictory to the fulfilment of this, but engagement-based practices of ATD have the potential to do so.

After 2 years of the pilot study in all three countries, only 11.9% of participants had disengaged from the programme or absconded, whilst 25% reached a case resolution, 60% continued to cooperate with their case worker, and 2.4% were forcibly removed.[484] These statistics indicate a lack of necessity for detention, particularly with the purpose of deportation.

Another alternative to detention that has been reported to have great success and improve the wellbeing of migrants is voice reporting in Canada. A regular check in via telephone on a pre-arranged day increases autonomy and avoids the fear that in-person reporting instils.[485] Hassan, a 39-year-old from Afghanistan who engaged with this process, detailed the distress he experienced every time he had to report in person, afraid he would be detained. Once he began to report through telephone calls and voice recordings, he found that his anxiety and depression improved.[486] This is a direct correlation with the realisation of the right to health. When we consider that women are at an increased risk of mental health deterioration within immigration detention, the facilitation of voice-reporting whilst living in the community would be an undeniable improvement.

Immigration detention alternatives can be specifically tailored to vulnerable migrants. The Government of the Federal State of Berlin implemented a policy that required refugees and asylum seekers who are lesbian, gay, bisexual, transgender or intersex to be housed in special reception and accommodation centres that enable specific needs to be met.[487] This was different to policies of immigration detention, as it was a provision of accommodation that did not embody incarceration, respecting the fundamental health principles such as autonomy and privacy, enabling asylum seekers to maintain control over their lives whilst awaiting a legal resolution.

When considering the above examples of alternatives to detention, there are several factors that should be highlighted. Exemption from detention does not automatically eliminate the harm that States can impose upon a third-country national. The World Health Organisation argued that measures such as

[483] *Ibid.*. Page 1

[484] (Human Rights Watch 2021)
[485] *Ibid.*
[486] *Ibid.*
[487] (The World Health Organisation 2022) Page 46

electric monitoring or continuous surveillance should instead be recognised as 'alternative forms of detention,' rather than alternatives *to* detention.[488] The implicit restriction of liberty, whilst not as overt as being locked within a prison-like building, still has a damaging impact on the realisation of health. Surveillance focused schemes inherently oppose mental wellbeing through a sense of control and lack of agency, embodying characteristics that are representative of the immigration detention complex.

Community-based, holistic ATD schemes, however, are a valid way to eliminate the harm of immigration detention particularly with regards to health, maintain border control measures, and create a culture of integration and support. This is essential when we consider Goldberg's theory of 'law as a social determinant of health'.[489] Legislature and policies advocating for community acceptance will inevitably improve migrant health, which is prosperous from a non-discrimination perspective, and is fiscally responsible. For instance, family detention in the US costs an estimated $319 per family, per day. [490] Whereas a Family Case Management Program, involving ICE check-ins and court appearances, was only $38 per day.[491] This is a significant economic improvement, indicating that immigration detention is not only irresponsible from a rights-based perspective, but also from a financial perspective. The WHO reaffirms this, stating that immigration detention is not cost-effective in the short or long term, and therefore elimination of such a practice would be financially responsible.[492]

We must maintain a future-looking objective and remain dedicated to the elimination of immigration detention as means of border control and deterrence. However, it would be optimistic, and unrealistic, to presume that this change will happen in the near future. As such, recommendations for a humane approach to immigration detention must be explored.

4.3 Recommendations for Addressing Women's Health Experiences in Immigration Detention: Harm Reduction

The paradoxical nature of advocating for human rights whilst also maintaining a system of oppression is one that can only be addressed by eradicating the current system and implementing detention alternatives. The Global Detention Project aligns recommendations for improving immigration detention with a

[488] *Ibid.* Page 47 (own emphasis)
[489] (S.Goldberg 2013)
[490] (Human Rights Watch 2021, Dismantling Detention)
[491] *Ibid.*
[492] (The World Health Organisation 2022) Page 48

system of harm reduction, rather than 'good practice', as there cannot be a 'good' way to deprive migrants of their liberty via border control securitisation.[493]

The previous chapters have explored the barriers to health in immigration detention, including lack of respect for human dignity, environmental harm, re-traumatisation for survivors of gender-based violence and human trafficking, a lack of gender-sensitivity, and conflicting duties for healthcare professionals. In order to successfully abide by the obligation to realise the right to health, and to do so with the fundamental principle of non-discrimination guided by the aim of substantive equality, then States should consider the below recommendations in order to address failings in health infrastructures.

4.3.1 Improved Mental Health Care and Psychosocial Support

In order to minimise the detriment of immigration detention on women's mental health, psychosocial support and gender-sensitive care should be integrated throughout immigration detention.[494] As the Royal College of Psychiatrists state, mental health care should be holistic and continuous.[495] This means that it cannot be reliant solely on pharmaceutical support and must utilise additional support methods, such as developing therapeutic relationships,[496] as well as a basic context of physical and emotional safety.[497] It is unlikely that it would be entirely possible to achieve this in immigration detention, due to the nature of the practice, but ensuring that detainees have access to regular and empathetic mental health support, and contact with friends and family is essential.[498]

Communication with the outside world would involve family visitation, phone calls that are accessible and sufficient, the availability of computers or internet access in which to maintain contact with family or friends.[499] This is essential in enabling female migrants to maintain relationships that provide emotional support, as well minimising the feeling of separation and punishment that immigration detention infers.

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[493] Global Detention Project. 2019. *Good Practices and Initiatives of Gender-Responsive Migration Legislation, Policies, and Practices.* Submission to the Special Rapporteur on the Human Rights of Migrants, Geneva: Global Detention Project. Page 3

[494] (The World Health Organisation 2022) Page 52
[495] (Royal College of Psychiatrists 2021) Page 7
[496] *Ibid.* Page 7
[497] *Ibid.* Page 8
[498] (The World Health Organisation 2022) Page 54
[499] *Ibid.* Page 55

To achieve a higher equivalence of care, the British Medical Association require that immigration detention policy frameworks recognise that there will be cases where it is no longer possible to adequate support a detainee's mental health within detention.[500] To adapt to this, regular reviews should be employed, and once treatment is no longer as effective as it would be in the community, then they should be considered for release.[501]

4.3.2 Enhancing Dignity in Immigration Detention: Addressing and Promoting Agency from a Gendered Perspective

Numerous factors contribute to the erosion of human dignity in immigration detention. The lack of privacy, autonomy, and respect are of particular relevance, and the failure to establish informed consent in all areas of medical care. Not only does this intensify the degrading impact of immigration detention, but it also embodies an exertion of State control over women's bodies that is inherently depersonalising and harmful.

In the interests of tackling such challenges, States must ensure that legal literacy is promoted in the realm of health rights. Vissandjée et al state that everyone with a community must be equipped to access, understand and critically participate in their own healthcare.[502] Women in immigration detention should therefore be empowered to advocate for their own health and make informed decisions without any form of coercion. This is essential to an ethical, rights-based healthcare policy for immigration detention.

The liminality of immigration detention removes any sense of control and agency a person may have over their life, particularly in circumstances on indefinite detention. Strict time limits must be implemented that are reasonable, necessary and proportionate to the aims of detention.[503] If the prospect of deportation is not imminent, then the individual should be released back into the community. As we have seen, the risk of absconding is lower when the appropriate support is provided. States must consider this and ensure that migrants have access to legal representation and community care.

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[500] (British Medical Association 2017) Page 60
[501] *Ibid.* Page 60
[502] Vissandjée, Bilkis, Wendy E. Short, and Karine Bates. 2017. "Health and legal literacy for migrants: twinned strands woven in the cloth of social justice and the human right to health care." *BMC International Health and Human Rights* 17 (10). Page 1

[503] UN Human Rights Committee (HRC), *General comment no. 35, Article 9 (Liberty and security of person)*, 16 December 2014, CCPR/C/GC/35 Para 18

Reproductive justice is an essential facet of autonomous health care. It is also intrinsically linked with reproductive and sexual health. Female detainees must be centred in this approach, with access to sexual health screenings, abortion care, if necessary, maternal support, and health related education. The realisation of this in immigration detention necessitates continuity of care and an explicit understanding of the unique vulnerabilities to trauma that women face. If we refer back to the Convention on the Rights of the Child, and the right to psychological care for sexual violence and torture, [504] the duties conveyed would be essential to the realisation of migrant women's health. Despite this Convention focusing on children's rights, the benefits of such as provision are undoubtable and must be adopted to apply to female migrants and asylum seekers.

4.3.3 Underlying Determinants of Health as a Guiding Influence: Phenomenological experiences and Physical health

The environment of detention is a key factor in health degradation. Detention officials are in a position of precarity that enables them to either exert power and control, reinforcing an environment of hostility, or they could demonstrate compassion and care. Reports of conduct that is abusive and rooted in misogyny are frequent within immigration detention centres, as we explored above. Officials who perpetuate such a culture are a dangerous sub-group within the detention complex and must be discouraged. As such, guards and detention officials should be hired on the basis of their 'integrity, humanity, professional capacity' and personal aptitude for working in detention.[505] There should be accountability mechanisms within immigration detention centres, such as whistleblowing lines that permit anonymous disclosure of abuse, or regular review from an independent body, such as the Committee for the Prevention or Torture, or a governmentally appointed one within domestic frameworks. Additionally, gender and culturally sensitive training programmes must be regularly available and mandatory. This recognises the intersectionality of female migrant experiences within immigration detention, and the multifaceted approach needed to sufficiently safeguard against health deterioration.

The physicality of immigration detention must be centred in any policy recommendations. Eliminating prisons as holding centres is essential, as well as removing any architectural features that intonate the

[504] *Ibid. (CRC)*, Article 39
[505] *Ibid.* Page 55

criminality of migrants. Whilst it does not completely remove the carceral nature of immigration detention, it may prevent the constant feeling of social exclusion that is typically pervasive.

Adjusting food discourse in immigration detention is essential; States should step away from the current system of regimented food times and dictated meals, to encompass a more inclusive approach. As Carney explores, the experience of eating is not only essential to survival and physical health, but also a therapeutic process for many.[506] The ability to share food with other detainees, cook meals, and exert autonomy over mealtimes would be revolutionary in the improvement of detainees' health. Understandably, there would be practical and financial implications with the realisation of this policy, but it is a consequence that States must accept if they wish to maintain systems of immigration detention whilst complying with their legal and moral obligations towards others.

4.4 The Conflict of Promoting a Rights-Based Approach to Immigration Detention

As explained by the Global Detention Project, adapting a future-looking approach to immigration detention is solely out of necessity. It is a means to ensure that the rights of current detainees are not subject to human rights violations but is not an endorsement of the practice. The risks of improving immigration detention conditions should not be a means to promote longevity, but a rights-based temporary resolution to a practice that should be eliminated.

Morris refers to the concept of 'ethical capitalism' and construes it to mean 'softer' forms of accumulation, or in this context, expansion of immigration detention, which inevitably still result in human rights violations.[507] The detention rights movement, whilst necessary, could also be implicated in the permitted expansion of the immigration detention regime.[508] 'Normative covers' gives the impression that if certain recommendations are followed, then immigration detention is permissible.[509] Some human rights charitable organisations even earn a profit through delivery of 'humane' detention practices. The Italian Red Cross operates 'identification and expulsion' centres to process migrants, receiving €45 per day for each person detained.[510] Similarly, the Red Cross in Australia received $113 million to offer

[506] (Carney 2013)
[507] Morris, Julia. 2016. "In the market of morality: International human rights standards and the immigration detention 'improvement' complex." In *Intimate Economies of Immigration Detention: Critical Perspectives*, by Deirdre Conlon and Nancy Hiemstra. Routledge. Page 51

[508] *Ibid.* Page 51
[509] *Ibid.* Page 51
[510] (Flynn 2017) Page 185

welfare services in immigration detention.[511] This implies that 'ethical' structures only help to rationalise the economic benefits of perpetual detention.[512]

The paradoxical nature of advocating for human rights whilst also maintaining a system of oppression is one that can only be addressed by eradicating the current system and implementing detention alternatives. The Global Detention Project aligns this with a system of harm reduction, rather than 'good practice', as there cannot be a 'good' way to deprive migrants of their liberty via border control securitisation.[513]

Vulnerability is a central theme within this thesis, and throughout guidelines of immigration detention standards, as we have explored. However, the eradication of immigration detention should not solely be to protect the vulnerable. As Morris aptly points out, focusing on the most vulnerable implies that there are 'right' and 'wrong' people to detain.[514] Separating economic migrants from asylum seekers on the basis of vulnerability only serves to promote the idea of immigration detention as proportionate.[515] Instead, we should recognise the inherent harm of detention and the rights of all to persons to health, and dignity. Consequently, the right to health and inability to deliver equitable care should be rationalised as a strong motivation for the complete elimination of immigration detention practices.

[511] *Ibid.* Page 185
[512] (Morris 2016) Page 54
[513] Global Detention Project. 2019. *Good Practices and Initiatives of Gender-Responsive Migration Legislation, Policies, and Practices.* Submission to the Special Rapporteur on the Human Rights of Migrants, Geneva: Global Detention Project. Page 3

[514] *Ibid.* Page 55
[515] *Ibid.* Page 55

5.0 Conclusion

Traversing borders is not a new phenomenon, and yet it remains a source of particular controversy and conflict. Growing anti-migrant sentiment and fearmongering has resulted in an increased legitimation of restrictive border control measures, with little consideration for the human consequences. The complex balance between state sovereignty and individual rights and liberties is fraught with much difficulty. Immigration detention is an embodiment of such discourse, where security and sovereignty must compete with liberty and health.

Thus raising the questions that were the focus of this thesis: 'what are the key barriers and challenges faced by women in immigration detention regarding their right to health?' and 'to what extent is the nature of immigration detention inherently incompatible with the equitable realisation of migrant women's right to health?.' A gender-sensitive, rights-based approach was essential for this topic due to the gap in extant research and literature regarding women's experiences of immigration detention.

To provide a foundation for understanding 'health' as a concept, we explored legal and normative frameworks, adopting a definition of the health as the 'highest attainable standard', not as a right to be *healthy*. Moving away from a purely biological understanding of health, we considered social, environmental, physical, and mental health. The interdependent nature of these concepts of health are evident throughout the thesis, illustrating the multifaceted approach required to help a person realise the highest attainable standard of health. In order to understand the methods in which this could be practically realised, CESCR authoritative guidance was used. Application of the AAAQ framework, as well as consideration of underlying determinants of health ultimately led to the conclusion that immigration detention is fundamentally flawed and unable to comply with such expectations, regardless of the country context.

Examined through the lens of human rights concepts such as vulnerability, dignity, autonomy, and informed consent, research indicated that the barriers to women's health in immigration detention were manifold. Prior traumatic experiences such as gender-based violence predisposed individuals to mental health difficulties whilst detained, this was then exacerbated by insufficient and inconsistent psychiatric care. Moreover, it was deemed impossible to adopt the necessary therapeutic techniques required to appropriate support migrant women. A physically and emotionally hostile environment led to feelings of subjugation and de-personalisation; the hyper-surveillance and control that is a fundamental aspect of immigration detention embodied the concept of the panopticon, drawing in ideas of biopolitics and

racialised systemic violence. Gender-specific needs such as reproductive justice and menstrual care were often dismissed and stigmatised.

Furthermore the androcentric nature of immigration detention and human rights advocacy compounded this harm. Created to imprison male migrants, this system inflicts disproportionate harm upon the small number of female detainees. Whilst it is acknowledged in extant research, reports, and scholarship that harm is ubiquitous to immigration detention, failure to adapt an intersectional analysis compounds the patriarchal nature of society and the dismissal of women's health needs.

State specific exemplification of immigration detention harm can be seen through the use of Australia, the US, and Sweden as case studies. All provide a unique insight into the different structures that immigration detention may take. Despite provisions for women's health care needs in US frameworks, suggestions of extreme human rights violations such as rape and sexual violence within the walls of detention were present. There was a recurrent theme of indignity and stigma surrounding women's care needs, including personal hygiene and access to medical products. The US is particularly interesting in this regard due to its noncommittal to ICESCR and CEDAW, yet it does not show too much disparity with practices of immigration detention in Australia. Famed for its harsh offshore regime, Australia has made recent changes to such practices, but maintains that indefinite immigration detention is necessary. Gender-sensitivity is notably lacking within this environment, and vulnerability is dismissed without any concern for health repercussions. Sweden is a State that is deemed to be relatively harmless in terms of its immigration detention regime: time limits are imposed, human dignity is an essential component of the legal framework, and detention staff must promote a good relationship with migrants. However, there remain reports of privacy infringements, and men are held in the same detention centres as women, exposing women to further abuse, or reminders of previous gender-based violence.

Considering once again the statement made by António Guterres, '[d]o we want migration to be a source of prosperity and international solidarity, or a byword for inhumanity and social friction?' [516] it seems that States have chosen the latter. The disproportionate, unnecessary, and unreasonable detention of migrants embodies hostility and is fundamentally flawed in any attempt to ensure that female migrants have access to the highest attainable standard of health. However, it is possible to change this. As discussed within the last chapter, alternatives to detention are a real possibility and have been successfully

[516] Guterres, António. 2018. "Towards a new global compact migration." *United Nations: Secretary General.* January 11. Accessed July 11, 2023. https://www.un.org/sg/en/content/sg/articles/2018-01-11/towards-new-global-compact-migration.

implemented in several pilot studies. Caution must be exercised to ensure that they do not become an alternative form of detention and harm.

Ultimately, immigration detention is an unnecessary and antiquated form of subjugation. Furthering the marginalisation of women, particularly women of colour, and punishing administrative visa errors or irregular migration with deprivation of liberty, and consequently health. This thesis argues that the only way forward is by leaving this practice behind, prioritising women's health over unnecessarily restrictive surveillance and criminalisation of migrants.

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