NACCHO

Bridging the Gap: Integrating STI and Harm Reduction Services to Combat Syndemics in the United States

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Introduction

Sexually transmitted infections (STIs), HIV, viral hepatitis, and overdose are not separate crises, but overlapping epidemics driven by common factors such as poverty, stigma, and limited access to care. These conditions create a syndemic, in which the interaction of multiple health issues exacerbates their individual and collective impact. People who use drugs (PWUD) are at particular risk, often facing high rates of infection and systemic barriers to accessing sexual and reproductive health services.

Traditional, siloed public health systems struggle to address these overlapping needs. Service fragmentation leads to inefficiencies and missed opportunities to intervene holistically. The National Association of County and City Health Officials (NACCHO) report, *Bridging the Gap*, offers a roadmap for integrating STI and harm reduction (HR) services—an approach that promises more coordinated, person-centered care. By showcasing integration models implemented across 10 diverse communities, the report provides insights for public health agencies, providers, and advocates seeking to better respond to the syndemic.

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The Value of Integration

Integrated care models allow individuals to access multiple health services—such as STI testing, treatment, and HR services—in a single, trusted setting. This is especially important for marginalized populations, including PWUD, who may be distrustful of or disconnected from traditional health care systems. By embedding STI services within HR programs, or vice versa, organizations can increase reach, reduce stigma, and provide care that reflects clients' real-world needs.

The 10 sites funded by NACCHO implemented integration strategies tailored to their unique local contexts. While programs varied in structure and approach, they shared a common goal to better reach underserved populations, in particular PWUD, with more accessible and comprehensive STI and HR services. Public health department officials, in particular, expressed a desire to better address rising rates of syphilis, while HR agency leaders discussed a desire to provide more comprehensive services to their clients who may not have regular access to care elsewhere. The report showcases integration models and strategies, illustrating their practical implementation and offering lessons that are widely applicable across public health, HR, and health care settings.

Persistent Barriers to Integration

While the benefits of integrated care are clear, the report identifies several recurring challenges. Chief among these is the rigidity of existing funding mechanisms. Many organizations rely on categorical funding streams that prohibit or complicate the blending of resources across STI and HR services. This often results in duplicative administrative work and prevents seamless care delivery.

Staffing shortages and inadequate physical space were also significant hurdles. Many programs lacked sufficient personnel, and existing staff were not always trained to deliver both types of services. In some cases, facilities were not designed to

accommodate co-located care, making logistical coordination difficult. In particular, while mobile or community-based service delivery settings are more accessible, they often have limited infrastructure for STI clinical service delivery. These issues limited the scalability and sustainability of integration efforts.

Fragmented data systems further complicated service coordination. Incompatible electronic health record systems and reporting requirements created inefficiencies and obstructed comprehensive care tracking. Notably, the anonymity of many organizations' HR services made it difficult to follow clients across services or evaluate the impact of integrated interventions. Despite these challenges, all 10 sites emphasized that the benefits of integration—particularly in building trust and expanding access—far outweighed the obstacles.

HR as a Gateway to Care

One of the report's most important findings is the role of HR programs as entry points for STI prevention and treatment. HR programs are often community-based, low-threshold, and trusted by PWUD, making them ideal settings for delivering integrated services. By offering STI testing and care alongside syringe exchange, naloxone distribution, and counseling, these programs meet clients where they are and in the context of their lived experiences.

This model reimagines HR programs not only as providers of prevention supplies but as essential partners in the broader public health system. It also reduces reliance on traditional clinical settings, which some clients may avoid due to stigma or past negative experiences. The report makes a strong case for investing in HR programs and integrating them fully into STI response strategies.

Insights for Implementation

The integration efforts documented in *Bridging the Gap* produced several key insights for successful implementation. Partnerships emerged as a foundational element. Collaborations between public health departments, community organizations, health care organizations, and behavioral health providers enabled resource sharing, cross-referrals, and coordinated outreach. These partnerships not only improved service delivery but also supported sustainability and community trust.

Workforce development was another critical factor. Programs that invested in cross-training staff to deliver both STI and HR services saw improvements in service quality and operational flexibility. In addition to increasing STI staff knowledge and capacity to deliver HR services and vice versa, training often included trauma-informed care, cultural competency, and the use of motivational interviewing—all essential for working with marginalized populations.

Client-centered design has also proved essential. Integrated services must be tailored to the needs and preferences of those they serve. Features such as walk-in hours, mobile units, peer support workers, and flexible service options enhanced accessibility and engagement. By reducing stigma and increasing convenience, programs were better able to build long-term relationships with clients.

Continuous evaluation was critical to program improvement. Notably, the process of collecting and reporting data as part of this project alerted several sites to missed opportunities that contributed to low uptake of integrated services among certain clients. This prompted sites to adapt their protocols to better promote, educate, and engage clients around the full range of available services. At the end of the project, several sites expressed a deeper understanding of the reach and impact of their integration models and planned to make further changes to continue to better serve their communities.

Areas for Future Research

While the report demonstrates the value of integration, it also highlights the need for further research. One critical area is the long-term public health impact of integrated service models. While early evidence suggests increased access and client satisfaction, more data are needed to understand how these models affect STI incidence, overdose rates, and other health outcomes over time.

Economic evaluation is another research priority. Policymakers and funders need evidence about the cost-effectiveness of integration, including whether these models reduce health care expenditures by preventing infections and avoiding emergency care. Detailed cost-benefit analyses can also help justify the expansion of flexible funding arrangements.

Scaling and replicating successful models remain a challenge. Each integration effort was tailored to its local context, and integration models present tradeoffs. For example, permanent, brick and mortar locations can accommodate a broader range of staff and clinical infrastructure, but transportation barriers may persist for clients. Mobile and outreach models meet people where they are, but without adequate space for staff and supplies, private exam rooms, or restrooms, it can

be difficult to provide a comprehensive range of services. Future studies should explore how to adapt models across different jurisdictional and service delivery settings while preserving core principles of equity and access.

Finally, there is a need for policy research that examines the systemic and regulatory conditions that either support or obstruct integration. Understanding how policy environments influence program implementation can inform advocacy efforts and guide institutional reform. *Bridging the Gap* lays the groundwork for these lines of inquiry and invites continued evaluation from both academic and community-based researchers.

Conclusion

Bridging the Gap: Lessons Learned from Integrating Sexually Transmitted Infection and Harm Reduction Services makes a compelling case for shifting public health strategy toward integrated, syndemic-responsive care. By documenting the experiences of 10 diverse sites, the report illustrates how coordinated services can reduce barriers, expand access, and improve outcomes for those most affected by STIs, HIV, viral hepatitis, and overdose.

Though challenges remain, the collective findings from these sites offer a clear path forward. Integration is not only possible—it is essential. For public health leaders, community organizations, funders, and researchers, the report serves as both a practical guide and a call to action.

To explore detailed strategies, real-world case studies, and full recommendations, readers are strongly encouraged to access the complete NACCHO report: *Bridging the Gap: Lessons Learned from Integrating Sexually Transmitted Infection and Harm Reduction Services*.