



COVID-19 NATIONAL RAPID ASSESSMENT

The institutional impact of COVID-19 on organizations providing HIV/STI/HCV services to people of color across the U.S., Puerto Rico, U.S. Virgin Islands, and Affiliated Pacific Island Jurisdictions

STRONGER TOGETHER PARTNERSHIP



Table of Contents

Executive Summary	6
COVID-19 National Rapid Assessment Background	11
Assessment Design	12
Findings	15
<i>Impact of COVID-19 on clients / consumers</i>	17
<i>Impact of COVID-19 on staff</i>	21
<i>Impact of COVID-19 on program activities and service provision</i>	27
<i>Impact of COVID-19 on program management</i>	31
<i>Impact of COVID-19 on institutional stability</i>	33
<i>Engagement in COVID-19 activities</i>	36
<i>Effective strategies, lessons learned, and service opportunities</i>	40
<i>Moving forward</i>	44
Discussion	47
Recommendations	50



Suggested citation

Castellanos, Daniel, Mazarei, Mazdak, Newells, Robert, Hucks-Ortiz, Christopher, Copeland, Raniyah, Toma, Lance, & Chacón, Guillermo. (2020). COVID-19 National Rapid Assessment. The institutional impact of COVID-19 on organizations of color providing HIV/STI/HCV services to people of color across the U.S., Puerto Rico, U.S. Virgin Islands, and Affiliated Pacific Island Jurisdictions. Black AIDS Institute, San Francisco Community Health Center, and Latino Commission on AIDS. Los Angeles, San Francisco, New York: Available at <https://ilhe.org/stronger-together-partnership-c19-national-rapid-assessment-report/>.

We Want to Thank...

Our study participants:

The anonymous 451 front-line staff and program managers that in the midst of a pandemic, took time off from serving our communities to answer our comprehensive web-based survey about the institutional impact of COVID-19 on their personal and professional lives, their clients, services and programs. They also gave us a glimpse of their strengths and resources used to develop new strategies to continue providing much needed services.

The 59 leadership staff at 51 organizations who told us their personal, professional and institutional stories filled with challenges, resiliency, and strength. Their stories provided us with information about the impact of COVID-19 on their staff and programs, their organization's financial and programmatic outlook, and their ability to maintain institutional stability in the midst of major disruptions. Their stories also gave us an insider perspective on the larger public health infrastructure across the U.S.

Our partners:

We want to thank the numerous staff, at over 142 organizations, who participated in this timely and needed effort by providing us feedback throughout the project, distributing information about the assessment, answering our surveys, and/or participating in the interviews. Their participation in this project does not necessarily constitute a representation of their institutional affiliations or an institutional endorsement of the recommendations outlined in this report. We apologize for any incorrect information in this list as well as any unintentional omissions. Please let us know if there is any incorrect or missing information.

ACQC; Abounding Prosperity; ACR Health; After Hours Project; AID Atlanta; AIDS Alabama; AIDS Project of the East Bay; AIDS United; Albuquerque Area Indian Health Board; Alliance For Living; Alliance for Positive Health; Alliance of AIDS Services - Carolina; AltaMed; AMA; APAIT; APEB; Apex Community Care; APICHA Community Health Center; Argus Community; Arianna's Center; Asian & Pacific Islander American Health Forum; Association of Asian Pacific Community Health Organizations; Behavioral Health Services; Betances Health Center; Bienestar Human Services; Black AIDS Institute; Bros in Convo; Cal-PEP; CAMBA; CAN Community Health; CARE Resource; Center for Pan Asian Community Services; Center for

Southeast Asians (CSEA); Centro Ararat; Chicanos Por La Causa; Coai; Colorado Health Network; Community Education Group; Community Health Centers of Oklahoma; Community Healthcare Network; Compass; Comunilife; Cornerstone Family Healthcare; COSSMA; Destination Tomorrow; DIASPORA Community Services; Diversity Center of Oklahoma; Entre Hermanos; Evergreen Health; Face to Face; Family Health Centers of San Diego; Fundación Latino Americana de Acción Social; GALA (Guam); GMHC; Hawai'i Health & Harm Reduction Center-Kua'ana Project; Hawai'i Island HIV/AIDS Foundation; HBI-DC; Heart of Florida United Way; High Impacto; Hispanic Federation; HIV Racial Justice Now; Hope and Help; Hyacinth; IMPACCT Brooklyn; In The Meantime Men; Iniciativa Comunitaria; Insights Teen Parent Services; Iris House; Jordan Health; LA City; La Clínica del Pueblo; La Fondita de Jesús; Lantern; Latin American Youth Center; Latino Commission on AIDS; Latino Commission on AIDS - Latinos in the Deep South; Latino Community Development Agency; Latinos Salud; Latinx LGBTQI Initiative; League of United Latin American Citizens; Maui AIDS Foundation; Medical Advocacy and Outreach; Morris Heights Health Center; Multicultural AIDS Coalition; My Brother's Keeper; NAESM; National Native HIV Network/Begaye Consulting; Native Health; Nazareth College; NC AIDS Action Network; NMAC; Nova Salud; NYC Health and Hospitals; Okla. Area Tribal Epi Center/Southern Plains Tribal Health Board; OutMemphis; P.A.C.T.A. (Puentes Abiertos Comunidades Transformadas y Autosuficientes); Palmetto AIDS Life Support Services ; Piedmont Care; Piedmont Health Services and Sickle Cell Agency; Poderosos; Positively U; PR CONCREA; Prevention305; PROCEED; Promesa; QLatinx; Reach LA; Resource Center; Rising Against All Odds; Rollins College; Safe Horizon; San Antonio AIDS Foundation; San Francisco AIDS Foundation/ Apoyo Latino; San Francisco Community Health Center; Servicios de La Raza; Sister Love; South Jersey AIDS Alliance; Southern Arizona AIDS Foundation; Southside Help Center; Sun River Health; Tapestry Health Systems; The AMAAD Institute; The TransLatin@ Coalition; Thrive SS; Trans Justice Funding Project; TransLatinx Network; Triad Health Project; Trinitas Regional Medical Center; TruEvolution; UBtheCure; United Bronx Parents; University of Nevada at Reno; University of Puerto Rico; Valley AIDS Council; Vivent Health; Voces Latinas; Waikiki Health; We Care TN; Wellness AIDS Services; Westbrook Clinic; Western North Carolina AIDS Project.; Whitney M. Young, Jr. Health Center.

Members of the National Convening Committee of the Virtual Strategic Think Tank

We want to thank the members of the Convening Committee for their guidance and input in conducting this assessment.

Bamby Salcedo, President & CEO, The TransLatin@ Coalition; Cathy Kapua, Deputy Director, Trans Justice Funding Project; Cody Knight, TEC HIV Program Coordinator, Okla. Area Tribal Epi Center/Southern Plains Tribal Health Board; Dázon Diallo, Founder & President, SisterLove; Dwain Bridges, Director of Finance and Operations, Thrive SS; Elaine Andres, C4H Community Engagement Coordinator, Asian & Pacific Islander American Health Forum; Francie Spencer, Funds Development Officer, NACHCI; Gabe Maldonado, Founder & CEO, TruEvolution; Gary Daffin, Executive Director, Multicultural AIDS Coalition; Guillermo Chacón, President, Latino Commission on AIDS; Jamila Shipp, Managing Director for Capacity for Health, Asian & Pacific Islander American Health Forum; Jen Lee, Director of Community Services and Partnerships, Association of Asian Pacific Community Health Organizations; Jesse Milan, President & CEO, AIDS United; Jorge Zepeda, Associate Director of Latino Programs, San Francisco AIDS Foundation; José Joaquín Mulinelli-Rodriguez, Executive Director, Coai, Inc.; Krystian Palmero, Content Strategist, Asian & Pacific Islander American Health Forum; Kunane Dreier, LGBT Program & Training Manager, Hawai'i Health & Harm Reduction Center; Kurt Begaye, Capacity Building Specialist, National Native HIV Network/Begaye Consulting; Lance Toma, CEO, SFCHC; Larry Scott-Walker, Co-Founder and Executive Director, Thrive SS; Luis Scaccabarozzi, Vice President, Latino Commission on AIDS; Manuel J. Diaz-Ramirez, Director of Community Health Action, La Clinica del Pueblo, Inc.; Paul Kawata, Executive Director, NMAC; Rafaelé Narváez, Director of Health Programs, Latinos Salud; Raniyah Copeland, President & CEO, BAI; Robert Contreras, President & CEO, Bienestar Human Services; Savannah Gene, STD/HIV/AIDS Prevention Program Director, Albuquerque Area Indian Health Board (AAIHB); Sean Coleman, Founder & Executive Director, Destination Tomorrow; Therese Rodriguez, CEO, APICHA Community Health Center; Toni Young, CEO, Community Education Group; and Wally Cantu, Chief Executive Officer, Valley AIDS Council.

Our team:

Staff at Black AIDS Institute (BAI), San Francisco Community Health Center (SFCHC), and Latino

Commission on AIDS (LCOA) who spent uncountable hours discussing and implementing this assessment. Aaron Chandler, Director of Development, BAI; Audra Tobin Severson, Senior Capacity Building Specialist, SFCHC; Christopher Hucks-Ortiz, Director of Prevention and Care, BAI; Daniel Castellanos, Director of Research and Innovation, LCOA; Guillermo Chacón, President, LCOA; Julio Rolon-Mendez, NYS Latino Gay/Bi Men's Initiatives Manager, LCOA; Lance Toma, Chief Executive Officer, SFCHC; Luis Scaccabarozzi, Vice-President, Director of Health Policy and Advocacy, LCOA; Mazdak Mazarei, Director of Capacity Building and Organizational Learning, SFCHC; Natasha Quirch, Development Director, LCOA; Pamela Tassin, Associate Director of Capacity Building, SFCHC; Raniyah Copeland, President and Chief Executive Officer, BAI; Rev. Rob Newells, Director of National Programs, BAI; Rosy Mota, Director of Community Health Education, LCOA; and Tatyana Moaton, Senior Capacity Building Specialist, SFCHC. Consultants Bryan Medina and Chris Mann. Designer Daniel Ravelo, Graphics & Web Development, LCOA.

Our funding partners:

We want to thank **Chevron**, **Elton John Foundation**, **Gilead Sciences**, **Janssen Pharmaceuticals**, **Merck & Co.**, and **ViiV Healthcare** for their generous support for this project. We also want to recognize the amazing support of the Black AIDS Institute, San Francisco Community Health Center and the Latino Commission on AIDS on their seed funding and for their amazing comprehensive support to invest in this unique people of color community driven project.

About the Stronger Together Partnership

Under the name of **Stronger Together Partnership (STP)**, **The Black AIDS Institute**, **San Francisco Community Health Center**, and **Latino Commission on AIDS**, three organizations led by and serving people of color, are joining forces with over 90 other organizations to address the institutional challenges posed by the Novel Coronavirus (COVID-19) to the provision of HIV/STI/HCV services to communities of color in the U.S., Puerto Rico, U.S. Virgin Islands, and the Associated Pacific Island Jurisdictions.

The Black AIDS Institute (BAI) is a non-profit organization dedicated to ending the HIV/AIDS epidemic in the Black community. BAI is the only uniquely and unapologetically Black HIV think and do tank in America. We believe in complete freedom for Black people by eradicating systemic oppression so that we can live long, healthy lives. We source our capacity building, mobilization, policy and advocacy efforts from Black leaders and communities across the country and provide high-quality direct HIV services and linkage to care to Black people.

San Francisco Community Health Center (SFCHC) is an LGBTQ and people of color community health center that believes everyone deserves to be healthy and have access to the highest quality health care. SFCHC's comprehensive and integrated approach to individual and community health is inclusive of medical care, dental services, behavioral health and substance use services, HIV prevention and care services, and street medicine, as well as HIV prevention capacity building services.

The Latino Commission on AIDS, founded in 1990 in response to the unmet national need for HIV/AIDS prevention and care for Latinos, seeks to address health disparities by spearheading health advocacy, promoting health education, developing and replicating evidence-based programs for PLWHA and high-risk communities, and building capacity across the public health sector, including CBOs, health departments, healthcare organizations, and universities. The Commission's unique mission and corresponding model encompasses capacity building, disease prevention and health promotion, access to care (HIV and hepatitis testing, linkages), community mobilization, and research and evaluation.



Raniyah Copeland
CEO & President,
Black AIDS Institute



Lance Toma
CEO,
San Francisco Community Health Center



Guillermo Chacón
President,
Latino Commission on AIDS



+



SAN FRANCISCO
COMMUNITY
HEALTH CENTER

+



=

**Stronger
Together
Partnership**

Executive Summary

Organizations that have been providing long-standing and proven-effective HIV/STI/HCV services to communities of color are now struggling to provide vital services while also addressing our newest pandemic, COVID-19. This challenge has been exacerbated within our communities of color which have suffered the long-term impact of health inequalities and of being at ground zero for both pandemics.¹ When organizations, such as these, are under acute stress, they are more likely and, in many cases, need to operate in survival mode, which means that attention is more narrowly focused on the immediate, the here and now. As such, these organizations may struggle to implement their strategic plans; leadership may have difficulty providing adequate staff support; and organizations may not be prepared to make informed, and sometimes difficult, programmatic and funding decisions.

The Black AIDS Institute, San Francisco Community Health Center, and Latino Commission on AIDS, three organizations which have worked collaboratively over many years and are led by and serve people of color, joined forces to create the Stronger Together Partnership (STP) in April 2020. Reaching out to over 142 other organizations, STP assessed the institutional challenges posed by the Novel Coronavirus (COVID-19) to the provision of HIV/STI/HCV services to communities of color in the U.S., Puerto Rico, U.S. Virgin Islands, and the Associated Pacific Island Jurisdictions.

The COVID-19 National Rapid Assessment looked at (a) the impact of COVID-19 on the ability of organizations and their workforce to continue providing HIV/STI/HCV services and the strategies enacted to continue providing them; (b) their capacity to address emerging COVID-19-related needs among their clients/consumers; and (c) their capacity to integrate COVID-19 services as an added focus for their short- and long-term institutional strategies.



Assessment design:

In order to assess the ways that organizations were meeting the challenges of providing services in the time of COVID-19, we conducted purposive sampling of 90 organizations across the U.S. and its Territories to encompass a variety of institutional settings, organizational sizes, populations served, and geographic locations. The purposive sampling took into consideration those organizations that served primarily people of color, had people of color in upper leadership positions, and provided services directly related to the HIV continuum of care and/or high impact supportive services.

This report presents a rapid analysis of the data collected. Fifty (51) semi-structured interviews, including 6 in Spanish, were conducted with 59 upper management staff at 51 unique organizations. Located in 15 states and 3 territories, these 51 organizations served a variety of geographic locations and service areas, including large urban areas and rural areas. A total of 168 program managers from 115 different zip codes in 23 states, the District of Columbia, and Puerto Rico completed the online surveys. A total of 283 front-line staff from 135 different zip codes in 22 states, the District of Columbia, Puerto Rico, and Guam completed the online survey. Eighteen percent (18%) of managers and close to 28% of front-line staff responded to the survey in Spanish.

Impact of COVID-19 on clients / consumers:

According to HIV/STI/HCV staff, COVID-19 has greatly impacted clients' health and psycho-social life in multiple ways. They reported delays in HIV/STI/HCV screening/testing, STI/HCV treatment, HIV care, and specialty care. While the impact on health has been considerable and diverse, survey respondents reported an even greater impact on their clients' psycho-social life in the areas of mental health, food insecurity, financial stability, and community connectedness and integration. Information on HIV seroconversion or poor HIV clinical outcomes is still scarce. However, several leadership staff reported on the potential increase of HIV transmission due to lack of available prevention services. Overall, interviews shed light on the synergistic impact of long-term inequalities among communities of color on COVID-19 health outcomes.

Impact of COVID-19 on staff:

The workforce of these organizations has endured, and continues to withstand, the challenges of service and organizational disruption in the context of socio-political upheavals in the U.S., including protests against police brutality, hate and racism, xenophobia, and/or transphobia. Given the great impact of COVID-19 on communities of

color, it is not surprising that staff, their families, and social networks have been greatly impacted as they often come from these very same communities.

Most organizations avoided infection or great casualties among their staff by swiftly implementing COVID-19 prevention measures to ensure the safety, well-being, and performance of their staff. However, many leadership staff expressed concern about the long-term trauma, burn-out risk, and, in some cases, death among their staff, community, and family members. Furthermore, for some leadership staff, the emotional toll of feeling responsible for their staff's well-being was often compounded with the personal toll of losing family members to COVID-19.

Not only had staff been personally impacted, COVID-19 impacted them professionally. Staff reported on the challenges of staying focused while working from home or implementing their program activities with limited technological or physical resources. They also had to contend with the overlap of their personal and professional lives. Whether returning to work or working from home, staff with children felt overwhelmed with the additional home responsibilities due to the closing of schools and day care services.

Impact of COVID-19 on services and programs:

As the community's needs increased, organizations saw the need to increase their service capacity, even while going through staffing, funding, and infra-structure challenges. Faced with these challenges, some organizations discontinued or scaled down essential services, including core services for homeless populations, incarcerated individuals, and those lacking access to public transportation. While some organizations started providing virtual and telehealth services, others re-started face-to-face services albeit in a restricted manner. Whichever the choice, deciding on which essential services to re-start and prioritize was a painful professional and ethical challenge for many organizations.

COVID-19 precluded face-to-face contact with clients, disrupted service delivery, and diminished the numbers of clients served. Organizations canceled or rescheduled major fundraising and community events and incurred costs associated with remote work and health and safety procedures. Further, each organization was forced to engage in an agency-wide and programmatic review that led to hard decisions about which clients and services needed to be prioritized.

Medically-oriented services can rarely be postponed. Therefore, many clinics and medical settings remained open and provided essential HIV services such as

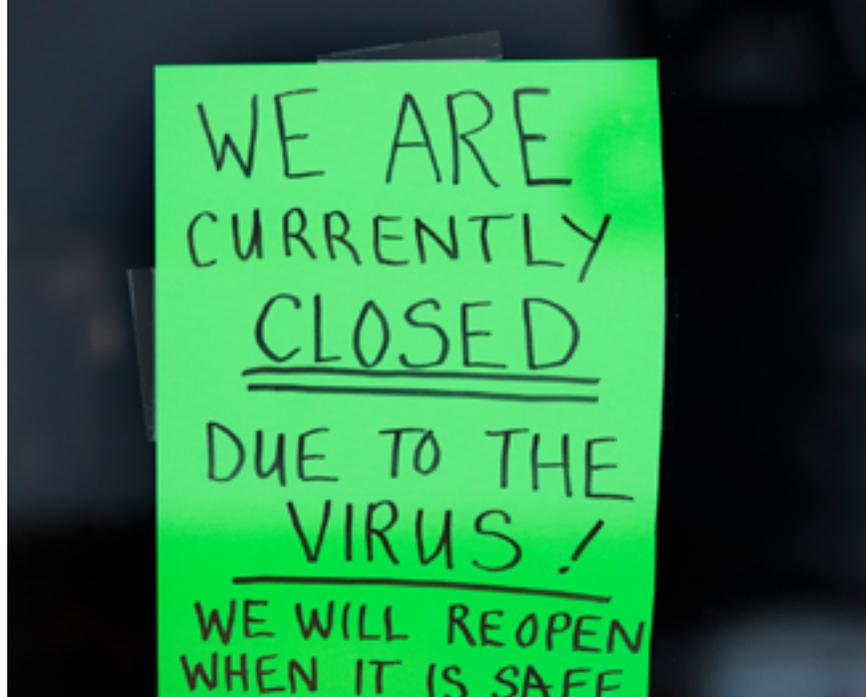
linkage to care, care, and treatment. On the other hand, low-threshold services such as social gatherings, community outreach and support groups, necessary to increase client engagement in services, were greatly impacted due to social distancing measures. Not surprisingly, services that rely on client engagement were also greatly impacted, including HIV testing, STI/HCV testing, and linkage to PrEP/PEP. In addition to impacting their direct services, COVID-19 impacted the work that organizations were doing in other service areas such as immigrant legal advocacy, leadership development, and peer training.

Impact of COVID-19 on institutional stability:

Most organizations were able to renegotiate their funding contracts, and most staff reported some or sufficient access to immediate resources needed to continue providing services, including policies and guidelines, PPE, work space, and COVID-19 training. However, a significant number of staff reported very little or no access at all to resources needed to adapt and implement services under these new conditions, including training in trauma-informed-care, technology training, and technical assistance to implement programmatic changes. Additionally, some staff expressed concern about the long-term impact of postponed program activities such as program evaluation and quality assurance.

Leadership staff were asked questions related to institutional stability, including the impact of COVID-19 on their finances and strategic planning. Organizations incurred a variety of expenses connected to the epidemic such as those related to safety measures, enhancement of infra-structure, or provision of new services. Organizations were often able to re-negotiate their contracts with funders to allow for these expenses. However, many small organizations were greatly impacted financially, including several that were not able to implement additional safety procedures such as acquiring PPE or installing plexiglass due to lack of funding.

Uncertainty about the future was felt across all organizations. Many organizations relied on annual fundraisers that were canceled or conducted virtually. Some organizations received additional assistance through COVID-19 emergency funds oftentimes made available from private foundations and utilized them to enhance their infrastructure. Other organizations utilized cost-saving measures, such as delaying the hiring of new staff.



Some organizations had healthy finances, enabling them to manage the additional costs associated with responding to the epidemic, often with unrestricted funds. Nonetheless, even organizations with adequate unrestricted funds expressed concern about the long-term sustainability of implementing ongoing safety procedures and work changes.

Engagement in COVID-19 activities:

As the COVID-19 epidemic unfolded, some staff reported that their organizations became involved in COVID-19 related activities, including community education about COVID-19 risks, protective measures, testing and treatment. Nonetheless, less than 50% of staff reported being involved in other key activities related to COVID-19 such as contact tracing, counseling to clients with or impacted by COVID-19, or case management to clients with COVID-19. Overall, staff reported a great need for a variety of resources and support in order to address emerging COVID-19-related needs among their clients. Requested resources and support ranged from educational materials and training to institutional policies and guidelines for emergency responses. About 70% felt that there was a clear need for technical assistance to integrate COVID-19 within their current HIV/STI/HCV programs.

Most leadership staff at health organizations reported they had already incorporated COVID-19 work within their scope of services, often in partnership with departments of health. Those in social service organizations were less certain about including COVID-19 as an added focus. They expressed concern about their staff's expertise to move from sexual health to general health, diverting the mission of the organizations, or overextending their capacity without appropriate funding.

Lessons learned and moving forward:

While COVID-19 has created numerous challenges for the participating organizations, many of them were able to rise to the occasion and meet those challenges. Some strategies utilized by organizations to meet those challenges included implementing team approaches to problem solving, embracing technological upgrades, and fostering innovation. Many leadership staff identified lessons learned from this pandemic and were doing their best to see this as an opportunity to develop new strategies and to expand their service portfolio.

Overall, staff reported a rapid increase in the use of new strategies to continue providing services, particularly the use of virtual media to provide counseling, health

education, and telehealth services. As expected, many organizations rapidly adopted Differentiated Service Delivery (DSD) as a strategy to account for the limitations imposed by COVID-19 on full delivery of services. In some cases, organizations proactively and creatively enhanced their ability to provide services under the new conditions, including digitizing their medical records, providing home testing, delivering sidewalk services and goods, and starting virtual services. Nonetheless, these new strategies were not universally adopted due to lack of infra-structure or resources, e.g., HIV home testing or telehealth.

In addition to service strategies, staff reported on program strategies utilized to continue providing services. In particular, programs utilized the prioritization of program activities and discussing grant requirements with funders, strategies that are also connected with DSD. Additionally, some organizations developed or enhanced partnerships with other organizations to pool resources to provide services such as HIV testing, telemedicine, and educational materials dissemination.

While many leadership staff saw potential for institutional growth in these changes and adjustments, they also expressed concern about what was being lost in these service adaptations. For instance, the use of social media resulted in positive outcomes in broader recruitment of clients and delivery of services. Nonetheless, the effectiveness of social media and electronic technology for services was not seen as generalizable across populations, particularly among those needing culturally appropriate services, requiring greater service engagement, or experiencing technological challenges due to their financial hardship, age, or geographic location.

Finally, over 50% of staff reported to be somewhat or very concerned about the impact of COVID-19 on service delivery moving forward. About 50% also reported to be somewhat or very concerned about their programs' ability to achieve overall program goals and complying with deliverables and funding requirements. Many leadership staff expressed concern about the future outlook of HIV, COVID-19 infections, and poor vaccination rates. In the short-term, leadership staff reported some level of uncertainty about the future landscape of services and funding. In the long-term, some leadership staff, particularly in the Southern States and in Puerto Rico, expressed concerns about the diversion of funding from HIV towards other health issues and the persistent geographic disparities in achieving the goals to End the HIV Epidemic.

Recommendations:

- While the use of electronic and virtual strategies may mitigate the impact of COVID-19 on the provision of client engagement activities, the technology gap (hardware, proper software, and quality of internet) among low-income individuals and those living in rural areas must be addressed.
- Supportive services for those at risk of HIV infection or living with HIV must be enhanced to address the exacerbating impact of COVID-19 on those already experiencing mental health issues, isolation, substance use, food insecurity, housing instability, and financial instability.
- Strategies to address burn-out, PTSD, and mental illness among staff need to be implemented and funded, including the presence of clinical support, time off, and childcare.
- Small organizations must receive infra-structure support and funding to continue providing HIV/STI/ HCV services in particular geographic areas and to particular populations to ensure the goals of Ending the HIV Epidemic and efforts to eliminate HCV are achieved across the U.S.
- Funding should be made available for critical institutional infrastructure enhancement, including staff development, technology upgrades, financial planning, contingency emergency planning, program innovation strategic, and succession planning.
- Research support and funding should be made available to organizations for program adaptation and for the development of original virtual interventions.
- Emergency plans at the local, state, and federal levels must be critically assessed and updated to ensure that social determinants of health impacting communities of color are taken into consideration.
- There is a need for engagement of communities of color in policy planning (specially on vaccine education, promotion, and provision) and on COVID-19 related policies, funding, and research.
- There is a need for policy and practice research with strong community participation to examine in-depth the ongoing changes in public health occurring as a result of COVID-19.



COVID-19 National Rapid Assessment Background

In order to continue making progress toward ending the HIV epidemic and addressing the emerging COVID-19 related needs of people of color, there is a need to understand the institutional impact of COVID-19 on organizations providing HIV/STI/HCV services. Although all Americans are experiencing the impact of COVID-19, the virus is especially widespread across states and cities with large minority populations.^{2,3} Specifically, there is concern about the institutional impact on organizations working on the End the HIV Epidemic goals.⁴ Several networks of non-profit organizations report a negative institutional impact due to the COVID-19 pandemic on HIV/STI/HCV services.⁵ The impact includes disruption of face-to-face contact with clients, disruptions to service delivery, and diminished numbers of clients served.^{6,7} It also includes drops in contributions, shifts in funder/donor engagement, collapsed revenues, and increased service-delivery costs. In response to COVID-19, organizations have canceled or rescheduled major events, increased remote work for staff, adopted new health and safety procedures, prioritized some clients and services, and revised agency wide and programmatic goals.^{6,9}

When organizations are under acute stress, they are more likely to operate in survival mode, which means that attention is more narrowly focused on the immediate, the here and now. As such, organizations may struggle to implement their strategic plans; organizations may not be prepared to make informed, and sometimes difficult, programmatic and funding decisions; and leadership may have financial and/or logistic difficulties providing adequate staff support.

To deeply understand these concerns, the Stronger Together Partnership (STP) conducted a national rapid assessment of the institutional impact of COVID-19 on organizations providing HIV/STI/HCV services to racial/ethnic minorities in the United States, Puerto Rico, U.S. Virgin Islands, and Associated Pacific Island Jurisdictions. Community-initiated and driven, this project was a proactive endeavor of multiple organizations seeking to obtain and analyze urgent information to guide

organizations in achieving the 2030 goals for Ending the HIV Epidemic and efforts to eliminate STI/HCV while responding to the impact of COVID-19 on communities of color and the organizations serving them.

Specifically, the assessment looked at the impact of COVID-19 on:

- a. The ability of organizations and their workforce to provide HIV/STI/HCV services as well as the strategies enacted to continue providing them;
- b. The institutional and workforce capacity to address the emerging COVID-19-related needs among the organizations' clients / consumers; and
- c. The institutional capacity to make COVID-19 an added organizational service focus while continuing to achieve institutional stability to implement their current strategic plans in service of ending the HIV epidemic.

Data collection, data analysis, and report writing occurred simultaneously over the duration of the project. Report writing included a preliminary brief report that was presented at the [COVID-19 Virtual Strategic Think Tank held on October 14th, 2020](#), and at the [USA Conference on HIV/AIDS on October 19th, 2020](#).

REACHING OUT TO OVER 142 OTHER ORGANIZATIONS, THIS REPORT ASSESSES THE INSTITUTIONAL CHALLENGES POSED BY COVID-19 TO THE PROVISION OF HIV/STI/HCV SERVICES TO COMMUNITIES OF COLOR IN THE U.S., PUERTO RICO, U.S. VIRGIN ISLANDS, AND THE ASSOCIATED PACIFIC ISLAND JURISDICTIONS.

Assessment Design

Drawing from rapid assessment methodologies,¹⁰⁻¹² this project focused on key pressing and immediate issues; used a mixed-methods approach (i.e., semi-structured interviews of upper leadership staff and anonymous surveys of program managers and front-line staff); gathered informed judgement from key informants (i.e., service providers); and focused on action oriented and pragmatic information (i.e., institutional impact, effective strategies, and resource needs). The project's design, planning, and implementation was a collaborative effort of multiple organizations. The research team was composed of staff at BAI, SFCHC, and LCOA, with guidance from service providers, community leaders, public health officials, and researchers.

Prior to data collection, the research team field tested the 60-minute semi-structured interview script for upper leadership staff, the program manager's survey, and the front-line staff's survey to ensure linguistic appropriateness, relevance of topics, and readability of data collection instruments. Field testing consisted of testing the survey among 6 staff at the partner organizations, 1 focus group session with the staff testing the design, and a follow-up team discussion. The interview was tested through 2 mock interviews with staff at the partner organizations and a follow-up team discussion.

The Latino Commission on AIDS IRB (US DHHS IORG0010660) approved the protocol on August 17th, 2020. The assessment adhered to standard practices for ensuring confidentiality of paper-based and electronic data, including password protections, restricted access, data de-identification, and training on Ethics and Research on Human Subjects for the research team.

Participating organizations were reminded that their participation was voluntary and that their participation or lack of would not impact the institutional relationship with STP's member organizations. The research team also discussed with contacts at organizations the voluntary nature of the study and requested their commitment to holding the ethical requirement of a coercion-free approach to data collection.

Interviewees received information about the project and informed consent several days prior to the interview, and interviewers requested verbal consent at the beginning of the recording. The anonymous online surveys provided similar information about the project and requested explicit informed consent before answering the survey. Given the anonymous nature of the surveys, the team did not collect any names or emails of the managers or front-line staff as part of the survey.

Because of their leadership role, interviewees did not receive compensation for their participation. On the other hand, survey participants had the option to receive a \$20 gift certificate in appreciation for their time by clicking a link that redirected them to a separate and independent page to maintain their anonymity with the survey data.

Sampling

In consultation with the leadership at the STP, members of the Convening Committee, and members of STP's professional network, the research team developed a list of organizations providing HIV/STI/HCV services to communities of color across the U.S. The team conducted purposive sampling of 90 organizations to encompass a variety of settings (i.e., community-based organizations, HIV organizations, community health clinics), organizational sizes (i.e., small and medium); populations served (i.e., African Americans/Black, Asian Pacific Islanders, American Indian, Native Hawaiian, and Latino/Hispanic) and geographic locations (i.e., U.S., Puerto Rico, U.S. Virgin Islands, and Affiliated Pacific Island Jurisdictions). The purposive sampling also took into consideration those organizations that serve primarily people of color and have people of color in upper leadership positions. Organizations selected provided services directly related to the HIV continuum of care (e.g., community education, psychosocial support, HIV/STI/HCV testing, PrEP engagement, linkage to and retention in care, and HIV care) or high impact supportive services (i.e., housing, substance abuse treatment, and mental health treatment).

The research team contacted upper management at these organizations to request their participation. To assess the impact at various institutional levels, organizations were asked to select (1) an upper management staff with direct and concrete knowledge of the organization's workforce capacity, service portfolio, strategic plans, funding, and institutional infrastructure (interview component), and (b) 1 to 2 mid-level managers and 5 to 7 front-line staff with direct and concrete knowledge of HIV/STI/HCV programs,

delivery of HIV/STI/HCV services, and clients/consumer needs (survey component). To be eligible to participate in the survey, front-line staff had to provide HIV/STI/HCV-related services and agree to participate after reading the informed consent. Eligible managers had to supervise HIV/STI/HCV-related services and agree to participate after reading the informed consent. Staff at over 142 organizations participated in the different components of this rapid assessment.

Data collection

The interviews of the upper leadership were conducted in English or Spanish via *Zoom*. The interview script included questions on the following domains: organizational characteristics; COVID-19's impact on grant compliance, services, staffing, funding and strategic plans; strategies utilized to continue providing services and to begin addressing COVID-19-related emerging needs; and assessment of capacity and resources (current or needed) to address COVID-19 as an added organizational focus.

Eight interviewers were trained on conducting semi-structured interviews and utilizing the project's interview guide. The audio recordings were electronically submitted to *Transcribeme.com* for transcription. The team reviewed the accuracy and completeness of the transcriptions. When necessary, sensitive information was removed from transcripts to ensure confidentiality. The MS Word transcriptions were then transferred to *dedoose* for analysis.

The anonymous online surveys for managers and front-line staff were hosted on *SurveyMonkey*, in English and Spanish. The surveys assessed the following domains: personal and professional impact of COVID-19; institutional impact of COVID-19 on HIV/STI/HCV services, staff, program resources, and program implementation; programmatic strategies utilized to continue providing HIV/STI/HCV services and to address the emerging COVID-19-related needs; and assessment of capacity and resources to address COVID-19 as an added organizational focus. Survey data was then transferred from *SurveyMonkey* to *SPSS 26* for analysis.

Data analysis

The research team developed a codebook for analyzing the transcripts that included the main research themes while providing some flexibility for coders to identify additional codes. The codebook was field tested as part of the interviewers and coders training. Three members

of the research team coded the interview transcripts in *dedoose* and debriefed regularly on the applicability of the codebook and the need for additional codes.

The research team analyzed the quantitative data using *SPSS 26*. For this report, the team focused on descriptive analysis, including means, standard deviations, frequencies and percentages. Further analysis may include, if appropriate, analysis of variance (*One-Way Anova and Post Hoc Multiple Comparisons*) to identify differences along major domains of inquiry, including organizational size, geographic location, and respondent role.

**THE DATA OF THE STUDY RELIES
IN ZOOM INTERVIEWS WITH
58 UPPER LEADERSHIP AND ONLINE
SURVEYS WITH 168 MANAGERS
AND 283 FRONT-LINE STAFF
ACROSS THE U.S.**

THE STUDY AIMED TO UNDERSTAND THE ORGANIZATIONS' RESPONSES TO THE COVID-19 CRISIS BY EXAMINING CHANGES TO THEIR SERVICES, FUNDING, FINANCES, TECHNOLOGY ADAPTIONS, AMONG OTHERS.



Findings

Interview component sample

A total of 51 interviews, including 6 in Spanish, with 59 upper management staff at 51 unique organizations were conducted. Thirty-four interviewees were executive directors / presidents / CEO / COO of their organizations; and twenty-four interviewees occupied upper leadership positions. Located in 15 states and 3 territories, these 51 organizations served a variety of geographic locations and service areas, including large urban areas and rural areas. Some organizations provided only HIV-related services while others provided a variety of health and social services in addition to HIV. To maintain the confidentiality of the interviewees, more detailed information about the organizations is not shown in this report.

Survey component sample

A total of 168 program managers from 115 different zip codes in 23 states, the District of Columbia, and Puerto Rico completed the online surveys. A total of 283 front-line staff from 135 different zip codes in 22 states, the District of Columbia, Puerto Rico, and Guam completed the online survey. Eighteen percent (18%) of managers and close to 28% of front-line staff responded to the survey in Spanish. Demographics for survey respondents are shown in Table 1.

DEMOGRAPHICS	Managers		Front-line staff	
Age	M=41.7 years (SD=10.5, n=159)		M=37.5 years (SD=11.4, n=269)	
Gender*				
Female	54.8%	92	59.0%	167
Male	40.5%	68	35.7%	101
Transgender	4.2%	7	4.6%	13
Race*				
Asian/Pacific Islander	4.2%	7	5.3%	15
Black	17.9%	30	17.0%	48
Latinx	53.0%	89	54.4%	154
Native/Indigenous	2.4%	4	3.9%	11
White	29.8%	50	26.5%	75
In your own words			2.8%	8
Education completed*				
HS / GED or less	4.2%	7	16.3%	46
Some college	17.3%	29	21.6%	61
Trade vocational	4.2%	7	6.0%	17
College degree	42.9%	72	42.4%	120
Graduate school	35.7%	60	21.9%	62
Length of time in the HIV field	11.0 years (SD=8.6, n=167)		5.8 years (SD=6.0, n=281)	
Length of time in the current role	4.5 years (SD=4.9, n=166)		3.7 years (SD=4.1, n=277)	
<i>Notes: To increase anonymity of survey respondents, demographic questions were optional. Only percentages above 2% are listed.</i>				
<i>* Multiple choice question.</i>				

Table 1. Demographics of survey respondents

While survey respondents came from a variety of organizations, the sampling strategies emphasized HIV service organizations and/or community-based organizations and organizations providing HIV/STI/HCV-related services to communities of color. Table 2 shows information about the survey respondents' organization type, populations served, and services provided/supervised. Close to two thirds were HIV service organizations and over half (56%) were community-based organizations. Overall, respondents provided/supervised a broad variety of services along the HIV prevention and treatment continuum of care to a variety of communities.

ORGANIZATIONAL INFORMATION	Managers (n=168)		Front-line staff (n=283)	
	%	N	%	N
Organization type*				
HIV service organization	61.3%	103	75.3%	213
Faith-based organization	1.2%	2	0.4%	1
Substance use center	9.5%	16	9.5%	27
LGBTQ organization/center	25.6%	43	33.2%	94
Multiservice organization	13.7%	23	24.0%	68
Youth organization/center	6.5%	11	4.9%	14
Senior organization/center	1.8%	3	1.4%	4
Community Health Center/FQHC	16.1%	27	24.4%	69
Community-based organization	56.0%	94	37.5%	106
Other	10.1%	17	4.9%	14
Main populations served*				
Asian	13.7%	23	18.7%	53
Black	64.3%	108	65.4%	185
Latinx/Hispanic	81.5%	137	84.1%	238
Middle Eastern	5.4%	9	11.3%	32
Native American / Indigenous	8.3%	14	15.2%	43
Pacific Islander	8.9%	15	13.8%	39
White	47.0%	79	57.2%	162
Gay and bisexual men / MSM	82.7%	139	85.2%	241
Lesbian and bisexual women / WSW	36.9%	62	48.8%	138
Transgender individuals	69.0%	116	72.1%	204
Families	17.3%	29	26.1%	74
Women	48.8%	82	58.7%	166
Youth	41.1%	69	38.2%	108
Elderly	29.2%	49	42.4%	120
HIV negative individuals	62.5%	105	62.9%	178
People living with HIV	83.9%	141	83.0%	235
Substance users	63.1%	106	66.4%	188
Homeless individuals	49.4%	83	54.4%	154
Individuals experiencing housing instability	59.5%	100	59.0%	167
Incarcerated or recently released individuals	36.3%	61	38.2%	108
Immigrants	44.0%	74	43.8%	124

Services supervised/provided*				
Social gatherings / community engagement	46.4%	78	36.0%	102
Condom distribution	65.5%	110	65.0%	184
Community outreach	73.2%	123	57.2%	162
Sexual health education	66.1%	111	67.5%	191
Support groups	54.2%	91	37.5%	106
Counseling	36.3%	61	43.8%	124
Mental health services	20.8%	35	24.0%	68
Harm reduction services	38.7%	65	38.9%	110
Housing case management	20.8%	35	27.9%	79
Transgender health	23.2%	39	24.4%	69
HIV testing	63.1%	106	59.0%	167
STI/HCV testing/screening	48.4%	82	42.4%	120
Linkage to PrEP and PEP	66.1%	111	61.1%	173
Linkage to HIV care	71.4%	120	67.1%	190
STI/HCV treatment	31.5%	53	31.8%	90
HIV case management	38.7%	65	40.3%	114
HIV care	32.1%	54	30.4%	86
HIV treatment adherence services	45.8%	77	41.0%	116
HIV viral load monitoring	31.0%	52	34.6%	98
Other	10.1%	17	9.2%	26

* Multiple choice question.

Table 2. Organizational information of survey respondents

Impact of COVID-19 on clients / consumers

COVID-19 has greatly impacted clients' health and psycho-social life in multiple ways. See figures 1 and 2 below. While access to HIV medication (HIV medication disruptions) was not as majorly or severely impacted, front-line staff and managers reported major or severe delays in screening/testing, HIV care, and specialty care. Perhaps because of the inability to have regular contact with clients, about 20% of staff did not know about the impact on hospitalizations and deaths.

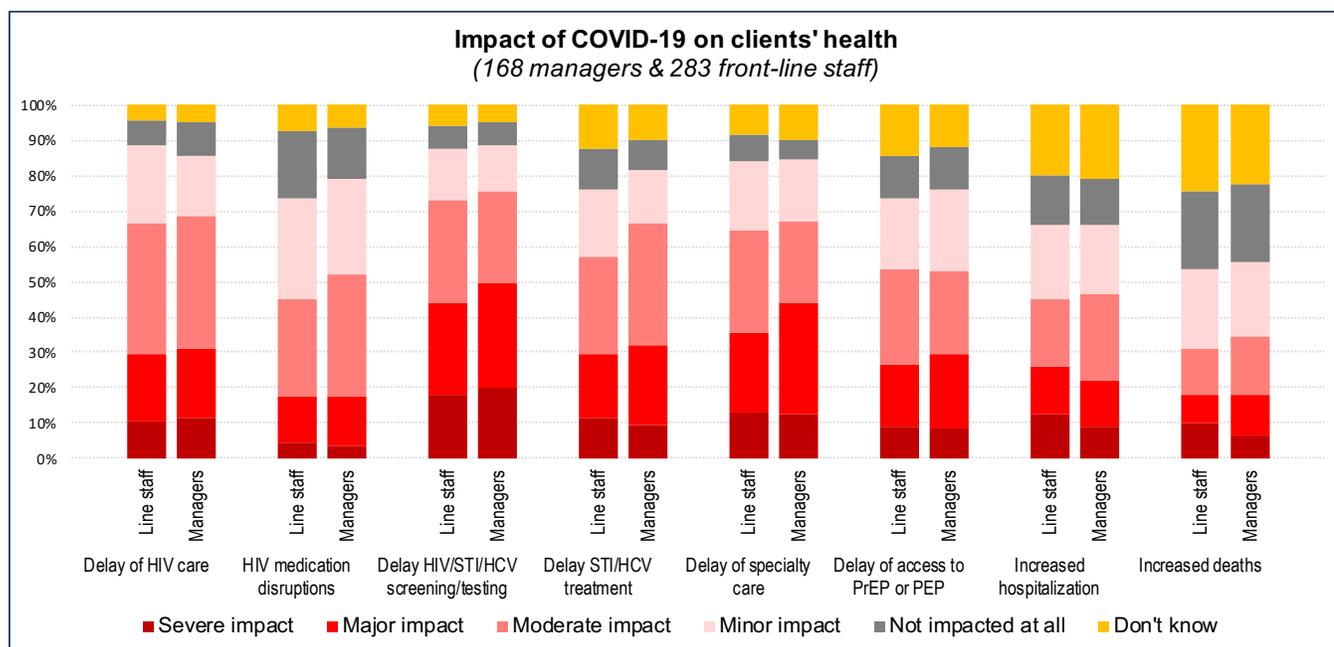


Figure 1. Impact of COVID-19 on clients' health

While the impact on health has been considerable and diverse, survey respondents reported on the greater impact of COVID-19 on their clients' psycho-social life. Staff reported major or severe impact on every domain of a client's psychosocial life, from isolation, to substance use, to basic living conditions. Over a third of respondents reported major or severe impact on interpersonal violence. At the same time, a quarter of respondents did not know about the impact of COVID-19 on interpersonal violence.

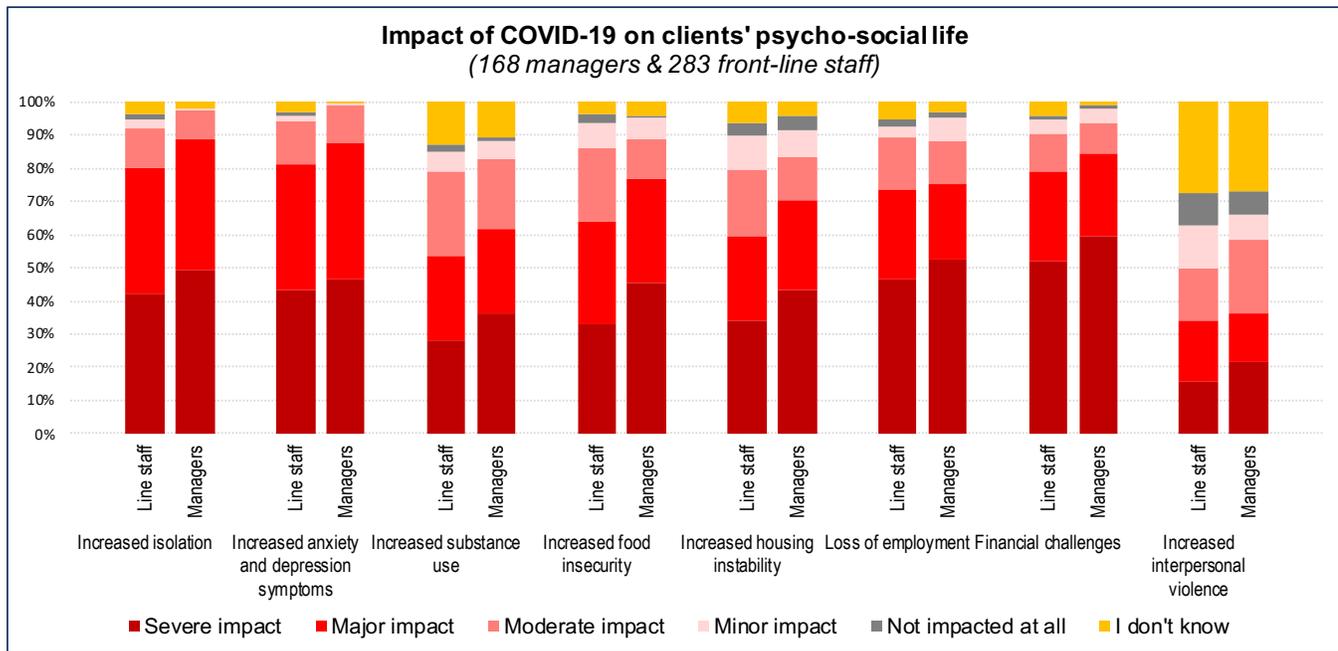


Figure 2. Impact of COVID-19 on a client's psychosocial life

Consistent with survey findings, interviews of leadership staff reported on the great impact of COVID-19 on their clients' psychosocial life and health status. For instance, many interviewees reported on the impact of COVID-19 on community connectedness and integration that could help clients maintain their social support systems.

But the connectedness has been a problem as well-- the lack of connectedness from the clients, because they're already isolated. A lot of them are just isolated in life, period, so when they would come to our agency and have group interaction, that helped them. (Executive Director, CBO, California)

So, it was challenging in the beginning. It was very challenging. It was hard for our clients to understand that they couldn't come to the agency when they really depended on our agency. When they needed that safe place, they really felt safe at our agency. When COVID hit, it was hard because a lot of them had no place to go. (Program Manager, CBO, Hawai'i)

Leadership staff also spoke of the impact of social distancing measures on increased isolation in their communities and decreased emotional support from service organizations.

I think for that population we work with, the whole point of coming to the center is they need to be around people who are like them and get that kind of support. So that's something that, I think, our youth are not getting that level of support while we have to keep that center closed. (Director of Programs, AIDS Organization, Arizona)

In addition, some staff spoke of the less tangible ability of staff to provide emotional support to their clients through a physical connection.

And that's very difficult and interesting conversation to have with some people who have especially been working in the field for the amount of time that they have, the experience to know that that is their best-- that's their best weapon, that's in their

arsenal to be able to help somebody -- it's their physical helping hand. That that emotional support that doesn't come from anything but the physical presence of another person. (Program Coordinator, Tribal Organization, Oklahoma)

Particularly on Saint Croix, we have a very strong Hispanic community here. And Caribbean people, African Americans, the Latino community, we are very social individuals. [...] Particularly, the Latino community, every time they greet each other, they kiss each other on the cheek on either side. And that's just if we're greeting, and so we're the kinda people that's used to that and wanna connect and sometimes also, a fear of the change. And so, we saw that struggle. (Management Team, DOH, U.S. Virgin Islands)

As two leadership staff reported, organizations were trying to implement service strategies to ameliorate the increase in mental health issues among their clients, particularly as the epidemic continued for months.

We sometimes get more folks on the virtual groups than we did in person because it's an easier mechanism. Although now folks are kind of-- I think they're COVID fatigued, right? And anxiety and depression and loneliness is starting to creep in. So, folks want that connection, which is why we reopened on three days out of the week to allow folks to come in. (Executive Director, Community Center, New York)

So, our clients come in for the takeout food and they hang around outside. So there's still some interaction among them. We try to discourage big groups getting together. But they're outside. We have some seating areas outside. And so, that's working out okay. But it's isolating because that was their place to come, to meet with others, to communicate. And there's less opportunity to do that now. (Executive Director, AIDS Organization, Texas)

While information on HIV seroconversion or poor HIV clinical outcomes is still scarce, several directors reported on the potential increase of HIV transmission due to the disruption of HIV prevention and care.

We also knew that people continue to have sexual relations regardless of the circumstance, and people continue to need testing and need those services. So, that was a big thing because the health department actually shut down and wasn't offering testing services other than just treating folks that were positive or potentially positive. (Director of Prevention, CBO, North Carolina)

[Not being] able to support clients who are in the midst of seroconversion or who are long term survivors of HIV who are in care is impacting their ability to meet those needs and meet those objectives. And as a result, it has impacted our entire region around HIV transmission. And we see data that reflects an uptake in HIV transmission from quarter to quarter in Central Florida in the midst of the pandemic. (Executive Director, CBO, Florida)

Several directors also reported on the increase in factors related to HIV risk, including substance use, domestic violence, and sex work. Seeing the need for supportive services, some organizations prioritized them.

Los casos reportados por nuestras clientas de violencia doméstica subieron exponencialmente. Pedidos para hacer pruebas de VIH ya en el segundo mes habían subido enormemente, para hacerse pruebas de VIH, para hablar estos temas de prevención [...] Ha subido el consumo de alcohol, ha subido el sexo sin protección. Entonces todos estos servicios que tienen que ver con orientación individual para desarrollar prácticas seguras de sexo o prácticas saludables en cuanto al cuidado de la salud mental siguen dándose, esto sí se sigue dando. (Director of Community Health, Health Clinic, District of Columbia)

The cases of domestic violence reported by our clients rose exponentially. Requests to do HIV tests already in the second month had risen enormously, to take HIV tests to talk about these prevention issues [...] Alcohol consumption has risen, unprotected sex has risen. So, all these services that have to do with individual guidance to develop safe sex practices or healthy practices in terms of mental health care continue to be given, this does continue to occur.

In addition to the impact on health, interviews also shed light on the synergistic impact of long-term socio-economic inequalities among communities of color and the impact of socioeconomic and service restrictions imposed by COVID-19.

The other program that saw a huge increase is our food distribution. So, because of the geographic isolation in our service area, a lot of people don't have access to healthy food. There's also a lot of people that rely on the food distribution that we do because either their food stamps are not enough, or because they're not eligible for food stamps for one reason or another. (Executive Director, AIDS Organization, North Carolina)

But people in our communities, Latino communities, they are undocumented or with documents but they are service workers. They're not saving money. They don't have money. Because the hours have been reduced because they don't have work, and they still need to cover basic needs. (Executive Director, AID Organization, Alabama)

Let's talk about our HIV positive folks. So, immediately, we stopped them coming into the office and we started to implement signing documents through just mobile phones, sending it electronically. A lot of them have food needs and our food pantry is a really big thing. So, what we would do is put together packages of food for them and they could come to the door and then we just hand it off to them at the door. A lot of that has kind of led to feelings of isolation for the clients and that human touch and interaction. Again, it's a very rural area. So, when they come to the office, it's kind of like they're getting to see people again. They love their case managers. They love the front desk people and we just cannot have that connection that we had before. So, it's put a lot of stress, definitely, on that population. (Executive Director, AIDS Organizations, Hawai'i)

These socio-economic inequalities will certainly hinder the ability of organizations to fully implement some of the new strategies for continuing providing services to the most vulnerable populations. For instance, utilization of telehealth services is not only hindered by a client's technological skills or hardware (e.g., phone or tablet) but also by the technological and infrastructure divide in many communities, impacting both clients and organizations.

Estábamos dando unos talleres de capacitación, en el nivel de autosuficiente, autoestima, trabajando área económica. Estábamos trabajando un montón de áreas para nuestros participantes. ¿Qué pasa? Que al venir la pandemia, hubo que cortar eso y entonces nos quedamos como "¡oh!". Ellos se quedaron con hambre, porque no pudieron terminar y nosotros nos quedamos en el limbo. Y entonces, ahí tratamos de hacerlo por Zoom, pero no todo el mundo tiene las herramientas para, a través del internet, poder acceder. O son limitadas[...]. De que puede ser que, a lo mejor sí, pues tienen su teléfono inteligente o su tableta, a lo mejor tienen su computadora; pero no necesariamente tienen la internet ilimitada, como quizás nosotros como organización tenemos [...] Tú conoces que aquí hay áreas que el internet donde quiera tú lo coges. Hay sitios que no, hay sitios que tenemos problemas porque la señal es [débil]. Otra cosa es que, si se va la luz, se fue el internet. (Management Team, CBO, Puerto Rico)

We were giving some training workshops on self-sufficiency, self-esteem, working in the economic area. We were working a lot of areas for our participants. What happened? That when the pandemic hit, we had to cut that and then we were like "oh!" They were left hungry because they couldn't finish, and we were left in limbo. And then, we tried to do it through Zoom, but not everyone has the tools to access it through the internet. Or they are limited [...] May be they have their smartphone or tablet, maybe they have their computer, but they do not necessarily have unlimited internet, as perhaps we as an organization have [...] You know that there are areas here where the internet signal is everywhere you want it. But there are places that don't, there are places that have problems because the signal is [weak]. Another thing is that, if the power goes out, the internet is gone.

Surveys and interviews in this assessment illuminated the broad and varied impact of COVID-19 on communities of color and the challenges organizations faced to appropriately respond to their clients' needs. Findings also stressed the severe impact of COVID-19 on populations already experiencing health, economic, and social challenges prior to COVID-19.

Impact of COVID-19 on staff

Understandably, close to half of staff reported COVID-19 had greatly increased anxiety and concerns over their own health. As seen in figure 3, they also reported on the major and severe impact of COVID-19 on the health of their families and social networks. Given the great impact of COVID-19 on communities of color, it is likely that staff have been personally impacted as they often come from these very same communities.

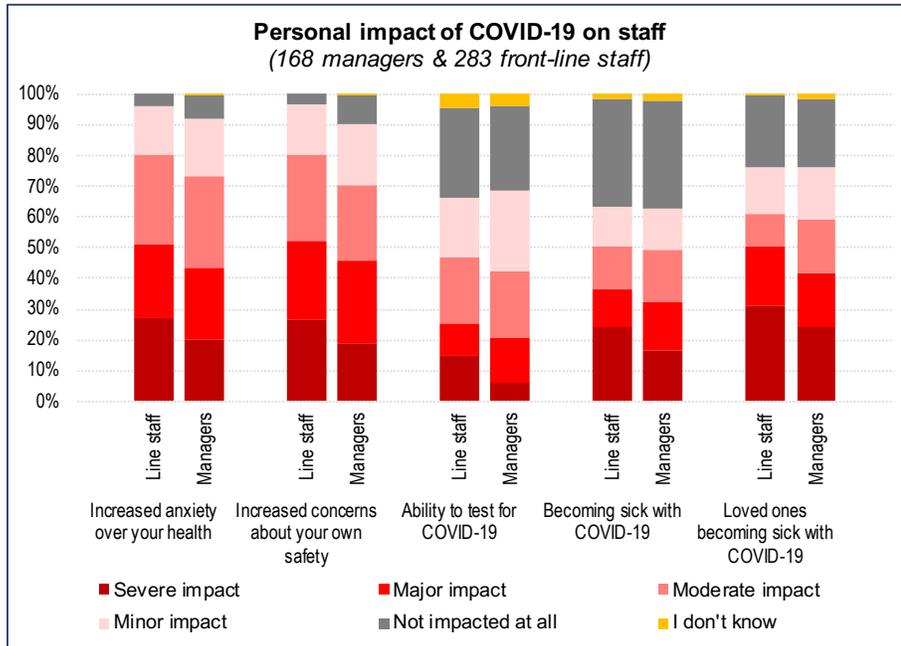


Figure 3. Personal impact of COVID-19 on staff

Managers were asked to assess the impact of COVID-19 on the staff they supervised. Compared with staff’s self-report, managers assessed a higher level of impact on their staff. For instance, while half of staff self-reported major or severe increased anxiety over their health (51.1%) and increased concerns over their safety (52.1%) as shown in figure 3, managers reported 65.5% of their staff experienced major or severe anxiety over their staff’s health and 64.9% experienced concerns over their safety (data not shown)

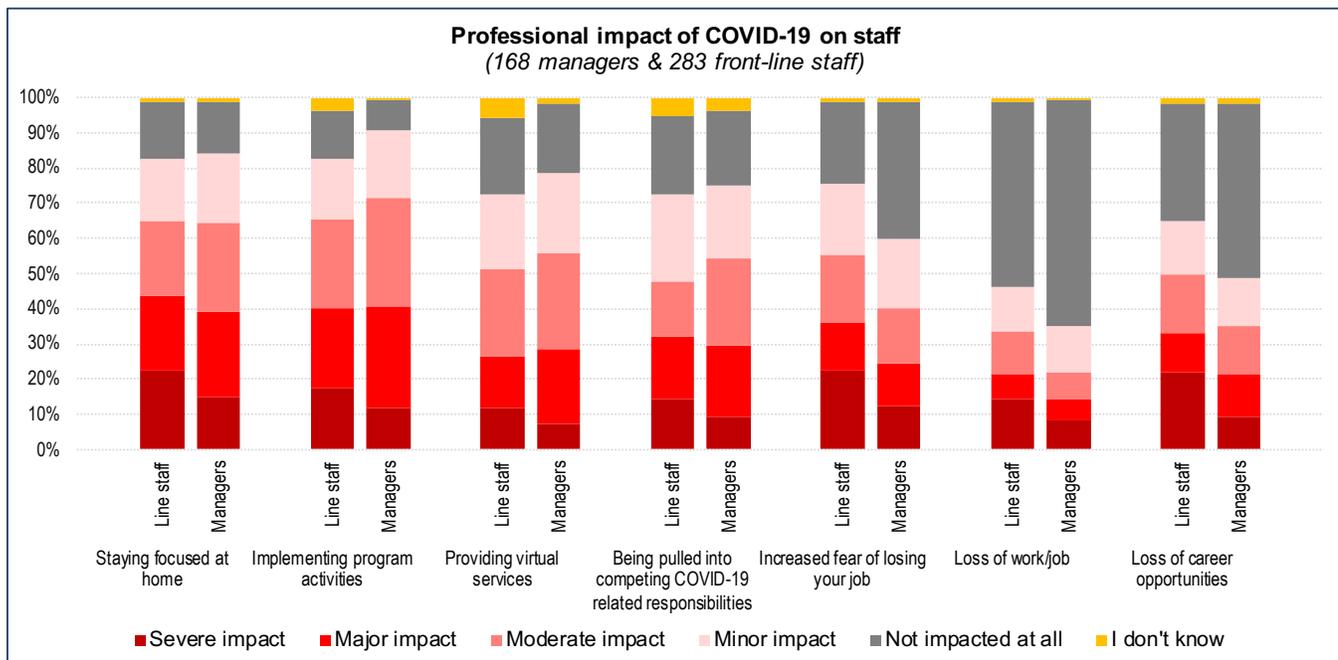


Figure 4. Impact of COVID-19 on staff’s professional life

In addition to the personal impact on staff, COVID-19 has impacted their professional lives as seen in figure 4 above. A great number of front-line staff reported major or severe impact on their ability to stay focused at home, implementing program activities, fear of losing their jobs, and career opportunities. On the other hand, the impact on actual employment was reported less severe than in other domains.

Managers were asked to assess the professional impact of COVID-19 on the staff they supervised (data not shown). Compared to staff's self-reports (see figure 4), managers reported higher levels of major or severe impact of COVID-19 on their staff's ability to stay focused at home (43.5% vs. 46.5%), implement program activities (39.9% vs. 47.0%), and providing virtual services (26.5% vs. 35.7%). On the other hand, compared to staff's self-reports, managers reported lower levels of major or severe impact of COVID-19 on their staff's future employment status (36.0% vs. 29.7%) and career opportunities (33.2% vs. 23.8%).

Similarly, leadership staff reported on the broad and varied impact of COVID-19 on their staff, including becoming sick and, in a several cases, dying. In particular, fear of returning to the office or engaging in face-to-face services was common among staff, often because of the presence of older relatives, multi-morbidities, or trauma.

Initially our navigators were really scared on the case management side. Because they're all people living with HIV, varying risk factors, different ages, etc. So, it was just scary. And at first, and certainly we weren't going to force anybody or pressure anybody to do it. (Executive Director, AIDS Organization, North Carolina)

We've had people who've lost folks. So yeah, so, I mean, people have said they were ready to come back to test, to do testing. And I think once it sort of got to the point where they had to do it, some people were less ready than they thought. (Executive Director, CBO, Massachusetts)

Yo no puedo obligar a los choferes a que trabajen, porque ellos tienen temores, tienen familia, y entonces, pues no quieren. Y si no quieren, pues no puedo, y yo tenía dos choferes muy buenos. Yo tengo un chofer que es local, que era el que más usábamos para el área local, pero ese es el que no quiere trabajar. (Management Team, CBO, Puerto Rico)

I cannot force drivers to work because they have fears, they have family, and then, well, they don't want to. And if they don't want to, then I can't, and I had two very good drivers. I have a driver who is local, who was the one we used the most for the local area, but that is the one who does not want to work.

Many directors were concerned about the emotional impact of the extended epidemic on their staff and the burden of changing work conditions.

So, I think folks are burnt out. Even with all the support that they're getting from working from home. People on some level just really want to get back to normal. So, it's like there's COVID fatigue. You know, we're at the six, seven months mark now. Everyone understands why we still need to be where we are, but they're tired [...] I mentioned it before, it's this kind of fatigue issue. We're trying to figure out how do we support our staff, who themselves either have had it and recovered from it, or know people who have had it, or someone that they knew died of it. All this stuff outside of their normal day to day. Because life is just more stressful for everybody, regardless of what you do for a living. (Director of Programs, AIDS Organization, Arizona)

Most interviewees reported that organizations and staff had implemented precautions, and for the most part, avoided infection. For those working in health care and allied professions, the impact of COVID-19 posed unique challenges. While navigating the challenges specific to their profession, health force workers also had to endure the issues that COVID-19 created for all Americans, and they reported on the impact of COVID-19 on staff's extended families and social networks.

Luckily, none of the staff have been directly impacted. We have all been able to maintain really good health. But we do have a lot of staff that also have extended family members like their parents that have been affected by COVID-19. (Management Team, CBO, Arizona)

And we have people who are living within the communities right now that are being the most-- that are being impacted the most right now across the country due to COVID. And just like I spoke earlier about the individual who's very, very integral in the ceremonial aspects of her [Native American] community, it's a conversation that comes up quite a bit of a check-in of how people are doing because it's their friends, their cousins of people who are being impacted directly. (Program Coordinator, Tribal Organization, Oklahoma)

Whether returning to work or working from home, staff with children have felt overwhelmed with additional home responsibilities due to the closing of schools and day care services.

I think for the staff, there is a little bit of burnout, not because they're overworked in the work setting, but because it's work plus everything else. The younger staff who have children at home who are being homeschooled because the schools are not open, it's challenge and it's a worry. And that is on top of their work responsibilities. (Management Team, health clinic, Puerto Rico)

So, definitely having access to the technology really pushed us to come back at least partially, and just staff not seeing patients. But I think that that was the hardest thing to do because some people had to make arrangements for their children because they're home schooling their children at this time, so it was really difficult for them to transition back to working in an office space and have those supports in place for their family. So that was tough, but we were able to work around it. We were able to find solutions. (Management Team, CBO, Arizona)

Interviewees reported heightened concerned about burn out issues among their staff, particularly with the lack of clear, concrete, or firm plans to return to work.

Burnout is a big one. We think how can we support our staff to continue doing this work? Because it's not letting up, right. In fact, we're entering or we've entered a whole new wave. I worry about that. So, having an adequate support, emotional support for staff is critical. (Division Director, CBO, California)

Al principio de la crisis sí hubo un poquito [de apoyo]. Vino alguien de la Cruz Roja, como un psicólogo, a dar un poco de counseling y todo eso, pero eso fue al principio. Ahorita es un desastre, la verdad. No, no siento que hay apoyo, ni emocional, ni apoyo económico. Estamos felices de tener todavía un sueldo, pero también hay preguntas o hay dudas en ciertas gentes, y no hay claridad, no hay-- como lo que me preguntabas, "¿Cuál es el plan para regresar?" No hay plan. (Vice-President, CBO, Washington)

At the beginning of the crisis, there was a little [support]. Someone from the Red Cross came, like a psychologist, to give some counseling and all that, but that was at the beginning. Right now, it's a disaster, really. No, I do not feel that there is support, or emotional, or financial support. We are happy to still have a salary, but there are also questions or there are doubts in certain people, and there is no clarity, there is no-- like what you were asking me, "What is the plan to return?" There is no plan.

For some directors, the emotional toll of feeling responsible for their staff's well-being was often compounded with the personal toll of feeling fearful for their lives, losing their own family members to COVID-19, and seeing the impact of COVID-19 in their communities.

My staff was... two of them were hospitalized, and one of them was intubated. And we didn't hear from him. His family was calling us. Thank God we know the CEO and people from [hospital] because we work really closely with them. And they were able to help us in locating him and letting us know how he was doing. And then I would relay that to his mother. So, it was a really, really rough. So, I was going through that with my staff at the same time that I was dealing with my father. So, it's very, very personal. And so now my staff-- and I lost two staff-- resigned as a result of getting sick. So, they didn't feel-- I think the whole change of working at home, the whole trauma that's left behind because one is really traumatized emotionally because we lost [community leader's name]. She worked out of my office. (Executive Director, CBO, New York)

With COVID, it's really brought out the cultural differences of the community. So, the COVID has impacted our Pacific Island community much higher than any other population, especially with multigenerational families in one house. I could just say for myself in the beginning, we had community leaders that passed away, and to not have a funeral was just beyond our scope

of understanding. And something small would turn into this huge thing. Birthdays, marriages, that's all things that our culture really thrives on and is such a big part of our culture. And in the beginning of this epidemic, the populations just could not adhere to all of those standards that needed to be in place, and it's because we value our people and family so highly that we put ourselves at risk. (Executive Director, AIDS Organization, Hawai'i)

Similarly to what was reported by survey respondents (figure 4), leadership staff reported that the impact on employment stability had not been generalized across the field or programs due to the flexibility of funding sources and Federal economic aid. Nonetheless, some organizations reported on the difficult decisions related to downsizing personnel and the impact on the staff remaining.

Tuvimos que, lamentablemente, lay off cinco miembros del personal de intérpretes, porque ya no era posible sostener esta unidad desde el punto de vista económico. Lo habíamos logrado por seis meses, lamentablemente, ya no. Y esto genera un impacto fuerte en el personal, porque es que la sensación de inestabilidad, a pesar de que se ha explicado bien la racionalidad. No es por performance, es básicamente por falta de fondos de esta unidad, y no se puede absorber el costo entre todas las demás unidades, porque hay otros departamentos que tienen una demanda mayor, y necesitan más personal al contrario. (Director of Programs, Health Clinic, Distric of Columbia)

We had to unfortunately lay off five interpreter staff, because it was no longer possible to sustain this unit from an economic point of view. We had been doing it for six months, sadly not anymore. And this generates a strong impact on the staff, because it is that feeling of instability, despite the fact that the rationality has been well explained. It is not due to performance, it is basically due to lack of funds for this unit, and the cost cannot be absorbed among all the other units, because there are other departments that have a higher demand and need more staff on the contrary.

In addition to feeling the personal impact of COVID-19, staff of color have experienced a tremendous emotional impact due to the socio-political upheavals in the U.S., including the exacerbated impact of COVID-19, police brutality, or xenophobia.

Professionally, I've watched-- a lot of our staff have to deal with post-traumatic stress disorder coming back-- that trauma around the pandemic. And not only the pandemic, once that hit, then we were involved in a race war, black men being killed, and it really had a profound effect on my staff and their ability to perform. (Executive Director, CBO, California)

Absolutely This has been a very trying time for everyone. It is, of course, not just COVID-19 that has been occurring. In addition, there is the importance and the weight of the Black Lives Matter movement as well as a very critical election. And for me and personally, definitely caused a ton of stress. Went back to therapy, which has been immensely helpful, which certainly has an impact professionally as well as everyone is feeling that same stress and also the importance of our work in the health-care field. Especially helping the most marginalized, it's just hard. And it gets hard especially when things that you do well are things that you're no longer able to do, especially reaching out to the community, understanding that building trust that's necessary to reach the most vulnerable people is very hard to do remotely. So that has certainly impacted Apicha, and we've done our best and done a very good job of switching to telehealth. We are a federally qualified health center, so there were certainly funds that we had access to that people who are not FQHCs didn't have access to. (Development Director, Health Center, New York)

As seen in figure 5 below, managers and front-line staff reported using a variety of strategies to ensure the safety, well-being, and performance of their staff. Some of the strategies utilized include working from home, social distancing, and use of PPE. While not widespread, staff also reported on the use of management software, increased staff meetings, and supervision. At the same time, a substantial percentage of staff reported not using management software nor increasing supervision frequency to cope with the challenges of providing services under the new paradigm. As discussed earlier, staff's emotional well-being has been greatly impacted; however, less than half of front-line staff (47.2%) reported taking time off/vacations as compared to (73.8%) reported by managers.

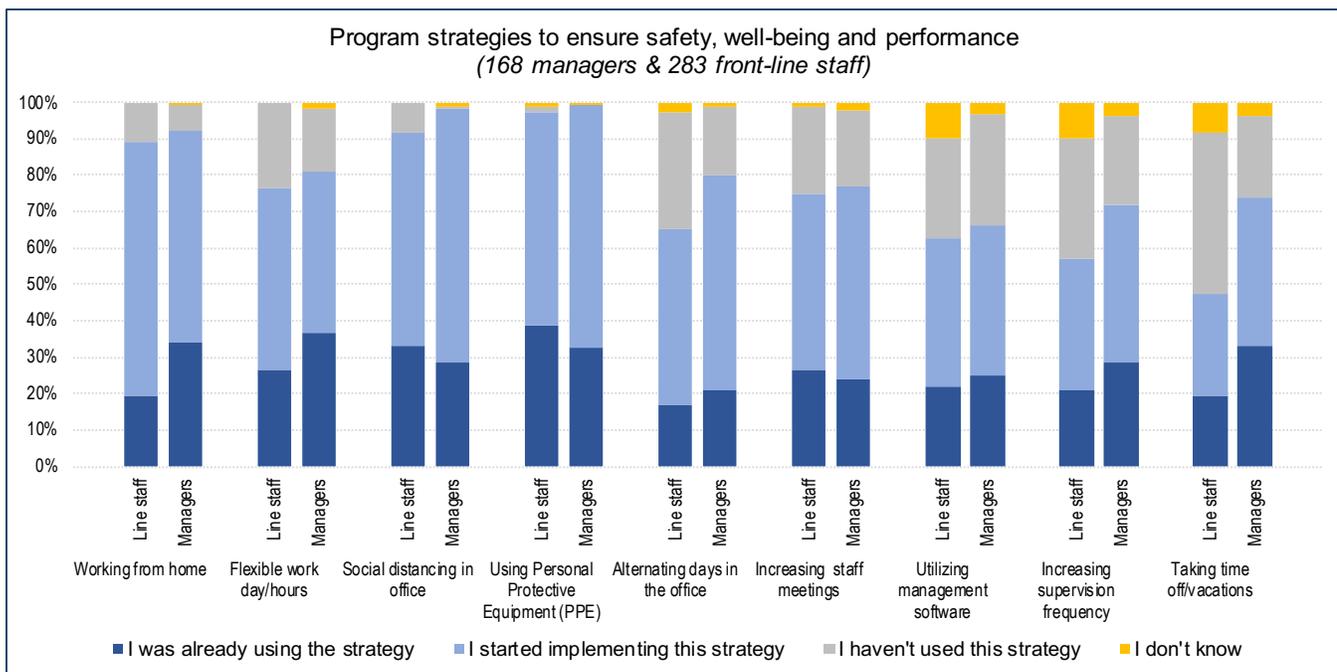


Figure 5. strategies to ensure the safety, well-being, and performance

Leadership staff began implementing a variety of strategies to support their staff as they continued providing services, including policy, programmatic, and infrastructure changes.

Having a staff with a lot of people with compromised immune systems, both people with HIV, and I have some people who are older, the older people, I've said early on, I was like, "[staff's name], you don't need to come here. You can work from home. You're the accountant. We can buy you a computer." [...] And I have another staff member who's, like, 69, and I was like, "You don't have to come to work." Though I said, "You can come to work if you want to, but I don't think you should." And then I have people who have a lung disease or-- so I was very careful. I was not going to make people come to work until the numbers here went down. (Executive Director, CBO, Massachusetts)

So, we one, got them computers to provide them means to be able to work, and then we also are supporting their phone and internet costs associated with working remotely. I think that we've also been very, very flexible with allowing people to be more creative during this time to truly take a focus on their programs and to be able to tighten up any loose ends or I guess enhance the programs as much as possible. And doing that in a way that makes them feel like they're getting something out of it, looking at it as an opportunity for professional development and not as an opportunity to like, "We don't have anything to do," or, "We're not able to do we want to do." (Executive Director, AIDS Organization, California)

We've been having a lot of discussions and trainings on self-care and putting emphasis into that. And when it comes to my team, I always try to do daily check-ins with them. And, of course, we have one-on-one meetings to really discuss care coordination. But just checking in quite a bit, seeing where peoples' head is at. Fortunately, my team-- they're so solid. They're just a solid group of individuals, and so as far as their concerns, just taking it day by day, nice and slow, try not to get overwhelmed, just kind of the basic things that we sometimes forget to do. But they're really good at it, and so just always trying to be there honestly and supportive as a supervisor and just be accommodating as much as possible. (Management team, AIDS Organization, Hawaii)

Some leadership staff reported that the impact of COVID-19 on public health workers had been significant, especially since many of these workers were also members of the most impacted communities. Leadership at many organizations stressed the importance of promoting and supporting self-care among their staff.

And oftentimes, there's sort of like this transference that happens, right, when we're talking to our clients about their needs, for instance, or their experiences that they may have had. And so, we have incorporated-- so, we have an employee assistance program that we have incorporated here. We have a licensed clinical supervisor who is also trans who is readily available for people to have access to mental health services. (President, Transgender Organization, California)

So, that's one of our constant reminders to each other, "Just take a breath, breathe," doing more breathing exercises as we're going throughout our day. I think, in my opinion, that's what our staff needs a lot more of is time to do self-care and time to just not feel like everything is just piling up. (Management team, AIDS Organization, Hawai'i)

Similarly to the reports from the surveys, leadership staff increased strategies and opportunities for maintaining ongoing communication with their staff, including open-door policies, increased supervision, and regular check-ins.

And our teams have been-- and each of our project teams and departmental teams has been trying to make sure that-- checking in with staff. I've been having one-on-one conversations with staff by Zoom, just to see how they are doing, and again, it gives me a window into their lives and into me. And, of course, we're continuing with our regular all-staff meetings. (Executive Director, AIDS Organization, District of Columbia)

And then we had a series of meetings where we kind of talked about what would it take for you to feel safe in the space? What do you want to see implemented to make sure that you feel protected? And so, they really drove how we build out the physical space and the policies and procedures around the screening and capacity. (Executive Director, CBO, Florida)

Due to office space, resources, and social distancing challenges, other organizations were still in the process of implementing support strategies for their staff.

So, honestly, that's a question I have to answer that honestly. When we had the space, we had a place to meditate and we were very intentional about going and centering yourself. Now, we didn't. We kind of left it up to our staff to do their own self-care, emotional wellness piece for themselves, but because you asked that question, I actually want to go and, yeah, investigate some things. (Executive Director, CBO, Georgia)

Leadership staff also spoke of the long-term impact of working under the new circumstances. In particular, they spoke of ensuring staff took time off for self-care in preparation for the long time managing the epidemic and its aftermath.

And so, in our policies, we can only carry over 80 hours of annual leave into the new year. And so, we have employees who have over 200 hours, plus they have comp time that they've built up, and they're having difficulty taking time off because they're doing contact tracing. So that's probably one place where we need to think about changing our policies to allow carryover. (Program Director, Tribal Organization, New Mexico)

We let folks know if they need any support or if they need any time off just to request it to make sure that they take that breather. Everybody, I feel like, in a job, we all come across days where we need a mental health day, and I think it's important to be able to have that freely to your employees and making sure that they feel supported. (Associate Director, AIDS Organization, North Carolina)

As a testimony to the commitment of the staff to their clients and organizations, many leaders reported staff, despite their own concerns, worried about not being able to meet their deliverables and provide needed services to their communities.

I think the most stress experienced has probably been for case managers initially because the idea of going and being face-to-face with another person was scary. And then also I think that level of-- I mean, clients become acquaintances as well. That level of concern about not being able to provide a level of service that you were able to for people you care about; there has definitely been a level of stress associated with that. (Operations Manager, Transgender Organization, Florida)

While most organizations have swiftly implemented strategies to ensure the safety, well-being, and performance of their staff, many leadership staff expressed concern about the long-term trauma, burn-out risk, and, in some case, death among their staff.

Impact of COVID-19 on program activities and service provision

We asked managers and front-line staff about the impact of COVID-19 on program activities necessary to provide services. Overall staff reported COVID-19 had somewhat impacted all program management activities, particularly those related to recruiting and engaging clients. As seen in figure 6, only a small percentage of staff reported their program activities not being impacted at all.

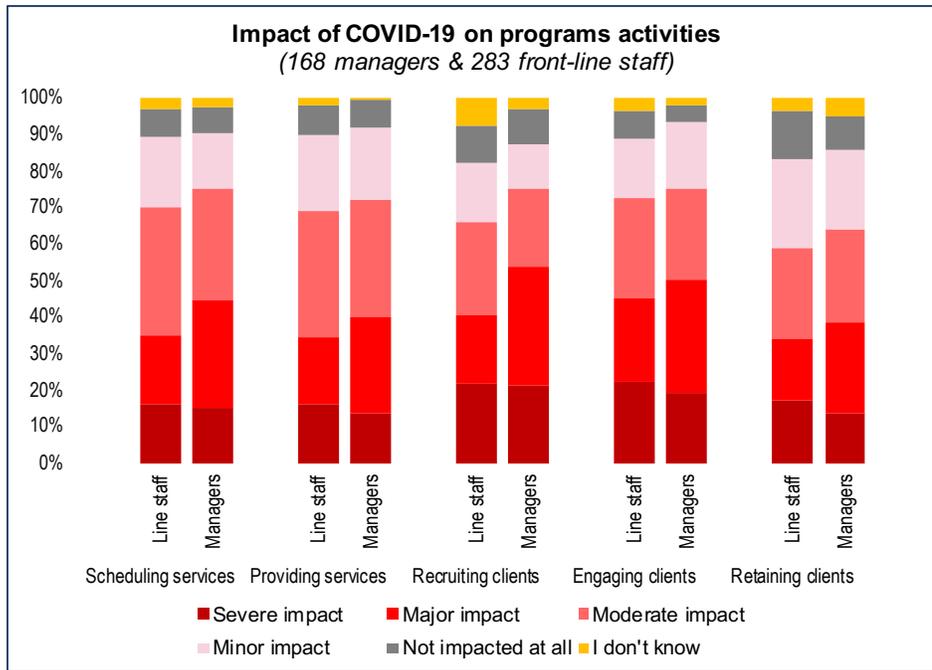


Figure 6. Impact of COVID-19 on programs activities

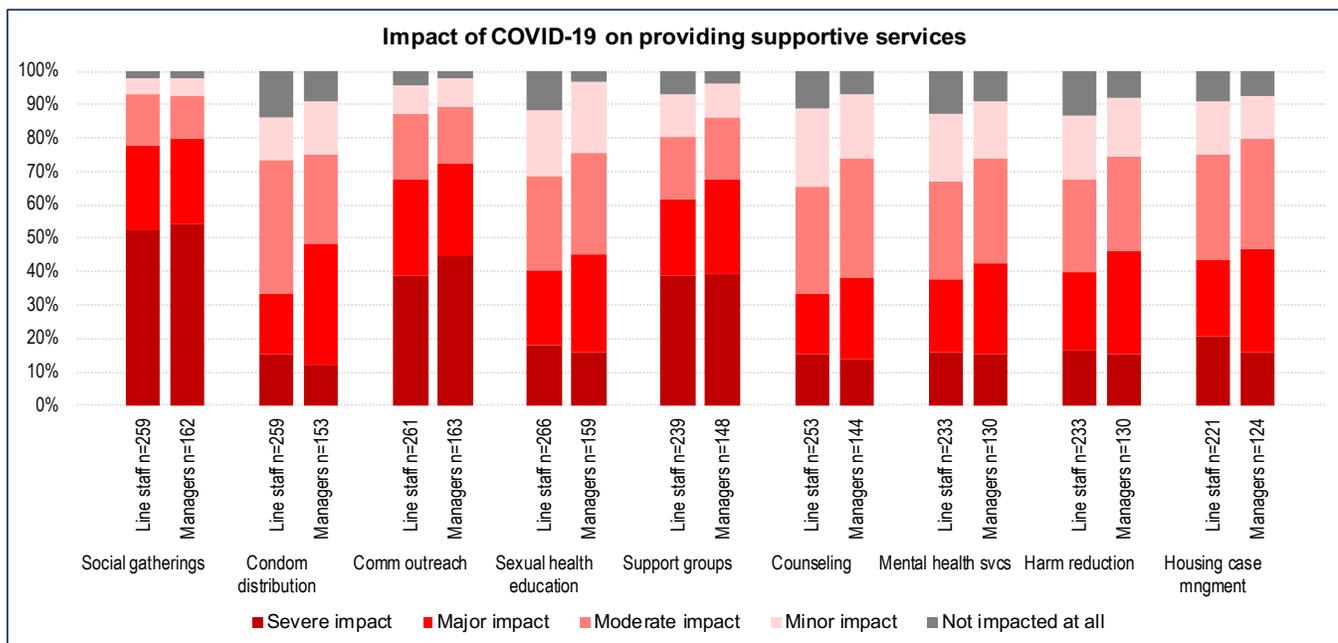


Figure 7. Impact of COVID-19 on supportive services

We also asked about the provision of a variety of services related to the HIV continuum of care. Front-line staff and managers reported on the impact of COVID-19 on their ability to provide HIV/STI/HCV supportive and health services. Figure 7 above shows the impact on supportive services as reported among staff providing or managing such services. As seen in figure 7,

staff reported severe or major impact on low-threshold services such as social gatherings, community outreach and support groups, necessary to increase client engagement in services. While other supportive services were less impacted, supportive services linked to HIV prevention and treatment, including sexual health education, behavioral health services, and housing case management faced great and severe impacts.

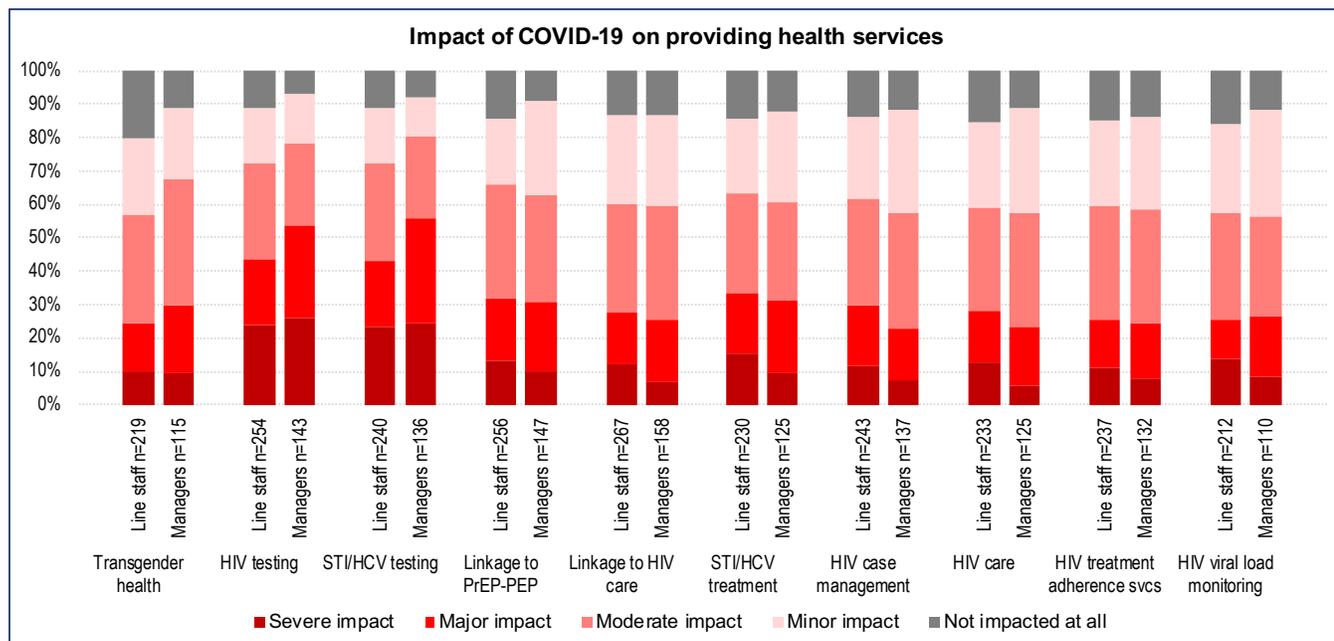


Figure 8. Impact of COVID-19 on health services

Figure 8 above shows the impact on health services as reported among staff providing or managing such services. Not surprisingly, services that rely on client engagement are also being greatly impacted, including HIV testing, STI/HCV testing, and linkage to PrEP/PEP. Medically-oriented services can rarely be postponed. As a result, many clinics and medical settings remained open and provided essential HIV services. Some of those services such as linkage to care, HIV case management, care and treatment have been less impacted than other services.

And at our prep clinic, we had to continue doing monitoring for labs and that sort of thing. Initially, we closed down for new patients, but then now that we've got everything going in a safe way, that's back open in both of our locations. So, it's been amazing to me. A lot of our organization is driven by billing. It's just like a lawyer would be, and our billing really has not gone down substantially because we have so many people who need help right now. (Executive Director, AIDS Organization, Alabama)

At the same time, some other services were more vulnerable to the changing environment, and staff had accepted the unavoidable impact. For instance, leadership staff spoke of the great impact on services that rely heavily on outreach and recruitment such as support groups, and group-level evidence-based interventions.

Testing is a whole other thing because then you're going out to find new people to give testing. So, we couldn't test. And then we had to create new protocols to figure out, though, what does this mean in terms of COVID and how are we going to get back to testing? (Executive Director, AIDS Organization, Massachusetts)

We didn't know, for example, we didn't know if we came in contact with someone for less than a minute, who was COVID-reactive, we were thinking that that constituted a close encounter, meaning that we had to do quarantine for 14 days. So, in order to do-- we err in the side of caution and we stop all the mobile testing, all the people accessing the center. We kind of shut down. We were only seeing clients by appointment, and that basically hurt our ability to see people-- not only for HIV testing, but our substance abuse programs, for our mental health programs. (President, Health Organization, California)

But many organizations felt that they had to continue providing these essential services. This required programmatic decisions that often involved concerns about equitable allocation of staffing, changes to service modalities, strategies to manage staff's concerns, or allocation of resources.

There hasn't been a place where they don't come into work or they can work from home. There might be [some] individuals, but if you look at them in totality, we have 24/7s here in Arizona. We're managing a homeless shelter services in Nevada which is 24/7. And then even if you think about our property managers, they can't work from home. They're at our properties, our real estate side that-- So, and then how do you make that equitable? (Management Team, CBO, Arizona)

We wanted to continue to offer HIV testing and PrEP and PrEP referrals, and just had to figure out a safe way to do it. So, we got our PPE and started organizing it by appointment only. So, we were able to kind of salvage that, and it's actually been robust in doing it that way. (Executive Director, Community Center, New York)

Yo tenía, antes de la pandemia, cuatro chóferes y yo sirvo la región de Arecibo, que son doce pueblos. Que no necesariamente es un pueblo o dos, son 12 pueblos, donde hay-- yo tengo más o menos-- casos activos son como 100, mensualmente podemos atender unos 45, por ahí. Y ese servicio se ha visto impactado porque ahora tengo dos chóferes disponibles. Porque los otros dos no se sienten seguros para continuar dando el servicio, aún con las medidas de prevención que se utilizan. (Management Team, CBO, Puerto Rico)

Before the pandemic, I had four drivers. I serve the Arecibo region, which are twelve towns. That it is not necessarily a town or two, there are 12 towns, where there are - I have more or less - active cases are like 100, monthly we can serve about 45, there. And that service has been impacted, because now I have two drivers available. Because the other two do not feel safe to continue giving the service, even with the prevention measures that are used.

As the community's needs increased, organizations saw the need to increase their service capacity, even while going through staffing, funding, and infra-structure challenges.

Previous to COVID, we were distributing [food] to around 100 households throughout the region. And over the first month and a half since COVID lockdown started, we started to distribute to 30 additional people over the course of that month and a half. So, 130 people doesn't sound like a lot, but for the kind of operation that we were organizing, it was a huge increase in capacity. (Executive Director, AIDS Organization, North Carolina)

While some organizations started providing virtual services, others re-started face-to-face services with some changes. Nonetheless, deciding on which essential services to re-start was a challenge for most organizations.

They were triaging in the parking lot without anybody coming inside. So, our navigators that provide transportation and our case managers, we basically told them, "If it's not urgent, if it's not going to change somebody's treatment, if it's not imminent, then we should reschedule the appointment to later, whenever it's less, when we know more about it." (Executive Director, AIDS Organization, North Carolina)

So, we also have our own kitchen where we prepare meals for about 30 homebound clients. And we deliver those a couple times a week to those folks. So, that was obviously very critical, though, that we're their only source of food for the most part. So, we knew we had to continue that. And then things like outreach were a little lower on the priority list, especially since places were closing and we couldn't do outreach in the places we were doing them anyway. Testing was somewhere in the middle. We knew we didn't shut it down, but we knew that we could reduce it and serve, really, those that are at the highest need. (Director of Programs, AIDS Organization, Arizona)

Staff reported on the challenges of providing social and supportive services that are often connected to positive health outcomes such as housing. Even when providing services, organizations providing housing, regardless of their size, saw their services impacted in ways that limited their ability to provide sufficient accommodations or adequate living conditions.

We have really limited their going in and out, and if they do go out, then they have to quarantine for two weeks. Keep in mind that the one facility is for people with a severe mental health diagnosis. So that's been challenging. But in overall, they've done really well. We have been trying to take them out somewhere periodically on an outing every couple of weeks just to get them out of the facility, take them somewhere out in the open like to a park to play games or something. (Executive Director, AIDS Organization Alabama)

So, we have two locations, each location has two beds in it, so at the moment, we can only have one person in each location. So that's basically-- we had capacity for four people at a time before, that's half our capacity. (Operations Manager, Transgender Organization, Florida)

In addition to impacting their direct social and supportive services, COVID-19 impacted the work that organizations were doing in other service areas such as immigrant legal advocacy, leadership development, and peer training. This impacted client advocacy services, increasing, in some cases, the precarious situation of many immigrant clients.

La migración, el Departamento de Migración, se ha visto impactado porque las cortes están cerradas, las transacciones burocráticas que se hacen con los asilos, con el Departamento de Justicia, con ICE, con los detenidos que están en el centro de detención, todo eso se ha cerrado. (Vice-President, CBO, Washington)

Immigration, the Department of Immigration has been impacted because the courts are closed, the bureaucratic transactions that are made with the asylums, with the Department of Justice, with ICE, with the detainees who are in the detention center, all that has closed.

I will say, in relation to the advocacy program, a big part of that program was that initial group trips to Tallahassee. But a big part of it was then one-on-one training and one-on-one meetings with community leaders and elected officials, and that's something that we haven't been able to do. We've had some elected officials who have been able to meet virtually, but it's kind of been harder than ever to get time on their calendars in the last few months as well just because of everything that's going on and all the extra stuff that they're dealing with. (Operations Manager, Transgender Organization, Florida)

COVID-19 has also impacted essential services that organizations were often providing with limited or zero direct funding. Faced with staffing and financial challenges, some organizations have discontinued or scaled these services down.

We have a shower service for our homeless clients. And so, because it's an unfunded program and we don't have kind of dedicated staff for that, it's one of those [services] we just kind of manage and we do. We made sure to work with some of our other partners. Everyone was making changes around shower services, unfortunately. But we managed to be able to get people some other resources, but we did kind of discontinue that, and we haven't reopened that service just yet either. (Director of Programs, AIDS Organization, Arizona)

And the transportation piece, we never have enough money to provide an adequate level of transportation, especially for our rural clients because many of them live three hours or more away from their medical care. There's no bus system or anything like that, and many of them don't have cars. A lot of times, they'll try to get neighbors to take them into the city, but now, neighbors don't want to do that anymore. (Executive Director, AIDS Organization, Alabama)

As mentioned earlier, the sociopolitical and economic conditions in many communities added to the impact of COVID-19 on communities, which in turn impacted organizations' ability to comply with their service plans.

So, we're not getting the numbers that we should be getting, or that we were getting before. So, people are not going out. And I think the other thing besides COVID that we got to talk about is the social unrest here in Los Angeles. We took a beating. There was a lot of protests, and a lot of people refrained from going out in the streets because they were scared. (Executive Director, CBO, California)

Overall, organizations were impacted in their ability to conduct program activities and provide supportive and health services to clients. A particular concern expressed by many leadership staff was related to their ability to provide supportive services that were often provided without direct funding, particularly at a time that the need for those services was increasing.

Impact of COVID-19 on program management

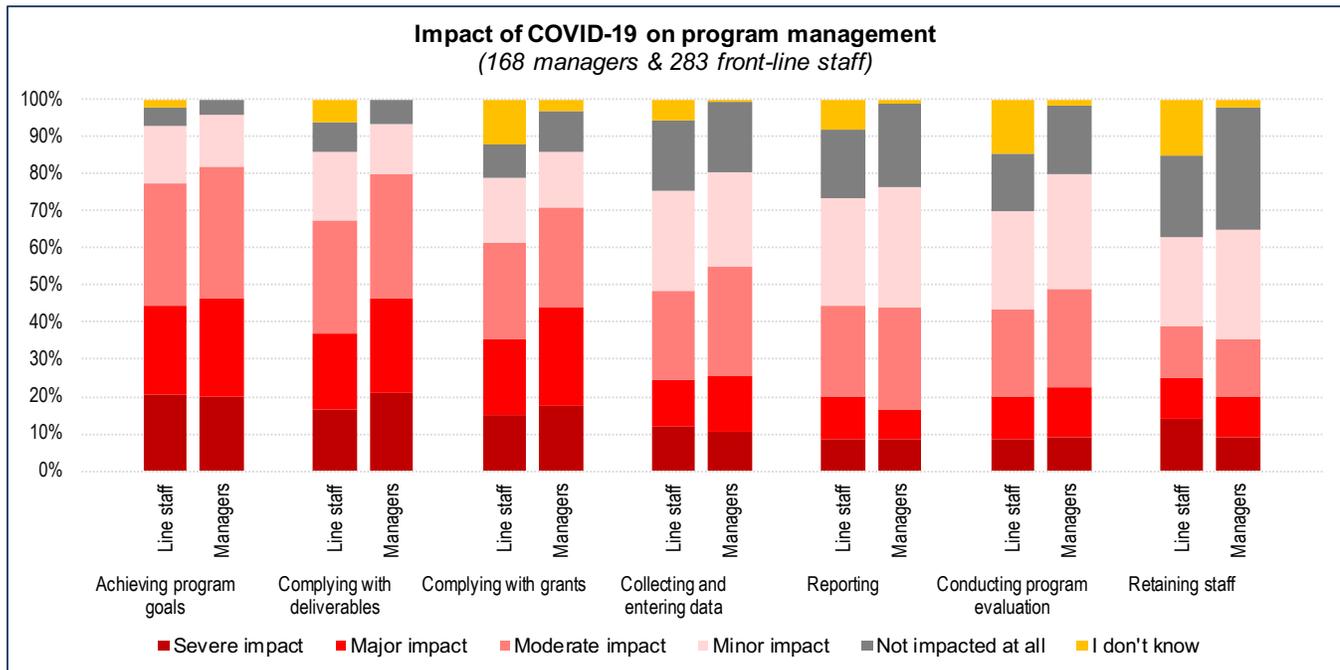


Figure 9. Impact of COVID-19 on program management

The assessment also asked about the program management aspect of their work. As shown in figure 9, staff reported COVID-19 had impacted activities related to program management, albeit with some differences. While the impact was felt across all domains, staff reported great challenges achieving program goals and complying with deliverables and grant expectations.

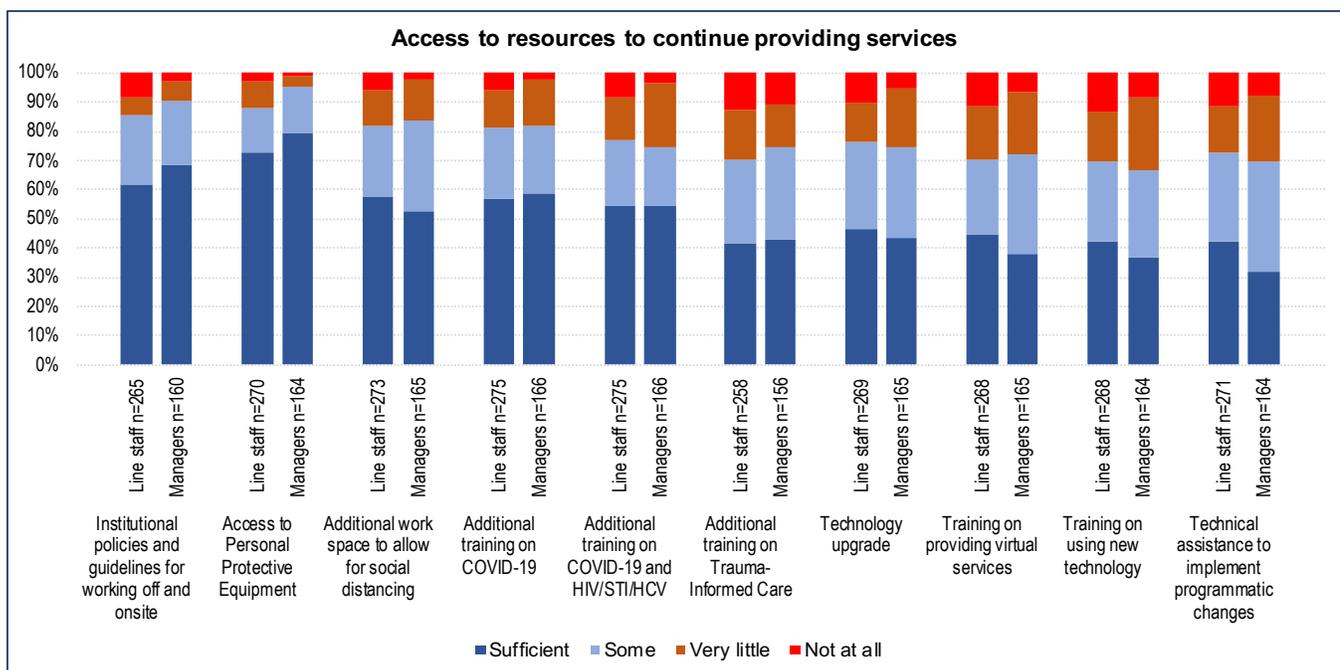


Figure 10. Access to resources to continue providing services

In order to continue providing services, organizations needed additional resources to implement new program and service strategies, including social distancing, working from home, or providing virtual services. As seen in figure 10, staff reported some or sufficient access to immediate resources needed to continue providing services, including policies and guidelines, PPE, workspace, and COVID-19 training (chart does not include N/A responses). However, about 30% of staff reported very little or not at all access to resources needed to adapt and implement services under these new conditions, including training in trauma-informed-care, training on providing virtual services, technology training, and technical assistance to implement programmatic changes.

Leadership staff described a variety of resources mobilized or needed in order to continue providing services. Organizations incurred in a variety of expenses connected to the epidemic, including those related to safety measures, enhancement of infrastructure, or provision of new services. Many leadership staff spoke of the infrastructure needs that arose for their organizations as they began providing services in a different context.

We invest a lot of money to clean, disinfect, and customize the locations to allow more physical distancing between employees and clients that begin to visit our centers. I think that is unprecedented. The second piece is to assign and buying equipment for the staff in order to navigate [virtual services]. You need a computer that sync with the latest technologies. You need extra equipment, from lighting, from cameras, webcam cameras, etc., all type of equipment in order to navigate the virtual space. (President, AIDS Organization, New York)

But we've got to train people to make sure that they adhere to all kinds of the HIPAA protocols or whatever. That's all doable, and moving to doing more of the community forums sort of virtual, meaning having to have a Zoom platform that can reach hundreds of people means... it's a lot of money. That's actually very expensive. I think we spent \$10,000 for it. (Executive Director, CBO, Massachusetts)

We have never used telemedicine before because in Puerto Rico you need to have another special license to do telemedicine. And that's something that we were starting working on last January, based on the [inaudible] that we are going to get this new license for the whole clinic, and we have 12 physicians in the whole institution. So, we had to get one license for each physician to do telemedicine. (Management Team, Health Clinic, Puerto Rico)

Some organizations were not able to implement some strategies due to lack of resources, including the enactment of safety procedures, staff training, or technology update. This was particularly true for small organizations with limited unrestricted budgets

Respecto al glass que se coloca en los escritorios, nosotros no lo hemos hecho por dos razones. La primera, para ser te bien honesta, económicamente no tengo ahora mismo de dónde identificar un fondo como para instalar esos acrílicos a los dos escritorios. (Management Team, CBO, Puerto Rico)

Regarding the glass that is placed between the desks, we have not done it for two reasons. The first, to be honest with you, economically right now I don't have funding to install those acrylics between the two desks.

But like I said, our funds are really low. So, taking some of the training is really hard for us because we don't have the finances for it. If we could partner with some other agencies, some larger agencies on programs, activities, and things that might generate revenue, that would be helpful to us. (Executive Director, Community Center, Oklahoma)

When everything hit, just getting your hands-on PPE was terrifying. It was one of the reasons that halted our services-- is that, "Oh, we can't even get our hands on a PPE that we actually need and even just our typical lab supplies." So, I mean definitely being able to maintain getting lab coats, gloves-- is still incredibly hard to find. And then even just ordering from other sites-- they're on allocation and you can only get a box here or there. So that's been one thing that we definitely need. And even funding for our tests-- they're still increasing. (Management Team, AIDS Organization, Hawai'i)

Todavía hay muchos gaps, todavía seguimos con deficiencia en personal que tenga computadoras que son reliable. Hemos tenido que actualizar, ahora estamos empezando a actualizar algunas computadoras que ya teníamos, laptops, pero que no resisten este nivel de uso constante, necesitan ser actualizadas, y cómo logramos acceder a fondos para eso? Porque no disponemos, no somos una corporación que tiene muchos millones ahí separados que puedes invertir en equipamiento, no, no lo somos. (Executive Director, CBO, New York)

There are still many gaps; we still have staff who have computers that aren't reliable. We have had to update, now we are starting to update some computers that we already had, laptops, but that do not withstand this level of constant use, they need to be updated. And how do we manage to access funds for that? Because we do not have, we are not a corporation that has many millions there allocated so that you can invest in equipment, no, we are not.

Leadership staff spoke of the need for capacity building resources to enable the organizations to adapt and innovate. Nonetheless, these resources were still scarce or limited.

I know right now we're looking into take-home tests, testing kits. The county or the state has picked, I believe, about three agencies from the state or Metro Atlanta area to do a pilot test of how that project will go. So, we're trying to see, "Is that something that we will have to do later on?" So, it's getting support in terms of implementing a project like that. Or what other ways could we do to be creative about test delivery, and ensuring that it's still safe? (Programs Director, CBO, Georgia)

We were actually looking for a consultant/facilitator to move on to the next steps for our strategic plan, but due to COVID, Hawaii seems to have a shortage of facilitators or consultants for strategic planning. And then a lot of the agencies or people that do the consultations, they let go or did furloughs with a lot of their staff, so, then there's the shortage of it. (Executive Director, AIDS Organization, Hawai'i)

Not only COVID-19 impacted the ongoing management of programs but also the ability of organizations to implement needed changes to reinstate services or find alternative strategies to service delivery.

Impact of COVID-19 on institutional stability

Leadership staff were asked questions related to institutional stability, including the impact of COVID-19 on their finances and strategic planning. A major concern was the financial impact of adapting to the new conditions in order to continue providing services. In some cases, organizations were able to negotiate their contracts with funders, for instance by changing deliverables or allowing budget modifications to cover other costs.

But no, financially we were really lucky. I think we were able to-- the cost reimbursement contracts that we have, the funders were very flexible. So, that was good, for last year. That year ended June 30th. So, now we're in a new year, and we have a whole new set of deliverables. The deliverables have not been reduced. Obviously, we'll be in a conversation with them, seeing where we are mid-year, if we're just not able to have people come in. (Executive Director, AIDS Organization, Massachusetts)

Mira, sí ha habido mayor gasto, pero sí también te puedo decir que ha habido mucho entendimiento por parte del CDC y nos han permitido algunos gastos relacionados en partidas que ya existen, que podemos utilizar por ahí. (Executive Director, CBO, Puerto Rico)

Look, there has been more spending, but I can also tell you that there has been a lot of understanding on the part of the CDC and they have allowed us some related expenses in grants that already exist, that we can use there.

In some cases, the impact on service delivery also impacted the financial stability of the organizations, particularly for those contracts with fee-for-service conditions. Many organizations relied on annual fundraisers that were canceled or conducted virtually. These organizations often used this unrestricted funding to cover service expenses they considered necessary for their clients.

All our fundraisers were also cancelled. We did not have any. Our major event, which it usually happens in September or October, depending-- is not happening, so that has also hurt us in terms of our administrative or unrestricted funds. (President, CBO, California)

Every year we put a fundraiser, the biggest fundraiser of our organization, which is a fashion show, right? And we raised about \$125,000 from this fundraiser. So, we need to figure out what we're going to do this year, right, because with that money is how we fund our transitional housing program, right? And so, we need to figure out how we're going to do that. (Executive Director, Transgender Organization, California)

Some organizations had healthy finances or appropriate unrestricted funds that allowed them to manage the additional costs associated with responding to the epidemic, including technology upgrade, PPE, or physical changes to workspace. Nonetheless, many organizations endured financial challenges due to delays in funding flow and reimbursement, in addition to the added expenses mentioned earlier.

So, having put cost saving measures in place years ago ensured that we had enough resiliency to bear the brunt of something like this. So, not spending to your limit has been key. We spend as much as we need to spend, knowing that something could happen, some unforeseen increase could happen, and we need to be able to respond. So, just kind of being fiscally responsible, we were able to not interrupt anything we were doing because we'd been doing that for three years by that point. (executive Director, AIDS Organization, North Carolina)

We did have a foundation that was six months late on paying us our first installment and that first installment was \$95,000 and our payroll is about \$30,000 a pay period, so you're talking about 30-- you're talking about \$90,000. You're talking about three pay periods, three pay periods worth of money to not have in your account. That was rough. Also, the counties were very delayed on paying their reimbursements. I think we were behind by about a month and a half to two months. So, all of that combined we really kind of put a strain on cash flow. (Executive Director, CBO, Georgia)

While many organizations have begun using their unrestricted funding to address the needs of their clients, they also expressed concern about the long-term sustainability of these efforts. Some organizations had received additional assistance through COVID-19 funds and utilized them to enhance their infrastructure. Other organizations have taken cost-saving measures by delaying the hiring of new staff.

I think that from a financial perspective, the assistance provided through the COVID funds that came in connection with our Ryan White program funding, it was about \$150 thousand between one and the other, maybe between-- 156 or something like that. It's mostly gone. And the thing is that we're going to need-- well, some of it is hardware, right? So, we have our acrylic dividers. We have the air filters in the air conditioners in the rooms. And okay, so that will last, but when it comes to the PPE, those are going to become recurring expenses that we don't have a source of funds, an ongoing or revolving loan type of funds, where, as this extends, we're able to continue. (Management Team, Sexual Health Clinic, Puerto Rico)

Then, there's also that fear of losing funds for the next year. And then, we're hearing that the state is also getting a funding cut. So, we need to prepare which funds will be available and which ones will not. So, there's a lot of pressure to remain competitive. (Programs Director, CBO, Georgia)

At the same time, leadership staff were concerned about the future funding of programs and additional ongoing expenses.

But a lot of additional expenses. The expenses aren't going away and there is a stop-date on that funding so we're kind of trying to figure out what's going to happen to make sure that we can continue to make sure that staff has all the PPE, make sure that we have additional dollars for the sanitation and everything that we need to do once that end date on those COVID dollars hits. (Executive Director, AIDS Organization, Texas)

I think the long term is where we're going to really feel it. We've had a couple of positions that are vacant, and, so, it could seem like on paper that we're fine and stuff like that, but once maybe we're fully staffed, you'll start to see the true I guess outcomes.

But I think the long-term outcome is going to be interesting to see because, again, we haven't made it to the point to where we have to start reporting to funders or where we have to start saying-- asking for more money given the new set of circumstances. (Executive Director, AIDS Organization, California)

Emergency and transitional housing programs provide a great example of the interconnectedness of various aspects of program management impacted by COVID-19. Due to social distancing, many housing programs could not house more than one resident per room/unit, which decreased the total number of clients served and required by funders. On the other hand, the management of the housing units still required the resources to manage the program.

Funders are frustrated with that because they've said, "You're only serving a small number of people. Do you really need these funds?" And I said, "Well, we still have to staff the house. I mean, we're at the bare minimum of staffing now. If we triple our numbers, we're going to have to get more staff. But right now, we need somebody there 24/7. And you have to have four people to do that." And so that was a challenge because what they see is the output, "You're only serving X number of clients. Why do you need more staff than clients?" "Well, because you have to have someone there." (executive Director, AIDS Organization, Texas)

Some organizations saw their short and long-term strategic service plans shattered, including expansion of services or financial allocations.

We bought the building. We're working on it right now. We just had furniture delivered yesterday. So, yeah, I mean, we're moving along with our plans, but I'm not quite sure when we'll be able to really full-blown open it. We'll still do some programming in there while this is going on. (Executive Director, AIDS Organization, Texas)

We launched a dental clinic right before COVID-19 hit and then we had to shut it down. We launched it in February, and so, of course, we had to shut it down in mid-March. (Executive Director, Community Health Center, California)

I think for grant deliverables, there's been a lot of programs who haven't been able to spend down their funding. Yeah. A lot of it was dedicated for travel, bringing people in for trainings, travelling to tribal communities, having large in-person meetings. And so, I think that's part of the reason why the board felt like we weren't being productive, or we weren't producing, because our funding wasn't going down. (Executive Director, Tribal Organization, New Mexico)

Leadership staff also expressed concern about new or continuing funding, particularly when these funds had been delayed by the funding sources.

So, two of the grants that we have been approved for from the state, one was supposed to start in April and was delayed. So, it started in mid-May. So obviously, for that, we had to adapt. And then we have another grant which is the PrEP grant that I've mentioned. That was supposed to start in March. And then they moved it. (Executive Director, Transgender Organization, California)

Well, some of the financial impact that I can say is we have two grants that have not been able to start because of COVID. And our state grant, which is a very large grant, we were supposed to start back in early January. It got delayed little by little, and then all of a sudden, March happened, COVID hit, and it's now September, and we still haven't started the grant. Yeah. So, I hired these staff. And I'm like, "[inaudible] to pay them." But we utilize other funds to do that right now. So, that was a big impact on us. And the thing is that this grant is not going to be extended because it's just a very limited grant. So, they had to double up our first year's budget into one year. So, there's a lot of money to spend now for one year, but now we have to spend it in 10 months. So, it's a little bit of a-- it's a little stressful. (Executive Director, LGBTQ Youth Organization California)

For many leadership staff, the current situation created a larger level of financial uncertainty than they had experienced before. The uncertainty was felt across organizations, from the small to the larger ones.

So, from what I'm seeing, funding for some of the programs may decrease by next year as some of the grants, I believe, will become competitive instead of continuation, or it will just get cut. So, I think there will be some loss, but, again, because we have a federally-qualified health center, even though the patient number has been low, we're able to generate unrestricted funds

through that. And I believe we're about to start a pharmacy. So, I think the agency is planning for any negative future outcome. I believe we have at least three months' worth of unrestricted funds to cover if we lose everything. (Programs Director, Health Center, Georgia)

We know that [our work] will just be better, be stronger. But until-- and that's only to say if we're still around, right, because we still have this fear of like, "What does the next year look like because we've had to take a huge financial hit? Are we going to be able to sustain ourselves year to year?" Because we're small. (Executive Director, CBO, Florida)

Engagement in COVID-19 activities

Over two-thirds of the staff reported becoming involved in community education about COVID-19 risks and protective measures, and about half of the staff reported involvement in counseling and linkage to care for clients with COVID-19 (see figure 11). Given the ongoing challenges of providing clinical COVID-19 services, it is not surprising that 50% of staff or less reported being involved in other key activities related to COVID-19 such as contact tracing or case management. Among staff already providing HIV care (front-line staff, N=86; managers, N=54), 54.7% of front-line staff and 59.3% of managers were also involved in providing care to clients with COVID-19 (data not shown).

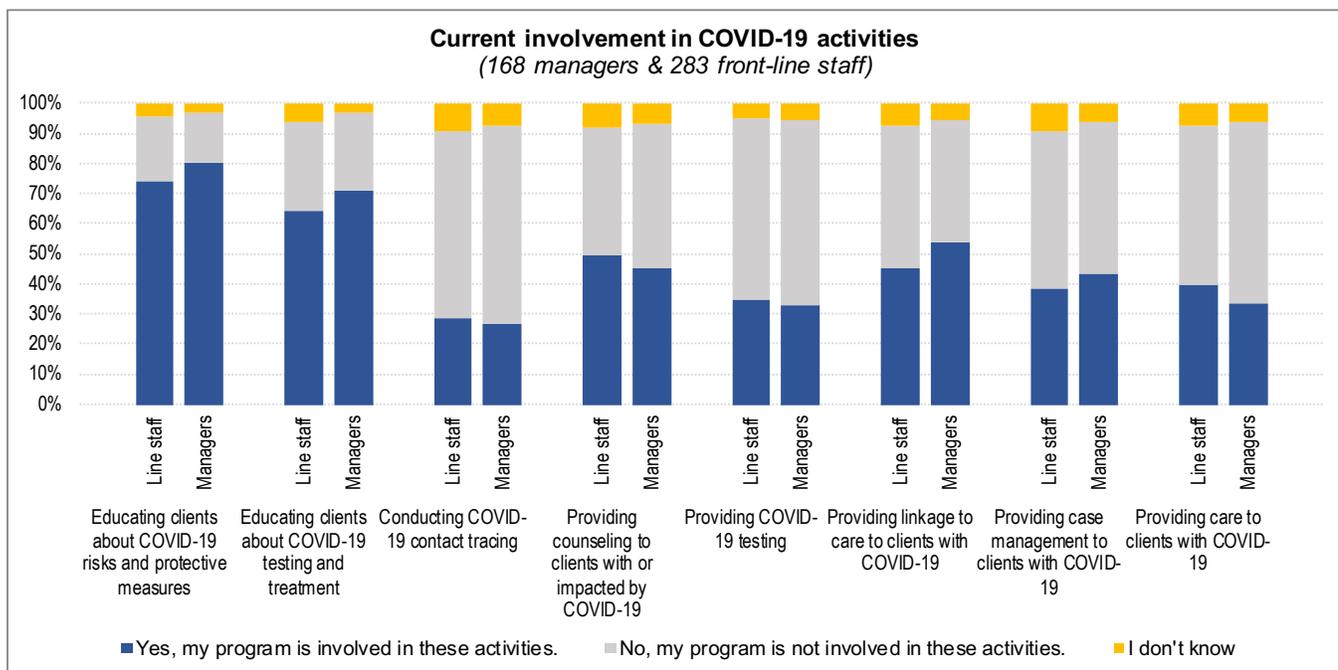


Figure 11. Current involvement in COVID-19 activities

As shown in figure 11, many organizations were already involved in these activities. On the other hand, only about a third felt they had somewhat sufficient or sufficient capacity to engage in COVID-19 contact tracing and testing. Survey questions also asked staff their perceptions about their capacity to address COVID-19 (see figure 12). Staff felt they had somewhat sufficient or sufficient capacity to provide client education on risks and protective measures. Among staff already providing HIV care (front-line staff, N=86; managers, N=54), 38.3% of front-line staff and 51.8% of managers felt they had the capacity to provide care to clients with COVID-19 (data not shown).

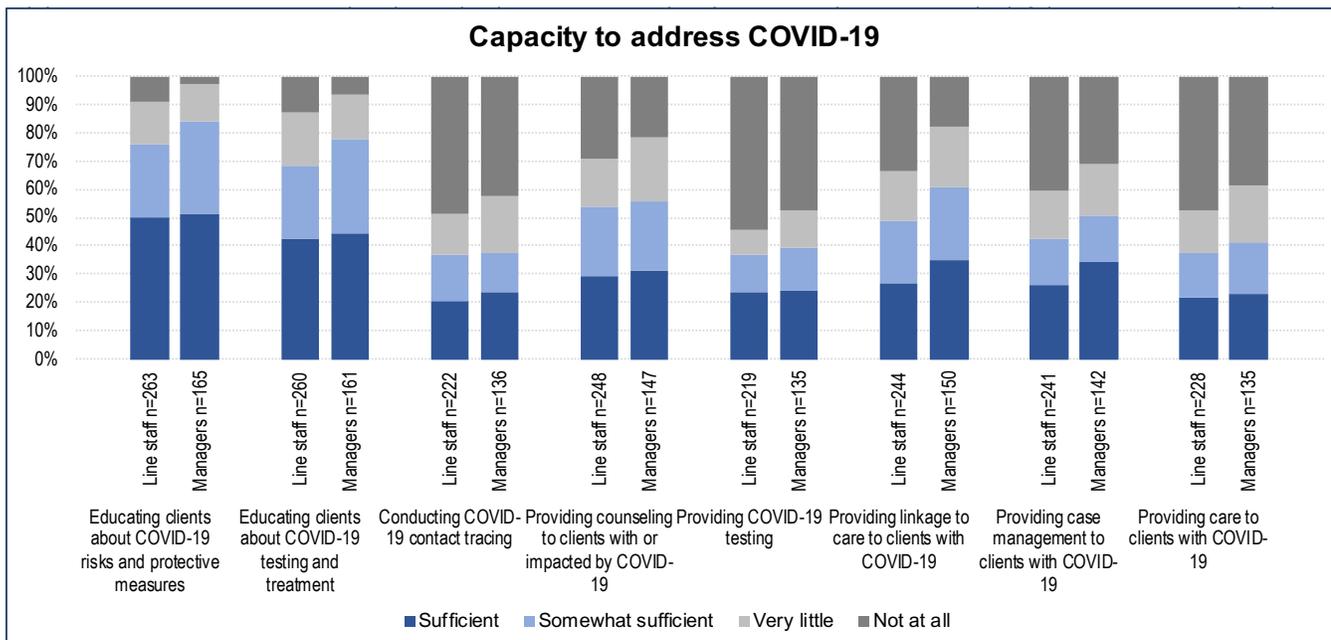


Figure 12. Capacity to address COVID-19

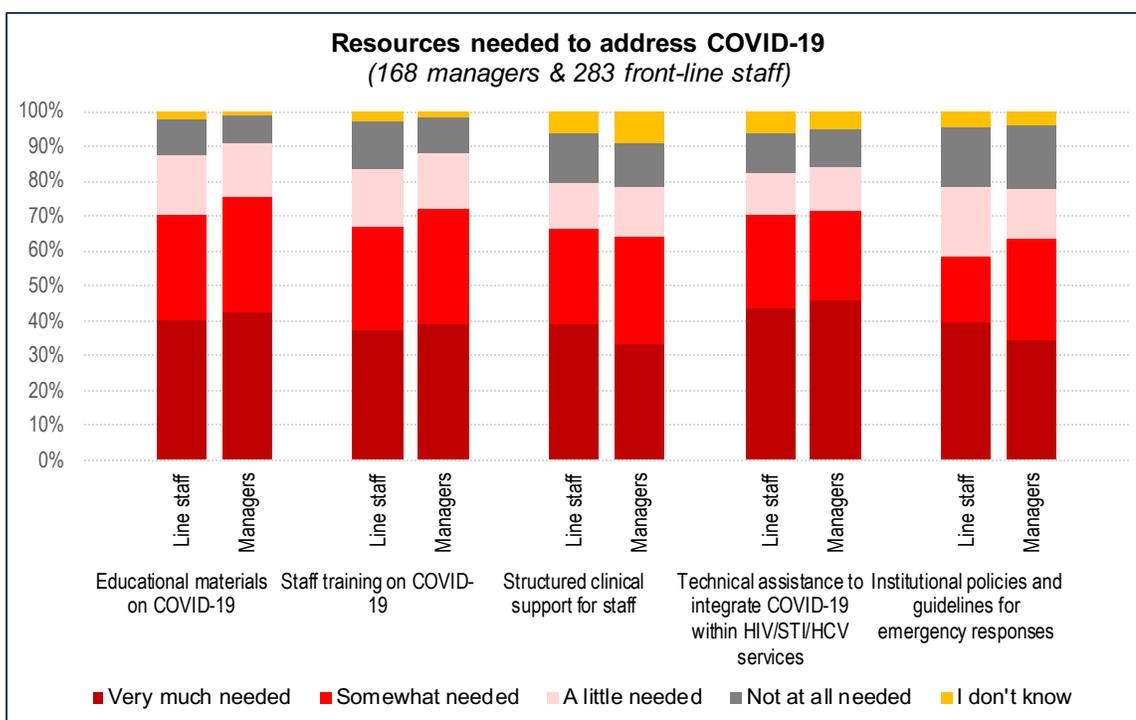


Figure 13. Resources needed to address COVID-19

Overall, staff reported a great need for a variety of resources in order to address emerging COVID-19-related needs among their clients, from educational materials to institutional policies and guidelines for emergency responses (see figure 13). In particular, about 70% of staff felt that there was a great need for technical assistance to integrate COVID-19 within their current HIV/STI/HCV programs.



While many organizations were already involved in COVID-19-related activities, the surveys asked if their organizations had considered adding COVID-19 as an organizational focus (see figure 14). While there seems to be differences between front-line staff and managers, only a small number of respondents reported their organizations were not planning on adding COVID-19 as an organizational focus. About 50% of front-line staff and 30% of managers reported not knowing if their organizations were contemplating changes to their programmatic portfolios.

Figure 14. Adding COVID-19 as service focus

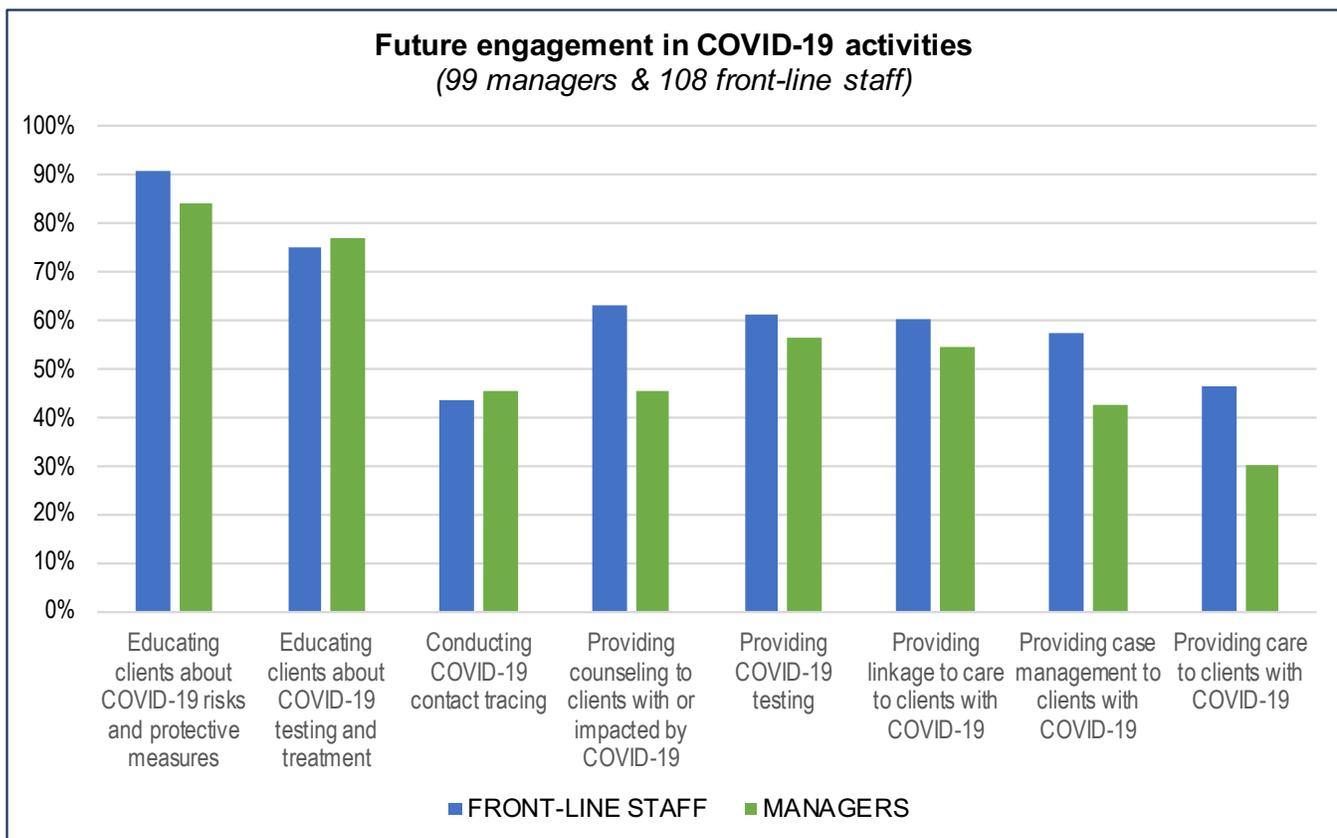


Figure 15. Future engagement in COVID-19 activities

Those who responded affirmatively (99 managers and 108 front-line staff) were asked the type of service activities their organizations may be engaged in moving forward (see figure 15). Perhaps building on their prior experience with HIV/STI/HCV services, staff reported their organizations may engage in a variety of services related to COVID-19, particularly client education. Among staff already providing HIV care (front-line staff, N=50; managers, N=51), 56.0% of front-line staff and 35.3% of managers reported their organizations were considering providing care to clients with COVID-19 (data not shown).

Many leadership staff at health organizations had already incorporated COVID-19 work within their institutional scope of services, often in partnership with departments of health.

I think another thing that was challenging was trying to get COVID-19 testing to these sites because initially, we did see a lack of testing services in our community. So that was very, very impactful for us and that was such a huge challenge. I think that [organization's] collaboration with the Arizona Department of Health Services, jumping at the opportunity to implement testing services [organization] has really helped resolve that challenge. (Management Team, Health Center, Arizona)

While leadership staff at health organizations were more certain about engaging in COVID-19-related work as an institutional focus, those in non-health organizations were less certain.

We are not set up as a medical provider, and, so, our infrastructure wouldn't even support us kind of doing that right now. And it felt like we know that there's a need for that, right? We know that there's a need for COVID testing and follow through and that kind of stuff. But we haven't made a decision. We've decided not to necessarily go into the COVID-19 business, at least right now. (Director of Programs, AIDS Organization, Arizona)

We definitely need some capacity building. I think we consider ourselves to be experts with infectious disease, but it's really sexual health. And given that this is not an STI, I think our expertise will be limited or could be challenged. So, I think we would definitely need capacity building for-- I would want it to be for all staff, but especially for the education staff that would be out in the community. (Executive Director, AIDS Organization, California)

Overall, the level of uncertainty about the future direction of COVID-19 pandemic and the impact on their HIV prevention focus presented leadership staff with some strategic planning challenges.

I mean, they [HIV and COVID-19 programs] kind of-- they are standalone right now because they're so separate, but the staff who are doing them are HIV prevention staff. Because actually, the contracts that we have that support their positions from the city, the city wants us to pivot them. But that means they could do less HIV prevention work, so it's a balance. So, we're trying to figure out how to do it. So, I don't know how to answer. I guess, yeah, I mean, maybe it's alongside-- I'm still figuring it out, yeah. (Executive Director, Health Center, California)

That was something that I was wondering about, to talk to our board. Because like I was saying earlier, people that work in the field of HIV care and prevention in some ways are already well equipped to do something like COVID testing, etc. But I never brought it up because I felt like we were just achieving enough stability for things to feel routine again. And I didn't want to introduce another variable that-- because doing that would have meant repurposing some of our prevention staff to do COVID testing. (Executive Director, AIDS Organization, North Carolina)

Non-health organizations who were willing to consider COVID-19 as an institutional focus expressed a need for considerable technical assistance and resources as well as rethinking their organizational characteristics.

And I think that if we are thinking on providing COVID in a bundle or on a batch to the population, we need to open up the work that we do in HIV, STIs, and hep C. So, we need to be more inclusive and embrace diversity in the way that we provide services. Because now, we are going to see a diverse community affected by COVID and all the infectious diseases. So, now, our services need to be more diverse. (Associate Director, AIDS Organization, California)

We never have enough people to do the work that we could do if we had more people, and we're always trying to broaden our reach. So, clearly, if we did get into the business of testing and contact tracing for COVID, we would need additional staff, and I would want to set it up in a safe way, so we would need resources to do that as well and make sure we have adequate PPE and all of that and adequate testing. (Executive Director, AIDS Organization, Alabama)

Organizations already providing COVID-19 services attempted to integrate them with their existing HIV/STI/HCV services. In particular, some organizations bundled HIV and COVID testing while others began including COVID-19 prevention education into their existing HIV/STI/HCV education.

Effective strategies, lessons learned, and service opportunities

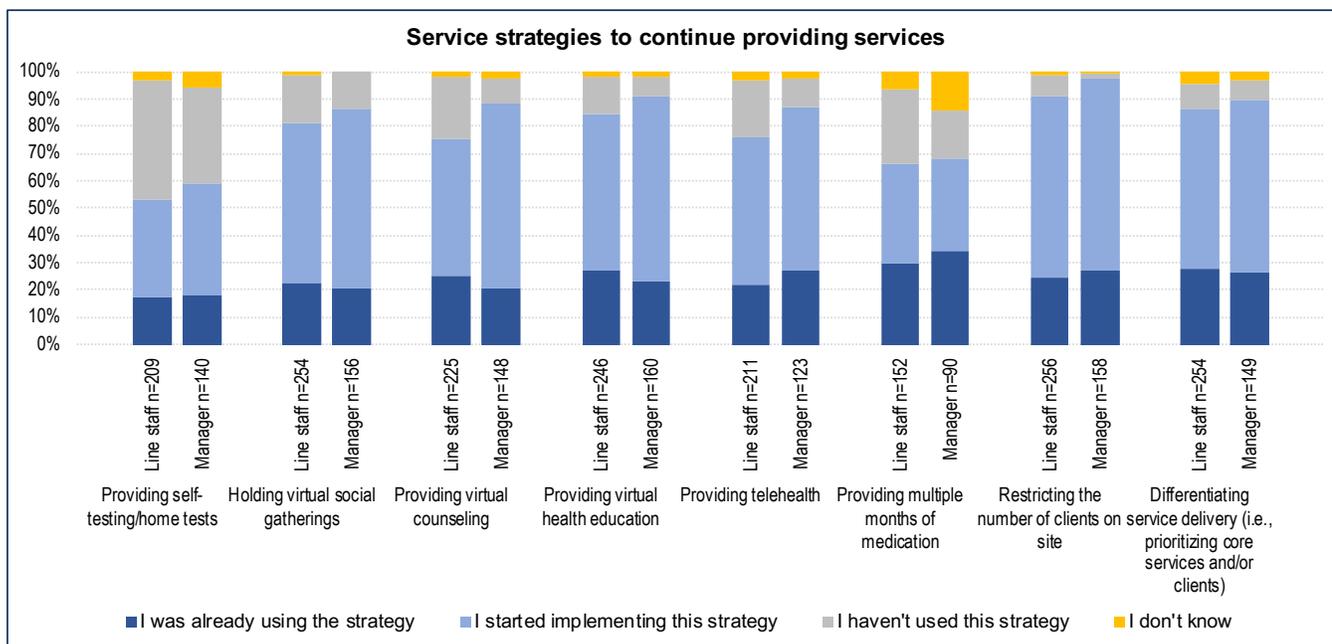


Figure 16. Service strategies to continue providing services

As compared to their strategies prior to COVID-19, staff reported an increase in the use of new strategies to continue providing such services, particularly the use of virtual media to hold social gatherings and provide counseling, health education and telehealth (see figure 16). As expected, many organizations have rapidly adopted Differentiated Service Delivery (DSD) and restricting the number of clients as strategies to manage the limitations imposed by COVID-19 on full delivery of services. On the other hand, while some staff reported on the use of self-testing/home tests to increase HIV testing, this strategy has not been widely adopted.

In addition to service strategies, staff reported on program strategies utilized to continue providing services (see figure 17). In particular, staff reported prioritizing program activities and discussing grant requirements with funders, strategies that are also connected with DSD. On the other hand, few staff reported reliance on external resources, i.e., consultants and subcontractors, to continue providing services.

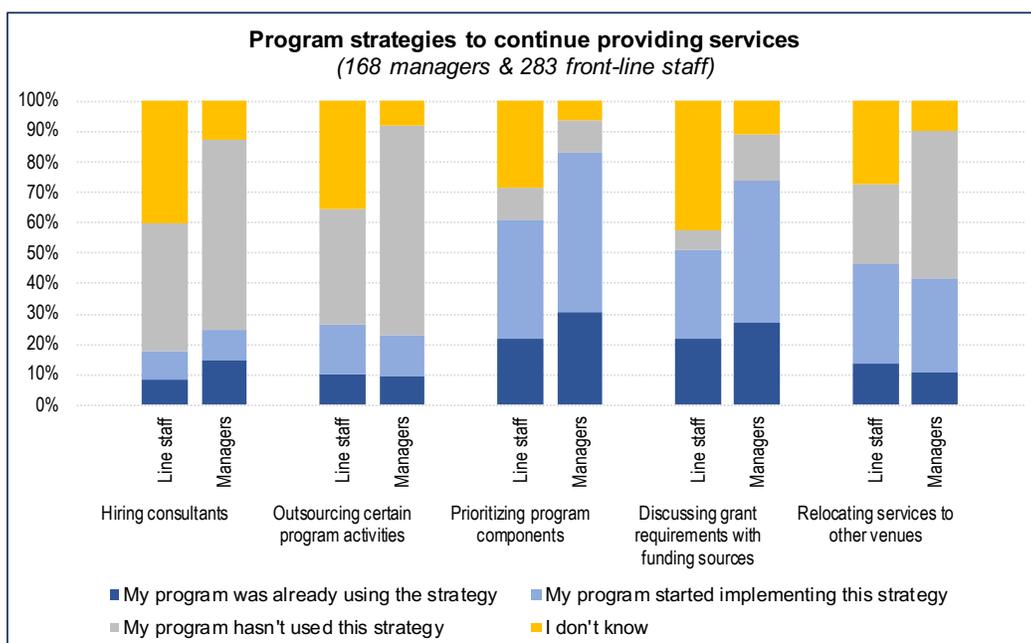


Figure 17. Program strategies to continue providing services

Most organizations had rapidly enhanced their infrastructure to address the challenges imposed by the epidemic and continue providing services.

We had to quickly digitize forms to be able to still do all of the monitoring that we have to capture the information we're supposed to be capturing. And that was a big challenge for that department. And it made us see that we can't keep putting off switching to EHR, to an electronic health record. (Executive Director, AIDS Organization, North Carolina)

We had to buy more naloxone, apply for funding to get more naloxone, because we were trying to encourage syringe exchange participants to access the service less frequently, so that they don't travel as much. Because to us, travel is exposure. You're going to drive here from two hours away because our service area is such that you can drive two hours west and you're still in our service area. (Executive Director, AIDS Organization, North Carolina)

So COVID, I think, made us look at the way we do things. There were some things that we already started or wanted to do. But, I think in some ways it has prepared or helped us to move forward faster in some things [...] For our surveillance component in the Virgin Islands, we had a challenge with our surveillance because we're on three different islands and we were on a physical standalone server [...] And so now we could say that we have been able to put our system where we could actually access and have our database at hand right there due to COVID. And then now, if we were to actually have another disaster such as another hurricane or earthquake or anything of that sort, we are not worried about the physical infrastructure of this database being destroyed because we have it in a web-based portal that is secured. (Management Team, DOH, U.S. Virgin Islands)

Many organizations re-started services using various adaptations to their service modalities, including evidence-based interventions developed for face-to-face encounters. Many leadership staff also spoke of how effective it had been to utilize a team approach to address the challenges placed on the organization by COVID-19.

We offer CLEAR concepts to the homeless and indigent to try to encourage behavioral change with them. And they love it. They love coming to groups. So, what we do is, we put a tent. It's been good weather. On the outside, we have two RVs next to the old RV. We put a tent up and some music. And they sit at a six-foot table and talk about and do the CLEAR sessions. (Executive Director, CBO, Florida)

Well, in particular, we are a very unique organization because I mentioned to you that we have so much talent internally. The staff has been gracious enough to be ready to go and to adapt. I know other agencies that have to spend a lot of money on consultants to write all these protocols, all these plans, and manage the adaptation, something that is, for us, very natural. (President, AIDS Organization, New York)

Some organizations developed or enhanced partnerships with other organizations to pool resources to provide services such as HIV testing, telemedicine, and educational materials dissemination.

So, we are working with community partners who are doing testing at their locations. And so, we refer them there to access testing because we're not having in-person services here. So, that's when it comes to HIVs and STI screenings. (Executive Director, Transgender Organization, New York)

So, we have been putting together personal care kits to distribute to clients who are sex workers that have things like soap, shampoo, hand sanitizer, condoms. There's also an information graphic of-- like less high-risk sexual positions or acts as well, as in no kissing, that type of thing, and that's in Spanish and English. And FIU University here in Miami actually developed that for us to include. (Operations Manager, Transgender Organization, Florida)

As we saw above, staff reported on adoption or increased utilization of various strategies to continue providing services. For some organizations, COVID-19 provided opportunities for developing new strategies and services that expanded their organizations, and many leadership staff saw the service changes and adjustments as institutional growth.

I think that there's definitely going to be an element of this that continues after the pandemic in some way because we've sort of seen that and been able to prove to ourselves that working remotely can be productive, and it doesn't necessarily take away from certain aspects of a business, an organization. (Operations Manager, Transgender Organization, Florida)

And even if it lets up and we get to a level of normalcy again, I think we'll continue to do this [virtual services], because it works for a lot of our participants, especially some of our trans women of trans experience who have safety issues, anyway, traveling from San Francisco to Oakland, or Contra Costa to Oakland. We've seen increased participation virtually because they feel safe when they're at home. (Executive Director, CBO, California)

While many organizations had emergency plans, few plans had been designed for the pandemics. COVID-19 allowed some organizations to rethink their emergency plans and service protocols in preparation for similar events.

Hawaii is just one of those places where anything can happen at any time and you're just kind of like a sitting duck out here. And we do have to plan because at any given time, we only have two weeks worth of supplies on the island. And so, that's kind of where we're at. We have to make sure that if something were to happen and we couldn't get ships or planes or anything in here quickly, we have to have that contingency plan. So, I mean, the other thing too is when I first came on, one thing we didn't have was a pandemic or epidemic plan. We didn't have any type of mitigation plan for that and that was two years ago. [...] So, when I got here, I discussed with her [executive director] about putting together a pandemic plan, about extra cleaning supplies. [...] So, I mean, our contingency plans were pretty good. We are required by law to have certain ones and by HRSA to have those types of things. And pandemics are so arbitrary that people just kind of randomly throw them together. But we were pretty-- we're pretty robust. (Program Director, Health Center, Hawaii)

We had some planning in place as a federally qualified health center, and as a health center general in New York State, there is certainly planning that happens around epidemics and infectious diseases. Whether for this particular situation? I'm trying to think if they were helpful, as it was more like the Ebola, where your clinic goes on lock-down and you're personally quarantined in your building, and it's a lot different than the situation around COVID where milder-- and the recommendations around it were very different. Luckily, both the New York State and New York City, health departments gave very clear guidance, which allowed us to follow their plan and not have to scramble too much to create our own. (Development Director, Health Center, New York)

Government organizations had also allowed new strategies and changed long-established protocols to facilitate the provision of services. Organizations welcomed these and hoped they remained in place after the epidemic.

At the COVID time, the people in the government decided that we can send through email, through WhatsApp, through fax, any medical order. Even for pharmacy, we can send for controlled substance prescription by email or by fax, and they will be accepting in that. Because for controlled substance, it had to be also on paper [...] Another important thing that the government do, especially for the government health insurance, they removed the requirement of the primary care signature to cover the lab or the medication or go to the specialty you have to see. So, any physician can see you, even if not in the network of the government. (Team Management, Health Clinic, Puerto Rico)

I don't think Medicaid would have changed their rules without COVID. They still were doing spoken hub model where telehealth was being in one clinic to another clinic. That's the only way you could do it. So, the locations that we have in other places, you still had to come into the clinic, to their hybrid clinic to get telehealth. So, it's like they couldn't fathom the fact that someone could actually be at home and have a telehealth appointment. But COVID now has forced our hands, and it's working. It's working well [...] But I'm thrilled with the fact that Medicaid has relaxed their rules, and it's over with. I don't think we ever go back to the way that they wanted to do telehealth. (Executive Director, Health Organization, Mississippi)

As we saw earlier, most organizations rapidly adopted social media and virtual programming to continue providing services. For the most part, the use of social media had resulted in positive outcomes in the recruitment of clients and delivery of services, as they addressed some of the former barriers to accessing services.

The other positive that we found was that, while we think that our community does not have access to technology, such as Zoom or a computer, we found that most of our clients have a cell phone and know well enough to be able to use that as a form of communicating via Zoom or via Facebook Live or Instagram when we are having all those. So, that's something positive came up, in terms of having to deal with COVID. (Executive Director, CBO, California)

Our recruitment was affected in terms of new clients, but our existing clients actually increased the utilization of the service and we had worried that offering the service remotely, virtually by Zoom or by other face to face electronic media would have a chilling effect. It did not. Actually I think clients, even those that had some pretty initial misgivings, appreciate the convenience of receiving those services remotely without having to-- without transportation issues, right, without having to leave their homes. (Executive Director, CBO, Georgia)

Staff at youth-oriented organizations reported great levels of acceptance and engagement in virtual services, from health-related services to social activities.

For the most part, the younger clients are very happy with the Zoom because [inaudible] clinic and they don't have to take the whole day off versus with the Zoom, they could be at work and then when their appointment comes, they just take a break. They go in the parking lot, get in their car, they do their appointment and they go back and they don't have to miss as much time off. (Executive Director, AIDS Organization, Texas)

So, when COVID hits, we just pivoted towards the virtual spaces. So, everybody's being trained how to do groups. So, I said, "Let's just train them how to do groups online." So, everybody was doing HIV testing. We wanted to make sure that we just amped up or ramped up our telehealth services and got people tested at home, in-home testing kits, laboratories, doctor visits for their prep. So, we just shifted everything to telehealth. The telehealth model that we just started creating. And luckily, we've enrolled over 500 people into prep services in the state of California. And we have four different discussion groups or social events online from dance classes, social game night, to discussion groups, and everything turned virtually. If anything, I think the big challenge is going to move from this new staff learning these new procedures to now shift them to the real space, real face-to-face space. (Executive Director, LGBTQ Youth Organization, California)

Nonetheless, the effectiveness of social media and electronic technology for services was not generalizable across populations, particularly among those lacking privacy, needing culturally appropriate services, requiring more intense services, or experiencing a technology gap.

The flipside of that is that for people that are not in comfortable environments, people who might be in a home life that isn't supportive, there's privacy concerns and it's difficult having telemedicine conversations with somebody in their home if their home environment isn't a safe space. (Executive Director, CBO, California)

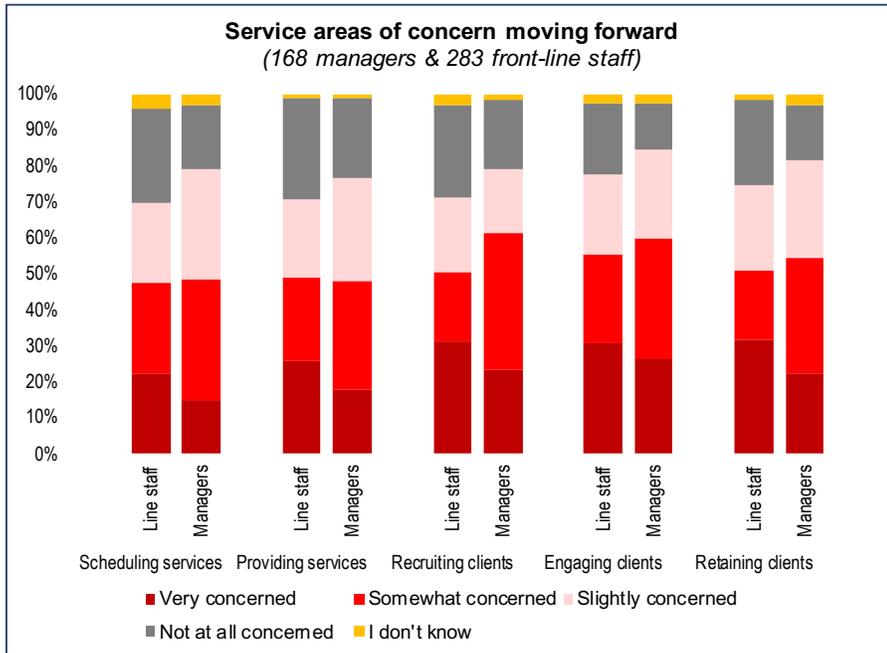
When dealing with our population, I think that face-to-face contact is necessary, especially when we're doing the counseling component [of HIV testing], because we see that as an opportunity to begin the engagement process, right, with the goal being long-term engagement. Whether the test comes back positive or negative, we want to make sure that we develop the relationship so that we can stay in touch with those clients. (Executive Director, CBO, New York)

So, as you know, we have a digital divide affecting mostly Latino communities and African American communities mostly. And within those communities, those that are over 50. Or those that are not English-speakers or indigenous individuals. So, even though that we have a lounge virtual services, but not everybody has the same access. Because they have different challenges. (Associate Director, AIDS Organization, California)

While COVID-19 created numerous challenges for the participating organizations, many of them were able to rise to the occasion and meet those challenges. Some strategies utilized by organizations to meet those challenges included implementing team approaches to problem solving, embracing technological upgrades, and fostering innovation. Many leadership staff identified lessons learned from this pandemic as permanent and were doing their best to see this as an opportunity to develop new strategies and to expand their service portfolio.

Moving forward

Over 50% of staff reported to be somewhat or very concerned about the impact of COVID-19 on service delivery moving forward. These concerns mirrored the perceptions about the impact of COVID-19 on service delivery mentioned above, particularly regarding the recruitment and engagement of clients.



About half of staff felt somewhat or very concerned about their programs' ability to continue providing services (see figure 18), including recruiting and engaging clients. These concerns mirrored their perceptions about the impact of COVID-19 on program management shown earlier. Similarly, staff expressed high concern over their ability to achieve program goals and deliverables and to comply with grant/funding requirements, most likely as a result of having challenges recruiting and engaging clients (see figure 19).

Figure 18. Services areas of concern moving forward

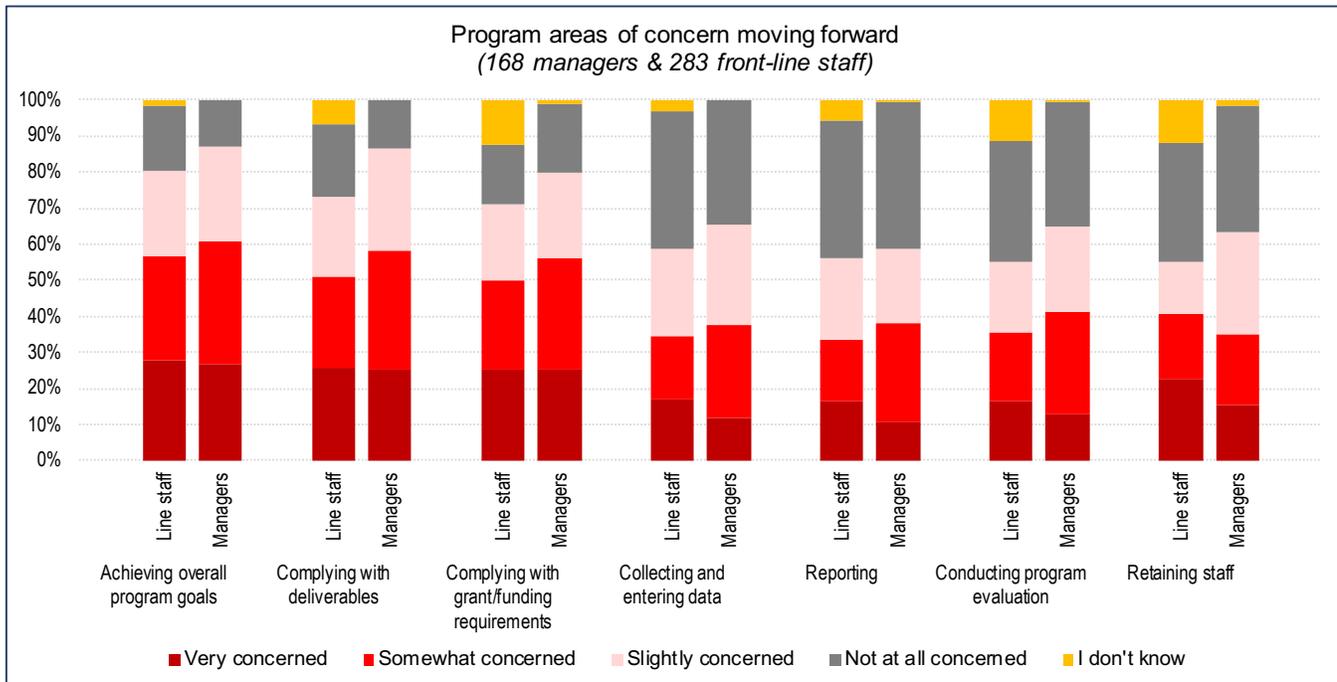


Figure 19. Program areas of concern moving forward

In the short-term, leadership staff reported some level of uncertainty about the future landscape of services and funding, particularly in areas already lacking adequate funding or infra-structure. Staff also pointed out differences in infra-structure capacity across organizations to maintain services and/or take advantages of future opportunities.

Right now, we're doing some days at the clinic and we're doing-- so two days at the clinic, three days remote work. But as we move forward with meeting the community needs that might change depending on also what our funder requires, so we don't know. We still are not certain 100% what that's going to look moving forward, if we're going to continue to maintain everything remote services or if we're going to be able to do a couple of days where people can actually access services face-to-face. It all depends on health regulations. (Team Management, CBO, Arizona)

I'm literally in the middle of writing a letter right now to CDC because West Virginia has been left out of the Ending the Epidemic strategy. Right? And what people don't get, I think, outside of West Virginia that this is a lot like operating in the 1990s or the very early 2000s because there's no infrastructure. There is no HIV infrastructure for me to build a hep C program on and then to build on a COVID program. (Executive Director, Capacity-Building Organization, District of Columbia)

If money becomes available for COVID or for extending their work [CBO's work] in the field to actually be able throughout the community, I think the vast majority of them still need grant writing skills. They don't have them. Most of the organizations that I know around the country, and this is through, let's say, the last two years while I'm still doing capacity building and as well as the little ones [CBOs] that I know here in the valley personally, they don't know how to write grants. So, they seek out somebody. They don't know how to evaluate their outcome. Some of them are doing fantastic work with immigrants with asylum seekers, but they're not collecting any data. So, that's a huge gap for the organizations that work with my community, which is both queer and brown/Latino. And they also don't have the connections. Many times when a grant becomes available, they don't even hear about it. (Executive Director, Capacity-Building Organization, Arizona)

In the long-term, many leadership staff expressed concerns about the diversion of funding from HIV towards other health issues, further increasing current funding gaps.

Uno, en que vamos a hacer de cara que esta pandemia nos va a durar unos años. Números dos, cómo esta pandemia va a afectar la iniciativa de terminación de la epidemia del VIH. Número tres, cómo vamos a trabajar, para que haya fondos separados, y que no nos veamos -como ha pasado en décadas anteriores- que se han utilizado dinero de una condición, para tratar de frenar otra. (Executive Director, CBO, Puerto Rico)

One, we are going to face that this pandemic is going to last us a few years. Numbers two, how this pandemic is going to affect the initiative to end the HIV epidemic. Number three, how are we going to work, so that there are separate funds, and that we do not see ourselves - as has happened in previous decades - that money from one condition has been used to try to stop another.

I think that if this COVID thing ever does stabilize, we'll get back to the ending the epidemic plan. But my fear is that while we ignore it, the epidemic is going to get worse. So, it's hard when you come from a place like Alabama when nobody has money, and the Medicaid is so bad, and the health department is stretched just like the AIDS Service Organizations are stretched. (Executive Director, AIDS Organization, Alabama)

So, I think policy is going to be a huge part of it. I mean, that includes maintaining the infrastructure of the Affordable Care Act. And so, people living with HIV can continue to access care without having to worry about their diagnosis preventing them from being able to have health insurance. There needs to be a separate pot of money for HIV that doesn't include COVID dollars. That's not to say that those organizations shouldn't also be able to access COVID dollars because as I said, many of us are doing both. (Executive Director, Advocacy Organization, Illinois)

Several leadership staff expressed concerns about the persistence of fundamental determinants of health impacting racial/ethnic minorities. Equally, they expressed some concerns about the geographic disparities in achieving the goals to End the HIV Epidemic, particularly in the South and in Puerto Rico.

Well, I mean, I don't think there's any doubt that the COVID epidemic has exposed the ugly underbelly of America in that it's the poor people, it's the brown and black people who are not being protected. That's always been the case with HIV, but you can take a map of the United States and put slavery on it. Then, you can put HIV on it, and it's the same areas. And you can put COVID on it, and it's beginning to look like the same areas. (Executive Director, AID Organization, Alabama)

If you look at what's happening with the COVID pandemic and if you look at the population of people that are impacted by this, it mirrors almost the same people that are impacted by HIV. So what that should hopefully open up, if it wasn't obvious, is that it doesn't matter what the virus is. What matters is how the virus will impact or infect certain people, and so if there were-- HIV was the same way. It's the same population of people. So if there's something that's coming after COVID, if we don't do what we need to do to fix that systemic problem, then those same people that are impacted by HIV that are impacted by COVID will also be impacted by whatever X is if something else were to happen. (Director of Prevention and Education, AIDS Organization, Georgia)

I think this could send us back in HIV if we don't continue that work. I think it's still being done in the big urban areas, New York and San Fran, and they were already much further down the road than we were to begin with. But I do contend that until you end HIV in the Southern of the United States, you're never going to end it in the United States. (Executive Director, AIDS Organization, Alabama)

Y cuando digo quién se está quedando rezagado, no solamente qué organización, sino qué área geográfica y qué poblaciones se están quedando rezagadas. Estamos viendo que el área sur de los Estados Unidos, el área fuera del área metropolitana de San Juan, en Puerto Rico, se está viendo bien rezagada. (Executive Director, CBO, Puerto Rico)

And when I say who is lagging behind, not just what organization, but what geographic area and what populations are lagging behind. We are seeing that the southern area of the United States, the area outside the San Juan metropolitan area, in Puerto Rico, is lagging well behind.

In the short-term, leadership staff reported some level of uncertainty about the future landscape of services and funding. In the long-term, some leadership staff, particularly in the Southern States and in Puerto Rico, expressed concerns about the diversion of funding from HIV towards other health issues and the persistent geographic disparities in achieving the goals to End the HIV Epidemic.



Discussion

Most organizations providing long-standing and proven-effective HIV/STI/HCV services to communities of color felt the impact of COVID-19-related challenges and, many, struggled to continue providing vital services. These challenges were felt acutely within communities and geographic areas already experiencing the long-term impact of health inequalities and of being at ground zero for both pandemics. This rapid assessment shed light on some of the impact on clients, staff, programs, and institutions. It also showed that even under acute personal and professional stress, staff rapidly adopted, expanded, or developed service and program strategies to ensure their clients received key services, staff remained safe and healthy, and organizations maintained a certain level of institutional stability to continue their mission of serving communities in need.

The findings of this rapid assessment should be considered in light of some limitations as well as strengths. First, while we collected information from different staff in the same organizations, the units of analysis were not organizations; therefore, findings are not generalizable to any specific organization or type of organization. Similarly, the purposive sampling strategy sought to obtain a broad and diverse sample of organizations across the U.S., which allowed for a greater understanding of the impact in many diverse geographic areas and types of institutional settings, but precludes us from extrapolating the findings to particular geographic areas or institutional settings. Another limitation of the research is that although we sought to include a diverse sample of survey respondents, over half of the sample identified as Latinx and over a quarter as White. Given the impact of COVID-19 on Native American and African-American communities, there is a need for studies that assess the particular and specific impact of COVID-19 on organizations led by these communities.

At the same time, this rapid assessment has several strengths that allow us to infer that other organizations and geographic areas may be experiencing similar challenges, implementing akin strategies, and in need of comparable resources. Standard methods for rapid assessments include mix methods and, often, a collaborative approach.¹⁰ Our assessment integrated surveys of both front-line staff and managers as well as interviews with leadership staff. This research strategy allowed us to obtain perspectives at various levels on the institutional impact of COVID-19 on the same organizational domains. In addition to allowing for triangulation of findings, the mix-method approach allowed us to capture subjective data in the midst of a social phenomenon, the COVID-19 pandemic, that is complex and dynamic in nature.

This assessment took advantage of the knowledge and experience of researchers and practitioners to guide a collaborative approach to methodology design, data collection, and data analysis. Furthermore, we conducted a preliminary analysis of the data collected mid-way through the project and presented it at a [COVID-19 Virtual Strategic Think Tank](#) held on October 14th, 2020, with over 162 practitioners, researchers, and public health officials from 105 different organizations. In addition to allowing us to triangulate some of the initial findings, their feedback allowed us to conduct more focused semi-structured interviews to further explore some of the qualitative and quantitative findings.



According to staff, COVID-19 greatly impacted clients' health and psycho-social life in multiple ways. They reported delays in HIV/STI/HCV screening/testing, STI/HCV treatment, HIV care, and specialty care. Furthermore, surveys and interviews shed light on the synergistic impact of long-term inequalities among communities of color and COVID-19. While the impact on health was considerable and diverse, staff reported an even greater impact of COVID-19 on their clients' psycho-social life in the areas of mental health, food insecurity, financial stability, community connectedness and integration.

The workforce of these organizations endured, and continues to withstand, the challenges of service and organizational disruption in the context of socio-political upheavals in the U.S., including protests against police brutality, hate and racism, xenophobia, and/or transphobia. Given the great impact of COVID-19 on communities of color, it is not surprising that staff, their families, and social networks were greatly impacted as they often came from the same communities they served. While most organizations avoided infection or great casualties among their staff by swiftly implementing COVID-19 prevention measures, many staff expressed concern about the long-term trauma, burn-out risk, and, in some cases, death among their staff, community, and family members.

Faced with COVID-19-related challenges, some organizations discontinued or scaled down essential services, including core services for homeless populations, incarcerated individuals, and those lacking access to public transportation. Organizations canceled or rescheduled major fundraising and community events, incurred costs associated with remote work as well as health and safety procedures. Furthermore, as agencies engaged in agency-wide and programmatic reviews, they were forced to make hard choices, prioritizing certain clients and services over others.

While some organizations started providing virtual and telehealth services, others re-started face-to-face services albeit in a restricted manner. Many clinics and medical settings remained open and provided essential HIV services such as linkage to care, care, and treatment. On the other hand, low-threshold services such as social gatherings, community outreach and support groups, necessary to increase client engagement in services, were greatly impacted due to social distancing measures. Not surprisingly, services that rely on client engagement were also being greatly impacted, including HIV testing, STI/HCV testing, and linkage to PrEP/PEP. In addition to impacting their direct services, COVID-19 impacted the work that organizations were doing in other service areas such as immigrant legal advocacy, leadership development, and peer training.

Most organizations were able to renegotiate their funding contracts, and the majority of staff reported some or sufficient access to immediate resources needed to continue providing services. However, a significant number of staff reported very little or no access at all to resources needed to adapt and implement services under these new conditions, including training in trauma-informed-care, technology training, and technical assistance to implement programmatic changes. Additionally, some staff expressed concern about the long-term impact on postponed program activities such as program evaluation and quality assurance.

Organizations incurred a variety of expenses connected to the pandemic such as those related to safety measures, enhancement of infra-structure, or provision of new services. Organizations were often able to re-negotiate their contracts with funders to allow for these expenses. However, many small organizations were greatly impacted financially, including several that were not able to implement additional safety procedures such as acquiring PPE or installing plexiglass due to lack of funding.

Some organizations had healthy finances that allowed them to manage the additional costs associated with responding to the pandemic, often with unrestricted funds. Nonetheless, even organizations with adequate unrestricted funds expressed concern about the long-term sustainability of implementing ongoing safety procedures and work changes. Uncertainty about the future was felt across organizations, from the small to the larger ones. Many organizations relied on annual fundraisers that were canceled or conducted virtually. Nonetheless, some organizations received additional assistance through COVID-19 emergency funds oftentimes made available from private foundations and utilized them to enhance their infrastructure. Other organizations took cost-saving measures such as delaying the hiring of new staff.

As the COVID-19 pandemic unfolded, some staff reported that their organizations became involved in COVID-19 related activities, including community education about COVID-19 risks, protective measures, testing and treatment. Nonetheless, less than 50% of staff reported being involved in other key activities related to COVID-19 such as contact tracing, counseling to clients with or impacted by COVID-19, or case management to clients with COVID-19. Overall, staff reported a great need for a variety of resources and support in order to address emerging COVID-19-related needs among their clients. Staff listed a variety of

resources needed from educational materials and training to institutional policies and guidelines for emergency responses. About 70% felt that there was a clear need for technical assistance to integrate COVID-19 within their current HIV/STI/HCV programs.

Most leadership staff at health organizations reported they had already incorporated COVID-19 work within their scope of services, often in partnership with departments of health. Those in social service organizations were less certain about including COVID-19 as an added focus. They expressed concern about their staff's expertise to move from sexual health to general health, diverting the mission of the organizations, or overextending their capacity without appropriate funding.

While COVID-19 created numerous challenges for organizations, many of them were able to take on the challenges by implementing team approaches to problem solving, embracing technological upgrades, and fostering innovation. Overall, staff reported a rapid increase in the use of new strategies to continue providing services, particularly the use of virtual media to provide counseling, health education, and telehealth services. In some cases, organizations proactively and creatively enhanced their ability to provide services under the new conditions, including digitizing their medical records, providing home testing, delivering sidewalk services and goods, and starting virtual services. In fact, many leadership staff identified lessons learned from the pandemic and were doing their best to see this as an opportunity to develop new strategies and to expand their service portfolio.

Many leadership staff saw potential for institutional growth in these changes and adjustments. They also expressed their concern about what was being lost in these service adaptations. For instance, the use of social media resulted in positive outcomes in broader recruitment of clients and delivery of services. Nonetheless, the effectiveness of social media and electronic technology for services was not seen as generalizable across populations, particularly among those needing culturally appropriate services, requiring greater service engagement, or experiencing technological challenges.

In the short-term, leadership staff reported some level of uncertainty about the future landscape of services and funding. In the long-term, some leadership staff, particularly in the Southern States and in Puerto Rico, expressed concerns about the diversion of funding from HIV towards other health issues and the persistent geographic disparities in achieving the goals to End the HIV Epidemic.

Recommendations

This national rapid assessment sought to understand the institutional impact of COVID-19 on organizations providing HIV/STI/HCV services to racial/ethnic minorities in the United States, Puerto Rico, U.S. Virgin Islands, and Associated Pacific Island Jurisdictions. There is, however, a need for a thorough and sustained assessment of the long-term impact of COVID-19 and of the capacity, strengths, and needs of health and social service organizations serving communities of color in responding to large scale public health emergencies. In the meantime, the following recommendations will hopefully increase the public health infrastructure and its institutional capacity to respond to the challenges ahead.

While the use of the electronic and virtual strategies may mitigate the impact of COVID-19 on the provision of client engagement activities, the technology gap (hardware, proper software, and quality of internet) among low-income individuals and those living in rural areas must be addressed.

Supportive services for those at risk of HIV infection or living with HIV must be enhanced to address the exacerbating impact of COVID-19 on those already experiencing mental health issues, isolation, substance use, food insecurity, housing instability, and financial instability.

Strategies to address burn-out, PTSD, and mental illness among staff need to be implemented and funded, including the presence of clinical support, time off, and childcare.

Small organizations must receive infra-structure support and funding to continue providing HIV/STI/HCV services in particular geographic areas and to particular populations to ensure the goals of Ending the HIV Epidemic and efforts to eliminate HCV are achieved across the U.S.

Funding should be made available for critical institutional infrastructure enhancements, including staff development, technology upgrades, financial planning, contingency emergency planning, program innovation, as well as strategic and succession planning.

Research support and funding should be made available to organizations for program adaptation and for the development of original virtual interventions.

Emergency plans at the local, state, and federal levels must be critically assessed and updated to ensure that social determinants of health impacting communities of color are taken into consideration.

There is a need for engagement of communities of color in policy planning (specially on vaccine education, promotion, and provision) and on COVID-19 related policies, funding, and research.

There is a need for policy and practice research with strong community participation to examine in-depth the ongoing changes in public health occurring as a result of COVID-19.

References

1. Greenaway C, Hargreaves S, Barkati S, et al. COVID-19: Exposing and addressing health disparities among ethnic minorities and migrants. *Journal of travel medicine*. 2020;27(7):taaa113.
2. Tai DBG, Shah A, Doubeni CA, Sia IG, Wieland ML. The disproportionate impact of COVID-19 on racial and ethnic minorities in the United States. *Clinical Infectious Diseases*. 2020. ciaa815
3. Kirby T. Evidence mounts on the disproportionate effect of COVID-19 on ethnic minorities. *The Lancet Respiratory Medicine*. 2020;8(6):547-548.
4. Stover J, Chagoma N, Taramusi I, Teng Y, Glaubius R, Mahiane SG. Estimation of the Potential Impact of COVID-19 Responses on the HIV Epidemic: Analysis using the Goals Model. *medRxiv*. 2020. The preprint server for Health Sciences. 2020:2020.05.04.20090399.
5. Pinto RM, Park S. COVID-19 Pandemic Disrupts HIV Continuum of Care and Prevention: Implications for Research and Practice Concerning Community-Based Organizations and Frontline Providers. *AIDS and Behavior*. 2020;24(9):2486-9.
6. Beima-Sofie K, Ortblad KF, Swanson F, Graham SM, Stekler JD, Simoni JM. "Keep It Going if You Can": HIV Service Provision for Priority Populations During the COVID-19 Pandemic in Seattle, WA. *AIDS and Behavior*. 2020;24:2760-3.
7. Jiang H, Zhou Y, Tang W. Maintaining HIV care during the COVID-19 pandemic. *The Lancet HIV*. 2020;7(5):e308-e309.
8. Kay ES, Musgrove K. From HIV to Coronavirus: AIDS Service Organizations Adaptive Responses to COVID-19, Birmingham, Alabama. *AIDS and Behavior*. 2020;24(9):2461-2.
9. Rogers BG, Coats CS, Adams E, et al. Development of Telemedicine Infrastructure at an LGBTQ+ Clinic to Support HIV Prevention and Care in Response to COVID-19, Providence, RI. *AIDS and Behavior*. 2020;24:2999-3002.
10. McNall M, Foster-Fishman PG. Methods of rapid evaluation, assessment, and appraisal. *American Journal of Evaluation*. 2007;28(2):151-168.
11. Scrimshaw NS, Gleason GR. *Rapid assessment procedures: qualitative methodologies for planning and evaluation of health related programmes*. International Nutrition Foundation for Developing Countries. Boston; 1992.
12. Trotter RT, Needle RH, Goosby E, Bates C, Singer M. A methodological model for rapid assessment, response, and evaluation: the RARE program in public health. *Field methods*. 2001;13(2):137-159.



“ So, it was challenging in the beginning... It was hard for our clients to understand that they couldn't come to the agency when they really depended on our agency. ”

“ We also knew that people continue to have sexual relations regardless of the circumstance, and people continue to need testing and need those services, ”

“ And not only the pandemic, once that hit, then we were involved in a race war, black men being killed, and it really had a profound effect on my staff and their ability to perform. ”

“ I think for the staff, there is a little bit of burnout, not because they're overworked in the work setting, but because it's work plus everything else. ”

“ So definitely having access to the technology really pushed us to come back at least partially. ”

“ We had to unfortunately lay off ... staff, because it was no longer possible to sustain this unit from an economic point of view. ”