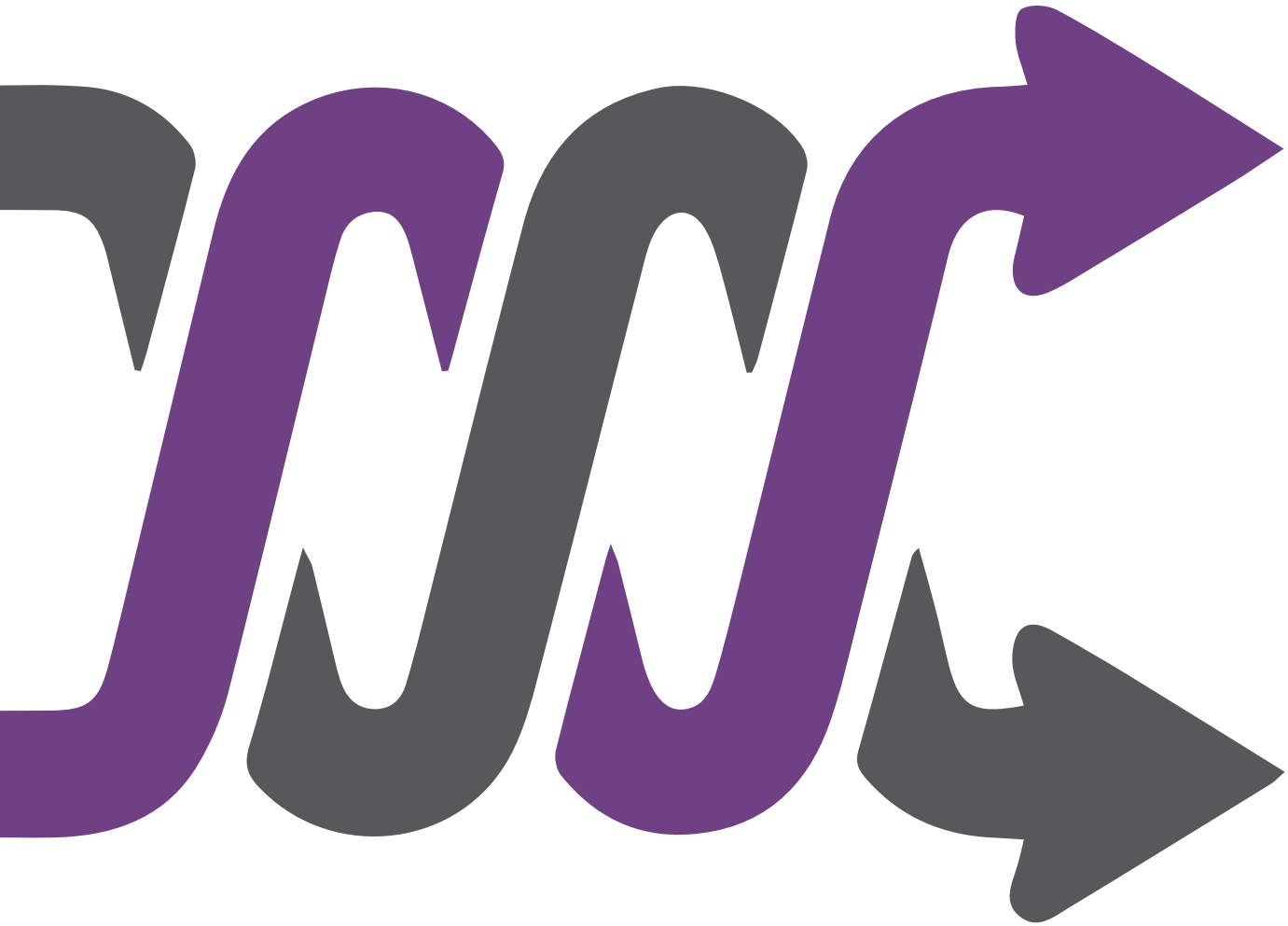
TOOLKIT

NATIONAL LGBTQ TASK FORCE

THE CENTER FOR HIV LAW & POLICY

The Intersection of Syringe Use and HIV Criminalization

An Advocate's Toolkit



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The Center for HIV Law and Policy is a national resource and advocacy organization working to advance the rights of people affected by HIV. We combine an online HIV Policy Resource Bank, a creative national advocacy agenda, and case assistance focused on systems and institutions with significant impact on marginalized communities.

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The mission of the National LGBTQ Task Force is to build the grassroots power of the lesbian, gay, bisexual and transgender (LGBTQ) community. By training activists and building the organizational capacity of our movement, we work to create a nation that respects the diversity of human expression and identity and creates opportunity for all.

Understanding the Intersection of Syringe Use and HIV Criminalization

People living with HIV (PLHIV) who inject substances face criminalization in three ways:

- Criminal laws that target PLHIV who share injection equipment;
- Laws criminalizing possession, purchase, or distribution of drug paraphernalia, and;
- Laws criminalizing drug use and possession.

HIV and substance use are public health issues, not criminal legal issues. In 2014, the Department of Justice called for states to reform HIV-specific criminal laws in part because they run counter to public health best practices.[1] In 2016, the Surgeon General released a report recognizing that substance use should be considered a public health issue, rather than a criminal legal issue.[2]

For PLHIV who inject substances, the barriers to care posed by criminalization can be fatal: 6% of new HIV diagnoses are attributed to injection drug use alone,[3] but people who use injection drugs account for almost 30% of deaths among those diagnosed with AIDS.[4] Broad reform must be prioritized in order to shift away from the criminal legal approach that has dominated the U.S. response to HIV and substance use and toward a rights-based, public health approach.

Harm Reduction: The Theory That Guides Syringe Access Advocacy

Harm Reduction principles are the foundation of effective syringe access advocacy. Harm Reduction is a comprehensive approach that centers the human rights of people who inject substances by offering practical strategies to reduce the negative consequences associated with drug use, like improving access to sterile syringes. The harm reduction approach centers the individual right to bodily autonomy [5] and extends to people who inject hormones, silicone, or steroids for gender affirmation. Centering people through harm reduction principles helps achieve long-term public and individual health outcomes. [6]

There is much to gain from HIV criminalization reform advocates adopting a harm reduction approach and joining forces with advocates for syringe access and drug decriminalization. Advocates on both sides would benefit from embracing the mutually reinforcing concepts of bodily autonomy, recognition of the role that stigma, poverty, and structural racism, transphobia and homophobia play in the HIV epidemic, and the need to respect, center and amplify the voices of those who are most affected.

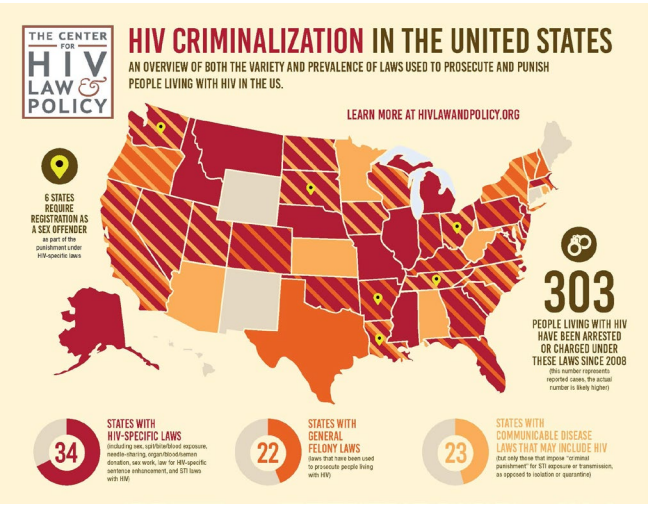
HIV-Specific Laws that Criminalize Syringe Sharing

More than 30 U.S. states and territories have HIV-specific criminal laws that punish exposure, non-disclosure, or transmission of HIV.[7] Twelve of those states and one U.S. territory have provisions criminalizing syringe sharing or sale by PLHIV, most of which impose a felony charge.[8] While there are few known prosecutions under HIV criminal laws for sharing syringes, the fact that these laws are on the books intensifies HIV stigma and poses a constant threat of incarceration for people who already tend to be socially isolated.[9] Stigma can have very real consequences: people who use drugs may be less likely to seek testing or treatment for HIV if they fear associated legal consequences.

For example, a PLHIV in Georgia who shares a syringe may be charged with a felony and imprisoned up to 10 years (see inset).

Defenses available under Georgia's law and many other states' HIV-specific laws require that PLHIV either disclose or be unaware of their HIV status prior to sharing a syringe. However, disclosure is often difficult to prove. Criminal penalties that hinge on knowledge of one's positive status may increase HIV stigma, which can disincentivize testing.[10]

Most HIV criminal laws do not require intent to transmit HIV, actual transmission, or substantial risk of transmission of HIV. On average, HIV transmission occurs only once per 160 instances of sharing a syringe with a PLHIV.[11]



O.C.G.A. § 16-5-60 (2010):

Reckless conduct causing harm to or endangering the bodily safety of another; conduct by HIV infected persons;

assault by HIV infected persons or hepatitis infected persons

(c) A person who is an HIV infected person who, after obtaining knowledge of being infected with HIV:

…

(2) Knowingly allows another person to use a hypodermic needle, syringe, or both for the introduction of drugs or any other substance into or for the withdrawal of body fluids from the other person's body and the needle or syringe so used had been previously used by the HIV infected person for the introduction of drugs or any other substance into or for the withdrawal of body fluids from the HIV infected person's body and where that infected person does not disclose to the other person the fact of that infected person's being an HIV infected person prior to such use;

…

is guilty of a felony and, upon conviction thereof, shall be punished by imprisonment for not more than ten years.

HIV criminalization laws also tend to ignore measures that can reduce the risk of HIV transmission to effectively zero, such as taking antiretroviral medication and reaching sustained viral suppression or use of pre-exposure prophylaxis (PrEP).[12] This means that PLHIV can face felony prosecution for sharing syringes even if they or their syringe-sharing partners took steps to eliminate the risk of transmission.

Criminalization of Paraphernalia and the Importance of Syringe Service Programs

Thirty-two states criminalize the possession of drug paraphernalia, including syringes.[13] These laws push people to avoid carrying

new syringes, forcing them to share injection equipment and risk exposure to blood-borne illnesses like HIV and Hepatitis C Virus (HCV). The health risks facing people who inject substances are worsened by restrictions on medical practitioners and pharmacists from prescribing or selling sterile syringes.

Laws criminalizing drug paraphernalia also create additional hazards for transgender PLHIV who use syringes to inject non-prescribed hormones, steroids, or silicone.[14]

The need to decriminalize paraphernalia is a response to the need to make more sterile syringes accessible. Syringe services programs (SSPs, also known as syringe exchange programs) are a critical public health intervention for people who inject drugs. SSPs provide people with sterile syringes, injection equipment, and ways to safely dispose of used syringes. They also provide education on safe use and linkage to treatment options.

In 2011, the U.S. Surgeon General published a notice in the Federal Register acknowledging the public health benefit of SSPs.[18]

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The benefits of SSPs include:

- Improved public health outcomes: HIV incidence is estimated to drop by 60% among people who inject drugs when SSPs are scaled up and combined with antiretroviral therapy (ART) and opioid substitution therapy.[19]
- Less public spending: Considering the cost per HIV infection averted and treatment costs saved by SSPs, $10 million of additional federal funding would save $7.50 in lifetime health costs for every $1 spent.[20]

More than 50% of people who inject drugs are estimated to have used an SSP in 2015, which is a significant increase from 36% in

Criminalization and Transgender Communities

In the 2015 National Transgender Survey, 25% of respondents reported being denied coverage for transition-related hormone replacement therapy (HRT),15 and 33% of respondents reported avoiding healthcare services that they needed due to fear of being discriminated against by providers.[16]

When prescription HRT is out of reach, some transgender people turn to non-prescribed 'street' hormones. Using street hormones can involve sharing syringes with others, which in turn increases a person's risk of exposure to HIV and HCV, or of criminalization for sharing a syringe if they are already living with HIV. A person using hormones may also be arrested and charged for paraphernalia possession. The risk of criminalization is compounded by the fact that transgender people, and particularly trans people of color, disproportionately experience homelessness and poverty and are frequently targeted by law enforcement.[17]

2005.[28] Nevertheless, access to SSPs must be improved and amplified, as utilization remains inconsistent.[29]

Laws in 15 states criminalizing paraphernalia contain exceptions for people who are engaged in SSPs,[30] but law enforcement personnel do not honor the exceptions consistently in every state.[31] For a public health approach to take hold over criminalization, strategies to reform criminal laws affecting PLHIV who inject substances must incorporate SSPs.

Criminalization of Drugs

Laws criminalizing drug possession devastate marginalized communities, worsen the effect of mass incarceration, and exacerbate racial disparities in the criminal legal system.[32] A 2017 global review of 106 studies on the relationship between the criminalization of drug use and HIV showed that criminalizing drug use harms HIV prevention and treatment efforts among people who inject drugs (PWID).[33] International bodies such as the United Nations Office on Drugs and Crime have recognized that criminalization does not deter drug use, and that such punitive policies instead harm the health and well-being of PWID.[34]

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The Increase and Effectiveness of Syringe Service Programs (SSPs)

Syringe Service Programs (SSPs) are used around the world and are part of a number of countries' strategies to end HIV.[21] The stigma surrounding SSPs in the U.S. has decreased as evidence of their public health efficacy grows.

In 2016, in response to advocacy by the Coalition for Syringe Access and others, Congress relaxed a ban on federal funding for SSPs.[22] The ban was introduced in 1998 and it also prohibited funds from being used locally in the District of Columbia.[23] The law changed in 2007, and D.C. was finally permitted to use local funds towards SSPs. What happened next is a testament to the rapid efficacy of SSPs: in just two years, new cases of HIV among injection drug users in D.C. decreased by 70%.[24]

Today, there are approximately 200 SSPs across the United States.[25] However, some elements of the ban remain in place. For example, SSP services can be federally funded, but the syringes cannot.[26] Additionally, in order to obtain approval for federal funding, a state, local, tribal or territorial health department must apply to the Centers for Disease Control and Prevention with evidence of either a current outbreak or risk of an outbreak of HIV or HCV.[27]

Nevertheless, all U.S. states and the federal government still criminalize drug possession, and police officers around the country make more arrests for drug charges than for any other crime.[35]

42 states deem possession of any amount of a controlled substance other than marijuana to be a felony offense.[36] The mere residue of a controlled substance in a syringe, even if insufficient for intake, can be grounds for arrest in most states. Only eight states exempt residue from state bans on controlled substances.[37]

Some communities are at higher risk of incarceration for injection drug use than others, and experience health disparities as a result:

- Because of systemic racism and discriminatory police profiling, Black people are two and a half times more likely to be arrested on drug charges than white people—even though white people are more likely to use drugs over the course of their lifetime.[38] Due to a lack of adequate prevention and treatment measures, Black and Latinx communities are also disproportionately affected by the HIV epidemic and therefore at greater risk of criminalization under HIV-specific laws.[39]
- 20-30% of LGBTQ people use drugs, compared to 9% of their heterosexual and cisgender counterparts.[40] LGBTQ people of color are also more likely to be profiled by law enforcement on the basis of both their race or ethnicity and their sexual orientation or gender identity.[41] At the same time, Black gay and bisexual men and transgender women of color are the groups who are most severely affected by HIV.[42]
- People experiencing poverty or homelessness are more likely to use or trade drugs outside or in public, with heightened visibility to law enforcement and corresponding risk of arrest.[43] Homeless youth—an estimated 40% of whom identify as LGBTQ—may rely on selling and trading drugs and sex work in order to survive.[44] One study of PLHIV who inject drugs found that more than half of the respondents reported being homeless, and 30% of respondents reported prior incarceration.[45]

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A better understanding of the linkages between the criminalization of HIV and drug use can help us mount a stronger movement against stigma, barriers to essential public health programs, and criminalization. And a united defense of basic human rights can build the momentum needed to ensure our common goals become a reality. See the organizing tipsheets on the following pages for concrete steps you can take to build and advance intersectional advocacy.

What can you do?

Advocates working to end HIV criminalization and those fighting for the decriminalization of syringes are natural allies. Building stronger linkages across these movements will support advocacy that is more intentional, intersectional, inclusive, and effective.

NETWORK

In addition to HIV criminalization and syringe access advocates, reach out to other social justice movements with shared values: LGBTQ organizations, networks of people living with HIV, public health advocates, and groups focused on mass incarceration, anti-poverty work, labor rights, immigrant rights, racial justice, and reproductive justice are but a few examples. This is an intersectional issue and you can each help amplify each other's efforts and form connections that will last in the future.

CREATE

Make shareable resources that are designed with each group and their stakeholders in mind. Distribute them and encourage everyone to share these materials throughout their networks. Create flyers, slogans, and stickers—whatever you need to get the message across.

BE STRATEGIC

Look for strategic opportunities to share your message. If there is a conference about economic justice issues or LGBTQ rights, try to attend or distribute flyers to conference attendees. Bring resources that explicitly connect the issues. Show up to events with your legislator to introduce yourself and your cause. Reach out to multiple media outlets. Write op-eds for local newspapers, web publications, and magazines that support you. Be anywhere and everywhere that will get you closer to your goal.

BE SENSITIVE

Stigma often makes it difficult for people to publicly claim a history of drug use, and public advocacy by people who use or have used drugs can even have consequences on current employment or parental rights. Some may prefer to not be out publicly as harm reduction/ syringe access advocates because of the stigma it could inflict on their children, families, etc. Ask people how they prefer to be identified and follow their lead. Make an effort not to assume anyone's gender pronouns.

General Organizing Tips

Look for common frameworks and language that can advance both advocacy goals. Hold safe-space forums to discuss criminalization and be sure to include the leadership of people who use syringes, syringe access advocates, and other service providers from the early planning stages. Make sure to incorporate public health and reproductive, economic, and racial justice.

FIRST STEPS TO ACTION

Connect with national and local advocacy organizations. Find syringe access advocacy organizations at harmreduction.org/connect-locally.

- **Connect with networks of people living with HIV and Hepatitis C.** See seroproject.com.
- **Get information about your area's policies.** Use the Center for HIV Law and Policy's *Sourcebook* (hivlawandpolicy.org/sourcebook) or lawatlas.org/topics to learn about your state and local governments' stance on syringe use and HIV criminalization. The legal landscape for SSPs has become more fluid since the relaxation of the funding ban: be on the lookout for a new resource coming soon.
- **Know who your elected officials are and how to contact them.** Find your federal, state and local elected officials' names and contact information at act.commoncause.org.

ADVOCATE AND EDUCATE

- **Create resources.** Create simple resources to use in education and outreach efforts like a fact sheet or talking points (you can use the facts and bullet points in this toolkit!)
- **Get the word out.** Use social media to educate others about the intersection between criminalization of syringes and HIV criminal laws. Contact the media and write op-eds to encourage responsible reporting on these topics
- **Organize in your community.** Organize town halls, community forums, and other events to educate your community and build awareness about these issues.
- **Advocate with policymakers.** Attend lobby day at your state capital and meet with legislators to provide education and build support.
- **Educate law enforcement.** If it feels safe, educate law enforcement on the routes and risks of HIV transmission and how criminalization of syringes causes harm.

INCREASE VISIBILITY

- **Encourage research.** Support efforts to learn more about consequences of the criminalization of syringes and HIV.
- **Start a campaign.** Start a campaign that highlights the intersection between criminalization of PLHIV and intravenous drug use, with an emphasis on cross-movement collaboration.

YOUR HEALTH: KNOW YOUR LOCAL RESOURCES

- **Find out if and where there are syringe access sites near you.** See harmreduction.org/connect-locally or nasen.org/directory.
- **Get tested.** Find out where you and members of your community can get tested for HIV and Hepatitis C.
- **Use safely.** There are many ways to reduce the harm that may be involved with using drugs. The Harm Reduction Coalition's guide *Getting Off Right* provides advice on using drugs safely: harmreduction.org/wp-content/uploads/2011/12/getting-off-right.pdf.
- **Get quality healthcare.** Until the right to health care is recognized under U.S. law, we as individuals must be vigilant advocates for our health needs. The Harm Reduction Coalition's *Healthcare Is Your Right* toolkit helps people who use drugs navigate the healthcare system: harmreduction.org/wp-content/uploads/2016/10/Quality-Healthcare-Is-Your-Right.pdf.

Media Tips for Activists

Here are some ways to engage the media in your work. Media culture varies from place to place, so your strategy and talking points should be adapted accordingly.

KEEP UP WITH THE MEDIA

- **Track the news.** Keep tabs on the latest developments and jump on opportunities to educate and share information.
- **Prioritize safety.** When working with issues of privacy and identities that are stigmatized and criminalized, make sure to have a plan on how to protect individuals and their rights—including your own.
- **Share information.** Usually it is only the sensational stories that wind up in mainstream news. Use social media and your networks to amplify the stories that aren't being told.

TALK TO THE MEDIA

- **Write letters to the editor in response to published stories or articles.** Be concise, state your case, and make sure to include your contact information.
- **Op-eds are longer, standalone opinion pieces that we write as "experts" on a topic.** Learn which outlets are HIV and PWID-friendly. Be persuasive and offer clear recommendations on how to make things better.
- **Conduct interviews and respond to media inquiries.** Be knowledgeable about your subject matter and have an outline of the main points you want to convert in advance. Connect media contacts to other resources and allies in the movement.

Endnotes

[1] U.S. Dep't of Justice, Civil Rights Div., *Best Practices Guide to Reform HIV-Specific Criminal Laws to Align with Scientifically-Supported Factors* (2014), hivlawandpolicy.org/sites/www.hivlawandpolicy.org/files/DOj-HIV-Criminal-Law-Best-Practices-Guide.pdf.

[2] U.S. Dep't of Health and Human Services, *Facing Addiction in America: The Surgeon General's Report on Alcohol Drugs and Health* (2016), addiction.surgeongeneral.gov/surgeon-generals-report.pdf.

[3] Centers for Disease Control and Prevention, *HIV and Injection Drug Use* (2017), cdc.gov/hiv/pdf/risk/cdc-hiv-idu-fact-sheet.pdf.

[4] Centers for Disease Control and Prevention, *HIV and Injection Drug Use* (2015), liaac.org/pdf/flyers/cdc-hiv-idu-fact-sheet.pdf. Note that data in the last five years has shown similar trends. *See*, Centers for Disease Control, *HIV Surveillance Report* (2015) at 67-76, cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2015-vol-27.pdf.

[5] *See* Positive Women's Network USA, *Bodily Autonomy: A Framework to Guide Our Future*, (last visited Sept. 1, 2017) pwn-usa.org/policy-agenda/bodily-autonomy-framework.

[6] National Alliance of States and Territorial AIDS Directors (NASTAD), *Modernizing Public Health to Meet the Needs of People who Use Drugs: Affordable Care Act Opportunities* (2015), nastad.org/sites/default/files/ModernizingPublicHealth-NASTAD.pdf.

[7] *See*, Center for HIV Law and Policy, *HIV Criminalization in the United States: A Sourcebook on State and Federal HIV Criminal Law and Practice* (2017), hivlawandpolicy.org/sourcebook.

[8] *Id*; Georgia, Kansas, Minnesota, Missouri, North Carolina, North Dakota, South Carolina, South Dakota, Tennessee, Indiana, Illinois, Idaho, and the U.S. Virgin Islands. Syringe sharing may be also be included under state statutes that broadly criminalize HIV, as in Arkansas, Iowa, Maryland, Nevada, and Wisconsin.

[9] Wolf LE, Vezina R., *Crime and punishment: is there a role for criminal law in HIV prevention policy?* 25 Whittier L. Rev. 821, 826 (2004), aidsetc.org/sites/default/files/resources_files/cf-pwp-caroldr.pdf; *see also* Lazzarini Z, Bray S, Burris S. *Evaluating the impact of criminal laws on HIV risk behavior*, 30 J Law Med Ethics 239 (2002), available at hivlawandpolicy.org/resources/zita-lazzarini-et-al-evaluating-impact-criminal-laws-hiv-risk-behavior-30-jl-med-ethics.

[10] Centers for Disease Control, *Today's HIV/AIDS Epidemic* (2016), cdc.gov/nchhstp/newsroom/docs/factsheets/todaysepidemic-508.pdf.

[11] *HIV and Injection Drug Use* (2017), *supra* note 3.

[12] Steven Shoptaw, *HIV prevention for people who use substances: Evidence-based strategies*, 21 J Food Drug Anal. S91 (2013), ncbi.nlm.nih.gov/pmc/articles/PMC4158848; *also see* PARTNER Study Group, *Sexual Activity Without Condoms and Risk of HIV Transmission in Serodifferent Couples When the HIV-Positive Partner Is Using Suppressive Antiretroviral Therapy*. 316 JAMA 171 (2016), jamanetwork.com/journals/jama/fullarticle/2533066. The 2016 PARTNER Study found zero HIV transmission among 888 sero-different heterosexual and MSM couples over 2 years where the partner living with HIV was using suppressive antiretroviral therapy.

[13] As of May 2017: Alabama, Arizona, Arkansas, California, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Mississippi, Missouri, Montana, Nebraska, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, and Washington. Remaining states have removed references to syringes from the definition of drug paraphernalia. California and Vermont legislation explicitly excludes syringes from drug paraphernalia criminalization. *See Syringe Distribution Laws*, LawAtlas (March 1, 2016), lawatlas.org/datasets/syringe-policies-laws-regulating-non-retail-distribution-of-drug-parapherna.

[14] *See* Scott Burris et al., *Racial Disparities in Injection-Related HIV: Case Study of Toxic Law*, 82 Temple L.R. 1263 (2010).

[15] *Id*. at 95.

[16] *Id*. at 3. More data is needed on prosecution rates of transgender people for syringe possession or sharing.

[17] National Center for Transgender Equality, *2015 U.S. Transgender Survey* 11,12 (2015), transequality.org/sites/default/files/docs/USTS-Full-Report-FINAL.PDF.

[18] 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, 36 Fed. Reg. 10038 (Feb. 23, 2011), gpo.gov/fdsys/pkg/FR-2011-02-23/pdf/2011-3990.pdf.

[19] Steven Shoptaw, *HIV prevention for people who use substances: evidence-based strategies*, J Food Drug Anal. 2013 Dec; 21(4): S91–S94, ncbi.nlm.nih.gov/pmc/articles/PMC4158848.

[20] *See* Centers for Disease Control and Prevention, *Access to Clean Syringes* (2016), cdc.gov/policy/hst/hi5/cleansyringes/index.html.

[21] Gay Men's Health Crisis, *Syringe Exchange Programs around the World: The Global Context* (2009), gmhc.org/files/editor/file/gmhc_intl_seps.pdf.

[22] Consolidated Appropriations Act, 2016, Pub. L. No. 114–113, §520, 129 Stat. 2242, 2652 (2015).

[23] *See*, Ruiz, M.S., O'Rourke, A. & Allen, S.T., *Impact Evaluation of a Policy Intervention for HIV Prevention in Washington, D.C.*, 20 AIDS Behav 22 (2015), link.springer.com/article/10.1007/s10461-015-1143-6; *also see* Kathleen Facklemann, *DC Needle Exchange Program Prevented 120 New Cases of HIV in Two Years*, Milken Institute School of Public Health at George Washington Univeristy (2015), publichealth.gwu.edu/content/dc-needle-exchange-program-prevented-120-new-cases-hiv-two-years.

[24] Monica S. Ruiz, *supra* note 23; *also see Access to Clean Syringes* (2016), *supra* note 20.

[25] Benjamin Ryan, *Syringe Services Programs Face an Uncertain Future in the Trump Era*, POZ (January 2017), poz.com/article/syringe-services-programs-face-uncertain-future-trump-era.

[26] *Id*.

[27] *See* Dep't of Health and Human Services, *Implementation Guidance to Support Certain Components of Syringe Services Programs (2016)*, aids.gov/pdf/hhs-ssp-guidance.pdf; *also see Syringe Services Programs* (2016) *supra* note 20.

[28] *HIV and Injection Drug Use* (2017), *supra* note 3.

[29] Centers for Disease Control and Prevention, *Use of syringe services programs increases, but access must improve for greater HIV prevention* (2016), cdc.gov/media/releases/2016/p1129-hiv-syringe-services.html.

[30] California, Colorado, New Mexico, Kentucky, North Carolina, Maryland, New Jersey, Delaware, Vermont, Maine, Montana, New York, Utah. *See Syringe Distribution Laws*, LawAtlas (March 1, 2016), lawatlas.org/datasets/syringe-policies-laws-regulating-non-retail-distribution-of-drug-parapherna.

[31] *See*, HIPS, *Policy Recommendations: Applying a Public Health, Harm Reduction Approach to Drug Use in D.C.* (last visited Sept. 1, 2017), hips.org/uploads/6/2/2/9/62290383/hips_drugusepolicies.pdf. In the District of Columbia, the Metropolitan Police Department does not have a protocol to recognize participants in the D.C. needle exchange program. The syringe access and sex work advocacy organization HIPS reports that D.C. police officers still arrest participants, whether for syringes or possession of other drug paraphernalia, even when participants show their exchange program membership.

[32] Brian Stauffer, *Every 25 Seconds: The Human Toll of Criminalizing Drug Use in the United States*, Human Rights Watch (2016), hrw.org/report/2016/10/12/every-25-seconds/human-toll-criminalizing-drug-use-united-states; Findings from a systematic review of 106 studies globally suggest that drug criminalization has a harmful effect on HIV prevention and treatment, *see*, Kora DeBeck et al, *HIV and the criminalisation of drug use among people who inject drugs: a systematic review*, 4 Lancet 2352 (2017), thelancet.com/pdfs/journals/lanhiv/PIIS2352-3018(17)30073-5.pdf.

[33] Kora DeBeck, *supra* note 32.

[34] UNODC, *World Drug Report* (2016), unodc.org/doc/wdr2016/WORLD_DRUG_REPORT_2016_web.pdf.

[35] Stauffer, *supra* note 32.

[36] *Id*.

[37] Nevada, Colorado, Kentucky, New York, Connecticut, New Jersey, Maine, District of Columbia.

[38] Stauffer, *supra* note 32.

[39] Centers for Disease Control, *HIV among Hispanics/Latinos* (March 2017), cdc.gov/hiv/group/racialethnic/hispaniclatinos/index.html.

[40] *See* Nat'l LGBTQ Task Force, *LGBTQ People and Syringe Services Program* (2015), hivlawandpolicy.org/sites/www.hivlawandpolicy.org/files/Syringe%20Access%20LGBT%20Fact%20Sheet.pdf.

[41] Catherine Hanssens et al., *Roadmap for Change: Federal Policy Recommendations for Addressing the Criminalization of LGBT People and People Living with HIV* 14 (2014), web.law.columbia.edu/sites/default/files/microsites/gender-sexuality/files/roadmap_for_change_full_report.pdf.

[42] *See*, Centers for Disease Control and Prevention, *HIV Among Transgender People* (2017), cdc.gov/hiv/group/gender/transgender; *also see* Centers for Disease Control, *HIV among Gay and Bisexual Men* (2015), cdc.gov/nchhstp/newsroom/docs/factsheets/cdc-msm-508.pdf.

[43] Jamie Fellner, *Race, Drugs, and Law Enforcement in the United States*, Human Rights Watch (2009), hrw.org/news/2009/06/19/race-drugs-and-law-enforcement-united-states.

[44] *Id.* In addition to the risk of interaction with law enforcement and the criminal legal or juvenile justice systems, homeless youth also face increased risk of HIV and HCV infection. *See*, Price, C., Wheeler, C., Shelton, J., & Maury, M. (Eds.), *At the Intersections: A Collaborative Resource on LGBTQ Youth Homelessness*, True Colors Fund and the National LGBTQ Task Force (2016), attheintersections.org/juvenile-justice.

[45] *Id*; *also see HIV and Injection Drug Use* (2017), *supra* note 3.

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