


## EMPIRICAL RESEARCH QUALITATIVE

# Exploring intersectional stigma and COVID-19 impact on human immunodeficiency virus service provision for African Americans in a Southern city

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## Abstract

**Aims/objectives:** Through interviews with clinical service providers, we explored stigma's impact on HIV service provision for African Americans during COVID-19.

**Background:** African Americans experience disproportionate rates of HIV and COVID-19. We explored COVID-19's impact on HIV services for African American adults in a Southern city.

**Design:** The study was qualitative and observational.

**Methods:** Key informant interviews were conducted ( $n = 11$ ) across two healthcare centres and two community-based organisations and thematically analysed using phenomenological approaches by two coders. Interviews explored pre- and post-COVID-19 service provision and parallels between COVID-19 and HIV, particularly as related to stigma. The COREQ checklist was utilised to ensure research quality.

**Results:** According to the providers interviewed, all providers offered HIV prevention/treatment, but PrEP and preventive services diminished greatly early in the COVID-19 pandemic. Successful transition to telehealth depended on existing telehealth use. Challenges exacerbated by COVID-19 included food/housing insecurity and physical distancing constraints. Clients' COVID-19 informational needs shifted from concerns to vaccine requests over time. Interviewees stated HIV and COVID-19 both carry 'risk taking'; however, HIV risk was more physically intimate than COVID-19. Notably, some providers used stigmatising language referring to clients with HIV/COVID and omitted person-centred language.

**Conclusions:** Findings suggest need to address challenges in telehealth to improve client experiences now and for future pandemics. More research is needed to examine intersectional stigmatisation of COVID-19 and HIV for African Americans to design person-centred counselling interventions.

**Relevance to Clinical Practice:** Results demonstrate need for provider training to re-frame stigma discussions using client centeredness, educating African Americans on HIV and COVID-19 prevention, and coordination with local organisations to address multiple care needs.

**Patient/Public Contribution:** This research highlights needs of clients based on the views of healthcare providers caring for predominantly African American communities in a Southern city. However, no patients, service users, caregivers or members of the public were directly involved in this study.

**KEYWORDS**

African Americans, COVID-19, health disparities, HIV, intersectional stigma

## 1 | INTRODUCTION

Rates of human immunodeficiency virus (HIV) infection among African Americans are higher than all other racial groups and are increasing in the South faster than anywhere else in the United States, with 19.3 diagnoses per 100,000 occurring in 2016. Meanwhile, the Northeastern, Western and Midwestern regions had incidence rates under 13 per 100,000 for the same year. Research suggests that some contributing factors to the higher rates of HIV in the South include higher rates of sexually transmitted infections (STI), the lowest median household incomes in the nation and a more conservative culture than other regions (Human Rights Watch, 2010; Reif et al., 2014).

African Americans had the highest rate of HIV infections in 2016, accounting for almost half of annual infections. Similarly, approximately 42% of people living with HIV were African American while Hispanic and White Americans only accounted for about 17% and 12%, respectively (AIDSvu, 2021; Centers for Disease Control and Prevention, 2019a; Sangaramoorthy et al., 2019). African Americans have reported higher levels of perceived discrimination in healthcare settings. Perceived discrimination in health care is associated with lower perceived quality of care, lower medication adherence, inconsistent care and delays in seeking care (Cuevas et al., 2016; Cuffee et al., 2013; Shavers et al., 2012).

The 'Ending the HIV Epidemic (EHE), 2020: A Plan for America' set forth by the Department of Health and Human Services calls for a multi-pronged approach to HIV and has identified several regions in the South, including North Carolina, as priority due to disproportionate rates of HIV incidence in the region (United States Department of Health and Human Services, 2020; CDC, 2021b; Official Web Site of the United States Health Resources & Services Administration, 2019). Statewide efforts in HIV prevention are crucially important for African Americans, who comprise over 22 per cent of North Carolina's population and over 60 per cent of new HIV diagnoses (AIDSvu, 2021; CDC, 2019a; Sangaramoorthy et al., 2019).

## 2 | BACKGROUND

Beyond existing challenges of HIV prevention in North Carolina for African American clients, many changes have been seen due to the current COVID-19 pandemic. As of March 2022, over 79 million cases of COVID-19 were reported in the United States, over 953,000

### What does this paper contribute to the wider global clinical community?

- The results identify a need for targeted outreach and support to African American clients and providers serving them to address underlying factors that disproportionately affect African Americans: the same factors that prevent them from acquiring necessary HIV services in the context of the COVID-19 pandemic.
- Results also suggest that that stigma due to COVID-19 diagnosis and risk is experienced by African American clients at risk of or living with HIV as described by their providers. This is not well studied in the scientific literature and calls for future research.
- Results also indicate that person-centred, destigmatized approaches to care that include long-term follow-up would support efforts to reduce COVID-19 stigma and cases among African Americans.

of which have been fatal (Johns Hopkins Center for Systems Science and Engineering, n.d.; CDC, 2019b; CDC, 2021c; Johns Hopkins ABX Guide, 2021; Johns Hopkins Coronavirus Resource Center, 2021). Currently, three vaccines are approved in the United States, with the vaccines generally available in all states. In North Carolina, as of March 2022, 71% of the state population is fully vaccinated (Johns Hopkins Center for Systems Science and Engineering, n.d.; NCDHHS, n.d.b; North Carolina Department of Health & Human Services, n.d.a). African Americans make up 30% of COVID-19 cases among states with available racial data, according to current data estimates, and 22% of cases in North Carolina but the majority of COVID-19 deaths (Johns Hopkins Center for Systems Science and Engineering, n.d.; NCDHHS, n.d.d; Poteat et al., 2020). Reasons for higher COVID-19 morbidity and mortality include higher likelihood of holding essential jobs in health care, public transportation and grocery stores than other races; although African Americans make up approximately 12% of the United States' population, they account for about 17% of the country's workforce in these positions (Brown et al., 2020). These jobs prevent their ability to socially distance compounded by existing chronic health inequities such as less access to care and testing for COVID-19 management (CDC, 2021d; Millett et al., 2020). Before racial disparities in COVID-19 deaths, African Americans also faced disproportionate impacts of HIV

(CDC, 2021d). Compounding effects of intersectional stigma, the convergence of multiple stigmatised identities within an individual or group, has resulted in disproportionate COVID-19 morbidity and mortality for African American communities that were already navigating racism, sexism, socioeconomic disparities, HIV stigma and many other multilevel issues (CDC, 2021c; Johns Hopkins ABX Guide, 2021; Poteat et al., 2020). Systemic inequalities including intersectional stigma leaves African Americans especially vulnerable for poor COVID-19 outcomes in the United States, this is particularly the case for African Americans living with immune-compromising chronic health conditions such as HIV (CDC, 2021a; Davis, 2020; Lagasse, 2020; NCDHHS, n.d.d; Poteat et al., 2020).

As mentioned, intersectional stigma is highly associated with HIV inequities among people of colour, particularly in the South where rates continue to rise. In addition to navigating HIV, people of colour in this region are also navigating consistently elevated rates of COVID-19 and both of these illnesses carry stigma (Nydegger & Hill, 2020; Poteat et al., 2020; Turan et al., 2019; Villa et al., 2020; Wakeel & Njoku, 2021). HIV researchers face the challenge of how to define, measure, address and reduce intersectional stigma in lasting ways that improve health outcomes given that stigma results in healthcare avoidance in African American communities (Poteat et al., 2020; Turan et al., 2019). A growing body of literature also suggests that stigma may reduce care seeking of any kind for individuals who are at risk of COVID-19 (Nydegger & Hill, 2020; Villa et al., 2020; Wakeel & Njoku, 2021). However, much of this stigma research has not explored COVID-19-specific stigma, nor has it focused on service provision for African Americans in the South given the disproportionate burden of this community already navigating HIV inequities.

Key to this assessment are the needs of healthcare providers caring for African American clients given the over-representation in morbidity and mortality for both HIV and COVID-19 (Gravlee, 2020; Gwadz et al., 2021; Peek et al., 2021). The present study aims to: (a) understand service delivery and protocol change processes over time and impact of changes on HIV service provision post-COVID-19; (b) identify new and emerging issues in real-time, including how to manage changes to their staff's client care and with clients themselves; and (c) identify emergent concerns and implications for future preparedness including the impact of COVID-19 stigma on services. Findings have implications for future research to measure and intervene upon COVID-19 inequities and healthcare provision, particularly as they related to the existing inequities experienced by African Americans in the South.

### 3 | METHODS

#### 3.1 | Design

This descriptive, exploratory, qualitative study consisting of key informant interviews used a phenomenological approach to generate rich contextualization of the experiences of HIV service providers during COVID-19. Because little was known about the impact of

COVID-19 on HIV service provision in North Carolina to date, key informant interviews were conducted with individuals specifically chosen for their in-depth and firsthand knowledge (Easterby-Smith et al., 2008; Smith et al., 1999). Due to the unprecedented nature of the pandemic resulting in lack of guidance for the provision of health care under these circumstances, a semi-structured approach was used to allow informants to freely raise their unique concerns. All interviews were conducted by two individuals (coders 1 and 2) using a semi-structured interview guide, and most were conducted by coder 1 through recruitment at organisations with which she already had working relationships. All interviews were conducted via Zoom and audio recorded within the Zoom software. Each audio file was transcribed verbatim using Zoom transcription software. Coder 2 cleaned each transcript to ensure accuracy. Each interviewer took notes during the duration of the interview to complement the transcript and wrote memos following each interview. Interviews lasted between 40 and 80 minutes.

Study rigour was maintained by minimising leading questions and assumptions based on previous interactions with participants, such as asking all background questions regardless of familiarity with the organisation (Smith et al., 1999; Smith & Osborn, 2008). Questions covered topics such as change processes, where participants discussed how their organisation's experiences changed before and after COVID-19. The guide also contained questions about adjusting to new issues in client care due to the pandemic (e.g. social distancing and patients at higher risk of getting COVID-19 or with limited social support at home) and emerging issues and theories from the pandemic (e.g. future concerns for their client population, utilising CDC tools, and similarities and differences between HIV and COVID-19 service delivery). Coder 1 (PhD, MPH) was a female social/behavioural scientist who has doctoral training in qualitative research and designed the research guide. Coder 2 (MS) was a female research specialist and has graduate-level training in qualitative and quantitative research methodologies in community and clinical settings. This study was fully approved by a legitimate Institutional Review Board with a quorum.

#### 3.2 | Study setting

Key informants were members of four organisations providing HIV services in a city in North Carolina. Based on existing knowledge by the research team about HIV services and treatment, these organisations were identified due to their availability of services, populations served and continuation of services during the COVID-19 pandemic. All four organisations predominantly cared for African American clients and provided both HIV prevention and treatment services. Two of these organisations were community-based organisations (CBOs) that provide wraparound services such as food pantries, housing and job assistance, and HIV preventive care. The other two organisations were healthcare centres, both of which provided HIV testing, pre-exposure prophylaxis (PrEP) counselling and medication, and antiretroviral therapy and treatment for individuals living with HIV.

### 3.3 | Participant eligibility and recruitment

Individuals working or associated with the HIV service organisations were eligible to participate if they: (1) were adults ages 18 and older; (2) were interested in participating, with clear understanding that participation was voluntary; (3) provided HIV services at their organisation to African American clients; (4) provided informed consent to participate in an approximately 60-minute interview by phone or Zoom; and (5) were willing to provide contact information (an email address at minimum) to receive the consent form and study incentive for participation by email. Upon receipt of IRB approval, Executive Directors of the four organisations shared study details with their employees. The outreach email also included explicit language that the participants were not to respond to their director if they were interested, and not to notify their director once they participated (to maintain confidentiality). All interviews were conducted using a secure video conference platform, and participants were able to join by phone or without webcam use if they preferred. Interviews lasted between 40 minutes and 80 minutes. At the completion of each interview, participants received Amazon e-gift cards.

### 3.4 | Data collection

Data collection was completed between September 2020 and March 2021, during the time when many HIV service providers were beginning to transition back to in-person care and prior to widespread availability of the COVID-19 vaccines. Key informant interview guide questions were informed by the study objectives, which were as follows: (a) identification of previous practices for HIV service provision; (b) identification of current practices for HIV service provision while following restrictions during the COVID-19 pandemic; and (c) identification of recommendations related to COVID-19 preparedness to promote continuity of HIV services. Major domains of the interview guide were informed by each of the elements outlined below:

1. Understanding service delivery and protocol change processes over time and impact of changes on service provision post-COVID-19: Impact of changes on service provision pre- and post-COVID-19; how staff have responded to COVID-19 control measures and main concerns and questions staff have received from their clients.
2. Helping to adjust to new issues as they emerge: real-time, real-world decision-making processes of organisations who provide HIV services and whose client care protocols are, or should be, revised through the everchanging COVID-19 guidance and requirements from local and government organisations; describing who decision-makers were at their organisations and what that process looked like over time.
3. Emergent concerns and implications for future preparedness related to COVID-19: how experiences with COVID-19 prevention and control might have a lasting impact on local HIV service

provision for clients. This included practical and logistical issues like physical space, but also factors like the impact of stigma in health outcomes in African American communities, as related to both HIV and COVID-19.

At the beginning of each interview, participants were asked to describe their patient population, including the racial and ethnic identities of their clients who accessed both HIV treatment and HIV preventive services. After providing that context, informants' comments were not specifically prompted as to whether they applied only to their African American clients. Instead, the interviewer noted when and if informants discussed African American clients in particular at any point during the interviews and asked for clarification as needed.

### 3.5 | Data analysis

Completed interviews were professionally transcribed verbatim and coded by coders 1 and 2. A codebook was inductively built from the data by the PI (coder 1) informed by a phenomenological approach focused on the major domains outlined above (Creswell & Creswell, 2018; Easterby-Smith et al., 2008; Smith et al., 1999; Smith & Osborn, 2008). Tentative codes were assigned to summarise text on a sample transcript coded by both coders informed by the categories described above in an inductive process. Next, codes were defined and reviewed, and refined as coding continued and data collection was completed (Creswell & Creswell, 2018; Easterby-Smith et al., 2008; Smith et al., 1999; Smith & Osborn, 2008). Coders 1 and 2 coded all transcripts, and met multiple times throughout the coding process, to achieve consensus coding and inter-coder consistency for all transcripts. Once thematic saturation (repetition in data, finding and consensus coding for all transcripts) was achieved, the codebook was finalised (Townsend, 2013). Coded text was then analysed for recurrent themes beyond the previously identified major domain topics that were explored in interviews. Analyses focused on comparing and contrasting experiences and decision-making by providers at healthcare centres as compared to community-based organisations and salient quotes were extracted to convey these findings. Analyses were conducted in NVivo 12.0 (QSR, 2018). This research used the Consolidated criteria for reporting qualitative research (COREQ) checklist upon completion of the data analysis and manuscript (Tong et al., 2007; File S1).

## 4 | RESULTS

### 4.1 | Demographic characteristics

A total of 11 key informant interviews were conducted. As shown in Table 1, participants were from four organisations: two community-based organisations and two healthcare centres (one federally qualified health centre [FQHC] and one academic medical centre [AMC]). Participants were nearly evenly split between female (6 out of 11)

and male sex at birth. Roughly half of participants were clinicians (i.e. physicians, nurse and physician assistant; 6 out of 11). Participants were also diverse in race/ethnicity (i.e. Black, White and Hispanic participants sampled). Because interviews were conducted in late 2020 and early 2021, participants discussed their experiences both retrospectively and currently. They also described experiences that inform future preparedness related to COVID-19.

## 4.2 | Theme 1: Understanding service delivery and protocol change processes over time

All four organisations' representatives reported providing both HIV prevention and treatment services. HIV prevention services included HIV testing and counselling, which was offered by all organisations. However, only the FQHC and the AMC healthcare centres provided pre-exposure prophylaxis (PrEP). Community-based organisations did not provide PrEP directly and instead offered referrals for PrEP and PrEP care navigation to the FQHC and AMC.

HIV treatment services included social work case management and behavioural health services, which were offered by all organisations. Only healthcare centres provided direct HIV treatment and care including bloodwork and other tests, and only community-based organisations provided supportive housing and food security services for clients. Even though all four organisations predominantly served African American clients, differences were identified depending on specific type of service provision. Most clients living with HIV were African American, and providers at both the FQHC and AMC mentioned that most of these clients were over the age of 50. Clients who accessed HIV preventive services at all four organisations (i.e. HIV testing and PrEP counselling) were mostly under the age of 30 and most were African American. However, most clients on PrEP were patients at the AMC, and most were White American

TABLE 1 Sociodemographic characteristics of interview participants

Demographic characteristic	N (%)
HIV service organisations (N = 4)	
Federally qualified health centre (FQHC)	1 (25%)
Academic medical centre (AMC)	1 (25%)
Community-based organisations (CBO)	2 (50%)
Race/Ethnicity (N = 11)	
Black	4 (36%)
White	5 (46%)
Hispanic	2 (18%)
Participant role (N = 11)	
Management role	3 (27%)
Clinical role	8 (72%)
Sex at birth (N = 11)	
Female	6 (54%)
Male	5 (46%)

men who have sex with men. When asked why most clients who received care were African American, but most clients on PrEP were White, a provider at the AMC cited socioeconomic barriers to care:

...my population [on PrEP] ...is mostly White males who identify as men who have sex with men...we're not necessarily seeing the folks who are highest risk of HIV acquisition...If you don't have health insurance or some sort of coverage to pay...[we're] on a bus line, but...our hours are very sort of bankers hours. So if someone can't get off work to come to the [PrEP] clinic...the usual barriers to care, often for a lot of people exist for people who are either trying to seek or need care. –Clinical role, Female, White

A main concern for providers was transitioning care to and from telehealth. One major telehealth-related challenge noted by healthcare centres was working to get bloodwork and laboratory testing completed for their clients due to the transition to and from telehealth. Laboratories that could have been done onsite in one visit before COVID-19 now required referrals for laboratories outside of the usual centre. One provider described similar challenges for PrEP clients, but also discussed the impact of telehealth on standard of care for clients living with HIV:

That's been the problem, like it's more convenient when the person is there in the labs there. They just go straight to the lab. Something about hanging up the phone or ending the zoom call you forget you're supposed to get your labs. So there have been a couple of, more than a couple of patients who have gone longer than [they would have before COVID-19]...we do have a lot of [name removed] clinics around the area with labs in it and so we just strongly encourage people to go there. So it's, it's, you know, that's been the one drawback [to telehealth services that we offer] – Clinical role, Female, White

One community-based organisation and one healthcare centre were already using telehealth prior to COVID-19 mandates, but all organisations still encountered challenges to routinely using telehealth. A persistent challenge expressed by both community-based organisations and healthcare centres was that clients experienced logistical issues with video chat and limited privacy options. These issues exacerbated challenges of waiting for laboratory results and conducting follow-up calls with clients to explain them given clients had limited privacy.

Providers at the healthcare centres reported that decision-making was left to individual providers to make the transition from telehealth to in-person care when stay-at-home orders were lifted. Additionally, providers explained the financial realities which favoured switching to in-person visits, because telehealth insurance reimbursement is much lower than a traditional in-person appointment. One provider explains:

... people were allowed to make some individual risk calculations, I suppose. [if] you know this person [with HIV is] undetectable let's shift it back another month or two to their next appointment...on the other side was the, you know, financial calculations ...particularly telephone visits were reimbursing very low... [that] wasn't the [main] reason, but it certainly that was in the background. – Clinical role, Female, White

#### 4.3 | Both community-based organisations described halting their HIV testing services in early 2020. A main reason was because testing was venue-based, and many places closed entirely and were not allowing any services to be conducted onsite. As explained by one provider

... our sites were closed. Every, every site was closed. So I was saying, the first two months, March, April. Probably part of May...We try to find out if we could do some telemedicine calling the person, calling the clients in [to talk] about the results that were pending...[but] we are not allowed to give any results by phone and was very hard because we cannot call the person...so that was the major concern. I would say that beginning of June or late May, we started to do some material prevention distributions like brochures in countdowns and condoms and lubricants. – Clinical role, Male, Hispanic

#### 4.4 | Theme 2: Adjusting to new and emerging issues

While healthcare providers at community-based organisations and health centres were able to make care decisions for themselves regarding how they handed their caseload, they were not directly involved in the ongoing decision-making for protocol changes in client care. The few that were involved were part of small groups leading the decision-making at their organisation. One organisational leader explained:

...we're [a] very, very small staff...but there's a few people who carry a lot of weight in terms of the workloads that they manage. So the people who manage the IT systems and the case management systems and all that, you know, we had, we were in constant conversation. And so the board, you know the non-profit. They provide the oversight and their voiced concern was just making sure that we had a position... put in place. Oh, staff knew what to do. [It was like] Okay. Got it. Yeah. The board was, you know, they

were allowing us to make the operational decisions.  
– Management role, Male, African American

One participant mentioned that at their healthcare centre, having a large group involved with decision-making increased the number of perspectives resulting in indecision and lack of action.

...We started off with a COVID-19 test team, which was pretty big. So, it included, you know, senior leadership... But then [they] included the chiefs of all of the different departments. The nurse managers to behavioral health provider. So it's kind of like all of leadership was in this COVID-19 test team...that only lasted for about two weeks because it was a mess. It was a mess because it was too many differing opinions. Too many, you know, I'm going to tell my staff to do this...we were giving different messages to the different departments...so quickly senior leadership decided, you know...this cannot be a democracy. – Clinical role, Female, Hispanic

Another issue that arose regarding care delivery during COVID-19 was the transition back to in-person socially distanced care. This transition was particularly difficult due to physical space limitations and client screening requirements that exacerbated existing challenges such as transportation to get to healthcare centres. One provider explained:

...That has been a little bit of a challenge with getting them [clients and staff] to wear the face shields but we're working on it. We've had challenges with social distancing, particularly in our pharmacy. We've tried different things, to try to do that curbside service delivery...we actually got approval to have chairs outside of our clinic area where patients can sit and wait that are six feet distance apart...we've tried to get patients wait outside in their cars, but, as you can imagine, some of them didn't even come in a car. And can't afford to run the gas to run heat or air conditioning or you know, depending on time of year... – Clinical role, Female, White

Although there were always patients who fall out of care, many providers mentioned increased concern about clients lost to care and patients who tested positive for COVID-19 due to immunocompromised status or inability to socially distance. One CBO-based provider mentioned that their organisation had to increase their provision of wraparound support services to clients with COVID-19 which necessitated remaining in constant contact. He explained:

...so we usually keep in contact with all of our clients... we couldn't stress enough how important it was to make sure that because people who are HIV positive

now fell into the category of being immune compromised ...unfortunately some of our HIV clients did actually end up testing positive for COVID-19...we tried to also make arrangements with them...like if they needed to pick up medication and we were there to help them do that and they needed food and we were able to provide food to them through our food pantry... - Management role, Male, African American

Adjusting to care provision during the COVID-19 pandemic brought challenges of navigating transitions to and from in-person care while maintaining safety procedures, and variability in implementation of organisation-wide decisions, and fears of clients falling through the cracks. From this pandemic and its associated challenges, one provider mentioned the need for leadership and guidance from the organisation level. At the time, many changes were happening in the county leadership which made COVID-19 mitigation more challenging for all health service providers looking for direction at their organisation. She explained:

We work very closely with both with [leadership] at multiple organizations in the county and partner in a really nice way. So we did reach out to [name removed] for and we still do for COVID-19 things... [but there have been so many leadership changes in the county, and some were] precisely at the time that COVID-19 hit, so there was a chief medical officer that had been here the whole time I've been here... And she was on top of everything for everything. But then she left right before COVID-19 hits. Then, a public health director retired. A couple month before COVID-19 hits, and a Director of Nursing left [not due to COVID-19]. [So, county officials] we felt that, you know, we should go to the [name removed] for advice and to kind of follow their lead. Well, that wasn't happening. It was quite the opposite. It was the [name removed] calling our chief medical officer, our chief of HIV services, kind of like, 'Hey, what are you doing with that and what should we do with this? And do you think this is right? Do you think this is not right?' ... -Clinical role, Female, Hispanic

#### 4.5 | Theme 3: Future preparedness related to COVID-19 and impact of stigma

Between fall 2020 and early spring 2021, nearly all providers mentioned that the most pressing concerns they saw for their HIV services clients went from COVID-19 symptoms to COVID-19 vaccine rollout. Many providers described concerns received from clients about the logistics of vaccine rollout, especially for clients living with HIV. One physician explained this transition as 'weird':

...I mean, like, it's going to be a really weird next couple of months...I have had patients telling me that they don't feel comfortable coming in because of their history of immunosuppression although, you know, I have very few people with advanced AIDS right now... I think it's really just the vaccine [people ask about], to be honest...it's really all just questions now about the vaccine and, you know, I actually am seeing more of my patients though just second wave more of my patients have tested positive for COVID-19. I've actually had to do a lot of COVID-19 counseling. But I haven't had anyone, knock on wood, who's had to be hospitalized as part of their COVID-19 infection. - Clinical role, Female, White

Providers were asked about whether their work related to HIV service provision had application to COVID-19 service provision. When asked about the impact of stigma on both illnesses, many providers felt that both HIV and COVID-19 carried stigma. One provider felt that in both cases, HIV and COVID-19 were viruses that should be viewed similarly especially when considering that the individuals experiencing inequities have stigmatised identities already.

There is stigma and everything we do. We've always been marginalized [African Americans, or people who are LGBTQ+], we always had to deal with stigmatization. However, we persevere and we need to find that way. I don't dwell in stigmas if I see it, or I'm involved, I correct it. Or I make it known to someone who was doing it, how they approach could be different or done differently. However, it exists. I don't want to put a whole lot of blame. I [we] need a cure for COVID-19. I [we] need a cure for HIV. - Management role, Male, African American

Most providers, however, felt that stigma relating to COVID-19 stemmed from economic consequences while HIV stigma was perceived as judgement on behaviours. As such, experiences of stigma were not viewed as similar or comparable by the majority. Two providers described the challenges of being diagnosed with COVID-19 impacting the family's economic stability and well-being and therefore minimising disclosure:

...I had one patient who wanted to get COVID-19 testing...if we were going to be able to get him a test. The next day, but that's fine, but you need to, you know, not go to work and then if you're positive course you need to not go to work. And he's like, oh no, I can't do that...I had multi-generational families [getting help]... with eviction something to help with getting people supplies. If they did have to quarantine... - Clinical role, Female, White

...There is still that COVID-19 stigma of like...somebody who's had [COVID-19] and are they still contagious...COVID-19 [stigma] more seems to be maybe economically- based because it's like, well, if I have COVID-19 I would like to know, I want to protect my family, friends, but I don't want to have to stay out of work to lose income... – Clinical role, Male, White

Other providers stated that COVID-19 stigma was reducing over time, partly because COVID-19 had increased so much in prevalence in the general population.

...Yeah, I mean, one of the things that I thought was happening in the beginning, although it seems less now is that there was the stigma associated with having COVID-19 and you know, there's stigma also with having HIV. But that seems to be changing. Because now everyone seems to actually have COVID-19. And so I think that the stigma has been reduced. And it's much less of a thing now, in my view. So, yeah, I think that was the primary, the primary thing... – Clinical role, Female, White

In contrast, consequences of HIV stigma were described as more pervasive. Providers explained that HIV acquisition was more associated with 'risky' personal choices, while COVID-19 could have occurred with very casual contact and less risk-taking. Two providers explained these differing consequences as:

...I guess like HIV stigma, right, you kind of have people, unfortunately, judging like lifestyles and values and beliefs and, you know, possibly getting kicked out of families and support systems and support groups. Over that, reasons [for stigma] with COVID-19, I don't see that so much... – Clinical role, Male, White

It was at a point where you would only get HIV if you had sex with someone who is HIV positive, or you shared needles with someone who was HIV positive. And of course, a long time ago was you know... if a pregnant woman was HIV positive and breastfed and that kind of stuff. But with COVID-19, it's about breathing and we all have to breathe. So, you, you. I think the um not discrimination, but the stigma. I think there is a little bit of it for those that get infected like, "shame on you, you did something wrong to get infected." Which was the same with HIV, you know, "shame on you." But the difference is that it's a pandemic versus an epidemic and that it's contracted by breathing and we all have to breathe. Whereas we don't all have to have sex and we don't all have to inject drugs. – Clinical role, Female, Hispanic

Many providers felt that a key lesson from the past year of managing HIV services and COVID-19 was addressing the digital divide to reach clients that do not have access to Internet, smartphones or social media. One organisation leader explains this as being an issue that existed but was exacerbated during the COVID-19 pandemic:

...Assuming everyone didn't have internet, right. So everyone couldn't do a zoom right everyone didn't have knowledge of using a laptop be focused on us with laptops. You know, let me focus, focus [on] folks aren't living, like, that they're not looking at social media every day...you know people who are not as is technologically engaged so that I think that's one of the areas you have to, we have to figure out how do we, how do we make sure people are digital digitally, you know, connected... – Management role, Male, African American

This individual went on to mention that one way that their organisation address the digital divide was providing leaflets about COVID-19 and condoms for HIV prevention. These materials were included in boxes for clients who were picking up their food donations, which was a service that both CBOs provided before COVID-19. Both CBO executive directors described food insecurity as a lasting and growing issue that was exacerbated in the community as a result of COVID-19. One stated that 'even when one need like HIV may start to come down, another will fill its place.'

....in the very beginning, like I said early on ...we have like a whole lot of education that information hand-outs and I personally had a lot of condoms. So as I began to see things begin to close down, and we still do the food service on Thursdays. – Management role, Male, African American

Yes. We have started doing a lot more with our food pantry. Because we've noticed, even though, the need for some things [like maybe HIV testing in COVID-19] isn't as much or starts to come down, there's another need that fills it that the Community has that they're looking to get filled. What our agency is doing. I just see as a part of something that's called [name removed] which is a big referral system for agencies to make referrals to other agencies for various services and lately we've been getting a lot of people who are in need of food and housing... – Management role, Male, African American

Another provider felt that one of the most important takeaways from the pandemic related to economic consequences, although not due to stigma. Instead, the provider described the need for financial preparedness due to the uncertainties everyone faced:



...Anything can happen if they said you can't leave your house for a month. And one of the things people fail to do is to save them budget their incomes...You get laid off, get fired...a lot of people after their first month, and they're already in jeopardy...They don't need and start saving for a rainy day. If they didn't learn that I hope they learned that you have to have a nest egg... - Clinical role, Female, African American

On a broader level, one provider felt that a key takeaway from the past 18 months was that people showed resilience and ability to adapt (as individuals, or in terms of jobs and society). Where challenges rose, solutions were tested, and best practices were established to move forward with improved pandemic preparedness that was not specific to COVID-19. One physician explained:

...with these big kind of emergencies. I mean, I also think that from science in general...within however many months that was, you know, everybody kind of consolidated their efforts and was able to tackle COVID-19 and come with hopefully a solution to it...if we have the funding and the effort and the focus and try, we can really adapt to, you know, catastrophic event and...overcome it... - Clinical role, Male, White

## 5 | DISCUSSION

The purpose of the present research was to understand the impact of stigma and the ongoing COVID-19 pandemic on HIV service provision for African American clients in the South from the vantage point of community service providers. Overall, findings reflect that providers experienced substantial differences in how they conducted their work, and that differences remained even after returning to in-person care provision due to requirements around physical distancing, client screening, and some continued use of telehealth by all four organisations. Irrespective of the type of organisation, nearly all providers described that the COVID-19 pandemic exacerbated many existing inequities such as limited transportation to access health care, noninsurance or underinsurance, lack of connectivity or telehealth access, and economic instability.

A key contribution of this work is its exploration of COVID-19 stigma specific to the experiences of African American communities simultaneously navigating inequities in HIV in a Southern city. When asked, respondents drew comparisons between HIV and COVID-19 stigma and cited similarities in stigma regarding the shame and sense of irresponsibility associated with disease acquisition. For respondents, both HIV and COVID-19 were associated with the individual 'not doing what they were supposed to' in order to keep themselves safe. Further, they stated that HIV and COVID-19 impacted overlapping communities, specifically African Americans and people with lower socioeconomic status with less ability to engage in physical distancing. In terms of differences between COVID-19 and HIV,

stigma associated with HIV was described as more severe because of the physically intimate methods of exposure. As more people contract COVID-19, the level of stigma seemed to decrease such that acquisition appeared more acceptable because transmission requires only casual contact. Similarly, 'anyone can get COVID-19 at any time', while HIV is typically acquired by populations that experience marginalisation due to stigmatisation of their sexual orientation, gender orientation and/or race/ethnicity.

It is noteworthy that when discussing perceived COVID-19 stigma and perceived HIV stigma, providers themselves often used stigmatising language. For example, providers used terms such as 'being risky', 'doing certain kinds of behavior' and 'being HIV-infected', which is language that has been shown to be stigmatising because it is not person-centred terminology. A few participants also used stigmatising language when referring to individuals exposing themselves to both COVID-19 and HIV and in association with behavioural health needs, such as 'high-risk drug user'. While it is possible that providers may have been less conscious of their language due to the flexible nature of key informant interviews, future research should further explore providers' own biases related to stigmatisation of COVID-19, HIV and clients highly vulnerable to both such as African American clients and individuals with greater socioeconomic disadvantage, and/or behavioural health needs. Early in the pandemic, US-based publications on COVID-19 largely explored COVID-19-related stigma in the context of Asian immigrants in the United States, with recent literature demonstrating the serious impact of COVID-19 stigma on mental well-being globally (Gunnell et al., 2020; Peprah & Gyasi, 2020). Given the global attention on stigma related to COVID-19 (Dubey et al., 2020; Javed et al., 2020), future research should explore the impact of intersectionality including COVID-19 stigma on healthcare access and outcomes among African Americans (Nydegger & Hill, 2020; Villa et al., 2020). It is also unknown whether the use of stigmatising language existed prior to the pandemic or arose due to the pandemic. Exploring the use of person-centred language when discussing intersectional HIV and COVID-19 in patients of colour has the potential to be an area of future research. Similarly, more research should be done to work on problematizing diseases rather than those who contract them.

Early on in the COVID-19 pandemic, community-based organisations described challenges with HIV preventive services and a simultaneous increase in issues of food insecurity with their clients. Healthcare centres described challenges in serving clients living with HIV because in-person services such as bloodwork now required referrals and additional wait time. All providers described challenges related to telehealth provision early in the pandemic, but also currently since telehealth services continued to be offered at all organisations. Within the context of healthcare centres, decision-making related to offering care via telehealth was left up to the providers who reported challenges associated with on-boarding clients to telehealth themselves. The lack of technology support posed a challenge to clients not already familiar with telehealth software, or clients without previous computer experience. When transitioning back to in-person care in late 2020, providers also cited challenges

of physical space limitations, given the requirement to physically distance without guaranteed space to do so. With protocols changing along with developments in COVID-19 safety recommendations, barriers to access shifted from telehealth viability, to accessing physical space, and proper screening procedures. These findings are in keeping with recent literature that healthcare centres are now providing new 'hybrid' models of health care, combining in-person and touchless health care whenever possible. A recent study by Lee and Lee suggests that *digitact* (i.e. digital contact or digital face-to-face) health care will permanently become more mainstream than it ever was before the pandemic (2021). Nonetheless, these advances to minimise COVID-19 spread will not benefit those at greatest risk, who were least likely to have digital access prior to the pandemic. More research is needed to develop innovative models for promoting telehealth access (Jean-Baptiste & Green, 2020).

Additional concerns relating to clients included clients living with HIV being at a higher risk for poor COVID-19 outcomes. Providers cited client concerns that their already compromised immune system could lead to greater COVID-19 risk and worse outcomes if COVID-19 were contracted. Because of this, providers cited difficulty to strike a balance between maintaining care for clients living with HIV and protecting them from potential COVID-19 exposure at the clinic. As interviews proceeded during early 2021, providers reported that client concerns shifted from symptom concerns to urgent requests to receive the COVID-19 vaccine. This may be due to the timing of vaccine rollout and availability, not necessarily because clients were no longer concerned with potential COVID-19 symptoms. Additionally, because providers offered services through community-based organisations, clients may have felt that their organisations would have earlier access to the vaccine.

Despite the challenges brought upon the healthcare system in light of the COVID-19 pandemic, providers had the resilience to continue providing some level support and services to patients. Providers noted still finding a way to reach patients even with the challenges of telehealth, and no providers reported any patients dying. Future research should focus on resiliency in navigating HIV and COVID-19 from the providers' perspective as well as shifting problematization from people to the diseases themselves.

## 5.1 | Limitations

The present study has several limitations. First, our sample size of 11 interviews from four organisations is small, although it is appropriate for key informant interviews and captured rich variation in experiences of HIV service providers (Townsend, 2013). The experiences of these CBOs and healthcare centres, their availability of resources and structure related to protocol changes related to managing COVID-19 guidelines and provision of HIV service delivery may not be widely generalizable. As a result, while CBOs could discontinue services, healthcare centres could not. Next, interviews were conducted after the very beginning of the pandemic, and prior to widespread availability of the COVID-19 vaccine for all

individuals ages 16 and older (Cable News Network, 2021; Frenck Jr. et al., 2021; Wakeel & Njoku, 2021). Therefore, temporality of findings must be considered and was noted in results above. While findings may not be widely generalizable to other regions, many of the service delivery challenges identified such as service disruptions, space limitations and telehealth challenges are known to have application beyond this study. For instance, a study by Qiao and colleagues in nearby South Carolina noted similar HIV service delivery disruptions and telehealth challenges during COVID-19, which were greater in lower income areas where African American clients were overrepresented (Qiao et al., 2021). Finally, providers were mostly highly educated and had held their respective roles for three or more years, and many had senior leadership positions. Findings may have differed with less-tenured staff.

## 6 | CONCLUSIONS

The present research provides important context about the realities of HIV service provision for organisations navigating both HIV and COVID-19. While all providers worked at organisations that predominantly served African American clients, neither interview questions nor respondents' answers are unique to only African American clients. However, barriers to care such as limited telehealth access, limited transportation for in-person healthcare visits, high rates of food and housing insecurity, and disparate rates of HIV and COVID-19 exacerbated by intersectional stigma were all issues discussed by providers that impact African Americans more than all other racial/ethnic groups. Providers also felt that future pandemic preparedness should centre on individuals being financially prepared for challenges such as job and housing shortages, and economic consequences if they or their loved ones were diagnosed with COVID-19.

Overall, findings reiterate the need for targeted outreach and support for African American clients as well as providers serving this population to promote continuity of HIV service provision in the context of an ongoing and everchanging pandemic. This outreach may include outreach and HIV prevention care offered in flexible locations and in-person but socially distanced clinic visits.

Future intersectional stigma-focused interventions should focus on eliciting person-centred approaches to service provision, addressing multiple determinants experienced by clients, the role of provider-level training in destigmatizing care, and long-term follow-up to promote successful reduction in poor HIV and COVID-19 outcomes among African Americans (Logie, 2020). Lastly, while the present research was conducted before the availability of COVID-19 vaccine booster shots in North Carolina, findings related to the need for addressing the digital divide and reducing COVID-19 stigma specifically for African Americans are crucial given their over-representation in COVID-19 cases (NCDHHS, 2021). Clients who previously received vaccines may need tailored education about the importance of additional vaccines, while addressing mistrust related to the efficacy of previous doses. Further, African Americans in particular may need tailored support related to vaccine acceptance among their children,

which was rolled out in late 2021 because preliminary data show uptake of COVID-19 vaccines for African American children to be lower than other races (NCDHHS, n.d.; White et al., 2021).

## 7 | RELEVANCE TO CLINICAL PRACTICE

Providers have the power to play a larger role in making services more accessible in light of the COVID-19 pandemic. Results from these interviews demonstrate a need for collaboration with local organisations to connect vulnerable patients to resources addressing limited telehealth access, food insecurity and housing insecurity. As for future preparedness, organisations should develop an emergency plan that outlines distanced HIV care to at-risk populations, strict safety precautions and alternative locations that are more spacious to perform in-person care when it is safe to do so. Additionally, the use of stigmatising language among participants suggests a need for training to reframe how providers associate stigma with patients and their behaviour. African Americans experience the greatest burden of both HIV and COVID-19 disparities, and require tailored education related to preventive behaviours related to both conditions.

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### CONFLICT OF INTEREST

The authors declared no conflict of interest for this article.

### DATA AVAILABILITY STATEMENT

Data sharing not applicable - no new data generated, or the article describes entirely theoretical research.

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## SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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