Strengthening the Capacity of SSPs to Respond to COVID-19

Final Funding Report

NASTAD

Evaluation Partner

FACENTE CONSULTING
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Introduction

In 2022, the Centers for Disease Control and Prevention (CDC) provided funding opportunities to syringe service programs (SSPs) to promote COVID, hepatitis A and B, and influenza vaccine uptake to people who use drugs. The funding portfolio for two funders, AIDS United (AU) and NASTAD, included 50 **Tier 1** grantees overseen by AU and six **Tier 2** and two **Tier 3** grantees managed by NASTAD. Tier 1 grantees generally had lower capacity to provide services (e.g., more resource-limited financially and/or fewer staff) and received $100,000 in funding to incorporate COVID, hepatitis A or B, and/or influenza vaccination and/or vaccination linkage services, while Tier 2 grantees received $200,000, and Tier 3 grantees (programs with the most robust infrastructure for service delivery and evaluation) received $650,000 each. The initial disbursement of the one-time funding for an eighteen-month period occurred in February of 2022, and a six month no-cost-extension was available to all grantees through January 31st, 2024.

This report reviews the findings derived from data collection in the final reporting period of the grant (February 2023 through June 2023). The report also explores the progress made in data collection capacity among Tier 2 and 3 grantees over the grant period, as well as the overall grantor and grantee impressions of the effectiveness of this project as an archetype of a grantmaking process that is aligned with the principles of harm reduction. Qualitative evaluation includes data collected during June 2023 through interviews and focus groups, and in some cases for programs who took advantage of the no-cost extension, quantitative data includes data collected during July and August 2023 in addition to the February 2023 through June 2023 time period.

Quantitative Data from Grantees in Grant Period 4

Tier 1 Data

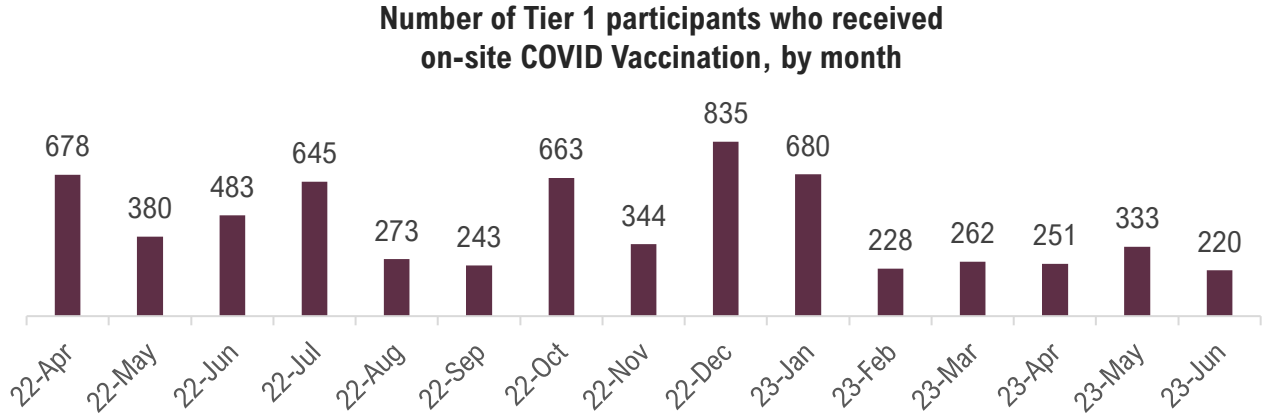
Tier 1 demographic data is collected periodically according to the following schedule:

Report	Reporting Period	Submission Date
1	February 15 – August 15, 2022	September 12, 2022
2	August 16, 2022 – February 15, 2023	March 15, 2023
3	February 16 – August 15, 2023	September 12, 2023

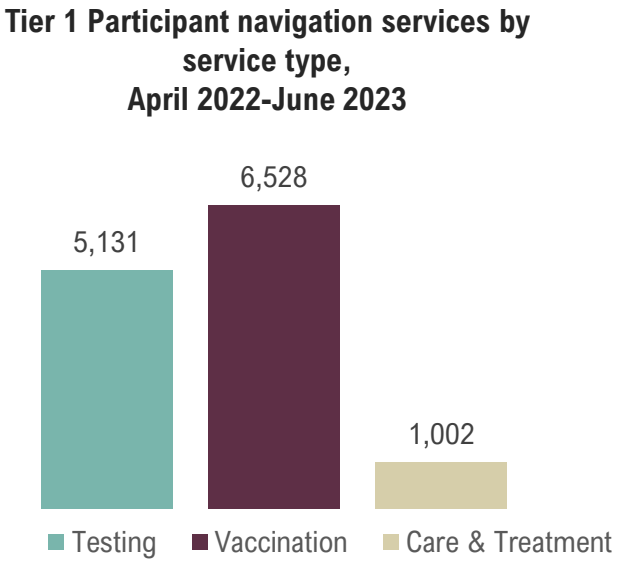
All three reporting periods were available for analysis and included in this report. For period 1, Tier 1 demographics were collected by service type, but this was changed for periods 2 and 3 when data were collected for all service types combined. Data are aggregated estimated percentages reported by Tier 1 programs.

Tier 1 Monthly Data Overview (April 2022-June 2023)

Data capacity for Tier 1 programs grew over time. In April 2022, only 54% of agencies provided any data. All 50 programs provided data most months; however, in June 2023 only 84% of grantees provided data. Throughout the duration of the project, Tier 1 programs developed 782 educational materials including informational brochures, pamphlets, slideshows, handouts, and social media graphics on COVID and COVID vaccination. Programs distributed these materials to 186,913 SSP participants. A total of 114,761 COVID risk reduction counseling sessions were conducted this quarter with 148,359 participants reached. 100,600 participants received a referral to COVID vaccination. Of these, 6,518 participants received on-site COVID vaccination. Another 6,528 received navigation to vaccination at another location.



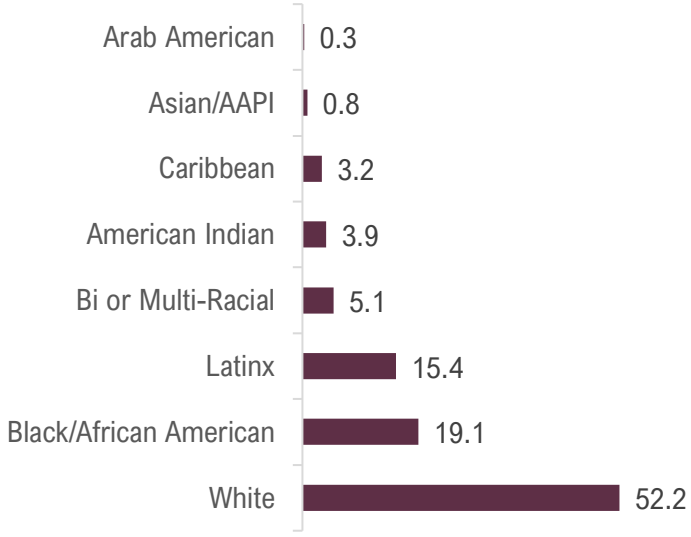
Tier 1 programs conducted 23,127 COVID tests on-site and provided COVID-related care and treatment on-site to 730 participants. In addition, Tier 1 programs provided referral and navigation to testing, vaccination, and care and treatment to those who required additional support to receive services. Over 136,000 referrals were made to testing (33,915), vaccination (100,600), and care and treatment (2,026). Navigation services were provided to 12,661 participants by Tier 1 programs.



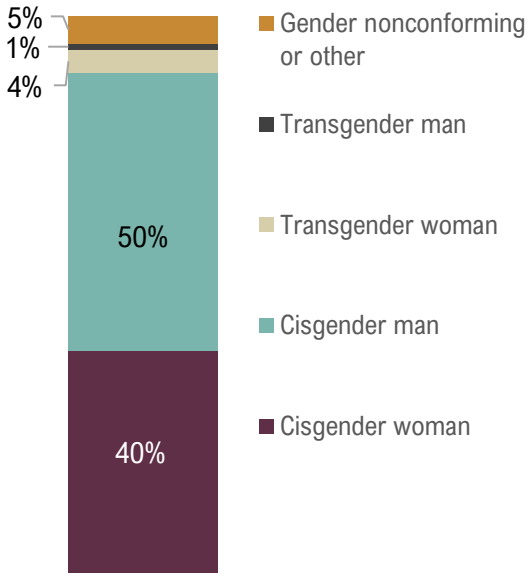
Tier 1 Periodic Data

Tier 1 periodic data includes estimates of the demographics of participants for Tier 1 programs. Demographics reported in these data are race/ethnicity, gender, and age. Of the 50 programs, 48 submitted their data and are included in this report. The majority of participants were white (52%), followed by Black/African American (19%), and Latinx (15%). While most participants were cisgender men (50%) and women (40%), 10% of participants identified as transgender, gender non-conforming, or another gender identity. Participant age spread followed a typical bell curve, with most participants (30%) in the 35-44 age range, followed by 25-34 and 45-54 age ranges (21% and 20% respectively).

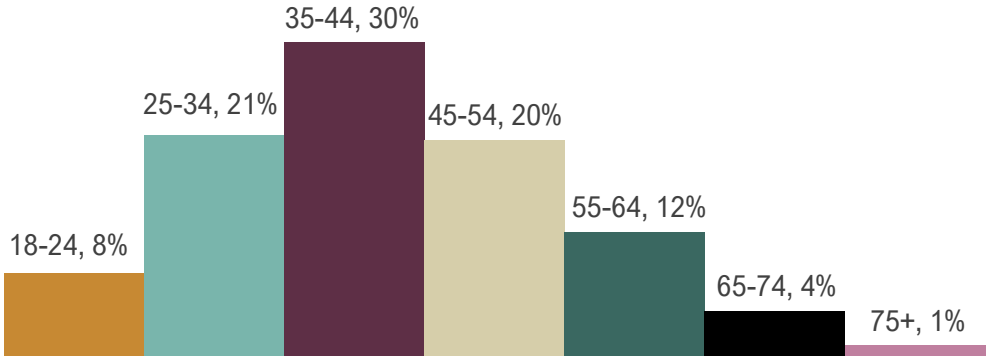
Tier 1 Participant Race/Ethnicity, Percentage, Feb-Aug 2023



Tier 1 Participant Gender, Percentage, February- August 2023



Tier 1 Participant Age, Percentage, February-August 2023



Tiers 2/3

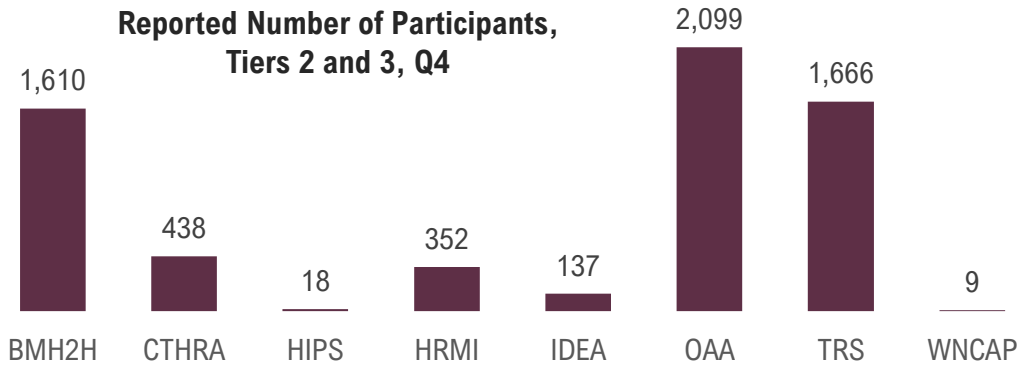
Tiers 2 and 3 demographic data is collected periodically according to the following schedule:

Period	Reporting Period	Submission Date
1	March 1 – May 31, 2022	June 10, 2022
2	June 1 – September 30, 2022	October 10, 2022
3	October 1, 2022 – January 31, 2023	February 10, 2023
4	February 1 – June 30, 2023	July 10, 2023

Period 4 data were the most complete and of the best quality. Aggregated data for all periods is presented below, as well as data from specific report periods.

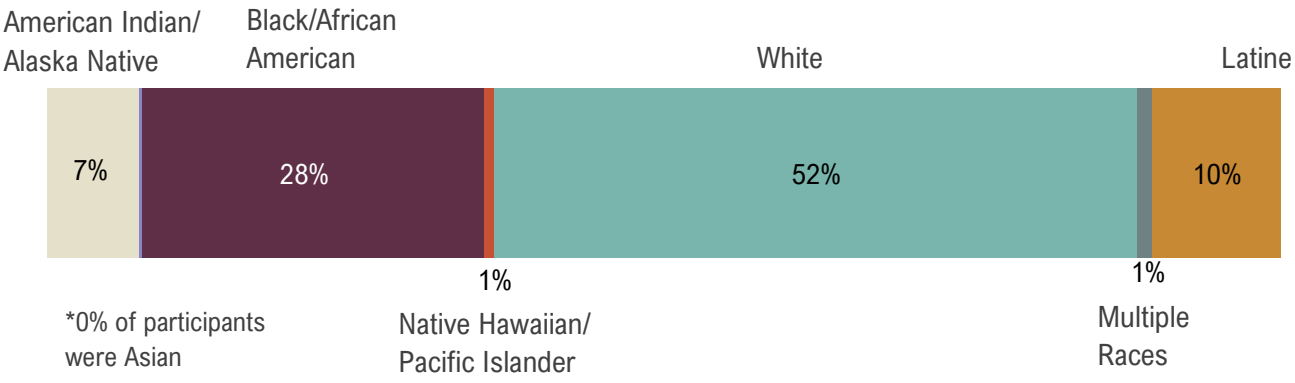
Tiers 2/3 Quarter 4 (February-June) Data Overview

All of the eight Tier 2 and 3 programs provided quarterly data for Quarter 4, February-June 2023: BMH2H, CTHRA, HIPS, HRMI, IDEA, OAA, TRS, and WNCAP. Though data continued to have limitations including incomplete data reporting, missing measures, or incomplete participant data, data were of overall higher quality than in previous quarters. Facente continued to provide ongoing opportunities for technical assistance through monthly office hours designed to provide tailored solutions to barriers as they are encountered. In addition, Facente met with each Tier 2 and 3 program individually in May or June 2023 to discuss data challenges, understand limitations in data reporting, and provide technical assistance to facilitate higher quality client-level data reporting.

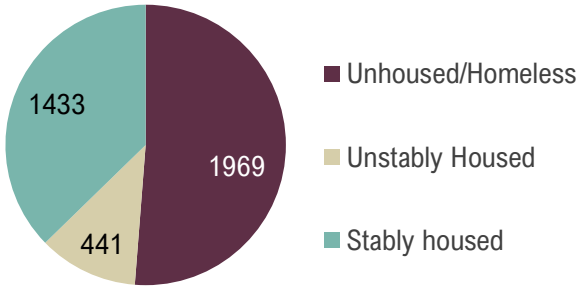


Data were provided for 5,977 participants. Data indicated a shift in participant demographics, though that is likely a result of better data quality from a select number of programs. In Quarter 4, most participants served were white, followed by Black/African American. This is likely because data on large numbers of participants were provided by OAA in Missoula, Montana and BMH2H in eastern Washington state, who serve primarily white individuals; and then TRS, in Chicago, Illinois who serves primarily Black/African American participants. The average participant across the project overall was white, 31-40 years of age, unhoused or homeless, and/or cisgender male.

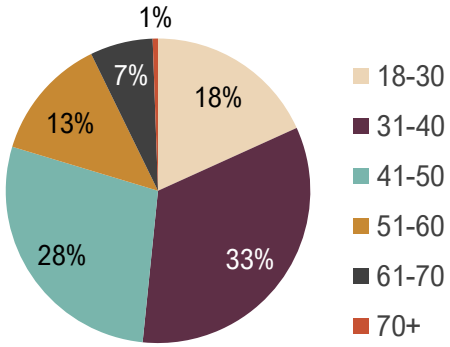
Race/Ethnicity* across all programs, Q4
(Data from all sites, n=5,939)



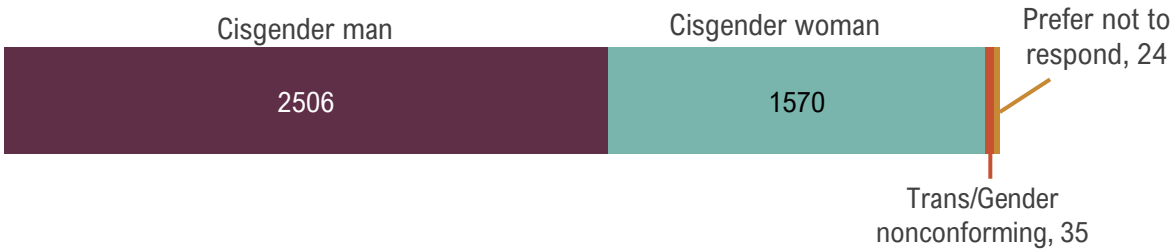
Housing status across all programs, Q4
(Data from all sites, n=3,843)



Age across all programs, Q4
(Data from BMH2H, CTHRA, HIPS, HRMI, IDEA, OAA, WNCAP; n=4,469)

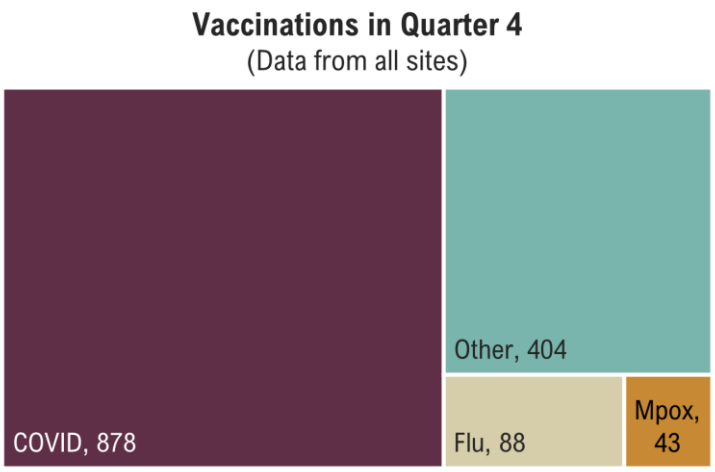


Gender across all programs, Q4
(Data from all sites; BMH2H, CTHRA, and OAA report only male/female responses which were categorized as cisgender man/woman; n=4,135)

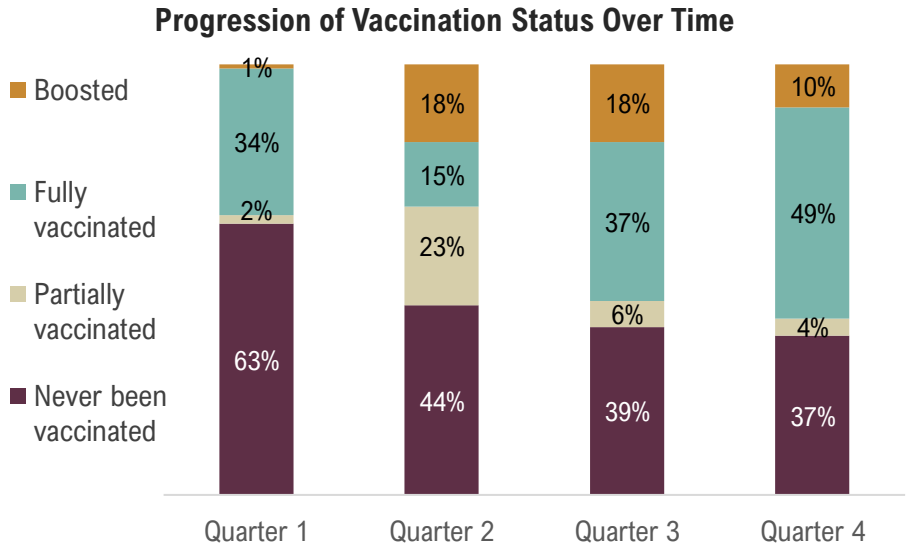


COVID-related measures
On-site vaccination: *The client received a COVID vaccine on-site during the reporting period.*
COVID vaccination status: *The client's vaccination status as of intake.*
Concern re: COVID: *The client's concern regarding getting COVID at the time of service.*
Ever had COVID: *Whether the client has ever had COVID.*

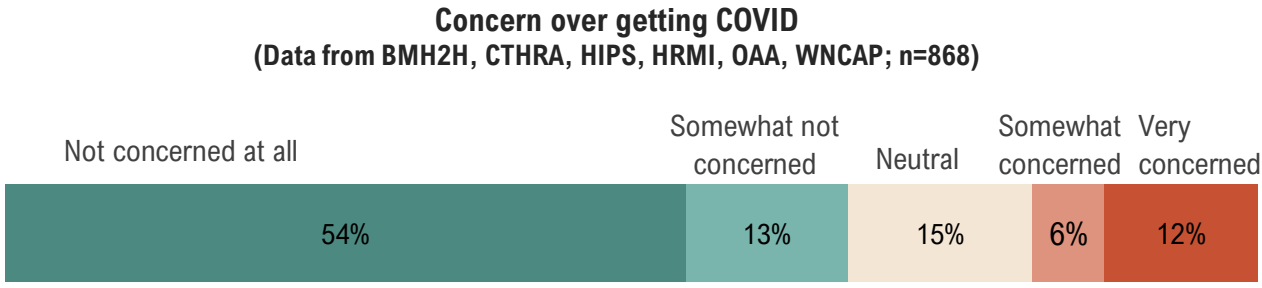
Between on-site COVID vaccinations, flu vaccination, mpox vaccination, and a slew of other vaccinations, a total of 1,413 vaccines were provided this quarter. Housing continued to be a major barrier to vaccination, as people experiencing homelessness made up 49% of participants, but only 42% of those reciving a COVID vaccine, and 37% of those receiving some other vaccine (flu, mpox, etc.)



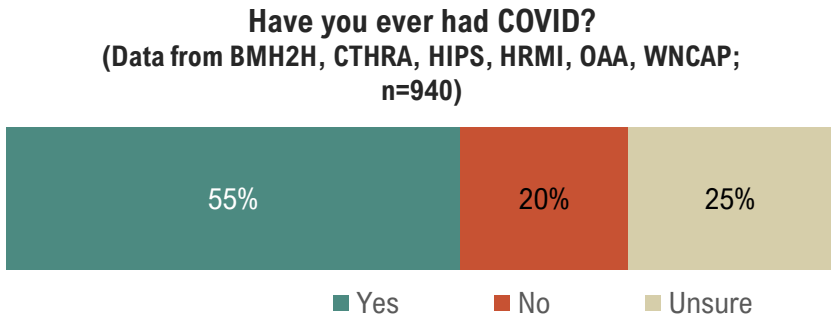
Participants were asked their COVID vaccination status when accessing services; however, data continue to be lacking in COVID-specific measures. Data for this measure were provided for 1,052 participants out of the total 6,329 for which some data was provided for Quarter 4. Of these, 37% had never been vaccinated, while 59% were fully vaccinated or boosted. Over time, the percentage of participants who had never been vaccinated decreased from 63% in Quarter 1 to 37% in Quarter 4, indicating that efforts to vaccinate this highly vulnerable population were successful. It is important to note the overall increase in vaccination among participants; however, 17% of those who had never been vaccinated in Quarter 4 were Latine, despite making up only 10% of participants. This demonstrates a need to continue to work with these populations to increase vaccine acceptance.



Q1 data includes TRS, HRMI, CTHRA; Q2 data includes BMH2H, CTHRA, HIPS, WNCAP; Q3 data includes BMH2H, CTHRA, HIPS, HRMI, OAA, WNCAP; Q4 data includes BMH2H, CTHRA, HIPS, HRMI, IDEA, OAA, WNCAP

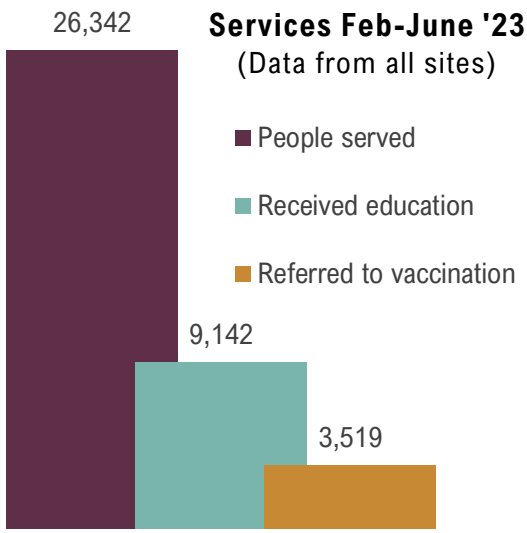


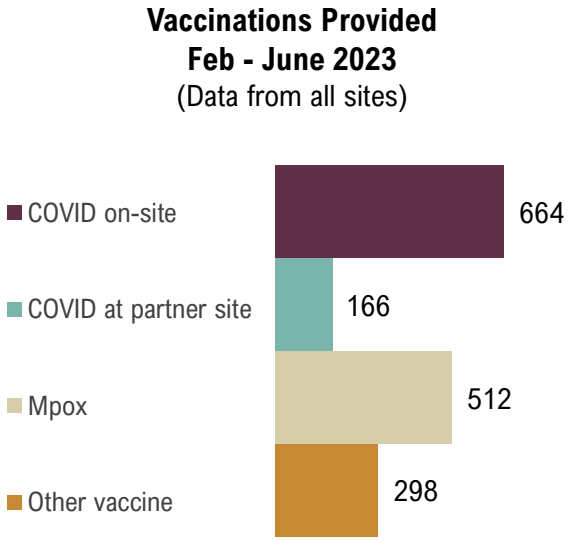
Most participants reported not being at all concerned with getting COVID. Only 18% reported feeling very or somewhat concerned with getting COVID (compared to 70% in Quarter 2, and 38% in Quarter 3), while 67% of participants reported feeling somewhat not concerned or not at all concerned with getting COVID. 55% reported having had COVID previously, and 20% reported never having had COVID. This is a departure from the previous quarter when reported numbers were somewhat flipped (37% had COVID previously; 63% had never had COVID). Facente also conducted analysis of subpopulations' experience of COVID-related measures utilizing data from BMH2H, CTHRA, HIPS, IDEA, OAA and WNCAP. Interestingly, 27% of unhoused and 30% of Latine participants were unsure whether they ever had COVID compared to 21% of total participants (n=779).



Tiers 2/3 Monthly Data Overview (February-June)

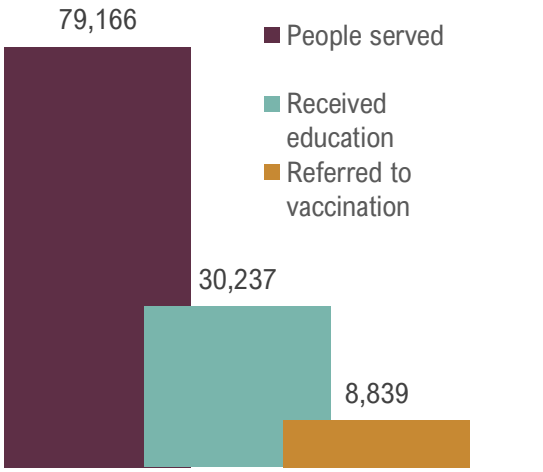
Seven of eight Tier 2 and 3 programs submitted monthly data via Alchemer for all five months, February through June 2023: BMH2H, CTHRA, HIPS, HRMI, OAA, TRS, and WNCAP. IDEA submitted data for February and March 2023. A total of 26,342 individuals were served in this time period across all groups. Of those, 9,142 people received education on COVID and COVID vaccination, 3,519 people were referred to COVID vaccination, and 664 participants were vaccinated against COVID. In addition, 166 participants received COVID vaccination through a referral or partner site, 512 participants received mpox vaccination, and 298 received some other vaccination, such as hepatitis A or B, or flu vaccine.

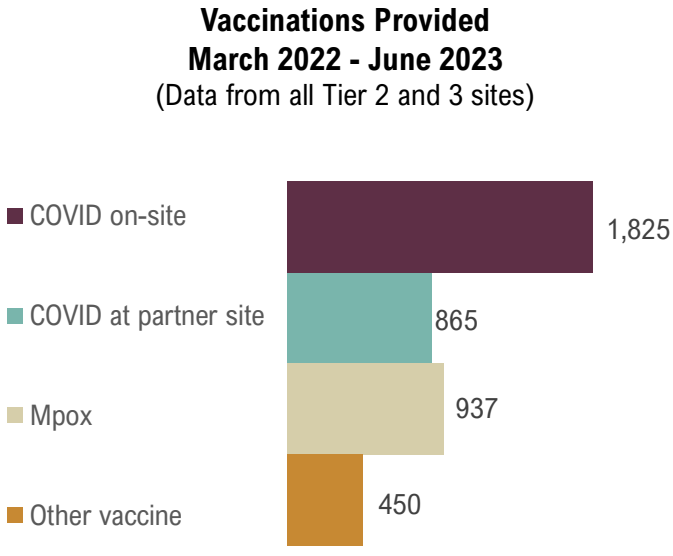




Tiers 2/3 Monthly Data Overview (Full project)

Tier 2 and 3 programs provided monthly data beginning in March 2022 through June 2023. Data indicate that over 79,000 individuals were seen by these eight programs over this 16-month period. Over 30,000 participants received education on COVID and COVID vaccination, almost 9,000 were referred to vaccination, and over 4,000 vaccinations were provided.





Data Quality—Tiers 2 and 3 Programs

Throughout grant period 4, Facente continued to work with each program to ensure data completeness and increase data quality. Though programs continued to expand their capacity for data collection and reporting, several fields were still lacking data in Quarter 4. There is some missing data to be expected with any data collection or reporting, and specific gaps with this data reporting have been identified. In Quarter 4, technical assistance was provided to each program tailored to its needs.

The following lists gaps in quarterly data for Quarter 4:

Race/Ethnicity	One program (HRMI and TRS) report race and ethnicity together, whereas all other programs list race and ethnicity separately.
Gender	Three programs (BMH2H, CTHRA and OAA) report on male and female without identifying cisgender or transgender male or female.
COVID Vaccination Status	One program (CTHRA) asked the question, "Have you ever received a COVID vaccine?" with a 'yes/no' response. 'No' responses were categorized as "never been vaccinated". Facente cannot be sure of the progression of vaccination for 'yes' responses; however, these responses were categorized as "fully vaccinated" for the purposes of this analysis.
COVID Vaccination Outcome	Most programs (BMH2H, HIPS, HRMI, IDEA, OAA, and TRS) are not collecting information on successful linkage to partnering vaccination sites, so information is lacking on vaccinations completed off-site.
Unknown	There continues to be a high percentage of unknown responses or otherwise missing data. Unknown cases per measure indicated below:

Race	740
Ethnicity	1713
Age	1860
Gender	2056
Housing	2486
COVID Vaccination Status	5277
Concern Re: Getting COVID	3496
Ever Had COVID	5303

Meeting the Grantees Where They're At:
Quantitative Data Collection Capacity Building for Tiers 2 and 3

For quantitative data collection, Facente Consulting understood the need to balance several priorities:

1) guarantee reporting was manageable for grantees,
2) maintain the ability to demonstrate program effectiveness, and
3) ensure the ability to analyze who is being served, particularly with respect to racial and ethnic disparities.

As such, Facente embarked on a journey to find a sensible approach that balanced the benefits and challenges of a rigorous evaluation model while being committed to collecting only necessary data; collected data that would be useful and informative; and demonstrated to funders that the work done at SSPs is vital and worthy of additional resources and support. The following narrative describes the participatory process used to determine an evaluation model that would be responsive to the needs of funders, program administrators, evaluators, and the community being served.

In an effort to be collaborative and for the evaluation to be as accessible as possible, NASTAD and Facente decided to delay the official data collection start date from April 1 to May 1, 2022; in the interim, Facente worked with NASTAD to convene a virtual evaluation meeting with the eight Tier 2 and 3 programs on April 13, 2022. The meeting goals were to familiarize grantees with Alchemer as a data collection platform, as well as to determine the best path forward for quarterly data collection to ensure a fruitful evaluation model that would also be low barrier for programs to implement.

At this meeting, Facente discussed the need to balance ease of data collection and reporting with data that would tell the story of the important work being done. Facente then polled programs using the online interactive platform PollEverywhere to understand programs' comfort and capacity for each of four options proposed (see table below).

Proposed Quarterly Data Granularity Options and Models for Data Reporting	
Option A	**Overview:** All programs provide aggregate process-level data only. No client-level data reported in monthly or quarterly reports.
	+ Simple, quick, and not overly burdensome.
	- Encounter data is limited in telling us about program successes. There is no way to attach demographics to outcomes so limited in being able to assess equity (e.g. don't we want to know if we're only vaccinating housed, white folks?).
Option B	**Overview:** All programs provide client-level data for those vaccinated on-site. No client-level data reported in monthly reports; quarterly reports include client-level data only on participants who have been vaccinated with support of the program.
	+ Not overly burdensome as numbers of folks who are vaccinated should be manageable. Helps us better characterize who has benefitted from these efforts.

	- Collecting client level data may be a challenge for some programs (but likely not a ton of data collection necessary here). Will not have a complete picture of those that do not vaccinate through the program.
Option C	**Overview:** All programs provide client-level data for any participant in the program. No client-level data reported in monthly reports; quarterly reports include client-level data only on all program participants who have engaged with SSP vaccination efforts, regardless of vaccination outcome.
	+ Will provide the fullest picture in terms of programs outcomes and effectiveness, and who is being served.
	- Collecting client-level data may be a challenge for some programs.
Option D	**Overview:** Each program would decide what level of data reporting they could do. In this hybrid model programs can opt to do process/activity tallies only, or some client-level data reporting as capacity allows.
	+ Everyone is operating at their comfort level, responsive to grantees' preferences and needs. Some more nuanced data is better than none; meanwhile, we can meet programs where they currently are and work with them to get to client-level reporting for all participants.
	- Data not consistent across all programs. Trickier for evaluators to piece together the full story.

At the conclusion of this discussion, grantees overwhelmingly indicated the ability to collect and report on some client-level data reporting (Option B), and a preference for implementing the hybrid model (Option D), given an understanding that programs would be at different capacity and capability levels.

Integrating the grantee feedback into the decision-making process, Facente and NASTAD agreed to implement a hybrid model that embodied the principle of "meeting grantees where they're at." Facente instructed grantees to report at whatever level they were able to start, and then work with Facente to build capacity over time to move to the next level of complexity in data reporting.

Over the course of the project Facente worked with NASTAD to provide TA in two main formats:

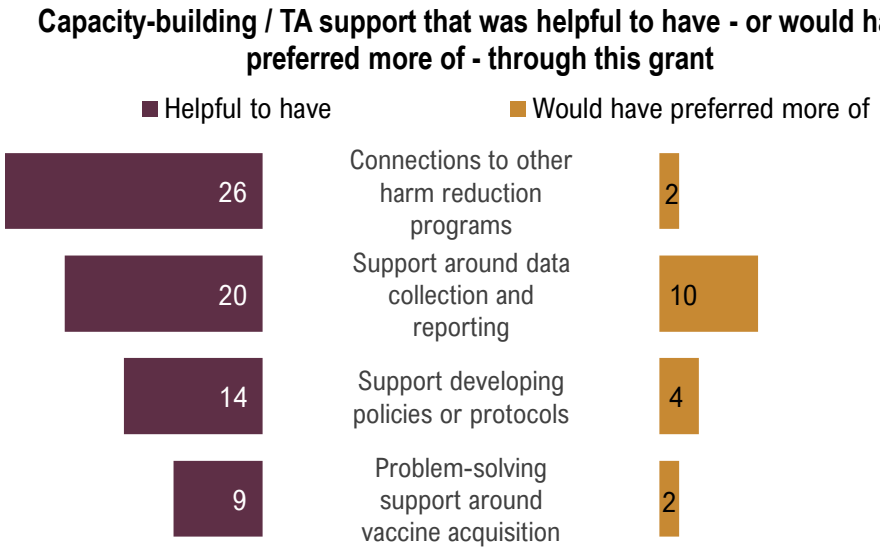
1) Monthly office hours, in which Facente staff would remain online in an open Zoom room and invite grantees to pop in with data questions or problem-solving support requests.
2) Individualized TA, in which Facente would utilize existing TA meetings between grantees and their NASTAD TA provider to join and provide feedback to the grantee on the quality of their data reporting, supporting and problem-solving to help them achieve better quality reporting.

Grantee	**Period 1**	**Period 2**	**Period 3**	**Period 4**
BMH2H	---	Option B	Option B	Option C
CTHRA	Option B	Option B	Option B	Option B
HIPS	---	Option B	Option B	Option B
HRMI	Option A	---	Option A	Option A
IDEA	Option C	Option C	Option C	Option C
OAA	---	Option A	Option C	Option C
TRS	Option A	Option A	Option A	Option C
WNCAP	---	Option B	Option B	Option B

This flexible and supportive approach to data collection has yielded significant growth of programs' capacity to collect, report, and analyze client-level data. The table to the right indicates where programs started in terms of their data collection efforts, and what they were able to accomplish over the course of the project. Note that options A, B, and C are defined in the table above, with C being the most complex degree of data collection. The majority of Tier 2 and 3 programs reported no data at all or aggregate process data (Option A) in the first reporting period. By the fourth reporting period, half were providing client-level data for all program participants (Option C), 3 were providing client-level data for those vaccinated through the program (Option B), and only one was still providing aggregate data (Option A).

While acknowledging and celebrating these advances, it is also important to note that data collection progress has not been uniformly linear. Some programs would make significant strides in their reporting practices only to backslide for a future report. This suggests an ongoing role for capacity building, support, and checking in around these processes with grantees. However, it is Facente's observation that involving grantees in data collection design at the beginning of the project increased grantee buy-in to the process, and several grantees thanked Facente for posing the question and offering choice at the outset.

At the close of the project, grantees were asked to complete a survey about their experience. One question asked them to select from four types of capacity-building or TA associated with the grant, and indicate which were most helpful to them in their program (they could select anywhere from zero to four of the options). 20 of the 40 respondents selected the support around data collection and reporting as one of the most helpful areas of capacity-building from the grant (see the purple bars in the figure below). However, while 28 respondents said in a subsequent question that there had been plenty of TA opportunities and they hadn't wished to receive any additional capacity-building, the greatest number of respondents (n=10) said they would have preferred more support around data collection and reporting (see the gold bars in the figure below).



Understanding the Benefits and Drawbacks of this Novel Grantmaking Process: Best Practices and Lessons Learned

At the outset of this project, NASTAD and AU staff were explicit in their goals to make the SSP grants accessible to programs of various sizes and capacities, and to better align the overall grantmaking process with a harm reduction philosophy and approach. In order to contextualize both the project's quantitative outcome data and its survey data regarding the overall success of the project, Facente Consulting conducted one-on-one and dyad interviews with a diverse group of both grantors and grantees selected from a convenience sample, as delineated in the table below.

Interviewee Type	Number of people interviewed	Number of interviews	Region of country represented
Grantor—NASTAD staff	4	2	N/A
Grantor—AU staff	3	2	N/A
Grantee—Tier 1 program	3	2	Eastern (program #1), Western (program #2)
Grantee—Tier 2 program	1	1	Central
Grantee—Tier 3 program	1	1	Western

Each of these interviews was recorded and transcribed using transcription software. Facente Consulting staff coded and analyzed the qualitative data, using immersion and crystallization techniques.

In addition to the qualitative interviews, Facente also requested that grantees from all tiers complete a brief, 10-question survey on similar topics, administered through Qualtrics. From June 30 to July 31, 2023, 41 people from 35 unique organizations across the country took the survey. A detailed summary of the emerging themes from the interviews and survey can be found below.

Defining harm reduction grantmaking

In order to evaluate the success of a harm reduction grantmaking process, it is important to establish an understanding of how harm reduction grant-making is defined, and what employing such a process may look like. When asked to describe the elements or characteristics of a harm reduction grant-making approach, several of the interviewees identified the centrality of the harm reduction principle of "meeting people/grantees where they're at." In grantmaking, meeting grantees where they're at involves employing a flexible approach that honors the diversity of resources and experiences each program may have, and holds attention to the environment in which they operate.

Harm reduction grantmaking also necessitates keeping grants reasonably low-threshold, offering technical assistance to grantees, and prioritizing the relationship building process between grantors and grantees. As one grantor explained, "Harm reduction grantmaking requires us to be in relationship with community and hear from them…and provid[e] the supports that folks need." It also involves taking a strengths-based approach which could mean, for example, understanding how effectively a program may be doing street outreach even if they struggle with administrative tasks related to the grant.

Another important tenant of harm reduction grantmaking identified by interviewees is prioritizing and uplifting the experiences and voices of community members who are marginalized, particularly people who use drugs (PWUD) and people who are Black, Indigenous, and People of Color (BIPOC). One interviewee noted the care the grantors took in "encouraging [programs] that are BIPOC or BIPOC-led…one of the best things we've been able to do is really connect with communities that are in great need." Another grantor further explained that prioritizing programs led by BIPOC and PWUD is a necessary step to correct the ways these populations have been excluded or harmed by grant-making processes in the past.

Approaching grantmaking by centering the question of "what does a grantee need?" as opposed to "is the grantee complying or performing?" helps to undo what another interviewee called the "bureaucratic messiness and paternalistic nature" of philanthropy.

> "I think that one of the most important things about harm reduction grantmaking from our perspective has been recognizing and holding how grantmaking has been for certain service programs historically. And just how challenging, difficult, and frankly traumatic accepting grant funds and especially larger and more strict or federal grants can be for those SSPs. And looking for as many ways as possible to support, you know, folks who have lived experience and small, scrappy programs that are doing such great work in their communities that are the most connected to the people who are receiving services."

Successes in harm reduction grantmaking for the project

Low-threshold application and reporting processes

Interviewees were able to identify several examples of this project as a successful experiment in harm reduction grantmaking. One of the grantors explained they were intentional in trying to create an accessible application process and reasonable, purposeful data asks. "We worked really hard at keeping it as simple as we could and only collecting information that would actually be valuable." The process of granting federal funding streams is not generally known for being uncomplicated and low-threshold, so passing funds to grantees through AU and NASTAD was an important component of this strategy. One grantee confirmed the success of efforts to streamline and simplify application and reporting processes, saying, "I think the submission process was relatively easy…the low-threshold level of reporting, they've got that down."

Flexibility

Both grantors and grantees emphasized the myriad ways that flexibility supported the grantor-grantee relationship and enabled the success of the harm reduction grantmaking process. For example, the grantors designed a tiered program, where programs with more developed capacity could potentially be awarded more funding and be responsible for higher-level outputs. This strategy helped ensure that programs of similar budgets and capacities were competing against each other for funding. One grantee said this strategy was noted and appreciated, explaining, "It's nice to see that it's not just a huge hurdle

to then compete with huge FQHCs. And you know, you have no f*cking chance [in those cases]…It's kind of like [in this case] you're really competing with people who you're seeing eye-to-eye.'"

One of the grantors described the "services first" philosophy that their team held in managing these grants, which meant that it was allowed and even expected that administrative requirements affiliated with the grant would come second to providing harm reduction services in the community. Grantees from smaller programs would often be performing outreach during meetings, for example, and appreciated that this was permissible and not something they felt they needed to hide. "They were constantly okay with, if people were in the meeting [but] couldn't really participate at all, were just kind of listening…they would acknowledge to you that you [can] do this meeting while you're out in the van, or I did a couple of what I was like out on outreach, and being cool with cameras off, with people only contributing as much as they could."

Most important in terms of flexibility, though, was the ability to adapt and shift from the plans described in grantees' initial proposals as the environment in which the programs operated shifted. This framing was also intentionally built directly into the process. One grantor explained that harm reduction grantmaking entailed "not having specific metrics that we were looking for, recognizing the context and environment is going to be wildly different for each particular program based on how they're structured. So much of traditional grantmaking is like, 'I'm going to reach 500 people. And then I'm going to compare that across the different applications'…[we're] embedding in here that fundamental understanding of that [varying] context and environment." This mindset enabled important, bidirectional communication with grantees when circumstances changed, requiring strategies to shift. One grantee explained, "[The grantors] were very upfront about the objectives being important, but at the same time not being like a [strait]jacket, right? That you can't constrain yourself to that."

This flexibility related to outcomes enabled one of the most important successes of the grant: while the project was initially focused on COVID vaccination for PWUD, several months into the first year the overriding public health focus on COVID had significantly diminished. One grantor explained that "not having something be as explicitly outcome-driven to where a project started [versus] where it ended up is directly aligned with harm reduction philosophy." Many grantees were able to take the lessons learned from their COVID vaccination work and apply it to Mpox vaccination as that crisis emerged, and/or focus on ramping up hepatitis or influenza vaccination. One grantor explained, "The response to [Mpox] was particularly awesome, because the infrastructure that was created for COVID-19 vaccinations allowed for people to vaccinate more individuals that were in need for Mpox…it's like, we're trying to prevent one communicable disease. And then now we have all these others." Several interviewees referenced the pride grantees had in being able to pivot to effective Mpox responses.

Partnership

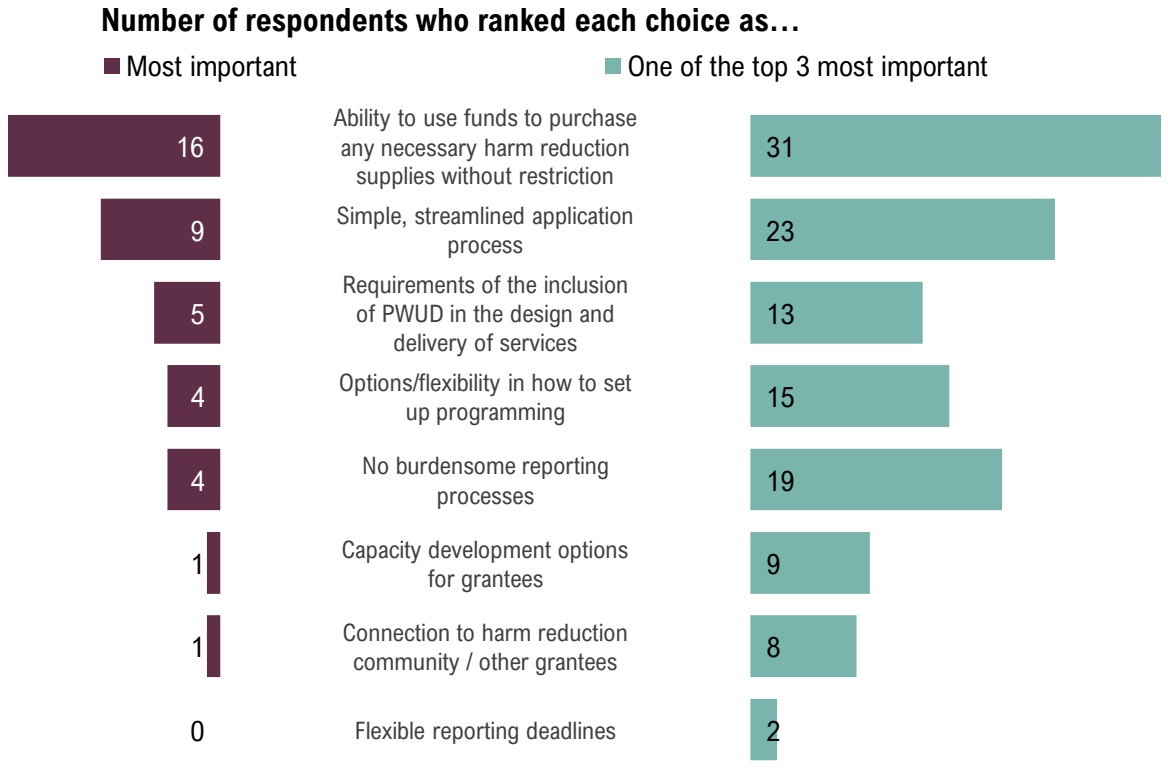
Several grantor interviewees invoked the terms "non-punitive" and "strengths-based" when describing their approach to partnership with the grantees. The grantors deliberately worked to gain the trust and partnership of the grantees, and to help problem-solve as issues came up. One grantor explicitly defined success as evidence of a trusting relationship between grantor and grantee. "It's such a great sign of success when I hear grantees coming to us like being like, 'I don't know what to do…This isn't working out.' And like, to me, that's just a fundamentally different way of defining what success in grantmaking is. And fundamental to harm reduction grant making." Interviews with grantees reinforced this notion of grantor-as-partner in this project. One grantee described the "funder being a partner in the grant and

the project. And being a supportive partner, not being the police…So it's really [NASTAD and AU] act more like a partner in the work than a parent."

Capacity Building Support

Several different types of capacity-building support were offered to grantees via sessions with staff at AU and NASTAD, data management support via the evaluation consultants (Facente), and a variety of webinars and peer-to-peer presentations for grantees. Grantees noted with appreciation the efforts of their grantors to provide them with what was needed, and contrasted it to their experiences with other government grants. One grantee stated, "What has impacted me the most is that our programmatic officers were always offering technical assistance for whatever we needed. And whenever I requested resources, they would be very, very diligent about sharing information, linking me up to articles, to sources of information that were very productive for our efforts. We haven't had that from other from our other sponsors." Another grantee agreed, saying, "I was kind of surprised just how supportive they were…They notified us of an additional grant through the National Council of Mental Well-Being. And we applied and we got that grant."

In the survey, grantees were asked to rank a series of aspects of a harm reduction-aligned grantmaking process, with the most important aspect being ranked #1, and two more aspects being ranked #2 and #3 from the list. By far, the most important aspect among respondents was the ability to use funds to purchase any necessary harm reduction supplies without restriction, including syringes, glass pipes, spectrometers, or drug testing strips, with 16 of the 40 respondents answering this question ranking this aspect as the most important, and 31/40 ranking it in the top 3. The second-most important aspect was a simple, streamlined application process, which was ranked as the #1 most important by 9/40 respondents, and in the top 3 for 23/40. More details about other aspects and their rankings are available in the figure below.



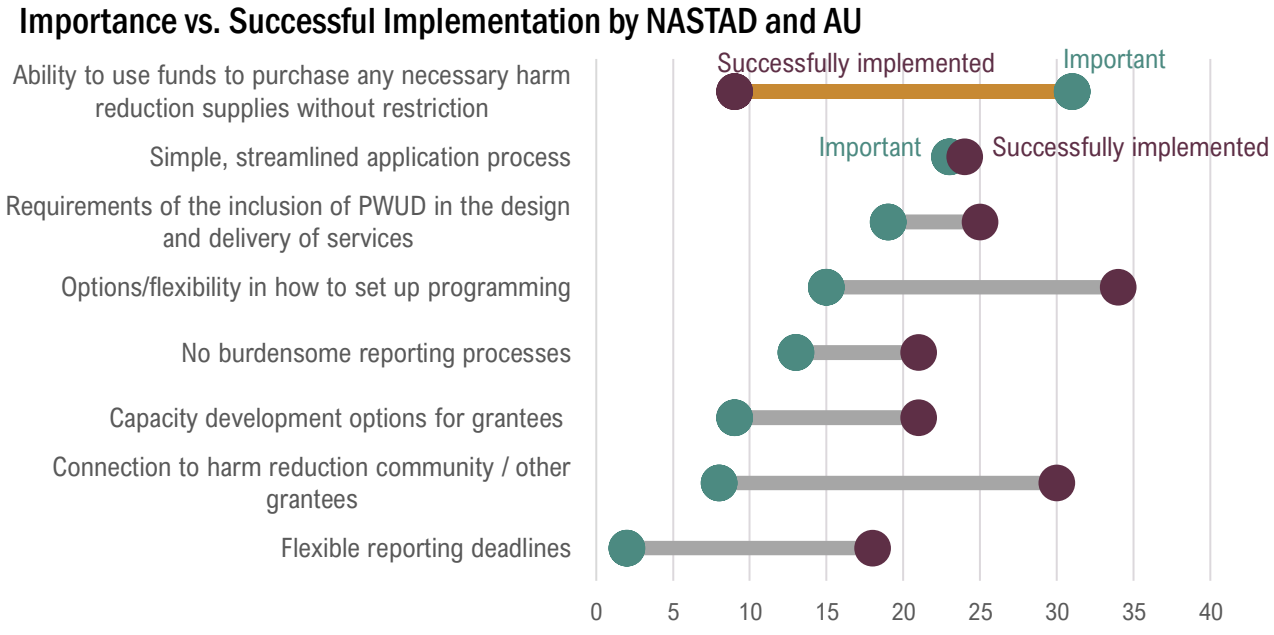
Undermining a Harm Reduction-Oriented Grantmaking Approach

Funding Restrictions

While there was striking consensus among interviewees about the characteristics of good harm reduction grantmaking processes, and a shared appreciation for the successes of this project as a harm reduction grantmaking example, interviewees were also able to identify several factors that challenged the harm reduction grantmaking process during this project. Most commonly cited by interviewees was the fact that due to federal funding restrictions, grantees could not utilize funds to pay for syringes, glass pipes, or cash stipends.

While interviewees generally acknowledged these factors as out of the control of AU and NASTAD, they still expressed dissatisfaction around having their budgetary decision-making limited by these restrictions. One interviewee explained, "Some budget-related things made it a bit difficult. Restrictions on funding, like what they could and could not do with the dollars. A lot of the programs would like to – we've heard this a few times – incentivize with cash, which is not an option. Or aren't able to spend on glass [pipes], which is a big need." Cash incentives are particularly important for programs that hire people from the community they serve for temporary and part-time work. Oftentimes these individuals may not have bank accounts to accept checks, so cash incentives are a crucial tool to keep them engaged. And glass pipes, an essential engagement tool for PWUD, are costly and difficult or impossible to purchase with many funding streams.

The figure below shows the same rankings of importance of various aspects of harm reduction-aligned grantmaking (the numbers in the blue circles are the number of times that choice was ranked in the top 3 by a respondent), but this time with purple circles that identify the number of times a respondent said they thought NASTAD and AU successfully implemented that aspect during this process. In all cases except funding restrictions and flexible reporting deadlines, more than 50% of respondents (20 people) said they thought each of these aspects was successfully implemented. In addition, funding restrictions (top row; gold bar) was the only choice for which the number of people who felt the choice was successfully implemented was less than the number of people who felt the choice was important.



Time Crunch

Other interviewees identified challenges about different pieces of the project, such as struggling with the application portal, or lack of community involvement in funding decisions. One interviewee stated, "I would have preferred more community involvement in the funding decisions. I also feel like it would have been nice to give people more time to respond and develop their proposals…we need better tech that is user-friendly in a different way. Because that is extremely frustrating for everyone." The ambitious schedule attached to this funding led to some kinks in the process that could likely have been ironed out with more time.

Lack of Funding Continuity

The most significant factor undermining this project as a harm reduction grantmaking success was the short and finite timeline that was a product of the funding coming out of COVID-related emergency funds. Grantors and grantees alike were demoralized to have made such significant strides in developing vaccination infrastructure in their respective programs, only to see funding end. One grantor explained the difficulty of their position fielding questions about future opportunities. "Almost every one of my grantees have asked me, 'So what's the next funding for this stuff? Where's the next one?'…There is no other vaccine funding coming anywhere...There was nothing to offer them." One grantee likened the abrupt ending of the project to poorly executed public health campaigns in struggling communities.

In short, the grantors struggled with not having options for continued funding for the programs to share with grantees, and as the quotation in the text box to the right exemplifies, many grantees anticipated struggling to maintain the programming they developed with these funds.

> "I would say that the hardest element of all this, and not, maybe not as in line with harm reduction, is the continuity. For example, in harm reduction, continuity is very important. If we're out in the community, we need to be there every week. Otherwise, we are not able to establish the kind of relationship that we want with the community to build that trust...A lot of nonprofits go and offer a lot of things and then they're there for a year and disappear. And people are left stuck where they were, you know, at the beginning. So in this sense, I think being able to connect us maybe with other resources that could allow us to provide continuity for this project would have been a little better. I know, one or two times they shared information they have with regards to, like, big grants that were out there. But I think that the transition from having all this funding to then all of a sudden, next year, having a very reduced amount for kind of doing the same job or related jobs...that was a difficult time for us, you know, just like figuring out how we're gonna retain the staff that we recruited that were very, very good. How can we keep them in our in our team when we don't have the resources, or we don't have the security?"

Navigating the Tensions with the Harm Reduction Community and Federal Funding

There has been significant progress in recent years regarding increased federal investment in harm reduction programs and interventions, but this progress comes after a long and storied history between the federal government and SSPs in particular. Federal funds for SSPs have been outright banned or highly restricted since 1988, excepting a brief pause between 2010 and 2012, and this project is noteworthy in that federal funds are being utilized explicitly to support SSPs. Interviewees and survey respondents were asked to reflect on the significance of this shift, and the opportunities and pitfalls related to it.

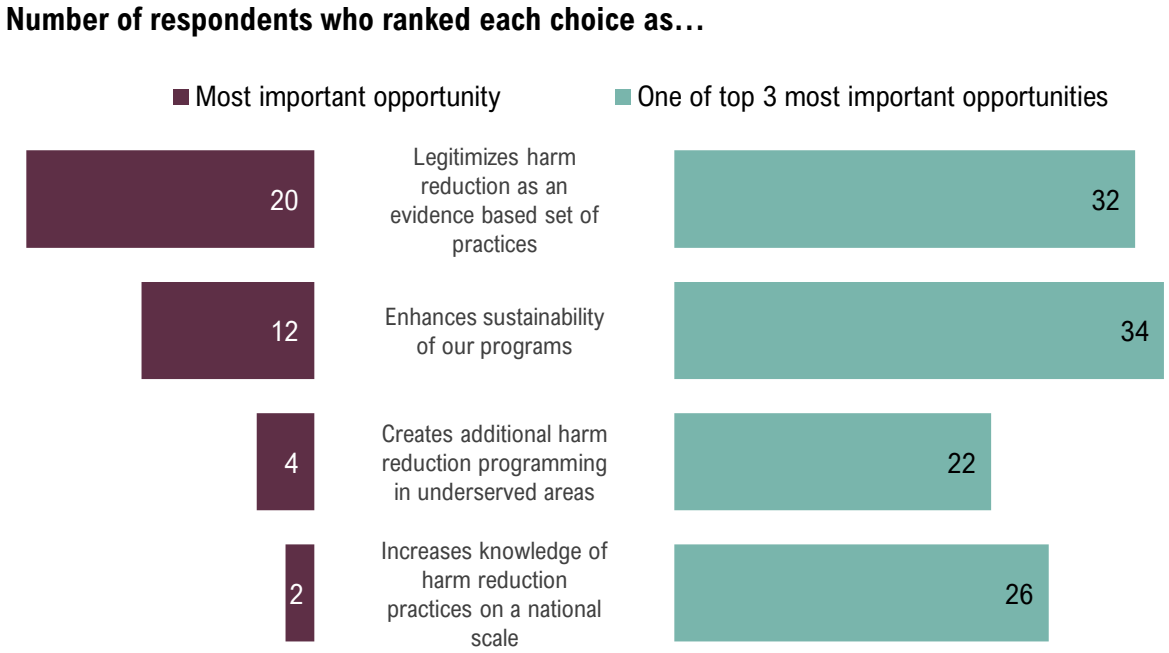
Opportunities

Unsurprisingly, interviewees commented on what was perhaps the most obvious benefit of having the federal government invest in SSPs—enhanced program stability and sustainability. The investments from this particular grant led to significant program growth in terms of staffing and service provision. One grantor noted, "Definitely staffing was a huge thing. I had some programs go from all-volunteer to being able to hire staff for the first time." Another grantor stated that of their grantees, "I had one that was able to open up a drop-in center, because they were able to shift funds around. And so instead of being all street-based outreach, they then had a drop-in center." Other grantees described having significantly expanded their service catchment area—one purchased a mobile van and provided services to 5 additional counties in the state, while another opened a second office in another part of the city in which it operates.

The programmatic transformations were impressive, but several interviewees also pointed to a less tangible benefit of federal funding for the SSPs: a sense of the federal government's long-awaited endorsement for the effectiveness of SSPs. One grantor explained, "I think [federal funding for SSPs] also lends a certain amount of legitimacy to some programming in some public health spaces. Definitely…where you see a small, scrappy program that is getting federal grant[s], that kind of shows that these programs are working on this kind of other level."

Grantees expressed a similar sense of legitimacy gained through federal grants, and pointed to the ways this sense of legitimacy may help them on a local level. "The recognition of harm reduction and syringe service programs as important tools for health care [and] public health allows us to also have a bigger push against people who don't necessarily like the things that we do or don't agree with what we're doing. It gives us some amount of legitimacy in their eyes, right?" One grantee described that after trying to work with their local health department to acquire vaccine for months, "something clicked" after the program received an AU grant, and the health department started supplying vaccine and accompanying the program on weekly mobile vaccination shifts to administer vaccine to SSP clients. Another grantee expressed gratitude at the government "putting their money where their mouth is," and a sense of vindication in the government's support of SSPs. "The biggest thing is it shows they believe in us. They know, we know, there's so much evidence for harm reduction, and that harm reduction works."

In the survey, grantees were asked to rank four choices as big opportunities related to having the federal government directly and intentionally fund harm reduction programs. The legitimization of harm reduction as an evidence-based set of practices was deemed the biggest opportunity by 20 of the 40 respondents; enhancing sustainability of their programs was second biggest, as can be seen below.

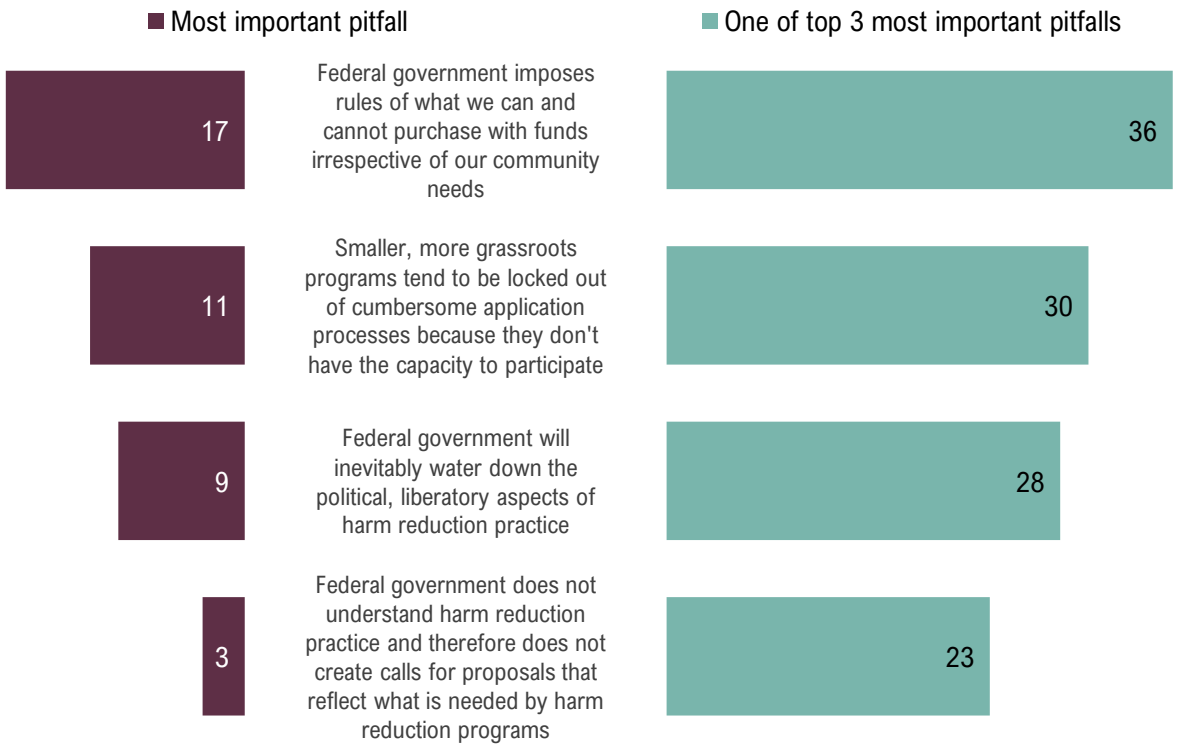


Challenges

While interviewees were largely in agreement that federal funding for SSPs was a welcome development, several acknowledged that the change in the landscape came with some growing pains. One such issue was that in general, as federal funding became available for harm reduction services the funding was not always directed to under-resourced harm reduction programs that had been doing unsupported work for years. "It is challenging to see harm reduction's profile raised and more folks becoming aware of it, particularly through funding opportunities. Because the process of co-opting the movement has been ongoing for years now. And I feel like it just, it does make it all the easier for opportunistic folks out there to be receiving support that long-standing activists and harm reductionists have needed for years, decades, however long." The question of the co-option of harm reduction and the watering down of the human rights framework underpinning harm reduction has preoccupied many longtime harm reductionists for years, and is complicated by the federal government's involvement in funding programs.

Another challenge of having federal funding in the harm reduction landscape is that some grantors perceived the shift as also leading to other funders abandoning the harm reduction space. One interviewee explained, "I think there's also a perception that once any federal dollars start dripping into anything that it's been taken care of, that it absolves philanthropy or other folks of their responsibilities. And not understanding how deeply under-resourced the field truly is." All interviewees described an environment in which SSPs continued to be in dire need of funds; even with new federal funding opportunities, the demand for funds in harm reduction programs far outstripped the supply.

A further challenge noted by interviewees is that federal funding for harm reduction programs has entailed a sometimes-uncomfortable degree of scrutiny around program operations and budgets. One grantor described this tension saying, "Then our federal partners got really excited and proud and their



leadership…wanted to be 'all in,' which meant they wanted their eyes on everything, they wanted to ask all the questions, they wanted to make sure everything was picture perfect. And, like, they wanted access to too much, too much information, too many line-item budgets." The grantors' role, then, becomes to protect the programs from extra work and scrutiny related to the government's interest. A happy medium, one interviewee argued, would be to just "treat harm reduction as normal. And don't make a big deal out of it, don't advertise it in a legislative briefing, current state level office…just don't make a big deal out of it. You're just funding infectious disease and overdose prevention services."

In the survey, grantees were asked to rank choices for what they thought were the biggest pitfalls related to having the federal government directly and intentionally fund harm reduction programs. In alignment with themes discussed earlier, the highest-ranked choice was "Federal government imposes rules of what we can and cannot purchase with funds irrespective of our community needs," with 17 respondents choosing that as the top pitfall, and 36/40 respondents ranking it in the top 3. Closely following was the idea that smaller, more grassroots programs tend to be locked out of cumbersome application processes because they don't have the capacity to participate (with 11 respondents choosing that as the top pitfall and 30/40 ranking it in the top 3) and the idea that the federal government will inevitably water down the political, liberatory aspects of harm reduction practice, with 9 respondents choosing that as the top pitfall and 28/40 ranking it in the top 3.

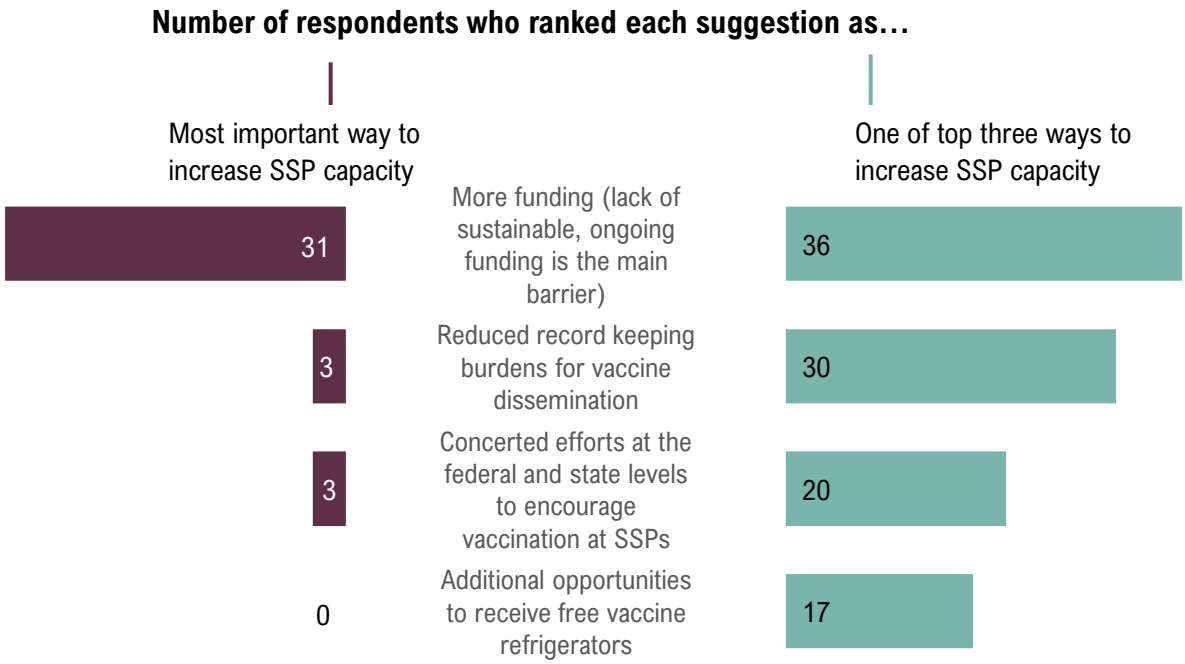
Summary and Lessons Learned

Analysis of qualitative and quantitative data throughout the course of this project have brought forth several overarching learnings.

1. **There are ways to make federal funding accessible to small and growing programs**. Although interviewees had some minor suggestions for streamlining or extending the process timeline, overall the grantee interviewees agreed that during this project, the grant application process lent opportunities for smaller programs to successfully apply for funding, and that working with AU and NASTAD as intermediaries with expertise in the challenges faced by SSPs helped ensure the success of the overall project.

2. **Focusing on capacity building and investing in grantor/grantee relationships pays dividends.** Throughout the project cycle, grantees expressed almost unanimous appreciation for the role that NASTAD and AU played in supporting their work and developing a partnership with their team, as opposed to a more traditional grantor/grantee relationship. One survey respondent even exclaimed in the open field at the end, "This was our favorite grant that we've done in a while!" Another noted, "Thank you for your support of harm reduction services. We are in a state that has restricted us from best practices, which makes our job harder and more important than ever! We appreciate you all!" Grantees consistently described feeling heard and supported by NASTAD and AU, and identified flexibility as a core aspect that contributed to the success of this project. Grantees also regularly utilized the technical assistance offered by NASTAD and AU, and grew the capacity of their programs through the engagement in these opportunities, and with the support of their grantors and other programs in their cohort.

   In the survey, respondents were asked to rank the importance of four possible suggestions as the most important ways to increase capacity of SSPs; they also had an opportunity to select "other" and specify additional suggestions they had. By *far* the most-selected suggestion as the top ranked most important way to increase SSP capacity was more funding, with the idea that the main barrier to providing SSP services is sustainable, ongoing funding. While only 3 people chose it as the *most* important capacity-building suggestion, 30/40 respondents ranked "concerted efforts at the federal and state levels to encourage vaccination at SSPs" in the top 3. More details of respondent answers to this question are provided in the figures below.



For those grantees that suggested other items as very important ways to increase SSP capacity, some of the suggestions included increased funding for provision of hepatitis A and B vaccines at SSPs; support for hardware, infrastructure development, and implementation of electronic health record systems; increased funding for participant incentives; support for infectious disease emergency response planning and preparation for SSPs to help meet the needs of PWUD during emergencies; and as one person said, "More use of SSPs as warriors of public health! We're able to reach populations that traditional clinical spaces and staff can't, or won't." During this project, NASTAD and AU worked to build relationships such that grantees felt generally seen and supported – but unless this experience is replicated on a grander scale by a wider variety of funders, the full potential of SSPs to improve the public's health will not be realized.

3. **Short-term, one-time funding has had significant impacts, which longer-term, sustained funding would likely proliferate.**

The outcomes of the overall project have been tremendous, including 9,208 COVID vaccinations in addition to significant growth in programs' capacities and relationships with local health departments and systems. Grantors and grantees both expressed pride and excitement regarding the program outcomes. As one grantee stated, "In my opinion, it is kind of just the tip of the iceberg of what we could do. Which is really exciting…I think it just leaves a solid groundwork of 'we can do this, and it can work really well.'"

Grantees also acknowledged the difficulty in having the funds end after such a short period of time, although they understood that it was the nature of utilization of the emergency funds. The ending of this funding threatens the progress that was made over the course of the grant cycle, and

grantees are hopeful that more long-term and sustained investments will be made available in the near future.

4. **SSPs will stretch modest amounts of funding to address the needs of marginalized populations and respond to emerging health crises.**
   As was demonstrated by programs' seamless adaptations to take on Mpox vaccination as it emerged as a community threat while COVID receded from the forefront, SSPs tend to act quickly and creatively to respond to the issues that impact their communities. Unrestricted funding not attached to one disease or program activity is optimal to create space for this creativity and flexibility.

   As one grantor stated, "If you just resource SSPs generally, they're gonna do COVID if COVID is a problem. And then when it turns into something else, like it did with [Mpox], they're going to address that too. And probably are going to address it before other people will…Harm reduction pivots earlier than anyone anyway. Just give people money to address the things and it'll happen."

Closing Thoughts

On the whole, the individual funding amounts for each SSP funded through this program were relatively moderate, with the vast majority of programs receiving a one-time payment of $100,000, six additional programs receiving $200,000, and two programs out of 58 total programs receiving $650,000 each. The grantmaking process itself was lean and efficient, reducing indirect costs and bureaucratic process by passing through NASTAD and AU instead of health departments, and making funding accessible for smaller, less resourced programs that do not have the bandwidth to engage directly in complex federal funding processes. This investment yielded impressive outcomes in terms of vaccination numbers for populations that tend to be mistrustful of traditional medical services, in addition to significant growth in program capacity around clinical protocols, community partnerships, and data collection processes. Harm reduction program staff expressed gratitude for the opportunities afforded by these grants and noted that it is an important start in terms of investment in their programming, but also that ongoing and meaningful federal investment would create opportunities for larger scale impacts—suggesting new possibilities for closing the gaps in disparities in health outcomes for people who use drugs and/or are experiencing homelessness.