Resilience among small community-based organizations during the COVID-19 pandemic: Insights for future public health crises

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ABSTRACT

The COVID-19 pandemic has created numerous challenges for many community-based organizations (CBOs) to sustain delivery of services and programs. This paper offers perspectives from leadership of three small community-based organizations serving diverse populations in the Hartford, CT region on how they were impacted and responded to disruptions during the first year of the COVID-19 pandemic. CBOs' commitment to the populations they serve and agility with regard to programming, staffing, and finances were highlighted as key to their resilience, enabling them to serve their clients with stability. The ability to collect information on the impact of the pandemic on clients supported by a well-established, long-term partnership with researchers at the University of Connecticut School of Medicine and Institute for Community Research facilitated their making data-driven decisions on how to best allocate limited resources. The lessons learned about organizational challenges and resilience may be applicable to future public health emergencies.

KEYWORDS

Community-Based Participatory Research, Community health partnerships, Health promotion, Public Health, Urban Population, COVID-19

Introduction

Community-based organizations (CBOs) are major access points to communities due to their in-depth knowledge of and established base of trust with the populations they serve.[1,2] In times of crisis, they are often called upon by state and local governments to expand services to hard to reach sectors. While CBOs have played an important role in reducing COVID-19 transmission and its impacts,[3,4] the pandemic has created numerous challenges for many to be able to sustain delivery of services and programs.[5] This is particularly true for small CBOs with limited financial reserves, making them extremely vulnerable to fluctuations in demand for services, revenues, and costs.[6] The nonprofit sector is overwhelmingly comprised of small CBOs serving local needs, with 92% spending less than $1M and 88% spending less than $500,000 annually.[7] Non-profit health and human service organizations have an average of 6.3 months of operating reserves; nearly one-quarter (23%) do not maintain any operating reserves.[8]

Disruptions of varying intensity are common in non-profit organizational contexts and can include: sudden crises (e.g., natural disasters, infectious disease outbreaks), leadership transitions, public policy and political changes, external attention (e.g., investigations), funding and economic shifts (e.g., rising costs of operation, funding priority shifts), internal issues (e.g., governance conflicts), industry and demographic shifts (e.g., increase/decrease in demand for services), and organization-initiated changes (e.g., scaling initiatives).[9] These types of disruptions in CBOs during the COVID-19 pandemic have been well documented in national and state-level reports.[5,10] A survey of 258 nonprofit organizations across Connecticut found that service demands were increasing, while staff and client safety and logistic challenges prevented re-opening at full capacity, and financial resources were limited.[11] Individuals studies also echo these challenges. For example, CBOs serving the homeless have reported concerns that

suspension or limitation of services and efforts to conduct remote services would affect rapport and limit the ability to address needs.[12] CBOs serving people living with HIV reported low staff morale, resource shortages, and disruption to patient-centered service provision.[13]

While a number of papers have documented CBO challenges with COVID-19, especially related to finances,[5,10,14-16] organizational resilience during the pandemic has received less attention. Resiliency in the non-profit sector, defined as how well-prepared organizations are to overcome or react to disruptions,[17] may be found in different areas, including: financial, human resources, outreach, program and services, and management and leadership. At best, resilient CBOs not only survive and continue to serve clients with stability through disruptions of any magnitude, but they also find opportunities to learn, grow, evolve, and ultimately, better serve their communities.[9] In one of the few studies examining organizational resilience during the first year of the COVID-19 pandemic, qualitative findings among a dozen CBOs indicated they began to think about their work in completely new ways as they transitioned to not only providing, but embracing, virtual services and the new opportunities offered by the post-COVID landscape.[18]

This paper presents the perspectives of leaders from three small CBOs serving diverse populations in the Hartford, CT region on how they were impacted by and have responded to COVID-19, and the ways in which a research partnership facilitated that response. Documenting how these CBOs handled change, setbacks, distress, and trauma associated with the pandemic can contribute to greater readiness for future disruptions CBOs may face and adds to what is known about factors that contribute to non-profit organizational resilience.

CBO Descriptions

The three CBOs profiled - Family Life Education (FLE), The Sudanese American House in CT Corp (SAHC), and Connecticut Harm Reduction Alliance (CTHRA) - predominantly serve low-income communities of color including Hispanic women and families, Arabic-speaking, Muslim migrants from Sudan and other North African countries, and people who use drugs, respectively. FLE's mission is to build a stronger community by fostering self-efficacy and skills for dealing with pregnancy, early parenting, food insecurity, and complex family dynamics. Services focus on life skills and leadership development, parent education and support, family relationships, removing barriers to employment, and promoting wellness. SAHC's signature program, Social Intervention for Health Action (SIHA, "health" in Arabic), comprises: (1) conducting regular community engagement integrating women's health into celebratory events; (2) collecting data from migrants of Arab and Muslim countries to identify their health and social needs via focus groups and needs assessment surveys; and (3) designing and implementing a cultural competency training to service providers on how to better interact with this population. SIHA operates as a multi-sectoral partnership bringing together governmental and non-governmental organizations, local mosques, and ethnic community associations. CTHRA aims to ensure the availability, adequacy, accessibility, and acceptability of services and resources that address the adverse consequences of drug use, homelessness, and sex work. CTHRA empowers its constituents to have a legitimate voice in program design and delivery, which includes services such as a drop-in center, infectious disease testing, a mobile clinic, and syringe exchanges.

FLE, SAHC, and CTHRA are located in, and conduct outreach to, the neighborhoods where their clients reside. These organizations are staffed by employees and volunteers who live

in the same communities, giving them an insider's perspective on the issues faced by the people whom they serve. They run on small budgets with narrow margins, derived largely from grants that are time limited and often earmarked for specific projects rather than general operating support. Each CBO also plays a broader role in the community through advocacy to promote health equity in the Greater Hartford region and Connecticut.

CBOs Research Partnerships

Researchers from the Department of Public Health Sciences at the University of Connecticut School of Medicine (UConn) and Institute for Community Research (ICR) have a decades long history of partnering together and with local CBOs on community-based participatory research projects. This commitment was further codified in 2010 with the formation of the Community Research Alliance (CRA), which aims to engage communities and organizations in equitable relationships to conduct research, evaluation, and associated activities that address health-related disparities. As a result, at the start of the COVID-19 pandemic in Spring 2020, CRA members, including the authors of this paper, were able to quickly mobilize to develop, administer, and analyze surveys that facilitated CBOs' understanding of the impact of the pandemic on their constituencies and ability to plan data-informed responses to meet community needs. The authors received a planning grant from UConn to explore additional COVID-19 preventative services appropriate for the CBO context. Several collaborative meetings were held to reflect on the challenges CBOs faced and strategies they employed during the first year of the pandemic with the goal of documenting unique and shared lessons learned. Based on these meetings, CBO and researcher co-authors conceptualized the idea for this manuscript, noting the paucity of information in the peer-reviewed literature on the resiliency of

small CBOs. Below, co-authors representing the participating CBOs summarize their perspectives that resulted from these collaborative meetings. This project was deemed exempt by the UConn Health IRB.

Amplifying Community Leaders' Voices: Perspectives of CBO Leaders One Year into the COVID-19 Pandemic

Commitment and Agility in the Face of Challenges

COVID-19 led to significant changes in the day-to-day operations of our CBOs. We had to change the way that we do business and make investments in equipment, training, and technology to keep staff, volunteers, and clients safe. Common challenges during the first year of the pandemic included: shifting from in-person to virtual/online services; conducting in-person services with safety precautions or cancelling in-person services; maintaining ongoing contact and relationships with clients; staffing shortages and challenges in hiring new staff to address the pandemic; accommodating staff to work from home; staff stress due to COVID impacts in their communities and high client demands; uncertainty about the organization's future; shifts in donor funding along with delays in deploying new funding; and needing to adapt to changing client needs (e.g., housing and food insecurity) and provide additional services (e.g., dissemination of COVID-19 information and personal protective equipment).

FLE: At FLE, we made a firm commitment to adapt to a new way of servicing clients and ensuring a seamless transition with minimal or no interruption of services. All staff maintained a steady caseload, while adding other necessary services to meet other emerging needs, such as assessing clients' qualifications to receive funds for housing and other supports (e.g., rent, food, clothing). Our staff were available during and outside work hours to support clients' emotional

needs and to teach them how to use telehealth and other online services. Having staff that were generalists and fully crossed trained with no compartmentalized services made it easier to pivot and expand our efforts to address COVID-19 related needs. Some funders demonstrated they were empathetic and cognizant of our needs during this time by allowing us to use some of the money that had been given for specific programs at our discretion.

SAHC: At SAHC, we paused the SIHA program at the beginning of the pandemic so that we could evaluate how to move forward in such an unprecedented time. Questions we asked ourselves included: "How do we conduct engagement activities during the lockdown and with social distancing requirements?," "What additional resources are needed?," "What training does our team need to be able to function safely?", and "How will the mental health of our staff and clients be affected during this difficult time?" Answering these questions required us to think outside the box. For example, we implemented virtual meetings and community events that were attended by more participants than we had for our pre-COVID activities. People wanted to talk to someone whom they knew and trusted. They asked many questions that we did not have all the answers for, but we listened and worked hard to provide accurate, up-to-date information on local and state COVID-19 prevention guidelines, testing, and vaccination. We experienced a decrease in our operational budget as funders diverted resources to COVID-focused projects. When our efforts to apply for additional funding were not successful, we put more emphasis on raising money via donations. Staff donated both their time and own money.

CTHRA: Prior to the pandemic, our drop-in center at CTHRA was our main point of contact with clients. However, to comply with public health guidelines, we quickly had to shift. Instead of having people come to us, we tripled our mobile outreach. We also became a food distribution facility for the community, not just for people who use our other services but also for

anyone in the area. We provided kits containing hand sanitizer, soap, masks, gloves, and an informational pamphlet (an extension of the safe injection kits to which our clients were accustomed), let people know where to get tested for COVID-19, and we registered our agency to be able to provide on-site vaccinations. One challenge we faced is that when you have people that are working in such a high trauma environment already, you will have burnout. However, we have also found that many people have become a lot more giving and want to do what they can to aid and give back.

Key Partnerships

We leveraged collaborations with the local health department and other community and health care agencies to maintain and expand delivery of certain services. For example, the Hartford Health Department received funding that was passed through to FLE to hire community health workers to provide information to the community about the pandemic and how to keep their families safe. At FLE, we also established an agreement with ConnectiCorp to add a part-time intern dedicated to recruiting volunteers to assist with staffing gaps and supporting program activities.

We leveraged our existing partnerships with researchers at UConn and ICR to facilitate our ability to make data-driven decisions on how to best allocate limited resources given the challenges. At SAHC, participating in the COVID-19 research helped our team to better understand the needs and concerns of our constituents and set priorities for service delivery. It also added more visibility to our organization and to the Arab and Muslim communities in Connecticut who are often excluded from research efforts. At CTHRA, we were able to assess how the pandemic impacted our clients' lives and how their needs changed. COVID-19 presented

additional hardships and with the information we gathered, we were able to make programmatic shifts to continue meeting folks where they were at, ensuring that they would get their particular needs met.

Lessons Learned

COVID-19 has resulted in disruptions for CBOs. At the same time, CBO's work to bridge the gap between governmental agencies, social service agencies, and health care systems has never been more needed, whether for promoting COVID-19 mitigation, facilitating testing and vaccination, or ensuring peoples' basic needs are met. Emergency funds from national and state entities are not enough to offset all the challenges CBOs have faced.

The small CBOs profiled in this article were proactive and flexible in the face of an unprecedented public health emergency, changing program delivery formats, expanding services, advocating with funders, leveraging volunteers and relationships with other local organizations, and collaborating with researchers to generate and analyze data to inform allocation of resources. Funders, policy makers, and other stakeholders can further strengthen CBO resilience by providing flexible support and investing in infrastructure and capacity-building. Additional ways that researchers can partner with CBOs to support their resilience include enhancing capacity to conduct needs assessments, evaluating the impact of changes implemented to service delivery, and sharing lessons learned with other CBOs and stakeholders.

Disrupting events of varying magnitudes may affect CBO operations at any time. Finding ways to build and sustain CBO's resilience should be a priority for future research. At the same time, CBOs do not function independently, but rather are embedded in a larger system of hospital and clinic health providers and funding agencies with their own mandates, limitations,

and priorities. This system often results in the larger entities receiving the bulk of the funding, leaving CBOs to compete for a limited piece of the pie. The period described in this paper is limited to the first year of the COVID-19 crisis. During this time, state and local health departments were under great pressure to promote strategies to mitigate and prevent COVID-19 transmission. CBOs willingly answered the call to assist while also being faced with multiple and immediate concerns among their constituencies related to social determinants of health (e.g., housing and food security). Without a coordinated approach, they were compelled to work independently, forging their own strategies and solutions without guidance.

Two key elements are required for CBOs to address the continuing COVID-19 challenges and prepare for future public health crises: (1) More general support to enhance their stability, reach, and advocacy capacity; and (2) an organized, proactive commission or legislated body that recognizes the importance of small CBOs reaching diverse populations and can plan, coordinate funding opportunities, prepare for rapid deployment, and create a collaborative response. Only such proactive planning can maximize individual and community-wide reach, minimize inequities in prevention and treatment availability, and organize and disseminate accurate information through trusted knowledge bearers.

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