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DETAINED

UNITED STATES DEPARTMENT OF JUSTICE
EXECUTIVE OFFICE OF IMMIGRATION REVIEW
BOARD OF IMMIGRATION APPEALS

In the Matter of:	
Jose Luis RAMIREZ	**File No:**
In removal proceedings	

BRIEF FOR AMICI CURIAE AMERICAN ACADEMY OF HIV MEDICINE, ASSOCIATION OF NURSES IN AIDS CARE, GLMA: HEALTH PROFESSIONALS ADVANCING LGBT EQUALITY, L.A. GAY & LESBIAN CENTER, NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS, AND SAN FRANCISCO AIDS FOUNDATION

ON BEHALF OF RESPONDENT

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INTERESTS OF *AMICI CURIAE*

Amici curiae American Academy of HIV Medicine ("AAHIVM"), Association of Nurses in AIDS Care ("ANAC"), GLMA: Health Professionals Advancing LGBT Equality ("GLMA"); L.A. Gay and Lesbian Center ("LAGLC"), National Alliance of State and Territorial AIDS Directors ("NASTAD"), and San Francisco AIDS Foundation ("SFAF") submit this brief in support of Respondent Jose Luis Ramirez.

The American Academy of HIV Medicine ("AAHIVM") is an independent organization of HIV specialists and other medical providers dedicated to promoting excellence in HIV/AIDS care. Through advocacy and education, AAHIVM is committed to supporting health care providers in HIV medicine and to ensuring better care for those living with AIDS and HIV disease. As the largest independent organization of HIV frontline providers, its 2,000 members provide direct care to more than 340,000 HIV patients (more than two-thirds of the patients in active treatment for HIV disease). AAHIVM has a diverse membership composed of infectious disease, internal medicine, family practitioners and general practice specialists, as well as nurse practitioners, physician's assistants, and pharmacists. AAHIVM believes that it is important that courts rely on accurate medical and scientific information when considering issues related to HIV/AIDS.

The Association of Nurses in AIDS Care ("ANAC") is dedicated to promoting the individual and collective professional development of nurses involved in the delivery of health care to persons infected or affected by HIV and to promoting the health and welfare of infected persons by: creating an effective network among nurses; studying, researching and exchanging information, experiences, and ideas leading to improved care for persons living with and at risk of HIV; providing leadership to the nursing community in HIV and HIV-related prevention, care,

treatment and research; advocating for scientifically sound and human rights based health policy; and promoting social awareness concerning issues related to HIV. ANAC has nearly 2,000 members who work in all aspects of HIV and HIV-related prevention, care, treatment, research, policy and education. Inherent in ANAC's mission and goals is an abiding commitment to the prevention of further HIV infection through sound science and evidence-based programs. ANAC's commitment includes promoting an accurate understanding of HIV infection and modes of transmission.

GLMA: Health Professionals Advancing LGBT Equality ("GLMA") is the largest and oldest association of lesbian, gay, bisexual and transgender (LGBT) healthcare professionals. GLMA's mission is to ensure equality in healthcare for LGBT individuals and healthcare professionals, using the medical and health expertise of GLMA members in public policy and advocacy, professional education, patient education and referrals, and the promotion of research. GLMA (formerly known as the Gay & Lesbian Medical Association) was founded in 1981 in part as a response to the call to advocate for policy and services to address the growing health crisis that would become the HIV/AIDS epidemic. Since then, GLMA's mission has broadened to address the full range of health issues affecting LGBT people, including ensuring that all healthcare providers provide a welcoming environment to LGBT individuals and their families and are competent to address specific health disparities affecting LGBT people, including HIV and AIDS.

The L.A. Gay & Lesbian Center began as an all-volunteer organization in 1969 and was formally incorporated in 1971. Each month, the Center welcomes at its five locations approximately 25,000 people utilizing the Center's wide variety of programs and services, including people of all ages, races, religions, genders and sexual orientations. Most of the

Center's programs are provided free or at low cost, since a majority of its clients are people who do not have insurance or the resources to pay for the care that they need. Because of the Center's size and scope, it plays a national leadership and advocacy role, primarily in areas related to LGBT health (including HIV/AIDS). In order to reduce the stigma associated with persons living with HIV, it is important that the public fully understands how HIV is and is not transmitted. Stigma not only makes it difficult for people who have been diagnosed with HIV to manage their illness, but it also interferes with efforts to fight the disease by acting as a barrier to public action and making individuals reluctant to access HIV testing and care.

The National Alliance of State and Territorial AIDS Directors ("NASTAD") represents the nation's chief state health agency staff who have programmatic responsibility for administering HIV/AIDS and viral hepatitis healthcare, prevention, education, and supportive service programs funded by state and federal governments. NASTAD is dedicated to reducing the incidence of HIV/AIDS and viral hepatitis infections in the United States and its territories, providing comprehensive, compassionate, and high-quality care to all persons living with HIV/AIDS and viral hepatitis, and ensuring responsible public policies. NASTAD provides national leadership to achieve these goals, and to educate about and advocate for the necessary federal funding to achieve them, as well as to promote communication between state and local health departments and HIV/AIDS and viral hepatitis care and treatment programs.

The San Francisco AIDS Foundation ("SFAF") works to end the epidemic where it first took hold—and eventually everywhere. Established in 1982, its mission is the radical reduction of new infections in San Francisco. Through education, advocacy, and direct services for prevention and care, we are confronting HIV in communities most vulnerable to the disease. We refuse to accept that HIV transmission is inevitable. Stigma is one of the most significant

barriers in our efforts to prevent new HIV infections. Even thirty years into the epidemic, roughly one in four Americans continue to believe that people can get HIV from sharing a drinking glass. Fear of HIV and misconceptions not only about how it is (and is not) transmitted, but also about the primary routes and actual risks of transmission, perpetuate stigma and hamper our efforts to fight the epidemic.

Amici are vitally interested in ensuring that individuals who have HIV are afforded the full protection of the law, that the criminal law and immigration law serve as vehicles for only legitimate state purposes, and that people living with HIV are not prosecuted, incarcerated, deported, or placed at risk of abuse and persecution due to ignorance or misunderstandings about HIV. *Amici* provide information below for the Board about the routes and actual risks of HIV transmission, the treatability of HIV and much improved prognosis for those diagnosed with HIV today, and the proper allocation of the shared responsibility to prevent HIV transmission, all of which will facilitate the Board's review of the matter at hand.

Statement of Relevant Facts

As a result of the repeated abuse he suffered at the hands of police officers in Mexico, Respondent Jose Luis Ramirez, a gay man living with HIV, qualified for withholding of removal under section 241(b)(3) of Immigration and Nationality Act ("INA") in May 2006. *See* Order of Immigration Judge, dated May 8, 2006 (Dept. of Homeland Security's ("DHS") Mot. to Reopen, Exh. A). In 2009, after becoming homeless when the nonprofit for which he worked for five years went bankrupt and his long-term relationship ended, Mr. Ramirez was arrested and charged with solicitation after agreeing to perform oral sex on an undercover police officer in exchange for money. *See* "Updated Statement, from May 8th, 2006 to Present," supplement to Form I-589, submitted on Aug. 2, 2012 ("2012 Statement"); Fel. Compl., Case No. BA362642 (DHS's Suppl. Docs., Exh. A); Arrest Rep., dated Sept. 26, 2009 (DHS's Suppl. Docs., Exh. C). By the police officer's own admission, Mr. Ramirez agreed to use condoms for this act of consensual oral sex. *Id.*

Because Mr. Ramirez had been tested for HIV and informed of a positive result after a previous conviction under Cal. Penal Code § 647(b), his prior conviction and knowledge of a positive test result were also alleged pursuant to Cal. Penal Code § 674f. *See* Fel. Compl., Case No. BA362642 (DHS's Suppl. Docs., Exh. A). Under § 674f, if those allegations are proven or are admitted by the defendant, a conviction under § 647(b) is classified as a felony. *See* Cal. Pen. Code § 647f. Mr. Ramirez pled guilty and was sentenced to 16 months in prison. *See* Plea Tr., Case No. BA 362642, at 6:2-21 (DHS's Suppl. Docs., Exh. C).

In May 2012, the U.S. government ("Government") moved to reopen immigration proceedings against Mr. Ramirez, seeking to terminate his withholding of removal, alleging that he had committed a "particularly serious crime." *See* DHS's Mot. to Reopen; *see also* 8 C.F.R. §

1208.24(f); INA § 241(b)(3)(B)(ii). The Government originally brought its motion based upon a 2005 conviction under § 647(b)—which also included a sentence enhancement under § 674f—but offered to withdraw that motion after realizing that the immigration judge who granted the withholding of removal and the government attorney at those proceedings agreed that the conduct leading to Mr. Ramirez's 2005 conviction did not constitute a "particularly serious crime." *See* DHS's Mot. to Reopen; Tr. of Hr'g (May 8, 2006) (excerpts attached hereto as Exh. A), at 46:20–47:21; Tr. of Hr'g (July 2, 2012) (excerpts attached hereto as Exh. B), at 74:13–75:13. At the urging of Immigration Judge Lorraine J. Munoz (IJ), the Government substituted the 2009 conviction for the 2005 conviction and proceeded with its motion to terminate withholding of removal. *Id.* at 75:14–78:1. During the hearing on its motion, in addition to reiterating that condoms were to be used during the proposed oral sex, Mr. Ramirez indicated that he intended to disclose his status prior to engaging in the agreed upon activity. Tr. of Hr'g (July 11, 2012) (excerpts attached hereto as Exh. C), at 91:20–93:43.

At the hearing on July 11, 2012, the IJ terminated Mr. Ramirez's withholding of removal. *Id.* at 118:14-16. In a written decision entered October 12, 2012 (attached hereto as Exh. D), the IJ did not credit Mr. Ramirez's testimony regarding his intent to use a condom and held that any intent he may have had to disclose his HIV status prior to performing oral sex was irrelevant, because "it does not mitigate the danger Respondent's behavior posed to the subsequent sexual partners of his client." *See* I.J. Removal Proceeding Decision (October 12, 2012) at 7. Focusing upon whether Mr. Ramirez posed a danger to the community, the IJ held that he did, because of "the highly communicable nature of AIDS, its lethality, and the continued risk of exposure to multiple individuals arising from Respondent's behavior." I.J. at 7. Based on these findings, the

IJ held that the 2009 conviction was a "particularly serious crime" and terminated Mr. Ramirez's withholding of removal. *Id.*

Because the IJ's determination is based on commonly-held misconceptions about the transmissibility of HIV, outdated notions regarding the consequences of an HIV diagnosis, and a misallocation of the responsibilities two consenting adults share with respect to preventing the sexual transmission of HIV, *amici* respectfully submit this brief to provide the Board of Immigration Appeals (the "Board") with more accurate and up-to-date information regarding these subjects.

Legal Standard

To succeed on a motion to terminate withholding of removal based on Mr. Ramirez's 2009 conviction under § 647(b), the Government must establish by a preponderance of the evidence that the offense constitutes a "particularly serious crime." *See* 8 C.F.R. § 1208.24(f); *see also* INA § 241(b)(3)(B)(ii). A "particularly serious crime" is more serious than a "serious nonpolitical crime," which in itself must be a capital crime or a very grave punishable act. *Matter of Frentescu*, 18 I&N Dec. 244, 245-47 (BIA 1982). Crimes against the person are more likely to be categorized as "particularly serious crimes" than are crimes against property. *Id.* at 247. In evaluating whether an offense is a "particularly serious crime," the relevant factors are "the nature of the conviction, the circumstances and underlying facts of the conviction, the type of sentence imposed, and, most importantly, whether the type and circumstances of the crime indicate that the alien will be a danger to the community." *Id.*[1]

[1] As of 1995, all aggravated felonies were considered particularly serious crimes, but changes to the INA since that time removed aggravated felonies resulting in sentences of less than five years from the category of *per se* "particularly serious crimes," in order to ensure compliance with the 1967 United Nations Protocol Relating to the Status of Refugees. *Matter of N-A-M*, 24 I&N Dec. 336, at *9 (BIA 2007). While the Board has acknowledged there are situations in which

In applying the *Frentescu* standard, the most important consideration is whether the circumstances and underlying facts of the conviction indicate that the person presents a danger to the community. *Matter of N-A-M*, 24 I&N Dec. 336, at *15 (BIA 2007). While there are some circumstances in which merely examining the nature of the offense (i.e., the elements of the crime) may be dispositive, in most cases a careful examination of the individual facts and circumstances is necessary. *Id.*; *see also Alfridi v. Gonzales*, 442 F.3d 1212, 1221 (9th Cir. 2006) (remanding for the BIA to consider the specific facts and circumstances underlying petitioner's conviction). If an examination of the nature of the offense potentially brings the offense within the ambit of a particularly serious crime, all reliable information may be considered in making the determination. *Matter of N-A-M*, 24 I&N Dec. 336, at *16. The sentence imposed, however, is not considered the most accurate or salient factor to consider in determining the seriousness of the offense. *Id.* at *18. The proper focus is on the conduct underlying the conviction at issue. *Id.* at *16-*17; *see also Alfridi,* 442 F.3d at 1220 (citing *Beltran-Zavala v. INS*, 912 F.2d 1027, 1031 (9th Cir. 1990)). In rendering this determination, the IJ must rely upon the evidence and record before the court, and may not rely upon preconceived notions about the salient issues in the case. *See, e.g., Ali v. Mukasey*, 529 F.3d 478, 492-93 (2nd Cir. 2008) (remanding to the Board and ordering that a different IJ be assigned, because the IJ below had relied upon "preconceived assumptions about homosexuality and homosexuals").

The Board conducts a *de novo* review of the IJ's legal determination as to the whether the underlying circumstances indicate that the conviction under review was a "particularly serious

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even non-aggravated felonies, such as the offense in question here, would require a "particularly serious crime" designation under *Frentescu*, it may be presumed that such situations are the exception rather than the rule. *See id.*; *see also Matter of C--*, 20 I&N Dec. 529 (BIA 1992).

crime." *See* 8 C.F.R. § 1003.1(d)(ii). *Amici* respectfully submit this brief to assist the Board in its *de novo* review. At issue in this case is whether an individual living with HIV who has engaged in solicitation to perform oral sex upon another person presents a danger to the community. Because the IJ drastically overestimated the risk of transmission via oral sex (even in the absence of condom use), misunderstood the current consequences of an HIV diagnosis, and misattributed to Mr. Ramirez the responsibility for any potential onward transmission,[2] the IJ erred when she terminated withholding of removal. Therefore, the Board should reverse the decision of the IJ and remand with instructions to reconsider this case in light of the information presented in this brief.

ARGUMENT

I. If Not Zero, the Risk of HIV Transmission Through Oral Sex Is So Extremely Low That It Does Not Support a Finding That a Person Living with HIV Who Offers to Engage in Oral Sex for Money Presents a Danger to the Community.

The risk of HIV transmission via unprotected oral sex is extremely low, or perhaps even zero, in the absence of a combination of extenuating circumstances. *See* Campo et al., "Oral Transmission of HIV, Reality or Fiction? An Update," Oral Diseases 12:219-28 (2006) ("Oral Transmission") (attached hereto as Exh. E), at 219 (the vast majority of HIV infections occur during vaginal or anal intercourse, and epidemiological studies have reported very little or no transmission via oral sex). Therefore, the possibility of transmission in the single act of oral sex in which Mr. Ramirez agreed to engage with the undercover officer is so remote that it should

[2] In this context, "onward transmission" refers to the potential transmission of HIV from Mr. Ramirez's sexual partner to others, in the unlikely event that Mr. Ramirez's sexual partner would have become infected with HIV as a result of the oral sex giving rise to the solicitation charge. *See* Centers for Disease Control and Prevention ("CDC"), "Background Brief on Prevention Benefits of HIV Treatment" (published Jan. 13, 2013), *available at* www.cdc.gov/hiv/topics/treatment/resources/factsheets/pdf/Prevention_Benefits_of_HIV_Treatement.pdf ("Prevention Benefits of HIV Treatment"), at 1 (describing "onward transmission") (Exhibit U).

not weigh against him in determining whether the offense of which he was convicted is a "particularly serious crime."

A. There Have Been No Documented Cases of HIV Transmission as a Result of an HIV-Positive Person Performing Oral Sex.

Because saliva is not a bodily fluid capable of transmitting HIV, it is generally impossible for an HIV-positive person performing oral sex on another to transmit HIV. *See* Centers for Disease Control and Prevention ("CDC"), "HIV Transmission Questions and Answers" (reviewed and modified Mar. 25, 2010), http://www.cdc.gov/hiv/resources/qa/transmission.htm (last visited Apr. 8, 2013) (attached hereto as Exh. F) (saliva not a bodily fluid that transmits HIV); Center for HIV Law and Policy ("CHLP") et al., "Spit Does Not Transmit" (published Mar. 25, 2013), http://hivlawandpolicy.org/resources/view/834 (last visited Apr. 8, 2013) (gathering evidence that HIV is not transmitted via saliva) (attached hereto as Exh. G); Dosekun & Fox, "An Overview of the Relative Risks of Different Sexual Behaviours on HIV Transmission," Current Op. in HIV and AIDS, 5:291-97 (2010) ("Relative Risks") (attached hereto as Exh. H) (stating that the per-act risk of acquiring HIV for the insertive partner during oral intercourse estimated in the studies under review was zero ("range 0–0")). Quite simply, if an infectious fluid—such as the semen of the person with HIV—is not present in the oral cavity of the uninfected individual, there cannot be transmission. *See, e.g.*, Univ. Cal. San Francisco ("UCSF"), "Risk of HIV Infection Through Receptive Oral Sex," HIV InSite (panel discussion on Mar. 14, 2003), http://hivinsite.ucsf.edu/insite?page=pr-rr-05 (last visited Apr. 8, 2013) ("HIV InSite") (attached hereto as Exh. I), at 2 (J. Klausner, MD, MPH: "[T]here has to be exposure to infectious substance . . . . If there is no infectious [substance], there should be no transmission, there should be no exposure to virus."). Because saliva does not transmit HIV, and generally no other

HIV-transmitting fluid is present if the HIV-positive person is *performing* oral sex, transmission should not occur under these circumstances.

It is true that medical researchers are able to imagine a plausible scenario in which transmission is *theoretically* possible during oral sex performed by someone who is HIV-positive.[3] However, it is also true that if one is willing to reach far enough into the realm of wildly unlikely occurrences, then just about any activity in which an HIV-positive person engages would present at least some imaginable risk of transmission to others. Such unlikely scenarios—and the "theoretical" risk of HIV transmission that results from entertaining them—should not serve as the basis for a determination that Mr. Ramirez presents a "danger to the community." *See, e.g., Matter of L-S-*, 22 I&N Dec. 645, 656 (BIA 1999) (holding that person did not present a danger to the community, even though there was some risk of harm to person being smuggled in the event of an auto accident). Because a review of the conviction record reveals that Mr. Ramirez had agreed to perform oral sex on the undercover officer, *see* Arrest Rep., dated Sept. 26, 2009 (DHS's Suppl. Docs., Exh. C) (indicating that the officer agreed to pay for a "BJ," which is the acronym for "blow-job," the act of performing fellatio), and because it is generally impossible for an HIV-positive person to transmit HIV by performing oral sex on another, the IJ erred in concluding that HIV was "highly communicable" in these circumstances and that Mr. Ramirez had, therefore, committed a "particularly serious crime."

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[3] For example, it may be hypothesized that if the HIV-positive person performing oral sex were *actively* bleeding from a wound inside the mouth *and* the HIV-negative person had an open sore or abrasion on or near their genitalia, then it *might* be possible to transmit HIV. *See* AVERT, "Oral Sex: Can HIV Be Transmitted Via Oral Sex?", http://www.avert.org/oral-sex.htm (last visited Apr. 8, 2013), at 2 (explaining that this unlikely scenario may present a risk of transmission) (attached hereto as Exh. J); UCSF, "HIV InSite," at 2 (S. Buchbinder, MD: hypothesizing that transmission could occur without ejaculation, but conceding that transmission through fellatio without ejaculation is "exceedingly rare") (Exh. I). But no one has been—or likely ever will be—able to prove that such an unlikely scenario has ever actually resulted in transmission.

B. The Risk of HIV Transmission When the Uninfected Person Is Performing Oral Sex on Someone Who Is HIV-Positive Is Extremely Low, If Not Zero.

Even assuming *arguendo* that Mr. Ramirez was going to be the insertive partner during oral sex—*and* that he intended to ejaculate during that oral sex—the IJ's determination regarding the "highly communicable" nature of HIV in such circumstances would be inaccurate.

1. Information on the CDC Website Is Useful in Guiding the Public Regarding the Level of Risk Involved in a Particular Activity, But Other Credible Sources Provide a More Nuanced and Detailed Analysis.

Any judicial inquiry into the degree of risk involved in a particular activity appropriately begins with the Centers for Disease Control and Prevention ("CDC").[4] *Bragdon v. Abbott,* 524 U.S. 624, 650 (1998) (acknowledging that the views of public health authorities are of special weight). In information available on its website as of June 14, 2012, the CDC states that transmission via oral sex is a "rare" event. *See* CDC, "HIV Transmission Risk," (published June 14, 2012), http://www.cdc.gov/hiv/law/transmission.htm (last visited Apr. 8, 2013) (attached hereto as Exh. K). Because transmission through oral sex is such a rare occurrence, if it indeed occurs at all, the CDC cannot provide an estimate of the per-act probability of acquiring HIV in this manner from an infected source, as it does for other activities. *See id.* (conceding that "[a]ccurate estimates of risk are not available" and merely describing the risk as "low"). The

[4] Unfortunately, the IJ in this case was not supplied with current information from the CDC regarding the risk of transmission via oral sex. *See* CDC, "HIV Transmission, Questions and Answers," *available at* www.cdc.gov/hiv/resources/qa/transmission.htm (submitted by Government at July 11, 2012 hearing, at 86:2-5) (last reviewed and modified Mar. 25, 2010) (Exh. F). Note that the date on this document (July 10, 2012) is the date it was *printed*, not the date the information was published, last reviewed or modified. The only information on this subject the Government submitted—and the IJ considered—was not inaccurate *per se*, but it was also not the most current and/or detailed information that was available on the CDC website at that time. *Compare* CDC, "HIV Transmission, Questions and Answers" (last reviewed and modified on Mar. 10, 2010) *with* Centers for Disease Control and Prevention, "HIV Transmission Risk," *available at* www.cdc.gov/hiv/law/transmission.htm (attached hereto as Exh. K) (last reviewed and modified on June 14, 2012).

article to which the CDC cites for its description of the risk of transmission through oral sex as "low" does not actually establish that any risk exists in these circumstances and admits that when published estimates were not available, the authors simply used "best-guess estimates." *See* Varghese et al., "Reducing the Risk of Sexual HIV Transmission: Quantifying the Per-Act Risk for HIV on the Basis of Choice of Partner, Sex Act and Condom Use," Sex. Trans. Dis. Vol. 29, 1:39 (2002) ("Reducing the Risk") (attached hereto as Exh. L). Furthermore, despite the article's assessment that insertive oral sex is significantly less risky than receptive oral sex, that information is not reflected in the chart published on the CDC website, which merely classifies both risks as "low." *Compare id.* at 1:39-40 *with* CDC, "HIV Transmission Risk" (Exh. K).

While the inquiry into the degree of risk presented by a particular activity appropriately starts with the CDC, that is not where it necessarily ends. *See Bragdon*, 524 U.S. at 650 (noting that the views of public health authorities, such as the CDC, are not conclusive). Given its role in safe-guarding the public health—and the difficulties involved in quantifying the risk presented by various sexual acts—it is not surprising that the CDC takes a conservative and cautious approach when describing to the public the degree of risk presented by oral sex. For this reason, it is also helpful to examine the source articles and studies upon which the CDC's assessment relies and to better understand the biases, uncertainties and assumptions underlying the data and conclusions presented in those articles and studies. *See generally* UCSF, "HIV InSite" (Exh. I) at 5 (E. Vittinghoff, PhD: acknowledging that his estimate for per-act risk is only "interpretable in terms of a confidence interval and a lot of understanding about kinds of biases that could go into the estimation of that number"). A review of these materials reveals that scientists cannot definitely say that a risk of transmission through oral sex actually exists and, most certainly, cannot quantify that risk—however, all indications point to the conclusion that, if there is any

risk at all, it is extremely low. *See, e.g.,* Page-Shafer et al., "Risk of HIV Infection Attributable to Oral Sex Among Men Who Have Sex with Men and in the Population of Men Who Have Sex with Men," AIDS, Vol. 16, Issue 17: 2350 (2002) ("Oral Sex Among MSM")[5] (attached hereto as Exh. M), at 2351 ("[S]uch infection is rare; and . . . HIV attributable to fellatio is extremely low."); UCSF, "HIV InSite" (Exh. I) at 5 (T. Coates, PhD: "[T]hat transmission by oral sex/fellatio with ejaculation, being the receptive partner, transmission is biologically plausible. . . . It's a relatively rare event.")

2. The Nature of Scientific Inquiry With Respect to HIV Makes It Difficult to Definitively Establish That Any Risk of Transmission Via Oral Sex Exists.

Scientists are extremely reluctant to speak in the absolutes that, at times, the courts would like. As the adage goes: if you ask a scientist under oath if the sun will rise in the east tomorrow morning, the response will be that it is "very likely." This reluctance on the part of scientists, to provide definitive answers if there is even the slightest possibility of being wrong or of a different outcome, is reflected in the CDC chart on HIV transmission risks, which describes the risk of contracting HIV through spitting as "negligible." *See* CDC, "HIV Transmission Risk" (Exh. K). Even though there has never been a reported case of transmission in this manner, and after more than three decades of study, scientists do not believe that saliva is a bodily fluid capable of transmitting HIV, the CDC does not definitively state that the risk of transmission is zero. *Compare* CHLP, "Spit Does Not Transmit" (citing to credible sources explaining that saliva does not transmit HIV) (Exh. G) *with* CDC, "HIV Transmission Risk" (classifying the risk

[5] The "term men who have sex with men (MSM) is used in CDC surveillance systems. It indicates the behaviors that transmit HIV infection, rather than how individuals self-identify in terms of their sexuality." CDC, "HIV Among Gay and Bisexual Men," http://www.cdc.gov/hiv/topics/msm/, at n. "a." (last updated Mar. 21, 2013) (attached hereto as Exh. N)

of transmission via spitting as "negligible") (Exh. K). It is in this light that the CDC's characterization of the risk of transmission via oral sex as merely "low" must be considered.

Just as the reluctance to speak in absolutes prevents scientists from stating there is *no risk* of transmission via oral sex, it also prevents them from definitively declaring that this activity presents any risk at all. *See, e.g.*, Vittinghoff et al., "Per-Contact Risk of Human Immunodeficiency Virus Transmission Between Male Sexual Partners," Am. J. Epidemiol. 150 (3): 306, 310 (1998) ("Per-Contact Risk of HIV") (stating that "zero risk cannot be ruled out") (attached hereto as Exh. P). For one thing, this is not a theory that can be tested in the laboratory or through strictly controlled studies involving human beings, because such testing or studies would be impossible and/or unethical. Furthermore, the animal testing that has been done on this subject is inconclusive, both because it involves a different version of the virus (simian immunodeficiency virus (SIV)) and because the method of exposing the animal does not sufficiently approximate the exposure that occurs during oral sex. *See* UCSF, "HIV InSite," at 3, 4 (K. Page Shafer, PhD, MPH, and J. Klausner, MD, MPH: critiquing the laboratory modeling of HIV transmission using SIV and macaque monkeys) (Exh. I). For these reasons, scientists must rely almost exclusively on epidemiological field studies, which attempt to assess retrospectively the number and type of exposures participants had—as well as determine what risk cofactors may have played a role in any transmissions that occurred—over the time span of the study. *See id.* at 4 (J. Klausner, MD, MPH: "So you're left with epidemiological data and the history of epidemiological data comes from case reports."); *see also* Campo, "Oral Transmission," at 219 (stating epidemiological studies have reported very little or no transmission via oral sex) (Exh. E).

The self-reporting involved in these studies, as well as in the random and infrequent reported cases of transmission that are subsequently investigated by public health officials, makes it extremely difficult to substantiate that a transmission has occurred through oral sex. While the CDC and other researchers base their belief that some risk of transmission via oral sex exists as a result of relatively few, so-called "documented" cases in which other types of exposure have allegedly been ruled out, there is always a degree of uncertainty as a result of the reliance on self-reporting. *See* CDC, "HIV Transmission Risk," at note "i." ("HIV transmission through oral sex has been documented, but rare.") (Exh. K); Page-Shafer et al., "Oral Sex Among MSM," at 2351 ("HIV-positive MSM may inaccurately report higher-risk exposures for reasons including social desirability and recall.") (Exh. M); UCSF, "HIV InSite," at 4 (J. Klausner, MD, MPH: "When relying on patient history, it is often not really substantiated when you re-interview people.") (Exh. I); UCSF, "HIV InSite," at 6 (D. Osmond, PhD: "I've been following cohorts for 20 years and I still have yet to see what I think is really a documented case.").

In addition to the problems associated with faulty recall, there is a fair degree of reporting bias based on what scientists refer to as "desirability"—which is a reluctance to admit to engaging in riskier activities because of the social/psychological trauma and stigma associated with doing so. *Id.* at 3; *id.* at 4 (F. Hecht, MD: "There are people who are reluctant to disclose other risks, or will not immediately disclose a risk[.]") In fact, this type of self-reporting bias based on desirability has been documented in at least two studies in which participants who at first claimed no exposure other than oral sex later recanted and reported higher risk exposures. *See* Keet et al., "Orogenital Sex and the Transmission of HIV Among Homosexual Men," AIDS 6:223-26 (1992) (attached hereto as Exh. O) (first study); UCSF, "HIV InSite," at 3 (describing

the second study) (Exh. I). In the second of those two studies, the participants went through two separate screenings and a very in-depth interview maintaining that they had only had exposure via oral sex, before 25% of them eventually reported a higher risk exposure during a subsequent in-depth interview that took place after they had learned that they tested negative for HIV. *See id.* With admitted reporting bias figures running this high, it is difficult to place much faith in the veracity of any of the so-called "documented" cases of transmission via oral sex.

3. If Not Zero, the Risk of Transmission Via Oral Sex Is So Extremely Low, Scientists Are Unable to Quantify It With Any Degree of Accuracy.

Such self-reporting bias makes it difficult to establish whether any risk of transmission via oral sex—absent some extenuating circumstances—actually exists, in turn making it all but impossible to quantify any risk that exists. *See* UCSF, "HIV InSite," at 3 (K. Page-Shafer: "The problem with the discussion, though, continues to revolve around the inability to quantify risk. … [B]esides saying 'exceedingly low risk' or 'very low risk,' that's the best you can do. It is all still hypothetical.") For one thing, it is best to have a large number of study participants within a particular category—in this case, people who have only engaged in oral sex— in order to isolate the risk, but most people who engage in oral sex also engage in other higher-risk sexual activities. *See* Campo, "Oral Transmission," at 220 ("It is extremely difficult to estimate the precise risk associated with oral exposure because most individuals have various sexual behaviors so that whether the route was oral, vaginal or anal cannot easily be established.") (Exh. E); Page-Shafer et al., "Oral Sex Among MSM," at 2351 (noting modest sample size, and that "the proportion of individuals who engage exclusively in fellatio is very low, thus obtaining precise and reliable estimates of the per-partner and per-contact risks of acquiring HIV from fellatio will be difficult") (Exh. M); UCSF, "HIV InSite," at 4 (F. Hecht: "One of the problems

here . . . is there really are not that many men who have sex with men who are only having oral sex.") (Exh. I).

When examining a broader population of study participants (those who engage in sexual activities other than oral sex) and taking into account the risk differential between receptive anal or vaginal intercourse and receptive oral sex, the relatively low number of seroconversions[6] on which to base any probabilistic conclusions, and the problem with self-reporting bias described above (which can affect the ratio of low-risk to higher-risk contacts a participant reports), it becomes extremely difficult to tease out and quantify the risk associated with oral sex. *See* Vittinghoff et al., "Per-Contact Risk of HIV" (Exh. P), at 306 -08, 310-11 (describing these problems in quantifying any risk associated with oral sex); UCSF, "HIV InSite," at 2 (S. Buchbinder: "So clearly, the riskiest practices can overwhelm our ability to look at the risk that is associated with having this lower-risk type of exposure."); UCSF, "HIV InSite," at 3 (K. Page-Shafer: stating that because the infectivity of anal sex is so relatively high in comparison, it is difficult to verify any risk attributable to oral sex). Therefore, establishing the top end of the range of per-act risk for oral sex involves a significant number of assumptions and a fair amount of guess work. *See* Vittinghoff et al., "Per-Contact Risk of HIV," at 306-07, 311 (relying on Bernoulli modeling to (admittedly) *imprecisely* estimate the risk of transmission via oral sex as .04%, which would be 4 transmissions in 10,000 contacts (or 1 in 2500)) (Exh. P); Baggeley et al., "Systematic Review of Orogenital HIV-1 Transmission Probabilities," Int. J. Epidemiol. 37(6): 1255-65 (2008) (attached hereto as Exh. Q) (noting none of the MSM who exclusively reported oral sex as a risk factor seroconverted in Vittinghoff *et al.*'s study); UCSF, "HIV

[6] In the context of HIV, "seroconversion" is the medical term for the process by which a person goes from being HIV-negative to HIV-positive. *See* Cichocki, "HIV Seroconversion," http://aids.about.com/od/hivaidsletterh/g/seroconversion.htm (last updated Aug. 19, 2007) (attached hereto as Exh. R)

InSite," at 6 (D. Osmond, PhD: critiquing the 1 in 2500 estimate as "probably too high") (Exh. I).

Researchers have, however, established *zero* as the low-end of the range of the per-act risk for receptive oral sex. *See* Dosekun & Fox, "Relative Risks," at 291 (transmission estimates for "receptive oral intercourse (range 0–0.04)") (Exh. H). Two studies involving participants whose only unprotected exposure was oral sex, one encompassing over 19,000 oral sex contacts within heterosexual serodiscordant[7] couples and the other involving over 5,000 oral sex contacts between two men (one HIV negative and the other's status unknown) bear out the extremely low—and possibly even zero—risk of HIV transmission via oral sex, as neither of those studies reported a single transmission. *See* del Romero et al., "Evaluating the Risk of HIV Transmission Through Unprotected Orogenital Sex," AIDS, Vol. 16, No. 9, 1296-97 (2002) (attached hereto as Exh. S); Page-Shafer et al., "Oral Sex Among MSM," at 2351 (Exh. M); USCF, "HIV InSite," at 3 (Page-Shafer, PhD, MPH: describing the two studies, and stating: "[W]e have huge problems in terms of self-reported risk behavior when it comes to the oral sex question that will always plague us if we try to quantify risk.") (Exh. I).

In sum, what the scientific literature reveals is that, absent some fairly unusual extenuating circumstances, there appears to be *almost zero risk* of transmission for an uninfected individual receiving oral sex from someone who is HIV-positive, and that the risk of transmission for an uninfected person performing oral sex is so low that scientists are unable to quantify it or even definitively establish that a risk exists as a result of this activity. Given the very low number of so-called "documented" cases of oral transmission (purportedly in the

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[7] A "serodiscordant" couple or sexual contact is one in which one person has HIV and the other does not. *See* Boskey, "Serodiscordant Couple," *available at* http://std.about.com/od/glossary/g/serodiscgloss.htm (last updated Feb. 6, 2009) (attached hereto as Exh. T)

absence of other types of exposure), the problems in verifying the actual method of transmission in these relatively few cases, and the total number of encounters between serodiscordant sexual partners involving oral sex there have been over the course of this 30-year epidemic, it is fairly safe to say that transmission via oral sex—if it happens at all—is an exceedingly rare event. Page-Shafer et al., "Oral Sex Among MSM," at 1250 ("The risk of HIV attributable to fellatio is extremely low."); *id.* at 1251 ("[O]rally acquired HIV infection is rare."); Campo, "Oral Transmission," at 219 ("[T]he oral cavity appears to be an extremely uncommon transmission route for HIV.") (Exh. E); *id.* at 220 (noting the large number of oral sex acts that take place in comparison to the very low number of reported transmissions via this route indicates a low risk); USCF, "HIV InSite," at 3 (K. Page-Shafer: "I would emphasize that the number of case reports is extremely low when one considers the size and the duration of this epidemic."). Such a low probability of transmission does not support the IJ's characterization of HIV as "highly communicable" under the facts and circumstances presented in this case and, therefore, does not support the finding that Mr. Ramirez presents a danger to the community.

II. By Overestimating the Lethality of HIV and Misallocating the Responsibility for Potential Transmission, the Immigration Judge Miscalculated the Danger to the Community, Resulting in a Holding Contrary to Public Policy and Reason.

In addition to laboring under some misconceptions regarding the degree of risk associated with oral sex, the IJ miscalculated in other ways the danger to the community presented by the conduct underlying Mr. Ramirez's 2009 conviction.

A. HIV Is More and More Frequently a Chronic, Manageable Condition.

HIV is no longer as lethal as is widely assumed. *See, e.g.,* I.J. at 7 (inappropriately basing "[t]he Court's determination" on its "lethality") (Exh. D). While no one would deny that HIV remains incurable, or that it is a life-long condition requiring regular care and consistent

treatment with medications, it is certainly not the "death sentence" that it was once more validly considered. Thanks to advances in medicine and the advent of highly active antiretroviral treatment ("HAART")—or the "drug cocktail," as it is referred to by many—HIV has been transformed, for those with adequate access to regular care and treatment, into a chronic, manageable condition. *See* CDC, "Background Brief on the Prevention Benefits of HIV Treatment" (published Jan. 13, 2013) ("Prevention Benefits of HIV Treatment") (describing HAART and its effect on life expectancy), *available at* www.cdc.gov/hiv/topics/treatment/resources/factsheets/pdf/Prevention_Benefits_of_HIV_Treatement.pdf (attached hereto as Exh. U); Broder, MD, "The Development of Antiretroviral Therapy and Its Impact on the HIV-1/AIDS Pandemic," Antiviral Research 85 (1):1 (Jan. 2010), www.ncbi.nlm.nih.gov/pmc/articles/PMC2815149/ (attached hereto as Exh. V).

Moreover, during the seventeen years since the introduction of the first HIV "drug cocktail," adjustments to dosing and the consistent introduction of more refined antiretrovirals have greatly reduced the side effects associated with HAART, and a number of people living with HIV take just one or two pills a day that do not require refrigeration or other special handling/administration. As a result of these treatments, recent studies have established that someone who is newly-diagnosed—and provided with the necessary access to quality medical care and treatment—has a near-normal life expectancy. Cairns, "Many Patients Diagnosed with HIV Today Will Have Normal Life Expectancies, European Studies Find" (Feb. 22, 2010), http://www.aidsmap.com/Many-patients-diagnosed-with-HIV-today-will-have-normal-life-expectancies-European-studies-find/page/1437877/ (attached hereto as Exh. W). While HIV remains a disease of consequence requiring life-long care and treatment, the IJ was wrong to characterize it as particularly "lethal" in her legal assessment as to the seriousness of this crime.

B. Preventing Transmission of HIV and Other Sexually Transmitted Infections Is the Responsibility of Each Person Who Engages in Sexual Activity—A Responsibility That Can Be Met in a Variety of Ways.

Similarly, the IJ improperly focuses on the potential for onward transmission to those with whom Mr. Ramirez's putative sexual partner might subsequently have had sexual contact. First, as is established above, the risk of transmission via oral sex, particularly when it is the HIV-positive individual performing oral sex, is extremely low—therefore, the chance that the undercover officer would have acquired HIV from Mr. Ramirez, had the officer been an actual client and followed through on their agreement, is very remote. *See* Section I.A., *supra.*

Second, it is undisputed that Mr. Ramirez agreed to use condoms during the sexual activities in which the two men were supposed to engage, *see* Arrest Rep. (DHS's Suppl. Docs., Exh. C), which would have further reduced the already remote possibility of transmission via oral sex. That Mr. Ramirez did not have condoms on his person—the possession of which is sometimes used in and of itself as evidence of an intent to engage in prostitution, *see* Human Rights Watch, "Sex Workers at Risk: Condoms as Evidence of Prostitution in Four U.S. Cities" (published July 19, 2012), *available at* http://www.hrw.org/reports/2012/07/19/sex-workers-risk —or that he did not first raise the prospect of condom usage, is irrelevant in terms of the seriousness of the crime. The record from the criminal proceeding reveals that Mr. Ramirez was willing to take these precautionary measures, that the two men made plans to obtain condoms, and contains no evidence that condoms would not have been used as planned. *See* Arrest Rep., dated Sept. 26, 2009 (DHS's Suppl. Docs., Exh. C); Plea Tr., Case No. BA 362642, at 6:2-21 (DHS's Suppl. Docs., Exh. C). The IJ should not have ignored the evidentiary record before her. *See Matter of L-S-*, 22 I&N Dec. 645, 651 (BIA 1999) (stating that to make a "particularly serious crime" determination, the Board looks to the conviction records).

Third, the IJ inappropriately dismisses the consequence and import of Mr. Ramirez's alleged plans to disclose his HIV status to his sexual partner prior to engaging in oral sex. The IJ makes the unwarranted and unsupported statement that, even if such disclosure occurred, "it does not mitigate the danger the Respondent's behavior posed to the subsequent sexual partners of his client." I.J. at 7 (Exh. D). This is simply not true, and it removes the agency of the "client" from the equation. The criminal justice system does not hold the person with HIV responsible for transmission resulting from a decision made by a fully-informed, consenting adult to have sex—regardless of the degree of risk presented—with someone who has HIV. *See, e.g.,* Cal. Health & Safety Code § 120291 (including non-disclosure of HIV status as an element of the crime penalizing exposure to HIV); Fla. Stat. Ann. § 384.24(2) (same); Ga. Code Ann. § 16-5-60(C) (same); Mo. Rev. Stat. § 191.677 (same); Okla. Stat. tit. 21, § 1192.1 (same); *see also Matter of L-S-*, 22 I&N Dec. 645, 656 (finding that the crime of alien smuggling, which involved some potential harm to the alien, was not a "particularly serious crime," where the alien was neither kidnapped or brought into the U.S. as part of an organized criminal enterprise, but rather, made the arrangements through her family and willingly undertook the trip).

Furthermore, with respect to the ostensibly unsuspecting, subsequent sexual partners of this fully-informed individual—which is the group with which the IJ actually seems concerned—it is inappropriate to hold the person living with HIV responsible for any lack of communication, mendacity or failure to disclosure in the future sexual relationships in which this other individual engages. However unlikely, any transmission of HIV that were to result from one of those interactions would be a consequence of the choices made by *those* two individuals to engage in an activity with inherent risks, and cannot be pinned on Mr. Ramirez. *See, e.g., Lackner v. North*, 135 Cal. App 4th 1188, 1201-08 (Cal. Ct. App 2006) (holding that third-parties ski resort

and high school skiing coach could not be held liable for injuries caused by collision of student skier and patron of ski resort, because of doctrine of primary assumption of the risk); *see also* Varghese et al., "Reducing the Risk," at 38 ("For an uninfected person, every sexual encounter presents a risk of acquiring HIV.") (Exh. L). Essentially, the IJ is saying that any sexually active individual living with HIV is, by definition, a danger to the community—regardless of the precautions taken or disclosures made—merely because the individual with HIV has no control over the conduct in which a sexual partner subsequently engages with others. This is an unwarranted, unjustified and—given the fundamental rights at stake—constitutionally-suspect assertion that finds no support in the law.

C. California's HIV-Specific Intentional Transmission Statute Exempts Exposure Via Oral Sex, Because Oral Sex Does Not Present a Significant Risk of Transmission.

The law of California demonstrates a public policy contrary to the IJ's decision that Mr. Ramirez's 2009 conviction for solicitation of oral sex is a "particularly serious crime." It must first be acknowledged that it is not the commercial nature of the interaction that brings this conviction within the ambit of a "particularly serious crime," because solicitation is merely a misdemeanor and the Government does not attempt to terminate withholding of removal based on misdemeanor solicitation or prostitution convictions. *See* Tr. of Hr'g, (July 11, 2012), at 95:6-7 (IJ states that prostitution is not inherently a particularly serious crime) (Exh. C). Once the commercial nature of the transaction is removed from the equation, it becomes clear that the State of California does not view the conduct in which Mr. Ramirez engaged as particularly serious or dangerous. Under Cal. Health & Safety Code § 120291, the California statute enacted in 1998 that applies to the potential transmission of HIV in the non-commercial context, Mr. Ramirez would not only have to: (1) engage in *unprotected* sex; (2) *fail to disclose* his status; and

(3) *act with the specific intent* to infect the other person, but he would—most importantly in terms of the conviction under review here—have to (4) *engage in vaginal or anal intercourse* to be found guilty under this code section. Cal. Health & Safety Code § 120291; *see also* 720 Ill. Comp. Stat. § 5/12-16.2 (amended in 2012 to remove exposure via oral sex from statute criminalizing exposure to HIV).

In the non-commercial context, it is not even possible to violate the HIV-specific California transmission law by engaging in oral sex, which is the only conduct at issue in this case. *See* Cal. Health & Safety Code § 120291. And while the Government may argue that the solicitation statute does not draw a distinction between oral sex and anal/vaginal intercourse, *amici* respectfully submit that the more recent statute reflects the current public policy of California with respect to the potential sexual transmission of HIV—a policy rooted in a modern and evidence-based understanding of HIV transmission, the consequences of an HIV diagnosis in the post-HAART era, and the appropriate allocation of rights and responsibilities between the two parties to any consensual sexual contact. *Compare* S.B. 705, 1997-98 Sess. (Cal. 1997), as introduced, (attached hereto as Exh. X) (including "oral intercourse" among the sexual activities through which a violation of the statute could occur) *with* Cal. Health & Safety Code § 120291 (attached hereto as Exh. Y) (as enacted in 1998, statute does not include "oral intercourse" among sexual activities potentially resulting in criminal sanction). In the exercise of its discretion, it is this more recent and scientifically informed statute to which this Board should look in rendering the decision as to whether the conduct in which Mr. Ramirez engaged is truly a "particularly serious crime." *See, e.g., Alfridi*, 442 F.3d at 1217, 1221 (noting the discretion of the Attorney General and the duty to render a determination based on the facts and circumstances underlying the conviction rather than on blanket conclusions regarding the nature of the crime).

Given the policy choices reflected in this more recent statute, the Board should exercise its discretion to determine that Mr. Ramirez's 2009 conviction is not a "particularly serious crime" under 8 C.F.R. § 1208.24(f).

Conclusion

This Board should respect the clear mandate of California law—and the solid science and public health policy choices it reflects—by reversing the decision of the IJ and denying DHS's motion to terminate Mr. Ramirez's withholding of removal or, in the alternative, by vacating and remanding for reconsideration in accord with the instructions of the Board in light of the information presented in this brief.

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Respectfully submitted,

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