

# Syringe Service Programs and HIV Prevention in West Virginia

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HIV, the virus that can lead to AIDS, is spread via contact with infected bodily fluids. As such, people who inject drugs (PWID) can contract HIV through contaminated syringes. Syringe service programs (SSPs) dispose of used needles and distribute sterile syringes with the goal of reducing disease spread amongst PWID. This Science and Technology Note discusses HIV and SSPs in West Virginia and offers policy options to limit HIV outbreaks by expanding West Virginians' access to SSPs.

## HIV Transmission Among IV Drug Users

Of the approximately [2,200](#) West Virginians living with [HIV](#), [23.3%](#) attribute their infection to contaminated syringes. This percentage is the third highest in the country and far surpasses levels in the rest of Appalachia.

In 2020, an outbreak of [35](#) HIV cases among PWID in Kanawha County was named the "[most concerning \[outbreak\] in the country](#)" by the CDC's Chief of HIV Prevention. New York City, which is [~50 times more populated](#), recorded only [36 cases](#). A similar outbreak in Cabell County reached [82 cases](#) in PWID over 18 months in 2018-2019.

## Syringe Service Programs in West Virginia

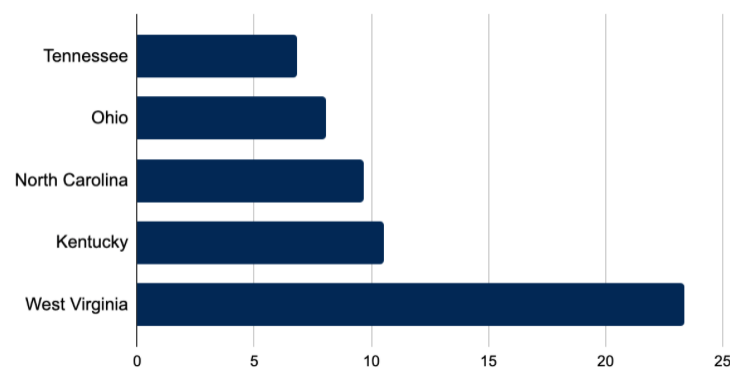
Signed into law in 2021, [SB334](#) requires SSPs in West Virginia to provide additional harm reduction services, require proof of residency, and account for each syringe under penalty of fines. While supporters of SB334 have shared apprehension about potential [crime](#), [needle litter](#), and [enabling of drug use](#) surrounding SSPs, others have raised concerns about increasing the burden on SSPs without additional funding and with decreased participation due to ID requirements.

The US Office of National Drug Control Policy [lists SB334](#) as an example of policy creating barriers to SSP implementation. The total number of SSPs in West Virginia has dropped from [18 sites](#) in 2019 to [10](#) in 2024, with [3 closures](#) specifically citing SB334 as the cause. The 10 remaining SSPs serve 12 counties, including [3 programs](#) that reach [4 counties](#) via mobile service.

## Research Highlights

- Nearly 1 in 4 West Virginians with HIV acquired their HIV infection through use of contaminated syringes—the third highest percentage in the country.
- The number of syringe service programs (SSPs), which dispose of used needles and distribute sterile syringes to PWID, has dropped to just 10 programs serving 12 counties in West Virginia.
- Expanding West Virginians' access to SSPs could potentially prevent future HIV outbreaks, increase enrollment in treatment programs for substance use disorder, and decrease needle litter.
- Two policy options for achieving this are (1) returning regulatory power to county governments and local health departments and (2) implementing regional or state-supported mobile SSPs.

## Percent of Persons Living with HIV Attributed to Injection Drug Use, 2021

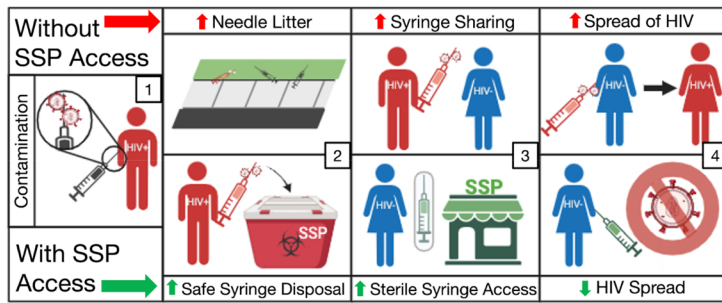


Source: CDC [AIDSvU](#)

## Benefits of Expanding SSP Access in West Virginia

SSPs have been shown to [decrease needle litter](#), [increase enrollment](#) in treatment for substance use disorders, and [decrease infectious disease](#) through both syringe exchange and administration of pre-exposure prophylactic medications (PrEP), all with an [over 7-fold](#) return on investment for each dollar spent. While West Virginia currently has 10 SSPs serving 12 counties, 43 counties are without local access to an SSP.

## The Role of SSPs in Reducing HIV Transmission



1. Syringes can become contaminated with HIV when used by an HIV+ individual.
2. SSPs provide opportunities to safely dispose of used syringes, [reducing needle litter](#) in the community.
3. SSPs dispense sterile syringes, [decreasing the likelihood](#) of contaminated syringe sharing among PWID.
4. In promoting the use of sterile syringes, SSPs have been shown to reduce HIV transmission rates among PWID by [up to 60%](#).

## Comparing Syringe Service Programs in West Virginia, Kentucky, and North Carolina

[Kentucky](#) and [North Carolina](#) are illustrations of two policy options for expanding SSP access: the county-by-county and mobile models. In Kentucky, SSP implementation requires approval from the local health department, city government, and county government. As a result of local support, KY has [84 SSPs](#) serving 65 of 120 counties. North Carolina [follows a similar model](#), but most counties ([52%](#)) have access to a mobile SSP.

### Syringe Service Programs in West Virginia, Kentucky, and North Carolina

	West Virginia	Kentucky	North Carolina
<b>Model</b>	State managed	County managed	County managed, mobile service focus
<b>Approval Required</b>	State, county, city	County, city	County, city
<b>State-mandated ancillary Services</b>	Disease screening, vaccinations, birth control, harm reduction*	None	None
<b>ID Requirements</b>	18+, proof of WV residency	County-determined	County-determined
<b>Oversight Level</b>	State	County, city	County, city
<b>Total SSPs</b>	10	84	50
<b>% of Counties with any SSP Access</b>	21.8% (12/55)	54.2% (65/120)	58% (58/100) + 1 tribe
<b>% of Counties with Mobile SSP Access</b>	7.2% (4/55)	Data Unavailable	52% (52/100)

\*including referral/access to overdose prevention supplies and education, treatment for substance use disorders, behavioral health services, health care practitioners

## Options to Expand SSP Access in West Virginia

One approach is to return the regulatory burden to the individual West Virginia counties, rather than requiring state licensure. By enabling community input (including from local PWID), restrictions on services can be more appropriately tailored to the locality. This could potentially lead to more efficient and equitable SSP implementation. However, this does not address disparities in funding and staffing that may prevent more rural counties from enacting SSPs; it also leaves programs vulnerable to instability based on local elections.

Another option is to provide regional and/or state-supported [mobile SSPs](#). Mobile SSPs enable syringe exchange from a vehicle that stops at designated locations at preset times. They can serve multiple rural counties, increasing the numbers served for lower investment and with no need for physical facilities. Mobile SSPs provide the [fewest barriers](#) to establishing services and are widely supported by harm reduction advocates and healthcare systems. While mobile units mitigate concerns about aggregation of PWID near fixed sites, they are often not able to provide the same level of access due to their transient nature.

This Science & Technology Note was written by Kensey Bergdorf-Smith, PhD and West Virginia Science and Technology Policy Fellow, on behalf of West Virginia University's Bridge Initiative for Science and Technology Policy, Leadership, and Communications. Please see <https://scitechpolicy.wvu.edu/> or contact [scitechpolicy@mail.wvu.edu](mailto:scitechpolicy@mail.wvu.edu) for more information.