Declaration of Joseph J. Amon, Ph.D. MSPH

I, Joseph J. Amon, declare as follows:

Background and Expertise

1. I am an infectious disease epidemiologist, Director of Global Health and Clinical Professor in the department of Community Health and Prevention at the Drexel Dornsife School of Public Health. I also hold an appointment as an Associate in the department of epidemiology of the Johns Hopkins University Bloomberg School of Public Health. My Ph.D. is from the Uniformed Services University of the Health Sciences in Bethesda, Maryland and my Master of Science in Public Health (MSPH) degree in Tropical Medicine is from the Tulane University School of Public Health and Tropical Medicine.

2. Prior to my current position, I have worked for a range of non-governmental organizations and as an epidemiologist in the Epidemic Intelligence Service of the US Centers for Disease Control and Prevention. Between 2010 and 2018, I was a Visiting Lecturer at Princeton University, teaching courses on epidemiology and global health. I currently serve on advisory boards for UNAIDS and the Global Fund against HIV, TB and Malaria and have previously served on advisory committees for the World Health Organization.

3. I have published 60 peer-reviewed journal articles and more than 100 book chapters, letters, commentaries and opinion articles on issues related to public health and health policy.

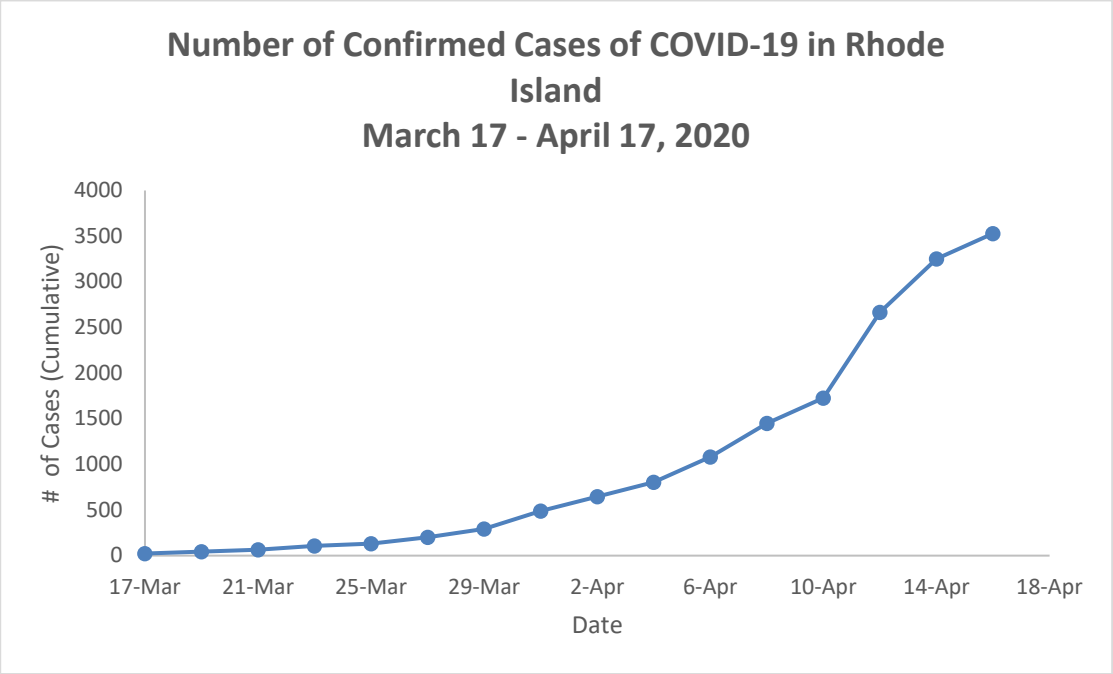
4. One of my main areas of research focus relates to infectious disease control, clinical care, and obligations of government related to individuals in detention settings, in which I have published a number of reports assessing health issues in prison and detention settings and more than a dozen peer-reviewed articles. In 2015-2016, I was a co-editor of a special issue of the British journal, "The Lancet," on HIV, TB and hepatitis in prisons. I also serve on the editorial boards of two public health journals. My resume is attached as Exhibit A.

Information on COVID-19 and Vulnerable Populations

5. COVID-19 is a coronavirus disease that has reached pandemic status. As of April 16, according to the World Health Organization 2,034,802 confirmed cases have been diagnosed in 213 countries or territories around the world and more than 135,163 deaths due to COVID-19 have been reported.[1] In the United States, which has the highest number of reported cases in the world, 671,425 confirmed cases have been reported with the disease and 33,286 people have died thus far,[2] though

[1] See https://www.who.int/emergencies/diseases/novel-coronavirus-2019 accessed April 17, 2020.
[2] See https://coronavirus.jhu.edu/map.html accessed April 17, 2020

these numbers likely underreport the actual infections and deaths.[3] In Rhode Island, as of 12:00 pm on April 16, 2020, there were 3,838 confirmed cases and 105 deaths reported by the state department of health.[4] Rhode Island ranks in the top 10 states in terms of the number of cases per 1 million population.[5] There has been an exponential increase in cases and deaths in Rhode Island over the past month with the number of people infected increasing, on average, by 20% every day[6]:



6. COVID-19 is a serious disease, ranging from no symptoms or mild ones for people at low risk, to respiratory failure and death. There is no vaccine to prevent COVID-19. There is no known cure or anti-viral treatment for COVID-19 at this time. The specific mechanism of mortality of critically ill COVID-19 patients is uncertain but may be related to virus-induced acute lung injury, inflammatory response, multiple organ damage and secondary nosocomial infections.

7. The World Health Organization (WHO) identifies individuals at highest risk to include those over 60 years of age and those with cardiovascular disease, diabetes, chronic respiratory disease, and cancer.[7] The WHO further states that the

[3] See https://www.washingtonpost.com/national/us-deaths-from-coronavirus-top-1000-amid-incomplete-reporting-from-authorities-and-anguish-from-those-left-behind/2020/03/26/2c487ba2-6ad0-11ea-9923-57073adce27c_story.html accessed April 3, 2020.
[4] See https://ri-department-of-health-covid-19-data-rihealth.hub.arcgis.com/ accessed April 16, 2020
[5] See http://91-divoc.com/pages/covid-visualization/ accessed April 17, 2020
[6] See http://91-divoc.com/pages/covid-visualization/ accessed April 17, 2020
[7] See https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200311-sitrep-51-covid-

risk of severe disease increases with age starting from around 40 years.

8. The US CDC identifies "older adults [65 and older] and people of any age who have serious underlying medical conditions" as at higher risk of severe disease and death.[8] The CDC identifies underlying medical conditions to include: blood disorders, chronic kidney or liver disease, compromised immune system, endocrine disorders, including diabetes, metabolic disorders, heart and lung disease ("including asthma or chronic obstructive pulmonary disease [chronic bronchitis or emphysema] or other chronic conditions associated with impaired lung function"), neurological and neurologic and neurodevelopmental conditions "[including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy (seizure disorders), stroke, intellectual disability…"], and current or recent pregnancy.[9] The CDC also identifies individuals with a body mass index (BMI) greater than 40 to be at higher risk for severe illness.[10] According to the CDC, hypertension has been associated with increased illness severity and outcomes.[11] Hypertension is the most common of underlying condition, either alone or in combination with others, for people hospitalized for COVID-19.[12] Based upon reports of a high proportion of ICU patients with cerebrovascular disease and diabetes, some researchers have speculated that increased risk of severe illness may be associated with common medicines (ACE2-stimulating drugs) prescribed for hypertension and diabetes.[13]

9. Data from US COVID-19 cases published by the CDC on March 19, 2020, found that hospitalization rates and intensive care unit (ICU) admission rates were nearly identical for individuals aged 45-54 and individuals aged 55-64 (between approximately 20-30% for both groups for hospitalization and between 5-11% for both groups for ICU admission).[14] This suggests that individuals >45 years could be considered high risk for severe disease while those ≥54 years could be considered high risk for severe disease and death.

Understanding of COVID-19 Transmission

10. According to the US CDC, the disease is transmitted mainly between people who are

19. pdf?sfvrsn=1ba62e57_4 accessed March 21, 2020

[8] See https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html accessed March 21, 2020

[9] See https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf accessed March 21, 2020

[10] See https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html accessed April 3, 2020

[11] https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html April 14, 2020.

[12] See https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s_cid=mm6915e3_w accessed April 13, 2020. Hypertension may be an indicator of heart disease. It is a stronger indicator when coupled with high cholesterol.

[13] See https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30116-8/fulltext?fbclid=IwAR2oRXHweQuw3CLmgJuAh7q556SJ83lnw4m8_G9LK8GtppeAPUtwGG1Fn9o accessed April 3, 2020

[14] See https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm, accessed March 21, 2020

in close contact with one another (within about 6 feet) via respiratory droplets produced when an infected person coughs or sneezes.[15] It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.[16] New data examining the potential for air and surface contamination, conducted in a hospital setting, suggests that the transmission distance of COVID-19 may extend to 4 meters or about 13 feet.[17] This same study found that half the samples taken from the soles of the shoes of hospital staff were positive for SARS-CoV-2 virus.

11. People are thought to be most contagious when they are most symptomatic (the sickest), however there is increasing evidence of asymptomatic[18] and presymptomatic transmission. A recent report by the CDC of presymptomatic transmission in Singapore identified seven clusters of COVID-19 in which presymptomatic transmission likely occurred, accounting for 6.4% of locally acquired cases examined.[19] These findings are similar to research outside of Hubei province, China, which found that 12.6% of transmissions could have occurred before symptom onset in the source patient.[20] While the degree of asymptomatic transmission is still uncertain, a CDC MMWR stated that, "Because persons with asymptomatic and mild disease…are likely playing a role in transmission and spread of COVID-19 in the community, social distancing and everyday preventive behaviors are recommended for persons of all ages to slow the spread of the virus, protect the health care system from being overloaded, and protect older adults and persons of any age with serious underlying medical conditions."[21] In some studies, up to half of individuals testing positive for the coronavirus reported no or mild symptoms.[22] Speech and other vocal activities such as singing have been shown to generate air particles which could transmit the virus responsible for COVID-19, with the rate of emission corresponding to voice loudness. News outlets have reported that during a choir practice in Washington on March 10, presymptomatic transmission likely played a role in SARS-CoV-2 transmission to approximately 40 of 60 choir members.[23]

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[15] See https://www.cdc.gov/coronavirus/2019-ncov/prepare/prevention.html accessed March 21, 2020
[16] See https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html accessed March 21, 2020
[17] See https://wwwnc.cdc.gov/eid/article/26/7/20-0885_article accessed April 13, 2020/
[18] See https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html accessed March 21, 2020; See also: Bai Y, Yao L, Wei T, et al. Presumed asymptomatic carrier transmission of COVID-19.JAMA. Published online February 21, 2020. doi:10.1001/jama.2020.2565 and Zhang W, Du RH, Li B, et al. Molecular and serological investigation of 2019-nCoV infected patients: implication of multiple shedding routes. Emerg Microbes Infect. 2020;9(1):386-389.
[19] See https://www.cdc.gov/mmwr/volumes/69/wr/mm6914e1.htm?s_cid=mm6914e1_w accessed April 2, 2020
[20] See https://wwwnc.cdc.gov/eid/article/26/6/20-0357_article accessed April 2, 2020
[21] *See Coronavirus Disease 2019 in Children — United States, February 12–April 2, 2020*, CENTERS FOR DISEASE CONTROL & PREVENTION (Apr. 20, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6914e4.htm?s_cid=mm6914e4_w.
[22] *See* Pien Huang, *What We Know About The Silent Spreaders Of COVID-19*, NATIONAL PUBLIC RADIO (Apr. 13, 2020), https://www.npr.org/sections/goatsandsoda/2020/04/13/831883560/can-a-coronavirus-patient-who-isnt-showing-symptoms-infect-others.
[23] See https://www.latimes.com/world-nation/story/2020-03-29/coronavirus-choir-outbreak accessed April 2, 2020

12. **The understanding of direct transmission as the most likely means of SARS-CoV-2 transmission combined with evidence of asymptomatic and presymptomatic transmission suggests that, while hand washing and disinfecting surfaces is advisable, the main strategy for limiting disease transmission is social distancing and that for such distancing to be effective it must occur before individuals display symptoms.** Because of the risk of airborne spread, the CDC now recommends that everyone who is coming into contact with the air that others may breathe covers their face, though the CDC recognizes that a face covering is not a substitute for social distancing.[24]

13. Recognizing the importance of social distancing, public health officials have recommended extraordinary measures to combat the spread of COVID-19. Schools, courts, collegiate and professional sports, theater and other congregate settings have been closed as part of risk mitigation strategy. 50 states, 7 territories, and the District of Columbia have taken some type of formal executive action in response to the COVID-19 outbreak.[25] Through one form or another, these jurisdictions have declared, proclaimed, or ordered a state of emergency, public health emergency, or other preparedness and response activity for the outbreak. On March 9, Rhode Island Governor, Gina Raimondo, declared a state of emergency.[26] On March 28 Governor Raimondo buttressed that by closing all non-critical businesses and issuing a stay at home order to cover the entire state of Rhode Island.[27] These kinds of orders are quickly spreading nationwide, after beginning in California on March 19. As of April 7, at least 316 million people in at least 42 states, 3 counties, 9 cities, the District of Columbia, and Puerto Rico are being directed to stay home.[28]

14. These public health measures aim to "flatten the curve" of the rates of infection so that those most vulnerable to serious complications from infection will be least likely to be exposed and, if they are the numbers of infected individuals will be low enough that medical facilities will have enough beds, masks, and ventilators for those who need them.

15. In other countries that have seen steadily growing death rates, authorities have taken measures to release individuals from immigration detention. In Spain, immigration authorities began gradually releasing people held in closed immigration detention centers (CIEs) on March 18.[29] In Belgium, federal authorities released an estimated 300 migrants from detention on March 19 because detention conditions did not allow for safe social distancing.[30] The UK government released 300 people from detention centers following legal action which argued that the government had failed to protect

[24] See https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html
[25] See https://www.astho.org/COVID-19/ accessed March 21, 2020
[26] See https://governor.ri.gov/documents/orders/Executive-Order-20-02.pdf
[27] See https://governor.ri.gov/documents/orders/Executive-Order-20-13.pdf
[28] See https://www.nytimes.com/interactive/2020/us/coronavirus-stay-at-home-order.html accessed April 14, 2020.
[29] See: https://www.lavanguardia.com/politica/20200319/474263064358/interior-abre-puerta-liberar-internos-cie.html accessed March 23, 2020
[30] See: https://www.demorgen.be/nieuws/300-mensen-zonder-papieren-vrijgelaten-coronavirus-zet-dvz-onder-druk~bf3d626d/ accessed March 23, 2020

immigration detainees from the COVID-19 outbreak and failed to identify which detainees were at particular risk of serious harm or death if they do contract the virus due to their age or underlying health conditions. As part of the legal action, Professor Richard Coker of the London School of Hygiene and Tropical Medicine stated that prisons and detention centers provide "ideal incubation conditions for the rapid spread of the coronavirus, and that about 60% of those in detention could be rapidly infected if the virus gets into detention centers."[31]

Risk of COVID-19 in Immigration Detention Facilities

16. The conditions of immigration detention facilities pose a heightened public health risk to the spread of COVID-19, even greater than other non-carceral institutions.

17. Immigration detention facilities are enclosed environments. These kinds of enclosed environments, like cruise ships and nursing homes, have seen higher rates of COVID-19 infection than the general population. Immigration detention facilities have even greater risk of COVID-19 transmission than other enclosed environments because of crowding within the facility, and limited access to hygiene, and structural limitations. People in immigration detention are housed in crowded spaces of limited size and are subjected to security measures that force them into close contact with guards. They cannot practice the "social distancing" necessary to effectively prevent the spread of COVID-19. Bathrooms facilities—toilets, showers, and sinks—and other common areas are shared, without adequate surface disinfection between users. Food preparation and distribution without proper precautions also presents a further site for the virus to spread. Infectious spread presents a particular challenge in these facilities where the population often is disproportionately vulnerable, while facilities provide limited medical care.[32]

18. CDC guidance on correctional and detention facilities,[33] posted March 23, 2020, specifically recommends implementing social distancing strategies to increase the physical space between incarcerated/detained persons "ideally 6 feet between all individuals, regardless of the presence of symptoms" including: 1) increased space between individuals in holding cells, as well as in lines and waiting areas such as intake; stagger time in recreation spaces; restrict recreation space usage to a single housing unit per space; stagger meals; rearrange seating in the dining hall so that there is more space between individuals (e.g., remove every other chair and use only one side of the table); provide meals inside housing units or cells; limit the size of group activities; reassign bunks to provide more space between individuals, ideally 6 feet or more in all directions.

19. The CDC guidance also describes necessary disinfection procedures including to

[31] See: https://www.theguardian.com/uk-news/2020/mar/21/home-office-releases-300-from-detention-centres-amid-covid-19-pandemic accessed March 23, 2020
[32] https://www.prisonpolicy.org/health.html accessed March 26, 2020.
[33] See: https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html accessed March 23, 2020

thoroughly clean and disinfect all areas where a confirmed or suspected COVID-19 case spent time.[34]

Existing Protocols Will Not Prevent Introduction of COVID-19

20. I have reviewed ICE guidance on its website on COVID-19, updated on April 6, 2020[35], and ICE's protocol for a clinical response to COVID-19 ("Interim Reference Sheet on 2019-Novel Coronavirus (COVID-19)" version 6.0 issued March 6, 2020).[36] I have also reviewed the March 27, 2020 Memo entitled "Memorandum on Coronavirus Disease (COVID-19) Action Plan, Revision 1" ("ICE Action Plan"), from Enrique M. Lucero, Executive Associate Director, Enforcement and Removal Operations, addressed to Detention Wardens and Superintendents,[37] the April 4, 2020 guidance from ICE Enforcement and Removal Operations (April 4 Memo),[38] and the April 10, 2020 ICE ERO COVID-19 Pandemic Response Requirements guidance (April 10 Guidance).[39]

21. I have also reviewed the declarations of the following individuals:

    a. Adriano da Silva Medeiros is a 55-year-old man from Portugal. He has been detained at Donald W. Wyatt Detention Facility ("Wyatt") since February 2020.

    b. Jose Marcos Palacios Molina is a 43-year-old man from Mexico. He has been detained at Wyatt since November 2019.

    c. Luis Orlando Durand Luyo is a 40-year-old man from Peru. He has been detained at Wyatt since February 2020.

22. Based on my training and decades of professional experience in public health, the procedures described therein are entirely inadequate to prevent or mitigate the rapid transmission of COVID-19 in Wyatt Detention Facility. I am unaware of any epidemiologist or any public health expert who would consider these procedures to be sufficient preventive measures. The protocols do not sufficiently implement any of the preventative measures outlined below. The lack of specific attention to date in ICE's guidance on COVID-19 indicates that they do not plan to establish special protections for high-risk patients, instead waiting for them to become symptomatic. This will lead to unnecessary illness and death for the people most vulnerable to this disease.

23. **Social distancing**: Although ICE recognizes that social distancing is an important preventive measure, its guidance remains inadequate insofar as it fails to make clear that social distancing is required rather than just recommended, to adequately

[34] Ibid
[35] https://www.ice.gov/coronavirus accessed April 12, 2020.
[36] https://www.aila.org/infonet/ice-interim-reference-sheet-coronavirus
[37] Memo on file.
[38] Memo on file.
[39] Memo on file.

mitigate the spread of COVID-19. Thus, the measures are merely aspirational and therefore insufficient.

a. The "ICE Action Plan" states that "Wardens and Facility Administrators should implement modified operations to maximize social distancing in facilities, as much as practicable. For example, Wardens and Facility Administrators should consider staggered mealtimes and recreation times in order to limit congregate gatherings. All community service projects are suspended until further notice." ICE's April 10 Guidance states that facilities should stagger detainee access to activities like recreation, law library and meals to limit the number of interactions between detainees from other housing units. While ICE is correct to emphasize maximizing social distancing, however these suggested steps fall short of what is necessary to prevent transmission if SARS-CoV-2 is introduced and say nothing about crowding in housing units.

b. On its website, ICE states that it is taking measures to reduce the population of the prisons to 70 percent. ICE's April 10 Guidance is inconsistent and says that efforts should be made to reduce the population to 75 percent capacity. In either case, the number is arbitrary as ICE provides no indication that there is a basis to believe that social distancing within dormitories and cells will be possible when the facilities are operating at 70 percent of capacity. Nor is there any indication that social distancing will be possible where bathrooms are shared by many individuals if the facilities are at 70 or 75 percent capacity.

c. ICE's April 10 guidance recognizes "that strict social distancing may not be possible" given crowding in facilities and physical infrastructure, and couches guidance in terms of feasibility instead of as a mandatory directive (for example, directing to rearrange beds, only "[i]f practicable" and to maintain a distance of six feet from one another "[w]henever possible"). Because social distancing is the primary means of preventing transmission of the virus, ICE's failure to create a plan that meaningfully implements social distancing renders the plan ineffective.

d. The optional measures that ICE has identified do not appear to be in operation at Wyatt. No Plaintiffs reported beds being moved around to accommodate more space between people while sleeping. No one stated that they were currently being housed in individual rooms, and though one Plaintiff does not currently have a cellmate, one could be assigned to his room at any time.

24. **Review of High-Risk Individuals:** ICE's April 10 Guidance directs local jails housing ICE detainees to identify any detainee who meets the Center for Disease Control and Prevention ("CDC")'s identified criteria for populations being at higher-risk for serious illness from COVID-19. ICE's April 10 Guidance is inconsistent with the guidance given by ERO just days earlier, and they both actually fail to adhere to CDC guidelines.

a. For instance, this new guidance fails to identify pregnant or post-partum women

and people with histories of smoking. The previous guidelines earlier failed to identify smoking history or body mass index over 40 as risk factors, both of which are included by the CDC. In an April 8 CDC Morbidity and Mortality Weekly Report ("MMWR"), obesity (BMI ≥ 30) was second only to hypertension among the most commonly reported underlying medical conditions among individuals hospitalized due to COVID-19, with 48.3 percent of patients.[40]

b. Criteria for high-risk factors are not comprehensive and are constantly evolving based on new studies and data. For instance, data from U.S. COVID-19 cases published by the CDC found a similarly higher hospitalization rate and intensive care unit ("ICU") admission rates for those aged 45-54 and 55-64, suggesting that ICE's cut-off age of 60 (in the prior guidance) and 65 (in the newest document) are both insufficient.

c. ICE's April 10 Guidance does not identify the steps they are taking to protect these high-risk patients from contracting COVID-19. The guidance merely notes that ICE must identify these individuals, their medical issues, and location. There is nothing that mandates their release or requires any other protective measures. If, for example, they are cohorted – as I explain below – that measure will facilitate rather than prevent the spread of COVID-19 in the absence of adequate social distancing and sanitation measures. Because the ICE guidance fails to create increased protections for people with risk factors for serious illness and death from COVID-19, they are unlikely to detect illness in these patients until many of them are have already been exposed to and contracted the coronavirus and fallen critically ill.

d. ICE also does not appear to be following its own guidance at Wyatt. No Plaintiffs reported ICE identifying high-risk individuals, or taking protective measures regarding potentially infected individuals, let alone isolating them in a separate room.

25. **Screening Measures**: ICE's protocols do not address how the facilities will account for the large number of people who may have potentially already been exposed to COVID-19. This includes not only new detainees, but also staff, vendors and other individuals who go in and out of detention facilities. Screening measures will not be sufficient to identify infected individuals who come into ICE facilities because of presymptomatic transmission and community spread, which make temperature checks and questions about past contacts insufficient. Facilities would also need increased physical space to isolate those who may be infected upon entry.

a. The ICE Action Plan states that "enhanced health screening of both ICE and facility staff should be implemented by ICE detention facilities with 'sustained

[40] *See* Shikha Garg et al., *Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019 — COVID-NET, 14 States, March 1–30, 2020*, CENTERS FOR DISEASE CONTROL & PREVENTION (Apr. 8, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm?s_cid=mm6915e3_w#T1_down.

community transmission'" as determined by the CDC. The entire state of Rhode Island is listed as having "widespread" community transmission,[41] requiring enhanced screening. The enhanced screening is identified as verbal screening and temperature checks. However, we know that this is insufficient due to both asymptomatic and presymptomatic transmission.

b. ICE's April 10 Guidance states that asymptomatic people with suspected COVID-19 contact or those who meet epidemiological risk criteria will be quarantined and monitored for 14 days with symptom checks. The protocol is written as if this is a rare occurrence, reflecting smaller outbreak management, but the prevalence of COVID-19 is now growing to such an extent that a large share of newly arrived people may have recent contact with someone who is infected, or will have been in areas of community spread. ICE would therefore need to use this level of individual monitoring for every person arriving in detention. Accordingly, ICE would need to dramatically expand its medical facilities and staffing to conduct this daily monitoring of every newly arrived person for 14 days. ICE has not indicated that it has the capacity to meet this demand.

c. Under ICE's April 10 Guidance, ICE would also need to isolate these individuals, as release of presymptomatic and asymptomatic individuals into the general population of any housing configuration short of single-celling could facilitate transmission. ICE does not suggest it is taking these measures, instead calling for intakes in cohorts where transmission between intakes may occur. It does not appear that ICE has the physical infrastructure in which to isolate these individuals. As I discussed below, the CDC guidance recommends *individual* quarantine and isolation as best practices. The practice of cohorting—grouping similarly-situated individuals—is not preferred because it results in potentially asymptomatic carriers mixing in even closer quarters with those who are not yet sick.

d. Given presymptomatic and asymptomatic transmission, to effectively screen staff, the facilities would have to conduct frequent (daily) tests, implemented at multiple times a day as staff and detainees entered the facility. In addition to the cost and labor required to implement this approach, the United States is currently facing a shortage of COVID-19 tests that make such a solution impracticable: In a survey of U.S. cities, 92.1% of cities reported that they do not have an adequate supply of test kits.[42] Shortages are likely to become more severe over the next three to four weeks when there will be a major shortage of chemical reagents for COVID-19 testing and enormous increases in demand.[43] Given the shortage of COVID-19 testing in the United States, it is likely that jails are and will continue

[41] See https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcases-in-us.html accessed April 16, 2020

[42] https://www.usmayors.org/issues/covid-19/equipment-survey/ accessed March 28, 2020.

[43] https://www.nytimes.com/2020/03/27/opinion/coronavirus-trump-testing-shortages.html accessed March 28, 2020.

to be unable to conduct aggressive, widespread testing to identify all positive cases of COVID-19.

26. **Testing:** ICE's guidance also fails to provide clear metrics for when to test individuals. The April 10 guidance does not address the lack of adequate testing in facilities. While the guidelines for testing may evolve over time, the protocol should create a structure for daily dissemination of testing criteria from ICE leadership, and time for daily briefings among all health staff at the start of every shift, to review this and other elements of the COVID-19 response.

    a. The lack of metrics for staff and clinicians further limits the efficacy of the isolation procedures discussed more fully below. To the extent that ICE is not providing clear guidance or sufficient resources to test for COVID-19, it will not be able to identify "confirmed cases." Yet much of its guidance on when to isolate individuals relies upon identifying these confirmed cases. Even were institutions have capacity for isolation of confirmed cases and safe cohorting of close contacts, if the facilities are not identifying who is a confirmed case, they will not be able to trigger the necessary precautions to prevent transmission from this case. I address more fully the limitations on infrastructure in isolation and cohorting more fully below.

    b. While ICE's website states that it will test individuals in compliance with CDC guidelines, the CDC's webpage links to testing guidelines for clinicians.[44] The CDC testing guidelines identify high risk individuals as priority two out of three priority categories. Yet none of the Plaintiffs, who are people with risk factors for serious illness and death from COVID-19, reported testing. None of the ICE guidance provides any indication that ICE is training its clinicians based on these guidelines. As a result, ICE is unlikely to detect illness in these patients until many of them are critically ill.

27. **Staffing**: ICE's protocols fail to include guidance for health staff or administrators regarding how to plan their surge capacity needs as the level of medical encounters increases and the number of available staff decreases, due to illness.

    a. The ICE memo states that facilities are "expected to be appropriately staffed" but it provides with no further criteria for what will be appropriate as needs increase. Similarly, ICE's April 10 guidance states only that facilities should determine "minimal levels of staff." Nor is there guidance as to the qualifications of staff, particularly in the medical unit.

    b. This is of particular concern as Wyatt is served by hospitals in Providence, Rhode Island, which currently has the highest number of cases of people who have tested positive for COVID-19 in the state. Planning to meet the surge of needs is a critical component of the CDC guidance on long term care response and is a critical omission in this protocol.

[44] https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html accessed April 12, 2020.

c. As clinical staff have no experience with this disease, ICE should develop rational clinical criteria for transfer to an acute care hospital. As with the lack of guidance on testing, this lack of clear guidance on how to determine who meets criteria for hospital transfer may prove deadly for detained people.

28. **Isolation**: The CDC recommends medical isolation of confirmed or suspected cases. A range of strategies are presented for isolation depending upon the infrastructure of the facility, however what is recommended as the most effective approach is confining confirmed and suspected cases individually "to a single cell with solid walls and a solid door that closes" to prevent contact with others and to reduce the risk of transmission. Individuals in isolation should also be provided their own bathroom space.[45]

a. ICE's protocol for isolation states: "ICE places detainees with fever and/or respiratory symptoms in a single medical housing room, or in a medical airborne infection isolation room specifically designed to contain biological agents, such as COVID-19." These procedures would be sufficient to address a limited number of infected individuals. However, many facilities only have 1-4 of these medical rooms available in the facility. Given the rate of spread in detention facilities, there will be many more than 1-4 people with COVID-19 in the detention centers. This limited physical infrastructure will mean that ICE cannot comply with this protocol. ICE fails to provide a plan for how it will isolate symptomatic or exposed individuals when the number of these individuals exceeds the number of these medical isolation rooms. As discussed above, ICE also fails to address how it will staff facilities when there are many individuals in isolation and quarantine.

b. ICE's April 10 guidance seems to recognize that it does not have the capacity at many facilities to isolate even confirmed cases, let alone preventing transmission among pre-symptomatic and asymptomatic close contacts to these confirmed cases. ICE's guidance states that ICE be notified when confirmed cases exceeds number of individual isolation spaces available so that transfer to other facilities, hospitals, or release can be coordinated. This plan is likely already a non-viable alternative as COVID-19 cases spread throughout the country. To date, ICE has reported infections at facilities in Pennsylvania, New York, New Jersey, Florida, Georgia, Arizona, Texas, Louisiana, Mississippi, New Mexico, Illinois, Michigan, and California.[46] Transfer also risks spread of infection. As discussed above, ICE provides no indication that it has the space to safely cohort during the potential incubation period, and transfer during this period to open up space in one facility could facilitate transmission to another.

c. Based on Plaintiffs' declarations, ICE has not adopted an isolation protocol, and Wyatt does not have the capacity for isolation.

[45] Ibid.
[46] https://www.ice.gov/coronavirus, accessed April 16, 2020.

29. **Cohorting:**

a. Even where ICE has stated that it is addressing this source of infection, discrepancies between the stated policies and the declarations of the Plaintiffs provide a basis for concerns that ideal response plans are not being implemented: For example, while ICE states that soap dispensers and paper towels are "routinely checked and available for use", and that "liquid soap, running water… disposable paper towels, and no touch receptacles" are available, Plaintiffs report being given only one bar of soap, one towel to use for cleaning each week, and no paper towels for personal use.

b. ICE also states in its April 10 guidance that hand sanitizer will be provided where permissible, but Plaintiffs report that sanitizer has not been provided. ICE directs to properly launder, but Plaintiffs' blankets are not being washed (Declaration of Silva Medeiros). Many individuals reported that individuals in detention were given only diluted disinfectants to clean the facilities, and no Plaintiffs reported masks being supplied for cleaning.

30. **PPE**: As discussed above, the CDC recognizes that masks are not a substitute for social distancing. Therefore, even when masks are worn, it is still important for facilities to practice social distancing. This is especially true where the masks are only cloth masks, not the medical grade N-95 masks that are being used in hospitals to prevent spread of COVID-19 between workers who come into close contact with the virus.

a. ICE's April 10 guidance recognizes that N-95 masks may be in short supply and indicates that detained individuals and staff wear cloth face coverings. In precautions for using this mask, it does not recognize the need for social distancing even when masks are worn, which is especially important considering that cloth face coverings do not provide the same level of protection as N-95 masks.

b. Plaintiffs reported receiving masks for the first time on April 14, but did not receive any instructions to wear them. Face masks are effective only when used in combination with frequent hand-cleaning with alcohol-based hand rub or soap and water. Detainees should be instructed in how to properly put on and take off masks, including cleaning their hands every time they touch the mask, covering the mouth and nose with the mask and making sure there are no gaps, avoiding touching the mask while using it; and replacing the mask with a new one if it becomes damp (e.g., from sneezing) and not to re-use single-use masks. There are times when detainees will necessarily not be able to wear masks, for example, during meals. In these instances, detainees should eat individually or with proper distancing from others.

c. Individuals report that many of the guards and detainees do not wear the masks when around others. The April 10 guidance states that masks should be changed

at least daily, but Plaintiffs did not report new masks being provided daily.

Conditions at the Wyatt Detention Facility

31. Based upon the declarations I reviewed, I have identified the following vectors of COVID-19 infection at the Wyatt Detention Facility:

    - Crowding and inability to practice social distancing (e.g., 60 people held in one large area, common eating tables small enough that people are arms' length apart) (Declaration of Silva Medeiros) (Declaration of Palacios Molina) (Declaration of Durand Luyo);
    - Small cells in which detained individuals cannot practice social distancing (e.g. two to a cell with bunk beds) (Declaration of Silva Medeiros) (Declaration of Palacios Molina);
    - Potential exposure via a large number of people sharing facilities and objects not frequently disinfected (limited number of bathrooms shared among unit; phones not cleaned) (Declaration of Silva Medeiros) (Declaration of Palacios Molina) (Declaration of Durand Luyo);
    - Evidence of insufficient cleaning in shared spaces (mold in bathrooms; common tables not cleaned except after meals) (Declaration of Silva Medeiros) (Declaration of Palacios Molina) (Declaration of Durand Luyo);
    - Movement of individuals in crowded spaces without attention to necessary distancing;
    - Lack of protective measures in food preparation (food delivery by handing off trays) (Declaration of Palacios Molina);
    - Limited or no access to hygiene products including soap and hand sanitizer for personal use (Declaration of Silva Medeiros) (Declaration of Palacios Molina) (Declaration of Durand Luyo);
    - Availability of a single cloth mask with no instructions for use (Declaration of Silva Medeiros) (Declaration of Palacios Molina) (Declaration of Durand Luyo);
    - Insufficient isolation spaces to isolate detained individuals (Declaration of Silva Medeiros) (Declaration of Durand Luyo); and
    - Reports of failure to test individuals coming into the facilities (Declaration of Silva Medeiros)

32. No individuals at Wyatt reported observing medical staff administering tests nasal swab tests to any individuals or temperature checks. One individual reported speaking to people who were brought in and did not receive testing (Declaration of Silva Medeiros).

Heightened Rates of COVID-19 Infection and Spread Within Detention Facilities

33. The rates of spread in the facilities that have been testing for COVID-19 illustrates the dangers the conditions in these facilities pose to those who are detained there,

and to the broader community. Cook County Jail in Chicago has become the site of the single-largest COVID-19 infection, with 524 confirmed cases as of April 13, 2020.[47] Rates have infection have grown exponentially since the virus's introduction a few weeks ago: in a matter of two days, the number of individuals infected jumped from 38 inmates[48] to 89 inmates and 12 staff members.[49] Confirmed cases among detained individuals have risen even after the release of several hundred individuals.[50] At Rikers Island in New York, on Saturday March 21, a jail oversight agency indicated that 21 inmates and 17 employees tested positive.[51] Four days later, on Wednesday, March 26, 75 inmates and 37 employees tested positive.[52] While the NYC BOC is not releasing cumulative data, as of April 15, 2020, there were currently 334 positive test cases of individuals at Rikers Island.[53] **The Legal Aid Society in New York recently reported that the infection rate for COVID-19 at local jails is more than seven times higher than the rate citywide and 87 times higher than the country at large.[54]** As of April 16, 2020, there were at least 100 confirmed cases of immigrants in custody who had coronavirus, up from 6 a mere 14 days earlier on April 2.[55] Twenty-five ICE facility employees have also tested positive.[56]

34. The data above also confirms high rates of infection among correctional officers and other staff. These individuals all face an increased risk of COVID-19 exposure as they are less able to practice the recommended strategy of social distancing in carrying out their official duties. If corrections officers are significantly affected by COVID-19, whether through being infected, exposed by detainees, their fellow officers or in the community, large numbers will be unavailable to work due to self-quarantine or isolation, at the same time that large numbers of detainees who are potentially exposed will need to be put into individual isolation or transferred to advanced medical care, putting tremendous stress on detention facilities.

35. Although there are currently no confirmed cases at Wyatt, Central Falls, as of April 16, 2020, has reported 103 cases due to COVID-19. Statewide there are 3,838 cases

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[47] https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html accessed April 13, 2020.
[48] See https://www.nbcchicago.com/news/local/cook-county-jail-says-17-inmates-have-tested-positive-for-coronavirus/2244652/ accessed March 26, 2020.
[49] See https://www.politico.com/news/2020/03/29/federal-prison-first-coronavirus-death-153387 accessed March 29, 2020.
[50] See https://www.nbcchicago.com/news/local/167-cook-county-jail-detainees-have-tested-positive-for-covid-19-officials-say/2248892/ accessed April 2, 2020; https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html accessed April 12, 2020.
[51] https://www.nbcnewyork.com/news/coronavirus/21-inmates-17-employees-test-positive-for-covid-19-on-rikers-island-officials/2338242/ accessed March 23, 2020.
[52] See https://nypost.com/2020/03/25/new-coronavirus-cases-in-nyc-jails-outpacing-rest-of-the-city/ accessed March 26, 2020
[53] See https://legalaidnyc.org/covid-19-infection-tracking-in-nyc-jails/ accessed April 14, 2020; see also https://www.theguardian.com/us-news/2020/apr/01/rikers-island-jail-coronavirus-public-health-disaster accessed April 2, 2020.
[54] See: https://newyork.cbslocal.com/2020/03/26/coronavirus-rikers-island/ accessed March 26, 2020
[55] See https://www.ice.gov/coronavirus accessed April 16, 2020.
[56] Ibid.

and 105 fatalities.[57] These are likely underestimates. It is reasonable to expect this kind of introduction of COVID-19 into the detention facilities from staff exposed in the community given the current local transmission of COVID-19 in Rhode Island, reflecting the continued movement of people between specific locales.

Infrastructure in Detention Facilities and Surrounding Communities Will Likely Be Insufficient to Address Needs of COVID-19 Patients

36. As COVID-19 enters into the immigration detention facilities, these facilities will likely be unable to address the needs of infected individuals due to lack of testing and insufficient physical and medical infrastructure.

37. Many immigration detention facilities lack adequate medical care infrastructure to address the spread of infectious disease and treatment of high-risk people in detention. As examples, immigration detention facilities often use practical nurses who practice beyond the scope of their licenses; have part-time physicians who have limited availability to be on-site; and facilities with no formal linkages with local health departments or hospitals. Based on my review of declarations, it appears that, even without a public health crisis, inadequate provision of medical care is already reported (Declaration of Palacios Molina) (Declaration of Durand Luyo). A COVID-19 outbreak would put severe strain on this already strained system.

38. Large numbers of ill detainees and corrections staff will also strain the limited medical infrastructure in Rhode Island. On April 15, Dr. Deborah Birx, Coronavirus Response Coordinator for the White House Coronavirus Task Force, singled out Rhode Island and the Providence area specifically, as in a uniquely concerning situation because the area is "caught between two incredible [coronavirus] hot spots in the country": first, the Providence area "had increasing cases from the New York City area and now they have an increase in cases from the Boston area."[58] If infection spreads throughout the detention center, overwhelming the center's own limited resources, the burden of caring for these individuals will shift to local medical facilities. The few facilities will likely not be able to provide care to all infected individuals with serious cases, increasing the likelihood that these individuals will die.[59]

Conclusions

39. CDC guidance on correctional and detention facilities,[60] posted March 23, 2020 reiterates many of the points previously made in this declaration, including: 1) Incarcerated/detained persons are at "heightened" risk for COVID-19 infection once

[57] https://ri-department-of-health-covid-19-data-rihealth.hub.arcgis.com/ accessed April 16, 2020
[58] https://www.cnn.com/asia/live-news/coronavirus-pandemic-intl-04-15-20/h_af7368925ea3d84fd67369e9e6ac0559 accessed April 16, 2020
[59] Even in regions with highly developed health systems, COVID-19 is straining ability to care, creating cause for alarm for less-equipped health care systems in regions that do not act to mitigate risk of infection. See https://www.nytimes.com/2020/03/12/world/europe/12italy-coronavirus-health-care.html accessed March 23, 2020
[60] See: https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html accessed March 23, 2020

the virus is introduced; 2) There are many opportunities for COVID-19 to be introduced into a correctional or detention facility, including from staff and transfer of incarcerated/detained persons; 3) Options for medical isolation of COVID-19 cases are limited; 4) Incarcerated/detained persons and staff may have medical conditions that increase their risk of severe disease from COVID-19; 5) The ability of incarcerated/detained persons to exercise disease prevention measures (e.g., frequent handwashing) may be limited and many facilities restrict access to soap and paper towels and prohibit alcohol-based hand sanitizer and many disinfectants; and 6) Incarcerated persons may hesitate to report symptoms of COVID-19 or seek medical care due to co-pay requirements and fear of isolation.

40. Based upon the Plaintiffs' declarations, none of the ICE facilities are following CDC guidance in relation to social distancing putting all detainees, and especially those at high risk of severe disease and death, in jeopardy.

41. Even if ICE is to implement its own guidance at the facilities, it will not prevent the spread of COVID-19 because of the potential for asymptomatic transmission from other detainees or ICE facility staff of COVID-19.

42. Although the ICE guidance states that individuals at epidemiologic risk will be housed separately, based upon the Plaintiffs' declaration, this practice is not being implemented. Nor is there clarity as to what separate housing looks like: housing people who are not confirmed positives with people who are symptomatic creates a grave risk of transmission. This puts Plaintiffs at increased risk for exposure to COVID-19 as discussed above. The close quarters, the lack of testing and the inability to enforce appropriate social distancing are an urgent problem. Procedures that may have worked for other outbreaks, like flu, will not be sufficient to control COVID-19 and physical distancing is essential.

43. The only viable public health strategy available is risk mitigation. Even with the best-laid plans to address the spread of COVID-19 in detention facilities, the release of individuals who can be considered at high-risk of severe disease if infected with COVID-19 is a key part of a risk mitigation strategy. In my opinion, the public health recommendation is to release high-risk people from detention, given the heightened risks to their health and safety, especially given the lack of a viable vaccine for prevention or effective treatment at this stage.

44. To the extent that vulnerable detainees have had exposure to known cases with laboratory-confirmed infection with the virus that causes COVID-19, they should be tested immediately in concert with the local health department. Those who test negative should be released to home quarantine for 14 days. Where there is not a suitable location for home quarantine available, these individuals could be released to housing identified by the county or state Department of Health.

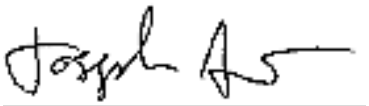
45. Other individuals who may not be identified as high risk should also be considered for release. Reducing the overall number of individuals in detention facilities will facilitate social distancing for remaining detainees and lessen the burden of ensuring

the safety of detainees and corrections officers.

46. Given the physical infrastructure of facilities, the challenges of providing security without close contact, and the lack of proper equipment (such as sufficient numbers of masks) to prevent transmission, I do not believe detention facilities are equipped to ensure the safety of those in their custody. Releasing individuals at highest risk who can then self-isolate – either in their homes or in facilities arranged by the local department of health – provides a significantly better likelihood of preventing infection, disease spread and death, both in the facility and in the community at large.

Pursuant to 28 U.S.C. 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this 17th day in April 2020 in Princeton, New Jersey.



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EDUCATION

08/1998-10/2002	Dept. of Preventive Medicine/Biometrics, Uniformed Services University of the Health Sciences, F. Edward Hebert School of Medicine *PhD, Dissertation: Molecular Epidemiology of Malaria in Kenya*	Bethesda, MD
08/1991-12/1994	Dept. of Parasitology and Tropical Medicine, Tulane University School of Public Health & Tropical Medicine *MSPH, Tropical Medicine*	New Orleans, LA
08/1987-05/1991	Hampshire College *BA, Interdisciplinary Studies*	Amherst, MA

ACADEMIC APPOINTMENTS

9/2018 – Present	Dornsife School of Public Health, Drexel University *Director, Global Health* *Clinical Professor, Dept of Community Health and Prevention*	Philadelphia, PA
01/2010 – Present	Dept. of Epidemiology and Center for Public Health and Human Rights, Bloomberg School of Public Health, Johns Hopkins *Associate*	Baltimore, MD
09/2010 – 06/2018	Woodrow Wilson School of Public and International Affairs, Princeton University *Visiting Lecturer*	Princeton, NJ
01/2015 – 05/2018	Dept. of Epidemiology, Mailman School of Public Health, Columbia University *Adjunct Associate Professor*	New York, NY
06/2014 – 07/2014	School of Social Science, Institute for Advanced Study *Short-term Visitor*	Princeton, NJ
09/2012 – 12/2012	Institut d'Études Politiques de Paris (SciencesPo) *Distinguished Visiting Lecturer*	Paris, France
01/2003–06/2007	Dept. of Preventive Medicine, Hebert School of Medicine, Uniformed Services University of the Health Sciences *Adjunct Assistant Professor*	Bethesda, MD

TEACHING EXPERIENCE

Professor		
2019 - Present	Drexel University	Theory and Practice of Community Health (graduate) Health and Human Rights (undergrad/graduate) Community Health: Cuba (graduate)
2011 – 2018	Princeton University	Health and Human Rights (undergraduate) Epidemiology (undergraduate)
09-12/2012	SciencesPo	Health and Human Rights (graduate)
Co-Instructor		
2012-2013	Global School of Socioeconomic Rights, Harvard University	Health Rights Litigation (graduate)

COMMITTEES AND ADVISORY BOARD MEMBERSHIP

Editorial

09/2019 – Present	Senior Editor, Health and Human Rights Journal
01/2010 – Present	Journal of the International AIDS Society, Editorial Board
07/2012 – Present	Journal of the International AIDS Society, Ethics Committee
01/2015 – 07/2016	Co-Editor, The Lancet HIV Special Issue on HIV and Prisoners
09/2017 – 06/2018	Co-Editor, Health and Human Rights Journal Special Issue on NTDs and Human Rights

Advisory

09/2016 – Present	The Global Fund, Working Group on Monitoring and Evaluating Programmes to Remove Human Rights Barriers to HIV, TB and Malaria Services
12/2014 – Present	UNAIDS, Strategic and Technical Advisory Group
07/2008 – Present	UNAIDS, HIV and Human Rights Reference Group (co-chair Aug 2014 – present)
06/2012 – 6/2018	Global Institute for Health and Human Rights, University at Albany, International Advisory Board
02/2012 – 01/2016	Founding member, Coalition for the Protection of Health Workers in Armed Conflict
01/2014 – 01/2016	Founding member: Robert Carr Award for Research on HIV and Human Rights
07/2011 – 07/2012	XIX International AIDS Conference, Scientific Programme Committee
11/2009 – 09/2012	WHO/STOP TB Partnership, TB and Human Rights Task Force

FULL-TIME WORK EXPERIENCE

09/2018-Present — **Drexel University, Dornsife School of Public Health,** *Philadelphia, PA.*
- *Director, Global Health*
- *Clinical Professor, Dept of Community Health and Prevention*

02/2016–08/2018 — **Helen Keller International,** *New York, NY.*
- *Vice President, Neglected Tropical Diseases*

Provided strategic, technical and overall management for >$125m portfolio of work on NTDs. Led development of proposals resulting in >$80m in new projects.

08/2005–01/2016 — **Human Rights Watch,** *New York, NY.*
- *Director, Health Division (Sept 2008 – Jan 2016)*
- *Founded Disability Rights Division (2013); Environment Division (2015)*
- *Director, HIV/AIDS Program (August 2005 – August 2008)*

Led research and advocacy division focused on human rights and health. Founded programs on disability rights and environment. Responsible for financial and personnel management, fundraising and communications.

07/2003–06/2005 — **Centers for Disease Control and Prevention,** *Atlanta, GA.*
- *Epidemiologist, EIS Officer*

Led hepatitis outbreak investigations in US and overseas. Collaborated with U.S. and international academic and government researchers. Analyzed trends in hepatitis prevalence and vaccination rates in diverse populations.

07/2000–09/2002 — **Walter Reed Army Institute of Research,** *Silver Spring, MD.*
- *Research Fellow*

Conducted molecular epidemiologic and immunologic research on malaria, examining host-parasite interaction, vaccine efficacy, and correlates of disease severity.

07/1995–06/1998 — **Family Health International,** *Arlington, VA.*
- *Technical Officer (Jan – June 1998)*
- *Evaluation Officer (Aug 1996 – Dec 1997)*
- *Associate Evaluation Officer (July 1995 – July 1996)*

Designed and analyzed HIV behavioral research and program evaluation studies. Supervised field-based research and evaluation staff in U.S., Brazil, Jamaica, Dominican Republic, Kenya, Ghana, and Haiti.

09/1992–11/1994 — **U.S. Peace Corps,** *Lomé, Togo.*
- *Volunteer*

Designed and implemented process monitoring system for national Guinea Worm eradication program. Conducted health education training. Supervised village health workers.

SHORT-TERM AND CONSULTING EXPERIENCE

Human Rights Watch, *New York, NY.*	Provide technical review for research design, analysis and documents related to health and environment and human rights.	Sept 2018 – Present
The Futures Group International, *REACH Project, Washington DC.*	Co-investigator for HIV/AIDS operations research related to orphans and vulnerable children and adolescent-oriented HIV volunteer counseling and testing.	Mar 2002 – June 2003
Walter Reed Army Institute of Research, *Silver Spring, MD.*	Developed database and provided statistical support to malaria vaccine clinical trial project.	Apr 2002 – June 2003
John Snow, Inc., *Arlington, VA.*	Developed curriculum and provided training on HIV/AIDS monitoring and evaluation to Ministry of Health staff from 8 countries.	Dec. 2002 – June 2003
TvT Associates, *SYNERGY Project, Washington, DC.*	Designed $20+ million comprehensive HIV/AIDS strategy for USAID Ukraine and USAID Russia.	Dec. 2001 – April 2003
PACT, *Washington, DC.*	Designed outcome and impact evaluation of HIV behavioral intervention project.	June 2002
Encompass LLC, *Bethesda, MD.*	Designed evaluation of World Bank health sector reform training.	January – May 2002
U of Washington, *Center for Health Education and Research.*	Developed guidelines and training materials for monitoring and evaluating HIV/AIDS programs.	April – May 2002
Family Health International, *Arlington, VA.*	Analyzed HIV-related behavioral surveillance results from studies in Honduras, Nigeria, Ghana, and Senegal.	Sept 1998 – Mar 2002
Datex Inc., *Falls Church, VA.*	Provided expert review for USAID-funded HIV/AIDS behavioral intervention grants competition.	May– Jun 2001 Jan – Feb 2000
PLAN International *Bamako, Mali and Arlington, VA.*	Designed and implemented quantitative and qualitative evaluation of HIV/AIDS program and developed $6 million follow-on program.	May – Dec 2000
Ministry of Health, *Kingston, Jamaica.*	Analyzed behavioral surveillance results and facilitated workshop examining HIV trends.	Oct 1998
Eli Lilly Foundation, *Diabetes Control Program, Accra, Ghana.*	Designed and implemented outcome and impact evaluation of diabetes prevention and care program.	Sept 1996
Carter Center, *Niger Guinea Worm Eradication Program, Zinder, Niger.*	Designed and implemented outcome and impact evaluation of guinea worm eradication program.	Mar – May 1995

PEER REVIEW JOURNAL PUBLICATIONS

1 Kotellos KA, **Amon JJ**, Githens Benazerga W. *Field Experiences: measuring capacity building efforts in HIV/AIDS prevention programmes.* AIDS 1998; 12 (supl 2):109-17.

2 Figueroa JP, Brathwaite AR, Wedderburn M, Ward E, Lewis-Bell K, **Amon JJ**, Williams Y, Williams E. *Is HIV/STD control in Jamaica making a difference?* AIDS 1998; 12 (supl 2):S89-S98.

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13 Murray NJ, Chatterji M, Dougherty L, Mulenga Y, Jones A, Buek K, Winfrey B, **Amon J**.. *Examining the impact of orphanhood and duration of orphanhood on sexual initiation among adolescents ages 10-19 in Rwanda and Zambia.* International Union for the Scientific Study of Population. International Population Conference France, July, 2005.

14 Cohen J, Schleifer R, Richardson J, Kaplan K, Suwannawong P, Nagle J, **Amon J.** *Documenting Human Rights Violations Against Injection Drug Users: Advocacy for Health*. 17th International Conference on the Reduction of Drug Related Harm. May 2006. Vancouver.

15 Schleifer R, Cohen J, Nagle J, **Amon J.** *Injection Drug Users, Harm Reduction, and Human Rights in Ukraine.* 17th International Conference on the Reduction of Drug Related Harm. May 2006. Vancouver, Canada.

16 Bencomo C, **Amon J,** Iordache R, Schleifer R, Asandi S, Bohiltea A, Bucata C, Terragni C, Velica L. *How gaps in Romania's social support undermine HIV/AIDS prevention and treatment for children and youth.* XVI International AIDS Conference: Abstract no. MOPE0922. August 2006.

17 Tate T, Bencomo C, Lisumbu J, Mafu Sasa R, Schleifer R, **Amon J**. *Local and cultural beliefs about HIV transmission fuel childrenīs rights abuses in the Democratic Republic of Congo (DRC).* XVI International AIDS Conference: Abstract no. CDE0086. August 2006.

18 Cohen J, Epstein H, **Amon J**. *Human rights implications of AIDS-affected children's unequal access to education.* XVI International AIDS Conference: Abstract no. TUAE0202. August 2006.

19 Schleifer R, Skala P, Lezhentsev K, **Amon J**. *Rhetoric and risk: human rights abuses impeding Ukraine's fight against HIV/AIDS.* XVI International AIDS Conference: Abstract no. THAE0302. August 2006.

20 **Amon, J**. *Using a Human Rights Framework to Examine HIV/AIDS Programs and Policies.* Abstract #139834. American Public Health Association Annual Meeting. November 2006. Boston, MA.

21 Ngonyama L, Lohman D, Clayton M, **Amon J**. *The Role of Lay Counselors in Expanding HIV Testing: Lesotho's Know Your Status Campaign.* Abstract 1631. 2008 HIV/AIDS Implementers Meeting. Kampala, Uganda. June 2008.

22 Lohman D, Ovchinnikova M, **Amon J**. *The role of Russia's drug dependence treatment system in fighting HIV.* XVII International AIDS Conference: Abstract no. TUAX0102. August 2008.

23 **Amon J**. *HIV-specific travel restrictions: human rights, legal and ethical considerations.* XVII International AIDS Conference: Abstract no. TUSS0406. August 2008.

24 Lohman D, Ngonyama L, Clayton M, **Amon J**. *Expanding HIV testing and human rights: Lesotho's Know Your Status Campaign.* XVII International AIDS Conference: Abstract no. TUPE0469. August 2008.

25 Cohen JE, **Amon J.** *Human Rights abuses and threats to health: recent experiences of Chinese drug users in detoxification and re-education through labor centers in Guangxi Province*. XVII International AIDS Conference: Abstract no. THPE1085. August 2008.

26 **Amon J**. Protecting the human rights of people at risk of and affected by TB. 3rd Stop TB Partners Forum, Rio March 2009

27 **Amon J.** *Undocumented Migrants and Drug Users in Asia: Tuberculosis Care and Human Rights.* 3rd Stop TB Partners Forum, Rio March 2009

28 **Amon J.** *Protecting the rights of drug users in China.* 20th International Conference of the International Harm Reduction Association meeting. April, 2009.

29 Lohman D, **Amon J.** *Pain and Policy: The Battle with Needless Suffering.* Unite for Sight, Yale University. April, 2009.

30 **Amon J.** *HIV testing for hard-to-reach populations.* In: New Strategies and Controversies in HIV Testing and Surveillance, International AIDS Society Conference. Cape Town, South Africa. July 2009.

31 **Amon J**. *Human Rights context of routine testing.* In: Maximizing the benefits of treatment for individuals and communities. International AIDS Society Conference. Cape Town, South Africa. July 2009.

32 **Amon J.** *Scaling up HIV testing through scaling up human rights protections.* In: Scaling up

Biomedical Prevention and Treatment Interventions - The Critical Role of Social Science, Law and Human Rights. International AIDS Society Conference. Cape Town, South Africa. July 2009.

33 **Amon J.** *HIV testing and human rights: competing claims and conflicting views.* American Anthropological Association. Philadelphia, PA. December 2009.

34 Pearshouse R, **Amon JJ**. *Engagement with compulsory drug detention centers: a legal and ethical framework.* 21st International Conference of the International Harm Reduction Association meeting. April, 2010.

35 Lohman D, Tymoshevska V, Rokhanski A, Kotenko G, Druzhinina A, Schleifer R, **Amon J**. *Availability and accessibility of opioid medications in Ukraine.* XVIII International AIDS Conference. July 2010. Abstract no. MOAF0202

36 Jones L, Akugizibwe P, **Amon J**, et al. *Human rights costing of ART for prevention.* XVIII International AIDS Conference. July 2010. Abstract no. TUPE1033

37 Lemmen K, Wiessner P, Haerry DHU, Todrys K, **Amon J**. *Deportation of HIV-positive migrants in 29 countries: impact on health and human rights.* XVIII International AIDS Conference. July 2010. Abstract no. TUAF0101

38 McLemore M, Winter M, **Amon J**. *Sentenced to stigma: segregation of HIV-positive prisoners.* XVIII International AIDS Conference. July 2010. Abstract no. THPE0942

39 Todrys K, Malembeka G, Clayton M, McLemore M, Shaeffer R, **Amon J**. *HIV and TB management in 6 Zambian prisons demonstrate improved but ongoing prevention, testing and treatment gaps.* XVIII International AIDS Conference. July 2010. Abstract no. THPDX105 (Awarded prize for best abstract on HIV/TB integration)

40 Pearshouse R, Cohen JE, **Amon J**. *Drug detention centers and HIV in China and Cambodia.* XVIII International AIDS Conference. July 2010. Abstract no. MOAF0203

41 Lohman D, Palat G, Nair S, **Amon J**, Schleifer R. *Palliative care: needs of and availability for people living with HIV in India.* XVIII International AIDS Conference. July 2010.

42 Kippenberg J, Thomas L, Lohman D, **Amon J**. *Children's access to HIV testing, treatment and palliative care in Kenya.* XVIII International AIDS Conference. July 2010.

43 Lohman D, Thomas L, **Amon J.** *Access to pain treatment and palliative care as a human right.* XVIII International AIDS Conference. July 2010. Abstract no. WEPE0982.

44 **Amon J.** *HIV and human rights.* XVIII International AIDS Conference. July 2010.

45 **Amon J.** *HIV treatment as prevention: human rights issues.* HIV10 Conference. Glasgow, Scotland. November 2010.

46 **Amon J.** *TB and human rights in Zambian prisons.* IULTB. Berlin, Germany. Nov 2010.

47 **Amon J.** *TB and Human Rights.* IULTB. Berlin, Germany. November 2010. (panel chair)

48 Todrys K, Kwon S-R, Burnett M, Lamia M, **Amon J.** *HIV and TB Prevention, Testing, and Treatment in 16 Ugandan Prisons.* 6th IAS Conference on HIV Pathogenesis, Treatment and Prevention. Rome, July, 2011.

49 Pearshouse R, **Amon J.** *Drug Detention Centers and HIV In Vietnam.* 10th International Congress on AIDS in Asia. August, 2011.

50 **Amon J.** *Reforms to protect health and rights in East African prisons.* IULTB. Lille, France. Oct. 2011.

51 **Amon J.** *Ethics and Human Rights in Publishing.* (Meet the Editors session). XIX International AIDS Conference. July 2012.

52 **Amon J.** *Balance Between Justice System and Provision of Services.* XIX International AIDS Conference. Washington, DC. July 2012. (co-moderator)

53 **Amon J.** *Advancing global health through human rights accountability.* IV Consortium of

Universities for Global Health. Washington, DC. March 2013.

54 **Amon J.** *Enhanced HIV testing in the context of human rights*. 8th IAS Conference on HIV Pathogenesis, Treatment and Prevention. Vancouver, July 2015.

55 Beletsky L, Vera A, Gaines T, Arredondo J, Werb D, Bañuelos A, Rocha T, Rolon ML, Abramovitz D, **Amon J**, Brower K, Strathdee SA. *Utilization of Google Earth to Georeference Survey Data among People who Inject Drugs: Strategic Application for HIV Research.* 8th IAS Conference on HIV Pathogenesis, Treatment and Prevention. Vancouver, July 2015.

56 **Amon J.** *The impact of climate change and population mobility on neglected tropical disease elimination*. International Meeting on Emerging Diseases and Surveillance (IMED). Vienna, Nov 2016.

57 **Amon J.** *Getting to Zero: Lessons for NTD Elimination from Successful STH Control Programs.* Neglected Tropical Disease NGO Network Annual Meeting. Dakar, Senegal, Sept 2017. (moderator)

58 Hoppe A, Coltart C, Parker M, Dawson L, **Amon JJ,** et al. *Ethical Considerations in HIV Phylogenetic Research.* 2018 International AIDS Conference. Amsterdam, Netherlands.

59 **Amon J.** Epidemic transition: How will we achieve it while ensuring equity and quality? 2018 International AIDS Conference. Amsterdam, Netherlands.

INVITED LECTURES

1 University of North Carolina School of Public Health (March 2006)

2 Duke University School of Public Policy (October 2006)

3 University of Chicago (October 2006)

4 University of Toronto Law School (November 2006)

5 Columbia University Law School (Dec 2006, 2007, 2009)

6 University of Denver School of International Affairs (March 2007)

7 Georgetown University Law School (April 2007)

8 Columbia University School of International and Public Affairs (Feb and Oct 2007)

9 University of Connecticut School of Law (April 2009)

10 New York University (January 2011, November 2014)

11 University of Zurich (September 2011)

12 Columbia University Mailman School of Public Health (Feb, Nov 2009; Dec 2013; Nov 2014,-15)

13 Yale University Law School (March 2013)

14 Johns Hopkins University Bloomberg School of Public Health (annually: May 2008-2019)

15 UCLA Law School (January 2014)

16 Stanford University Law & Medical Schools (January 2014)

17 University of Melbourne, Nossal Institute for Global Health (July 2014)

18 Fordham Law School (October 2014)

19 Northwestern University (November 2014; Nov 2015)

20 Dornsife School of Public Health, Drexel University (February 2018)

21 University of California San Diego (March 2018)

AWARDS

Centers for Disease Control and Prevention, Epidemic Intelligence Service, Mackel Award (Apr 2004)
Department of Health and Human Services, Public Health Service, Unit Commendation (Oct 2004)
Department of Health and Human Services, Secretary's Award for Distinguished Service (Aug 2005)

AD HOC REVIEWER

Journals:

New England Journal of Medicine, Lancet, International Journal of Epidemiology, STI, Global Public Health, Addiction, Hepatology, Health and Human Rights, Bulletin of the World Health Organization, Journal of the International AIDS Society, PLoS One, PLoS Medicine, Journal of the American Public Health Association, Anthropological Quarterly, Drug and Alcohol Dependence, Conflict and Health, BMC Public Health, Harm Reduction Journal, Law & Social Inquiry, Social Science and Medicine, Health and Human Rights Journal, International Journal of Drug Policy.

Grants:

Open Society Foundations, Public Health Program