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Federal Funds for Syringe Exchange Programs: A Necessary Component Toward Achieving an AIDS-Free Generation

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I. INTRODUCTION

In November 2011, then U.S. Secretary of State Hillary Clinton declared: "The goal of an AIDS-free generation may be ambitious, but it is possible with the knowledge and interventions we have right now."[1] In advance of World AIDS Day 2012, the U.S. Department of State expanded on that vision with its publication, "PEPFAR Blueprint: Creating an AIDS-free Generation." It described the Blueprint as a "policy imperative:" "The United States believes that by making smart investments based on sound science, and a shared global responsibility, we can save millions of lives and achieve an AIDS-free generation."[2] Ironically, U.S. policy forbids investment in one prevention measure with strong evidence of effectiveness—needle and syringe exchange programs ("SEPs").[3] As a result, the Blueprint fails to discuss strategies for reducing human immunodeficiency virus ("HIV") transmission among injecting drug users ("IDUs"), undermining the ability to achieve the underlying goal of an AIDS-free generation.

The federal ban on funding for SEPs is generally consistent with U.S. drug policy, rooted in President Richard Nixon's 1971 "War on Drugs." In response to the growing drug epidemic affecting the United States, President Nixon signed into law the Controlled Substances Act of 1970,[4] which created classifications of controlled substances and delegated enforcement power to

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1. Hillary Clinton, United States Sec'y of State, Remarks on Creating an AIDS-free Generation at National Institutes of Health (Nov. 8, 2011), available at http://www.state.gov/secretary/rm/2011/11/176810.htm.

2. U.S. DEP'T OF STATE, PEPFAR BLUEPRINT: CREATING AN AIDS-FREE GENERATION 5 (2012), available at http://www.pepfar.gov/documents/organization/201386.pdf.

3. See discussion infra Part II.

4. See Controlled Substances Act of 1970, Pub. L. No. 91-513, 84 Stat. 1242 (codified at 21 U.S.C. §§ 801–904 (2012)).

the Attorney General.[5] Nixon then established the Drug Enforcement Administration in 1973 to enforce federal laws and to consolidate many organizations already attempting to combat drug use.[6] Nixon's "War on Drugs," continued by subsequent administrations, employs a punitive approach that treats drug users as criminals for possessing and using drugs and drug paraphernalia.[7] The approach has been largely unsuccessful: forty years later, drug abuse remains a pervasive and important problem.[8]

The punitive model persists and negatively impacts efforts to prevent HIV transmission among IDUs in several ways.[9] It erects barriers to access clean needles and syringes that make it challenging for IDUs to follow prevention measures. Its imposition of criminal penalties may inhibit IDUs from admitting their drug use, which gives rise to their HIV risk, and, thus, from getting accurate prevention information and help. This model predates the Acquired Immune Deficiency Syndrome ("AIDS") epidemic, caused by HIV, which was first recognized in the U.S. in five men originally diagnosed with pneumonia in 1981.[10] Since then, more than half a million people have died from AIDS in the U.S. alone,[11] and more than one million are living with

5. Id. §§ 812, 871.

6. Thirty Years of America's Drug War, FRONTLINE, http://www.pbs.org/wgbh/pages/frontline/shows/drugs/cron/ (last visited Mar. 4, 2013).

7. President Richard Nixon first introduced the phrase "War on Drugs" in the 1970s. The effort instigated decades of stringent drug laws largely enforced against drug users rather than transporters and distributors. The "War on Drugs" is now considered to have failed at preventing illicit drug use. GLOBAL COMM'N ON DRUG POLICY, WAR ON DRUGS: A REPORT OF THE GLOBAL COMMISSION ON DRUG POLICY 4 (2011); Amy Windham, Zero Tolerance, in 4 ENCYCLOPEDIA OF DRUGS, ALCOHOL, AND ADDICTIVE BEHAVIOR 317–18 (3d ed. 2008).

8. In 2011 alone, the FBI reported over 1.5 million arrests for drug abuse violations. Uniform Crime Reports: Estimated Number of Arrests, United States, 2011, FED. BUREAU OF INVESTIGATION, http://www.fbi.gov/about-us/cjis/ucr/crime-in-the-u.s/2011/crime-in-the-u.s.-2011/tables/table-29 (last visited Mar. 4, 2013).

9. INT'L FED'N OF RED CROSS & RED CRESCENT SOCIETIES, SPREADING THE LIGHT OF SCIENCE 1 (2003). According to International Federation of Red Cross and Red Crescent Societies President Juan Manuel Suárez del Toro Rivero, "political imperatives, donor demands, and ignorance and fear continue to impede the work of preventing and alleviating suffering and protecting human dignity." Id.

10. See M. S. Gottlieb et al., Pneumocystis Pneumonia—Los Angeles, 30 MORBIDITY & MORTALITY WKLY. REP. 1 (1981).

11. CTRS. FOR DISEASE CONTROL & PREVENTION, HIV SURVEILLANCE REPORT: DIAGNOSES OF HIV INFECTION AND AIDS IN THE UNITED STATES AND DEPENDENT AREAS, 2008, at 69 (2010), available at http://www.cdc.gov/hiv/surveillance/resources/reports/2008report/pdf/2008SurveillanceReport.pdf; NAT'L INST. OF ALLERGY & INFECTIOUS DISEASES, U.S. DEP'T OF HEALTH & HUMAN SERVS., UNDERSTANDING THE IMMUNE SYSTEM: HOW IT WORKS 33, 48 (2007), available at http://www.niaid.nih.gov/topics/immuneSystem/Documents/theimmunesystem.pdf; Ctrs. for Disease Control & Prevention, Thirty Years of HIV—1981–2011, 60 MORBIDITY & MORTALITY WKLY. REP. 689 (2011) [hereinafter CDC, Thirty Years of HIV]. HIV causes AIDS by destroying cells in the body that make up and

HIV.[12] Injecting drug use is a pervasive mode of HIV transmission that accounts for 18% of males and 32% of females living with HIV in the United States.[13] After men who have sex with men, IDUs have the second largest rate of HIV transmission.[14]

The Centers for Disease Control and Prevention ("CDC") recommends that IDUs cease drug use altogether because sharing used needles and syringes or preparation equipment increases the chance of HIV transmission between IDUs.[15] However, public health organizations including CDC, the American Foundation for AIDS Research ("amFAR"), and the World Health Organization ("WHO") have found that a comprehensive approach to substance abuse prevention, HIV treatment, and access to clean, sterile syringes can curb the rate of new HIV infections among IDUs.[16] While eliminating injecting drug use is the most effective HIV prevention strategy, SEPs are a valuable means for preventing the spread of HIV among IDUs.[17]

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operate the human immune system, thus removing the body's primary disease barrier and making it easy for opportunistic diseases to cause infection. NAT'L INST. OF ALLERGY & INFECTIOUS DISEASES, supra, at 33; see also How HIV Causes AIDS, NAT'L INST. OF ALLERGY & INFECTIOUS DISEASES, http://www.niaid.nih.gov/topics/hivaids/understanding/howhivcausesaids/Pages/cause.aspx (last updated Apr. 3, 2012).

12. CDC, Thirty Years of HIV, supra note 11; Lucian Torian et al., HIV Surveillance—United States, 1981–2008, 60 MORBIDITY & MORTALITY WKLY. REP. 689 (2011). As of 2009, there remain 1,178,350 people in the United States living with HIV. Id. In the United States alone, a total of 594,495 people have died from AIDS since it was discovered in 1981. Injecting drugs users account for the lowest proportion of HIV-positive individuals surviving twelve, twenty-four, and thirty-six months after diagnosis. 21 CTRS. FOR DISEASE CONTROL & PREVENTION, HIV SURVEILLANCE REPORT: DIAGNOSES OF HIV INFECTION AND AIDS IN THE UNITED STATES AND DEPENDENT AREAS, 2009, at 10, 46 (2011), available at http://www.cdc.gov/hiv/surveillance/resources/reports/2009report/pdf/2009SurveillanceReport.pdf [hereinafter CDC, DIAGNOSES 2009]. While the number of new diagnoses of HIV remained stable between 2006 and 2009 at a rate of 17.4 persons per 100,000, there may be a decreasing trend in infections attributed to injecting drug use. Id. at 6–7.

13. CDC, DIAGNOSES 2009, supra note 12, at 10. The transmission categories commonly used to study HIV/AIDS transmission and prevention are different for male and female adults. Male transmission categories include male-to-male sexual contact, injecting drug use, male-to-male sexual contact and injecting drug use, heterosexual contact, and other. Female transmission categories include injecting drug use, heterosexual contact, and other. Id. at 34.

14. Div. of HIV/AIDS Prevention, Ctrs. for Disease Control & Prevention, AIDS Associated with Injecting-Drug Use—United States, 1995, 45 MORBIDITY & MORTALITY WKLY. REP. 392 (1996) [hereinafter Div. of HIV/AIDS Prevention, AIDS Associated with Injecting-Drug Use]; Dennis H. Osmond, Epidemiology of HIV/AIDS in the United States, HIV INSITE (Mar. 2003), http://hivinsite.ucsf.edu/insite?page=kb-01-03.

15. Access to Sterile Syringes, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 2005), http://www.cdc.gov/idu/facts/aed_idu_acc.htm; see also Don C. Des Jarlais et al., Doing Harm Reduction Better: Syringe Exchange in the United States, 104 ADDICTION 1441 (2009).

16. Syringe Exchange Programs, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 2005), http://www.cdc.gov/idu/facts/aed_idu_syr.pdf.

17. Questions and Answers: HIV Prevention, CTRS. FOR DISEASE CONTROL &

Providing access to sterile syringes and needles through SEPs is controversial because it conflicts with the U.S. drug policy.[18] Some organizations and politicians oppose SEPs out of fear that they merely encourage IDUs to continue their risky behavior and that the programs will increase the number of syringes found in the streets.[19] Although research has debunked most of these concerns,[20] SEPs have been slow to gain national support.[21] In 1988, Congress banned the use of federal funds for SEPs. This

PREVENTION, http://www.cdc.gov/hiv/resources/qa/prevention.htm#2 (last modified Oct. 20, 2006).

18. Des Jarlais et al., supra note 15, at 1441. Injecting drug users are often labeled as criminals, rather than people with mental or physical illness. This stigma creates significant barriers that hinder societal support for SEP operations. Barbara Tempalski et al., Social and Political Factors Predicting the Presence of Syringe Exchange Programs in 96 US Metropolitan Areas, 97 AM. J. PUB. HEALTH 437, 437–38 (2007). Where politics have historically slowed the response to public health issues, social movements have often sparked the creation of necessary health policy. Id. at 437. However, because this issue involves illicit drugs and drug users, some drug prevention entities oppose SEPs, while HIV prevention organizations support them. See id. Former President George H.W. Bush's Chief of Drug Policy argued that such programs "undercut[] the credibility of society's message that drug use is illegal and morally wrong." Bob Egelko, U.S. Ends Funding Ban for Needle Exchanges, S.F. CHRON., Dec. 18, 2009, at A126.

19. Denise Paone et al., Syringe Exchange: HIV Prevention, Key Findings, and Future Directions, 30 INT'L J. ADDICTION 1647 (1995); Ban Lifted on Federal Funding for Needle Exchange, (Nat'l Pub. Radio Dec. 18, 2009), http://www.npr.org/templates/transcript/transcript.php?storyId=121511681 (reporting that those criticizing the modification to the ban fear that doing so provides incentives to continue use). Opposition to SEP operation comes from many places. Many state statutes include hypodermic syringes and needles in their definition of prohibited "drug paraphernalia," creating legal opposition to SEPs. Tempalski et al., supra note 18, at 438. Law enforcement, politicians, and other policy makers also oppose SEPs. Id. Religious and neighborhood organizations and business associations create opposition from within the communities where SEPs operate. Id.

20. Access to Sterile Syringes, supra note 15 ("Ensuring access to sterile syringes does not increase the number of persons who inject drugs or the number of drug injections. It does reduce the sharing and reuse of syringes."). Studies evaluating the effectiveness of syringe and needle exchange generally demonstrate a reduction in risky behaviors such as needle sharing or reusing and a decrease in frequency of injecting drug use. COMM. ON THE PREVENTION OF HIV INFECTION AMONG INJECTING DRUG USERS IN HIGH-RISK COUNTRIES, INST. OF MED., Sterile Needle and Syringe Access, and Outreach and Education, in PREVENTING HIV INFECTION AMONG INJECTING DRUG USERS IN HIGH RISK COUNTRIES: AN ASSESSMENT OF THE EVIDENCE 137, 141–44 (2006). Drug-related arrests should increase if the introduction of an SEP into a community actually resulted in an increase in crime; however, the rate of drug-related arrests remains the same. Melissa A. Marx et al., Trends in Crime and the Introduction of a Needle Exchange Program, 90 AM. J. OF PUBLIC HEALTH 1933, 1934 (2000). The instances of resisting arrest are used to measure an IDU's perception of "lawlessness," and this frequency also has not increased after the introduction of an SEP. Id.

21. Ricky N. Bluthenthal, Sterile Syringe Access Conditions and Variations in HIV Risk Among Drug Injectors in Three Cities, 99 ADDICTION 1136, 1137 (2004) (blaming the lack of predictability in syringe access between states on the fact that there is no "national policy"). It was not until 2009 when President Obama signed the Consolidated Appropriations Act of

left the burden of funding programs entirely to the states and private funders for the next two decades.[22]

In 2009, as part of his National HIV Strategy,[23] President Obama modified the ban on federal funds for SEPs when he signed the Consolidated Appropriations Act of 2010.[24] However, the federal government failed to allocate funding for SEPs, and existing programs continued to face significant barriers to obtaining resources.[25] Ultimately, Congress reinstated the ban in 2011 as part of its spending plan through fiscal year 2012.[26]

To achieve the goal of an AIDS-free generation, the U.S. must support SEPs legally and financially. Part I provides background on HIV transmission among IDUs and evidence supporting the use of SEPs to curb HIV transmission in this population.[27] Part II examines state and federal laws and policies that create legal barriers to effective SEP implementation.[28] Part III discusses the shortcomings of President Obama's modified ban and proposes alternative language.[29] Finally, Part IV recommends specific legal and policy changes regarding explicit authorization of SEPs—necessary to achieve an AIDS-free generation.[30]

2010, that the federal government expressed any support for syringe and needle exchange programs. Consolidated Appropriations Act of 2010, Pub. L. No. 111-117, § 505, 123 Stat. 3034, 3279 (2009).

22. Public Health Service Act, 42 U.S.C. § 300ee (2012). This Act states:

> The purpose of [Subchapter XXIII. Prevention of Acquired Immune Deficiency Syndrome,] is to provide for the establishment of education and information programs to prevent and reduce exposure to, and the transmission of, the etiologic agent for acquired immune deficiency syndrome . . . [but] [n]one of the funds appropriated to carry out this subchapter may be used to provide education or information designed to promote or encourage, directly, . . . intravenous substance abuse.

Id. § 300ee(a), (c); see also Thirty Years of America 's Drug War, supra note 6.

23. WHITE HOUSE OFFICE OF NAT'L AIDS POL'Y, NATIONAL HIV/AIDS STRATEGY FOR THE UNITED STATES (2010), available at http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf.

24. Consolidated Appropriations Act § 505.

25. Traci C. Green et al., Life After the Ban: An Assessment of US Syringe Exchange Programs' Attitudes About and Early Experiences With Federal Funding, 5 AM. J. PUB. HEALTH e9 (2012). Only three programs received federal funds, and the money did not help to create new legally authorized programs or to enable existing programs to expand services. Id. at e11.

26. Consolidated Appropriations Act of 2012, Pub. L. No. 112-74, § 523, 125 Stat. 786, 1115 (2011).

27. See discussion infra Part I.

28. See discussion infra Part II.

29. See discussion infra Part III.

30. See discussion infra Part IV.

II. EVIDENCE-BASED HIV PREVENTION FOR INJECTING DRUG USERS

Sharing hypodermic needles, syringes, and other drug devices can transmit HIV among IDUs. Injection drug use remains an important mechanism for HIV transmission in the United States, with disproportionate impact on women and minorities. However, as detailed below, SEPs have proven effective in reducing the risk of HIV transmission among IDUs.

A. HIV Transmission by Injecting Drug Users

HIV transmission among IDUs begins when drug users share hypodermic needles, syringes, and other drug devices.[31] "Needle sharing" may transfer bodily fluids and blood contaminated with HIV, or other infectious diseases such as hepatitis and syphilis.[32] When a user injects drugs into a vein or muscle, a small amount of the user's blood is deposited back into the needle.[33] If the needle is shared with another IDU, the residual blood—potentially infected with HIV—is injected into that person's bloodstream, easily transmitting the virus.[34] In addition to sharing needles, IDUs can transmit blood between users who share other drug-related equipment.[35]

In addition to increasing the risk of HIV transmission between IDUs, injecting drug use greatly increases the risk of infection for individuals otherwise not considered at risk, such as heterosexual sex partners of IDUs, children of mothers who are IDUs, or heterosexual sex partners of IDUs.[36]

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31. DIV. OF HIV/AIDS PREVENTION, CTRS. FOR DISEASE CONTROL & PREVENTION, HIV AMONG WOMEN 1–2 (2011), available at http://www.cdc.gov/hiv/topics/women/pdf/women.pdf; Div. of HIV/AIDS Prevention, AIDS Associated with Injecting-Drug Use, supra note 14; Des Jarlais, supra note 15, at 1441; A. Grigoryan et al., HIV Infection Among Injection-Drug Users—34 States, 2004–2007, 58 MORBIDITY & MORTALITY WKLY. REP. 1291 (2009); Access to Sterile Syringes, supra note 15.

32. Lawrence O. Gostin, The Interconnected Epidemics of Drug Dependency and AIDS, 26 HARV. C.R.-C.L. L. REV. 113, 115, 117 (1991); Access to Sterile Syringes, supra note 15.

33. HIV Transmission, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/hiv/resources/qa/transmission.htm (last modified Mar. 25, 2010).

34. Gostin, supra note 32, at 115–16; HIV Transmission, supra note 33.

35. HIV Transmission, supra note 33. Other drug-related equipment that can transmit blood includes "spoons" and "cookers" designed to dissolve drugs in water, cotton filters used to remove particles from the drug solution, and unclean water used to rinse syringes after their use. Id.; see also Why is Injecting Drug Use a Risk for HIV Transmission?, AIDSMAP, http://www.aidsmap.com/Why-is-injecting-drug-use-a-risk-for-HIV-transmission/page/1324128/ (last visited Mar. 7, 2013).

36. Div. of HIV/AIDS Prevention, AIDS Associated with Injecting-Drug Use, supra note 14; Gostin, supra note 32, at 117. Heterosexual partners of IDUs and their children are labeled "non-risk" groups but for their contact with IDUs. Id. ("Nearly seventy-two percent of all heterosexual cases of AIDS reported in the United States involve persons who have had sexual contact with an [IDU]. . . . Seventy-nine percent of all children born infected with HIV have a mother who either was an [IDU] or had sexual relations with an [IDU]."). Id. Importantly,

Transmission to individuals without risk behaviors creates opportunities for HIV to spread further into the general population.[37] This "bridging" from IDUs to the greater population poses a significant risk of new HIV infections that makes prevention of HIV transmission among IDUs even more critical.[38]

B. Populations Affected by Injecting Drug Use and HIV

The CDC identified IDUs as one of the primary "transmission categories" for contracting HIV.[39] Although the number of new HIV infections among IDUs has declined since the early 1990s,[40] IDUs still account for nearly one-fifth of all HIV cases nationally.[41]

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sexual partners of IDUs may not be aware of their partner's drug use and, thus, may not appreciate their own HIV risk. In addition, an estimated 20% of people infected with HIV are unaware of their infection. DIV. OF HIV/AIDS PREVENTION, CTRS. FOR DISEASE CONTROL & PREVENTION, HIV IN THE UNITED STATES (2011), available at http://www.cdc.gov/hiv/resources/factsheets/PDF/us.pdf. People may not take advantage of HIV prevention measures if they are unaware of their HIV risk.

37. Don C. Des Jarlais, Preventing HIV Transmission Among Injecting Drug Users (IDUs) and From IDUs to Noninjecting Sexual Partners in Sichuan, China, 34 SEXUALLY TRANSMITTED DISEASES 583, 583–84 (2007). A "generalized epidemic" is present "where HIV infection is transmitted primarily through heterosexual activity and 1% or more of the adult population is infected." Id. at 583. HIV transmission through needle sharing is a risk factor only for those who use hypodermic needles and syringes, thus creating an isolated HIV epidemic. Id. However, when an HIV-infected IDU has sex with a non-IDU sexual partner, this could introduce HIV into the general non-IDU population. Id.

38. Id. at 584.

39. DIV. OF HIV/AIDS PREVENTION, CTRS. FOR DISEASE CONTROL & PREVENTION, HIV IN THE UNITED STATES (2011), available at http://www.cdc.gov/hiv/resources/factsheets/PDF/us.pdf. The CDC estimates that injection drug users account for 9% of new infections that occur each year in the United States. Id. at 2.

40. CTRS. FOR DISEASE CONTROL & PREVENTION, AIDS DIAGNOSES AND DEATHS OF PERSONS WITH AIDS, WITH INFECTION ATTRIBUTED TO INJECTION DRUG USE, 1985–2008—UNITED STATES AND DEPENDENT AREAS (2008), available at http://www.cdc.gov/hiv/topics/surveillance/resources/slides/trends/slides/trends11.pdf. IDU-associated AIDS diagnoses rose to almost 25,000 in 1993. Id. Since then, the number of IDU-associated AIDS diagnoses has declined steadily each year, hovering just over 5,000 in 2008. Id.

41. CTRS. FOR DISEASE CONTROL & PREVENTION, HIV IN THE UNITED STATES (2011), available at http://www.cdc.gov/hiv/resources/factsheets/PDF/us.pdf. This represents a decline from 2002, when approximately 36% of the cumulative cases in the United States were attributed to IDUs. CTRS. FOR DISEASE CONTROL & PREVENTION, DRUG-ASSOCIATED HIV TRANSMISSION CONTINUES IN THE UNITED STATES (2002), available at http://www.cdc.gov/hiv/resources/factsheets/PDF/idu.pdf [hereinafter CTRS. FOR DISEASE CONTROL & PREVENTION (2002)]. The decline is attributed in part to the success of SEPs and other prevention measures. Salaam Semaan et al., Potential Role of Safer Injection Facilities in Reducing HIV and Hepatitis C Infections and Overdose Mortality in the United States, 118 DRUG & ALCOHOL DEPENDENCE 100, 101 (2011). In 2009, IDUs accounted for approximately 9% of new infections. Joseph Prejean et al., Estimated HIV Incidence in the United States, 2006–2009, 6 PLoS ONE e17502 (2011). These percentages would be higher if they included women infected as a result of heterosexual contact with an IDU. Samuel M. Jenness et al.,

HIV transmission through injecting drug use disproportionally affects women and minorities. Injecting drug use and high-risk sexual behavior are the two most common modes of HIV transmission among women.[42] More than half of all HIV cases among women relate to injecting drug use.[43] In 2010 alone, approximately 15% of females diagnosed with HIV attributed transmission of the virus to injecting drug use, compared to 7% of males.[44] HIV disproportionately affects African-Americans and Latinos regardless of transmission mode.[45]

These statistics make a strong case for investment in prevention strategies for IDUs as part of the effort toward an AIDS-free generation. IDUs may account for up to one-third of infections among certain populations. Failure to include IDU-directed strategies may undermine important goals of the Blueprint. As Fauci and Folkers state, "reducing HIV infections among reproductive-age women . . . is essential to eliminate mother-to-child transmission of HIV."[46] Failing to address a major source of infection among women may undermine such efforts.[47] Similarly, underestimating IDUs' role

Heterosexual HIV and Sexual Partnerships Between Injection Drug Users and Noninjection Drug Users, 24 AIDS PATIENT CARE & STDS 175 (2010). IDUs continue to represent a significant risk group globally, accounting for approximately one-third of people living with HIV outside of sub-Saharan Africa. Libby Topp et al., Fifteen Years of HIV Surveillance Among People Who Inject Drugs: The Australian Needle and Syringe Exchange Program Survey 1995–2009, 25 AIDS 835, 835 (2011) (citing UNAIDS 2008 Report on the Global AIDS Epidemic).

42. DIV. OF HIV/AIDS PREVENTION, supra note 31, at 1.

43. CTRS. FOR DISEASE CONTROL & PREVENTION (2002), supra note 41, at 1. As of 2000, 57% percent of all cases of HIV in women were associated with injecting drug use or sexual contact with an HIV-infected IDU. Id. at 1. A small proportion of HIV transmissions result from blood transfusions, receiving blood products or organs, and from mother to baby. HIV Transmission, supra note 33.

44. Ctrs. for Disease Control & Prevention, HIV Surveillance in Injection Drug Users (through 2010), http://www.cdc.gov/hiv/idu/resources/slides/ (last modified July 23, 2012).

45. While Hispanics/Latinos made up 15% of the U.S. population in 2006, this group accounted for 17% of new HIV infections that year. DIV. OF HIV/AIDS PREVENTION, CTRS. FOR DISEASE CONTROL & PREVENTION, HIV AMONG HISPANICS/LATINOS 1 (2010), available at http://www.cdc.gov/hiv/hispanics/resources/factsheets/pdf/hispanic.pdf. In 2009, the rate of new HIV infection among African American men was six and a half times greater than white men and two and a half times greater than Hispanic/Latino men. DIV. OF HIV/AIDS PREVENTION, CTRS. FOR DISEASE CONTROL & PREVENTION, HIV AMONG AFRICAN AMERICANS 1 (2011), available at http://www.cdc.gov/hiv/topics/aa/pdf/aa.pdf; see also B. Laffoon et al., Disparities in Diagnoses of HIV Infection Between Blacks/African Americans and Other Racial/Ethnic Populations—37 States, 2005–2008, 60 MORBIDITY & MORTALITY WKLY. REP. 93 (2011).

46. Anthony S. Fauci & Gregory K. Folkers, Towards an AIDS-Free Generation, 308 JAMA 343, 343 (2012).

47. While highly active antiretroviral therapy (HAART) during pregnancy can substantially reduce the risk of transmission, it requires women to be aware of their infection. See HHS PANEL ON TREATMENT OF HIV-INFECTED PREGNANT WOMEN AND PREVENTION OF

in HIV infection may further exacerbate disparities in the populations most affected by HIV. As discussed in the next section, SEPs are an important component of prevention measures for IDUs.

C. Preventing the Spread of HIV

National efforts to provide education on HIV prevention techniques have decreased the number of new infections since the epidemic began in the 1980's.[48] Despite continued education on the modes of transmission and means for prevention,[49] risky behavior among IDUs continues, in part, because of the lack of available clean syringes.[50] Recognizing that an IDU may not be ready or able to stop using drugs, the CDC recommends using clean or sterile drug equipment to avoid contact with HIV-infected blood.[51]

PERINATAL TRANSMISSION, RECOMMENDATIONS FOR USE OF ANTIRETROVIRAL DRUGS IN PREGNANT HIV-1-INFECTED WOMEN FOR MATERNAL HEALTH AND INTERVENTIONS TO REDUCE PERINATAL HIV TRANSMISSION IN THE UNITED STATES B-1 (2012), available at http://aidsinfo.nih.gov/guidelines/html/3/perinatal-guidelines/0/; see also MICHAEL A. STOTO ET AL., REDUCING THE ODDS: PREVENTING PERINATAL TRANSMISSION OF HIV IN THE UNITED STATES 45, 47–50 (1999). HIV testing is recommended during pregnancy, but is not always offered or accepted. Id. at 68. Moreover, IDUs may be less likely to access care. See generally, Lesley Simmonds & Ross Coomber, Injecting Drug Users: A Stigmatised and Stigmatising Population, 20 INT'L J. DRUG POL'Y 121, 121 (2009). "In general, IDUs have poorer levels of access to ART compared with non-IDUs, despite the fact that provision of [antiretroviral therapy (ART)] to IDUs has population-wide health benefits and despite evidence that IDUs can successfully undergo treatment and benefit from ART." WORLD HEALTH ORG. ET AL., WHO, UNODC, UNAIDS TECHNICAL GUIDE FOR COUNTRIES TO SET TARGETS FOR UNIVERSAL ACCESS TO HIV PREVENTION, TREATMENT AND CARE FOR INJECTING DRUG USERS 6 (1999) (citations omitted), available at http://www.unodc.org/documents/hiv-aids/idu_target_setting_guide.pdf.

48. NATIONAL CTR. FOR HIV/AIDS, CTRS. FOR DISEASE CONTROL & PREVENTION, HIV PREVENTION IN THE UNITED STATES 2 (2009), available at http://www.cdc.gov/hiv/resources/reports/pdf/hiv_prev_us.pdf; see also H. Irene Hall et al., Estimation of HIV Incidence in the United States, 300 J. AM. MED. ASSOC. 520, 528 (2008). However, by the end of 2006, one in five people infected with HIV still did not know their HIV status. HIV Testing, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/hiv/topics/testing/index.htm (last modified Feb. 27, 2013).

49. WHITE HOUSE OFFICE OF NAT'L AIDS POL'Y, supra note 23.

50. Des Jarlais, supra note 37, at 584. Despite their local success, SEPs in the United States cannot meet the needs for clean injection equipment, reaching only an estimated 3% of the IDU population. Semaan et al., supra note 41, at 104. A study in China demonstrated that education alone is not enough to significantly decrease an IDU's risk for HIV transmission. Joseph T.F. Lau et al., Clustering of Syringe Sharing and Unprotected Sex Risk Behaviors in Male Injecting Drug Users in China, 34 SEXUALLY TRANSMITTED DISEASES 574 (2007). Over 80% of the study subjects correctly answered four out of five questions on modes HIV transmission, but 35.7% of the subjects reported injecting with a syringe used by another IDU in the last 6 months. Id. at 575–76. These studies suggest that this discrepancy is because "necessary materials (clean needles and syringes, condoms)" are not sufficiently available. Des Jarlais, supra note 37, at 584.

51. Syringe Exchange Programs, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec.

However, IDUs inject drugs an estimated 1,000 times per year per person.[52] To comply with CDC recommendations, an average individual would need to obtain 1,000 sterile syringes and needles each year. However, sterile syringes and needles are not available in the quantities needed to actually reduce risk.[53] State and federal laws limiting or prohibiting the distribution of syringes and needles prevent IDUs from receiving sterile equipment.[54] They also perpetuate the negative perception of IDUs as criminals rather than persons with medical needs.[55] Many states criminalize the possession of hypodermic syringes and needles,[56] limit distribution by pharmacists and

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2005), http://www.cdc.gov/idu/facts/aed_idu_syr.pdf. The recommendations include using only new, sterile equipment; avoiding needle sharing; and purchasing syringes from a "reliable source." Id. Several other government agencies and prevention organizations recommend using sterile equipment to reduce the risk of HIV transmission in IDUs. See Access to Sterile Syringes, supra note 15. For example, the Institute of Medicine of the National Academy of Sciences published recommendations that for "injection drug users who cannot or will not stop injecting drugs, the once-only use of sterile needles and syringes remains the safest, most effective approach for limiting HIV transmission." Jennifer McNeely et al., Sterile Syringe Access and Disposal Among Injection Drug Users Newly Enrolled in Methadone Maintenance Treatment: A Cross-Sectional Survey, 3 HARM REDUCTION J. 8, 8 (2006) (quoting J. Normand et al., executive summary of PREVENTING HIV TRANSMISSION: THE ROLE OF STERILE NEEDLES AND BLEACH 2 (J. Normand et al. eds., 1995)). This approach, often referred to as "harm reduction," recognizes the reality of drug use and addiction and seeks to minimize harms when the underlying drug using behavior continues. See Canadian Paediatric Soc'y, Harm Reduction: An Approach to Reducing Risky Health Behaviours In Adolescents, 13 PAEDIATRICS & CHILD HEALTH 53, 53 (2008) (describing history of harm reduction concept). Addiction "is a chronic, relapsing disease, characterized by compulsive drug-seeking and use and by molecular changes in the brain." Semaan et al., supra note 41, at 102.

52. P. Lurie et al., A Sterile Syringe for Every Drug User Injection: How Many Injections Take Place Annually, and How Might Pharmacists Contribute to Syringe Distribution?, 18 J. ACQUIRED IMMUNE DEFICIENCY SYNDROMES & HUMAN RETROVIROLOGY S45 (1998); see also David Vlahov & Benjamin Junge, The Role of Needle Exchange Programs in HIV Prevention, 113 PUB. HEALTH REPS. 75 (1998); Access to Sterile Syringes, supra note 15.

53. Semaan et al., supra note 41, at 104; see also Larry Gostin et al., Prevention of HIV/AIDS and Other Blood-Borne Diseases Among Injection Drug Users: A National Survey on the Regulation of Syringes and Needles, 277 J. AM. MED. ASS'N 53 (1997). Forty-seven states and Washington, D.C. limit the availability of syringes and needles to zero when the known use of these items is illegal injecting drug use. Id. at 54–55. Eight states have further limited the sale of syringes and needles in pharmacies by requiring a doctor's prescription. Id. at 56. See also discussion infra Part II.A.

54. Access to Sterile Syringes, supra note 15.

55. INT'L FED'N OF RED CROSS & RED CRESCENT SOCIETIES, supra note 9, at 7. Stigma creates a barrier to successful treatment and prevention for IDUs, both within the IDU population and the greater community. Simmonds & Coomber, supra note 47, at 121. A community may view an IDU with HIV as more "blameworthy" than an individual who contracts HIV by more "innocent[]" means. Id. at 122.

56. Access to Sterile Syringes, supra note 15; see, e.g., ALA. CODE § 13A-12-260 (2012). The term "drug paraphernalia" includes "[h]ypodermic syringes, needles and other objects used, intended for use, or designed for use in parenterally injecting controlled substances into the human body." Id. § 13A-12-260(a)(11). The Alabama code prohibits the possession, use,

doctors,[57] and inhibit the operation of SEPs.[58] Stigmatizing and criminalizing IDUs may prevent them from seeking or receiving medical services.[59] Substance abuse behaviors make IDUs a unique at-risk population because HIV prevention measures necessarily include treatment for the chronic illness of addiction.[60] To the extent that the punitive approach to IDUs fails to address mental health and addiction treatment, it fails to significantly reduce IDU activity and resulting HIV transmissions.

The most effective prevention strategies take a comprehensive approach to drug addiction and HIV prevention.[61] SEPs seek to change risky behavior—using unclean syringes and needles—while also addressing substance abuse, thereby taking a more inclusive approach to the issues of drug addiction and HIV prevention and treatment.[62] Among other services,

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delivery and sale of "drug paraphernalia." Id. § 13A-12-260(c)–(e).

57. Access to Sterile Syringes, supra note 15; see, e.g., CAL. BUS. & PROF. CODE § 4145 (2011). "[A] pharmacist may furnish or sell 10 or fewer hypodermic needles or syringes at any one time to a person 18 years of age or older . . . ." Id. § 4145(a)(2).

58. Alexis N. Martinez et al., The Impact of Legalizing Syringe Exchange Programs on Arrests Among Injection Drug Users in California, 84 J. URBAN HEALTH 423, 424 (2007); Access to Sterile Syringes, supra note 15. Law enforcement plays an influential role in the success or failure of a syringe exchange program. Martinez et al., supra, at 432. "Police crackdowns" and "heightened street-level police intervention" are associated with decreased syringe exchange participation. Without agreements with police, SEP activity may be viewed as a reason to "crackdown," resulting in lower participation. Id.

59. Simmonds & Coomber, supra note 47, at 121.

60. Definition of Addiction, AM. SOC'Y OF ADDICTION MED. (Apr. 19, 2011), http://www.asam.org/for-the-public/definition-of-addiction. "A particularly pathological aspect of the way that persons with addiction pursue substance use or external rewards is that preoccupation with, obsession with and/or pursuit of rewards (e.g., alcohol and other drug use) persist despite the accumulation of adverse consequences. These manifestations can occur compulsively or impulsively, as a reflection of impaired control." Id.

61. Access to Sterile Syringes, supra note 15. An effective comprehensive approach requires a combination of substance abuse treatment and prevention to address the injecting drug use, HIV treatment services, and access to sterile syringes and needles. DEP'T OF HEALTH & HUMAN SERVS., IMPLEMENTATION GUIDANCE FOR SYRINGE SERVICES PROGRAMS 1 (2010), available at http://www.cdc.gov/hiv/resources/guidelines/PDF/SSP-guidanceacc.pdf. The prohibition of SEPs is unique to the United States, and such programs implemented in other countries are effective in reducing needle-sharing behaviors, rates of HIV transmission, and improving access to substance abuse treatment and prevention services. COMM. ON THE PREVENTION OF HIV INFECTION AMONG INJECTING DRUG USERS IN HIGH-RISK COUNTRIES, supra note 20; Lawrence O. Gostin & Zita Lazzarini, Prevention of HIV/AIDS Among Injection Drug Users: The Theory and Science of Public Health and Criminal Justice Approaches to Disease Prevention, 46 EMORY L.J. 587, 676–80 (1997).

62. DEP'T OF HEALTH & HUMAN SERVS., supra note 61. "The term SSP is inclusive of syringe access, disposal, and needle exchange programs, as well as referral and linkage to HIV prevention services, substance abuse treatment, and medical and mental health care." Id. The WHO, UNODC, UNAIDS TECHNICAL GUIDE FOR COUNTRIES TO SET TARGETS FOR UNIVERSAL ACCESS TO HIV PREVENTION, TREATMENT AND CARE FOR INJECTING DRUG USERS recommends a comprehensive package for prevention, treatment and care of HIV among IDUs because the

SEPs provide IDUs with a place to bring dirty and potentially infectious injection equipment to exchange for clean, sterile replacements.[63] The weight of public health research consistently shows that programs facilitating dirty-for-clean exchanges successfully curb the infection rate of blood-borne viral illnesses in IDUs. The programs also create opportunities for addiction treatment by offering recovery services, such as counseling, referral to treatment centers, and connection with other medical resources in conjunction with a syringe exchange.[64]

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interventions "have the greatest beneficial impact when delivered together." WORLD HEALTH ORG. ET AL., supra note 47, at 7. The WHO's position is consistent with the scientific data. Studies show that SEPs are "an effective way to link some hard-to-reach IDUs with important public health services, including TB and STD screening and treatment. Through their referrals to substance abuse treatment, SEPs can help IDUs stop using drugs. Studies also show that SEPs do not encourage drug use among SEP participants or the recruitment of first-time drug users." Syringe Exchange Programs, CTRS. FOR DISEASE CONTROL & PREVENTION (Dec. 2005), http://www.cdc.gov/idu/facts/aed_idu_syr.pdf. Safe injection facilities offer services similar to SEPs but also allow IDUs to inject at the facility. Studies show safe injection facilities are "associated with use of drug treatment, health care, and social welfare services" and "more rapid entry into detoxification programs" and result in less public injection and litter in the neighborhood. Semaan et al., supra note 41, at 100, 102.

63. V. Guardino et al., Syringe Exchange Programs—United States, 2008, 59 MORBIDITY & MORTALITY WKLY. REP. 1488, 1488 (2010) (defining SEPs); C.A. McKnight et al., Update: Syringe Exchange Programs—United States, 2002, 54 MORBIDITY & MORTALITY WKLY. REP. 673, 673 (2005). Operations take place out of stores, mobile units, and in health clinics. Syringe Exchange Programs, supra note 16.

64. SEPs can reduce HIV transmission by 33–42% in some settings. For this reason, SEPs are included in the "comprehensive package for the prevention, treatment and care of HIV among IDUs." WORLD HEALTH ORG. ET AL., supra note 47, at 6. "An impressive body of evidence suggests powerful effects from needle exchange programs . . . . Studies show reduction in risk behavior as high as 80%, with estimates of a 30% or greater reduction of HIV in IDUs." CTRS. FOR DISEASE CONTROL & PREVENTION, supra note 62 (quoting the 1997 National Institutes of Health Consensus Panel on HIV Prevention); Carol Strike et al., Guidelines for Better Harm Reduction: Evaluating Implementation of Best Practice Recommendations for Needle and Syringe Programs (NSPs), 22 INTERNAT'L J. DRUG POL'Y 34, 34 (2011) ("Three decades of international evidence demonstrates that needle and syringe programs (NSPs) reduce needle sharing, HIV incidence and prevalence, and are cost effective when compared with the costs of treating individuals with HIV/AIDs.") (citations omitted). See Ricky N. Bluthenthal et al., Higher Syringe Coverage is Associated with Lower Odds of HIV Risk and Does Not Increase Unsafe Syringe Disposal Among Syringe Exchange Program Clients, 89 DRUG & ALCOHOL DEPENDENCE 214, 219 (2007) (finding a "strong[] associat[ion]" between the percentage of an individual's syringes obtained from an SEP and lower HIV risk); Bluthenthal et al., supra note 21, at 1136 (describing programs that improve access to sterile needles and syringes as "among the most effective methods for preventing the spread of HIV . . . among injection drug users"); Margaret MacDonald et al., Effectiveness of Needle and Syringe Programmes for Preventing HIV Transmission, 14 INT'L J. DRUG POL'Y 353 (2003); Alan Neaigus et al., Greater Drug Injecting Risk for HIV, HBV, and HCV Infection in a City Where Syringe Exchange and Pharmacy Syringe Distribution are Illegal, 85 J. URBAN HEALTH 309, 310 (2008) (reporting that most of the prior studies have found SEPs reduce the risk of infection); J.M. Raboud et al., The Impact of Needle-Exchange Programs on the Spread

Despite the evidence supporting SEPs as a prevention measure, SEPs face strong opposition.[65] Opponents express concern that supporting SEPs excuses injecting drug use[66] and will increase the number of IDUs by creating a network of known users.[67] In some states, "zero tolerance" policies for drugs and drug paraphernalia allow no exceptions for even the most compelling reasons—such as preventing transmission of life-threatening diseases like HIV.[68] Zero tolerance policies perpetuate tension between health care professionals who consider IDUs to be patients, and law enforcement officials who consider them to be criminals.[69] Moreover, as described further in Part II, any programs that do operate may do so at their legal peril.[70]

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of HIV Among Injection Drug Users: A Simulation Study, 80 J. URBAN HEALTH 302 (2003) (finding that while needle exchange programs, NEPs, are effective at reducing general risk, the greatest impact of NEPs is on populations of "high-risk" IDUs); Abby E. Rudolph et al., Comparison of Injection Drug Users Accessing Syringes from Pharmacies, Syringe Exchange Programs, and Other Syringe Sources to Inform Targeted HIV Prevention and Intervention Strategies, 50 J. AM. PHARM. ASS'N 140 (2010) (finding IDUs more likely to use a new sterile syringe for each injection when obtained from an SEP).

65. Semaan et al., supra note 41, at 103; David J. Merrill, Comment, Compassion for Drug Addicts or Government-Sanctioned Drug Use?: An Overview of the Needle Exchange Controversy, 23 PEPP. L. REV. 939, 941–42 (1996).

66. WILLIAM MARTIN, NEEDLE EXCHANGE PROGRAMS: SENDING THE RIGHT MESSAGE 10 (2009), available at http://bakerinstitute.org/publications/DRUG-pub-MartinNeedle ExchangeUpdate-011609.pdf; Gostin, supra note 32, at 132; Ban Lifted on Federal Funding for Needle Exchange, supra note 19 (reporting that those criticizing the modification to the ban fear that doing so provides incentives to continue drug use).

67. Martin T. Schechter et al., Do Needle Exchange Programmes Increase the Spread of HIV Among Injection Drug Users?: An Investigation of the Vancouver Outbreak, 13 AIDS F45, F49 (1999). However, this study found no evidence that participation in NEPs increased needle sharing or risky behavior. See id.; see also Am. Found. for AIDS Research, Syringe Exchange, BACKGROUNDER (June 2011), http://www.amfar.org/uploadedFiles/On_The_Hill/ SEPbackgrounder.pdf?n=3777; Joseph Guydish et al., Evaluating Needle Exchange: Are There Negative Effects?, 7 AIDS 871 (1993).

68. See, e.g., State v. McCague, 714 A.2d 937, 944 (N.J. Super. Ct. App. Div. 1998); State v. Sorge, 591 A.2d 1382, 1384–85 (N.J. Super. Ct. App. Div. 1991) (The state of New Jersey "refuse[d] to treat as trivial the possession of even the most miniscule amounts of a controlled dangerous substance," under the state's "zero tolerance drug policy."); Tempalski et al., supra note 18, at 437–38 ("[T]he United States has been the historical leader in law enforcement and abstinence-based approaches to illicit drug use . . . ."). However, there is little evidence that an aggressive criminal law approach has "succeeded in reducing drug use, infectious diseases in [IDUs], or overdose mortality of [IDUs]." Semaan et al., supra note 41, at 103.

69. Tempalski et al., supra note 18, at 437.

70. See infra notes 90–93 and accompanying text (discussing State v. McCague, 714 A.2d 937); Leo Beletsky et al., The Roles of Law, Client Race and Program Visibility in Shaping Police Interference with the Operation of US Syringe Exchange Programs, 106 ADDICTION 357, 362 (2010) (concluding that "SEP authorization and laws governing syringe possession do not influence substantially the frequency of police interference").

III. LAWS AND POLICIES CREATING BARRIERS TO SEP IMPLEMENTATION

Several existing policies create barriers to SEP implementation, including (1) state drug paraphernalia laws rooted in the federal War on Drugs and (2) the federal ban on funding SEPs. This section explores how these policies impede not only SEPs, but also the goal of an AIDS-free generation.

A. State Laws Regulating Drug Paraphernalia, Possession, Distribution, and SEPs

State statutes and regulations pose a significant barrier to clean syringe and needle access.[71] State regulation of syringe distribution and possession began in Oregon, which passed the country's first drug paraphernalia law.[72] The Oregon legislature based its statute on the U.S. Drug Enforcement Administration's 1979 Model Drug Paraphernalia Act ("Model Act").[73] After Oregon, thirty-seven additional states and Washington, D.C. also adopted drug paraphernalia statutes based on the Model Act.[74]

Only fourteen states, Washington, D.C., and Puerto Rico have laws that explicitly authorize SEP operations.[75] For example, California's statute

71. Access to Sterile Syringes, supra note 15.

72. See OR. REV. STAT. § 475.525 (2011). This statute prohibits the sale, delivery, and possession of "drug paraphernalia." Id.; Non-Prescription Access, LAW, POLICY & PUBLIC HEALTH AT TEMPLE UNIVERSITY'S BEASLEY SCHOOL OF LAW, http://www.temple.edu/lawschool/phrhcs/otc.htm (last updated Nov. 28, 2008).

73. The Model Drug Paraphernalia Act states: "The term 'drug paraphernalia' means all equipment, products and materials of any kind which are used, intended for use, or designed for use, in . . . injecting . . . . It includes, but is not limited to: . . . (11) Hypodermic syringes, needles and other objects used, intended for use, or designed for use in parenterally injected controlled substances into the human body . . . ." MODEL DRUG PARAPHERNALIA ACT (1979) (full text of Model Act is published in Appendix B of United States v. Main Street Distributing, 700 F.Supp 655, 671 (E.D.N.Y. 1988)); Non-Prescription Access, supra note 72.

74. For a list of the thirty-seven states, see Steven E. Gersten, Drug Paraphernalia: Illustrative of the Need for Federal-State Cooperation in Law Enforcement in an Era of New Federalism, 26 SW. U. L. REV.1067, 1079 n.80 (1997).

75. California, Colorado, Connecticut, Delaware, Hawaii, Maine, Maryland, Massachusetts, New Jersey, New Mexico, New York, Puerto Rico, Rhode Island, Texas, Vermont, and the District of Columbia explicitly authorize SEPs. See CAL. HEALTH & SAFETY CODE § 121349 (West 2012); COLO. REV. STAT. § 25-1-520 (2010); CONN. GEN. STAT. § 19a-124 (2011); DEL. CODE ANN. tit. 29, § 7991 (2011); HAW. REV. STAT. § 325-112 (2012); ME. REV. STAT. tit. 22, § 1341 (2011); MD. CODE ANN., HEALTH-GEN. §§ 24-802, 24-902 (West 2013); MASS. GEN. LAWS ch. 111, § 215 (1995); N.J. STAT. ANN. § 26:5C-27 (2012); N.M. STAT. ANN. § 24-2C-4 (West 1997); N.Y. COMP. CODES R. & REGS. tit. 10, § 80.135 (1993); P.R. LAWS ANN. tit. 24, § 2608 (2000); R.I. GEN. LAWS § 23-11-19 (2006); TEX. GOV'T CODE ANN. § 531.0972 (West 2007); VT. STAT. ANN. tit. 18, § 4478 (1999); D.C. CODE § 48-1103.01 (2012). Although Washington does not explicitly authorize SEPs, it recently adopted legislation that may implicitly authorize programs. See WASH. REV. CODE § 69.50.4121 (2012); see also Spokane Cnty. Health Dist. v. Brockett, 839 P.2d 324 (Wash. 1992)

provides: "In order to reduce the spread of HIV infection and bloodborne hepatitis among the intravenous drug user population within California, the Legislature hereby authorizes a clean needle and syringe exchange project."[76] Additionally, eleven states have removed or abstained from adding "hypodermic syringes, needles, and other equipment" to drug paraphernalia laws.[77] Absence of such language means that, in these eleven states, criminal distribution and possession of "drug paraphernalia" may not include hypodermic needles and syringes. However, SEPs in these states cannot rely on the same strength of authority as an express authorization when battling law enforcement.[78] The remaining states include hypodermic syringes and needles in their statutory definitions of drug paraphernalia, preventing SEPs from operating legally without other authorization.[79]

The decisions of the few courts that have addressed the legality of SEPs are inconsistent.[80] In 1992, in Spokane County Health District. v. Brockett,

(interpreting the Omnibus AIDS Act and other public health statutes as authorizing SEPs). Interestingly, this list of states does not reflect the current epidemic. The states with the highest rates of new AIDS diagnoses per year include Florida, Illinois, Pennsylvania, North Carolina, and Georgia. HENRY J. KAISER FAMILY FOUND., THE HIV/AIDS EPIDEMIC IN THE UNITED STATES 1 (2012), available at http://www.kff.org/hivaids/upload/3029-13.pdf.

76. CAL. HEALTH & SAFETY CODE § 121349(b). Section (a) of this statute contains legislative findings and declarations in line with public health research findings that SEPs do not increase or encourage drug use and are effective at reducing the spread of HIV. Id. § 121349(a).

77. The eleven states that have removed hypodermic syringes and needles from the statutory definition of "drug paraphernalia" are Illinois, Michigan, Montana, Minnesota, Nevada, New Hampshire, Oregon, Tennessee, Vermont, Wisconsin, and Wyoming. See 720 ILL. COMP. STAT. 600/2 (2012); MICH. COMP. LAWS § 333.7451 (1988); Minn. Stat. § 152.01 (2011); MONT. CODE ANN. § 45-10-101 (1981); NEV. REV. STAT. § 453.554 (1981); N.H. REV. STAT. ANN § 318-B:1 (2013); OR. REV. STAT. § 475.525 (1995) (explicitly exempt from the definition of paraphernalia); TENN. CODE ANN. § 39-17-402 (2012); VT. STAT. ANN. tit. 18, § 4475 (explicitly exempt from the definition of paraphernalia); WIS. STAT. § 961.571 (2012) (explicitly exempt from the definition of paraphernalia); WYO. STAT. ANN. § 35-7-1002 (2011). Where that statutory description of "drug paraphernalia" is non-exclusive, a court could still read it as covering hypodermic needles and syringes, although such an interpretation would be weaker in those states where the legislature specifically removed the language, rather than those that simply omitted them from the list.

78. Providing explicit authorization for an SEP reduces the amount of legal uncertainty by removing the need for law enforcement officials to interpret the legality of such programs. Providing an explicit authorization, rather than merely making SEPs "not illegal," limits law enforcement officials' prosecutorial discretion in generally enforcing paraphernalia laws.

79. Non-Prescription Access, supra note 72; Dale Joseph Gilsinger, Construction and Application of State Drug Paraphernalia Acts, 23 A.L.R.6th 307 (2007) (collecting cases and laws).

80. Compare Spokane Cnty. Health Dist. v. Brockett, 839 P.2d 324 (Wash. 1992) (finding that a needle exchange program aiming to prevent transmission of HIV between IDUs did not violate drug paraphernalia laws), with Commonwealth v. Leno, 616 N.E.2d 453 (Mass. 1993) (finding a necessity defense could not be awarded where defendants attempted to distribute

the Spokane County Health District ("SCHD") sought a declaration on the legality of an SEP proposed by its local Board of Health.[81] The SCHD Health Board authorized the operation of an SEP in Spokane County, based on Washington's Omnibus AIDS Act, which allows the Office on AIDS to provide services for "intervention strategies specifically addressing groups that are at a high risk of being infected with the human immunodeficiency virus."[82] The statute specifically identifies "needle sterilization" as a possible strategy.[83] However, even before the SEP began operating, Spokane County Prosecuting Attorney Donald Brockett pledged to "take action" against the operation.[84] Brockett argued that distributing drug paraphernalia would violate the state's Uniform Controlled Substances Act.[85] The Spokane County Superior Court found the program lawful.[86] Reviewing the lower court ruling, the Supreme Court of Washington recognized the apparent conflict between the drug paraphernalia law and the establishment of an SEP, but deferred to the legislature's public health goals—particularly its aim to control the spread of HIV/AIDS.[87] The Court relied on the Washington legislature's "statement of intent" in promulgating the AIDS Act.[88] The legislature intended "to provide a program that is sufficiently flexible to meet emerging needs," and thus the court interpreted the statute broadly, finding the program lawful.[89]

On the other hand, in State v. McCague, a New Jersey state court found defendants' operation of a syringe exchange violated state law prohibiting possession and distribution of hypodermic needles and syringes.[90] Using private funds, defendants operated an SEP through a non-profit corporation, though the program was affiliated with clinics at a state university.[91] The

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sterile needles and syringes in an effort to prevent transmission of HIV among IDUs).

81. Spokane Cnty. Health Dist., 839 P.2d at 326.

82. WASH. REV. CODE § 70.24.400 (2010) (cited in Spokane Cnty. Health Dist., 839 P.2d at 326–27).

83. Spokane Health Dist., 839 P.2d at 327.

84. Id.

85. Id. at 326–27. Washington's Uniform Controlled Substances Act was amended in 2012 to specifically exempt application to SEPs operated by public health or community HIV prevention programs. WASH. REV. CODE § 69.50.4121(3), supra note 75.

86. Spokane Cnty. Health Dist., 839 P.2d at 328.

87. Id. at 328, 332; see also People v. Bordowitz, 588 N.Y.S.2d 507 (N.Y. Crim. Ct. 1991) (finding the harm caused by HIV outweighed the harm in violating the statute, thus invoking the medical necessity defense where defendants possessed sterile syringes).

88. Spokane Cnty. Health Dist., 839 P.2d at 330.

89. Id. at 329.

90. State v. McCague, 714 A.2d 937 (N.J. Super. Ct. App. Div. 1998); see N.J. STAT. ANN. § 2C:36-6 (West 1999).

91. State v. McCague, 714 A.2d at 257–58.

court refused to overturn defendants' convictions, citing New Jersey's "zero tolerance" policy as a rigid standard for drug paraphernalia possession and distribution that did not require a culpable mental state.[92] Unlike the court in Spokane County Health District, which relied upon the legislature's statements in finding SEPs lawful despite the lack of express authorization and the conflicting criminal statute, the McCague court did not discuss New Jersey's public health stance or its public health statutes, perhaps because the SEP was privately operated.

Drug paraphernalia laws remain an important barrier to legal operation of SEPs. Federal funding alone will not change that. However, because these laws spring from federal recommendations rooted in the War on Drugs, federal policy affirming SEPs as a tool in the National HIV/AIDS Strategy could influence the way states formulate or interpret their statutes. In addition, Congressional endorsement of SEPs for preventing HIV could help create a record for the public health rationale, similar to the effect that the Washington legislature's statements had in Spokane County. Accordingly, federal leadership authorizing and funding SEPs could contribute to the pursuit of an AIDS-free generation.[93]

B. The Ban On Federal Funding For Syringe And Needle Exchange Programs

Consistent with federal anti-drug policies, Congress first banned federal funding for SEPs in 1988. Except for a brief period in the first Obama administration, the ban has been in place since 1988.[94]

1. Circumstances Leading Up to the Ban

When President Ronald Reagan entered office in 1981, he prioritized Nixon's "War on Drugs." First Lady Nancy Reagan's anti-drug campaign, "Just Say No," soon followed.[95] Following the Anti-Drug Abuse Act of 1986, which created mandatory minimum sentencing guidelines for drug-related convictions,[96] and the Chemical Diversion and Trafficking Act of 1988,

92. Id. at 944; see also Commonwealth v. Leno, 616 N.E.2d 453 (Mass. 1993) (finding a necessity defense could not be awarded where defendants attempted to distribute sterile needles and syringes in an effort to prevent transmission of HIV among IDUs).

93. All three of the programs that received federal funds prior to the ban's reinstatement were legally authorized. See Green et al., supra note 25, at e11. None of the unauthorized SEPs received any state or federal funding. Id. at e10.

94. See Am. Found. for AIDS Research, supra note 67.

95. Thirty Years of America's Drug War, supra note 6.

96. See Anti-Drug Abuse Act of 1986, Pub. L. No. 99-570, 100 Stat 3207 (1986). This Act outlined penalties for drug possession violations. For example, "[i]n the case of a

which added airplanes and boats to the DEA's jurisdiction,[97] Congress passed a ban on federal funding for SEPs.[98] The 1988 ban declared:

> None of the funds provided under this Act or an amendment made by this Act shall be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for acquired immune deficiency syndrome.[99]

This ban, written during the height of the HIV epidemic in the United States, limited federal influence on HIV/AIDS prevention policy with respect to IDUs and left it to the states, local governments, and private organizations to craft responses to the epidemic.[100]

2. The Modified Ban and Reinstated Ban

As part of his campaign during the 2008 presidential election, Senator Barack Obama pledged to lift the twenty-one-year ban on federal funding for

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violation . . . involving 1 kilogram or more of a mixture or substance containing a detectable amount of heroin . . . such person shall be sentenced to a term of imprisonment which may not be less than 10 years or more than life." 21 U.S.C. § 841(b) (2006); see also Thirty Years of America 's Drug War, supra note 6.

97. See Chemical Diversion and Trafficking Act of 1988, Pub. L. No. 100-690, 102 Stat. 4312 (1988). In addition to adding registration requirements for aircrafts and boats, this Act added the option of capital punishment for certain violations of the Anti Drug-Abuse Act of 1986: "[A]ny person engaging in an offense punishable under section 841(b)(1)(A) . . . shall be sentenced to any term of imprisonment, which shall not be less than 20 years, and which may be up to life imprisonment, or may be sentenced to death." 21 U.S.C. § 848 (2006).

98. Health Omnibus Programs Extension of 1988, Pub. L. No. 100-607, § 256(b), 102 Stat. 3110 (codified as 42 U.S.C. § 300ee-5 (1988)). Peter A. Clark & M. Fadus, Federal Funding for Needle Exchange Programs, 16 MEDICAL SCI. MONITOR PH 1 (2010).

99. 42 U.S.C. § 300ee-5.

100. On February 23, 2011, Vice Admiral Regina Benjamin, Surgeon General of the United States Public Health Service, published her determination that a demonstration needle exchange program would be "effective in reducing drug abuse and the risk of infection with the etiologic agent for acquired immune deficiency syndrome." Determination That a Demonstration Needle Exchange Program Would be Effective in Reducing Drug Abuse and the Risk of Acquired Immune Deficiency Syndrome Infection Among Intravenous Drug Users, 76 Fed. Reg. 10038–01 (Feb. 23, 2011). Vice Admiral Benjamin cited studies showing that "SSPs are widely considered to be an effective way of reducing HIV transmission among individuals who inject illicit drugs and there is ample evidence that SSPs also promote entry and retention into treatment." Id. However, approving "demonstration" programs is not the same as a large-scale endorsement of SEPs as part of a comprehensive HIV prevention program.

SEPs.[101] Although President Obama signed the Consolidated Appropriations Act of 2010 after taking office,[102] the act did not remove the rider provision to lift the ban. Instead, the Act only modified the ban to say:

> None of the funds contained in this Act may be used to distribute any needle or syringe for the purpose of preventing the spread of blood borne pathogens in any location that has been determined by the local public health or local law enforcement authorities to be inappropriate for such distribution.[103]

Thus, under the new bill, using federal funds to operate SEPs is allowed unless local authorities determine the location is "inappropriate."

In response to the ban modification, the Department of Health and Human Services ("HHS"), through CDC, published Implementation Guidance for Syringe Services Programs as a template for organizations seeking federal funding for SEPs.[104] This document outlined "guiding principles" for grantees of federal funds, namely adherence to state and local laws and the coordination of services for substance abuse and HIV prevention.[105] Interestingly, it also calls for affirmative documentation showing that local law enforcement and health officials have approved the location of an SEP.[106] This last requirement shifts the statutory requirement from a restriction on using funds where the location is deemed inappropriate, into a positive eligibility requirement. This may make practical sense—perhaps the federal government does not want to issue funds to an SEP only to have local objections arise.[107] However, this shift also suggests more limited support for

101. See Am. Found. for AIDS Research, supra note 67; Ryan Grim, Obama Budget Bans Federal Funding For Needle Exchange, Breaking Campaign Pledge, HUFFINGTON POST (June 7, 2009), http://www.huffingtonpost.com/2009/05/07/obama-budget-bans-federal_n_199436.html; Editorial, Righting a Wrong, Much Too Late, N.Y. TIMES, Dec. 26, 2009, at A22.

102. Consolidated Appropriations Act of 2010, Pub. L. No. 111-117, § 505, 123 Stat. 3034, 3279; Richard C. Boldt, Drug Policy in Context: Rhetoric and Practice in the United States and the United Kingdom, 62 S.C. L. REV. 261, 339 (2010); Ban Lifted on Federal Funding for Needle Exchange, supra note 19.

103. Consolidated Appropriations Act of 2010 § 505.

104. DEP'T OF HEALTH & HUMAN SERVS., supra note 61.

105. Id. at 1–2.

106. Id. at 2.

107. The success of SEPs may also require cooperation with local law enforcement. However, this recognizes the practical realities of the conflict between traditional criminal law relating to drugs and drug use and public health goals. Leo Beletsky et al. surveyed 111 SEP program managers (representing 59% of all SEPs), and a significant minority reported "client harassment" by police (43%) and at least monthly, unauthorized confiscation of clients' syringes (31%). Beletsky et al., supra note 70, at 359. They concluded that "legal status of SEP, jurisdiction's syringe regulation environment and affiliation with health department were

SEPs than the modification appeared to offer.

Some HIV prevention advocates and SEP supporters celebrated the modification of the federal funding ban, taking it as a sign that the federal government supports SEPs as a tool for HIV prevention, thus legitimizing the practice.[108] However, other HIV prevention groups, such as the Harm Reduction Coalition, argue that the modification did not go far enough to make SEPs a legal reality at the national level.[109] Only three of the 203 SEPs recognized in the United States received federal funding under the modified ban.[110] SEPs still cited a lack of stable funding as the most common problem

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not associated with frequency of police interference." Id. at 357. Programs serving IDUs of color experienced greater frequency of policy interference. Id. These results led the researchers to conclude that "without targeted efforts to change police policies and practices on the local level, formal legal reform alone may be insufficient to maximize the impact of SEPS and other interventions targeting IDUs." Id. at 362. Additionally, "communication and coordination between police and SEPs may reduce police interference, yielding improvements in overall effectiveness and cost-effectiveness" of SEPs. Id. Working closely with law enforcement can minimize such problems. See Basha Silverman et al., Harmonizing Disease Prevention and Police Practice in the Implementation of HIV Prevention Programs: Up-stream Strategies from Wilmington, Delaware, 9 HARM REDUCTION J. 17 (2012).

108. Righting a Wrong, Much Too Late, supra note 101; Ban Lifted on Federal Funding for Needle Exchange, supra note 19; In Wake of Syringe Ban Victory, CDC, Goosby Contemplate Future Funding, HOUSING WORKS BLOGS (Dec. 17, 2009), http://www.housingworks.org/blogs/detail/what-the-end-of-the-syringe-exchange-ban-means/; see also Daniel Geyser, Needle Exchange Program Funding, 37 HARV. J. ON LEGIS. 265, 265 (2000) (commenting on the generally passive strategy the federal government has taken to avoid a firm statement on its position on syringe and needle exchange programs, focusing instead on funding for such programs).

109. Daniel Raymond, 194 Days and Counting: Syringe Exchange Is Working, So Why Isn't the Administration Supporting It?, HUFFINGTON POST (June 28, 2010), http://www.huffingtonpost.com/allan-clear/194-days-and-counting-syr_b_627949.html ("Bureaucratic inertia has repeatedly delayed the release of revised guidance from federal agencies that would enable health departments and non-profit groups to apply their federal dollars to syringe exchange. As states and local organizations continue to wrestle with their own budget cuts, the lack of leadership and direction from the federal government has paralyzed their efforts to plan, prioritize, and deliver services."); Letter from AIDS Action Council, The Foundation for AIDS Research, Harm Reduction Coalition, National Alliance of State & Territorial AIDS Directors, North American Syringe Exchange Network, Physicians for Human rights, Open Society Institute, and Urban Coalition for HIV/AIDS Prevention Services, to Jonathan Mermin, Dir., Div. of HIV/AIDS Prevention, Ctrs. for Disease Control and Prevention (Mar. 5, 2010) (on file with author). The authors of this letter expressed concern at requiring the involvement of law enforcement in granting permission for SEP operation: "Community members and health officials have raised concerns about how federal agencies will interpret this language, given both the diverse and complex histories of siting negotiations for syringe access program and the complicated relationships between public health, law enforcement, and syringe access." Id. at 1. "Syringe access is a public health intervention, and thus properly falls under the jurisdiction of public health officials, and not law enforcement." Id. at 2.

110. Green et al., supra note 25, at e11.

they faced.[111] In fact, existing programs reported that without clear guidelines on how the funds may be used, technical assistance from health departments, and legal reform at the state level, lifting the ban was insufficient, and SEP success required further affirmative authorization.[112] Ultimately, the need for permanent authority and funding became evident with the reinstatement of the ban on SEP funding in December 2011.[113]

IV. THE FAILURE OF THE MODIFIED BAN

The Obama administration's attempt to modify the ban on federally funding SEPs failed to achieve lasting change for two reasons: 1) its language was confusing and 2) it did not affirmatively authorize SEPs.

A. A Failure of Language

The language of the Consolidated Appropriations Act of 2010, modifying the ban on using federal funds for SEPs, presents three problems that perpetuate the legal barrier created by the original 1988 ban: 1) it uses negatively-phrased language; 2) it distributes authority to both local public health and law enforcement authorities; and 3) it does not define what locations are "inappropriate" for SEPs.

> None of the funds contained in this Act may be used to distribute any needle or syringe for the purpose of preventing the spread of blood borne pathogens in any location that has been determined by the local public health or local law enforcement authorities to be inappropriate for such distribution.[114]

Use of negative language in the modified ban obfuscates what is actually permitted. The phrase "[n]one of the funds . . . may be used . . . in any location" does not naturally lead to the inference that funding would be allowed for SEPs. Provisions that are designed to authorize funding in appropriations bills generally use the language "shall be available" and "funds are available." In contrast, this language could be read to mean that

111. Id. at e9. The challenges for funding are not surprising given the effects of the recession on resources, including state and local government budgets and the endowments of private foundations. Semaan et al., supra note 41, at 103.

112. Green et al., supra note 25, at e15.

113. Consolidated Appropriations Act of 2012, Pub. L. No. 112-74, 125 Stat 786. The prohibition was included in Division F, Title V, Sec. 523. Letter from Ronoldo O. Valdiserri, Deputy Assistant for the Sec'y of Health, Dep't of Health & Human Servs. (Mar. 29, 2012), available at http://www.cdc.gov/hiv/resources/guidelines/PDF/SEC523.pdf.

114. Consolidated Appropriations Act of 2010, Pub. L. No. 111-117, § 505, 123 Stat. 3034, 3279 (emphasis added).

funding is not available to any SEP unless it can qualify under an exception.[115] Indeed, as discussed in Part II, HHS took this approach in its Guidance and required documentation that local public health authorities and law enforcement approved a location as "appropriate." Congress could have avoided this confusion with an affirmative statement (i.e., HHS shall or may fund SEPs, except . . .).[116]

Additionally, by granting authority to public health or law enforcement, the modified ban created confusion about authority and responsibility for SEPs. Specifically, the modified ban relied on local entities—"local public health or local law enforcement authorities"[117]—to determine which locations were "inappropriate" for SEPs and, thus, ineligible for funding. However, the fundamental challenge for SEPs is that the priorities of a public health agency differ from those of local law enforcement. [118] The modified ban's broad language not only fails to resolve this tension, but also perpetuates it by dividing authority between these two groups without providing a mechanism for balancing their competing priorities.

While public health agencies focus on the fight against HIV transmission among IDUs, law enforcement agencies focus on the "fight against illegal drug use."[119] Studies suggest rigid law enforcement policies and a lack of collaborative training between law enforcement and SEP promoters erodes the efficacy of SEPs and deters participation.[120] Gaps in state and local SEP

115. "Where Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied, in the absence of a contrary legislative intent." YULE KIM, CONGRESSIONAL RESEARCH SERVICE REPORT FOR CONGRESS, STATUTORY INTERPRETATION: GENERAL PRINCIPLES AND RECENT TRENDS CRS-16–17 (2008) (quoting Andrus v. Glover Const. Co., 446 U.S. 608, 616–17 (1980)).

116. For example, President Obama's Executive Order 13505, titled Removing Barriers to Responsible Scientific Research Involving Human Stem Cells, repealed the ban on federal funding for hESC research by providing, "The Secretary of Health and Human Services . . . , through the Director of NIH, may support and conduct responsible, scientifically worthy human stem cell research, including human embryonic stem cell research, to the extent permitted by law." Exec. Order No. 13505, 74 Fed. Reg. 10,667 (Mar. 9, 2009).

117. Consolidated Appropriations Act of 2010 § 505.

118. For example, the mission of the Fulton County, Georgia, Department of Health and Wellness is "to promote, protect and assure the health and Wellness of the people of Fulton County." Health & Wellness, FULTON CNTY. GOV'T, http://www.fultoncountyga.gov/dhw-about (last visited Mar. 23, 2013). The mission of the Fulton County, Georgia, Police Department is "to preserve life, protect property, and maintain order through a partnership between the department and the citizens." FULTON COUNTY POLICE DEP'T, http://www.fultonpolice.org/ (last visited Mar. 23, 2013).

119. Steven R. Salbu, Needle Exchange, HIV Transmission, and Illegal Drug Use: Informing Law and Public Policy with Science and Rational Discourse, 33 HARV. J. ON LEGIS. 105, 110 (1996). Some states attempt to write legislation authorizing SEPs within "potentially hostile anti-drug laws." Id.

120. See generally Scott Burris et al., Addressing the "Risk Environment" for Injection

policy give rise to the possibility of continued police confiscation of hypodermic syringes and needles. Researchers predict an increase in arrests as the visibility of SEPs increases.[121] Yet law enforcement views can change with better understanding of SEP operations.[122] Moreover, as Spokane County Health District[123] demonstrates, the endorsement of public health authorities can tip the balance in favor of public health priorities when conflicts arise with law enforcement, creating a more favorable environment for SEPs.

Potential problems with the split authority between public health officials and law enforcement are not simply theoretical. As indicated previously, HHS's "Guiding Principles" for obtaining federal funding required "documentation that local law enforcement and local public health authorities have agreed upon the location for the operation of the [SEPs]."[124] HIV/AIDS advocacy organizations expressed concern about the interpretation of this language because it requires public health and law enforcement to agree about the location of an SEP when seeking federal funding.[125] In a letter to the Division of HIV/AIDS Prevention at CDC, eight advocacy groups outlined issues with giving law enforcement organizations a formal role in the decision-making process.[126] They argued that "syringe access programs remain an arena governed by a delicate balance between public health imperatives and law enforcement agendas." Public health officials have authority over the programs, and giving law enforcement

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Drug Users: The Mysterious Case of the Missing Cop, 82 MILBANK Q. 125 (2004); Jonathan Cohen & Joanne Csete, As Strong as the Weakest Pillar: Harm Reduction, Law Enforcement and Human Rights, 17 INT'L J. DRUG POL'Y 101 (2006); Zita Lazzarini et al., Evaluating the Impact of Criminal Laws on HIV Risk Behavior, 30 J. L., MED. & ETHICS 239 (2002); Beletsky et al., supra note 70; Silverman et al., supra note 107.

121. Silverman et al., supra note 107; Beletsky et al., supra note 70.

122. For example, Wilmington, Delaware's Police Chief was initially against the initiation of SEPs:

> [B]efore the pilot program was authorized, the Wilmington Police Chief spoke out adamantly against the initiative: "No matter how you look at this issue, both sides would have to agree that it boils down to putting clean needles in the hands of the addicted so they can continue their illegal and dangerous activity."

Silverman et al., supra note 107, at 6. However, after two years of "relation-building efforts," the Police Chief changed his mind about the legality of SEPs. "My opinion of the program is no longer relevant, but the success of this program is. . . . I'm committed to providing leadership and cooperation from the law-enforcement end." Id. at 6 (alteration omitted). But see generally Beletsky et al., supra note 70 (concluding that police activities still significantly limit SEP operations).

123. See discussion supra notes 80–89 and accompanying text.

124. DEP'T OF HEALTH & HUMAN SERVICES, supra note 61, at 2 (emphasis added); see also discussion supra Part II.A.

125. See Letter to Jonathan Mermin, supra note 109.

126. Id.

officials a formal role in funding decisions "would jeopardize that delicate balance."[127]

The final problem with the language of the modified ban is its prohibition on using federal funds for SEPs in locations deemed "inappropriate" without defining the term "inappropriate" or "appropriate" in the statute or in the HHS Guidelines.[128] The House and Senate Joint Appropriations Committee removed a proposed "1,000-foot Rule"[129] that would have prohibited operation of an SEP within 1,000 feet of a public or private daycare center, elementary school, vocational school, secondary school, college, junior college or university; or within 1,000 feet of any public swimming pool, park, playground, video arcade or youth center, or an event sponsored by any such entity.[130] Although it severely limited possible siting for SEPs—especially within urban environments—the 1,000-foot proposed rule is the only clue as to appropriate location requirements.[131] Given the lack of guidance, the difference between "public health imperatives" and "law enforcement agendas" could, again, result in varying definitions of an "inappropriate" location for purposes of eligibility for federal funding.[132]

Because of these three problems with the language of the modified ban, even if President Obama reinstated his modified provision into the Consolidated Appropriations Act, its effectiveness as a tool for true SEP promotion is limited. Additionally, as discussed in the next section, using the appropriations process itself is unlikely to bring about the support for SEPs that is needed to achieve an AIDS-free generation.

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127. See id.

128. Consolidated Appropriations Act of 2010, Pub. L. No. 111-117, § 505, 123 Stat. 3034, 3279.

129. Darryl Fears, House Passes Bill that Lifts Ban on Using Federal Money for Needle Exchanges, WASH. POST, July 25, 2009, http://www.washingtonpost.com/wp-dyn/content/article/2009/07/24/AR2009072403632.html (noting that while the House Bill removed the ban on federal funding for SEPs, a 1,000-foot rule would prevent SEPs in Washington D.C. from operating in the city).

130. Ryan Grim, House Dems Reverse Obama, Remove Ban on Needle Exchange Funding, HUFFINGTON POST (Aug. 10, 2009), http://www.huffingtonpost.com/2009/07/10/house-dems-reverse-obama_n_229551.html. But "[t]his restriction is really designed to shut down" needle exchange programs, rather than identify "appropriate" locations. Id.; see also Mike Lillis, Congress Looks to Lift Two-Decade Ban on Federal Needle Exchange Funds, WASH. IND. (July 31, 2009), http://washingtonindependent.com/53339/congress-looks-to-lift-two-decade-ban-on-federal-needle-exchange-funds (accusing House Appropriations Chairman David Obey of including the ban to "appease conservative critics"). Id.

131. See Fears, supra note 129. As a practical matter, the 1,000-foot rule could have prevented existing SEPs who operated within that boundary from obtaining federal funding unless they relocated.

132. Letter to Jonathan Mermin, supra note 109.

B. A Failure of Approach

An alternative approach could explicitly authorize funding for SEPs in the appropriations bill. Other provisions in appropriations bills provide explicit authorization for the use of federal funds.[133] By publishing a more explicit authorization, Congress can clarify that the ban no longer exists. Such a provision in the Consolidated Appropriations Act, phrased similarly to other affirmative provisions in the Act, could read: "The Secretary of Health and Human Services is authorized to make available funds to be used to distribute any needle or syringe for the purpose of preventing the spread of blood borne pathogens in any location."[134]

The proposed funding provision avoids the three problems identified in the previous modified ban and sets the course for an affirmative program. The affirmative phrasing portrays a distinctly different political intent from the current SEP funding provision.[135] The proposed provision also clearly indicates that the HHS Secretary controls the fund dispersion. This minimizes potential battles between local law enforcement and public health authorities. Finally, the affirmative provision removes the arbitrary "appropriate location" requirement.

This affirmative statement, explicitly authorizing SEPs, could become federal law in the same way President Obama implemented the modified ban—by inserting it into the appropriations bill. The benefits and drawbacks of this approach become evident with a better understanding of the appropriations process. The U.S. House and Senate Committees on Appropriations have been in charge of authorizing federal spending since the 1860s.[136] The Constitution requires that such appropriations begin in the House of Representatives, and may be amended or approved by the Senate.[137] Each year the committees assign, prohibit, and renew funding for federal

133. Consolidated Appropriations Act of 2010 § 505. For example, section 504 affirmatively enables funding "official reception and representation expenses" by the Department of Labor and Education: "The Secretaries of Labor and Education are authorized to make available not to exceed $28,000 and $22,000, respectively, from funds available for salaries and expenses . . . ." Id. § 504 (emphasis added).

134. This proposed provision is based on the language appearing in similar appropriations bill provisions. See id.

135. Consolidated Appropriations Act of 2012, Pub. L. No. 112-74, § 807, 125 Stat. 786, 941.

136. See About the Committee, U.S. HOUSE OF REPRESENTATIVES COMM. ON APPROPRIATIONS, http://appropriations.house.gov/About/ (last visited Mar. 18, 2013); see also About the Committee, U.S. SENATE COMM. ON APPROPRIATIONS, http://www.appropriations.senate.gov/about-history.cfm (last visited Mar. 18, 2013).

137. "All Bills for raising Revenue shall originate in the House of Representatives; but the Senate may propose or concur with Amendments as on other Bills." U.S. CONST. art. I, § 7, cl. 1.

programs.[138] At the end of each fiscal year—typically September 30—federally funded projects halt spending until a new appropriations bill passes.[139] Because appropriations for federal funding always depend on the yearly passage of a new bill, a certain amount of instability exists for federally funded programs. "Riders," like the controversial SEP funding provision, must survive from year to year.[140]

Looking at both the yearly renewal requirement for appropriations bills and the inertia inherent in_passing bills in Congress, the appropriations process may be the more politically expedient option for earning federal funding for SEPs.[141] However, for these same reasons, the appropriations option is instable, as evidenced by the reinstatement of the ban in 2012.[142] A permanent, affirmative statement that the federal government supports SEPs is necessary to encourage states to allow them.

V. THE NEED FOR EXPLICIT FEDERAL LAW SUPPORTING SEPS

The current federal position on SEPs creates a significant barrier to HIV prevention and the achievement of an AIDS-free generation. The ban's brief absence and subsequent reinstatement demonstrate why stronger endorsement on a federal level is needed. The modified ban failed to improve political and legal conditions for existing SEPs because it lacked teeth and

138. 63C AM. JUR. 2D Public Funds § 31 (2013).

139. Id. § 40.

140. An appropriations bill must originate in the House of Representatives, and, once the House passes the bill, must be approved by the Senate. As indicated by the fact that Congress has failed for fifteen consecutive years to pass an appropriations bill on time (the deadline is October 1), it is no easy task. See Walter Alarkon, Another Omnibus Appropriations Bill Likely as the End of the Year Approaches, THE HILL (Nov. 12, 2009), http://thehill.com/homenews/house/67453-another-omnibus-likely-as-appropriations-bills-remain. A consolidated or omnibus appropriations bill combines several fiscal year appropriations bills when one has not been passed as the end of the calendar year approaches. Id.

141. The process of passing a bill can be arduous, and the solution is not politically expedient. The challenges of passing legislation apply beyond the appropriations process. A sponsoring Representative or Senator must first introduce the proposal, and, even if both chambers of Congress vote to pass a bill, it must still survive presidential scrutiny. See generally S. DOC. NO. 105-14 (1997). In addition to the inherent inertia in the legislative process, partisanship in today's Congress significantly limits the ability to move legislation forward so much so that comparisons to Truman's "Do-Nothing Congress" abound. See, e.g., Amanda Terkel, 112th Congress Set To Become Most Unproductive Since 1940s, HUFFINGTON POST (Dec. 28, 2012, 9:37 AM), http://www.huffingtonpost.com/2012/12/28/congress-unproductive_n_2371387.html.

142. The appropriations process may also make it less likely that a presidential administration will fight for the provision. Support for funding of SEPs could jeopardize funding for numerous other programs important to the administration, the federal government as a whole, and the public.

permanence. Its quick reinstatement confirmed the need for more forceful and lasting endorsement of SEPs. In support of the argument that the federal government must act to legally and financially support SEPs, this Article first looks to other ways the federal government has influenced local policy through its own actions. It next considers what affirmative endorsement for SEPs should look like.

A. Lessons from Other Federal Funding Examples

The federal government has limited powers—primarily the authority to tax, spend, and regulate interstate commerce enumerated in the Constitution.[143] The Tenth Amendment reserves all remaining powers to the states. In particular, protection of public health is traditionally a state power. Accordingly, the federal government cannot directly authorize or prohibit policies for public health programs such as SEPs. However, it can and does indirectly influence policy through funding decisions.[144] When Congress banned federal funds for SEPs, it symbolically disapproved of the programs.[145] This position appeared to gain support when, in 1993, after reviewing a University of California-San Francisco study declaring that SEPs deserve federal funds, the CDC made no statement regarding federal funding. Health officials interpreted the inaction as skepticism.[146] President Obama countered those positions when he modified the ban after promising support for HIV prevention and SEPs.[147]

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143. LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 78 (2d ed. 2008).

144. Salbu, supra note 119, at 117 (observing that federal laws aim to control funding "[b]ecause direct public health policy traditionally falls within the states' police powers").

145. Congress banned funding for syringe and needle exchange programs in 1988, in the wake of President Reagan's "War on Drugs." See Health Omnibus Programs Extension of 1988, Pub. L. No. 100-607, 102 Stat. 3048 (1988) (codified at 42 U.S.C. § 300ee-5 (2006)).

146. Salbu, supra note 119, at 117–19, 168–69 (reviewing federal actions and their influence on the success of authorizing SEP).

147. See, e.g., Fears, supra note 129. AIDS advocate Ronald Johnson, who considered the legislation to remove the funding ban, emphasized the "recognition by the federal government of the proven cost-effectiveness and impact of syringe exchange as a very important tool for prevention of HIV infection and viral hepatitis." Id. The CDC described the studies of cost-effective as follows: "At an average cost of $0.97 per syringe distributed, SEPs can save money in all IDU populations where the annual HIV seroincidence exceeds 2.1 per 100 person years. The cost per HIV infection prevented by SEPs has been calculated at $4,000 to $12,000, considerably less than the estimated $190,000 medical costs of treating a person infected with HIV." Syringe Exchange Programs, supra note 16 (footnotes omitted). Similarly, President Obama stated that his repeal of the ban on federal funds for human embryonic stem cell research "restore[d] our commitment to science." President Barack Obama, Remarks at the Signing of Stem Cell Executive Order and Scientific Integrity Presidential Memorandum (Mar. 9, 2009), available at http://www.

Federal funding influences public health policy in a variety of ways. For example, in the 1970s, the federal government allocated transportation funds to states on the condition they change maximum highway speeds to fifty-five miles per hour.[148] Similarly, the federal government used funding incentives to persuade states to adopt names-based HIV reporting.[149]

Coextensively, prohibitions on federal funding are common in controversial areas of science and can have profound effects on a field.[150] The federal ban on funding related to human embryonic stem cell ("hESC") research demonstrates why explicit federal support for SEPs is necessary to achieving an AIDS-free generation. Research on hESC is controversial because, while it promises much in terms of scientific advancement, it destroys human embryos.[151] Until 1993, federal regulations banned federal

whitehouse.gov/the_press_office/Remarks-of-the-President-As-Prepared-for-Delivery-Signing-of-Stem-Cell-Executive-Order-and-Scientific-Integrity-Presidential-Memorandum.

148. Emergency Highway Energy Conservation Act, Pub. L. No. 93-239, 87 Stat. 1046 (1974).

149. See Ctrs. for Disease Control & Prevention, Guidelines for National Human Immunodeficiency Virus Case Surveillance, Including Monitoring for Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome, 48 MORBIDITY & MORTALITY WKLY. REP. 1 (1999) ("CDC will evaluate and award proposals for federal funding of state and local surveillance programs based on their capacity to meet these performance standards. At that time, CDC will require that recipients of federal funds for HIV/AIDS case surveillance adopt surveillance methods and practices that will enable them to achieve the standards to ensure that federal funds are awarded responsibly."); Letter from Julie Louise Gerberding, Director of Ctrs. for Disease Control & Prevention, to Colleagues (Jul. 5, 2005), available at http://www.cdc.gov/hiv/pubs/070505_dearcolleague_gerberding.pdf (strengthening name-based surveillance from advice to a recommendation, thus adding it to the list of performance standards established in 1999). Most recently, the federal government sought to condition receipt of all state Medicaid funds on expansion of Medicaid eligibility under the Patient Protection and Affordable Care Act. The U.S. Supreme Court found this particular approach to be unconstitutionally coercive. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2607 (2012).

150. See CHRISTOPHER THOMAS SCOTT, STEM CELL NOW: FROM THE EXPERIMENT THAT SHOOK THE WORLD TO THE NEW POLITICS OF LIFE 6–7 (2006); Paul Root Wolpe & Glenn McGee, "Expert Bioethics" as Professional Discourse: The Case of Stem Cells, in THE HUMAN EMBRYONIC STEM CELL DEBATE: SCIENCE, ETHICS, AND PUBLIC POLICY 190–92 (Suzanne Holland et al. eds., 2001); Edward A. Fallone, Funding Stem Cell Research: The Convergence of Science, Religion & Politics in the Formation of Public Health Policy, 12 MARQ. ELDER'S ADVISOR 247 (2011). Politics, religion, and scientific research converge, and the interests of conflicting interest groups have affected stem cell research using human embryonic stem cells (hESC). Id. at 247. When AIDS first appeared in the United States in the 1980s, politicians and scientists clashed over funding sources for vaccine research. Id. at 249. Similarly, controversy arose regarding public funding for promotion of condom use and education. Id.; see also O. Carter Snead, Science, Public Bioethics, and the Problem of Integration, 43 U.C. DAVIS L. REV. 1529, 1532 (2010). Uncertain funding for stem cell research is an example of the conflicts that occur when trying to satisfy both moral principles and science, resulting in the dilemma of "public bioethics." Id.

151. Snead, supra note 150, at 1544.

funding for any hESC research.[152] Beginning with President Clinton's administration in 1993, and continuing through subsequent administrations, the status of federal funding reflects each Presidency's moral and ethical views on hESC research.[153] Under President Clinton, Congress repealed the funding moratorium. Clinton's administration initiated an investigation, led by the National Institutes of Health ("NIH"), to promulgate recommendations on future funding.[154] Before further funding was authorized, however, a newly elected Republican Congress enacted the Balanced Budget Downpayment Act, which prohibited funding for research that created or destroyed human embryos.[155]

President Clinton's Secretary of the Department of Health and Human Services, Donna Shalala, attempted to work around this ban by determining that it applied to the destruction of embryos, permitting federal monies to be used for research on privately created cell lines.[156] However, even after Secretary Shalala's announcement, few researchers applied for funds because of the likelihood of a policy reversal.[157] These fears were realized in 2001 when President Bush limited federal funding to the seventy-eight cell lines existing at the time of his announcement.[158]

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152. Additional Protections for Pregnant Women, Human Fetuses and Neonates Involved in Research, 45 C.F.R. § 46.204(d) (1982), repealed by National Institutes of Health Revitalization Act of 1993, Pub. L. No. 103-43, § 121(c), 107 Stat. 122. The Ethics Advisory Board (EAB) was required to annually approve funding for research involving human embryos. Interestingly, the ban occurred because the EAB's charter expired in 1979 without renewal, but the federal requirement of EAB funding approval remained. Snead, supra note 150, at 1545.

153. Snead, supra note 150, at 1545. Federal funds for scientific research are awarded or withheld by the President, primarily through allotment to the National Institutes of Health. Id.

154. National Institutes of Health Revitalization Act of 1993, Pub. L. No. 103-43, 107 Stat. 122. Section 113(b) ensured federal funding by requiring that, "in the case of any proposal for research on the transplantation of human fetal tissue for therapeutic purposes, the Secretary of Health and Human Services may not withhold funds for the research . . . ." Id. § 113(b). This legislation further removed the EAB approval requirement for these funds. Id. § 121(c).

155. Balanced Budget Downpayment Act, I, Pub. L. No. 104-99, § 128, 110 Stat. 26, 34 (1996). The provision explicitly prohibited funding for "the creation of a human embryo or embryos for research purposes; or [] research in which a human embryo or embryos are destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero." Id. Congress "put teeth to the ban in the form of a funding rider" renewed annually in the Appropriations Act. SCOTT, supra note 150, at 153–54.

156. SCOTT, supra note 150, at 154.

157. Id. at 154–55. At the time NIH began soliciting proposal applications in 2000, presidential candidate Governor George W. Bush promised to reverse the policy if elected. Id. at 155.

158. Id. at 155. President Bush made a televised announcement on August 9, 2001, that only research on existing cell lines could use federal funds. Id. In 2009, federal support shifted back in favor of stem-cell research when President Obama lifted the ban on funding. See

As a result of the federal government's internal struggle to balance moral, political, and scientific interests, the United States has fallen behind its global counterparts in its stem-cell-based medical research.[159] As Christopher Scott explained, "No young scientist cares to pin his or her career . . . on a subject that could be outlawed at any moment."[160] The long-term manipulation of federal funding policies with each administration has created a chilling effect that makes new scientists reluctant to enter the field and makes existing organizations fear that they will unintentionally violate federal regulations.[161]

Because of the promise of hESC research, states stepped in to fill the federal funding void, mitigating—but not eliminating—the effects of the federal funding ban.[162] States are less likely to fill the void in SEP funding, in light of conflicting federal drug policies and the absence of strong federal support. Indeed, as the evidence shows, state authorization of SEPs has been impeded by a twenty-one-year ban on federal funding. Other also see a

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Remarks of President Barack Obama, supra note 147 ("[W]e will lift the ban on federal funding for promising embryonic stem cell research. We will vigorously support scientists who pursue this research.").

159. Scholars discuss the repercussions only ten years later:

> [T]he uncertain availability of federal funds for hESC research over the past decade has slowed progress towards translating basic science into cures, has deterred graduate students and other researchers from entering the entire field, and has jeopardized the United States' leadership position in stem cell research versus our global competitors.

Fallone, supra note 150, at 293. Aaron D. Levine, Identifying Under- and Overperforming Countries in Research Related to Human Embryonic Stem Cells, 2 CELL STEM CELL 521, 523 (2008) (empirically examining the relationship between hESC policy and hESC research publications and finding the United States "the largest underperformer by the metric used here").

160. SCOTT, supra note 150, at 176 (discussing how instability and uncertainty among federal funding policies for hESC research has stunted the progress of medical research in the U.S.); see also Aaron D. Levine, Policy Uncertainty and the Conduct of Stem Cell Research, 2 CELL STEM CELL 521 (2008) (surveying U.S. stem cell scientists regarding effect of uncertainty of funding following legal challenge to President Obama's lifting of ban on hESC research funding on their research).

161. SCOTT, supra note 150, at 176; see also Sarah A. Webb, U.S. Embryonic Stem Cell Research: Can Young Researchers Succeed?, SCIENCE CAREERS (Sept. 22, 2006), http://sciencecareers.sciencemag.org/career_magazine/previous_issues/articles/2006_09_22/noDOI.64905739594056635 7. Because of the limitations placed on federal funding, before 2009 research facilities had to take extreme measures to ensure that research using federal funds did not overlap with non-federally-funded activities. Id. In fear of violating a federal law, researchers used separate equipment for federally funded research, and some research organizations even built separate buildings for their federally funded work. Id. Separate equipment and buildings is not feasible for all researchers, especially new operations that do not receive enough money to afford duplicate operations. Id.

162. Aaron D. Levine, Research Policy and the Mobility of Stem Cell Scientists, 24 NATURE BIOTECHNOLOGY 865 (2006) (discussing impact of state hESC policies on mobility of stem cell scientists).

connection between the stem cell funding ban and the ban on federal funding of SEPs. One author has called on President Obama to lift the prohibition, stating, "While lifting a similarly boneheaded ban on stem cell research, Obama issued a memo to agency heads, demanding, 'Science and the scientific process must inform and guide decisions of my administration.' Time to walk the talk, Mr. President."[163]

President Obama's own National HIV/AIDS strategy and his administration's Blueprint for addressing the global HIV/AIDS pandemic calls on science to guide federal investment. Given that the brief period under the modified ban did little to facilitate SEP funding,[164] and that only seventeen jurisdictions have passed statutes authorizing SEPs, it is clear that there is reluctance to operate such programs without federal support.[165] A different approach is warranted.

B. Explicitly Authorizing SEPs and SEP Funding by Statute

If President Obama's administration is serious about an AIDS-free generation, it must support all the tools necessary to achieve it. Anthony Fauci, Director of the National Institute of Allergy and Infectious Disease ("NIAID") recognizes the need for multiple approaches: "Achieving [the] goal [of an AIDS-free generation], however, will require implementing a multifaceted global effort to expand testing, treatment and prevention programs, as well as meet the scientific challenges of developing an HIV vaccine and possibly a cure."[166] However, neither Fauci nor the Blueprint include prevention strategies for IDUs in their plans of action. This critical omission could undermine the ability to reach the goal. HIV/AIDS advocates recognize the need for policies that address those populations disproportionately affected by HIV, including IDUs, who are "most poorly

163. Kai Wright, Letting Science Lead, Again, ROOT (July 28, 2009), http://www.theroot.com/views/letting-science-lead-again; see also Obama's Budget Proposal Expands HIV Prevention, Remains Silent on Syringes, AIDS FOUND. OF CHICAGO, http://archive.aidschicago.org/advocacy/Obama_Budget.php (last modified May 8, 2009).

164. During the few years before Congress reinstated the ban, SEPs reported that the lack of infrastructure for implementing federal funding requirements continued to pose a significant barrier for effectively receiving and using the funds. Green et al., supra note 25, at e14.

165. California is one of the fifteen states that have authorized SEPs. See CAL. HEALTH & SAFETY CODE § 121349 (West 2012). The statute's legislative findings and declarations rely on information from reports created by the federal government. See id. See also Tempalski et al., supra note 18 (reviewing the influence of politics on public health policy decision-making for SEP authorization as well as health policies of the past). Interestingly, California also authorized stem cell research when the federal government did not. See CAL. CONST. art. XXXV, § 5.

166. Fauci & Folkers, supra note 46, at 344.

served by both the existing prevention and medical systems."[167] The challenge is in "connect[ing] the political will to the appropriations process. Those are very big dots."[168] Placing the political debate about authorization and funding of SEPs within the context of the larger goal of achieving an AIDS-free generation should make the request more palatable.

1. How to Authorize SEPs

The experience of funding through the appropriations process suggests the need for a more permanent, affirmative method for expressing legal and financial support for SEPs. As suggested in Part III, the language should clearly express unequivocal support for SEPs as a prevention measure and should explicitly authorize funding. To make the strongest impact for SEPs,[169] any such statement should be included as part of a national HIV/AIDS-prevention and treatment program. The HIV/AIDS-prevention community has already seen similar success with the Ryan White Comprehensive AIDS Resources Emergency ("CARE") Act of 1990, which provides essential support to HIV and AIDS patients throughout the United States. Including SEPs in a comprehensive statute takes discretion out of the hands of appropriations committees. Situating SEPs within the panoply of available tools to combat HIV could also minimize political battles. Further, passing a statute would also create a record showing that SEPs are a public health necessity, much like the statements that were so useful in Spokane County Health District.[170]

The Ryan White CARE Act exemplifies the strengths of an affirmatively authorized funding program and provides a workable template for SEP funding.[171] It provides federal funds for low-income, underinsured, and uninsured people living with HIV, and their families.[172] The program also

167. John-Manuel Andriote, How Close Are We to an AIDS-Free Generation?, ATLANTIC (2012), http://www.theatlantic.com/health/print/2012/12/how-close-are-we-to-an-aids-free-generation/265857/ (last visited Mar. 23, 2013) (quoting Nancy Mahon, Global Executive Director of the MAC AIDS Fund and chair of the Presidential Advisory Council on HIV/AIDS).

168. Id. Stefano Bertozzi, M.D., Ph.D, director of the Bill and Melinda Gates Foundation's HIV program, echoes Mahon's sentiments: "There is an opportunity to invest more intelligently [ ] to make sure that we are investing in the most effective interventions and make sure they are most focused on populations at greatest risk." Id.

169. For discussion of the expressive function of law, see Cass R. Sunstein, On the Expressive Function of Law, 144 U. PA. L. REV. 2021 (1996); Richard H. McAdams, An Attitudinal Theory of Expressive Law, 79 OR. L. REV. 339 (2000).

170. See discussion supra Part II.A.

171. Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White CARE Act), Pub. L. No. 111-87, 123 Stat. 2885 (2009).

172. Health Res. & Servs. Admin., U.S. Dep't of Health & Human Servs., Legislation,

funds service providers, based on geographic location, population need, and services provided.[173] The legislation is divided into "parts" to address a comprehensive list of variable concerns for patients and providers[174] and does not rely on yearly appropriations approval. It provides a stable funding source for programs.[175]

Australia's experience further supports this approach. With bipartisan political support, Australia established federally funded SEPs in 1986.[176] The government-funded SEPs are users' primary source of injecting equipment. The low prevalence of HIV among Australian IDUs evidences the SEPs' success.[177]

While affirmative federal legal and financial support for SEPs is essential to achieving an AIDS-free generation, there are various political challenges in achieving the necessary statutory change. Congressional opponents to SEPs tried for many years to permanently ban the use of federal funds for such programs by passing an independent statute.[178] Others in Congress attempted to prevent prohibiting the use of federal funds for SEP operation without success.[179] In the current political climate, passing any statute is

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HRSA HIV/AIDS PROGRAMS, http://hab.hrsa.gov/abouthab/legislation.html (last visited Nov. 16, 2012).

173. Id.

174. About the Ryan White HIV/AIDS Program, U.S. DEP'T OF HEALTH & HUMAN SERVS., http://hab.hrsa.gov/abouthab/aboutprogram.html (last visited Mar. 23, 2013). Part A provides emergency assistance to areas that are most severely affected by HIV/AIDS; Part B establishes grants for states; Part C addresses intervention services; Part F provides funds for a variety of "Demonstration and Training" programs. See id.

175. President Bush reauthorized the Act in 2006 after extending it for one year when Congress could not agree on changes to the Act during its 2005 reauthorization. Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. No. 109-415, 120 Stat. 2767 (2006); see also HENRY J. KAISER FAMILY FOUND., THE RYAN WHITE CARE ACT: A SIDE-BY-SIDE COMPARISON OF PRIOR LAW TO THE NEWLY REAUTHORIZED CARE ACT 1 (2006), available at http://www.kff.org/hivaids/upload/7531-03.pdf. President Obama signed the Ryan White HIV/AIDS Treatment Extension Act of 2009, extending the program for another four years. Pub. L. No. 111-87, 123 Stat. 2885 (2009).

176. Topp et al., supra note 41, at 836.

177. Id. at 836, 837–38. Australian SEPs are "legal, relatively widespread and generally accessible to the population of [IDUs]." Id. at 836, 840.

178. For example, in 1998, the House of Representatives passed a bill that would permanently prohibit the use of any funds under any law from being used for the distribution of needles and syringes. H.R. 3717, 105th Cong. (1998); see also H.R. 982, 106th Cong. (1999) ("Notwithstanding any other provision of law, none of the amounts made available under any Federal law for any fiscal year may be expended, directly or indirectly, to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.").

179. In 2008, a bill "[t]o permit the use of Federal funds for syringe exchange programs" was referred to the House Committee on Energy and Commerce but went no further. H.R. 6680, 110th Cong. (2008). The bill proposed that "nothing shall prohibit the use of Federal

challenging, and it is not clear whether there is a lawmaker with the political will and clout to advance the cause.[180] IDUs typically do not have champions in the houses of power. However, the goal of an AIDS-free generation is not reachable without addressing the prevalence of HIV in the IDU community.

Affirmatively authorizing funding for the distribution of needles and syringes for disease transmission prevention is the ideal solution for funding problems facing SEPs. SEPs could operate under more stable funding conditions if they are no longer funded through an appropriations bill. In turn, this type of legislation sends a clear message to the states that the federal government actively encourages SEPs. Perhaps then states will be encouraged to change their drug paraphernalia statutes, recognize the realities of a thirty-year epidemic, move past the failed War on Drugs, and authorize SEP operations.

VI. CONCLUSION

Since the early 1980s, when scientists first discovered HIV,[181] the virus has spread throughout the American population, resulting in an epidemic that has caused over 500,000 deaths.[182] Public health professionals and HIV/AIDS prevention advocates identify SEPs as an effective prevention strategy.[183] Providing IDUs with a clean needle for every injection significantly reduces the risk of transmitting HIV to another person.[184] However, because SEPs are incompatible with the "War on Drugs," an avoidable mode of transmission continues to spread the virus.

Efforts of law enforcement agencies—consistent with federal policy—

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funds to establish or carry out a program of distributing sterile syringes." Id.

180. Until his death in 2009, Senator Edward Kennedy was considered the "champion of social justice," proposing legislation to promote the needs of the general population, most often in terms of health care reform. Arnold Schwarzenegger, Edward Kennedy, TIME (Apr. 30, 2009), http://www.time.com/time/specials/packages/article/0,28804,1894410_1893847,00.html; see also Martin F. Nolan, Kennedy Dead at 77, BOSTON GLOBE (Aug. 26, 2009), http://www.boston.com/news/local/massachusetts/articles/2009/08/26/kennedy_dead_at_77/?page=1 (calling Senator Kennedy the "'last lion' of the Senate"). However, it is not clear that there is another "champion" to take Senator Kennedy's place.

181. See supra note 10.

182. See supra note 11; see also HENRY J. KAISER FAMILY FOUND., THE HIV/AIDS EPIDEMIC IN THE UNITED STATES 1 (2012), available at http://www.kff.org/hivaids/upload/3029-12.pdf.

183. See supra notes 37–38; Access to Sterile Syringes, supra note 15. Legislation attempting to authorize SEP funding also includes legislative findings. For example, House Bill 6680 included findings that SEPs were successful in reducing HIV transmission and were cost-effective, but did not increase the prevalence of illegal drug use or increase an IDU's drug use. H.R. 6680, 110th Cong. (2008).

184. Guardino et al., supra note 63.

discourage the distribution of drug paraphernalia for use with illegal drugs.[185] The punitive focus on drug users hinders policies that could reduce HIV among IDUs.[186] Federal support for SEPs has been politically controversial and erratic. Federal policy regarding injecting drug use culminated in an (almost) uninterrupted ban on the use of federal funding for SEPs since 1989. This policy represents a significant barrier to the President's stated goal of achieving an AIDS-free generation. Without federal support, states have been unwilling or unable to consistently support SEPs. Accordingly, the federal government must act in unequivocal support for SEPs as part of a comprehensive HIV prevention program, and provide funding to facilitate prevention services for IDUs. Only with decisive federal funding and guidance can an AIDS-free generation be realized.

185. See supra notes 65–69 and accompanying text. Law enforcement agencies operate under a "zero tolerance" policy toward illegal drug use.

186. See supra notes 69–70 and accompanying text.