Exhibit 1
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’s 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 today (3/23), according to the World Health Organization, more than 332,900 people have been diagnosed with COVID-19 in 190 countries or territories around the world and 14,510 have died.1 In the United States, about 41,000 people have been diagnosed with the disease and 479 people have died thus far.2 In Pennsylvania, there are 644

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2 See https://coronavirus.jhu.edu/map.html Accessed March 23, 2020
confirmed cases and five deaths thus far. These numbers are likely an underestimate, due to the lack of availability of testing. In many settings, the numbers of infected people are growing at an exponential rate.

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. The WHO further states that the 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. 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, neurological and neurologic and neurodevelopmental conditions, and current or recent pregnancy.

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). 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.

10. Public Health England, the public health authority of the United Kingdom, identifies a broader list of individuals at increased risk of severe illness and who should be “particularly stringent in following social distancing measures”. These include: individuals with: chronic (long-term) respiratory diseases, such as asthma, chronic obstructive pulmonary disease (COPD), emphysema or bronchitis; chronic heart

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3 See https://www.health.pa.gov/topics/disease/coronavirus/Pages/Coronavirus.aspx accessed March 23, 2020
disease, such as heart failure; chronic kidney disease; chronic liver disease, such as hepatitis; chronic neurological conditions, such as Parkinson’s disease, motor neurone disease, multiple sclerosis (MS), a learning disability or cerebral palsy; diabetes; spleen-related disorders or having had your spleen removed; having a weakened immune system; having a body mass index (BMI) of 40 or above; and those who are pregnant.

Health profile of plaintiffs

11. I have reviewed the declarations of the following individuals: Bharatkumar G. Thakker; Adebodun Adebomi Idowu; Courtney Stubbs; Meiling Lin; Rodolfo Agustín Juarez Juarez; Dexter Anthony Hillocks; Rigoberto Gomez Hernandez; Henry Pratt; Mayowa Abayomi Oyediran; Mr. Mansyur; and Agus Prajoga.

12. Bharatkumar G. Thakker is a 65-year-old citizen of India. He has been detained by ICE at Pike County Correctional Facility for the last 27 months. Including his age, Mr. Thakker has several health conditions, according to his declaration, that put him at high risk for severe illness and death from COVID-19, including chronic kidney disease and high blood pressure and high cholesterol which are associated with cardiovascular disease. He currently reports that he has chills, myalgia, asthenia and dizziness and has been coughing for a few days, and that his cell mate recently started coughing.

13. Courtney Stubbs is a 52-year-old citizen of Jamaica. He has been detained by ICE at Clinton County Correctional Facility since June 2019. Mr. Stubbs has several health conditions, according to his declaration, that put him at high risk for severe illness and death from COVID-19, including diabetes, cardiovascular disease, chronic kidney disease, and immunosuppression stemming from a kidney transplant.

14. Meiling Lin is a 45-year-old citizen of China. She has been detained by ICE at York County Prison since March 2019. Ms. Lin, according to her declaration, she suffers from chronic hepatitis B and liver disease, that puts her at high risk for severe illness and death from COVID-19.

14.a. Jean Herdy Christy Augustin is a 34-year-old citizen of Haiti. He is detained by ICE at York County Prison. According to his declaration, Mr. Augustin suffers from diabetes which puts him at high risk for severe illness and death from COVID-19. Mr. Augustin also has multiple other health issues, including high blood pressure and anemia that might complicate his treatment if infected with the virus causing COVID-19.

15. Rodolfo Agustín Juarez Juarez is a 21-year-old citizen of El Salvador. He has been detained by ICE at York County Prison since February 26, 2020. Mr. Juarez, according to his declaration, suffers from diabetes which puts him at high risk for severe illness and death from COVID-19. In addition, in his declaration he states that he has had a fever, persistent cough, and trouble breathing for the past week, all of which are common symptoms of COVID-19 and, according to current guidance, require testing and isolation. In his declaration, he states that he has not been tested for COVID-19 and
has been told by correctional officers that COVID-19 tests are not available at York.

16. Adebodun Adebomi Idowu is a 57-year-old from Nigeria. He has been detained by ICE at Clinton County Correctional Facility for the past 17 months. Mr. Idowu has several health conditions, according to his declaration, that put him at high risk for severe illness and death from COVID-19, including diabetes and high blood pressure and high cholesterol which are associated with cardiovascular disease.

16.b. Catalino Domingo Gomez Lopez is a 51-year-old citizen of Guatemala. He is detained by ICE at York County Prison. According to his declaration, since being detained in November 2018, Mr. Gomez Lopez has had the flu four times. He states that the most recent instance he was ill for four weeks, during which time he had a fever and a cough with hemoptysis (coughing blood). Hemoptysis requires medical assessment as it may be related to a range of serious health conditions, including tuberculosis, lung cancer, and pneumonia (among others). Due to his age and his stated history of hemoptysis, Mr. Gomez Lopez may be at high risk for severe illness and death from COVID-19.

17. Dexter Anthony Hillocks is a 54-year-old from Trinidad and Tobago. He has been detained at the Pike County Correctional Facility since 2015. Mr. Hillocks, according to his declaration, has several health conditions that put him at high risk for severe illness and death from COVID-19, including diabetes, high blood pressure and high cholesterol which are associate with cardiovascular disease, and leukemia.

18. Rigoberto Gomez Hernandez is a 52-year-old Mexican national. He is detained by ICE at Pike County Prison. Mr. Gomez Hernandez, according to his declaration, has diabetes, which puts him at high risk for severe illness and death from COVID-19. He also reports that his detention has also caused him mental anguish.

19. Henry Pratt is a 50-year-old citizen of Liberia. He is detained by ICE at Clinton County Correctional Facility. According to his declaration, Mr. Pratt suffers from Type II diabetes and high blood pressure, which puts him at high risk for severe illness and death from COVID-19.

20. Mayowa Abayomi Oyediran is a forty-year-old citizen of Nigeria. He has been detained by ICE since November 7, 2019 at York County Prison. Mr. Oyediran, according to his declaration, has severe asthma and an infection in his lungs, which put him at high risk of severe illness and death from COVID-19. His declaration states that he has not been given an inhaler or any other kind of treatment for his asthma or treatment for his lung infection.

21. Mr. Mansyur is a 41-year-old citizen of Indonesian. He is detained by ICE at Pike County Prison since December 19, 2019. Mr. Mansyur, according to his declaration, has diabetes and high blood pressure, which puts him at high risk for severe illness and death from COVID-19.
22. Agus Prajoga is a 48-year-old citizen of Indonesia. He is detained by ICE at Pike County Prison since January 13, 2020. Mr. Parjoga has diabetes and high blood pressure and cholesterol which are associated with cardiovascular disease, which puts him at high risk for severe illness and death from COVID-19.

Understanding of COVID-19 Transmission

23. According to the US CDC, the disease is transmitted mainly between people who are in close contact with one another (within about 6 feet) via respiratory droplets produced when an infected person coughs or sneezes.\(^9\) 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.\(^10\) People are thought to be most contagious when they are most symptomatic (the sickest), however there is increasing evidence of asymptomatic transmission.\(^11\) This 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.

24. 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.\(^12\) 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. Earlier this month Pennsylvania Governor, Tom Wolf, declared a state of emergency, which he buttressed on March 19 with an order closing non-essential businesses.\(^13\) On Monday, March 23, 2020, Governor Wolf issued a stay at home order for residents of Bucks, Chester, Delaware, Monroe and Montgomery counties. Philadelphia has been under a stay at home order since Saturday, March 21, 2020.\(^14\)

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\(^12\) See [https://www.astho.org/COVID-19/](https://www.astho.org/COVID-19/) accessed March 21, 2020


\(^14\) See [https://www.wtae.com/article/stay-at-home-order-to-begin-tonight-for-several-pa-counties-including-allegheny/31900786](https://www.wtae.com/article/stay-at-home-order-to-begin-tonight-for-several-pa-counties-including-allegheny/31900786) accessed March 23, 2020
25. As of March 23, in response to the threat of COVID-19 transmission, five states (California; Illinois; New Jersey; New York; and Ohio) prohibit gatherings of any size; nine states prohibit gatherings of >10 individuals (Colorado; Hawaii; Louisiana; Maine; Maryland; Texas; Utah; Vermont and Wisconsin); four states prohibit gatherings of >25 individuals (Alabama; Massachusetts; Oregon and Rhode Island) and eight states prohibit gatherings of >50 individuals. The five states that prohibited gathering have also issued quarantine orders directing residents to stay at home except under certain narrow exceptions.\textsuperscript{15} These orders are expanding, increasing for example from at least 158 million people in 16 states, nine counties and three cities are being urged to stay home on March 23 to at least 163 million people in 17 states, 14 counties and eight cities being urged to stay home on March 24, 2020.\textsuperscript{16}

26. 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.

27. In countries where the virus’s course of infection began earlier, and where death rates grew steadily governments have imposed national emergency measures to prevent contagion from human contact, In Italy and Spain, for example, the governments have imposed national lockdowns to keep people from coming into contact with each other.\textsuperscript{17}

28. In Spain, immigration authorities began gradually releasing people held in closed immigration detention centers (CIEs) on March 18.\textsuperscript{18} In Belgium, federal authorities released an estimated 300 migrants from detention on March 19 because detention conditions did not allow for safe social distancing.\textsuperscript{19} The UK government released 300 people from detention centers following legal action which argued that the government had failed to protect 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.”\textsuperscript{20}

\textsuperscript{17} See https://www.cnbc.com/2020/03/14/spain-declares-state-of-emergency-due-to-coronavirus.html accessed March 23, 2020
Risk of COVID-19 in Immigration Detention Facilities

29. 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.

30. Immigration detention facilities are enclosed environments, much like the cruise ships that were the site of the largest concentrated outbreaks of COVID-19. Immigration detention facilities have even greater risk of infectious spread because of conditions of crowding, the proportion of vulnerable people detained, and often scant medical care. People live in close quarters and are also subject to security measures which prohibit successful “social distancing” that is needed to effectively prevent the spread of COVID-19. Toilets, sinks, and showers are shared, without disinfection between use. Food preparation and food service is communal, with little opportunity for surface disinfection. Staff arrive and leave on a shift basis; there is little to no ability to adequately screen staff for new, asymptomatic infection.

31. Based upon the declarations of Bharatkumar G. Thakker; Adebodun Adebomi Idowu; Courtney Stubbs; Meiling Lin and Rodolfo Agustín Juarez Juarez, conditions at Pike County Correctional Facility, York County Prison and Clinton County Correctional Facility do not appear to be adopting the procedures necessary to prevent COVID-19 transmission.

32. In the York facility, plaintiff declarations stated a range of concerns that suggest an inability to control transmission of COVID-19, including: crowding and inability to practice social distancing (e.g., 56 people held in one large area; close seating during meals); potential exposure via a large number of people sharing facilities and objects not frequently disinfected (water fountains, phones and tablets); the lack of availability of tests for infection, which would hamper isolation of infected detainees; and lack of screening or use of masks among facility staff (Declaration of Juarez). The Declaration by Lin on conditions in the York facility similarly highlights crowding and inability to practice social distancing (50 people in one large area with beds 3-4 feet apart; close seating during meals); shared objects and facilities (shared bathrooms, three phones and eleven tablets among 50 people).

33. In the Clinton County facility, the plaintiff declaration by Idowu stated similar concerns including crowding and inability to practice social distancing (72 people in one open unit with bunk beds); lack of staff screening and precautions; lack of screening of new detainees; and potential exposure via shared facilities (bathrooms, sinks, showers) (Declaration of Idowu).

34. In the Pike County facility, plaintiff declarations by Thakker and Stubbs stated similar concerns including crowding and inability to practice social distances (including in social areas and during meals); lack of staff precautions (masks) (Thakker); and the transfer of detainees from one block to another, despite symptoms of illness (Stubbs).

35. Many immigration detention facilities also 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 led to health complications (Declaration of Idowu). A COVID-19 outbreak would put severe strain on this already strained system.

Risks of COVID-19 to and from Police, First Responders, and Corrections Officers

36. Police, first responders and correctional officers 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. These officials also potentially present a link from transmission occurring in the community to those who are detained.

37. An increasing number of public safety personnel – police officers, firefighters, EMTs and paramedics have been found to be infected with COVID-19 and a larger number have been ordered into 14-day quarantine at home or in quarters after exposure to an individual with COVID-19. For example, in Kirkland Washington 27 firefighters and two police officers were in quarantine along with four King County (Wash.) EMS paramedics. In San Jose California 77 firefighters were in quarantine. More than 140 firefighters were quarantined in Washington DC. Six New Jersey police officers tested positive for COVID-19 and another 20 officers were under self-quarantine, as of March 19.

38. So far, two state prison employees tested positive for COVID-19 in California, two in Michigan, a county jail officer in Washington state, and one Georgia Department of Corrections employee tested positive. 21 inmates and 17 employees in Rikers Island (NY) have tested positive; an investigator with NYC’s department of corrections died

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of COVID-19. In Wisconsin, a prison doctor tested positive. In New Jersey, a member of the medical staff at Elizabeth Detention Center in New Jersey a private immigration detention center tested positive for coronavirus. A correctional officer at Bergen County Jail (NJ), which contracts with ICE, also tested positive for COVID-19. As a result of these cases, hunger strikes have broken out in three ICE detention centers in New Jersey “as detainees protest what they describe as deteriorating conditions and a failure to adequately address the potential spread of COVID-19”.

If police, first responders, and 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.

Large numbers of ill detainees and corrections staff will also strain the limited medical infrastructure in the rural counties in which these detention facilities are located. 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.

Conclusions

Current conditions and procedures in place at the three ICE facilities, as described by plaintiff declarations, cannot be seen as sufficient to prevent the introduction of COVID-19 or prevent its rapid transmission among both detainees and staff. The lack

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29 See https://fox6now.com/2020/03/19/employee-or-client-at-waupun-prison-tested-positive-for-covid-19/ March 21, 2020
30 See https://www.themarshallproject.org/2020/03/19/first-ice-employee-tests-positive-for-coronavirus accessed March 21, 2020
of daily tests of staff who have ongoing community contacts presents a risk of introduction of the virus into the detention facility. The possibility of asymptomatic transmission means that monitoring fever of staff or detainees is also inadequate for identifying all who may be infected and preventing transmission. This is also true because not all individuals infected with COVID-19 report fever in early stages of infection. The lack of widespread testing in communities and the current presence of COVID-19 in all 50 states means that it is impractical to ask detainees about their travel history— all communities should be assumed to have community transmission which is why statewide and national restrictions on movement and gatherings have been put in place. The crowded conditions, in both sleeping areas and social areas, and the shared objects (bathrooms, sinks, etc.) will facilitate transmission.

43. I have also reviewed the guidance ICE first issued on March 15, and most recently updated March 21. Most notably, the guidance mentions “social distancing” only once, in the first section entitled “What is ICE doing to safeguard its employees/personnel during this crisis?” The strategies that the guidance outline for the protection of individuals in their custody include: 1) temporarily suspending social visitation in all detention facilities; 2) regularly updating infection prevention and control protocols, and issuing guidance to ICE Health Service Corps (IHSC) staff for the screening and management of potential exposure among detainees; 3) working with state and local health partners to determine if any detainee requires additional testing or monitoring to combat the spread of the virus. These are insufficient to prevent introduction or transmission of COVID-19 in facilities.

44. The guidance further states that “In detention settings, cohorting serves as an alternative to self-monitoring at home.” “Cohorting” is not defined in the guidance, but can be understood in combination with the guidance under the section entitled “How does ICE mitigate the spread of COVID-19 within its detention facilities?” which states that “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. Detainees who do not have fever or symptoms, but meet CDC criteria for epidemiologic risk, are housed separately in a single cell, or as a group, depending on available space.”

45. Even if ICE is to implement this 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, as referred to in paragraph 17. 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. 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.

46. The ICE guidance repeatedly refers to CDC guidance, for example stating that “ICE reviews CDC guidance daily and continues to update protocols to remain consistent with CDC guidance.” CDC guidance on correctional and detention facilities,\(^{35}\) 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 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.

47. CDC guidance 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.

48. 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. 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.

49. 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.

50. 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.
Pursuant to 28 U.S.C. 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this 24th day in March 2020 in Princeton, New Jersey.

[Signature]

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EDUCATION

<table>
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<tr>
<th>Date</th>
<th>Institution</th>
<th>Degree(s)</th>
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<tr>
<td>08/1998-10/2002</td>
<td>Dept. of Preventive Medicine/Biometrics, Uniformed Services University of the Health Sciences, F. Edward Hebert School of Medicine</td>
<td>PhD, Dissertation: Molecular Epidemiology of Malaria in Kenya</td>
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<td>08/1991-12/1994</td>
<td>Dept. of Parasitology and Tropical Medicine, Tulane University School of Public Health &amp; Tropical Medicine</td>
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<td>08/1987-05/1991</td>
<td>Hampshire College</td>
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ACADEMIC APPOINTMENTS

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


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.

**Family Health International, Arlington, VA.**  
- Technical Officer (Jan – June 1998)  
- 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.

**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

<table>
<thead>
<tr>
<th>Institution</th>
<th>Role Description</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Rights Watch, New York, NY.</td>
<td>Provide technical review for research design, analysis and documents related to health and environment and human rights.</td>
<td>Sept 2018 – Present</td>
</tr>
<tr>
<td>Walter Reed Army Institute of Research, Silver Spring, MD.</td>
<td>Developed database and provided statistical support to malaria vaccine clinical trial project.</td>
<td>Apr 2002 – June 2003</td>
</tr>
<tr>
<td>PACT, Washington, DC.</td>
<td>Designed outcome and impact evaluation of HIV behavioral intervention project.</td>
<td>June 2002</td>
</tr>
<tr>
<td>Encompass LLC, Bethesda, MD.</td>
<td>Designed evaluation of World Bank health sector reform training.</td>
<td>January – May 2002</td>
</tr>
<tr>
<td>U of Washington, Center for Health Education and Research.</td>
<td>Developed guidelines and training materials for monitoring and evaluating HIV/AIDS programs.</td>
<td>April – May 2002</td>
</tr>
<tr>
<td>PLAN International Bamako, Mali and Arlington, VA.</td>
<td>Designed and implemented quantitative and qualitative evaluation of HIV/AIDS program and developed $6 million follow-on program.</td>
<td>May – Dec 2000</td>
</tr>
</tbody>
</table>
**PEER REVIEW JOURNAL PUBLICATIONS**


**BOOK CHAPTERS**


EDITORIAL/COMMENT


LETTERS
6 Amon J, Lohman D, Thomas L. Access to pain treatment a luxury for most. Lancet 2009 Nov 14; 374:1676

OPINION

1 Empowering Women and Realizing Rights. Toronto Star. August 11, 2006
2 Why We Need an International AIDS Conference. Toronto Globe and Mail. August 15, 2006
4 Diagnosis and Prescriptions. Foreign Affairs. May/June 2007
8 Blaming Foreigners. The Korea Times. March 12, 2009
9 Progress against HIV at risk. Phnom Penh Post. November 16, 2009
13 Treatment or punishment? Bangkok Post. January 24, 2010
15 Cambodian drug rehab centers: Abusive, illegal, ineffective. The Nation (Bangkok). Jan 27 2010
16 Drug dependence is not a moral issue. Phnom Penh Post. January 29, 2010
17 Condoms and Bibles. The National (PNG). February 8, 2010
18 Chronic Pain and Torture. Huffington Post. February 23, 2010
19 Invisible Women. Huffington Post. March 8, 2010
20 How Not to Protect Children. Phnom Penh Post. March 8, 2010
21 Choam Chao needs independent investigation. Phnom Penh Post. March 24, 2010
Holiday in Cambodia? Huffington Post. April 6, 2010
When the Government Sponsors Stigma. Huffington Post. April 27, 2010 (with M. McLemore)
Zambia’s TB-ridden prisons. The Guardian. April 27, 2010
Why the Vietnamese Don’t Want to Go to Rehab. Foreign Policy. May 28, 2010
Aids and TB are breaking out of prisons. East African. June 7, 2010
Uganda AIDS Policy: from Exemplary to Ineffective. The Observer (Kampala) June 24, 2010
When a Problem Comes Along, You Must Whip It. Huffington Post. June 26, 2010
HIV Behind Bars. The Post (Lusaka). July 11, 2010
Jailing TB patients not remedy for the disease. The Star (Nairobi). Sept 17, 2010
Rights and Health, Right Now, for Migrants. Africa Now (Tokyo). October 2010 (with Kanae Doi)
The Beginning of the End for the War on Drugs? San Francisco Chronicle. November 21, 2010
Rights Abuses Belie Success in AIDS Fight. South China Morning Post. December 1, 2010
China is hurting its future by not acting on lead. South China Morning Post. June 20, 2011
Hard life in Ugandan prisons. The Independent (Uganda). July 8, 2011
A centre for abuse and beating. The Nation (Bangkok). October 11, 2011
Laos’ Murky War on Drugs. The Diplomat. October 12, 2011
One AIDS march that should end. Washington Blade. October 28, 2011
Drug treatment centres give more abuse than therapy. Bangkok Post. December 18, 2013
Enlightened drug policies emerge globally, Cambodia remains rigid. Global Post. Jan 9, 2014
Health Under Attack. HRW Dispatch. May 19, 2014 (with Jennifer Pierre)
Canada's prostitution bill a step in the wrong direction. Ottawa Citizen. June 18, 2014
Defeating AIDS. HRW Dispatch. June 30, 2015
How not to handle Ebola. CNN. September 12, 2014
58 Taking Care of the Caregivers. HRW Dispatch. December 17, 2014
59 Alert in a Time of Cholera. HRW Dispatch. March 26, 2015
60 Stop Using Hospitals as Debtor Prisons. HRW Dispatch. April 14, 2015
63 Health workers are under attack around the world. Here’s how bad it’s getting. Philadelphia Inquirer. May 28, 2019. (with Jennifer Taylor)

**INVITED PRESENTATIONS (SELECT)**


Health and Human Rights in Prisons. European Infectious Disease meeting. Italy. September 2012. (Keynote)


CONFERENCE PRESENTATIONS


7 Essah KAS, Jackson D, Attafuah JD, Amon J, Yeboah KG. Findings from the 2000 behavioral surveillance survey in Ghana. XIV International AIDS Conference: Abstract no. C11062


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


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


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


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


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)
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:


Grants:

Open Society Foundations, Public Health Program