



Chronic Indifference

HIV/AIDS Services for Immigrants Detained by the United States

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I. Executive Summary

Victoria's condition steadily worsened during the month of July, and she began to vomit blood, and blood appeared in her urine. The detainees in Pod 3 at San Pedro became increasingly concerned for her welfare as she became too weak to sit up in her bunk. Victoria was seen in the medical clinic, but she was told only to take Tylenol and drink large amounts of water...she died a week later.

—excerpt from a cellmate's account of the death in immigration detention of Victoria Arellano, a 23-year-old transgender detainee with HIV/AIDS

The death of Victoria Arellano in federal immigration custody is an extreme, but not surprising, example of the suffering experienced by immigration detainees with HIV/AIDS. The US Department of Homeland Security (DHS) fails to collect basic information to monitor immigrant detainees with HIV/AIDS, has sub-standard policies and procedures for ensuring appropriate HIV/AIDS care and services, and inadequately supervises the care that is provided. The consequence of this willful indifference is poor care, untreated infection, increased risk of resistance to HIV medications, and even death.

Human Rights Watch's investigation of HIV/AIDS care for detained immigrants which included interviews with current and former detainees, DHS and detention facility officials, and an independent medical review of treatment provided, found that ICE-supervised facilities:

- Failed to deliver complete anti-retroviral regimens in a consistent manner. This practice creates a risk of drug resistance that endangers the health of the detainee and can impact public health.
- Failed to conduct the necessary monitoring of detainees' clinical condition, including CD₄ and viral load testing as well as resistance testing. These tests are fundamental to effective treatment of HIV and AIDS.
- Failed to prescribe prophylactic medications when medically indicated to prevent opportunistic infections.

- Failed to ensure continuity of care as detainees are transferred between facilities, including failure to ensure access to necessary specialty care.
- Failed to ensure confidentiality of medical care, exposing detainees to discrimination and harassment.

With inadequate monitoring and unenforceable standards, it is not surprising that Human Rights Watch found that medical care for HIV positive detainees in ICE custody was delayed, interrupted, and inconsistent to an extent that endangered the health and lives of the detainees.

DHS fails to collect basic information concerning HIV/AIDS cases in the hundreds of detention facilities contracting with Immigration and Customs Enforcement (ICE) to incarcerate immigrants. Human Rights Watch requested, through the Freedom of Information Act, data as fundamental as the number of immigration detainees with HIV/AIDS—only to discover that this information is “not tracked.” Failure to collect this vital information, as well as information about the treatment and services provided to detainees with HIV/AIDS, prevents DHS from improving its programs to meet the needs of this vulnerable population.

The DHS policies and procedures for HIV/AIDS should describe appropriate treatment protocols for people living with HIV/AIDS to be followed in its own facilities as well as those it utilizes to provide care. DHS policies and procedures, however, are conflicting, confusing and incomplete, and fail to conform to national and international guidelines for HIV/AIDS care in correctional settings. Further, DHS has failed to adopt the detention standards as formal administrative regulations, making the standards largely unenforceable. Although ICE “outsources” much of its immigration detention to local jails and facilities across the United States, its responsibility for adequate standards of care may not be delegated or evaded by contracting with third parties.

The current ICE inspection system is limited to one brief visit per year to each jail or detention center. These visits fail to provide the oversight necessary to identify and resolve the deficiencies in medical care. The Government Accountability Office (GAO)

recently found serious flaws in ICE's mechanisms for ensuring that detainee complaints, including those pertaining to medical care, are properly monitored and resolved. Further, ICE has no policies designed to protect HIV-positive detainees from harassment and discrimination by staff or other prisoners.

Without improved standards for medical care, strengthened external and internal oversight and meaningful accountability to the public, immigrant detainees with HIV/AIDS will continue to needlessly suffer, and in some cases, die in US immigration detention.

II. Recommendations

To the U.S. Department of Homeland Security

- Ensure the adequacy of care for detainees by increasing the number and quality of inspections by the DHS Office of Inspector General. This will require strengthening the internal monitoring capacity of the Detention Standards Compliance Unit that should have the capacity to conduct multiple on-site inspections, including unannounced ones, of each facility housing detainees. Monitors should interview detainees. Monitors should possess the expertise to ensure that each facility complies with national and international correctional health care standards by providing medical care equivalent to that afforded in the community.
- Ensure the adequacy of care for detainees by revising the Medical Care Detention Standard, including the provisions related to HIV/AIDS, to conform to standards established by the National Commission on Correctional Health Care, the American Public Health Association Standards for Health Care in a Correctional Setting, or other nationally recognized standards that require medical care equivalent to that afforded in the community.
- Protect vulnerable populations from abuse and harassment by revising the Detention Standards to include a non-discrimination policy with education, training and enforcement provisions for the protection of lesbian, gay, bisexual, and transgender detainees and detainees with HIV/AIDS.
- Ensure transparency and accountability to the public by converting the Medical Care and other Detention Standards to federal administrative regulations. The promulgation of regulations would provide the public with an opportunity for comment and dialogue with the Department, increasing the transparency of immigration detention procedures. The issuance of regulations would provide legal recourse to detainees in the case of violation.
- Promote alternatives to detention for immigrants with HIV/AIDS and other chronic medical conditions. Ensure implementation of existing policies permitting prosecutorial discretion in such cases.

To the Division of Immigration Health Services

- Ensure the adequacy of care for detainees by gathering information from all detention facilities holding immigrants about the number of detainees with HIV/AIDS and the treatment and services provided to them. This information should inform the development of evidence-based policies and programs designed to address the needs of this vulnerable population.
- Ensure the adequacy of care for detainees by revising the HIV/AIDS provisions of the Medical Care Detention Standard to ensure access to voluntary testing and counseling. These provisions should ensure informed consent, confidentiality and counseling and should conform to national and international recommended standards for HIV/AIDS testing in a correctional setting.

To Immigration and Customs Enforcement

- Incorporate and require compliance with Medical Care Detention Standards (as revised above) as an express condition of contracts with private, local or county facilities. Provide training to each facility designed to ensure compliance with the standards.
- Improve the current system for tracking complaints from detainees. Ensure that complaints relating to medical care can be monitored and serious or systematic violations of the medical care standards can be identified and redressed. Ensure that detainees who complain are protected from retaliation. Ensure that all immigrants detained by ICE receive notification of complaint procedures in their native languages.
- Ensure that all detainees receive medical services free of charge.

To the U.S. Government Accountability Office

- Increase executive and legislative branch oversight of conditions of detention for immigrants by ensuring that ICE has taken appropriate action in response to the recommendations in its recent report.

To the U.S. Congress

- Ensure that all immigrants detained in federal custody are subject to comparable standards of medical care. These standards should comply with national and international correctional health care standards by requiring medical care equivalent to that afforded in the community.
- Establish a monitoring body independent of the Department of Homeland Security with the responsibility and the expertise to ensure that each facility housing immigration detainees complies with national and international correctional health care standards by providing medical care equivalent to that afforded in the community.

III. Background

Detention of Immigrants by the United States

Immigrants to the United States were first detained in significant numbers at Ellis Island, New York in the 1890s. A gateway to a new life for many, Ellis Island also earned a reputation for grim detention conditions, particularly in its last three decades of operation from 1924 to 1954. In 1954, the Immigration and Naturalization Service ceased its policy of detention except in limited circumstances and this approach remained the norm until the 1980s.¹ The detention policy resurfaced in the 1980s when thousands of Cuban and Haitian refugees arrived on US soil. Cubans from the Mariel boatlift were held in long-term detention during “processing” by the Carter Administration. Haitians who managed to survive treacherous boat trips to Miami faced detention and deportation as “economic” rather than “political” refugees. The practice of detention upon arrival was extended to Central Americans throughout the decade.²

In the 1990s detention became an integral part of United States immigration policy. Between 1994 and 2001, the average daily detention population nearly quadrupled, from 5,532 to 19,533.³ Presently, the US holds nearly 28,000 immigrants in federal detention centers, privately run prisons, and county jails.⁴ The US Immigration and Customs Enforcement agency (ICE), the enforcement unit of the Department of Homeland Security (DHS), incarcerates not only undocumented persons but legal permanent residents (LPRs), asylum seekers, families, and unaccompanied children.

¹ William S. Bernard, “A History of U.S. Immigration Policy,” in *Immigration: Dimensions of Ethnicity*, ed. Richard A. Easterlin, et al, (Cambridge, Mass.: Belknap Press, 1992); Arthur C. Helton, “The Legality of Detaining Refugees in the United States,” *NYU Rev. of Law and Social Change*, Vol 14:2 (1986).

² Mark Dow, *American Gulag: Inside US Immigration Prisons* (Berkeley: University of California Press, 2004), at 7; Helsinki Watch, *Detained, Denied, Deported: Asylum Seekers in the United States*, (New York: Human Rights Watch, June 1989).

³ Statement of Joseph Greene, INS Acting Deputy Executive Associate Commissioner for Field Operations to Congress, December 19, 2001, www.rapidimmigration.com/www/news/greene_121901.pdf, (accessed September 16, 2007)

⁴ Immigration and Customs Enforcement Fact Sheet (ICE Fact Sheet,) “ICE Office of Detention and Removal” November 2, 2006. This and other ICE Fact Sheets cited herein are available at www.ice.gov. (accessed November 18, 2007.) ICE Annual Report FY 2006, <http://www.ice.gov/doclib/about/ICE-o6AR.pdf>, (accessed July 7, 2007.)

The growing number of detainees reflects changes in law and policy intended to escalate enforcement of immigration restrictions and deportation. The first major change occurred in 1996 with the passage of the Antiterrorism and Effective Death Penalty Act (AEDPA) and the Illegal Immigration Reform and Immigrant Responsibility Act (IIRAIRA). These laws significantly changed the immigration landscape by expanding mandatory detention and eliminating much of the discretion previously exercised by administrative law judges. Mandatory detention was expanded to include perpetrators not only of crimes designated as “aggravated felonies”, which include everything from misdemeanor non-violent theft offenses to violent crimes, but of any crime involving “moral turpitude” a phrase interpreted to justify the detention and deportation of persons guilty of shoplifting, drunk driving and minor drug offenses, with reduced discretion for review of individual circumstances.⁵ Many people, including Legal Permanent Residents, are detained and deported for minor transgressions of the law for which they have already served brief sentences in their communities. Human Rights Watch has reported on the painful separation of families resulting from these harsh immigration policies.⁶

Persons subject to the United States’ “HIV Ban” may also be detained while awaiting decision on an application for waiver. Section 212 (a) (1) (A) (i) of the Immigration and Nationality Act states that any foreign national with a “communicable disease of public health significance,” including HIV, is “inadmissible.” HIV positive persons may obtain Legal Permanent Resident status only if they qualify for a waiver. Persons not eligible for waiver may be detained pending removal proceedings. Human Rights Watch and Immigration Equality have reported on the harmful and discriminatory effect of the “HIV ban”.⁷

⁵ AEDPA Section 401 and IIRAIRA Section 1229 b (a) (3), expanding the mandatory detention provisions of Section 236 (c) of the Immigration and Naturalization Act. *See*, Montag, J., “Detention and Bond Issues in Immigration Law”, *AILA Immigration Law Today*, Vol. 25: No. 6 (November/December 2006).

⁶ Human Rights Watch, *Forced Apart: Families Separated and Immigrants Harmed by United States Deportation Policy* (New York: July 2007), www.hrw.org/reports/2007/us0707/

⁷ *Human Rights Watch and Immigration Equality, “Family Unvalued: Discrimination, Denial and the Fate of Same-Sex Couples Under US Law”* (New York: May 2005) <http://hrw.org/reports/2006/us0506/>

After the September 11, 2001 attacks on the United States, the Immigration and Naturalization Service (INS) was replaced by several new agencies and placed under the jurisdiction of the newly-created Department of Homeland Security.⁸ The largest of these agencies is Immigration and Customs Enforcement (ICE). As stated in the ICE 2006 Annual Report:

On a daily basis, ICE aggressively uses powerful immigration and customs authorities to protect the American people from the illegal introduction of goods and the entry of terrorists and other criminals seeking to access our nation's borders. ICE entirely reengineered the detention and removal process and adopted a business model approach for effectively removing aliens and dangerous criminals from the country.⁹

With this extensive enforcement mandate, a budget of 4.2 billion dollars (FY 2006), and 5,300 officers, ICE has become one of the world's largest police forces, and its expansion is likely to continue. ICE added 6,300 new detention beds in FY 2006.¹⁰ Congress has authorized 40,000 new detention beds by 2010, bringing detention capacity close to 80,000 beds.¹¹

The average length of stay in immigration detention is unclear. An ICE report dated April 2006 states that detainees from "developing countries" are held for an average of 89 days.¹² Recent ICE statements indicate that the length of stay is decreasing as deportation operations intensify.¹³ These numbers, however, fail to account for the

⁸ The Homeland Security Act of 2002 abolished the Immigration and Naturalization Service (INS) and created three separate immigration bureaus within the DHS. These are the US Citizenship and Immigration Services (USCIS), Customs and Border protection (CBP) and Immigration and Customs Enforcement (ICE). Since 2003, ICE has had jurisdiction over detention and removal responsibilities.

⁹ ICE Annual Report (FY06), *supra*, at 3.

¹⁰ Immigration and Customs Enforcement (ICE) Fact Sheet, "Key Accomplishments for Fiscal Year 2006", November 2, 2006.

¹¹ Intelligence Reform and Terrorism Prevention Act of 2004, Section 5204.

¹² Department of Homeland Security, Office of Audits, "Detention and Removal of Illegal Aliens," April 14, 2006, OIG-06-33.

¹³ Nina Bernstein, "New Scrutiny as Immigrants Die in Custody," *The New York Times*, June 26, 2007.

longer term detention of many asylum seekers, unaccompanied children, and persons for whom repatriation is problematic.¹⁴

Detention Facilities

Immigration detainees are held in four types of facilities:

- Service processing centers (SPC)
- Private contract detention facilities (CDF)
- Federal Bureau of Prison facilities
- Intergovernmental service agreement (IGSA) facilities. These are state and local government facilities, primarily county jails

The eight Service Processing Centers are operated directly by ICE. Seven Contract Detention Facilities are owned and operated by private prison corporations, and five federal prisons hold immigration detainees. The majority of detainees (65 percent) are housed in more than 300 local jails dispersed throughout the country.¹⁵

For county jails and private corporations, ICE's new "business model" approach to immigration detention represents a growing and lucrative business. ICE contracts with county facilities individually and on a *per diem* basis, paying in the range of \$50-95 per day for each detainee housed in that facility.¹⁶ Profits earned from ICE contracts can be substantial. For example, in Frederick County, Maryland, the county earns a profit of 13 dollars per day per detainee; in Bergen County, New Jersey, daily

¹⁴ See, e.g., Physicians for Human Rights and the Bellevue/NYU Program for Survivors of Torture, *From Persecution to Prison: the Health Consequences of Detention for Asylum Seekers*, (June 2003) <http://physiciansforhumanrights.org/library/report-persprison.html>(accessed October 11,2007); Amnesty International, *United States of America: Unaccompanied Children in Immigration Detention* (2004); *Zadvydas v. Davis*, 533 US 678 (2001) and *Clark v. Martinez*, 543 US 371 (2005) mandating the release after 180 days of persons for whom repatriation is unlikely.

¹⁵ Department of Homeland Security, Office of Inspector General, "Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities," December 2006, (OIG Report); ICE Fact Sheet, "Detention Management Program" www.ice.gov/partners/dro/dmp.htm, accessed September 19, 2007; Testimony of Gary Mead, Asst. Director of Detention and Removal Operations, ICE, before the House Judiciary Committee, Subcommittee on Immigration, Citizenship, Refugees, Border Security and International Law, October 4, 2007.

¹⁶ Meredith Kolodner, "County Jails Boost Their Income," News21 (A Project of the Columbia and Harvard Schools of Journalism), July 27, 2006 http://newsinitiative.org/project/homeland_security/about,(accessed September 18, 2007); J. Greene and S. Patel, "The Immigrant Gold Rush: The Profit Motive Behind Immigrant Detention" in Briefing Materials Submitted to the United Nations Special Rapporteur on the Human Rights of Migrants, April 2007, www.immigrantjustice.org/mediaadvocacy.asp, (accessed July 7, 2007).

profits are estimated at 40 dollars for each detainee.¹⁷ Immigration detention is an increasingly large component of the for-profit prison industry. Companies such as the Corrections Corporation of America (CCA) have seen revenue from holding immigrants increase at the rate of 21 percent per year.¹⁸

Conditions in Detention

In a 1998 report, Human Rights Watch documented inhumane conditions in local jails contracting with immigration authorities for the detention of immigrants.¹⁹ These conditions included overcrowding, inadequate medical and dental care, inappropriate use of force, lack of access to telephone services, and frequent transfers that disrupted access to legal counsel. Human Rights Watch found that many immigration detainees were held in punitive conditions and were treated no differently than persons who had been criminally accused or convicted.²⁰ The report found that immigration authorities (then the INS) failed to adequately monitor conditions for detainees confined in the jails.

Although progress has been made in certain respects, many of these problems persist. In November 2000, in response to widespread criticism and legal challenges concerning conditions of confinement,²¹ the INS adopted 36 National Detention Standards. These standards, now part of the DHS Detention Operations Manual (DOM),²² establish minimum conditions and procedures for many aspects of detention, including legal access, medical care, and discipline. The development of

¹⁷ Sherry Greenfield, "County Earns Cash Detaining Illegals", *Maryland Gazette*, September 13, 2007, www.gazette.net/stories/091307/frednew72204_32359.shtml, (accessed September 19, 2007); Greene and Patel, "The Immigrant Gold Rush," *supra*.

¹⁸ Meredith Kolodner, "Immigration Enforcement Benefits Prison Firms," *The New York Times*, July 19, 2006.

¹⁹ Human Rights Watch, *Locked Away: Immigration Detainees in Jails in the United States*, (New York: September 1998) www.hrw.org/reports98/us-immig/Ins989.htm.

²⁰ As discussed in Section VII below, immigration detainees are not convicted prisoners, but are civil detainees held pursuant to civil immigration laws. Their constitutional protections derive from the Fifth Amendment, and their conditions of confinement must not be punitive. See, *Wong Wing v. United States*, 163 U.S. 228, 237 (1896); *Jones v. Blanas*, 393 F. 3d 918 (9th Cir. 2004).

²¹ Chris Hedges, "Policy to Protect Jailed Immigrants is Adopted by U.S.," *The New York Times*, January 2, 2001. For a detailed account of detention conditions as well as public pressure and legal action against INS in the 1990s, see Dow, *American Gulag*, *supra*.

²² Department of Homeland Security, Detention Operations Manual, 2006, www.ice.gov/partners/dro/opsmanual/index.htm, (accessed July 20, 2007).

standards represented a step forward and was a result of cooperation with the American Bar Association and national immigration advocacy organizations. However, as discussed below, the ICE health care standards, particularly those addressing HIV/AIDS, fall below correctional health care standards established by nationally recognized experts and fail to comply with international recommendations for the treatment of prisoners with HIV/AIDS. Because even these lower standards have not been codified as federal regulations they are non-binding and unenforceable, leaving detainees with limited legal recourse if the standards are violated. Moreover, ICE carves out exceptions for many provisions of the standards, stating that for the hundreds of local jail facilities contracting individually with ICE to house detainees, these provisions are only “guidelines.”²³

Complaints of abuse, neglect, and inhumane conditions in immigration detention continue despite the issuance of internal standards. In June 2007 *The New York Times* and *The Washington Post* investigated the 62 deaths in immigration detention since 2004.²⁴ Four additional immigrants died in detention since those articles appeared.²⁵ Class action lawsuits filed in February and June 2007 challenge overcrowded conditions and inadequate medical and dental care at ICE’s San Diego facility, operated by Corrections Corporation of America.²⁶ Conditions adverse to the physical and mental health of the detainees were found at ICE’s “family detention centers.”²⁷ (ICE recently settled consolidated lawsuits challenging the conditions of detention for children in one such center).²⁸ At the five county jails in New Jersey that contracted with ICE, detainees experienced inadequate medical and dental care, verbal and physical abuse, and denial of access to the law library and to

²³ See, e.g. DOM, Medical Care, section II.

²⁴ Nina Bernstein, “New Scrutiny as Immigrants Die In Custody,” *The New York Times*, June 26, 2007; Darryl Fears, “Illegal Immigrants Received Poor Care in Jail, Lawyers Say”, *The Washington Post*, June 12, 2007.

²⁵ Congressional Testimony of Gary Mead, *supra*.

²⁶ *Kiniti, et al. v. Myers*, (3:05-cv-01013-DMS-PCL) U.S.D.C., S.D. CA (2007); *Woods et al v. Myers, et al.*, (3:07-cv-1078DMS-PCL), (2007) U.S.D.C., S.D. CA (2007).

²⁷ “Locking Up Family Values: The Detention of Immigrant Families”, Women’s Commission for Refugee Women and Children and Lutheran Immigration and Refugee Service, February 2007, www.womenscommission.org/pdf/famdeten.pdf, (accessed July 11, 2007).

²⁸ *In re Hutto Family Detention Center*, A-07-CA-164-SS, U.S.D.C., W.D. Tex. (2007).

telephones.²⁹ The National Immigrant Justice Center, Amnesty International and other members of a coalition of immigrants' and human rights organizations submitted comprehensive briefing materials to the United Nations Special Rapporteur for the Human Rights of Migrants describing overcrowding, lack of access to telephone services and legal counsel, inadequate medical, dental and mental health care, and other substandard conditions in immigration detention facilities throughout the U.S.³⁰ The San Pedro Service Processing Center, an ICE-operated detention facility in San Pedro California, closed in October 2007 after losing its accreditation from the American Correctional Association.

Recent government audits also found violations of the detention standards in facilities operated by ICE, by private corporations, and in county jails. The DHS Office of Inspector General (OIG) and the US Government Accountability Office (GAO) identified violations in the areas of health care, environmental health and safety, overcrowding, food service, and reporting incidents of abuse to ICE management.³¹ The Government Accountability Office (GAO) report found "insufficient internal controls and weaknesses in the ICE compliance review process."³²

Accountability

The OIG and GAO reports criticize government oversight of detention conditions in ICE contract facilities. Currently, the ICE system for internal oversight consists of one inspection per year of each of its 300-plus detention facilities. These inspections failed to identify many of the serious violations found by the OIG report, causing the OIG to question the adequacy of ICE compliance monitoring.³³ Similarly, the GAO

²⁹ American Civil Liberties Union of New Jersey, "Behind Bars: The Failure of the Department of Homeland Security to Ensure Adequate Treatment of Immigration Detainees in New Jersey," May 2007, www.aclu-nj.org/downloads/051507DetentionReport.pdf, (accessed July 11, 2007).; New Jersey Civil Rights Defense Committee, "Voices of the Disappeared: An Investigative Report of New Jersey Immigration Detention," October 2007, <http://www.nj-civilrights.org/literature/VoicesoftheDisappeared.pdf>, (accessed November 5, 2007).

³⁰ Detention and Deportation Working Group "Briefing Materials Submitted to the United Nations Special Rapporteur on the Human Rights of Migrants", May 2007, available on the website of the National Immigrant Justice Center, www.immigrantjustice.org/mediaAdvocacy.asp#UNSR, (accessed July 11, 2007).

³¹ OIG Report, *supra*.

³² Government Accountability Office Report GAO-07-875 (GAO Report): Alien Detention Standards, July 2007.

³³ OIG report, *supra*, at 36.

report addressed the failure of ICE's Department of Removal Operations (DRO) to adequately review and investigate detainee complaints:

ICE's lack of a formalized tracking process for documenting detainee complaints hinders its ability to 1) identify potential patterns of noncompliance that may be system wide and 2) ensure that all detainee complaints are reviewed and acted upon if necessary.³⁴

Because the detention standards are not codified as federal regulations, they cannot provide formal grounds for relief for detainees in any type of immigration detention facility. The failure of DHS to provide legal recourse to detainees alleging inhumane or substandard conditions has been challenged by immigration rights advocates in the form of a Petition for Rulemaking filed January 25, 2007 under the Administrative Procedure Act. The Petition seeks promulgation of regulations governing detention standards for immigrants, which would then trigger notice and comment provisions, opening a dialogue between DHS, ICE, and the public regarding detention policies.³⁵ As of this date, DHS has taken no action on the petition.

The unwillingness of ICE to provide information to the public further hinders oversight of its compliance and monitoring activities. For example, ICE permits the American Bar Association (ABA) to conduct inquiries into complaints received from immigration detainees; ICE, however, prohibits the ABA from any public release of the results of these inquiries. While acknowledging 66 deaths in immigration detention since 2004, ICE has made it difficult for the families of the deceased to obtain information about the incidents, and there is no requirement that ICE publicly report deaths in its custody.³⁶ The UN Special Rapporteur for the Human Rights of Migrants was turned away from two of the three facilities he attempted to visit during his May 2007 mission to the United States.³⁷ Congress fares little better when it comes to disclosure from ICE. Congresswoman Zoe Lofgren (D-CA), Chair of the

³⁴ GAO report, *supra*, at 39.

³⁵ Petition for Rule-Making to Promulgate Regulations Governing Detention Standards for Immigration Detainees, filed January 25, 2007, www.nationalimmigrationproject.org/Press.html, (accessed July 11, 2007).

³⁶ Bernstein, *NYT*, 6/26/07, *supra*.

³⁷ Statement of the Special Rapporteur for the Human Rights of Migrants, May 17, 2007, United Nations Office at Geneva, News Briefing, www.unog.ch/, (accessed July 11, 2007).

House Subcommittee on Immigration, recently wrote ICE seeking information about revised detention standards that had reportedly been prepared and even distributed to several detention centers with no notice to the Committee.³⁸ Despite this and other inquiries from immigration advocates, ICE has released little information regarding the issuance of revised detention standards as of the date of this report.³⁹ ICE's consistent avoidance of scrutiny has resulted in an agency recently characterized by the *Miami Herald* as "shrouded in secrecy."⁴⁰

³⁸ Letter to DHS Asst. Secretary Julie Myers dated September 7, 2007.

³⁹ As this report went to press Julie Myers, Assistant Secretary of Homeland Security for Immigration Customs and Enforcement, agreed to meet with a small number of NGOs to discuss the revision of the detention standards. The parameters of this discussion had not yet been determined.

⁴⁰ Editorial, "Immigration Lockup a Serious Health Risk", *Miami Herald*, July 3, 2007.

IV. Methodology

This investigation began in early 2007 with a review of complaints received by Human Rights Watch from detained immigrants and their advocates regarding medical care for detainees with HIV/AIDS.

Human Rights Watch first examined the policies and procedures of the Department of Homeland Security (DHS) and its sub-agencies (ICE and DIHS) relating to HIV-positive immigration detainees. We examined how these policies and procedures compared to national and international standards and ensured quality care for all HIV positive detainees, including those held in the hundreds of local and county jails to which ICE outsources its immigration detention.

The policies and procedures of DHS, ICE, and DIHS relating to HIV-positive detainees are discussed in section VI below. Also discussed are the results of a Freedom of Information Act (FOIA) request to DHS requesting data concerning the detention, testing, treatment and services provided for immigrants with HIV/AIDS in all facilities supervised by, or contracting with, ICE.

Human Rights Watch next interviewed twelve current and former immigrant detainees living with HIV/AIDS about medical care and services for HIV infection provided in detention. The immigrants were referred to Human Rights Watch by their attorneys or, in some cases, local community advocates. They were interviewed in English, under conditions that ensured privacy and confidentiality. Detainees were interviewed at detention facilities in California, Alabama, New Jersey and Virginia. These facilities included one Service Processing Center, one corporate-owned facility, and four county jails. Ex-detainees described their experiences at detention facilities in Pennsylvania, Texas, Louisiana, Illinois, Wisconsin, and Virginia.

Regarding the death of Victoria Arellano, Human Rights Watch interviewed one current and one former detainee and reviewed the testimony submitted to civil rights attorneys by dozens of detainees from her housing unit. Human Rights Watch attempted to interview her cellmates but more than 20 key witnesses to her death

were transferred days before the arrival of Human Rights Watch at the San Pedro Service Processing Center (see text box below). Human Rights Watch has requested a copy of the coroner's report as the investigation of her death continues.

Human Rights Watch also interviewed wardens at a privately owned prison in Alabama and a county jail in Virginia, and a medical liaison officer at a county jail in New Jersey. On October 25, 2007 Human Rights Watch attended a meeting with ICE officials, including Gary Mead, Asst. Director for Detention and Removal, US Immigration and Customs Enforcement.

With the consent of the interviewees, Human Rights Watch engaged the services of a medical expert to review detainee medical records and provide an independent opinion concerning compliance of the medical care with community standards. Dr. Jaswinder Legha is board-certified in Internal Medicine and received her medical and Master's degree in public health from Columbia University. Dr. Legha completed her residency training in Internal Medicine at Bellevue/NYU Medical Center, an institution which serves a significant population of individuals living with HIV. Her review was necessarily limited to the records received by Human Rights Watch from the various facilities, which in some cases were incomplete or partially legible. Highlights of the medical review appear below following the testimony of the detainees.

Because the Division of Immigration Health Services does not monitor the number of detainees living with HIV/AIDS, it is impossible to determine the scope and representativeness of the medical care provided to detainees interviewed for this report. Although the number of detainees interviewed is limited, the methodology supports generalized conclusions regarding the quality of medical services provided to detainees living with HIV/AIDS. The testimony provides geographical coverage (9 states), covers the three major types of facilities utilized by ICE (Service Processing Centers, corporate-owned, and county jails), and is supported by continuing correspondence to Human Rights Watch from additional detainees and their advocates. The independent medical review found a consistent pattern of sub-standard care.

HIV/AIDS and Medical Treatment

AIDS is caused by the human immunodeficiency virus, or HIV. By killing cells in the immune system called CD₄+ T cells (CD₄), HIV progressively destroys the body's ability to fight infections and certain cancers. Regular monitoring of CD₄ cells and the amount of HIV in the body, or viral load, is essential to determining appropriate treatment. Antiretroviral therapy, or ART, treats HIV with a combination of medications that each attacks the virus's life cycle in a different way. Based on laboratory test results, doctors also prescribe different prophylactic drugs to prevent patients from developing opportunistic infections such as PCP (*pneumocystis pneumonia*).

A key aspect to achieving the benefit of ART is full adherence to the therapy regimen. Due to the rapid multiplication and mutation rate of HIV and other factors, very high levels of adherence to antiretroviral schedules are necessary to avoid viral resistance. In comparison with patients who are adherent to ART, non-adherent people have higher mortality rates, less improvement in CD₄ cell count and spend more days in the hospital. Viral resistance not only affects the health of the individual, but also that of the community, as resistant strains can be transmitted to others.

Sources: Panel on Antiretroviral Guidelines for Adult and Adolescents. Guidelines for the use of antiretroviral agents in HIV-infected adults and adolescents. United States Department of Health and Human Services. October 10, 2006; 1-113. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. Accessed November 5, 2007); WHO/UNAIDS/UNODC, *Effectiveness of interventions to manage HIV in prisons- HIV care, treatment and support* (Geneva, WHO,2007).

V. Findings

The US Department of Homeland Security (DHS) fails to collect basic information to monitor immigrant detainees with HIV/AIDS, has sub-standard policies and procedures for HIV/AIDS care and services, and inadequately supervises the care that is provided. These policies are discussed in section VI below.

The consequence of these policies is sub-standard care. ICE fails to ensure that detainees with HIV/AIDS receive medical care that reflects human rights standards, or best medical practice. Nor does the care provided comply with community, national, or international standards for correctional health care. The statements of current and former immigrant detainees, set forth in detail below, demonstrate delayed, inconsistent, and insufficient care as well as a failure to protect confidentiality for a vulnerable population.

Deficient medical care included:

1) Failure to consistently deliver anti-retroviral medications.

Sometimes I will get no medication at all. Other times I will get 1 or 2 out of 3.
—Peter R., a 43-year-old Jamaican man detained at Hampton Roads Regional Jail in Portsmouth, Virginia. Peter's diary for July 2007 showed that he received a full dosage of HIV/AIDS medication only 65 percent of the time.

Detainees frequently missed entire dosages or only partial doses were delivered. The risk of drug resistance created by this practice not only endangers the detainee but is a serious threat to public health.

2) Failure to conduct necessary laboratory tests in a timely manner, including CD4 and viral load testing as well as resistance testing.

I have no idea what my T cells are, or how I am doing with this virus.
—Diane P., a 41-year-old woman from Trinidad detained at Monmouth County Correctional Institution in Freehold, New Jersey.

Regular laboratory monitoring is critical to effective ART treatment for patients living with HIV and AIDS. CD4 and viral load testing indicate whether ART regimens should be initiated and how effectively they are treating HIV/AIDS. Resistance testing is imperative to identify whether the patient has developed resistance to certain classes of drugs and, if so, how to adjust the ART regimen.

3) Failure to prevent opportunistic infections.

Independent medical review of detainee records found consistent failures to provide appropriate, timely treatment to prevent opportunistic infections. HIV attacks the body's immune system, leaving patients vulnerable to serious opportunistic infections such as PCP (*pneumocystis pneumonia*) and toxoplasmosis.

4) Failure to ensure continuity of care including access to necessary specialty care.

I have been here for six months now and I haven't seen a specialist on chronic disease. When I was in Arizona, the health care provider scheduled me to see a specialist....But I wasn't able to go because I [was transferred] back to California.

—Letter to Human Rights Watch from Samuel L., detained at the San Pedro Service Processing Center (see text box.)

In ICE custody, continuity of care for this complex, chronic disease is frequently interrupted by frequent transfer of detainees within the system and failure to transfer medical records between detention facilities.

5) Failure to ensure confidentiality of medical care, exposing detainees to discrimination and harassment.

Are you the one that's HIV positive?

—Question asked by ICE officer to Anna F. in front of other detainees, at the Varick Street facility in New York City.

Detainees described crowded, hectic pill distribution systems and staff insensitivity that failed to protect the confidentiality of prisoners with HIV/AIDS. Still stigmatized, HIV-positive, gay, and transgender detainees face abuse and harassment from staff

and other prisoners in the absence of any ICE policies designed to prevent or punish discrimination.

These treatment deficiencies are demonstrated by the following testimony and medical review.

Statements and Information from Immigrants in Detention Living with HIV/AIDS

Peter R.

There seemed to be no system for giving us the AIDS drugs.

—Testimony of Peter R., a 43-year-old Jamaican man detained at Hampton Roads Regional Jail in Portsmouth, Virginia

Peter R.⁴¹ is a 43-year-old man from Jamaica, trained as a pharmacist and a resident of the United States for 23 years. After serving time at the Washington, DC Jail, he was transferred to ICE custody in September 2006. He spent the first three months at the Piedmont Regional Jail in Farmville, Virginia. In December 2006 he was transferred from Piedmont to the Hampton Roads Regional Jail in Hampton Roads, Virginia. He has filed a claim for relief from deportation on the grounds that he will be persecuted in Jamaica because he is gay.

Peter was diagnosed as HIV positive in 1988 while living in Washington, DC. He began treatment in 1997, and was on an anti-retroviral regimen when he arrived at Piedmont Jail. ICE officials permitted him to bring one week's supply of medication with him upon transfer, but when the medication ran out after one week, they had not yet ordered more. *"They told me, we don't have those meds, we'll have to order them, and get ICE to authorize them."* He received no HIV/AIDS medications for two and a half weeks. Over the next 3 months, there were two additional one week interruptions in his medications. Each time they told him they had to "re-order" the prescription. As Peter stated, *"There seemed to be no system for giving us the AIDS drugs."*

⁴¹ Human Rights Watch interview with Peter R., Hampton Roads Regional Jail, Portsmouth, Virginia, June 20, 2007. Peter R. is a pseudonym used at his request.

At Piedmont Jail, Peter found it necessary to advocate for himself in order to receive medical care. *“The doctor at Piedmont wouldn’t touch me. I had to beg them to do lab work to find out my CD4 (count) and my viral load.”*

At night, I was coerced into sex- they would line up and I would have to perform, you know, oral sex on them. I reported this to the guards but they did nothing. After the shower incident (in which Peter was threatened with rape) I wrote to my lawyer and she got me transferred to Hampton Roads.

Piedmont Jail transferred Peter with only two of his three anti-retroviral medications. At Hampton Roads Jail, medical staff told him that he would have to see the doctor before they could renew his medications. They took away the medications he arrived with, and two and a half weeks passed before he returned to a medication regimen. According to Peter, the medication supply situation at Hampton Roads was even worse than it was at Piedmont. *“The supply situation with AIDS meds is totally a mess- I have had to beg for my medicine every month for six months, because every month they run out and they don’t have any more meds on hand.”* Peter states that he has had repeated two to three week delays in receiving his AIDS medication.

Peter was initially housed at Hampton Roads in the ICE unit with other detainees but he was once again harassed. Now housed in a non-ICE unit with county jail prisoners, he feels safer. However, he continues to experience delays and interruptions in his medications. *“On the ICE pod, they let me self-administer the drugs so I took them at regular times. Now, on the other pod, they won’t let me self-administer so my medications arrive at all times of the day... Sometimes I will get no medication at all. Other times I will get 1 or 2 out of 3.”*

Peter kept a diary in July 2007 to record his medication delivery. This diary shows an erratic delivery of HIV/AIDS medication in which he received a correct dosage (3 pills in the morning, 3 pills in the evening) only 65 percent of the time.

A pharmacist by profession, Peter is knowledgeable about his own health. *“I know more about HIV/AIDS than the doctors do. I told him that Vitamin C was good for me,*

so he said I could have it. I knew to look out for the triglyceride levels due to Kaletra, but he wasn't aware of that."

Peter's diary of HIV/AIDS medications received July 2007

- *July 4: no medication received*
- *July 5: A.M. : two of three medications received (no Epivir)*
P.M: no medications received
- *July 6: P.M. no medications received*
- *July 7: P.M. received Kaletra only*
- *July 8: P.M. no medications received*
- *July 9: P.M. no medications received*
- *July 10: P.M. no medications received*
- *July 11: A.M. two of three medications received (no Epivir)*
P.M. no medications received
- *July 12: A.M. two of three medications received (no Viread)*
P.M. no medications received
- *July 13: received both AM and PM dosages*
- *July 14: received both AM and PM dosages*
- *July 15: P.M. received two medications and only one-half of Epivir dosage*
- *July 16: P.M. received two medications and only one-half of Epivir dosage*
- *July 17: received both AM and PM dosages*
- *July 18: AM: received two of three medications (no Epivir)*
- *July 19: received both AM and PM dosages*
- *July 20: received both AM and PM dosages*
- *July 21: received both AM and PM dosages*
- *July 22: received both AM and PM dosages*
- *July 23: received both AM and PM dosages*
- *July 24: AM: received two of three medications (no Kaletra)*
- *July 25: received both AM and PM dosages*
- *July 26: PM: no medications received*
- *July 27: received AM dosage at 1 PM, received PM dosage*
- *July 28: received both AM and PM dosages*
- *July 29: received AM dosage only*

Diary ends.

Independent Medical Review

- Mr. R. was on an appropriate antiretroviral medication combination.
- Mr. R's medical records document some findings that suggest inconsistent ART delivery.
 - On May 14, 2007 a clinic note documents that "patient reports no Kaletra (Lopinavir/Ritonavir) given."
 - According to medication administration records, several doses of Mr. R's antiretroviral medications were not given in March 2007.
 - The records indicate inconsistent delivery of Mr. R's psychiatric medications during several months in 2007. These medications should be taken regularly to be effective.
- The medical records reviewed ended in May 2007. If Mr. R's medication diary for July 2007 is accurate, such inconsistent medication delivery for July 2007 is quite concerning and potentially dangerous.
 - Of 51 doses recorded, he received only 33 as prescribed, or 65 percent of doses. The goal should be as close to 100 percent as possible.
 - Taking only a partial ART regimen puts one at high risk for developing drug resistance. This in turn can increase the risk of becoming sicker sooner, having limited treatment options later, as well as having a potentially harmful impact on public health.
- Mr. R's blood work (including CD4 count, viral load, triglycerides, etc.) was monitored with appropriate frequency. Viral load results, however, suggested that his medication regimen was failing, and that his ART regimen should have been reevaluated. The chart documents continued use of the same regimen without evidence of such reevaluation.⁴²
- According to medical request forms in the chart, Mr. R. was charged fees for his sick call requests.

⁴² Following Dr. Legha's review Peter R. was contacted and advised to undergo resistance testing if possible.

Victoria Arellano: Death in Detention

Victoria⁴³ Arellano, a 23-year-old transgendered woman from Mexico with HIV/AIDS, died in ICE custody on July 20, 2007. She had been detained at the San Pedro Service Processing Center (SPSPC) for 8 weeks. According to her cellmates,⁴⁴ her health began to deteriorate when medical staff refused to continue her regular prescriptions.

Victoria's condition steadily worsened during the month of July, and she began to vomit blood, and blood appeared in her urine. The detainees in Pod 3 at San Pedro became increasingly concerned for her welfare as she became too weak to sit up in her bunk. Victoria was seen in the medical clinic, but she was told only to take Tylenol and drink large amounts of water.

On the night of July 12, 2007, her condition appeared critical to her cellmates, who were cleaning her and disposing of her bodily fluids. The "leader" of Pod 3 asked for an ICE representative to come to the pod. An ICE Captain responded to this request. He walked over to Victoria's bunk, placed his shoe on her pillow and asked rudely, "What's wrong with you?" The detainees were shocked. "They were treating her like a dog."

The detainees began chanting "Hospital! Hospital!" A nurse came down and said "Oh it's Victoria! There's nothing we can do. She just needs Tylenol and water." Later that night, Victoria was taken to the hospital, but returned the next day. She was very weak and told her cellmates that the medical and security staff had put her in a holding cell and taunted her. Victoria told her cellmates that "it was a nightmare." The following morning she was taken to the hospital again, where she died a week later of meningitis, a condition often associated with advanced AIDS.

On August 9, 2007 an article about Victoria's death appeared in the *Los Angeles Daily Journal*. Three of Victoria's former cellmates were quoted by

⁴³ Victoria Arellano's birth name was Victor.

⁴⁴ The information in this account is based upon testimony provided to Human Rights Watch and the ACLU of Southern California by Victoria Arellano's cellmates in July and August 2007.

name in the article. Human Rights Watch attempted to interview these and other of Victoria's former cellmates at the SPSPC only to find that more than 20 of Victoria's cellmates from Pod 3 had been transferred to other ICE facilities throughout the United States. Human Rights Watch and the ACLU of Southern California demanded that ICE conduct a prompt, comprehensive and transparent investigation of Victoria's death as well as the sudden transfer of more than 20 of her former cellmates from Pod 3. As of the date of publication of this report, ICE has failed to respond to Human Rights Watch's demand for a formal investigation.

The United States is a party to the Convention Against Torture (CAT), which requires that detainees must not be subjected to any form of torture or cruel, inhuman or degrading treatment while in detention.⁴⁵ If true, the neglect of Victoria's suffering, the failure to provide medical care and her subjection to taunting, harassment, and insults may constitute violations of the Torture Convention.

Anna F.

Almost every other day one of my pills is missing. I get my full dose only 60 percent of the time.

- Anna F., a 51-year-old woman detained at Bergen County Jail in Hackensack, New Jersey.

Anna F.⁴⁶ was born of Latvian parents in a refugee camp in Germany. She has lived in the United States since she was four years old, primarily in Brooklyn with her son and daughter (both US citizens) and her father. Doctors diagnosed Anna with HIV in 1987. Anna stated that she also has a deteriorating hip joint, high blood pressure and depression.

⁴⁵ Convention Against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment (CAT), adopted December 10, 1984, G.A. Res. 39/46, annex, 39 UN GAOR Supp. (no. 51) at 197, UN Doc. A/39/51 (1984) entered into force June 26, 1987, ratified by the U.S. on October 14, 1994, article 16 (1).

⁴⁶ Human Rights Watch interview with Anna F., Bergen County Jail, Hackensack, New Jersey, July 10, 2007. Anna F. is a pseudonym used at her request.

In May 2007, Anna was arrested on a drug offense and spent a month in jail at Rikers Island. At Rikers Island, they told her that her CD4 count was 33, and she was given anti-retroviral medications. On the day she was to be released from Rikers, she was transferred by ICE to immigration detention at the Bergen County Jail, where she has been detained for four weeks.

Bergen County Jail conducted an intake medical exam within 24 hours of Anna's arrival. Anna was suffering badly from methadone withdrawal. Anna had taken methadone on a regular basis for 27 years. At Rikers she received methadone, but at Bergen County she said she was told flatly that "we don't give methadone." Anna lay ill for 6 days in the infirmary. *"I couldn't even think about my AIDS medication because I was so sick from going cold turkey- I didn't think I was going to make it through that."* After 6 days in the infirmary, she moved to the dorm and it took another week to get her AIDS medication started.

Anna makes notes in her diary of the days she does not get all of her medications. She states that *"almost every other day one of my pills is missing. I get my full dose only 60 percent of the time."* Anna describes the medical staff at Bergen as very disorganized. For example, she stated, the other day they gave her someone else's medication and just before she was about to take it, they realized their mistake and stopped her.

The medical people are also very rude to us (immigration detainees).
The doctor's first question was 'when are you leaving?' How do we know when we're leaving? ⁴⁷

Concerned about the confidentiality of her HIV status, Anna tells the following story. At the ICE detention facility on Varick Street in New York City where she was held for a day between Rikers and Bergen County Jail, an ICE officer said to her, in front of other detainees, *"Are you the one that's HIV positive?"* Among those who overheard this question was a detainee on her way to Bergen County Jail and she has told other detainees of Anna's HIV status. Anna stated that the pill distribution procedure at

⁴⁷ Human Rights Watch interview with Anna F., Bergen County Jail, Hackensack, New Jersey, July 10, 2007.

Bergen County Jail is not confidential. Prisoners and detainees crowd up to the pill cart, where individual medical files are sometimes left open with the contents visible.

At Bergen County Jail they house the female immigration detainees in the “medical clearance” dormitory. According to Anna, this dorm is where newly arrived prisoners are housed until they receive medical clearance to be housed in other dorms. Anna worries that with a compromised immune system, she is being exposed to contagious medical conditions. Also, Anna is very upset that her daughter cannot visit her at the facility—Bergen County offers no visiting hours on the weekends for immigration detainees. Because her daughter works Monday through Friday, she has not been able to visit her mother.

Anna has received no HIV counseling, education, or information at the Bergen County Jail.

Independent Medical Review

- Ms. F. received a full medical and mental health assessment upon arrival at the facility. The chart suggests appropriate psychiatric evaluation and care during her incarceration.
- She was prescribed an appropriate ART regimen which included the drugs Truvada (Emtricitabine/Tenofovir) and Kaletra (Lopinavir/Ritonavir).
- HIV patients, particularly someone with a history of substance use, should be screened for hepatitis B and C. People taking Truvada (Emtricitabine/Tenofovir) in particular should also be screened, as its discontinuation can cause Hepatitis B to flare up. These results were not present in the record.
- With low CD4 counts of 57 and then 87, Ms. F. should be taking prophylaxis against opportunistic infections such as PCP and possibly toxoplasmosis. The chart does not indicate that such action was taken, nor does it document any contraindications to such treatment.⁴⁸

⁴⁸ Following Dr. Legha’s review Anna was contacted to inform her of the need for prophylactic medication.

- Medication administration records were not available. If Ms. F. received her complete ART regimen only 60 percent of the time, it would not be surprising if she developed drug resistance.

Diane P.

I have no idea what my T cells are, or how I am doing with this virus.

—Diane P., a 41-year-old woman from Trinidad detained in New Jersey.

Diane P.⁴⁹ is a 41-year-old woman detained at the Monmouth County Correctional Institution (MCCI) in Freehold, New Jersey. Originally from Trinidad, Diane has been in the United States since 1983. She spent two months in jail at Rikers Island on criminal charges, and then transferred to ICE custody in January, 2007.

Diane received her HIV/AIDS diagnosis in 2002 when she was living in Poughkeepsie, New York. Quite ill at the time, she was told by doctors that she had fewer than 50 CD4+T cells. She began anti-retroviral treatment at that time. During her incarceration at Rikers Island, lab work showed that her CD4 cell count was up to 400. The medical staff at Rikers Island continued her medication regimen.

When she was transferred to ICE custody at MCCI, no bloodwork was done to evaluate her CD4 count or viral load. She brought her medications with her but they were confiscated, and two days passed before new medications were provided. Diane told Human Rights Watch that despite the fact that she had recently had very low CD4 counts, no lab work had been conducted for six months. She said *“I have no idea what my T cells are, or how I am doing with this virus.”*

Diane said that she has pain in her hands, a condition she believes to be HIV/AIDS-related neuropathy. After filling out “many” sick call requests, Diane saw a doctor who prescribed ibuprofen, which she must purchase herself from the commissary. She stated that the symptoms of pain and stinging have not subsided. Diane described the attitude of the nursing staff to sick call requests: *“They try to*

⁴⁹ Human Rights Watch interview with Diane P., Monmouth County Correctional Institution (MCCI), Freehold, New Jersey, May 1, 2007. Diane P. is a pseudonym used at her request.

discourage you from putting in a sick call request. I had one nurse tell me ‘don’t put in a request unless it’s an emergency.’”

Diane describes the pill distribution at MCCI as irregular. Diane said that detainees who participate in programs risk missing the pill delivery. *“The meds are given out at completely random hours; literally, they are never given out at the same time two days in a row... On Saturdays when I go to Bible class I miss my morning pills altogether because they don’t come back to the dorm and find the people who were at work or at class.”* Diane says she was prescribed vitamins and was receiving them for a time, but they have recently been stopped without explanation.

Diane stated that the pill line procedure fails to protect confidentiality. *“There is no order to it and no private space,”* she said. Prisoners jostle each other around the cart and medical records on the top of the cart are visible to all. *“The other detainees are too interested in my condition and ask me why I take so many meds.”* One male nurse even calls out the names of the medications sometimes, and once he called out the names of Diane’s medications as he administered them to her.

Diane has received no HIV counseling, education or information at MCCI.

Independent Medical Review

- The chart indicates that Ms. P. received medical and mental health assessments when she arrived at the facility.
- The chart documents some, but not all, lab results from Rikers from January 2007. Ms. P. received some, but not all, necessary lab work in May 2007, four months after arrival at the facility.
- The chart indicates that Ms. P. was prescribed an appropriate ART regimen. Medication administration records indicate reliable medication distribution during some months but missed doses during others.
- Ms. P’s viral load was not suppressed as should be expected after months on ART; therefore her ART regimen should have been reevaluated. There is no indication that a reevaluation occurred.
- The chart indicates that Ms. P. was charged a fee for medical visits.

Nargis R.

The doctor ‘recommended’ that I start treatment, but she wasn’t forceful about it so ICE ignored it. I never went on (HIV/AIDS) medication at York.

—Nargis R., a 31-year-old woman from Trinidad detained in ICE custody for three and a half years.

Nargis R.⁵⁰ is a 31-year-old woman from Trinidad who has been in the United States since she was 9 years old. After serving a 69-day sentence for a misdemeanor fraudulent check charge, Nargis spent three-and-a-half years in immigration detention. With the assistance of her lawyer, she obtained release in 2004 and is living in a homeless shelter in New York City.

Nargis lived most of her life in upstate New York. A Legal Permanent Resident, she graduated from high school in Albany, New York and worked as a secretary. Nargis contracted HIV from her first husband, who died of AIDS several years ago. He was a US citizen, but lacked the financial means to sponsor her for citizenship. Nargis has since remarried, again to a US citizen, but he too lacks the requisite resources to finance a sponsorship application. Nargis’ family, including her parents, siblings, nieces and nephews, lives in the United States. She has not been back to Trinidad since she arrived in the United States 22 years ago.

After Nargis had served 69 days for the misdemeanor charge, ICE placed a hold on her case and immediately transferred her into ICE custody at the York County Jail in York, Pennsylvania. She recalled the medical care she experienced at the York County Jail. They told her that according to her lab work, her CD4 counts were high enough that she did not need HIV/AIDS medication. She fell ill, however, with severe stomach pain and boils on her skin. *“The pain was so bad that sometimes I couldn’t get out of bed.”* She was moved to a unit used to isolate jail prisoners for both medical and disciplinary reasons.

The doctors at York requested from ICE that she be permitted a visit with an HIV specialist. ICE denied this request and continued to deny it for more than a year. Nargis and her attorney persisted and after the appeal went to the level of the ICE

⁵⁰ Human Rights Watch interview with Nargis R., New York, NY, March 23, 2007.

District Director she was permitted to see a specialist. The specialist told her that her CD 4 count was dropping and her viral load was increasing. *“The doctor ‘recommended’ that I start treatment, but she wasn’t forceful about it so ICE ignored it. I never went on [HIV/AIDS] medication at York.”*

Nargis said that confidentiality was a problem at York. Security officers remained in the room during sick call visits, overhearing all that was said between the detainee and the nurse. She believes that the guards talked about her condition in front of the other detainees. She once offered to serve the meals to the other detainees in the dorm, but the detainees told her that they did not want her to touch their food. *“The guards said that the detainees were right, and that I should clean the toilets instead.”*

In the meantime, Nargis became seriously ill with repeated urinary tract infections and stomach pain. The medical staff treated her only with Tylenol, and her condition worsened. One night in the dorm she could not move, her skin was a dark color, and her stomach was bloated. *“The officer on duty noticed how sick I looked and called the medical team to the dorm. They rushed me to the hospital, where I spent three days with a severe kidney infection. They gave a morphine drip every ten minutes for the pain.”*

After 14 months at York County Jail, Nargis was transferred to Denton County Jail in Denton, Texas and then to the Rolling Hills Regional Jail and Detention Center in Haskell, Texas. At Denton County Jail, the doctor placed Nargis on an inappropriate regimen not recommended for treatment of HIV/AIDS. After several months of legal advocacy, the doctor at Rolling Hills rectified the mistake and Nargis received an appropriate three-drug anti-retroviral regimen.⁵¹

Samuel L: Letter to Human Rights Watch

San Pedro Service Processing Center

I have been here for six months now and I haven’t seen a specialist on chronic disease. When I was in Arizona, the health care provider scheduled

⁵¹ Documented in the contemporaneous notes of Olivia Cassin, Esq., Legal Aid Society of New York.

me to see a specialist...It was called “infectious disease” or something like that. But I wasn’t able to go because I (was transferred) back to California two weeks after she scheduled me. Otherwise, here in San Pedro, beside for the in-house doctors, I haven’t seen any specialist to explain what my current condition is.

I have been drawn blood samples a week before I was transferred to Arizona, but I haven’t gotten any comprehensive explanation on what my condition is. I have heard complaints from other detainees that are HIV positive that they don’t receive their medications on time or they don’t administer them correctly. (This person was very much concerned that he’s taking more dosage that he’s supposed to.) I, myself, am very concern about replenishing my medications. There were times when it takes a week or two to get my medication, which is very alarming since I need to get them on a daily basis.

In general, I don’t think the facility takes HIV patients/detainees and our needs very seriously. It seems to me that this facility in particular treats HIV as if it were nothing. If there is anything like “Chronic Care Clinics” I am not well aware of them and have not been through the program.

Juan L.

I didn’t get the full dose every day.

—Juan L., a 45-year-old man from Aruba who spent five months in immigration detention in Virginia.

Juan L.⁵² is a 45-year-old man from Aruba, a Netherlands territory. Juan served a sentence in federal prison until April 2005, when he was transferred into ICE custody. He spent one month at the Federal Correctional Institution in Petersburg, Virginia, and four months at the Piedmont Regional Jail in Farmville, Virginia. He was deported to Aruba and now lives in the Netherlands. His wife, a US citizen, lives in Brooklyn, New York.

⁵² Human Rights Watch telephone interview with Juan L., July, 2, 2007.

A carpenter by trade, Juan was diagnosed with HIV/AIDS in 1987, when he was living and working in the Bronx. He began taking anti-retroviral medication while in federal prison, and the prison medical staff gave him a month's supply of his medication to take with him when he was transferred to ICE custody. When he arrived at the Petersburg, Virginia facility the officers took his medication away, and he was without medication for 4 days. After that, he received anti-retroviral medication but the delivery was irregular. Juan told Human Rights Watch, *"I didn't get the full dose every day."*

Upon transfer to Piedmont Regional Jail, Juan experienced a two week delay in receiving his HIV/AIDS medications. *"They told me they had to wait for an order to come through...When they finally arrived, they made a big deal out of the fact that they had to buy a refrigerator to put my medication in. They made me feel like I was causing a lot of trouble."*

The Piedmont Regional Jail charges its prisoners for medical, dental and mental health care. Piedmont Superintendent Lewis Barlowe told Human Rights Watch that ICE detainees are exempt from these fees.⁵³ However, Juan recalled:

At Piedmont, I had a big fight with the Lieutenant about paying for my treatment. They wanted to charge me to see the nurse or the doctor. The only way they didn't charge me is that I called my consulate."

When I was deported, they told me they would give me a two week supply of my [HIV/AIDS] medications. But when it came time to get on the plane, they could not locate them, so I was deported without any meds. Neither ICE nor my embassy would give me any information about HIV/AIDS care in Aruba. We're not only deported, we're sentenced to death because they don't care about us.⁵⁴

⁵³ Human Rights Watch interview with Superintendent Lewis Barlowe, Farmville, Virginia, June 20, 2007. Another detainee at Piedmont provided to Human Rights Watch a copy of a notice he had received from jail officials advising him that he would be charged 10 dollars to see the nurse and 40 dollars to see the doctor.

⁵⁴ Human Rights Watch telephone interview with Juan L., New York City, July 2, 2007.

James L.

James L.⁵⁵ is a 44-year-old former musician and drum instructor from Haiti. In 2006, James served time for drug charges at Rikers Island, where he participated in an intensive drug and mental health counseling program. This program had an outpatient component, and James planned to continue with the program upon his release. On the final day of his sentence, however, ICE placed a hold on his case and transferred him to ICE custody at the Monmouth County Correctional Institution (MCCI) in Freehold, New Jersey. James spent approximately one month at Monmouth. During this time, the Legal Aid Society investigated possible representation in his immigration case. Before the representation could be formalized, however, ICE transferred James to Perry County Correctional Facility (PCCF) in Uniontown, Alabama. After three months, James was transferred to Tensas Parish Detention Center in Waterproof, Louisiana. Recently released from custody, James now lives in a homeless shelter in New York City.

James suffers from both HIV/AIDS and mental illness. When Human Rights Watch interviewed James in detention in Alabama, he had been living in the segregation unit for more than six weeks. Extremely agitated, he did not know why he had been placed in segregation. James stated that the jail officials told him it was because of a sore on his leg, but he said that the sore had healed so he did not understand why he had to be isolated. He stated that he was severely depressed and upset by the continuing isolation and that *“I feel like hanging myself in my cell.”*

James told Human Rights Watch that he was receiving both HIV/AIDS medications and psychiatric medications. He said that he has asked to see the counselor but was told that he comes only once a month. He showed Human Rights Watch a sick call request dated 5 days earlier, and said he had still not seen the doctor.

Officials at PCCF told Human Rights Watch that James was segregated due to a staphylococcal infection that was not responding to antibiotics. Warden David Streiff denied that James had been placed in segregation for reasons related to his HIV

⁵⁵ Human Rights Watch interview with James L., Perry County Correctional Center, Uniontown, Alabama, May 3, 2007.

status.⁵⁶ According to Warden Streiff, medical staff had placed James on “visual observation” status for suicide prevention. Warden Streiff stated that there is a doctor on site four times a week, and a psychiatrist on site 3 times a week. The warden further stated that James had seen the psychiatrist.

Independent Medical Review

- Mr. L. was on an appropriate ART regimen and appropriately started on prophylaxis for PCP.
- Lipids were checked appropriately as they should be for someone on Kaletra (Lopinavir/Ritonavir). However, there is no record of screening for hepatitis B, as he should be if taking Truvada (Emtricitabine/Tenofovir.)
- There was no documentation of viral load testing in the chart, critical for assessing response to ART.
- Lab work indicated abnormal levels of protein and blood in Mr. L’s urine as well as low serum albumin. Such highly abnormal findings should prompt further investigation and possible referral to a nephrologist. The chart did not show evidence of further work-up or referral.⁵⁷

Antonio O.

The guards yell at me, make fun of me, they look at me with disgust. They look at us as if we’re inferior, not only because we’re gay but because we’re immigrants. To them, we’re nothing but maggots from another country that need to be swept out. They don’t even treat us like people. One of them told me, ‘you don’t have any rights, you’re not a US citizen.’ But we’re human beings, we have human rights. We have the right to keep our dignity.

—Antonio O., a 33-year-old man from El Salvador, detained at the San Pedro Service Processing Center in San Pedro, California.

⁵⁶ Human Rights Watch interview with Warden David Streiff, Uniontown, Alabama, May 3, 2007.

⁵⁷ Following Dr. Legha’s review of the medical records, James was contacted to inform him of the existence of a potentially serious kidney condition as there was no evidence that this had ever been addressed during his detention.

Antonio O.⁵⁸ is a 33-year-old man from El Salvador detained at the San Pedro Service Processing Center in San Pedro, California. Antonio is a Legal Permanent Resident of the United States. Before his arrest on a minor drug offense, he worked as an x-ray technician. Antonio spent one month in the Los Angeles County Jail. Transferred into ICE custody on the day of his release, he had been detained at San Pedro for approximately one month.

Antonio was diagnosed with HIV/AIDS in 2005, and he began taking anti-retroviral medication treatment right away. He has been struggling to maintain his medication regimen since his incarceration. At the Los Angeles County Jail, it took three days to begin his medication regimen. He said *“They wanted to give me two out of the three medications. They said they didn’t have one of them. I told them no, you can’t take two out of three, it’s bad for you. They finally gave me all three.”*

When Antonio arrived at San Pedro, officials confiscated the ten day supply that he had taken with him from the county jail. He had no medication for three days. No medical records accompanied him. Antonio recounts, *“They didn’t even take my blood pressure. They didn’t verify that those were the [HIV/AIDS] meds I was on, they just took my word for it. I told them my T cell count and viral load, and they just entered it into the computer, based on what I told them. I haven’t had any lab work done here.”*

Antonio told Human Rights Watch that he was experiencing numbness in his toes. He had put in a sick call request 6 days previously but had not received a response.

San Pedro provided no HIV/AIDS education, counseling or information.

Antonio is an openly gay man. He told Human Rights Watch that the guards at San Pedro harass him and make fun of him, and will “send him to the hole” (disciplinary segregation) for the slightest physical contact with other detainees, however innocent it might be. Antonio explained, *“It’s ok to write us up if we’re being sexual... but it gets applied to us no matter what.”* According to Antonio, the housing units,

⁵⁸ Human Rights Watch interview with Antonio O., San Pedro Service Processing Center, San Pedro, California, August 22, 2007. Antonio O. is a pseudonym used at his request.

called “pods”, are run not by the security staff but by certain detainees called “pod leaders.” The leader of his pod permits the gay and transgender detainees to place their bunks together in one area of the pod, where he said, “*there is safety in numbers.*” The transgender detainees, stated Antonio, get “sent to the hole” even more frequently than the gay detainees.

Antonio told Human Rights Watch that his pod was very overcrowded a few weeks ago, with 15-20 detainees sleeping in “boats”⁵⁹ on the floor. He said that ICE finally moved some of them out after the detainees in his pod held a protest, threatening to go on hunger strike if the overcrowding and medical care did not improve.⁶⁰

Charles B: Creating Resistance to AIDS Drugs

Charles B.⁶¹ emigrated from Jamaica to Brooklyn, New York in 1987 as a Lawful Permanent Resident. Immigration authorities (initially the INS, subsequently ICE) detained Charles for four years and eight months, from September 2000 until May 2005. At the time he entered ICE custody, Charles was HIV positive but otherwise healthy. During detention his health deteriorated significantly, declining to a point where his condition verged on full-blown AIDS.

Documents filed on behalf of Charles in federal district court and in his immigration case⁶² provide testimony from medical experts describing the gross mismanagement of his condition by medical staff at two ICE detention facilities:

- When Charles entered immigration detention in September 2000, his CD4 count was 500 (within normal range) and his viral load was undetectable.

⁵⁹ “Boats” are plastic containers containing thin sleeping mats utilized by ICE for detainees to sleep in when the number of detainees exceeds bed capacity. The boats are placed on the floors of already occupied cells, or in the dayrooms of housing units. See, *Kiniti, et al v. Myers, et al*, 3:05-cv-01013-DMS-PCL, USDC, SD CA (2007), a class action lawsuit challenging overcrowded conditions at the San Diego Service Processing Center.

⁶⁰ As noted above, the San Pedro Service Processing Center closed in October 2007. Detainees were abruptly transferred to detention centers and jails across the country. Several HIV positive detainees were transferred to the South Texas Detention Center in Pearsall, Texas. According to their attorneys, they experienced delays in resuming ART regimens. One transferred detainee reported receiving an incomplete ART regimen for more than three weeks, during which time she developed symptoms of an opportunistic infection. Human Rights Watch interview with Laurie Aranoff, coordinator of volunteer attorney services, HIV/AIDS Legal Services Alliance, Los Angeles, CA, November 16, 2007.

⁶¹ Human Rights Watch interview with Charles B., New York City, March 19, 2007. Charles B. is a pseudonym used at his request.

⁶² Documents in the files of the Human Rights Watch HIV/AIDS Program, citations withheld at Charles’ request for reasons of confidentiality.

- From January-March 2001 medical staff at the Oakdale Federal Detention Center in Oakdale, Louisiana failed to properly fill his prescription by providing only two of the three drugs prescribed.
- From March-July 2001 Oakdale medical staff provided the third drug in the prescription and documented, but did not address, his failure to respond to this regimen.
- In July 2001 Oakdale medical staff improperly substituted only two of his medications rather than all three, a practice contrary to all US HIV treatment guidelines since 1996.
- Two of these new medications were contraindicated for use together, resulting in a condition known as neuropathy, a disorder of the nervous system.
- In December 2001 one of Charles' drugs was replaced by another drug to which Charles had already demonstrated resistance.
- This failing regimen continued until June of 2003, at which time Charles was placed on a new regimen that included the drug that had caused his neuropathy. He remained on this regimen until December 2004, despite tests in September 2004 showing he was resistant to two of the three drugs prescribed.
- By December 2004 Charles' CD4 count had fallen to 223; a count of 200 constitutes full-blown AIDS. His regimen was again modified to include a drug that had proven ineffective in the past. He was transferred shortly thereafter to Passaic County Jail in New Jersey where his ineffective prescription remained unchanged until his release in May 2005.
- During his detention at the Passaic County Jail, Charles experienced delays, interruptions and irregularities in the administration of his medications.
- Tests conducted after Charles left detention revealed that he is resistant to 13 primary anti-retroviral medications. This resistance severely restricts his treatment options even in the United States. Had Charles lost his asylum claim and been deported to Jamaica, he would have faced possibly fatal obstacles to treatment. He also suffers from peripheral neuropathy which prevents him from working at his former employment as an auto mechanic.

Gloria M.

[At McHenry] they told me they would not put me on AIDS meds because I was a resident of Indiana, not Illinois, so the state would not pay.

—Gloria M., a 43-year-old woman from South Africa who was detained at McHenry County Jail in Woodstock, Illinois.

Gloria M.⁶³ is a 43-year-old woman from South Africa. In 1995 Gloria served jail time on a criminal charge, but after release obtained her green card and worked as an AIDS counselor at a non-profit agency in Indiana. She has two American-born children and her fiancé is a US citizen.

In 2003, she was detained at the airport while returning from a trip to South Africa. She was released, but immigration officials kept her green card and told her she would be notified where to pick it up at a later date. In January 2004, immigration advised her that she could pick up her green card at an office in Chicago. Upon her arrival at the office, she was told that they planned to deport her because of her 1995 criminal conviction. ICE officials directed her to change into an orange jumpsuit, and then they handcuffed her and placed her in a van. Her hands and feet were shackled during the three hour trip to McHenry County Jail in Woodstock, Illinois.

Gloria recalled, “I was devastated. I had two small children at home, and a fiancé, and a job. They processed us like criminals... The McHenry facility was chaos. They told me they would not put me on AIDS medication because I was a resident of Indiana, not Illinois, so the state would not pay. I begged them to let my fiancée bring me my medicine from Indiana, and that is how I stayed on my medicine.”

At McHenry, no intake medical exam was conducted and Gloria received no HIV/AIDS education, counseling or information.

Gloria’s HIV/AIDS status was a major issue at her deportation hearing. Gloria recalled that the prosecutor focused on it as a basis for deporting her. *“He said that ‘the American taxpayers are paying for her AIDS medications’. He said this despite the fact that I had a job as an AIDS counselor, and my employee health plan paid for*

⁶³ Human Rights Watch telephone interview with Gloria M., New York City, April 26, 2007.

my medication.” Gloria’s attorney brought in her employer and other character witnesses. Gloria was released after nearly a month in detention.

Jean P.

“The pill cart comes in, everyone crowds around it, there’s no privacy in getting your meds. Your pill order can be lying open on the cart.

—Jean P., a 35-year-old man from Haiti detained at Perry County Correctional Center in Uniontown, Alabama.

Jean P.⁶⁴ is a 35-year-old man from Haiti who came to the US in 1991 with his father. Jean witnessed his mother’s decapitation during an outbreak of violence and destruction in his country. Jean told Human Rights Watch that he *“fell in with the wrong crowd and got into trouble with drugs.”* Jean served a two-year sentence in a Florida state prison before his transfer to ICE custody in May, 2005. Since 2005 Jean has been detained at the Manatee County Jail in Bradenton, Florida; the Krome Service Processing Center in Miami, Florida and the Perry County Correctional Center (PCCC) in Uniontown, Alabama.⁶⁵

Jean’s medical conditions include HIV/AIDS and hypertension. In 1997 he had what he terms a “stroke” which left him blind in one eye and limping on his left side. He stated that the medical care at the Krome Service Processing Center was better than at either Manatee County Jail or at PCCC in Alabama. *“At Bradenton they tried to kill me. There was one nurse who would always give out the wrong medication. One time after I took my meds they had to rush me to the hospital (because) my heart was beating so fast. I think they were somebody else’s meds...The doctor didn’t seem to know much about HIV either, I think he was a trainee, from the questions he asked.”*

Jean described the medical care at PCCC as *“very bad. I’ve been here since March, and I haven’t seen a doctor. I always ask to see the doctor but nothing happens. I don’t even know if the doctor is a woman or a man.”* Jean told Human Rights Watch

⁶⁴ Human Rights Watch interview with Jean P., Perry County Correctional Facility, Uniontown, Alabama, May 3, 2007. Jean P. is a pseudonym used at his request.

⁶⁵ Since Human Rights Watch interviewed Jean at PCCC, he has been transferred two additional times. According to his attorneys at the Florida Immigrant Advocacy Center, no reason has been given by ICE for the frequent transfers that have made legal advocacy on his behalf extremely difficult.

that they drew his blood when he first arrived at the facility. He never received the results, and when he asked them about it, they said “Have you had blood drawn?” They had lost the specimen. They drew the blood again, but that was weeks ago and he still has not received any results. There was no delay or interruption in his anti-retroviral medications when he was transferred. However, he worried, *“They look different than the ones I took at Krome, and nobody has explained that to me.”* PCCC has provided no HIV/AIDS education, counseling or information.

Jean told Human Rights Watch that he is very concerned about the lack of treatment at PCCC for his hypertension. Jean stated that his blood pressure has been taken only two times since he arrived more than 6 weeks ago; he said that at Krome they took his blood pressure every day. *“They’ve only taken it twice here, and that’s only when I asked them to,”* he stated. Jean showed Human Rights Watch a slip from the medical staff ordering a low sodium diet due to his hypertension, but none has been provided.

Jean did not feel that he had been discriminated against on the basis of his HIV status, but he expressed concern about the lack of confidentiality in the pill line. *“The pill cart comes in, everyone crowds around it, there’s no privacy in getting your meds. Your pill order can be lying open on the cart.”*

Jean recounts that two days prior, approximately 100 detainees had refused to eat for one day because it had been two weeks since they received any soap or toothpaste and *“we can’t afford to buy it from the commissary.”* Soap and toothpaste were provided after the protest. The transfer to Alabama, he stated, interfered with his immigration case as it made it very difficult to contact his lawyer in Florida. *“The phone card costs ten dollars for twenty minutes, and they use up a lot of the minutes telling you they are monitoring your phone call.”*

Jean told Human Rights Watch that he is anxious, depressed and *“tired of being locked up...I put in a request to see the psychologist but they just keep telling me I’m on the list.”*

Independent Medical Review

- In 2004 Mr. P. was detained at a non-ICE facility (Florida Department of Corrections). Medical records from that facility show that he was prescribed an inappropriate ART regimen. His viral load increased during this time, suggesting drug resistance. When resistance testing was finally ordered several months later, the results were incomplete.
- Mr. P's blood pressure was monitored and well-controlled while in ICE custody.
- He was also referred to a hematologist when indicated.
- The chart suggests some confusion regarding Mr. P's left eye blindness, which was attributed to laser surgery, stroke, and CMV (cytomegalovirus) retinitis in different parts of the chart.⁶⁶ In 2003 (pre-ICE custody) Mr. P. was under the care of an ophthalmologist for CMV retinitis. If a patient's CD4 counts improve on ART over a sustained period of time, it is acceptable to discontinue medication for CMV retinitis, as was done for Mr. P; however, such patients should continue to be regularly monitored by an ophthalmologist to evaluate for relapse.⁶⁷ However, the chart documents that Mr. P's last eye exam was in 2003.
- Mr. P's viral load increased in October 2006. Resistance testing was appropriately ordered, but not drawn until January 2007. As of February 2007, the results from this time-critical test were not available. Mr. P. was then transferred to another facility. It is unclear why there was a delay in obtaining these results, as well as whether the results were forwarded to or rechecked at the next facility.
- Mr. P's frequent transfers interrupted his continuity of care, particularly important for someone with a complicated medical history and lengthy detention. At times, it appears that the medical records from each facility did not refer to his records from the previous detention, such as the confusion

⁶⁶ CMV retinitis is an opportunistic infection found in advanced AIDS patients which can lead to blindness.

⁶⁷ Kaplan JE., Masur H., Holmes KK. Guidelines for preventing opportunistic infections among HIV-infected persons—2002. Recommendations of the U.S. Public Health Service and the Infectious Diseases Society of America. *MMWR Recomm. Rep.* 2002;51:1.

surrounding his blindness and apparent lack of awareness of his history of CMV retinitis.⁶⁸

Albert P.

They had no medical records for me when I was transferred here from across the street. After six weeks, I finally made copies for them from the records in my property. Now those are the only records they have.

—Albert P., a 48-year-old-man from Mexico detained at the San Pedro Service Processing Center in San Pedro, California.

Albert P.⁶⁹ is a 48-year-old man from Mexico detained at the San Pedro Service Processing Center in San Pedro, California. Albert served a two year sentence at the Federal Correctional Institution at San Pedro, a facility directly across the street from ICE's San Pedro Service Processing Center (SPSPC). On May 17, 2007 Albert was transferred to ICE custody and taken across the street. According to Albert, his extensive medical file failed to accompany him. *"They had no medical records for me when I was transferred here from across the street. After six weeks, I finally made copies for them from the records in my property. Now those are the only records they have."*

Upon his arrival at SPSPC, Albert told the medical staff which anti-retroviral medications he had been taking. He saw them make a telephone call to verify this information, after which they prescribed these medications. No lab work has been done since his arrival more than three months ago. *"They took me downstairs to draw blood three weeks ago, but the doctor looked at me and said 'he doesn't need blood drawn. He's out of here.'...I don't understand why that happened. I didn't sign the consent to be deported. I'm going to a hearing because of my medical issues."*

Albert has received no HIV/AIDS education, counseling or information.

⁶⁸ Following Dr. Legha's review Jean was contacted to advise him to seek follow up care for his eye condition if possible.

⁶⁹ Human Rights Watch interview with Albert P., San Pedro Service Processing Center, San Pedro, California, August 22, 2007. Albert P. is a pseudonym used at his request.

David E.

I told them I was HIV positive, but they did nothing. No tests or anything.

—David E., a 50-year-old man from Liberia, of his detention at the Dodge County Jail in Juneau, Wisconsin.

David E.⁷⁰ is a 50-year-old man from Liberia. David drove a taxi in New York City for more than 20 years. During that period he had a series of misdemeanor arrests. In 2006, David and his wife moved to the Chicago area. In August of that year he went to an ICE office in Chicago to check in for an interview regarding his green card. He was detained and transported to Dodge County Jail in Juneau, Wisconsin.

At the time of his detention, David was under the care of a physician for HIV/AIDS but had not started taking anti-retroviral medication. At Dodge County Jail, they did no physical examination. David said, *“they didn’t even take my blood pressure,”* even though he told them that he was taking high blood pressure medication at the time. As for his HIV status, the medical staff did not ask. *“The only way they knew about it was (that) I told them.”* There was no response during the four weeks of David’s detention. *“I told them I was HIV positive, but they did nothing. No tests or anything.”*

⁷⁰ Human Rights Watch interview with David E., Chicago, Illinois, June 28, 2007. David E. is a pseudonym used at his request.

VI. Access to HIV/AIDS Treatment in Immigration Detention

ICE Policy and Procedures

The DIHS Covered Services Package

The United States Public Health Service (USPHS) provides medical and dental services to immigration detainees pursuant to federal law.⁷¹ This mandate is carried out by the Division of Immigration Health Services (DIHS), a component of the Health Resources and Services Administration (HRSA). DIHS operates the medical systems directly at the eight Service Processing Centers and at seven Contract Detention Facilities. DIHS policies cover the medical care provided at all facilities, including county jails, through the application of the “DIHS Medical Dental Covered Services Package.”⁷² Similar to the coverage brochure from an HMO or managed health care network, this document establishes guidelines for approval or denial of health care that will be reimbursed by ICE to contracting detention facilities.

From the outset, the DIHS Services Package makes it clear that medical treatment shall be limited, whenever possible, to emergency care:

The DIHS Detainee Covered Services Package primarily provides health care services for emergency care. Emergency care is defined as “a condition that poses an imminent threat to life, limb, hearing or sight” Accidental or traumatic injuries incurred while in the custody of ICE or BP(Bureau of Prisons) and acute illnesses will be reviewed for appropriate care.⁷³

The Services Package states that *“Elective, non-emergent care requires prior authorization...Requests for pre-existing, non-life threatening conditions will be reviewed on a case by case basis...Other medical conditions which the physician believes, if left untreated during the period of ICE/BP custody, would cause*

⁷¹ 42 USC 249 (a); 42 CFR 34.7 (a) (2003)

⁷² DIHS Medical Dental Covered Services Package, updated 9/4/07.http://inshealth.org/managed_care/combined%20benefit%20package%202005.doc (accessed October 11, 2007).

⁷³ DIHS Services Package, p.1.

deterioration of the detainee's health or uncontrolled suffering affecting his/her deportation status will be assessed and evaluated for care.”⁷⁴

Under this provision, the treating physician must evaluate the appropriateness of care based upon an estimate of how long the detainee will be in ICE custody and/or whether the medical condition will affect the detainee's “deportation status.”⁷⁵

Regarding HIV/AIDS, the Services Package contains only one reference, under the section entitled “Other Services.” This section provides:

Follow up health care services, with periodic check ups, for detainees with conditions that are considered chronic will be determined by the health care provider. These conditions may include but not be limited to:

- *Asthma*
- *Hypertension*
- *Diabetes*
- *Mental Health*
- *HIV/AIDS*
- *Seizure Disorder*
- *TB/INH*⁷⁶

The Services Package fails to provide coverage for HIV/AIDS testing except in very limited circumstances. The test may not be covered even when it is requested by the detainee. Rather, the Services Package provides:

*HIV testing will be approved if a provider determines that the HIV testing is indicated based upon clinical evaluation or if the detainee requested the test **and** it is deemed necessary by the medical provider (highlight in original).*⁷⁷

⁷⁴ Ibid.

⁷⁵ Ibid.

⁷⁶ DIHS Services Package p. 29.

⁷⁷ Ibid.

The HIV/AIDS Detention Standard

As discussed above, ICE has adopted a Detention Operations Manual (DOM) that sets forth 38 standards for conditions in immigration detention. The “Medical Care” standard set forth in this Manual contains a specific section addressing the treatment of detainees with HIV/AIDS. The Medical Care standard states, however, that all of its provisions apply only to Service Processing Centers and Contract Detention Facilities; some provisions, italicized in the text, apply only as “guidelines” for local jails and other facilities contracting with ICE. Even when applied, the HIV/AIDS provisions fail to establish an acceptable standard of care. The HIV/AIDS “standard” requires medical staff merely to “promote”, rather than to provide, accurate diagnosis and medical management and then only “to the extent possible”. The standard makes no reference to current clinical guidelines, testing and counseling, confidentiality or access to specialty care, as it should according to the National Commission on Correctional Health Care, the American Public Health Association, World Health Organization, and UNAIDS guidelines.⁷⁸ As a result of these omissions the HIV/AIDS provisions fail to meet community standards of care and fall below national and international recommended standards for the treatment of HIV/AIDS in correctional settings.

Which Standards Apply?

The conflicting array of variably applicable guidelines, standards, and policies fails to provide clear direction to the administrators of any ICE facility, whether a Service Processing Center, a Contract Detention Facility, or the hundreds of local jails contracting with ICE. Wardens and correctional staff interviewed by Human Rights Watch, while defending the quality of medical care in their facility, each gave different descriptions of the standards they considered applicable to the immigration detainees.⁷⁹ The ACLU of New Jersey reviewed the contracts between ICE and each of the five New Jersey facilities holding immigration detainees. Each

⁷⁸ National Commission on Correctional Health Care, *Standards for Health Services in Jails*, 2003; American Public Health Association, *Standards for Health Care in Correctional Institutions*, (2003); World Health Organization, *Guidelines on HIV Infection and AIDS in Prisons* (1999); UNAIDS, *International Guidelines on HIV/AIDS and Human Rights* (2006); UNODC, *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for Effective National Response* (2006).

⁷⁹ Human Rights Watch interview with Warden David Streiff, Perry County Correctional Facility May 3, 2007; Human Rights Watch interview with Superintendent Lewis W. Barlowe, Piedmont Regional Jail June 20, 2007; Human Rights Watch interview with Lt. James Howell, Monmouth County Correctional Institution May 1, 2007..

contract contains different descriptions of the standards applicable to immigration detainees, and none of them specify, or incorporate by reference, the ICE detention standards.⁸⁰ As one county jail warden told Human Rights Watch, “I don’t know what standards apply. It’s hard to keep it all straight.”⁸¹

In addition to the DOM provisions relating to the treatment of HIV/AIDS, ICE cites additional standards as applicable to detainee medical care. For example, the DOM “Medical Care” standard cites the American Correctional Association (ACA) Standards for Adult Detention Facilities and the National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Jails (1996). According to the U.S. Government Accountability Office Audit, the ICE Detention Standards were “derived” from the American Correctional Association standards.⁸²

Neither the ACA nor the NCCHC standards, however, bear any resemblance to the HIV/AIDS “standard” set forth in the DOM. The ACA Health Care Standard since 1999 has been a performance-based standard that requires written treatment plans for individuals with HIV/AIDS that provide for testing, education, treatment guidelines, follow up lab work, and continuity of care.⁸³ The NCCHC Standards greatly exceed the limited provisions found in the DOM. In its position paper entitled “Administrative Management of HIV in Corrections” the NCCHC endorses what is known as the “equivalence standard,” the principle that “the medical management of HIV positive inmates and correctional staff should parallel that offered to individuals in the non-correctional community.” The NCCHC standards include provisions for adoption of the clinical guidelines established by the Centers for Disease Control for the treatment of HIV/AIDS; testing, counseling and education programs; prevention measures to reduce transmission; protection of confidentiality; and timely lab work, access to specialists and other measures designed to ensure continuity of care.⁸⁴

⁸⁰ “Behind Bars,” *supra*, p. 6.

⁸¹ Human Rights Watch interview with Superintendent Lewis W. Barlowe, *supra*.

⁸² GAO Report, *supra*, at 1.

⁸³ American Correctional Association, Performance-Based Standards for Correctional Health Care in Adult Correctional Institutions, January 2002.

⁸⁴ National Commission on Correctional Health Care, Position Statement, “Administrative Management of HIV in Corrections”, October 9, 2005, www.ncchc.org/resources/statements/admin_hiv2005.html, (accessed November 28, 2007.) See also, NCCHC Standards for Health Services in Jails, 2003 (2d Printing 2005), p. 187.

The DOM also states that neither the NCHC nor the ACA medical care standards are applicable to the local facilities (IGSAs) contracting with ICE.⁸⁵

The federal Bureau of Prisons, which also houses some immigration detainees, explicitly references community treatment standards and guidelines in its Clinical Practice Guidelines for Management of HIV. This 43 page document provides thorough guidance for its medical staff in treating prisoners with HIV, in accordance with nationally recognized treatment guidelines.⁸⁶ Detainees who happen to be placed in federal Bureau of Prisons facilities are subject to a different, and higher, standard of medical care. The current US government system lacks uniformity and consistency, creating distinct populations of immigrant detainees subject to differing standards of medical care depending upon their custodian.

In an effort to clarify the issue, Human Rights Watch submitted a Freedom of Information Act request⁸⁷ seeking copies of all policies and procedures related to HIV/AIDS care in immigration detention, ICE provided the DOM standards but also responded with additional documents. One document consisted of three pages identified only as “National Policy, chapter 8” (one page) and the other was entitled “Standard Operating Procedure” (two pages). These excerpts of larger documents state that chronic care in immigration detention shall be provided in a “chronic care clinic” and that chronically ill detainees shall receive “follow up” every 90 days. HIV/AIDS is on the list of “chronic” diseases. The source of these documents, however, was not identified, leaving it unclear which agency or agencies issued these policies and to which immigration facilities, if any, they apply.

ICE Oversight of HIV/AIDS Care in Immigration Detention

Inspection of Detention Facilities

ICE’s current mechanism for ensuring compliance with the National Detention Standards is one site visit per year to each of the 300 facilities housing immigrants

⁸⁵ DOM, Medical Care, p. 1.

⁸⁶ Federal Bureau of Prisons Clinical Practice Guidelines: Management of HIV, www.nicic.org/library/021582 (accessed November 28, 2007)

⁸⁷ Letter from Human Rights Watch to ICE FOIA Office dated April 4, 2007 (Appendix).

in the United States.⁸⁸ Inspections are conducted by the Detention Standards Compliance Unit, which employs 8 inspectors and three support staff.⁸⁹ Inspections typically last 3 days and cover all 38 detention standards.⁹⁰ Recent audits of detention centers by the Department of Homeland Security Office of Inspector General (OIG) and the US Government Accountability Service (GAO) identified significant defects in the ICE inspection system. In a section entitled “Thoroughness of ICE Detention Facility Inspection” the OIG addressed the failure of the ICE inspectors to identify the violations found shortly thereafter by the OIG:

A final rating of acceptable was given to all five detention facilities, meaning the detention facilities were determined to be adequate and operating within standards, with some deficiencies. However, our review of the five facilities identified instances of non-compliance regarding health care and general conditions of confinement that were not identified during the ICE annual inspection of the detention facilities... This observation was beyond the planned scope of our work. However, we believe it needed to be brought to the attention of ICE management.⁹¹

In response to the OIG report, ICE “concurred” and stated that it “recognizes the need for independent review of its inspection process.” ICE agreed to authorize three full time, funded positions to the ICE Office of Professional Responsibility in order to improve the quality of the inspection process.⁹²

Numerous prisons and jails contracting with ICE for immigration detention are accredited by the National Commission on Correctional Health Care (NCCHC) or the American Correctional Association (ACA). The Detention Standard for Medical Care recommends that contracting facilities be “accredited or accreditation-worthy.” Neither NCCHC nor ACA, however, requires on-site inspections of accredited facilities on either an annual or a semi-annual basis. Rather, once accreditation is achieved

⁸⁸ OIG Report, *supra*, p. 36.

⁸⁹ GAO Report, *supra*, p. 31.

⁹⁰ *Ibid*; Human Rights Watch interview with Warden David Streiff, *supra*.

⁹¹ OIG Report, *supra*, p. 36.

⁹² *Ibid*.

(requiring an initial on-site visit), it can be maintained for several years by submitting documentation of existing policies and procedures.⁹³

Detainee Complaints

Inadequate medical care is one of the primary complaints of immigration detainees. This is true for complaints filed within specific facilities through the grievance procedures,⁹⁴ communicated to ICE itself,⁹⁵ or addressed to NGOs such as the American Bar Association, the ACLU, and Human Rights Watch.⁹⁶ However, recent government audits reveal ICE's complaint monitoring procedures to be deficient in key respects. First, detainees are not sufficiently informed of how to communicate complaints to ICE. None of the five facility handbooks reviewed during the OIG audit advised detainees of the right to contact DOJ, ICE or anyone outside the facility.⁹⁷ The GAO report noted that although some units posted a hotline number to ICE for complaints, the number did not work in 8 of 23 facilities inspected.

ICE failed to effectively track, analyze, or resolve detainee complaints that they did receive. The GAO described a confusing process within ICE for handling detainee complaints involving three departments and sub-agencies and concluded that due to a lack of a formal monitoring system, "the number of reported allegations may not reflect the universe of detainee complaints." Although complaints worthy of investigation were supposed to be referred to the Department of Removal Operations (DRO) for follow up, the GAO "could not determine the number of cases referred to DRO or their disposition."⁹⁸ The absence of a coherent monitoring process hindered ICE's ability to identify patterns of violations in the nation's detention centers and to take corrective action if necessary. In addition, the report criticized the agency's lack of transparency, "...Our standards for internal control in the federal government call

⁹³ See, Accreditation Procedures at www.ncchc.org and www.aca.org, (accessed October 2, 2007).

⁹⁴ Human Rights Watch interviews with correctional officials, *fn 76 supra*.

⁹⁵ GAO Report, *supra*, p.36.

⁹⁶ GAO Report, *supra* p.37-38; Briefing Materials Submitted to the United Nations Special Rapporteur, *supra*; Human Rights Watch U.S. prisoner correspondence database.

⁹⁷ In October 2007 ICE issued a new Detainee Handbook that provides the telephone number and address of the DHS Office of Inspector General. Plans for distribution and translation have not been made public.

⁹⁸ GAO report, *supra*, p.37.

for clear documentation of transactions and events that is readily available for examination.”⁹⁹

ICE Data re: HIV/AIDS Cases regarding Detention

Human Rights Watch filed a Freedom of Information Act request seeking statistical information about immigrants with HIV/AIDS in immigration custody, including the number of detainees tested, diagnosed and treated for HIV/AIDS in the last five years.¹⁰⁰ The documents received from ICE indicate that the agency largely fails to track this information, or that the information tracked is incomplete, failing to account for the hundreds of facilities throughout the country contracting with ICE to hold detainees.

ICE responded “not tracked” to the following questions:

- The number of detainees receiving treatment for HIV/AIDS
- The number of detainees tested for HIV
- The number of HIV cases reported to federal, state, county or municipal public health agencies
- The number of detainees receiving off site specialty HIV/AIDS care
- The number of detainees with HIV/AIDS ordered deported or removed
- The number of detainees deported or removed with a supply of HIV/AIDS medication

ICE reported that *“the numbers below reflect all reported HIV cases to the DIHS Epidemiology Unit including those diagnosed per (sic) -ICE custody”*:

- 2002 not tracked
- 2003 30
- 2004 42
- 2005 40
- 2006 54
- 2007 (through April 2007) 47

⁹⁹ GAO report, *supra*, at 34-39.

¹⁰⁰ FOIA letter, *supra*.

ICE also reported the number of on-site “clinic visits” related to HIV/AIDS:

- *FY 2003- 1162 (12 sites)*
- *FY 2004- 2577 (13 sites)*
- *FY 2005 1125 (14 sites)*
- *FT 2006 478 (14 sites)*
- *FY 2007 (October 2006 through April 2007) 233 (20 sites)*

These numbers reflect that ICE collects HIV/AIDS statistics only from the few Service Processing Centers and Contract Detention Facilities where DIHS manages the health care services. The DIHS Epidemiology Unit collects no data related to HIV/AIDS from the more than 300 jails and regional centers housing the majority of detainees.¹⁰¹

¹⁰¹ The DIHS Epidemiology Unit declined Human Rights Watch’s request for an interview.

VII. Legal Standards

ICE Obligation to Ensure Medical Care

Under federal law, the Department of Homeland Security possesses ultimate authority over administration of all immigration-related matters.¹⁰² This authority includes responsibility for the conditions of confinement for immigrants detained by ICE. The statute expressly requires DHS to provide “necessary medical care” for immigrants in its custody, whether detained in federal institutions or in “non-federal” facilities contracting with ICE.

Although ICE has delegated the incarceration of many immigrants to local and county jails, ICE remains responsible for their welfare. As one federal court stated:

It is clear that the INS does not vest the power over detained aliens in the wardens of detention facilities because the INS relies on state and local governments to house federal INS detainees. Whatever daily control state and local governments have over federal INS detainees, they have that control solely pursuant to the direction of the INS.¹⁰³

The Right to Reasonable Medical Care

The Eighth Amendment to the US Constitution protects all convicted prisoners from “cruel and unusual punishment” and requires corrections officials to provide a “safe and humane environment.” *Estelle v. Gamble*, 429 U.S. 97 (1976). In the United States, prisoners have a right to health care that is not shared by the general population. As Justice Marshall explained in the *Estelle* decision:

These elementary principles establish the government’s obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those

¹⁰² U.S.C. Sec. 1103 (a) (1).

¹⁰³ *Roman v. Ashcroft*, 340 F3d 314, 320 (6th Cir. 2003).

*needs will not be met. In the worst cases, such a failure may actually produce physical torture or lingering death, the evils of most concern to the drafters of the Amendment.*¹⁰⁴

In *Estelle*, the Supreme Court established a narrow interpretation of the Eighth Amendment, requiring prisoners to demonstrate that officials were “deliberately indifferent to serious medical needs.”¹⁰⁵ Courts have consistently held that prisoners diagnosed with HIV/AIDS have demonstrated a “serious medical need” under the Eighth Amendment.¹⁰⁶

Immigration detainees, however, are not convicted prisoners. Rather, they are civil detainees held under administrative provisions. Their constitutional protection derives from the Fifth Amendment, which prohibits the imposition of punishment upon any person in the custody of the United States without due process of law.¹⁰⁷ Courts have held in a variety of contexts that persons in non-punitive detention need not demonstrate “deliberate indifference” in challenging their conditions of confinement.¹⁰⁸ Indeed, the Court of Appeals for the Ninth Circuit has held that the conditions of confinement for administrative detainees must be superior not only to those of convicted prisoners, but also to those of pre-trial criminal detainees.¹⁰⁹

One federal court has expressly endorsed a higher standard for medical care for administrative detainees:

Persons in non-punitive detention have a right to “reasonable medical care”, a standard demonstrably higher than the Eighth Amendment standard that protects convicted prisoners.¹¹⁰

¹⁰⁴ *Estelle v. Gamble*, 429 U.S. 97, 100 (1976), citations omitted.

¹⁰⁵ *Estelle*, *supra*, p. 104.

¹⁰⁶ *Smith v. Carpenter*, 316 F.3d 178 (2d Cir. 2003); *Montgomery v. Pinchak*, 294 F.3d 492 (3d Cir. 2002).

¹⁰⁷ *Wong Wing v. United States*, 163 U.S. 228 (1896).

¹⁰⁸ See, e.g., *Youngberg v. Romeo*, 457 US 307 (1982) ; *Jones v. Blanas*, 393 F.3d 918 (9th Cir. 2004); *Haitian Centers Council, Inc. v. Sale*, 823 F. Supp. 1028 (EDNY, 1993). *But see, Lancaster v. Monroe County, Ala.* 116 F.3d 1419,1425 (11th Cir. 1997) (8th amendment standard applied to medical care for pre-trial detainees)

¹⁰⁹ *Jones*, *supra*, at 934.

¹¹⁰ *Haitian Centers Council*, *supra*, at 1043.

The Right to Health under International Law

Key international instruments obligate governments to respect, protect, and fulfill the right to health by taking positive actions to ensure access to health services and by refraining from actions that interfere with this right.¹¹¹ The right to health is most explicitly expressed in the International Covenant on Economic, Social and Cultural Rights (ICESCR) which states that every person has a “right to the highest attainable standard of health.”¹¹² The United States has signed, but not ratified, the ICESCR,¹¹³ a position that requires the government to, at minimum, take no action that would undermine the intent and purpose of the treaty.¹¹⁴

The United States is a party to the International Covenant on Civil and Political Rights (ICCPR).¹¹⁵ The ICCPR incorporates several rights directly and indirectly linked to the enjoyment of the right to health, including the right to life (Article 6); the right not be subjected to torture or to cruel, inhuman or degrading treatment or punishment (Article 7); the right to be free from discrimination (Articles 2 and 3) and the right to privacy (Article 17).¹¹⁶

The rights protected by the ICCPR are not forfeited upon incarceration. On the contrary, Article 10 of the ICCPR specifically requires that all persons deprived of their liberty be treated with humanity and with respect for their inherent dignity.¹¹⁷ The Human Rights Committee has explained that states have a “positive obligation

¹¹¹ Universal Declaration of Human Rights (UDHR), adopted December 10, 1948, G.A. Res. 217A (III), U.N. Doc. A/810 at 71 (1948), Article 25; International Covenant on Economic, Social and Cultural Rights (ICESCR) adopted December 16, 1966 (G.A. Res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N. T.S. 3, entered into force January 3, 1976 (Article 12); Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), adopted December 18, 1979, GA Res. 34/180, 34 UN GAOR Supp. (No. 46) at 193, UN Doc A/34/46, entered into force September 3, 1981 (Article 12); Convention on the Rights of the Child (CRC), adopted November 20, 1989, GA Res. 44/25, annex, 44 UN GAOR Supp. (No. 49) at 167, UN Doc. A/ 44/49 (1989), entered into force September 2, 1990, Article 24.

¹¹² ICESCR, *supra*, Article 12.

¹¹³ Signed October 5, 1977.

¹¹⁴ Vienna Convention on the Law of Treaties (VCLT), adopted May 23, 1969, entered into force January 27, 1980, Article 18.

¹¹⁵ International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 52, UN Doc.A/6316 (1966), 999 UNTS 171, entered into force March 23, 1976, ratified by the U.S. on June 8, 1992, arts. 6,7 10(1).

¹¹⁶ Manfred Nowak’s authoritative treatise on the ICCPR discusses the impact of rights conferred under the ICCPR to the right to health, e.g. the right to privacy as it relates to medical confidentiality. Manfred Nowak, *UN Covenant on Civil and Political Rights: CCPR Commentary* (Kehl am Rhein: N.P. Engel, 1993) p. 296.

¹¹⁷ ICCPR, *supra*, Articles 6,7 and 10(1).

towards persons who are particularly vulnerable because of their status as persons deprived of their liberty,” stating that the deprivation of liberty itself should be the only form of punishment:

Not only may persons deprived of their liberty not be subjected to torture, or other cruel, inhuman or degrading treatment or punishment, including medical or scientific experimentation, but neither may they be subjected to any hardship or restraint other than that resulting from the deprivation of liberty; respect for the dignity of such persons must be guaranteed under the same conditions as that of free persons. Persons deprived of their liberty enjoy all the rights set forth in the ICCPR, subject to the restrictions that are unavoidable in a closed environment.¹¹⁸

International Standards for the Treatment of Prisoners

Key international instruments provide non-binding, but authoritative, interpretation of fundamental human rights standards for all persons in detention. The Standard Minimum Rules for the Treatment of Prisoners, The Basic Principles for the Treatment of Prisoners and the Body of Principles for the Protection of All Persons Under any form of Detention or Imprisonment establish the consensus that detainees are entitled to a standard of medical care equivalent to that available in the general community, without discrimination based on their legal status.¹¹⁹ International standards support the confinement of administrative and pre-trial detainees in non-punitive conditions.¹²⁰

In some cases, state obligations to protect prisoners’ fundamental rights, in particular the rights to be free from ill-treatment, the right to health, and ultimately the right to life, may require states to ensure a higher standard of care than is available to people outside prison who are not wholly dependent upon the state for

¹¹⁸ UN Committee on Human Rights, General Comment No. 21, Article 10, Humane Treatment of Prisoners Deprived of their Liberty, UN Doc. HRI/Gen/1/Rev.1 at 33 (1994), para. 3.

¹¹⁹ United Nations Standard Minimum Rules for the Treatment of Prisoners, May 13, 1977, Economic and Social Council Res., 2076 (LXII); Basic Principles for the Treatment of Prisoners, UN General Assembly Resolution 45/111 (1990); Body of Principles for the Protection of All Persons Under any form of Detention or Imprisonment, UN General Assembly Resolution 43/173/(1988).

¹²⁰ UN Standard Minimum Rules, *supra*, para.8.

protection of those rights.¹²¹ In prison, where most material conditions of incarceration are directly attributable to the state, and inmates have been deprived of their liberty and means of self-protection, the requirement to protect individuals from risk of torture or ill treatment can give rise to a positive duty of care, which has been interpreted to include effective methods of screening, prevention and treatment of life-threatening diseases.¹²²

The Equivalence Standard

Human Rights Watch maintains that all prisoners, whether administratively or criminally detained, are entitled to adequate and appropriate medical care in compliance with human rights standards and medical best practice. While no US court has yet articulated in detail what is “reasonable” health care for administrative detainees, “reasonable” should equate to medical care that meets human rights standards and medical best practice. In line with human rights standards, correctional health experts, in the US and internationally, consider that prison health care should meet the “equivalence standard,” which means it should meet at least the same standards of health care applicable in the community. In the case of HIV/AIDS, US correctional health experts have made clear that this standard reflects the principle that “the medical management of HIV-positive inmates...should parallel that offered to individuals in the non-correctional community.”¹²³ Specifically, “medical care must meet the professional standards of the community and be performed by appropriately trained and credentialed providers who are properly supervised and who use clinical protocols.”¹²⁴

Key elements of the standard of equivalence for HIV/AIDS care in a correctional setting, as detailed by the National Commission on Correctional Health Care and the American Public Health Association include:

¹²¹ See, Rick Lines, “From equivalence of standards to equivalence of objectives: the entitlement of prisoners to standards of health higher than those outside prisons,” *International Journal of Prisoner Health*, vol 2 (2006), p. 269.

¹²² See, e.g. European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), CPT Standards, CPT/IN/E2002, para. 31.

¹²³ National Commission on Correctional Health Care, Position Statement, “Administrative Management of HIV in Corrections”, *supra*.

¹²⁴ American Public Health Association, Standards for Health Care in Correctional Institutions, (2003) p. 2.

- HIV prevention education, availability and promotion of voluntary testing, and counseling;
- Adherence to Center for Disease Control, Department of Health and Human Services or other nationally accepted clinical protocols for the treatment of HIV;
- Consultation and/or supervision of HIV-related care by clinicians with expertise in HIV care;
- Procedures to ensure maintenance of confidentiality in a correctional setting¹²⁵

Yet, medical care for detainees failed to meet any of the key elements of the “equivalence standard” outlined:

- ICE has no program for voluntary testing, education or counseling detainees with HIV/AIDS
- The Detention Standard for HIV/AIDS makes no reference to the nationally accepted clinical protocols for the treatment of HIV/AIDS
- The Detention Standard for HIV/AIDS fails to require training or consultation with specialists for physicians treating detainees with HIV/AIDS
- The Detention Standards inadequately address the issue of confidentiality, leaving detainees with HIV/AIDS exposed to discrimination and harassment. Gay and transgender detainees are particularly vulnerable to discrimination.¹²⁶

International Guidelines for the Treatment of Prisoners with HIV/AIDS

The World Health Organization (WHO) Guidelines on HIV Infection and AIDS in Prison, the UNAIDS International Guidelines on HIV/AIDS and Human Rights, and the UN Office of Drug and Crime (UNODC) HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings provide guidance to states on protecting prisoners’ fundamental

¹²⁵ NCCHC Position Statement, *supra*, pp.1-4; APHA Standards, *supra*, p.2; pp. 67-70.

¹²⁶ For an account of the linkage between transgendered prisoners, HIV/AIDS and discrimination, see Sylvia Rivera Law Project, *“It’s War in Here: A Report on the Treatment of Transgender and Intersex People in New York State Prisons*, (New York: 2007).

right to HIV/AIDS prevention and medical care.¹²⁷ These documents establish international best practices with regard to prison HIV/AIDS care, and uniformly underscore the principle of equivalence. As stated by the UNODC:

The following principles reflect the international consensus on effective prison management and the ethical treatment of prisoners as defined in various international health, HIV/AIDS and human rights instruments...Prisoners are entitled, without discrimination, to a standard of health care equivalent to that available in the outside community, including preventive measures.¹²⁸

Providing health care equivalent to that available in the community includes access to voluntary testing and counseling; adequate access to licensed health care providers (registered nurses, licensed physicians, and specialty care); laboratory and diagnostic testing at appropriate intervals; access to anti-retroviral and other medications when medically necessary and continuity of care.¹²⁹

International standards also require protection of the confidentiality of medical information for prisoners with HIV/AIDS:

Information on the health status and medical treatment of prisoners is confidential and should be recorded in files available only to health personnel....Routine communication of the HIV status of prisoners to the prison administration should never take place. No mark, label, stamp or other visible sign should be placed on prisoners' files, cells or papers to indicate their HIV status.¹³⁰

¹²⁷ WHO Guidelines on HIV Infection and AIDS in Prisons (1999); UNAIDS International Guidelines on HIV/AIDS and Human Rights (2006), para 130; UNODC, HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings: A Framework for Effective National Response (2006).

¹²⁸ UNODC "Framework", *supra*, General Principles, page ix.

¹²⁹ WHO Guidelines, *supra*, paragraphs. 34-40; UNODC, pp.18, 41.

¹³⁰ WHO Guidelines, *supra*, paragraphs. 31, 33.

Under international guidelines, health services shall be provided to prisoners “free of charge.”¹³¹

¹³¹ UNODC, *supra*, p. 22.

VIII. Conclusion

Anna F., 61-years-old and without the medicine needed to prevent PCP; Gloria M., an AIDS counselor and mother of two; Nargis R., wife of a US citizen, detained for two years after serving 69 days for writing bad checks; Antonio O., a Legal Permanent Resident and x-ray technician; Jean P., fleeing violence and persecution in Haiti. These are the people caught in the net of an aggressive US immigration policy that detains, then neglects, persons with HIV/AIDS.

ICE remains responsible for the health and welfare of the 30,000 immigrants in its custody, but the medical care described by detainees with HIV/AIDS could not meet any appropriate, required standard of medical care. Under what standard of care would the following be considered acceptable: delivery of the proper dosage of life-saving medications to Peter R. only 65 percent of the time; failure to prevent opportunistic infections that can be deadly to AIDS patients such as Anna F.; failure to appropriately monitor Jean P. for a condition that left him blind in one eye.

It is clear that the medical care provided by ICE does not meet the “equivalence” standard set by national correctional health experts, nor does it meet the recommended standards under international law for compliance with human rights and best medical practice. Following a review of detainee medical records, an independent medical expert found numerous instances of key medical services falling below the community standard of care. In four cases, detainees were notified and advised to obtain supplemental medical care and testing if possible.

The medical treatment of immigration detainees with HIV/AIDS clearly puts their rights to health, dignity and in some cases, right to life, at risk. Without delay, the detention standards must be upgraded and issued as formal administrative regulations, open to public notice and comment. Monitoring and oversight must improve, or people with HIV/AIDS will continue to needlessly suffer, and even to die, in immigration detention.

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Most of all, many thanks to the current and former detained immigrants with HIV/AIDS who were courageous enough to share their experiences for this report.

Appendix

April 3, 2007

RE: FREEDOM OF INFORMATION ACT REQUEST
VIA FACSIMILE AND US POSTAL SERVICE
FOIA/PA Section
Information Disclosure Unit
Mission Support Division
Office of Investigations
US Immigrations and Customs Enforcement
425 I Street NW, Room 4038
Washington, D.C. 20536

FOIA Office
US Immigration and Customs Enforcement
800 N. Capitol St NW
5th Floor, Room 585
Washington, DC 20536

To Whom It May Concern:

This letter constitutes a request (“Request”) pursuant to the Freedom of Information Act, 5 USC Section 552 (FOIA.) The Request is submitted on behalf of Human Rights Watch (“Requester”).

Definitions

For the purposes of this Request, the definitions of these terms are provided below:

- 1) “records” is defined as any document, memorandum, message, or other communication intended to be covered by 5 USC Sec. 552, including those in electronic format;
- 2) “HIV/AIDS” is defined as the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome;

- 3) “specialty care” is defined as any medical treatment provided by health care practitioners specializing in the treatment of HIV/AIDS or infectious disease;
- 4) “policies” and “procedures” includes any directives, instructions, memoranda, guidelines, practice, protocol, or requirements that have been established, published or followed by the agencies listed in the request.

Records Requested

I. Records Relating to Agency Policies and Procedures for Detainees with HIV/AIDS

We request disclosure of all records relating to any policies and procedures for detainees with HIV/AIDS, including but not limited to:

- 1) policies or procedures of US Immigration and Customs Enforcement related to the testing and/or medical treatment of detainees with HIV/AIDS;
- 2) policies and procedures of the Division of Immigration Health Services related to the testing and/or medical treatment of detainees with HIV/AIDS;
- 3) policies and procedures of US Immigration and Customs Enforcement related to the deportation and/or removal from the United States of detainees with HIV/AIDS;
- 4) policies and procedures of the Division of Immigration Health Services related to the deportation and/or removal of detainees with HIV/AIDS.

II. Records Indicating the Numbers of Detainees Receiving Medical Treatment for HIV/AIDS

We request disclosure of records indicating the numbers of detainees receiving medical testing and treatment services related to HIV/AIDS, including but not limited to:

- 1) the number of detainees tested for HIV;
- 2) the number of signed consent forms DIHS-075 (consent to HIV testing);
- 3) the number of detainees testing positive for HIV;
- 4) the number of detainees receiving treatment for HIV, including but not limited to anti-retroviral medications and/or treatment for opportunistic infections;
- 5) the number of HIV cases reported to federal ,state, county or municipal public health agencies;
- 6) the number of detainees receiving specialty medical care, either on or offsite, related to HIV;
- 7) the number of deaths in ICE custody, if any, related to HIV/AIDS.

III. Records Related to Deportation of Detainees With HIV/AIDS

We request all records indicating the numbers of detainees with HIV/AIDS ordered to be deported or removed from the United States, including but not limited to:

- 8) the number of detainees with HIV/AIDS ordered deported or removed;
- 9) the number of detainees with HIV deported or removed with a supply of HIV/AIDS medication;
- 10) the number of detainees granted removal exemption or waiver due to terminal illness related to HIV/AIDS.

IV. Time Period for Which Records Are Sought

We request disclosure of the records in sections I, II and III above for the time period 2002-present.

V. Category of ICE Facility

The records requested in sections II, and III above are requested for each of the following three categories of immigration detention centers operated and/or supervised by the US Immigration and Customs Enforcement Agency (“ICE”):

- 1) Service Processing Centers (SPC);
- 2) Contract Detention Facilities (CDF) operated by the Corrections Corporation of America or other private companies;
- 3) Intergovernmental Service Agreement Facilities (IGSA).

Request for Fee Waiver for Contributing to Public Understanding

Fees should be waived entirely or below the level of duplication costs because “disclosure of the information is in the public interest because it is likely to contribute significantly to public understanding of the operations or activities of the government and is not primarily in the commercial interest of the requester.” 5 U.S.C. § 552(a)(4)(A)(iii). It was the intent of Congress that the burden of proving that a request is in the public interest be “minimal.”

Institute for Wildlife Protection v. United States Fish and Wildlife Service, 290 F.Supp. 2d 1226, 1232 (D. Or. 2003).

This Request meets the four criteria laid out in Department of Homeland Security regulations for determining whether disclosures are “in the public interest.” First, the information requested concerns, “the operations or activities of the government.” 6 C.F.R. § 5.11(k)(2)(i) (2005). Medical treatment provided by the government to detained persons under its jurisdiction is a subject clearly within the public interest.

Second, the Request concerns information that is of significant value to informing the public. This information is not already in the public domain, and therefore its disclosure will greatly add to the public’s understanding since it will reveal new and important information about the medical treatment for detainees with HIV/AIDS, and the deportation and removal of such detainees. 6 C.F.R. 5.11(k)(2)(ii) (2005). The information we are seeking will be compiled and explained in an easy to understand format and distributed widely through extensive public advocacy by Requesters. The information is not available publicly at present. Disclosure will therefore have tremendous value to public understanding.

Third, a Request must be able to contribute to public understanding of “a reasonably broad audience..., as opposed to the individual understanding of the requester. A requester’s expertise in the subject area and ability and intention to effectively convey information to the public shall be considered.” 6 C.F.R. 5.11(k)(2)(iii) (2005). Human Rights Watch is the largest human rights organization based in the United States. Human Rights Watch employs over 150 professionals, among them lawyers, journalists, academics and country experts who are among the world’s leading experts in their fields. Human Rights Watch’s reports are made available in print and on our website and are the subjects of intensive publicity campaigns which utilize Human Rights Watch’s extensive contacts in the media. The information disclosed in this Request will be used in such a report. The Request therefore clearly meets the requirement of aiding public understanding by reaching a broad audience.

Fourth, “the level of public understanding existing prior to the disclosure” will “be enhanced by the disclosure to a significant extent.” 6 C.F.R. 5.11 (k)(2)(iv) (2005). Currently, there is little public understanding of the medical treatment and/or deportation of detainees with HIV/AIDS. What limited media attention there has been on the issue has generally treated only individual cases. Without statistics based on the disclosure requested, it is difficult, if not impossible, to have true public understanding of these issues. This will significantly enhance public understanding relative to its current level, as required.

The Request also meets the requirement that disclosure not be primarily in the commercial interest of the requester. 6 C.F.R. 5.11(k)(1)(ii) (2005). Human Rights Watch is a non-profit organization, and therefore has no commercial interest. 6 C.F.R. 5.11(k)(3)(i) (2005). As such, Human Rights Watch cannot put the disclosed information to “commercial use,” as defined under 6 C.F.R. 5.11(b)(1) (2005).

The Request meets all of the criteria set out by statute and regulation for the grant of a fee waiver for disclosures that further public understanding of government rather than commercial interest. Granting fee waivers in cases such as the instant Request furthers the intent of Congress in drafting the FOIA statute. Consequently, we request that you disclose the requested information without charge or at a level lower than that of duplication costs.

Request for Fee Waiver for Representatives of the News Media and Educational Institutions

We also request a fee waiver because Human Rights Watch is a representative of the news media. 5 U.S.C. §552(a)(4)(A)(ii)(II). Human Rights Watch is “an entity that is organized and operated to publish or broadcast...information that is about current events or that would be of current interest to the public.” 6 C.F.R. 5.11(b)(6) (2005). It is therefore appropriate to waive fees for this Request, especially considering that Congress intended that the term “representative of the news media” be interpreted broadly. *National Security Archive v. Department of Defense*, 880 F. 2d 1381, 1383 (D.C. Cir. 1989).

Human Rights Watch’s primary method of advocacy is investigating and publishing the findings of its investigations in reports in order to generate publicity and influence policy.¹³² In 2006, for example, Human Rights Watch published over 100 such reports. Human Rights Watch also publishes up-to-the-minute information concerning crises around the world. On average, fifty citations to our reports appeared in major newspapers and media around the world on each day from January 1, 2006 to January 1, 2007.¹³³ The information requested in

¹³² See e.g., www.hrw.org/about/faq/

¹³³ These newspapers are: The Advertiser/Sunday Mail (South Australia), The Atlanta Journal and Constitution, The Australian, The Baltimore Sun, The Boston Globe, The Boston Herald, Brisbane News, The Buffalo News, Business Times (Malaysia), The Business Times Singapore, The Charlotte Observer, Chicago Sun-Times, Chicago Tribune, The Christian Science Monitor, The Columbus Dispatch, The Courier Mail/The Sunday Mail (Australia), The Courier-Journal (Louisville, Kentucky), Daily News (New York), The Daily/Sunday Telegraph (London), Daily Telegraph and Sunday Telegraph (Sydney, Australia), The Daily Yomiuri (Tokyo), The Dallas Morning News, The Denver Post, Detroit Free Press, The Detroit News (Michigan), The Dominion Post (Wellington, New Zealand), The Dominion (Wellington), The Evening Post (Wellington), Financial Times (London), Het Financieel Dagblad (English), Fort Worth Star-Telegram, Gazeta Mercantil Online, The Gazette (Montreal), The Guardian (London), The Hartford Courant, The Herald (Glasgow), Herald Sun/Sunday Herald Sun (Melbourne, Australia), The Houston Chronicle, The Idaho Statesman (Boise), The Independent and Independent on Sunday (London), The Indianapolis Star (Indiana), The Irish Times, The Jerusalem Post, Journal of Commerce, The Kansas City Star, Los Angeles Times, The Mercury/Sunday Tasmanian (Australia), Miami Herald, The Milwaukee Journal Sentinel, The Myrtle Beach Sun-News, New

this Request will be published in such a report, which will be made available in print and on the internet. As such, we request that you grant a fee waiver to Human Rights Watch as a representative of the news media. 6 C.F.R. 5.11(d)(1) (2005).

In compliance with 6 C.F.R. 5.5(d)(3) (2005), the undersigned certify that the above information pertaining to a request for expedited processing is true and correct to the best of the undersigned's knowledge and belief.

We thank you for your attention in this matter and look forward to your response within 20 business days. 5 U.S.C. §552(a)(6)(A)(i).

Straits Times (Malaysia), The New York Times, The New Zealand Herald, Newsday (New York, NY), The Observer, Omaha World Herald, The Orange County Register, The Oregonian, Orlando Sentinel, Ottawa Citizen, The Philadelphia Daily News - Most Recent Two Weeks, The Philadelphia Daily News (PA), The Philadelphia Inquirer, The Philadelphia Inquirer - Most Recent Two Weeks, Pittsburgh Post-Gazette, The Plain Dealer, The Press (Christchurch, New Zealand), Rocky Mountain News, Sacramento Bee, Saint Paul Pioneer Press, San Antonio Express-News, San Diego Union-Tribune, The San Francisco Chronicle, San Jose Mercury News, The Scotsman & Scotland on Sunday, The Seattle Times, South China Morning Post, St. Louis Post-Dispatch, St. Petersburg Times, Star Tribune (Minneapolis MN), The Straits Times (Singapore), Sun-Sentinel (Fort Lauderdale), The Tampa Tribune, The Times-Picayune, The Toronto Star, USA Today and The Washington Post.