Build on What Works: Syndemic Approaches in Local Health Departments

Background

The United States is experiencing a **syndemic of HIV, sexually transmitted infections (STIs), and viral hepatitis.*** The syndemic is marked by **elevated case rates, clusters, and outbreaks, as well as significant overlap in the populations affected.**

HIV: Between 2022 and 2024 there were over 400 HIV clusters or outbreaks across the country.[1] Many of these clusters and outbreaks are *syndemic in nature*: across five major HIV outbreaks between 2014 and 2021, hepatitis C (HCV) co-infection occurred in 70–94% of people newly diagnosed with HIV.[2] Co-infection is also common beyond outbreak settings: an estimated 10% of people living with HIV have hepatitis B, and approximately 21% of people living with HIV also have HCV.[3,4,5]

STIs: Despite recent encouraging progress, STI rates remain 13% higher than a decade ago, with congenital syphilis increasing by more than 700%.[6] STIs such as chlamydia, gonorrhea, and syphilis also increase the likelihood of HIV acquisition; an estimated 6% of sexually acquired HIV infections are attributable to these STIs. HIV and STI co-infection rates are high, especially among populations most impacted by STIs.[7,8] In 2023, 37% of men who have sex with men who were diagnosed with primary and secondary syphilis were also living with HIV.[9]

Hepatitis: While hepatitis C cases have remained relatively stable in recent years, estimated annual infections remain 1.7 times higher than in 2016, and national progress against hepatitis B (HBV) has largely stalled since 2020.[10] Chronic HBV and HCV infections continue to disproportionately affect many of the same populations already burdened by HIV and STIs, reinforcing the need for integrated, syndemic approaches to detection, prevention, and response.

**Depending on local trends, health departments may define the scope of their syndemic more narrowly (e.g., focusing on syphilis rather than all STIs, or hepatitis C rather than all viral hepatitis) or more broadly (e.g., incorporating tuberculosis or substance use disorder).*

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What is a Syndemic?

A syndemic refers to the co-occurrence and interaction of multiple epidemics that worsen health outcomes within a population. A syndemic is defined by three features:

- Two or more diseases or health conditions cluster within a population;
- As a result of shared social and contextual factors;
- Resulting in adverse disease interactions—either biological, social, or behavioral—and worse health outcomes for the affected populations.[11]

How the HIV, STI, and Hepatitis Epidemics Interact and Overlap

High rates of HIV, STI, and hepatitis co-infection

Infection with HIV, another STI, or hepatitis increases the risk of acquiring or transmitting the others[12,13,14,15]

Co-infection compounds health impacts and worsens outcomes[16,17,18,19]

Benefits of a Syndemic Approach

Through engagement with our members, NACCHO observed that local health departments (LHDs) are increasingly adopting syndemic approaches to address the interconnected epidemics of HIV, STIs, and viral hepatitis. LHDs view this approach as an opportunity to:

- **Maximize resources** by addressing multiple infections and conditions across programs and within each client encounter;
- **Prioritize efforts** by focusing on the populations and settings most affected and least connected to public health and healthcare services;
- **Address shared barriers** to prevention, testing, and treatment across multiple diseases and conditions;
- **Promote health and well-being holistically** by mitigating adverse disease interactions and reducing the stigma associated with individual programs or services.

Recognizing the potential impact of this approach, NACCHO launched a multi-component assessment in late 2024 to define the core elements of a syndemic approach within LHDs, identify promising practices, and examine barriers and facilitators to implementation. The assessment included three listening sessions engaging more than 40 LHDs and in-depth interviews with eight LHDs.

Findings

Maximizing Client Encounters Through Integration and Same-Day Care

The assessment examined service delivery models and strategies that enable LHDs to advance a syndemic approach to HIV, STIs, and viral hepatitis. Many jurisdictions reported substantial loss to follow-up when clients were referred to additional services, whether for the same or another condition.

> **"Seeing somebody more than once is so rare, and so like really monopolizing on the opportunity within this population to offer them everything that you can…is so important."**
> **-Interviewee**

To address this, LHDs emphasized the importance of maximizing each client encounter, whether in a clinic, mobile unit, or community setting, and are increasingly implementing integrated screening, co-located services, warm handoffs, and same-day care models to more effectively meet clients' comprehensive health needs. These approaches improve service uptake and strengthen continuity of care, more effectively addressing syndemic diseases and conditions:

Integrated screening allows providers to assess individuals holistically, regardless of their initial reason for engagement. This approach reduces the need for multiple appointments or referrals, increases service uptake, and helps providers understand the broader context of a person's health, supporting more tailored and effective care plans.

Co-location and warm handoffs help mitigate barriers such as transportation, long wait times, and medical mistrust. Rather than simply providing a referral, staff directly introduce clients to another provider or accompany them to the next service. When services are physically co-located, clients can access comprehensive, same-day care. Programs using this approach report higher uptake of additional services, reduced no-show rates, and improved continuity of care.

Same-day care—the practice of offering testing and treatment during a single visit—is a cornerstone of low-barrier, client-centered service delivery. LHDs shared innovative models such as deploying clinicians to the field, staffing mobile units with prescribing providers, coordinating real-time remote orders, and delivering medications directly to clients. These strategies enable rapid treatment initiation and minimize the risk of losing contact between diagnosis and care.

Reaching People and Places Most Impacted by the Syndemic

Interviewees emphasized that many of the populations most impacted by the syndemic have limited interactions with public health and health care. Consequently, LHDs are re-prioritizing resources to better reach, engage, and support these populations.

> **"Congenital syphilis cases were not coming through public health doors."**
> **-Interviewee**

Core Strategies Include:

Data-Driven Outreach

Many LHDs are leveraging local epidemiological data and insights from the community to guide outreach strategies. Mapping ZIP-code-level trends, analyzing overdose clusters, and incorporating staff's field observations help determine where to deploy resources. Several LHDs regularly adjust outreach locations based on testing positivity or community feedback, allowing programs to stay responsive to shifting needs and emerging hotspots.

Building Trust to Increase Engagement

Establishing and maintaining trust is essential for engaging populations affected by the syndemic. LHDs shared that partnering with trusted community organizations and showing up consistently in the same spaces helped them connect with new clients. Offering basic supplies (e.g., snacks, hygiene items, or blankets) or parking mobile vans in high-need areas can spark conversation, signal care, and open the door to health services.

Community-Based Service Delivery

LHDs are increasingly taking services beyond clinic walls and into trusted community spaces. Mobile vans and co-located partnerships with organizations such as shelters, food banks, libraries, and community centers help bring testing, treatment, and prevention directly to those least likely to access traditional healthcare settings. Interviewees stressed that "meeting people where they are" is critical to overcoming logistical barriers, reducing stigma, and rebuilding trust in public health.

Community-Based Service Delivery: Where, When, How

On foot (e.g., in encampments)

In mobile vans

At a partner's facility (e.g., shelter, food bank)

At recurring, predictable times/locations

At community events

Screening drives/health fairs with partners

Barriers to a Syndemic Approach

The assessment revealed several organizational factors that can either impede or enable the advancement of syndemic approaches within LHDs.

Barriers

Siloed funding streams, programs, staffing structures, and data systems

Insufficient staffing due to funding cuts, low compensation, and workforce shortages

Risk-averse leadership and a culture that favors the status quo

Inflexible policies and protocols that hinder adaptation and innovation

Funding and Program Silos

Most available funding streams remain disease-specific and narrowly defined, posing major challenges for integrating services across programs. These categorical structures—marked by rigid deliverables, limited flexibility, and overlapping reporting requirements—were widely described as misaligned with the goals of syndemic integration. Siloed funding perpetuates siloed programs, staff roles, and data systems, ultimately hindering internal collaboration.

Workforce Capacity and Stability

Insufficient staffing, particularly among nurses and disease intervention specialists, was among the most frequently cited barriers. Many LHDs reported unfilled positions due to low compensation, workforce shortages, or hiring freezes. Others faced or anticipated funding cuts, short funding cycles, and unstable budgets. LHDs emphasized that unpredictable or expiring funding undermines long-term planning and limits their ability to sustain integrated efforts.

Data Fragmentation and Interoperability

Interviewees described juggling multiple data systems such as electronic medical records, surveillance databases, and program-specific spreadsheets, with limited ability to share or link data. This fragmentation hampers real-time coordination and complicates follow-up. Some LHDs are developing creative workarounds, including shared registries, internal chat systems, and centralized dashboards (for example, congenital syphilis tracking) to improve visibility and continuity of care.

Administrative and Bureaucratic Barriers

Internal processes can also slow innovation. Lengthy procurement timelines, rigid job classifications, and complex contracting requirements often delay implementation or prevent rapid response to emerging needs. Some LHDs have created adaptive solutions such as pre-approved vendor lists, revised supervisory policies, or discretionary funds to pilot new efforts. Leadership flexibility and willingness to reinterpret existing rules made a noticeable difference in how quickly programs could innovate.

"COVID showed us we can update policies quickly. Now we can just say, let's do this—and we do it." -Interviewee

Facilitators of a Syndemic Approach

LHDs highlighted several internal strengths that support syndemic approaches even when resources are limited.

Collaboration and Culture of Cooperation: Cross-program teamwork and a "make it work" mindset often transcend funding silos. Staff described sharing supplies, jointly staffing outreach or mobile events, and covering for one another to maintain integrated, person-centered care. Co-located spaces, shared planning, and real-time communication further strengthened these relationships.

Supportive and Empowering Leadership: Leadership buy-in and a culture that encourages experimentation were described as essential. When leaders gave teams flexibility and encouraged testing new ideas, staff were able to pilot cross-unit initiatives and modernize outdated procedures. In contrast, rigid adherence to categorical goals or lack of mid-level support often slowed progress. Leadership can also help navigate administrative barriers by modifying (or reinterpreting) organizational policies or liaising with other departments (e.g., Finance, Human Resources).

Continuous Learning and Program Improvement: LHDs that built reflection and data-driven learning into routine practice were better equipped to adapt and refine their approaches. Even with limited evaluation capacity, reviewing program data helped identify misaligned efforts, such as targeting the wrong populations or failing to link testing and treatment. These insights reinforced the need for ongoing learning, feedback, and course correction to ensure strategies are both effective and serve those who benefit from them most.

Ultimately, advancing a syndemic approach requires more than flexible funding and innovative programs. It depends on fostering collaboration, supportive leadership, and a culture of continuous learning within LHDs themselves.

"The data showed we were barking up the wrong tree." -Interviewee

Navigating Siloes and Fostering Innovation

To bridge gaps across categorical funding streams and programs, LHDs described **leveraging flexible resources** such as general funds and discretionary grants to support cross-program staff and activities. Examples included disease intervention specialists who "float" across programs to meet surge needs, or flexible funds used to address shared drivers like transportation or housing. Some departments **exchanged supplies across teams and partners,** for instance, STI teams sharing rapid syphilis tests with partner organizations. Others found inventive ways to repurpose budgets, such as converting promotional "swag" funds into practical supplies for unhoused residents, building trust while increasing the department's visibility. Several LHDs also **aligned services to tap new revenue streams** through insurance billing, Medicaid enrollment, or by adding Title X services to mobile units.

Cross-training emerged as another key strategy for overcoming silos and building resilience. By equipping staff to perform multiple roles—including outreach, testing, data entry, and case management—LHDs maintained service continuity during staffing shortages and adapted more easily to evolving community needs.

Leadership and organizational culture were also recurring themes. Risk-averse leadership or a preference for maintaining the status quo can stifle innovation; however, **framing new initiatives as pilots, supported by discretionary funds, and accompanied by evaluation, often helped secure buy-in.** Demonstrating early success through data provided justification to scale effective approaches or integrate them into existing grants.

Finally, LHDs discovered that some of the most persistent barriers were internal rather than external. Many policies once perceived as fixed—particularly those set locally or by Boards of Health—could be revisited and revised to streamline operations and improve integration. The COVID-19 pandemic underscored this lesson, revealing that numerous "requirements" could, in fact, be adapted at the local level to better meet community needs.

Strategies for Navigating Siloes and Fostering Innovation

Braid funding or use general funds to support cross-program goals, staff

Share supplies across teams, partners

Expand programming to tap into new funding sources

Cross train staff to support flexibility and facilitate integration

Use discretionary $$ to pilot programs (then scale up)

Revisit and reinterpret policies and protocols

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Strengthening Partnerships for a Community-Wide Syndemic Approach

LHDs consistently emphasized that they cannot advance syndemic approaches alone. Partnerships across sectors—ranging from community-based organizations and healthcare providers to housing authorities, correctional facilities, schools, and faith-based organizations—are essential for expanding reach, deepening trust, and delivering care that reflects people's lived experiences.

These cross-sector collaborations enable LHDs to engage populations disproportionately affected by the syndemic, extend services into nontraditional settings, and address barriers alongside clinical needs. Many jurisdictions described embedding peer navigators or clinicians in jails, shelters, and behavioral health centers, or partnering with correctional facilities to provide STI testing and other essential services. Although maintaining consistent communication with partners can be challenging, **these relationships help LHDs reach individuals they otherwise might not, in settings that feel more accessible and familiar to the communities served.**

Partnerships also underpin every other element of a syndemic approach. Integration depends not only on aligning programs within the LHD, but also on coordination across the broader service landscape so that care remains connected wherever a person enters the system. Some LHDs conduct partner detailing—which involves educating providers and partners about the importance of integrated services to address the syndemic—to strengthen referral networks and ensure providers across settings can offer or connect clients to comprehensive services. Others have restructured contracting processes to promote integration among funded partners, consolidating separate HIV, STI, and hepatitis contracts into a single agreement or hosting joint town halls to foster collaboration among subrecipients.

Several jurisdictions are also using partnership mapping to identify service gaps and new opportunities, leading to innovative collaborations with nontraditional partners. Ultimately, these partnerships not only expand and diversify service delivery, but they also allow community organizations to reach people in ways that government agencies often cannot, building credibility, and strengthening the foundation of a syndemic response.

Key Roles for Partners

Expand and deepen LHD reach, including among communities most impacted by the syndemic

Amplify public health education and messaging

Provide more comprehensive, whole-person care through joint service delivery, referrals

Syndemic Solutions in Action

LHDs participating in NACCHO's Syndemic Approaches Community of Practice (CoP) developed six-month action plans to guide their syndemic work. Through this process, LHDs convened relevant staff, discussed priorities, and identified strategies to prioritize for implementation.

While each plan reflects local context and capacity, several common themes emerged across jurisdictions:

- **Integrating programs** and services within the LHD and throughout the community
- **Expanding access** through **community-based service delivery**
- **Closing gaps** across the **care continuum**
- **Engaging communities** most impacted by the syndemic
- **Enhancing and leveraging data systems** to drive decision-making

Notably, many of the strategies and activities intersect multiple themes, reflecting the inherently interconnected nature of syndemic work. Selected examples from LHDs' action plans are highlighted below.

Integrate programs and services within the LHD and throughout the community

- Implement or expand co-located services (e.g., integrate STI care within correctional facilities)
- Expand service offerings (e.g., become a PrEP provider)
- Strengthen internal collaboration through recurring meetings
- Develop cross-training protocols or same-day care models (e.g., strengthen HCV referrals from street outreach and sexual health clinics)
- Strengthen partnerships with external agencies (e.g., meet with domestic-violence shelters, educate providers on congenital-syphilis response)

Expand access through community-based service delivery

- Increase use of mobile vans by expanding services, operating hours, or partnering with other programs
- Host comprehensive, community-based testing events
- Deliver services in partner settings (e.g., train partners to conduct rapid syphilis testing and link patients to LHD services)

Close gaps across the care continuum

- Develop regular reports to identify clients lost to follow-up and implement re-engagement strategies
- Strengthen case management to improve adherence and completion (e.g., retain clients in PrEP care or ensure syphilis treatment completion among those tested in jails)

Engage communities most impacted by the syndemic

- Create a repository of basic-needs supplies (e.g., socks, toothbrushes, food) to build trust and meet holistic needs
- Expand outreach and testing for priority populations or high-impact ZIP codes (e.g., people who are unstably housed, sex workers)
- Develop and distribute culturally appropriate educational materials on syndemic conditions
- Partner with local influencers to promote testing and care engagement

Enhance and leverage data systems to drive decision-making

- Update intake forms to more comprehensively identify client needs
- Standardize intake forms across clinical settings to support integration
- Modify electronic health records to prompt or facilitate referrals for syndemic conditions
- Develop heat maps of STI, overdose, and HCV cases to identify priority areas for street outreach

Conclusion

LHDs across the country are advancing innovative, person-centered strategies to address the interconnected epidemics of HIV, STIs, and viral hepatitis. Through service integration, community engagement, and cross-sector collaboration, they are redefining what it means to deliver public health services that meet people where they are and address their health needs holistically.

The findings from NACCHO's assessment and Community of Practice highlight both the challenges and the promise of adopting a syndemic approach. While categorical funding, staffing shortages, and data fragmentation remain persistent barriers, LHDs are demonstrating resilience and creativity by braiding funds, cross-training staff, piloting same-day care models, and forging partnerships that extend care beyond clinic walls.

A syndemic approach is not a single program or policy, but a way of working: one that emphasizes coordination, flexibility, and shared accountability across systems. Sustaining this progress will require continued investment in local capacity, supportive leadership, and policies that enable innovation rather than constrain it.

As LHDs continue to learn from one another and build on these successes, they are not only improving outcomes for people affected by HIV, STIs, and viral hepatitis, but are also strengthening the foundations of an integrated, effective, and resilient public health system.

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Scan the QR code to access additional information and resources about syndemic approaches.

This work was supported by the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $175,000 with 100 percent funded by CDC/HHS. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. Government.

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