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DETAINED

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

In the Matter of [redacted] *Respondent.* In Withholding Only Proceedings	No. [redacted] Appeal from decision of Immigration Judge Kevin W. Riley

REQUEST TO APPEAR AS *AMICI CURIAE*

AND

BRIEF OF THE CENTER FOR HIV LAW AND POLICY, NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS, THE HIV MEDICINE ASSOCIATION, THE ASSOCIATION OF NURSES IN AIDS CARE, AND BIENESTAR AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

REQUEST TO APPEAR AS *AMICI CURIAE*

Under Rules 2.10 and 4.6(i) of the Practice Manual of the Board of Immigration Appeals, *amici curiae* The Center for HIV Law and Policy, National Alliance of State and Territorial AIDS Directors, the HIV Medicine Association, the Association of Nurses in AIDS Care, and BIENESTAR (collectively, "*amici*") request leave to appear as *amici curiae* in these proceedings and file an *amicus* brief.

The Center for HIV Law and Policy ("CHLP") is a national legal and policy resource and strategy center for people with HIV and their advocates. CHLP is a national leader in HIV policy development. The organization works to reduce the impact of HIV on vulnerable and marginalized communities and to secure the human rights of people affected by HIV. Through its advocacy work, CHLP knows firsthand that exaggerated fears about HIV and ignorance about the routes and relative risks of HIV transmission perpetuate stigma, discrimination, and unfair treatment. Inconsistent and unbalanced interpretation and application of criminal law to individuals with HIV reinforces prejudice and undermines important government-funded HIV prevention and treatment efforts.

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 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 and viral hepatitis infections in the U.S. and its territories, providing comprehensive, compassionate, and high-quality care to all persons living with HIV 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 and viral hepatitis care and treatment programs. NASTAD supports and encourages the use of applied scientific knowledge and input from affected communities to guide the development of effective policies and programs.

The HIV Medicine Association ("HIVMA") of the Infectious Diseases Society of America represents more than 5,000 physicians and other health care providers who practice HIV medicine. Its members come from all 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, and 36 countries outside of the United States. HIVMA represents clinicians and researchers who devote a majority of their time to preventing, treating and eventually eradicating HIV disease. HIVMA strongly supports sound public-health policies that are grounded in science and social justice to promote effective HIV prevention, care and treatment, and research, and that end discrimination against people with HIV infection.

The Association of Nurses in AIDS Care ("ANAC") represents more than 2,000 nurses, nurse practitioners, and other health care providers who practice in a wide range of settings in HIV/AIDS care. It includes members from all 50 states, the District of Columbia, and a number of countries outside of the United States. ANAC represents nurses and nurse practitioners working in all aspects of HIV prevention, treatment, care and research. The fair application of the criminal and civil law to people living with HIV/AIDS is a priority for ANAC, which advocates for government policies that reflect sound science and current medical practices, and that promote effective HIV care and prevention.

BIENESTAR is a grassroots, non-profit, community-based service organization established in 1989. BIENESTAR advocates for human rights and social justice at the local, state, and national levels and serves the community at large by shedding light on emerging Latino issues. BIENESTAR provides health education and awareness regarding HIV, substance

abuse, and drug prevention. BIENESTAR's work positively impacts the health and well-being of the Latino community and other underserved communities in Southern California.

Amici are leading public interest organizations that represent the interests of, provide services to, and advocate on behalf of transgender individuals and people living with HIV, particularly those at the intersection of the immigration and criminal justice systems. *Amici* are interested in ensuring that individuals who have HIV are afforded the full protection of the law, that 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. Specifically, *amici* seek to ensure that people living with HIV are not deprived of immigration protection and relief based on misinformation and misconceptions about HIV transmission. *Amici* also seek to inform the Board of Immigration Appeals about the realities faced by transgender people living with HIV in Mexico, Respondent's country of origin.

Counsel for Respondent consented to this motion and *amici*'s participation in this case. Counsel for *amici* notified the U.S. Department of Homeland Security, but have not received a response from the government.

Based on their work and experience in representing transgender and HIV affected immigrants, *amici* have an interest in this matter as well as information that would assist the Board of Immigration Appeals in its consideration of the issues presented in the case. Accordingly, *amici* respectfully request leave to appear as *amici curiae* and file the following brief.

BRIEF OF *AMICI CURIAE*

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INTRODUCTION AND SUMMARY OF ARGUMENT

Amici curiae respectfully submit this brief in support of [redacted][1] to assist the Board of Immigration Appeals ("Board") in evaluating complex issues related to HIV. Specifically, *amici* raise two issues: the Immigration Judge ("IJ") erred in denying immigration relief based on Ms. [redacted]'s HIV status while simultaneously failing to consider how that status places her at imminent risk for future persecution in Mexico. *Amici* urge the Board to reverse the IJ's decision and grant Ms. [redacted]'s application for withholding of removal. In the alternative, *amici* respectfully request that the Board remand this matter to the IJ to ensure that Ms. [redacted] is not removed to Mexico to face the danger of living in that country as a transgender person with HIV.

Petitioner in this case, Ms. [redacted], is a transgender woman living with HIV. Although the IJ found that Ms. [redacted] successfully established "past persecution on account of a protected ground," the IJ improperly concluded that her HIV status trumps her imminent risk of persecution in Mexico. (IJ In Withholding Only Proceedings Decision (Mar. 11, 2013) ("IJ Dec.") at 9.) The IJ erred in finding that Ms. [redacted]'s HIV status should be used as an aggravating factor to deny immigration protection. *Id.* ("[t]he circumstances also weigh towards aggravation as the respondent [Ms. [redacted]] does have a disease that can be transmitted sexually to others. The potential impact of such transmission of the disease puts others at serious risk for their own health."). Based on misinformation and misconceptions about HIV, the IJ found that "[t]he type of disease also shows that the alien may be a danger to the community." *Id.* The IJ's improper and unwarranted connection between HIV and removal deters people from seeking HIV testing and lifesaving treatment. Using HIV – a protected

[1] This is Petitioner's preferred name. Since she identifies as female, this brief uses feminine pronouns to refer to Ms. [redacted]. Her immigration case and record, however, reflect the names: [redacted] and [redacted].

medical condition – as a basis for removal is also tantamount to an end-run around the lifting of the HIV ban in immigration proceedings.[2]

In contrast to the IJ's approach, this case must instead be considered in light of authoritative medical and scientific data, and current conditions in Mexico – not prejudice and erroneous beliefs about HIV. *See Ali v. Mukasey*, 529 F.3d 478, 492-93 (2d 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"); *see also Bragdon v. Abbott*, 524 U.S. 624, 650 (1998) (noting that "the views of public health authorities … are of special weight and authority" in assessing the relevance or risk of HIV). In adjudicating this case, the IJ failed to cite or reference current medical or scientific data regarding the risk of HIV transmission, or to take into account current conditions in Mexico that amply demonstrate Ms. [redacted]'s imminent risk of persecution. This was error. The IJ's determination that Ms. [redacted] committed a "particularly serious crime" based on her HIV status – a disability protected under the law, *Bragdon*, 524 U.S. at 650 – is not supported by authoritative medical and scientific data on HIV transmission. Regardless of the type of sexual conduct Ms. [redacted] purportedly engaged in – if any – the possibility of HIV transmission is so low that it is irrelevant in determining whether a sex work-related charge is a "particularly serious crime" for immigration purposes.

[2] Prior to 2010, U.S. immigration law prohibited people with HIV from entering the country. *See, e.g.*, Julia Preston, *Obama Lifts a Ban on Entry by HIV-Positive People*, N.Y. TIMES (Oct. 30, 2009), *available at* http://www.nytimes.com/2009/10/31/us/politics/31travel.html. Since 2010, the HIV ban has been lifted, and HIV status cannot be the basis for exclusion or removal from the United States. This makes sense because federal and state laws protect people living with HIV, a disability under the law. *See Bragdon v. Abbott*, 524 U.S. 624, 650 (1998). Nevertheless, in this case, the IJ denied immigration protection and relief to Ms. [redacted] based on her HIV status. The IJ improperly used a protected medical condition as a basis for removing Ms. [redacted].

Amici also seek to inform the Board about the grim realities faced by transgender people living with HIV in Mexico, Ms. [redacted]'s country of origin. On account of her transgender identity and HIV status, Ms. [redacted] faces a serious risk of life-threatening violence and persecution. The IJ failed to appreciate the complex nature of Ms. [redacted]'s HIV status and transgender identity, and how they affect the issues presented in this case. This too was error. If allowed to stand, the IJ's decision would have life-threatening consequences not just for Ms. [redacted], but also for similarly situated transgender people living with HIV who historically have had access to – and continue to need – the protections of United States immigration laws in order to survive.

ARGUMENT

I. HIV is Not Easily Transmitted, and a Person Living with HIV Does Not Present a Danger to the Community.

Three decades into the HIV epidemic, there is clear consensus among medical, scientific, and public health professionals that HIV is not easily transmitted. There are only four possible transmission routes:

1) anal or vaginal intercourse;
2) sharing infected needles or syringes;
3) mother to child before or during birth or through breast-feeding after birth; and
4) exposure to affected blood or blood products, or organ transplantation in very rare circumstances.[3]

[3] "HIV can be transmitted via the exchange of a variety of body fluids from infected individuals, such as blood, breast milk, semen and vaginal secretions." World Health Organization, *HIV/AIDS Factsheet* (Nov. 2011), *available at* http://www.who.int/mediacentre/factsheets/fs360/en/index.html. Centers for Disease Control & Prevention ("CDC"), *Questions and Answers: How is HIV Passed from One Person to Another?* (last updated Mar. 25, 2010) (hereinafter "CDC, *Q&A*"), *available at* http://www.cdc.gov/hiv/resources/qa/transmission.htm (describing HIV transmission); *see also*

The likelihood of transmission depends on numerous biological factors, such as a person's overall health, use of protective barriers such as condoms, and viral load (the amount of HIV in the person's bodily fluids).[4] Only certain bodily fluids, almost always blood or semen, carrying sufficient viral load can cause transmission.[5] During a sexual activity, HIV cannot be transmitted if there is no exposure to blood or semen containing a sufficient level of HIV.[6] Condom use and effective medical care and treatment can reduce the already low per-act risk of HIV transmission.[7] Yet even without these protections, studies on the risk of HIV transmission

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Joint United Nations Programme on HIV/AIDS ("UNAIDS"), *HIV Prevention Fast Facts*, *available at* http://www.unaids.org/en/media/unaids/contentassets/dataimport/pub/brochurepamphlet/2009/20090401_prevention_fast_facts_en.pdf (same).

[4] Nat'l. Inst. of Allergy & Infectious Diseases, *HIV Risk Factors* (last updated Mar. 25, 2009), *available at* http://www.niaid.nih.gov/topics/HIVAIDS/Understanding/Pages/riskFactors.aspx (describing the factors that increase risk of HIV transmission); Julia Fox et al., *Quantifying Sexual Exposure to HIV Within an HIV-Serodiscordant Relationship: Development of an Algorithm* (hereinafter, "Fox, *Sexual Exposure*"), 25(8) AIDS 1066 (2011) ("The risk of HIV transmission reflects two distinct entities, the relative risk of HIV acquisition amongst HIV uninfected individuals, which represents a composite of genetic factors, immunological factors, nature and frequency of sexual exposure, and presence of concurrent sexually transmitted infections (STIs) and the onward transmission risk posed by HIV infected individuals which is determined by HIV plasma and genital tract viral load, concomitant STIs, viral characteristics.") (citations omitted).

[5] CDC, *HIV and its Transmission* (July 1999) (hereinafter, "CDC, *HIV*") at 1-2 (noting that "HIV is found in varying concentrations of amounts in blood, semen, vaginal fluid, breast milk, saliva, and tears."), *available at* http://www.hivlawandpolicy.org/resources/download/360.

[6] CDC, *Questions and Answers: Can I Get HIV from Anal Sex?* (last updated Mar. 25, 2010), *available at* http://www.cdc.gov/hiv/resources/qa/transmission.htm; CDC, *Questions and Answers: Can I Get HIV from Vaginal Sex?* (Mar. 25, 2010), *available at* http://www.cdc.gov/hiv/resources/qa/transmission.htm.

[7] "The proper and consistent use of latex or polyurethane (a type of plastic) condoms when engaging in sexual intercourse—vaginal, anal, or oral—can greatly reduce a person's risk of acquiring or transmitting sexually transmitted diseases, including HIV infection." CDC, *HIV* at 4. In fact, "[c]ondom effectiveness for STD and HIV prevention has been demonstrated by both laboratory and epidemiologic studies." CDC, *Condom Fact Sheet in Brief* (last updated Mar. 25, 2013), *available at* http://www.cdc.gov/condomeffectiveness/brief.html. UNAIDS, *UNAIDS Best Practice Collection: Making Condoms Work for HIV Prevention* (June 2004), *available at* http://www.unaids.org/en/media/unaids/contentassets/dataimport/publications/irc-pub06/jc941-cuttingedge_en.pdf (describing the important role condoms play in reducing transmission risk);

associated with sexual acts indicate that the highest per-act risk of transmission is at most a three in 100 chance, or 3%.[8]

A. The risk of HIV transmission through oral sex is extremely low, if not zero.

The risk of HIV transmission through unprotected oral sex is extremely low – perhaps even zero – in the absence of a combination of extenuating circumstances.[9] If a person with HIV is performing oral sex, and no other HIV-transmitting bodily fluid is present in the oral cavity, then transmission rarely, if ever, occurs because saliva does not transmit HIV.[10] *See, e.g.*, *Henderson v. Thomas*, No. 11-CV-224, slip op. at 2 (M.D. Ala. Dec. 21, 2012) ("A person would have to drink a 55-gallon drum of saliva in order for it to potentially result in a transmission.").

Although transmission is theoretically possible during oral sex performed by an HIV affected person,[11] a 2011 analysis of several studies on HIV transmission in serodiscordant[12]

Steven D. Pinkerton & Paul R. Abramson, *Effectiveness of Condoms in Preventing HIV Transmission*, 44(9) SOC. SCI. MED. 1303, 1303 (1997) (noting that "condoms are 90 to 95% effective when used consistently, i.e. consistent condom users are 10 to 20 times less likely to become infected when exposed to the virus than are inconsistent or non-users"); David Wilson et al., *Relation Between HIV Viral Load and Infectiousness: A Model-Based Analysis*, 372 (9635) LANCET 314, 317 (2008) (finding that "[a]lthough the primary purpose of antiretroviral therapy is to slow disease progression in people with HIV infection, it is likely to have the secondary benefit of reducing the risk of new transmission to HIV-negative sexual partners"), *available at* http://www.who.int/hiv/events/artprevention/wilson_relation.pdf.

[8]Fox, *Sexual Exposure*, 25(8) AIDS at 1077 (finding the highest risk of transmission per exposure is between 0.04%-3% for unprotected receptive anal sex); Eric Vittinghoff et al., *Per-Contact Risk of Human Immunodeficiency Virus Transmission Between Male Sexual Partners*, 150 AM. J. EPIDEMIOLOGY 306, 309 (1999) (noting that unprotected anal intercourse with an HIV affected partner poses the highest per contact risk of HIV transmission, but the transmission rate is only 0.82% per contact).

[9] Fox, *Sexual Exposure*, 25(8) AIDS at 1077 (finding the risk of HIV transmission per sexual exposure for insertive oral sex to be zero).

[10] CDC, *Q&A*, *supra* (acknowledging that saliva is not a bodily fluid that transmits HIV); *see also* Jeffrey D. Klausner, MD, Panel Discussion on Risk of HIV Infection Through Receptive Oral Sex at Univ. Cal. S.F. (Mar. 14, 2003) ("[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."), *available at* http://hivinsite.ucsf.edu/insite?page=pr-rr-05.

[11] CDC, *HIV*, *supra.*

couples between 1988 and 2010 found that HIV infection through receptive oral intercourse is extremely unlikely – at most a four in 10,000 chance, or 0.04%.[13] Many scientific studies concerning HIV transmission took place prior to the availability of effective HIV medical care and treatment; as a result, the few recorded instances of transmission may have been due in part to higher viral loads in the specific patients studied compared with patients receiving modern treatment.[14] To put realistic probability of transmission into perspective, the theoretical possibility of HIV transmission during oral sex performed by an HIV affected person is equivalent to the odds of a person fatally slipping in the bath or shower.[15]

Even assuming *arguendo* that Ms. [redacted] was the insertive partner during oral sex and ejaculated, the transmission risk remains near zero.[16] In fact, the CDC declines to provide an estimate of the per-act probability of transmitting HIV in this manner, as it does for other sexual acts.[17] The CDC concedes that accurate estimates of the risk are not available, and merely describes the risk as "low."[18] The concept of theoretical risk does not necessarily mean that transmission is likely to happen; it simply suggests that the risk of transmitting an infectious

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[12] "'Seroconversion' and 'Serostatus' are terms often used in the discussion of HIV transmission. Seroconversion is a way to describe a change in HIV status (as measured by HIV antibody tests) from being HIV-negative to HIV-positive." The Center for HIV Law and Policy, *Transmission Routes, Viral Loads and Relative Risks: The Science of HIV for Lawyers and Advocates* (2011) at 5. Serostatus describes whether someone is HIV positive or negative.

[13] Fox, *Sexual Exposure*, 25(8) AIDS at 1075.

[14] *Id.*; *see also* Thomas C. Quinn et al., *Viral Load and Heterosexual Transmission of Human Immodeficiency Virus Type 1*, 342 NEW ENG. J. MED. 921 (2001) (finding that viral load is the most significant transmission risk factor).

[15] The Center for HIV Law and Policy, *Risk of HIV Infection Per Single Sexual Exposure to An Individual Living With HIV, And Other Life Events With Comparable Risk of Occurrence* (2011) (comparing risk of HIV transmission to other unlikely, yet fatal life events with comparable risk of occurrence), *available at* http://www.hivlawandpolicy.org/resources/view/849.

[16] Fox, *Sexual Exposure*, 25(8) AIDS at 1065.

[17] CDC, *HIV Transmission Risk* (last updated June 14, 2012) (conceding that "[a]ccurate estimates of risk are not available" and merely describing the risk as "low"), *available at* http://www.cdc.gov/hiv/law/transmission.htm.

[18] *Id.*

disease is possible even if there are no actual documented cases. It is extraordinarily difficult to assign a numeric statistical risk to an event that available evidence indicates will rarely, if ever, occur.

It is discriminatory to allow such unlikely scenarios and theoretical risks of HIV transmission to serve as the basis for determining that Ms. [redacted] presents a "danger to the community." (IJ Dec. at 8.) In a recent analogous case, the Board vacated a ruling ordering the removal of an immigrant living with HIV convicted of solicitation for oral sex. *See Matter of Ramirez*, No. [redacted] (BIA 2013) (attached as Exhibit A). In *Ramirez*, the government "retract[ed] the argument that the respondent's 2009 conviction for soliciting or engaging in prostitution, knowing he had AIDS, is a particularly serious crime that merits termination of withholding of removal," in light of current medical and scientific knowledge of HIV transmission that was presented on appeal.[19] *Id.* at 1 (citing U.S. Dep't of Homeland Security Motion to Remand at 1-2). Similarly, in this case, since authoritative medical and scientific data amply demonstrate that HIV transmission through oral sex is, at most, a rare occurrence, the Board should find that a sex work-related charge does not constitute a "particularly serious crime."

[19] In *Ramirez*, 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." (IJ Dec. at 7.) The IJ held that Mr. Ramirez posed a danger to the community because of "the highly communicable nature of AIDS, its lethality, and the continued risk of exposure to multiple individuals arising from Respondent's behavior." (*Id.*) Based on these findings, the IJ held that the 2009 conviction was a "particularly serious crime" and terminated Mr. Ramirez's withholding of removal.

B. The actual transmission rates for vaginal and anal intercourse are much lower than what the public generally believes.

Vaginal and anal intercourse account for most HIV transmissions.[20] Yet even with this type of exposure – and without condom use or effective medical care and treatment that reduces viral load – experts agree that HIV is transmitted at a significantly lower rate than what is generally perceived by the public. The transmission risk for the receptive partner of a person with HIV ranges from a high of three in 100 for unprotected anal sex to about three in 1000 for unprotected vaginal sex.[21] Unprotected insertive anal intercourse poses up to about a six in 10,000 chance of infection, or 0.06%.[22] Unprotected insertive vaginal intercourse poses a five in 10,000 chance of infection, or 0.05%.[23] Clearly, HIV is one of the least transmissible of all sexually transmitted infections.[24]

Although the risk of HIV transmission through vaginal and anal intercourse is beyond a mere theoretical possibility, it remains sufficiently low and so easily prevented that it cannot support a determination that Ms. [redacted] presents a "danger to the community." Board precedent amply demonstrates that Ms. [redacted]'s alleged conduct does not satisfy the standard applied when determining whether an individual poses a danger to the community. In fact, the Board has deemed that far more dangerous activities do not warrant removal.

For example, in *Matter of L-S*, a case raising allegations that a smuggling operation posed a heightened risk of harm to others, the Board held that despite the risk of harm to others, the

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[20] CDC, *Q&A* (stating that HIV is most commonly transmitted through anal and vaginal sex, and specific sexual behaviors), *available at* http://www.cdc.gov/hiv/resources/qa/transmission.htm.
[21] Fox, *Sexual Exposure*, 25(8) AIDS at 1077.
[22] *Id.* at 1075.
[23] *Id.* at 1074.
[24] The Center for HIV Law and Policy, *HIV, STIs & Relative Risks in the United States* (illustrating "that other sexually transmitted infections can pose similar, and sometimes equally great or greater, risks than HIV"), *available at* http://www.hivlawandpolicy.org/resources/download/681.

conviction did not constitute a particularly serious crime. 22 I&N Dec. 645, 656 (BIA 1999) (holding that a 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 a car accident). *L-S* involved a "woman [who] was kept in a small, confined compartment slung underneath [a] van . . . ." *Id.* (Patricia A. Cole, Board Member, dissenting). The Board noted that "[d]ue to the makeshift aspect of the compartment and its location on the floor of the van, this woman was at a heightened risk of asphyxiation or injury in the event of an accident brought about by a traffic collision or by a flight from authorities." *Id.* Despite the known and heightened risk of harm, including death, the Board held that the underlying conviction did not constitute a particularly serious crime. *Id.* Clearly, both the offense and risk of harm associated with smuggling a person in a car under dangerous circumstances is far greater than the theoretical risk of HIV transmission posed by Ms. [redacted]'s purported conduct, sex work, which typically is treated as disorderly conduct, a misdemeanor.[25]

Other courts have similarly found that activities posing a significant, known risk of injury to the public do not necessarily constitute a particularly serious crime for immigration purposes. *See, e.g.*, *Delgado v. Holder*, 563 F.3d 863, 889 (9th Cir. 2009) (finding that multiple convictions for driving under the influence, including one that resulted in an accident that caused injuries, did not constitute a particularly serious crime for immigration purposes). Even when an activity presents a likely risk of harm to others (or actually does harm others), the Board and other courts still have found that those activities do not support a determination that an individual presents a danger to the community. Since the likelihood of HIV transmission through any sexual conduct

[25] *See* Cal. Pen. Code § 647 ("Every person who commits any of the following acts is guilty of disorderly conduct, a misdemeanor: . . . Who solicits or who agrees to engage in or who engages in any act of prostitution.").

is relatively low, and any partner to sexual contact can take easily available measures to virtually eliminate any risk of infection, the IJ erred in concluding that Ms. [redacted]'s HIV status converted her alleged sex work into a "particularly serious crime."

While HIV remains a disease of consequence requiring lifelong care and treatment, for most affected people, it is now a chronic, manageable condition. There is neither medical nor legal support for singling out HIV as an aggravating factor in an assessment as to the seriousness of a crime, particularly in view of the higher transmission rates and sometimes quite serious consequences that other sexually transmitted infections pose.[26] *See also Ali*, 529 F.3d at 492 (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"). In the instant case, the IJ's determination was based on widely held, but seriously inaccurate misconceptions about HIV transmission, and outdated notions of the consequences of an HIV diagnosis.

II. Denying Immigration Protection to People Living with HIV Reflects and Further Fuels Stigma and Discrimination.

Stigma[27] is one of the most significant barriers to public health efforts to prevent HIV transmission:

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[26] The Center for HIV Law and Policy, *Relative Risks*, *supra* (illustrating "that other sexually transmitted infections can pose similar, and sometimes equally great or greater, risks than HIV"), *available at* http://www.hivlawandpolicy.org/resources/download/681.

[27] "[S]tigma exists when the following four interrelated components converge: 1) individuals distinguish and label human differences, 2) dominant cultural beliefs link labeled persons to undesirable characteristics (or negative stereotypes), 3) labeled persons are placed in distinct categories to accomplish some degree of separation of 'us' from 'them,' and 4) labeled persons experience status loss and discrimination that lead to unequal outcomes." Anish P. Mahajan et al., *Stigma in the HIV/AIDS Epidemic: A Review of the Literature & Recommendations for the Way Forward*, AIDS (Aug. 2008), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2835402/. "[D]ynamic social/economic/political processes [ ] simultaneously produce and intensify stigma and discrimination." *Id.*; *see also* Gina Bellafante, *Out, But Not About That*, N.Y.TIMES (May 3, 2013) (discussing the lingering stigma of HIV).

> Roughly one in four Americans have continued to either believe that one can get HIV from sharing a drinking glass, or remain unsure whether this is the case. Similarly, roughly one in six believe the same about HIV transmission via shared toilet seats, and 12 percent either think you can get HIV by swimming in a pool with someone with HIV, or are not sure whether this is the case.[28]

Misconceptions about the routes, relative risks, and consequences of HIV transmission are the foundation for social exclusion, discriminatory laws and policies, and other manifestations of stigma.[29] *See, e.g.*, *Mother Smith v. Milton Hershey Sch.*, No. 11-CV-7391 (E.D. Pa. 2012) (school refused to consider student for enrollment because he had HIV);[30] *see also* Settlement Agreement Between the U.S. Dep't of Justice ("DOJ") and City of Stockton, Cal., DOJ Complaint No. 204-11E-344 (Nov. 9, 2007)[31] (noting that a man "was denied emergency medical services by the City's Fire Department because he has HIV/AIDS"). Denying Ms. [redacted] immigration protection based on the belief that having sex while HIV positive makes her a danger to the community institutionalizes and promotes HIV stigma. It is particularly harmful when the government – through its representatives and judicial officials – effectively enshrines stigma. This provides a visible and powerful disincentive for those at risk for HIV to ever get tested, let alone access medical care and treatment that keeps them and their communities healthy.[32]

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[28] Kaiser Family Foundation, *HIV/AIDS at 30: A Public Opinion Perspective, A Report Based on the Kaiser Family Foundation's 2011 Survey of Americans on HIV/*AIDS (June 2011) at 6, *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8186.pdf.

[29] President's Advisory Council on AIDS, *Resolution on Ending Federal and State HIV-Specific Criminal Laws, Prosecutions, and Civil Commitments* (2013) (noting that the criminalization of HIV affected people fuels HIV stigma), *available at* http://hivlawandpolicy.org/resources/view/824.

[30] Settlement Agreement *available at* http://www.ada.gov/milton-hershey_sa_aids.htm.

[31] *Available at* www.hivlawandpolicy.org/resources/download/236.

[32] Center for American Progress, *HIV/AIDS Inequality: Structural Barriers to Prevention, Treatment, and Care in Communities of Color* (July 12, 2012) at 14 ("One of the biggest barriers

Furthermore, the IJ essentially held Ms. [redacted] responsible for the behavior of her purported contacts and their future sexual partners. (IJ Dec. at 9 ("[t]he circumstances also weigh towards aggravation as the respondent [Ms. [redacted]] does have a disease that can be transmitted sexually to others. The potential impact of such transmission of the disease puts others at serious risk for their own health.")). Preventing transmission of HIV and other sexually transmitted infections is the option of each individual who engages in sexual activity. Nevertheless, the IJ's decision ignores the actual decision-making role that two consenting adults share with respect to maintaining their sexual health. This reality could hardly be more obvious to parties engaging in commercial sex, where assumptions of monogamy that might deter the use of disease prophylaxis are unlikely. *See, e.g.*, *Lackner v. North*, 135 Cal. App. 4th 1188, 1201-08 (3d Dist. 2006) (holding that third-parties ski resort and school coach could not be held liable for injuries caused by a skiing accident because of the doctrine of assumption of the risk). Indeed, "[f]or an uninfected person, every sexual encounter presents a risk of acquiring HIV."[33] Because the IJ overestimated the risk of transmission, misunderstood the consequences of an HIV diagnosis, and misattributed to Ms. [redacted] the responsibility for any potential future transmission, the IJ erroneously concluded that any sexually active individual living with HIV is, by definition, a danger to the community.

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to health equity surrounding HIV/AIDS is the stigma and relative silence associated with the disease. In communities of color in particular, the stereotype of HIV/AIDS as the consequence of an individual's deviant behavior has perpetuated shame and discouraged people from knowing their status and treating it."), *available at* http://www.americanprogress.org/wp-content/uploads/issues/2012/07/pdf/hiv_community_of_color.pdf.

[33] Beena 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*, 29 SEXUALLY TRANSMITTED DISEASES 38 (2002).

III. Transgender Women Living with HIV, Like Ms. [redacted], Are at Heightened Risk of Life-Threatening Violence and Abuse.

While giving undue weight to Ms. [redacted]'s HIV status as an aggravating factor for denying immigration protection, the IJ failed to give any consideration to how living with HIV actually strengthens Ms. [redacted]'s application for withholding of removal. As a transgender woman living with HIV, Ms. [redacted] faces imminent violence and abuse in Mexico.

A. Transgender women in Mexico face persecution based on their nonconforming gender identity.

It has long been recognized that individuals in Mexico may establish eligibility for relief from removal based on evidence that they have been persecuted as members of the social group of "gay men with female sexual identities." *See, e.g., Hernandez-Montiel v. INS*, 225 F.3d 1084, 1095 (9th Cir. 2000). In that case, the Ninth Circuit reviewed extensive evidence and testimony demonstrating how this social group suffered violence and persecution in Mexico. As explained below, the record evidence and testimony here demonstrates conclusively that the risk of violence directed at transgender women continues unabated and is exacerbated for those living with HIV.

In *Hernandez-Montiel*, the Ninth Circuit recognized that gender nonconformity plays a crucial role in the persecution of LGBT individuals in Mexico because, as with a transgender woman like Ms. [redacted], it violates deeply ingrained social norms. Mexican culture embraces "a concept of masculinity (machismo) [that] requires that the division between male and female be clearly defined culturally as the division of those things active and male and those things passive and female." Joseph Carrier, *De Los Otros, Intimacy and Homosexuality Among Mexican Men* 21 (1995). For a culture steeped in machismo, the sort of gender transgression

expressed by a biological man identifying as female, like Ms. [redacted], has significant and deeply negative cultural implications. Indeed, "transgender[] female identities tend to be stigmatized because they are typically regarded as demasculinizing in character." Sonia Katyal, *Exporting Identity*, 14 YALE J.L. & FEMINISM 97, 134 (2002). Thus, in Mexico, society has long targeted individuals whose identities transgress social norms. *Id*.; Carrier, *supra*, at 15-16. Indeed, as the Ninth Circuit observed in *Hernandez-Montiel*, the fact that effeminate men "are perceived to assume the stereotypical 'female,' i.e., passive, role in gay relationship" motivates animus and violence toward them. 225 F.3d at 1094.

The same is true today, as these deeply rooted aspects of Mexican culture, including the widespread view that men should live up to a "macho" standard of masculinity, continue to result in stigmatization of, and violence toward, gender nonconforming identities and characteristics. Transgender people continue to be subject to a high level of violence, abuse, and persecution in Mexico. For LGBT persons in general, the numbers are staggering: from 1995 to 2009, over 500 people were killed in Mexico because of their sexual orientation or gender identity. (Ex. 2, Tab B at 34, 74, 97.) In 2005, the Citizen's Commission Against Hate Crimes estimated that 15 homophobic or transphobic murders occur in Mexico each month. (Ex. 2, Tab B at 43.) In the first eight months of 2009, 40 murders were linked to the victim's sexual orientation or gender identity in the Mexican state of Michoacán alone. (Ex. 2, Tab B at 34.) These are only reported cases; actual numbers are likely much higher. (Ex. 2, Tab B at 97, 126.) Notably, the numbers are increasing, doubling between 2003 and 2008. (Ex. 2, Tab B at 74, 147; *see also id.* at 94.)

The statistics tell an incomplete story, failing to capture the crimes' violent and brutal nature. Victims are often stabbed, beaten, or strangled. (Ex. 2, Tab B at 43, 70, 74-75, 78, 133, 147-48.) Some have been found decapitated and disemboweled while others have been subject to

torture, genital mutilation, castration, and rape. (Ex. 2, Tab B at 43, 78-79, 139, 147-48.) In many cases, the efforts to humiliate and defile continue even after the victim has died. (Ex. 2, Tab B at 78-79.) Oftentimes, the perpetrators leave demeaning notes on the bodies, such as "I'm a faggot." (Ex. 2, Tab B at 43, 75.)

Among marginalized LGBT groups, the transgender community is particularly targeted for persecution. Transgender people are subjected to brutal crimes (Ex. 2, Tab B at 42-44, 59-60, 63, 88, 105, 108-09, 139), and "to mass detentions, extortion, and physical abuse at the hands of police and military officials." (Ex. 2, Tab B at 29.) At least 27 transgender people were murdered in Mexico from 2008 through 2010,[34] in addition to 22 in the first nine months of 2011.[35] Transgender people are "the most affected [by discrimination] and the one[s] that face[] more violence."[36] According to a report published in 2008 by the Center for Health Systems Research in Mexico, transgender persons experienced stigma, violence, and discrimination from their families as well as social rejection, physical abuse, and sexual violence.[37]

Notably, even Mexican police officers participate in violence against transgender women. A March 2010 report prepared by several human rights organizations, including Harvard Law School's International Human Rights Clinic and the International Gay and Lesbian Human Rights Commission, revealed that:

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[34] *See* Transgender Europe: Transrespect Versus Transphobia Worldwide, *Trans Murder Monitoring Results: March 2011 Update*, *available at* http://www.transrespect-transphobia.org/en_US/tvt-project/tmm-results/tmm-march-2011.htm.

[35] *See* Rebekah Curtis, *Transgender People Murdered As World Resists Change*, REUTERS (Nov. 17, 2011), *available at* http://www.reuters.com/article/ 2011/11/17/us-transgender-idUSTRE7AF1UA20111117.

[36] Cecilia Vargas, *Homophobia and its Negative Effect on Public Health*, LA VERDAD (June 29, 2009), *translation available at* http://www.asylumlaw.org/docs/showDocument.cfm?documentID=7805.

[37] C. Infante et al., *Sex Work in Mexico: Vulnerability of Male, Travesti, Transgender and Transsexual Sex Workers*, 11(2) CULTURE, HEALTH & SEXUALITY 125, 135-36 (Feb. 2009).

- Public morality laws are "frequently used by police officials to harass, detain, and extort transgender persons and travestis" (Ex. 2, Tab B at 37);
- In May 2007, 40 transgender sex workers were detained and "brutally assaulted" by about 20 members of the military police in Ciudad Juarez (*id*. at 36);
- In July 2009, a transsexual woman was detained by municipal police and threatened with rape. When the police discovered that she had recorded the encounter on her cell phone, the police detained her again, seized the phone, erased the recording, and imposed a fine (*id*. at 37);
- In July 2009, a transgender sex worker was forced into a van by 10 military personnel, where she was kicked in the head and threatened with rape and murder (*id*. at 35);
- "Social cleansing" practices have been reported in Cancun as of December 2009, with about 40 transgender sex workers "robbed, beaten and arrested by the police." The president of the municipality confirmed the police action and justified it as "cleaning the garbage from the streets" (*id*. at 37).

In addition, countless cases of rape, violence, and murder against transgender persons go unreported out of fear of reprisal from the police, or lack of confidence that the cases will be taken seriously. (Ex. 2, Tab B at 34-35, 36.) For every transphobic or homophobic crime reported in the media, many more cases are likely hidden or not pursued by the victims' families because of social stigma.

B. People living with HIV in Mexico also face brutal persecution.

HIV affected individuals in Mexico – in particular those with gender nonconforming identities like Ms. [redacted] – are subject to life-threatening persecution. This occurs in all

aspects of life – family, healthcare, employment, and interactions with police and government officials – and comes in a variety of forms, from violence and brutality to pervasive denial of access to healthcare.

1. Anti-LGBT attitudes motivate violence against people living with HIV in Mexico.

Some of the brutality against LGBT people is perpetrated specifically because of actual or perceived HIV status, which in Mexico is widely associated with gay and transgender people. Thus, HIV affected individuals face an increased risk of persecution, particularly when a person is known or suspected to be LGBT. This risk is highest for transgender persons living with HIV because they are a highly visible and intensely hated segment of the LGBT community.

According to the United Nations High Commissioner for Refugees ("UNHCR"), Mexican society is "highly prejudiced" against those living with HIV, which is commonly identified as a "gay disease."[38] Misconceptions about how HIV is spread "give rise to fear, which, in tandem with deeply-ingrained homophobia, [lead to] ostracism and harassment."[39] Not surprisingly, these attitudes result in high rates of HIV-related persecution. In 2001, for example, a government official in Merida, Mexico, advocated for killing HIV affected individuals. (Ex. 2, Tab B at 79.) These attitudes are not isolated, nor have they improved over time. In 2005, "unknown assailants stabbed and killed Octovio Acuña . . . a prominent human rights activist who campaigned for the rights of persons with HIV/AIDS and worked for a sexual education association." (Ex. 2, Tab B at 43.) In 2008, a man with HIV was found dead "from asphyxiation

[38] UNHCR, *Update: Treatment of Homosexuals in Mexico* 33, 34 (May 30, 2006), *available at* http://www.asylumlaw.org/docs/sexualminorities/MexicoUNHCR053006.pdf.
[39] *Id.* at 34.

and blows" with his hands tied behind his back and a cardboard sign on his body reading in Spanish: "This happened to me for infecting innocent people with AIDS."[40]

Transgender women and gay men are often blamed for HIV. Even among health professionals, a large proportion (25%) consider homosexuality to be the cause of HIV in Mexico. (Ex. 2, Tab B at 156.) According to one recent report, "HIV proliferation, associated mostly as [an] illness linked to homosexuality, has resulted in homophobia and aggressions towards the gay community." (Ex. 2, Tab B at 79.) This scapegoating inevitably leads to further persecution and violence. In 2003, the government of one locality in Mexico changed its laws to target transgender sex workers, with the justification that "a man dressed as a women can transmit the HIV/AIDS." (Ex. 2, Tab B at 79.) Another locality prohibited sex work by "a man dressed [as] himself or disguised as a woman" because "one runs the risk of being infected with HIV/AIDS by a person of the same sex." (Ex. 2, Tab B at 79.)

2. Transgender people living with HIV are denied lifesaving medical care and treatment because of pervasive selective bias against them.

Deliberate, selective, and punitive bias against transgender people living with HIV also limits access to life-saving HIV medication and the delivery of HIV-related healthcare. The same anti-LGBT – and particularly transphobic – bias that leads to brutal violence and abuse also pervades the healthcare system. This problem is systemic and based on deep-seated bias against LGBT people. A report produced by Mexico's National Commission of Human Rights and the National Council for Prevention of HIV/AIDS notes that, "because of homophobia," men who have sex with men – who represent the largest segment of those affected by HIV – "may find themselves far from preventative measures, early detection and consequently, the best medical

[40] Kilian Melloy, *Gay Mexican Tortured, Stoned*, EDGE BOSTON (Feb. 29, 2008), *available at* http://www.edgeboston.com/index.php?ch=news&sc=glbt&sc3=&id=71031.

treatment options." (Ex. 2, Tab B at 156.) According to data published in 2009 by Mexico's National Commission of Human Rights, "[t]he majority of public hospitals in Mexico have a discriminatory and homophobic attitude towards citizens who live with HIV/AIDS and who are sexually diverse [namely, LGBT]."[41]

The Mexican government acknowledges that selective bias against LGBT individuals prevents these marginalized groups from receiving life-saving HIV medication[42] Mexican activists describe this as administrative homophobia – the deliberate withholding of healthcare, borne out of homophobia and transphobia.

In sum, transgender people in Mexico are deliberately excluded from HIV medical care and treatment based on hostility toward their identity.[43] This punitive exclusion from life-saving care, in addition to the constant threat of violence on account of being transgender and living with HIV, is more than sufficient to establish a reasonable fear of persecution.

C. Ms. [redacted] is likely to be persecuted in Mexico by government actors or private actors the government is unable or unwilling to control.

Ms. [redacted]'s experiences are consistent with the conditions in Mexico set forth above. She has already faced violence and abuse because of her sexual identity, including being raped by 14 men and sexually assaulted by the mayor of her town. (IJ Dec. at 4.) She was also mistreated by police, arrested and sexually abused countless times, and detained under "morals"

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[41] Vargas, *supra* n.36.

[42] *See* CONASIDA, *Informe Nacional Sobre Los Progresos Realizados en la Aplicación del UNGASS* 48 (Mar. 2010), *available (in Spanish) at* http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportssubmittedbycountries/mexico_2010_country_progress_report_es.pdf; *see also* USAID, *HIV/AIDS Health Profile: Mexico* 3, 4 (Sept. 2010), *available at* http://www.usaid.gov/our_work/global_health/aids/Countries/lac/mexico_profile.pdf.

[43] *See also Homophobia Justifies Forsaking of People Infected with HIV/AIDS in Mexico,* PRENSA LATINA (Aug. 15, 2009), *available at* http://www.asylumlaw.org/docs/sexualminorities/MexicoHIV_081509.pdf.

legislation, sometimes for several days. (IJ Dec. at 3.) Due to the Mexican government's overt hostility toward transgender people with HIV and prevalent pattern of selective and punitive denial of healthcare to transgender persons with HIV, Ms. [redacted] would certainly find it difficult if not impossible to access HIV treatment. Her resulting conditions (sores and weight loss, for example) – if not the violation of her medical confidentiality by transphobic healthcare providers – would make her a target for HIV-related violence. There is no doubt that Ms. [redacted]'s identity and characteristics, particularly her status as a transgender woman living with HIV, markedly increase her likelihood of persecution in Mexico. *See Eneh v. Holder*, 601 F.3d 943, 948-49 (9th Cir. 2010) (remanding to Board to consider claims that petitioner would be "single[d] . . . out for mistreatment" specifically because he had HIV).

CONCLUSION

Amici respectfully urge the Board to reverse the IJ's decision and grant Ms. [redacted]'s application for withholding of removal. In the alternative, *amici* request that the Board remand this matter to the IJ to ensure that Ms. [redacted] is not removed to Mexico to face the imminent danger of living in that country as a transgender person with HIV.

Dated: July 9, 2013

Respectfully submitted,

_____
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PROOF OF SERVICE

I hereby certify that on July 9, 2013, a true and correct copy of this

REQUEST TO APPEAR AS *AMICI CURIAE* AND BRIEF OF THE CENTER FOR HIV LAW AND POLICY, NATIONAL ALLIANCE OF STATE AND TERRITORIAL AIDS DIRECTORS, THE HIV MEDICINE ASSOCIATION, THE ASSOCIATION OF NURSES IN AIDS CARE, AND BIENESTAR AS *AMICI CURIAE* IN SUPPORT OF RESPONDENT

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