A PRACTICAL FIELD GUIDE

VOCES LATINAS

Strains and Strategies from the Front Lines of Latino/a/x HIV Care in the United States

A PRACTICAL FIELD GUIDE FOR

Clinicians, community leaders, researchers, and advocates working in the field of HIV — drawn from twenty in-depth interviews with attendees of the September 2024 *¡Adelante!* Summit.

Cover photograph: Katie Moum

About this guide

VOCES LATINAS: Strains and Strategies from the Front Lines of Latino/a/x HIV Care in the United States. A practical field guide for clinicians, community leaders, researchers, and advocates working in the field of HIV.

Drawn from twenty in-depth interviews conducted in 2025 with attendees of the September 2024 *¡Adelante!* Summit: A White House Convening to Accelerate Our Nation's HIV Response in Hispanic/Latino Communities, this field guide shares frontline perspectives on the rapidly shifting challenges shaping HIV prevention, care, outreach, and advocacy within Latino/a/x communities during the 2025–2026 sociopolitical changes in the United States.

Suggested citation

Saldana CS, Serrano PA, Mena LA, Patino-Mateus JD, Ramon S, Moscovich T, Ordoñez C. *VOCES LATINAS: A Practical Field Guide for Clinicians, Community Leaders, Researchers, and Advocates.* Emory University; 2026. Accessed [date accessed]. https://vocesl.netlify.app

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Executive summary

Latino/a/x communities in the United States are facing a moment without precedent. Federal funding for HIV care and prevention has been cut at a scale and speed that no organization can absorb without harm. Immigration enforcement is operating in clinics, neighborhoods, and workplaces in ways that block access to care for documented and undocumented people alike. Medicaid and other coverage pathways are being dismantled. The language used to name our communities has been banned from federal grants. And the public health infrastructure that once supported the response is being weakened and dismantled from the inside.

This field guide was created based on what we heard between September and December 2025 from 20 frontline clinicians, researchers, pharmacists, and community leaders who attended the White House *¡Adelante!* Summit in September 2024. Their voices shape every page of this guide.

What this guide does

This guide names the strains reshaping Latino/a/x HIV care from 2025 and beyond, the costs they create, and the strategies different organizations are already using in response. This is a practical field guide, written from the field, for the field.

Five strains, in brief

Strain	What providers are seeing
1. Federal funding cuts	Sudden, massive, and targeted. Multi-million-dollar grants eliminated overnight. Research projects terminated mid-cycle.
2. Immigration enforcement	Operating at scale in public spaces, workplaces, and near clinics. No-show rates have doubled or tripled in some healthcare settings.
3. Loss of coverage	Medicaid restrictions, ACA enrollment chilling effects, end of state-run programs for undocumented residents, new co-pays.
4. Targeted erasure	Federal grant language bans on “Latino,” “LGBTQ,” “transgender,” “underserved communities.” Trans populations removed from research.
5. Infrastructure dismantling	Workforce purges at federal, state, and local levels. Data systems weakened. Trust in CDC, NIH, and FDA undermined.

What it is costing

Patients are missing doses. Stable patients are disappearing from care. People are skipping work and other activities of daily life. Mental health crises are expanding. Organizations are closing or shrinking in real time. And providers themselves, many of whom belong to the same communities they serve, are carrying moral injury that will outlast any single policy.

Four areas of response

Domain	Strategy
Innovate to bring and keep patients in care	1. Bring care to where people are 2. Leverage trusted messengers 3. Make the clinic itself feel safe 4. Address the fear directly
‘Future-proof’ and sustain your organization	5. Adapt public-facing language while keeping the work the same 6. Diversify funding away from federal dependence 7. Use bureaucratic time as a defense 8. Build legal preparedness for the organization itself 9. Care for the staff carrying the work
Build coalitions and peer support	10. Name the isolation as deliberate and refuse it 11. Establish regular peer-to-peer contact between leaders 12. Convene: the gathering itself is the intervention 13. Build coalitions beyond the HIV field 14. Practice intentional solidarity, not competition
Advocacy and community education	15. Treat community education as a primary service 16. Protect and distribute scientific truth through alternative channels 17. Shift advocacy to the state level 18. Tell our stories: humanizing narrative as advocacy 19. Plan for electoral and civic engagement 20. Build the unifying message: this is not only our fight

The path forward

The strategies in this guide will not reverse federal funding cuts. They will not end immigration enforcement on their own. What they can do is keep organizations afloat and people engaged in care and connected to trusted relationships through this period. They are acts of continuity in a moment defined by disruption, and they are already working.

How to use this guide

This guide comes from the field. It is based on what we heard from clinicians, pharmacists, researchers, and community leaders who are responding to these changes in real time.

HERE WE

- Highlight the growing challenges affecting Latino/a/x HIV care
- Share what 20 frontline leaders told us in late 2025, who also attended the White House *¡Adelante!* Summit (September 2024)
- Focus on real-world strategies organizations are using right now
- Include practical resources to support implementation, advocacy, funding, legal preparedness, and community education

This is not a research review or a top-down set of rules, nor is it a comprehensive account of every challenge or strategy shaping our communities. Instead, it is a practical field guide grounded in the experiences of organizations that were once brought together to help map the U.S. HIV response in 2024, and what they are actually doing now, months after that summit, to sustain care, outreach, advocacy, and community support amid rapidly changing conditions.

Finally, we hope to reignite the collective passion, urgency, and vision that emerged from *¡Adelante!* 2024 — and carry that momentum forward through a far more challenging moment for our communities.

USE THIS GUIDE TO

- Adapt strategies
- Start conversations
- Share resources
- Act across clinical, research, public health, and community-based settings

Who this field guide is for

This guide is for anyone working to support Latino/a/x communities, including:

- Latino/a/x community members
- Clinicians and healthcare providers
- Community-based organizations (CBOs)
- Community health workers and peer navigators
- Researchers, advocates, and policy leaders

Methodology

To understand how 2025 federal policy changes are affecting Latino/a/x HIV care, prevention, mental health, and social services on the ground, we conducted semi-structured qualitative interviews with 20 participants between September and December 2025. All participants attended the September 2024 White House *¡Adelante!* Summit on Latino/a/x HIV.

Sample

Participants represented a range of roles across the HIV continuum of care: clinicians and pharmacists in federally qualified health centers and Ryan White clinics; researchers at academic institutions; leaders of community-based organizations and national nonprofits; community health workers and program supervisors; and founders of grassroots organizations serving trans Latino/a/x communities. Participants worked across four regions of the United States — Northeast, South, Midwest, and West — including Puerto Rico.

Interviews

Interviews lasted 45 to 75 minutes and were conducted virtually. Participants were asked about how 2025 federal policy changes are straining their work, the communities they serve, their organizations and staff, and the strategies they are using to adapt, advance, and chart a path forward. All interviews were audio-recorded with participant consent, transcribed, and de-identified prior to analysis.

Analysis

Transcripts were analyzed using a rapid thematic analysis approach. Themes were identified inductively and synthesized into five major strains affecting communities, five categories of cost, and twenty response strategies organizations and communities are leveraging to move forward under four domains.

How attribution works in this guide

Every quote in this guide is attributed only to a participant role and participant ID (PT01–PT20). Organizational names, geographic references, and other identifying details were removed to protect participant privacy. Quotes were lightly edited for readability, including the removal of filler words and verbal pauses, while preserving the original meaning and intent. All quotes were verified against the original transcripts for accuracy.

Limitations

These findings reflect the experiences of 20 providers and community leaders who attended a single national summit. They are not intended to be statistically representative of all Latino/a/x-serving organizations, and the qualitative signals presented here should be understood as illustrative rather than definitive. What this approach offers is depth: insight into the "why" and "how" behind shifts that quantitative data are only beginning to capture, as well as the real-world adaptations organizations are already making in response.

Our team

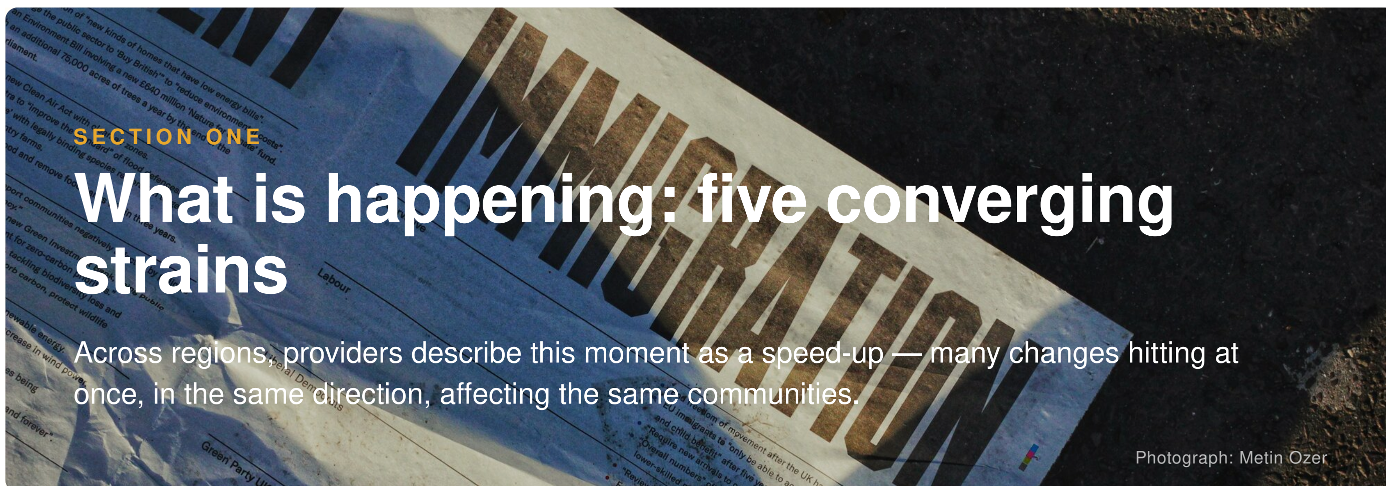
This guide was developed by a multidisciplinary research team based at Emory University and led by Dr. Carlos Saldana. The project was supported by the Chicago Queer Latine Collaborative (CQLC NFP) and created in partnership with leaders working across HIV care, public health, research, advocacy, and Latino/a/x community health.

Our team brings experience in HIV medicine, community-based research, qualitative methods, public health practice, immigrant health, and health equity. Together, we worked to document the experiences, challenges, and solutions identified by frontline leaders serving Latino/a/x communities during a period of major sociopolitical change in the United States.

Project team

Dr. Carlos Saldana — Principal Investigator
Pedro Alonso Serrano — Community, Policy and Advocacy Advisor
Dr. Leandro A. Mena — Policy Advisor
Dr. Juan David Patino-Mateus — Research Coordinator
Santiago Ramon — Research Coordinator
Tammy Moscovich — Research Coordinator
Claudia E. Ordoñez — Qualitative and Participatory Methods Lead

We are deeply grateful to the 20 participants who shared their experiences, insights, and hopes during an extraordinarily difficult period. Their voices, leadership, and lived experiences are the foundations of this guide.



SECTION ONE

What is happening: five converging strains

Across regions, providers describe this moment as a speed-up — many changes hitting at once, in the same direction, affecting the same communities.

Photograph: Metin Ozer

Latino/a/x communities in the United States have been disproportionately affected by HIV for decades[1]. In 2023, Hispanic/Latino people accounted for more than one-third of new HIV diagnoses nationally, despite representing approximately 18% of the U.S. population[2]. In recent years, HIV diagnoses among Hispanic/Latino communities have increased while remaining stable or declining in several other populations; CDC data documented a 17% increase in HIV diagnoses among Hispanic/Latino people between 2018 and 2022[3–4].

That is the starting point. That is where we were even before the policy and funding shifts of 2025.

> *"Latinos have not been a priority. Infection rates amongst other groups and ethnicities are going down. Latinos are the only group that's going up."*
>
> **— Leader at a Community-Based Organization (PT01)**

What is happening now is not just more of the same. The strains described in this section were the ones that emerged most consistently across interviews and thematic analysis. They are by no means the only forces shaping Latino/a/x HIV care and community health in this moment, but they were the patterns participants returned to repeatedly across regions, professional roles, and organizational settings.

> *"I see it as if someone is plowing our future — economically and in terms of health. It's terrible for our communities."*
>
> **— Leader in Housing Services (PT18)**

1. Guilamo-Ramos V, Thimm-Kaiser M, Benzekri A, et al. The invisible US Hispanic/Latino HIV crisis: addressing gaps in the national response. Am J Public Health. 2020;110(1):27-31. doi:10.2105/AJPH.2019.305436.
2. Centers for Disease Control and Prevention. Fast Facts: HIV and Hispanic/Latino People. Updated October 21, 2024. Accessed May 18, 2026.
3. Centers for Disease Control and Prevention. CDC Publishes New HIV Surveillance Reports. Published May 21, 2024. Accessed May 18, 2026.
4. HIV.gov. U.S. Statistics. Updated 2025. Accessed May 18, 2026.

Strain 1 — Federal funding cuts: sudden, massive, and targeted

Since early 2025, federal funding for HIV care and prevention has been cut in ways no organization can absorb without harm. The pattern is the same across regions: cuts came suddenly, with no phase-out or transition plan, and at a scale that forced immediate layoffs, service reductions, and program closures[5].

> *"We are a $12 million organization, and on March 16th we lost a third of our funding. From one day to the next, about $4 million was cut. We had to reduce services and lay off staff across centers."*
>
> **— Leader at a Community-Based Organization (PT01)**

> *"A $5 million grant was completely eliminated. That funding supported sexual health services, community health workers, PrEP navigation, and testing for uninsured and underinsured patients."*
>
> **— Leader at a Federally Qualified Health Center (PT11)**

The cuts are hitting direct services and the research base behind HIV response and innovation[6–7].

> *"At the beginning of 2025, I was affiliated with nine HIV-related research projects. Five of them were terminated."*
>
> **— HIV Researcher (PT04)**

These losses are not spread evenly. Programs serving Latino, LGBTQ, transgender, and other underserved communities have been hit the hardest[8–9]. This is not a routine budget cut[10]. It is a deliberate shift of public funding away from the communities and services most central to the HIV response.

Strain 2 — Aggressive and indiscriminate immigration enforcement

Immigration enforcement is unfolding in Latino/a/x communities at a scale and intensity many participants described as unprecedented. It is no longer perceived as confined to specific individuals or formal legal processes, but as a visible and pervasive presence in public spaces, workplaces, near schools, and around the clinics and community organizations that provide care. As a result, many people are avoiding the very settings designed to support their health and wellbeing[11].

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5. Rachamalu K, O'Connor D. Administration's Radical Personnel Cuts Bypassed Congress and Lacked Transparency. Center on Budget and Policy Priorities. January 15, 2026.
6. Chan PA, Nunn AS. Grant Terminations in the US Threaten HIV Research and Future Progress. JAMA. 2025;334(11):949–950. doi:10.1001/jama.2025.12688.
7. Sullivan PS, Wall KM, Juhasz M, et al. Excess HIV Infections and Costs Associated with Reductions in HIV Prevention Services in the US. JAMA Netw Open. 2025;8(9):e2531341. doi:10.1001/jamanetworkopen.2025.31341.
8. HHS Grants Terminated. taggs.hhs.gov/Content/Data/HHS_Grants_Terminated.pdf
9. grant-witness.us
10. Tomasko L, Martin H, et al. How Government Funding Disruptions Affected Nonprofits in Early 2025. Urban Institute. October 7, 2025.
11. Ong P, Ong J, Diaz S. Latino ICE Detentions Dramatically Reshaped Under Trump. January 20, 2026. UCLA Center for Neighborhood Knowledge.

> *"We used to have a 15–19% no-show rate. That increased to almost 50%. It's not just undocumented immigrants — permanent residents and U.S. citizens are afraid to go out because of indiscriminate raids."*
>
> **— Leader at a Community-Based Organization (PT01)**

> *"Our families are being torn apart. Most Latino people feel there is a risk just going to the supermarket, speaking with an accent, or gathering in places where there are a lot of Latinos. There is a constant fear of being targeted."*
>
> **— Leader at a National Nonprofit (PT03)**

> *"You can walk three or four blocks in the city and see the police or the National Guard. It feels like living under military occupation."*
>
> **— HIV Researcher (PT16)**

Latinos are being swept up as a group, not assessed as individuals based on documentation or legal process. This is not an unintended side effect. It is how enforcement is built. And it is producing widespread fear that blocks access to care, services, and daily life.

Strain 3 — Loss of insurance coverage and other safety-net programs

The infrastructure that connects low-income Latino/a/x communities to ongoing care — Medicaid, state-run insurance for undocumented residents[12], sliding fee scales, and ACA coverage — is being dismantled through several changes happening at once. Any of these alone would matter. Together, they are stripping coverage from hundreds of thousands of people across the country[13].

> *"The governor and legislature decided to stop enrolling undocumented people in Medicaid starting January 1st. On top of that, people now have to pay co-pays. A $40 co-pay is a major obstacle when someone is living paycheck to paycheck."*
>
> **— Leader at a Community-Based Organization (PT01)**

> *"Medicaid has been significantly reduced here. Sliding fee scales have been pushed to their minimum. A lot of people will lose their health insurance or have to pay a huge co-pay just to see a doctor."*
>
> **— Leader at a Federally Qualified Health Center (PT11)**

12. Castronuovo C. States Move to Halt Immigrant Health Coverage to Rein in Costs. Bloomberg Law. June 13, 2025.
13. Pillai A, Pillai D, Artiga S. State Health Coverage for Immigrants and Implications for Health Coverage and Care. KFF. May 19, 2026.

The mechanisms vary by state — eligibility cutoffs, shorter re-enrollment cycles, new co-pays, reduced sliding scales, laws that exclude undocumented residents, and a chilling effect on ACA enrollment[14]. The direction is the same everywhere: fewer people covered, fewer paths to care, and no real replacement system stepping in[15]. At the same time, the safety net that has historically caught people losing primary coverage is itself under threat: nearly 20 states have adopted cost-cutting changes to their AIDS Drug Assistance Programs (ADAP), which are funded through the federal Ryan White HIV/AIDS Program and pay for HIV medications and insurance premiums for low-income people with HIV[16].

Strain 4 — Targeted erasure of populations and language

Federal directives are doing two things at once. They are banning the words used to name specific communities in grants, reports, websites, and clinical research[17], and they are restricting the services those same communities can receive[18]. These are not separate actions. Together, they amount to a deliberate and systemic erasure of entire communities from the institutions, protections, services, and systems meant to recognize, support, and safeguard their wellbeing.

> *"They want to eliminate us as a population. They want to make believe that we don't exist. By beginning to do that, they can limit the resources and access to comprehensive services we've had access to."*
>
> **— Leader at a National Nonprofit (PT03)**

> *"We cannot use 'Latino,' we cannot use 'LGBTQ,' we cannot use 'Latinx,' we cannot use 'underserved communities.' They're saying yes, you can continue to provide services, but you cannot use any of this language."*
>
> **— Leader at a Community-Based Organization (PT01)**

This erasure is not symbolic. It is operational. It is the mechanism by which access, services, and visibility are being pulled away from the communities that need them most.

Strain 5 — Dismantling of the public health infrastructure

The public health system itself — the workforce that runs it, the data systems that inform it, and the institutions that give it credibility — is being dismantled through coordinated moves happening at the same time[19]. The workforce is being purged at federal, state, and local levels.

14. Pillai D, Rao A, Artiga S. 1.4 Million Lawfully Present Immigrants are Expected to Lose Health Coverage due to the 2025 Tax and Budget Law. KFF. Sep 25, 2025.
15. Key Facts on Health Coverage of Immigrants. KFF. May 19, 2026.
16. Mandavilli A. As HIV Drug Programs Are Squeezed, Patients Face Hard Choices. The New York Times. March 2, 2026. https://www.nytimes.com/2026/03/02/health/hiv-drugs-ryan-white.html
17. Amon JJ. Trump's Banned Words and Disastrous Health Policies. Health Hum Rights. 2025;27(1):83-86.
18. Dawson L, Kates J. Overview of President Trump's Executive Actions Impacting LGBTQ+ Health. KFF. May 20, 2026.
19. Halabi S, Gostin L, et al. Science and Public Health in the Trump Era. J Health Polit Policy Law. April 1, 2026;51(2):171–190. doi: 10.1215/03616878-12262640.

> *“Civil servants are being fired left and right. They’re being told from one day to the next that you no longer have a job because you said something or your job is considered DEI.”*
>
> **— National Nonprofit Leader (PT13)**

Data systems used to monitor and respond to the epidemic are being deliberately weakened.

> *“This administration feels like they want to erase a lot of patient populations by not collecting data. This whole 2025 move seems like one not to track any HIV information. If you don’t have the data, you can just pretend it doesn’t exist.”*
>
> **— Clinical Pharmacist (PT02)**

The credibility of public health institutions, and the information they produce, is actively undermined.

> *“It is purposeful to intentionally remove the trust from what we knew as trusted scientific agencies — the CDC, the FDA, the ACIP.”*
>
> **— National Nonprofit Leader (PT13)**

These are not three separate problems. Firing the people who collect the data, weakening the systems that house it, and undermining the institutions that publish it are lines of attack on the same target: the ability of public health to know what is happening, and to be believed when it says so.

SECTION TWO

What it is costing

Before we talk about what works, we need to be clear about what is being lost. This is not a forecast. It is what providers are already seeing.

Photograph: Nitish Meena

We had twenty conversations with people who have spent their careers in this work. They were specific. They named dollar amounts. They told us stories. They named programs. Independently, across four regions, they painted the same picture. The full cost is likely larger than the data can show. But what the data does show is bad enough.

The cost in lives and health

No-show rates have doubled or tripled in clinics serving our communities. Fear is reaching far past undocumented patients — permanent residents, U.S. citizens, and anyone who looks Latino/a/x is staying away from care.

> *“Our high no-show rate has increased a lot since the change. People are withdrawing from treatment because of fear, because of the phobia of leaving their homes.”*
>
> **— Leader at a Treatment Program (PT15)**

Patients on HIV treatment are missing doses. People who were stable are disappearing from care. Patients on long-acting injectable antiretrovirals, which must be taken on schedule to prevent drug resistance, are being detained without their medication.

> *“We’ve had a handful of patients detained by ICE. Two of them were on long-acting antiretrovirals. We had to help them figure out what they would be on in the meantime.”*
>
> **— Clinical Pharmacist (PT12)**

The cost in mental health

The same picture appears in every region: a community-wide mental health crisis that is not being measured and not being funded.

> *“It is a mental health pandemic. It started a long, long time ago, and now it’s in full moon, because people are so afraid.”*
>
> **— Senior Director, National Latino Health Organization (PT10)**

> *“We get calls every day from people who need help with mental health because they cannot cope. Suicide has increased. In Puerto Rico, in less than two weeks, 10 people have lost their lives.”*
>
> **— Leader at a Treatment Program (PT15)**

The cost to organizations and the workforce

Organizations are closing or shrinking in real time. Sister organizations with thirty-plus years of history have closed permanently. Every staff member laid off represents years of trust built with patients who were already hard to reach. That trust cannot be rebuilt by restoring a budget line.

> *“Sister organizations that had been in existence for 30-plus years, serving trans and Latino people, have closed their doors.”*
>
> **— Leader at a National Nonprofit (PT03)**

The cost in visibility and trust

Federal grant restrictions are forcing organizations to remove the very words that name the communities they serve. Anything labeled Diversity, Equity, and Inclusion (DEI) has become a liability. Trans communities, already underrepresented, are being explicitly removed from research and care records.

> *“We had to completely eliminate trans communities from all the research we did. In a Southern city that needs it so much — where they are about 50% of HIV cases per year.”*
>
> **— Leader in Housing Services (PT18)**

If you cannot name the community you serve, you cannot raise money for them, you cannot recruit staff for them, and eventually you cannot find them. That is the design.

The cost in moral injury

This is different from burnout, and it deserves to be named separately. It is not simply the result of overwork or lack of rest. Moral injury occurs when people are forced, through law, funding, or policy, to act against the very values that brought them to this work. It is the wound of being turned into a participant in the harm you dedicated your life to preventing.

> *"I haven't been coping. There is so much to process that I often dissociate from the world to protect myself. And then when I can, I sleep."*
>
> **— HIV Researcher (PT04)**

No one enters HIV care to choose which patients to abandon. No one becomes a community health worker to tell someone they are not allowed to use words for who they are. No one trains as a researcher to erase their own history. Yet that is what the work requires right now.

SECTION THREE · RESPONSE DOMAIN 1

Innovate to bring and keep patients in care

Nothing here is theoretical. These strategies are already being used in clinics and community-based organizations right now.

Photograph: Tim Mossholder

These strategies will not reverse federal funding cuts. They will not end immigration enforcement. What they can do is keep people engaged in care and connected to trusted relationships through this period.

> *"It is a promise we have made as an agency — not to abandon them, and to let them know they have us as a support."*
>
> **— Leader at a Treatment Program (PT15)**

1 Bring care to where people are

When people stop coming to appointments, organizations are not waiting for them to return. They are reaching out, calling, arranging transportation, doing home visits, and locating patients in detention when needed. Re-engagement is not an administrative task. It is urgent clinical work. For patients that cannot or will not come to the clinic, the clinic goes to them. Telehealth, mobile testing, and home visits are forming the backbone of care under current enforcement conditions[20–21–22].

> *"If people can't come in person, we call them. If they answer, we do a phone or Zoom visit."*
>
> **— Clinical Pharmacist (PT02)**

> *"When we call them to do a wellness check-in, they tell us the same excuse, that they can't come because they are afraid. We provide transportation, that is, Uber. If we have to call an Uber from their house to here, and from here to their house, we do it."*
>
> **— Associate Director of a Community Health Center (PT15)**

20. Walker D, Moucheraud C, et al. Experiences with telemedicine for HIV care in two federally qualified health centers in Los Angeles. BMC Health Serv Res. 2023;23(1):156. doi:10.1186/s12913-023-09107-1.
21. Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring. Geneva: World Health Organization; 2021.
22. Bradford JB, Coleman S, Cunningham W. HIV system navigation: an emerging model to improve HIV care access. AIDS Patient Care STDS. 2007;21(suppl 1):S49-S58. doi:10.1089/apc.2007.9987.

PATIENT OUTREACH AND CONTINUITY CHECKLIST

- ☐ Attempt contact within 24–72 hours of missed visit
- ☐ Offer phone/video visit immediately
- ☐ Confirm safe contact number and language preference
- ☐ Assess and address transportation or immigration-related concerns
- ☐ Arrange medication refill delivery or pickup
- ☐ Escalate to peer navigator/community health worker if unreachable
- ☐ Document follow-up attempts and re-engagement plan

2 Leverage trusted messengers

When official institutions have lost credibility, the people patients listen to are the ones who already know them: promotores, community health workers, peer navigators, and outreach staff who come from the same community as the patient[23–24].

> *"I adore community health workers. They are fantastic leaders of change. The most important piece is that they are a trusted source of information in communities that need this information right now."*
>
> **— Senior Director, National Latino Health Organization (PT10)**

TRUSTED MESSENGER CHECKLIST

- ☐ Partner with promotores, peer navigators, community health workers, and outreach staff from the communities being served
- ☐ Prioritize bilingual and culturally concordant outreach whenever possible
- ☐ Use trusted community spaces, social networks, and local leaders for education and engagement
- ☐ Train staff to provide accurate information about confidentiality, available services, and patient rights
- ☐ Compensate community health workers and peer navigators as integral members of the care team

3 Make the clinic itself feel safe

Safety is being rebuilt through the signals people encounter the moment they approach care: the clinic entrance, waiting room, intake process, staff identification, and the organizations visibly associated with the clinic, as well as the institutions intentionally kept at a distance.

23. Kim K, Choi JS, Choi E, et al. Effects of community-based health worker interventions to improve chronic disease management and care among vulnerable populations: a systematic review. Am J Public Health. 2016;106(4):e3-e28. doi:10.2105/AJPH.2015.302987.

24. Cabral HJ, Davis-Plourde K, Sarango M, et al. Peer Support and the HIV Continuum of Care: Results from a Multi-Site Randomized Clinical Trial in Three Urban Clinics in the United States. AIDS Behav. 2018;22(8):2627–2639. doi:10.1007/s10461-017-1999-8.

> *"If patients come in and we know they're undocumented, or they tell us at triage, they go directly back to a secure patient care area. They don't have to wait in the public waiting room."*
>
> **— Clinical Pharmacist (PT02)**

CLINIC SAFETY CHECKLIST

- ☐ Review entrances, waiting rooms, signage, and intake workflows from the patient perspective, ensuring spaces are welcoming, language-accessible, and clearly communicate privacy and non-participation in immigration enforcement
- ☐ Train staff in trauma-informed and culturally responsive communication
- ☐ Create rapid intake or direct-rooming workflows for patients with safety concerns
- ☐ Ensure bilingual staff and interpretation services are available
- ☐ Use discreet communication and appointment reminder practices when requested
- ☐ Develop protocols for responding to enforcement activity near clinic sites
- ☐ Partner with trusted community organizations to strengthen patient trust

4 Address the fear directly

The fear people are feeling is not a misunderstanding to be corrected. It is a rational response to an environment that is, in fact, dangerous. The work is not to talk people out of being afraid. It is to acknowledge the fear, share clear and accurate information about rights and options, surround people with trusted relationships, and refuse to let them face the fear alone.

> *"Talking to each other, building strong relationships, following up, checking in — that's the one thing that is ultimately going to save us. Making sure we are not alone through all of it."*
>
> **— National Nonprofit Leader (PT13)**

Example patient-facing language

"…Many people are feeling afraid right now, and you are not alone in that. We want you to know that your health and safety matter to us. We can talk through options together, including phone or video visits, transportation support, medication refills (and other services available), or other ways to help you stay in care. You do not have to do this alone. If coming to clinic feels unsafe, tell us what would help you feel more comfortable, and we will work with you…"

SECTION FOUR · RESPONSE DOMAIN 2

'Future-proof' and sustain your organization

Care cannot outlast the structures that make it possible. This section turns to the organization itself.

Photograph: Ari Dutilh

Every patient-facing strategy is being carried out under intense pressure: defunded, surveilled, threatened with loss of nonprofit status, and staffed by people who are themselves part of the affected community.

5 Adapt public-facing language to comply, while keeping the work the same

Organizations are changing their public language to meet federal restrictions while continuing the same work. The work has not changed. What has changed is how safely it can be named.

> *"We had to pivot. We removed the language related to gender and sexual minorities and communities of color so we could keep doing the work without explicitly naming those communities. It has driven everything more underground and covert."*
>
> **— HIV Researcher (PT16)**

LANGUAGE & GRANT TOOLS

Federal Grant Trigger Words Replacement Workbook — guidance on adapting grant language

Hemingway Editor — free tool to analyze drafts for readability, passive voice, and complex sentence structures

6 Diversify funding away from federal dependence

Organizations whose budgets relied on federal grants are moving quickly to find funding that does not carry federal restrictions. For many, this is no longer about growth or resilience. It is about immediate survival.

> *"We can no longer rely on NIH. We need to look at other funding sources — philanthropy, the private sector, you name it. As long as it's legal, we should accept it and invest in our communities."*
>
> **— HIV Researcher (PT04)**

FUNDING SEARCH RESOURCES

Foundation funding for nonprofits: Candid — Foundation Directory and nonprofit funding

AI-powered grant discovery: GrantOtter — AI-powered grant discovery for faculty and research teams

Health research funding: Robert Wood Johnson Foundation (RWJF); W.K. Kellogg Foundation (WKKF)

7 Use bureaucratic time as a defense

Many federal directives are being issued without clear instructions on how to comply. Some organizations are choosing to wait, allowing bureaucratic time to move at its usual pace rather than accelerating compliance through proactive inquiry.

> *"Rather than reaching out and asking how to implement this, our strategy is to slow the process down. Don't ask for directions. Don't ask for guidelines. If they're not telling you, just wait it out. That alone slows the process by a few months."*
>
> **— Regional Policy Director (PT05)**

8 Build legal preparedness for the organization itself

Organizations are preparing not only for program audits, but for investigation, litigation, public scrutiny, and threats to their nonprofit status. Legal preparedness is no longer a back-office function. It is part of day-to-day organizational survival.

> *"A medical-legal partnership model — having an attorney involved — can help inform providers on how to create a safe space, equip them with legal information, and at the same time provide patients with information, as well as referrals and linkage to legal services."*
>
> **— Director, Training Center (PT14)**

Legal preparedness resource

Partono et al. describe how medical-legal partnerships can support organizations navigating policy change, patient advocacy, compliance concerns, and legal threats affecting HIV care delivery.

9 Care for the staff carrying the work

The people doing the work inside these organizations are themselves part of the communities being targeted. Leadership goes first. Leadership names openly that staff are part of the affected community. Leadership models care. Caring for staff is not separate from sustaining services. It is the condition that makes sustained care possible.

> *"As a direct supervisor, first they are my staff. I need to know they are well. I offer to help. I go with them. I want to go in front of them, so I know they are okay."*
>
> **— Leader at a Treatment Program (PT15)**

Staff support & trauma-informed leadership resource

Harris et al. describe opportunities for healthcare leaders to address workforce trauma while sustaining care delivery in high-stress environments.

SECTION FIVE · RESPONSE DOMAIN 3

Build coalitions and peer support

This moment is designed, in part, to isolate. The response taking shape is a refusal to accept it.

Photograph: Helena Lopes

The same problem is emerging across regions: this moment is designed, in part, to isolate. Funding cuts eliminate the shared programs that once brought organizations together. Layoffs empty the tables where collaboration used to happen. Language restrictions make it harder to name common ground publicly. The fear in communities reaches leaders too.

10 Name the isolation as deliberate and refuse it

This isolation is not incidental. It is operating as a policy instrument. The response taking shape is a refusal to accept it.

> *"It's isolating, with purpose, what this administration is doing. But if we can just say, 'Hey, I'm here. Did you hear that? That's crazy. I'm not listening to that' — that is incredibly impactful."*
>
> **— National Nonprofit Leader (PT13)**

11 Establish regular peer-to-peer contact between leaders

Leaders at different organizations are calling each other, texting each other, checking in regularly. This is not networking. It is peer support.

> *"Constant communication helps. We have a network. 'I got this — have you received this? What do you have there?' That exchange of resources and information is so much more important now."*
>
> **— Leader in Housing Services (PT18)**

12 Convene: the gathering itself is the intervention

Bringing people together, in person whenever possible, has become urgent at a moment when isolation is the dominant condition. The form varies, from informal *charlas* to structured regional summits. The content is secondary to the act itself.

> *"I'm going to start informally having charlas, because there is a huge need to talk, to share, to cry together. Most of us don't have money — but convening people in person, like the summit last year, was so empowering."*
>
> **— Senior Director, National Latino Health Organization (PT10)**

13 Build coalitions beyond the HIV field

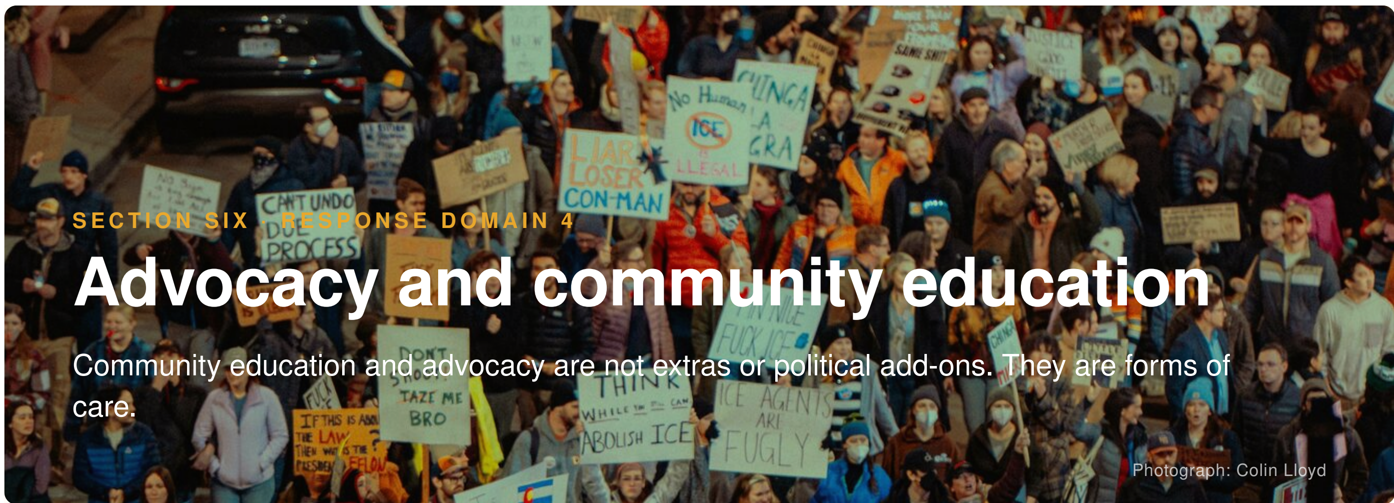
The threat is not specific to HIV. It is legal, political, economic, and cultural. A response limited to one sector cannot meet it at scale.

> *"The path forward is having coalitions not just within the medical field, not just within the HIV field, but including government and private industry."*
>
> **— Leader at a Community-Based Organization (PT01)**

14 Practice intentional solidarity, not competition

Under conditions of scarcity and fear, organizations serving the same communities can end up competing. Intentional solidarity is the refusal of that dynamic.

> *"What I always do is collaboration and intentional solidarity. If an agency comes to me with $5,000 or $1,000 to organize a Latino event, I'm not going to be selfish. I'm going to share it. There are ways to be intentional about collaborating."*
>
> **— Community Leader (PT20)**



SECTION SIX · RESPONSE DOMAIN 4

Advocacy and community education

Community education and advocacy are not extras or political add-ons. They are forms of care.

Photograph: Colin Lloyd

When people lack accurate information about their rights, their coverage, and what services still exist, they disengage — not because they do not care about their health, but because the information they are navigating has been deliberately degraded.

15 Treat community education as a primary service

When official public-health channels are degraded or distrusted, the organization that stays present in the community with accurate, trusted information is functioning as a lifeline. Education is not upstream of care. It is care. It is the intervention that keeps someone alive long enough to make it to the clinic door.

> *“They need to push on educating people that no matter what their legal status is, they have access to medication and treatment. Make it more accessible. Spread the word to these communities, because they probably don’t know.”*
>
> **— Volunteer Dental Provider (PT09)**

COMMUNITY EDUCATION RESOURCES

- National Immigration Law Center (NILC): Know Your Rights
- Immigrant Legal Resource Center (ILRC)
- Informed Immigrant

16 Protect and distribute scientific truth through alternative channels

When institutions long relied upon for accurate public-health guidance can no longer be trusted, organizations that remain credible in their communities take on a distinct role: identifying, translating, and distributing reliable science through channels that have not been compromised.

> *"Evidence-based information does exist. It is coming out through different avenues — the American Academy of Family Physicians, the American College of Physicians, ACOG. These medical societies are putting out great information that is useful for our communities."*
>
> **— National Nonprofit Leader (PT13)**

17 Shift advocacy to the state level

For the moment, federal advocacy is no longer a productive path for many organizations. The response taking shape is to redirect advocacy capacity to the state level, where federal directives are still interpreted and implemented, and where meaningful wins remain possible.

> *"Our focus has to be on the states and working with state partners to fill those gaps and create mitigation strategies, so the impact is not as heavy in our states."*
>
> **— Regional Policy Director (PT05)**

STATE-LEVEL ADVOCACY RESOURCES

Common Cause: Find Your Representatives

USA.gov: Elected Officials Directory

5 Calls — app that helps users quickly contact elected representatives about current policy issues

18 Tell our stories: humanizing narrative as advocacy

Participants described how Latino and LGBTQ+ communities are often portrayed as threats rather than as families, neighbors, workers, and community members. In this environment, sharing real stories through social media, community spaces, and public conversations becomes an important form of advocacy.

> *"People have to mobilize. It starts small. It starts with using your platforms and social media to share uplifting stories of trans people and Latino people. We are not these monsters. We are people who come from the families we live among."*
>
> **— Leader at a National Nonprofit (PT03)**

Storytelling & narrative change resource
Define American is a nonprofit focused on immigrant storytelling, media representation, and narrative change. Their 'Immigrants Belong Toolkit' is available at defineamerican.com/research/immigrants-belong-toolkit.

19 Plan for electoral and civic engagement

For 501(c)(3) organizations, electoral preparation is not the same as electoral activity, and the legal limits are real. But within those limits, there is substantial work organizations can do to ensure their communities are informed, registered, and prepared to participate.

> *"Getting ready for midterm elections — how are we going to show up? It is very important that there is a clear line of communication with communities, and a clear plan. Hopefully we will win a couple of seats. I am optimistic, despite the mess."*
>
> **— Senior Director, National Latino Health Organization (PT10)**

Civic engagement resource
Nonprofit VOTE provides practical guidance, toolkits, and legal resources to help nonprofits support voter registration, education, and community participation within 501(c)(3) guidelines.

20 Build the unifying message: this is not only our fight

> *"We need a united front and a unifying message — not 'me against you.' The message has to be: what is being dismantled in our country is not just going to affect me. It may affect me right now, but eventually, when they're done with me, they're coming after you."*
>
> **— Leader at a Community-Based Organization (PT01)**

Organizations such as Defend Public Health have been garnering recognition for grassroots organizing efforts on national public health priorities. Visit their site to see upcoming and past legislative actions that need your support.

Community members praying the rosary outside ICE's Atlanta Field Office. Advocacy as an act of faith and presence. Photograph: Carlos Saldana

Where we go from here

This guide began with a promise made at *¡Adelante!* 2024 — to re-ignite the passion and vision we shared at that gathering, and to carry it forward through a much harder moment. The voices in this guide have shown both what is being lost and what is already being built in response.

The strategies described here will not, on their own, restore federal funding, end immigration enforcement, or rebuild Medicaid coverage. What they do is keep people's voices alive and patients engaged in care through this period. They keep organizations functioning. They keep relationships intact. They keep the field connected to itself.

> *"We cannot allow them to keep us in the margins of society because of fear. We have to organize, strategize, and you know, the work will continue. We need to use that fear to strategize and figure ways to fight back."*
>
> **— Leader at a National Nonprofit (PT03)**

What this work asks of us is also clear. It asks us to gather, to refuse the isolation that has been engineered. It asks us to protect each other's organizations and people, even when our own are stretched thin. It asks us to make space for fear, grief, and exhaustion without surrendering to them. And it asks us to keep speaking, clearly and accurately, about what is happening to our communities, so that those communities are not erased from public memory the way they are being erased from federal records.

There is a path forward. It runs through community health workers and promotores who know their neighborhoods. It runs through clinic protocols that protect patients at the door. It runs through legal counsel that affirms the work rather than retreats from it. It runs through state-level coalitions that include partners outside of HIV. And it runs through every act of solidarity, from an outreach event in a rural neighborhood to a coordinated grant decision between two organizations who would once have competed.

¡Adelante! means forward. The strains described in this guide are real.
So is the response. We carry it together.

Resources

The resources below are organized by the kind of support they offer. Inclusion does not imply endorsement, and links or eligibility requirements should be verified before sharing with patients, staff, or community members.

POLICY, COVERAGE, AND HEALTH SYSTEMS

- KFF (Kaiser Family Foundation) — non-partisan analysis of Medicaid, ACA, HIV, and public health policy
- Center on Budget and Policy Priorities (CBPP) — analysis of federal and state budget decisions affecting low-income communities
- National Health Law Program (NHeLP) — legal advocacy and policy analysis on healthcare access and health equity

IMMIGRATION AND LEGAL SUPPORT

- National Immigration Law Center (NILC) — immigration and healthcare access resources, including "Know Your Rights" materials
- Immigrant Legal Resource Center (ILRC) — community education materials, legal training, and multilingual Red Cards
- Informed Immigrant — multilingual immigration information and practical guidance

COMMUNITY EDUCATION, ADVOCACY, AND CONVENING

- Latino Commission on AIDS — HIV education, advocacy, leadership development, and community engagement
- NMAC / USCHA and related conferences — national convening spaces for HIV providers, advocates, researchers, and community leaders

FUNDING, GRANT WRITING, AND ORGANIZATIONAL SUSTAINABILITY

- Funders Concerned About AIDS (FCAA) — tracks HIV philanthropy trends and connects organizations with private and community funders
- Candid Funding Search — search platform for nonprofit and foundation funding opportunities
- GrantOtter — grant discovery and funding opportunity tracking platform
- Robert Wood Johnson Foundation Funding Opportunities — active funding related to health equity and access
- Candid Learning: How to Write a Grant Proposal — practical guidance and sample documents for grant writing and adapting proposals

PROVIDER, WORKFORCE, AND ORGANIZATIONAL SUPPORT

- Physicians for Human Rights (PHR) — resources for clinicians and organizations serving immigrant communities, including guidance on immigration enforcement and healthcare access