SAFE PASSAGE:
A Texas Borderlands Immigrant Maternal and Child Rapid Health Assessment.

Central American immigrants detained for possible separation in McAllen, Texas, on June 12 by John Moore—Getty Images
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Letter from CEO/Founder

We are in the midst of a refugee crisis on many levels here at home in Texas, in the US, and around the world. This crisis is both policy-related and humanitarian in nature. The latter is Circle of Health International’s (COHI) area of expertise, and it is the area we are focusing on in our response activities ranging 800 miles of borderlands from El Paso to McAllen, Texas. Mothers, fathers, and children have been separated for at least the last four years, when COHI’s involvement in the Texas crisis first began. In the last four years, COHI has provided direct clinical care to thousands through the provision of professional clinical volunteers (midwives, nurses, OB/GYNs, and pediatricians) who’ve staffed a clinic housed in a Catholic Charities (CC) respite center in McAllen. At last count, 57,000 immigrants passed through Texas in 2017. These were the ones who were counted; we imagine there were many thousands more who were not. That number, while aggregate, is made of up mothers and fathers who made a decision most of us cannot imagine: to leave their homes and families behind and walk to a country where things might be better. They walked thousands of miles, facing dangers of the stuff nightmares are made of, enduring trauma, violence, hunger, and thirst. They arrived at the US border knowing that detention might await them, but still choosing this over the daily reality they fled. When COHI encounters them, they have been released from Border Patrol custody. Too often, the mothers are broken. They are exhausted, scared, and often sick with something they’ve contracted along the way—a cold, a flu, or worse.

The goal of this assessment it to tell the story of these mothers, fathers, and children through the lens of the social services and health care that await them here, and the impact that we can make when we organize our collective skills, talents, and treasure to contribute to the recovery and support of the newest immigrants to the United States of America.

In gratitude,

Sera Bonds  
Founder/CEO of COHI
Special thanks to:

The women, men, and children who have trusted COHI and our partners over the years to care for you. This is your story, thank you for allowing us to tell it.

This report was authored by Sera Bonds, Jennifer Camacho, and Heather Busby.
Circle of Health International (COHI) is a US-based non-governmental organization (NGO) providing reproductive, maternal, and newborn health care in crisis settings around the world. Founded in 2004 with the mission to increase the capacity of women's health care providers in crisis and disaster settings, COHI provides disaster relief, supplies, professional training, and sustainable livelihoods for vulnerable women. COHI has worked in Asia, Africa, Europe, the Middle East, and the United States and specializes in responding to the unmet health needs unique to women in natural disaster and conflict zones. We align with local, women-led organizations who are best suited to know and advise on the needs of the women and children that they serve, supporting them through the provision of professional volunteers in capacity- training efforts related to healthcare for women and children. COHI services have reached over 3 million women and children around the world, in 22 separate humanitarian crisis responses.

COHI currently offers critical support to an immigrant clinic in McAllen, Texas with COHI clinicians and volunteers. COHI began our work keeping families together along the Texas/Mexico border four years ago this month, July 4th weekend of 2014. Since then, we've cared for tens of thousands of mothers, kids, and babies through the provision of clinical volunteers who've staffed the Catholic Charities clinic in McAllen.
Executive Summary

Over the last four years, we've provided training to hundreds of social service and health care providers in the Rio Grande Valley region of Texas to identify those who've been trafficked, in addition to food and medicine to those being cared for at the McAllen clinic. We've provided food, medicine, and clinical care to the tens of thousands of individuals being released from border patrol in McAllen in the last four years. We are currently working with Texas-based legal aid agencies to provide forensic psychologists to support asylum request evaluations and providing clinical volunteers to care for this population in respite centers spanning 800 miles of Texas border from El Paso and McAllen.
**Demonstrated Need**

Border areas in the US are experiencing an unprecedented surge of immigrants from El Salvador, Guatemala, Honduras, and Mexico, many of them young, often adolescent, mothers with children and unaccompanied minors. New studies estimate that 90,000 unaccompanied minors will cross into the US this year. In addition, tens of thousands of young women - many under 18 and some pregnant or with babies and young children - will attempt the crossing. A recent report released by the UNHCR suggests that at least 58% of these migrants are, in fact, refugees from violence who require international protection.

Over the last four years since COHI began our work at the Texas border, we’ve heard two primary reasons that parents have risked bringing their young children to the US, often taking months to reach the border as they are trafficked and travel in unsafe conditions: women are often fleeing domestic violence, and both women and men are living in daily fear of the escalating gang violence in their home countries.

According to Human Rights First, “A rise in murders, rape, violence against women, kidnappings, extortion, and other brutality is prompting many people to flee their homes, often in fear of gangs and drug cartels.” –

Unfortunately, these women and children are the targets of violence and are extremely vulnerable to exploitation and trafficking—not only in their home countries, but also as they travel seeking refuge in the US.

The journey north is a long and difficult one for these young women and children. They traverse between 1,500 and 2,000 miles through scorching desert terrain with little, if any, food, water, infant formula, or medical care. Violence of all kinds and from various sources - gangs, drug cartels, political militants, coyotes, and human traffickers - awaits them at every
turn. Yet they prefer even these risks to the dangers they face in their respective home countries. According to the recent UNHCR report, “Children on the Run,” 41% of the children interviewed feared or had experienced violence due to organized crime, including gangs and drug cartels, and 58% said their reason for leaving home was violence. 1 Writes author Sonia Nazario, “Girls face particular dangers—one reason [that] around 40% of children who arrived in the United States this year were girls, compared with 27% in the past.” Nazario describes meeting a 19-year old girl named Milagro in Honduras. Narcos have repeatedly threatened to kill Milagro if she refuses their advances. Says Milagro, “Here there is only evil. It’s better to leave than have them kill me here.” 2

US law mandates that, after their journey through Central America and Mexico, these refugees be housed at one of the 961 immigrant detention facilities located throughout the country.

Map retrieved from The Economist report “Under-age and on the move” 2014.

1 http://unhcrwashington.org/children
Though there is a heavy concentration of centers in South Texas, current capacity is not nearly enough to handle the recent influx. As a result, many children are transported hundreds more miles on buses almost immediately upon arrival at US Border Patrol. This practice further endangers the refugees, complicates the protection of the minors under international and US law, and separates families. It also poses a significant public health risk. COHI observed no public health screening for infection and contagious diseases upon arrival within the centers serving the refugees in McAllen, Texas.

There is one policy in particular, pushed by the current administration that triggered myriad traumatic experiences and legal aid demand. On May 7th, 2018, Attorney General Jeff Sessions declared that the US will take a stricter stance on illegal crossings at the Mexico border by separating parents from children, rather than keeping them together in detention centers. The new policy aimed to have a 100% prosecution rate for those who illegally cross the southwest border, having charged adults sent directly to federal court and children sent to the Department of Health and Human Services’ Office of Refugee Resettlement. This policy threatens immigrants with prosecution if they make false statements to immigration officers or file a “fraudulent” asylum claim.

On June 20th, President Trump announced he would sign an Executive Order (EO) ending family separation. On June 26th, the Department of Health and Human services declared that 2,057 children had been separated from their parents. Trump’s executive order aims to keep entire families in ICE detention centers; at the writing of this report, thousands are still waiting to be released by the deadline.

To provide some context for the daily reality that these individual are fleeing, it’s important to note that after US interference in the 1980s and 90s led to a heavy migration from Central America, a large number of men ended up in Los Angeles. A brutal gang emerged, called MS-13. The US then deported these gang members back to Central America, creating hostile conditions in countries like Honduras and El Salvador. Hundreds, if not thousands, of women and children have been subsequently forced to flee the region due to violence including sexual assault and murder. As the country that created the very conditions they’re fleeing from, the US has a moral imperative to provide for mothers now foundering at our borders.

Violence against women, a result of gender inequality and unequal power relations between men and women, is a pervasive phenomenon in every community in the world. According to sector experts Nadine Gasman and Gabriela Alvarez, this remains one of the top human rights issues in the Americas today.
Although little research exists, available data suggest the situation is bleak across the region. The Economic Commission for Latin America and the Caribbean (ECLAC) estimates that up to 40% of women in the region have been victims of violence at some point during their lives. And, according to figures from the 2004 Demographic and Health Surveys Project, 44% of women in Colombia have suffered from spousal violence. In Peru, physical violence affects 47% of women.

Femicide—the killing of women—has reached alarming levels in Latin America. The most recent region-wide statistics available, from 2003, show that seven Latin American countries score among the worst 10 nations when measuring the rate of femicide per one million women in 40 countries. In 2003, Guatemala had the world’s highest rate with 123 femicides per one million women. Colombia (70), El Salvador (66), Bolivia (43), Dominican Republic (37), Mexico (24), and the United States (22) followed. Two more recent figures from Guatemala showed that in 2006 two women, on average, were murdered each day.3

Central American refugees in Mission, Texas. (Photo by John Moore/Getty Images)

3 http://www.americasquarterly.org/node/1930
In 2014 COHI collaborated with the clinic for torture survivors at Bellevue Hospital in NYC on a study to examine pre-migration trauma exposure and current mental health functioning of migrant families arriving at the US border from Latin America. The findings suggest that the majority of Central American migrants arriving at the US border have significant mental health symptoms in response to violence and persecution, and warrant careful consideration for asylum status. 4

Once they’ve arrived in the US, the average stay for unaccompanied minors in detention in Texas is 6-8 weeks, as they are processed for safe placement in the US, and 95% of them have somewhere they are going, either to a family member or host family. Federal government data obtained by TRAC indicates that 70% of people in immigration detention are held for one month or less; in fact, many people were released the same day they were detained, indicating that ICE did not need to obtain court approval to deport these individuals.

Federal government data obtained by the ILRC indicates that, on average, immigrant prisons and jails are holding people for longer periods of time under the Trump administration than under the Obama administration. In 2017, the average length of stay at any one immigrant prison or jail was 34 days, compared to 22 days in 2016 and 21 days in 2015. 5

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Graph retrieved from Freedom for Immigrants Detention Statistics

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5 https://www.freedomforimmigrants.org/detention-statistics
Lastly, and perhaps most significantly, a Human Rights Watch study by independent medical experts of ICE’s own investigations into deaths in their custody - and in a range of other cases that did not involve deaths - clearly determined that the quality of healthcare access to those in detention is not in keeping with international human rights law.  

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<tr>
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<th>Honduras</th>
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<th>El Salvador</th>
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<td><strong>Maternal Mortality</strong>(^7)</td>
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<td>(per 100,000 live births)</td>
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<td>(# of births per 1000 girls aged 15-19)</td>
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<td><strong>Infant Mortality</strong>(^7)</td>
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<td>(death within 28 days of birth; per 1000 live births)</td>
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<td>49</td>
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<td><strong>Stillbirth Rate</strong>(^10)</td>
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<td>(per 1000 total births)</td>
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<tr>
<td>(per 1000 live births)(^10)</td>
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<td><strong>Gender-based Violence</strong>(^6)</td>
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<td>(homicides per 100,000 people)</td>
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<td>(# of victims, 2007)</td>
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<td>43%</td>
<td>62%</td>
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<tr>
<td><strong>Human Trafficking</strong>(^12)</td>
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<td>(# of victims, 2007)</td>
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<td>59</td>
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</tbody>
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8 http://www.indexmundi.com/honduras/total_fertility_rate.html

9 http://data.worldbank.org/indicator/SP.ADO.TFR


Assessment Methodology

In each of COHI’s past initiatives, we have worked with other organizations to identify the immediate needs of the women affected by the conflict or disaster to offer evidence-based recommendations to address both the short- and long-term needs of the women living in these areas. COHI staff and volunteers consist of midwives, public health experts, physicians, epidemiologists, and other health professionals who specialize in addressing the unique needs of women in crisis settings. All of these participated in this assessment as well as the analysis of its findings.

Interview and stakeholder guides are in Appendix A

Key stakeholder interviews were conducted with the following individuals:

Taylor Levy  
Kathy Revtyak  
Samantha Romero  
Anna White  
Elizabeth Pacillas and Chantell Quiroz

Legal Coordinator, Annunciation House  
Trauma Informed Care Manager at Capacitar  
West Fund & Sen. Rodriguez’s office  	CNM in El Paso  
Doulas in El Paso

Site visits were conducted at:

Annunciation House  
Sacred Heart Respite Center

El Paso, Texas  
McAllen, Texas

Assessment Findings

- Medical staff willing to volunteer in their free time are over-saturated. Too many people already volunteer for multiple organizations to help the community.

- Maternal health care is often incomplete as the clinics in place have long wait times and additional medical equipment is needed. The prenatal and postnatal care available is not optimal; it varies from clinic to clinic. Patients aren’t seen as regularly as they should be. Sonograms are not timely. Some women are deported within 36 weeks, so no follow-up care is provided.

- There are gaps in health care and social service agency coordination within the border-wide response community
• The number of immigrants being released into the care of social service agencies along the border has been consistent over the last four years, with variations that seem to align seasonally.

• The rate of trauma in the population being served is higher than 80%, requiring a level of trauma-informed care that is not currently provided by the well-intended volunteer community.

• There is a lack of funding for emergent, emergency needs within the population such as emergency hospital stays and medicines requiring a prescription (over-the-counter/OTC drugs are being donated in adequate supply).

• The leadership within the agencies responding to this crisis is not representative of the population being served, often leaving out their feedback and participation.

• Follow-up and referral care is not offered.

• Legal aid is provided inconsistently.
Assessment Recommendations

Clinical Needs

Within detention, under the US Constitution and international law, anyone who is detained or incarcerated is entitled to adequate medical care. The Trump administration is obligated to ensure that all people in detention are treated humanely and with dignity, including through the provision of appropriate medical care, and to provide sufficient funding to meet these obligations. Congress and state governments should work to limit the scope of detention to what is truly necessary and ensure that those who are detained are treated humanely. Pediatric, especially adolescent reproductive health, and psychosocial counseling and basic primary health care, is a priority.

There is a need for:

- Dental care: many of the patients complained of infections and oral pain.
- Skin care: dermatitis, abrasions, fungal infections, bites, and other topical problems are common.
- Care for respiratory infections, which were observed in the majority of pediatric patients.
- Treatment for malnutrition and dehydration, which are very common.
- OB/GYN care, due to the fact that some of the young women are pregnant, have recently given birth, or have been sexually active.
- Sexual and reproductive health screening by a clinician trained in the needs of survivors of sexual violence and human trafficking.
- Funding to cover medicines needed to address the above-mentioned conditions.
**Trauma and Psychological Services**

Many of the patients seen by COHI’s team and partners reported having witnessed violence, either in their home countries or during their journey. Some estimates are as much as 30% of the women arriving at Border Patrol have been raped, either in their home countries or en route. COHI recommends:

- Support staff receive training on caring for survivors of rape, sexual assault, violence, and torture

- Trauma-informed care be required by all volunteers involved in this crisis

**Coordination**

While the generous people and faith communities along the borderlands have opened their hearts and checkbooks to care for the refugees, the coordination response requires a higher level of professionalization and logistical preparedness. COHI recommends:

- A training module be developed for local lay volunteers that covers the specific health and psychosocial needs of the refugees (malnutrition, sexual assault and trafficking, for example)

- A training module for volunteers be developed specifically on the risks of human trafficking that refugees face upon arrival in the US.

- Funding be secured for local, permanent clinics for this population to promote continuity of care.

- Mobile units be deployed to meet the immigrants immediately upon their release from border patrol.

- A local professional staff with experience of the unique needs of this refugee population be secured to lead local coordination efforts.
• A screening process for infectious and communicable diseases be implemented at the receiving centers, and results shared with state and federal agencies.

• Follow-up systems be created and monitored so that when the refugees reach a final resting spot (a detention center or a family member) medical and social service information can be received and coordinated by the responders

**COHI’s Strategy for Response**

COHI’s leadership believes that, based on the limited financial and professional resources in the communities responding and on the enormity of the crisis, a long-term strategy is needed.

COHI is raising funds immediately to scale our leadership role in coordinating and providing clinical care in the refugee response community spanning 800 miles of borderlands:

1. COHI will continue to recruit, organize, and support volunteer clinicians specializing in pediatric, adolescent, and reproductive health to supplement care available at the clinics hosted by organizations active along the border including Catholic Charities.

2. COHI will facilitate relationships with local, state, and national suppliers of nutritional supplements and supplies to coordinate delivery and distribution to border based coordination sites.

3. COHI will join coordination groups in El Paso and McAllen to lend its experience and technical expertise to ensure the inclusion of reproductive health and sexual violence screening, counseling, and training for support staff.

4. COHI will provide technical training for staff on the needs of survivors of human trafficking and offer community-based training for volunteers to increase knowledge of trafficking risks facing vulnerable populations.
HE WAS FOUR YEARS OLD, AND HE WAS SCARED OF ME. HE WAS HOLDING ON TIGHTLY TO HIS TIRED, ALSO SICK MOTHER AS SHE SAT IN HER LAP, AND SHE ASKED ME TO HELP HIM. THEY’D BEEN TRAVELING FOR 22 DAYS FROM HONDURAS AND STILL HAD A LONG BUS TRIP AHEAD OF THEM BEFORE THEY ARRIVED AT THEIR FINAL DESTINATION IN VIRGINIA. I SLOWED MY BREATH, SLOWED MY MOVEMENTS, AND SLOWED MY WORDS. I MADE SURE THAT I WAS NOT MAKING SUDDEN MOVEMENTS, AND THAT MY VOICE WAS TENDER AND KIND. I TOLD HIM I WAS THERE TO HELP, THAT I WOULD NOT HURT HIM, AND THAT HE COULD TELL ME WHEN HE WAS READY FOR ME TO TAKE HIS TEMPERATURE. I SAT STILL, SMILING, CALM, AND PATIENT, WAITING FOR THIS FRIGHTENED SMALL BOY TO TRUST ME ENOUGH TO PUT A THERMOMETER UNDER HIS ARM. HE SLOWED HIS BREATHING, HE STOPPED CRYING. HE LOOKED MY IN THE EYES, AND SLOWLY, TENTATIVELY, LIFTED HIS ARM. AND TOGETHER, WE CONTINUED OUR DANCE OF DOCTOR AND PATIENT, MOVING AT A PACE HE DETERMINED.

I WAS TRAINED TO BE A PEDIATRICIAN WHO WORKS IN GLOBAL HEALTH, WITH THE WORLD’S MOST MARGINALIZED AND VULNERABLE KIDS. I WENT TO MEDICAL SCHOOL SURROUNDED BY TEACHERS WHO’D WORKED IN HUMANITARIAN CRISIS SETTINGS AROUND THE WORLD: SUDAN, AFGHANISTAN, AMIDST CHOLERA AND TSUNAMIS. I’VE WORKED IN SRI LANKA, VIETNAM, TIBET, AND ETHIOPIA. WHAT I SAW, AS A CLINICIAN AND PUBLIC HEALTH PROFESSIONAL, IN THE RIO GRANDE VALLEY ALONG THE TEXAS/MEXICO BORDER, STANDS APART FROM THE OTHER EMERGENCIES I’VE WITNESSED. THE TRAUMA IS IMMENSE YET THE TIME WE HAVE AS CLINICIANS TO ADDRESS IT IS MINIMAL. THAT MAKES WORKING IN THIS PARTICULAR SETTING VERY HARD ON THE SPIRIT, FOR EVERYONE INVOLVED.”

Adam Rosenbloom MD, MPH, Clinical volunteer for COHI
Conclusion

There is a refugee, not immigration, crisis facing the US border states in the South. The impacted communities are generously opening their doors and hearts to the children fleeing unimaginable violence. It is our responsibility not to judge, but to respond with the humanity, care, and openness that we would want our children to receive if the tables were turned. We hope you will join Circle of Health International in responding to the ongoing health and psychosocial needs of the young refugees in a way that demonstrates that America, and Americans, care about children. Everyone's children.
Appendix A

Acronyms list

Circle of Health International  COHI
Non-Governmental Organization  NGO
Catholic Charities  CC
Executive Order  EO
Over the counter  OTC

Citations
1 http://unhcrwashington.org/children
3 http://www.americasquarterly.org/node/1930
5 https://www.freedomforimmigrants.org/detention-statistics
8 http://www.indexmundi.com/honduras/total_fertility_rate.html
9 http://data.worldbank.org/indicator/SP.ADO.TFRT
Immigration Assessment Survey:
Stakeholder Interview and Focus Questions

Immigration assessment survey: Stakeholder interview and focus questions

Name ____________________________________________
Title ____________________________________________

Dates of involvement with the evacuee community:
________________________________________________

1. How did your involvement with the immigrant community begin?
   __________________________________________________
   __________________________________________________
   ______

2. How would you describe the most urgent needs of the immigrant community?
   __________________________________________________
   __________________________________________________
   ______

3. How would you describe the response community’s capacity to meet the emerging needs?
   __________________________________________________
   __________________________________________________
   ______

4. How can this have been improved?
   __________________________________________________
   __________________________________________________
   __________________________________________________

5. What has worked and should it be replicated?
   __________________________________________________
   __________________________________________________
   __________________________________________________

6. Anything else you’d like us to know?
   __________________________________________________
   __________________________________________________
   __________________________________________________
Immigration Assessment Survey: Site visit guide

Staff roles
- Is there a designated staff person who provides health care?
- Is there a designated staff person who provides legal aid?
- Is there a designated staff person who provides psychosocial support?
- Is there a designated staff person who engaged the children in play therapy?
- If COHI wants to get involved, where the next steps?
- Who runs this facility (org and person’s name)

Resources
- Are your providers provided with any kind of orientation or training? If yes, what topics are covered? If no, what needs might they have?
- Number of beds for each hospital and health centre; and
- Type of drugs, equipment and supplies that should be available. Are they?
- Range of services expected to be provided in each health unit as defined for example in the Minimum Health Package or other local standards

Population information
- Population in the catchment area
- Number of women of childbearing age (15–49 years)
- Number of children under one year (0–11 months)
- Number of children under five years (0–59 months)
- Sex ratio (number of males/number of females)

Follow-up
- Is there any tracking for folks who pass through the center?
- If yes, what process?
- If no, do you wish that there was, and what would you want that to look like?

Budget/spending
- What funds are needed and for what?

Community
- Community involvement, who do you interact with and collaborate with?
- What are your health and health-related activities?

Organizational culture + values
- Are there a few words you would use to describe

Program plan
- Does the facility have a plan of action in place?
- If yes, what period does the plan cover?
- How often is it reviewed?
- Have the immigrants you are caring for been involved in the design on the plan, or the response?
Circle of Health International

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