Providers' Perceptions of and Receptivity toward Evidence-Based HIV Prevention Interventions

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Abstract

Since 1999, the Centers for Disease Control have trained over 10,000 service providers from more than 5,000 agencies to implement evidence-based HIV prevention interventions through its Diffusion of Effective Behavioral Interventions (DEBI) program. Based on in-depth, semi-structured interviews with a convenience sample of 22 HIV prevention service providers from 8 agencies in Wisconsin who participated in DEBI training, this article explores providers' motivations for attending DEBI training, perceptions of the utility and value of the DEBI program, and criticisms of the program. Providers indicated that they attended training as part of general skill-building efforts, as a way to improve services through the adoption of evidence-based interventions, and to better meet client needs. DEBI training participants were critical of the program's "top down" approach, perceived lack of fit between the DEBI and their target populations, and what they perceived as a lack of evidence that the interventions would work with their particular populations. These results suggest that in order for the DEBI program to be more widely accepted, the experiences and expertise of providers need to be more fully integrated into the processes of developing, disseminating, and adapting evidence-based HIV prevention interventions.

Keywords

DEBI Program; HIV Prevention Interventions; Dissemination; CBOs

Introduction

Each year, the Centers for Disease Control and Prevention (CDC) distribute more than $400 million to state and local health departments to support the HIV prevention service activities of community-based organizations (CBOs) (IOM, 2001), including more than $200 million for behavioral risk reduction interventions (Holtgrave, Pinkerton, & Merson, 2002). As a precondition of funding, many public health departments require that service providers

implement "evidence-based interventions" (EBIs), such as those promoted through the CDC's Diffusion of Effective Behavioral Interventions (DEBI) program (Dworkin, Pinto, Hunter, Rapkin & Remien, 2008). The DEBI program provides a framework for identifying and disseminating interventions shown to be efficacious in scientifically-rigorous trials, and training service providers to implement the intervention (Lyles, Crepaz, Herbst & Kay, 2006; Nutley, Walters & Davies, 2003; Rugg et al., 1999). Thus far, the CDC has identified 26 interventions with sufficient empirical evidence of their effectiveness to broadly disseminate. Between 1999 and 2008, the CDC's DEBI program trained over 10,000 service provider participants from more than 5,000 agencies.

The interventions included in the DEBI program reflect a broad range of approaches to HIV prevention, including individual, group, and community level interventions. These interventions target diverse populations at risk for HIV, including young men who have sex with men, current and former drug users, runaway and homeless youth, and African American heterosexual women. Training for these interventions includes both training of facilitators, designed for individuals who will implement the interventions, and "training of trainers," in which future trainers become qualified to teach specific interventions to providers. In facilitator trainings, CBO staff members attend training to learn how to implement a specific intervention, determine if their agencies have the capacity to implement the intervention and if the intervention matches the needs of their target populations, and assess the intervention's relative advantages compared to existing programs (Collins et al., 2006). Agencies that participate in these trainings include those that are directly funded by the CDC to implement a specific intervention, and those with secure funding from state health departments or other sources (e.g., private foundations) to implement the intervention. Other agencies without dedicated funding for implementation also participate in the training to determine the appropriateness and feasibility of that particular intervention for their agency and target populations.

Although the duration, format, and participant composition of trainings varies depending on the intervention, most training events last several days and occur throughout the year. DEBI trainings take place throughout the country, but primarily at STD/HIV Prevention Training Centers in Rochester, NY; Dallas, TX; Denver, CO; and Oakland, CA. These centers are funded by the CDC to train health professionals and other service providers in the DEBI interventions. In the trainings, participants are taught the intervention's core logic and underlying theory, the importance of implementing the intervention with fidelity to core elements (integral components of the intervention thought to be responsible for its effectiveness and that must be retained in order for HIV risk reduction to occur), and needs assessment and capacity building strategies. Providers can learn about training opportunities by visiting the DEBI program website (www.effectiveinterventions.org), through announcements from state health departments, and various listservs targeting HIV prevention service providers.

While some work has been conducted regarding intervention implementation fidelity (Harshbarger, Simmons, Coelho, Sloop & Collins, 2006; Prather et al., 2006), the factors that affect organizations' willingness and ability to adopt externally developed HIV prevention interventions remain underexplored. CBOs are the primary providers of HIV

prevention programs and services in the United States. Historically, their HIV prevention efforts have relied heavily on "outreach" efforts and other "homegrown" programs that the agency developed in direct response to needs they saw within their constituent populations (Cain, 1997). While these programs filled important service gaps, they were often developed without rigorous scientific evaluation of their effectiveness. At the same time, researchers primarily associated with academic institutions were developing and empirically evaluating behavior-based HIV prevention strategies based on established theories of psychology and behavior change. However, research studies of HIV prevention interventions do not—in and of themselves—significantly reduce the magnitude of the HIV epidemic. Research on HIV prevention methods can only curtail the epidemic when efficacious interventions are transferred to and effectively implemented by HIV service providers. The CDC developed the DEBI program to bridge the gap between researchers and providers.

Diverse factors, including funding levels, resource allocation, organization size, leadership styles, organizational policies, technical assistance, and management—loosely referred to as "organizational capacity"—affect program adoption and implementation (DiFranceisco et al., 1999; Durlak & DuPre, 2008; Korst, Signer, Aydin & Fink, 2008; Kelly et al., 2006; Livet, Courser & Wandersman, 2008; Miller et al., 2003; Ramos & Ferreira-Pinto, 2002). Although more difficult to measure, commitment to serve particular populations, organizational support for programs, stability of resources and personnel dedicated to the intervention, and organizational values and mission, also bear on the process of implementation (Ginexi & Hilton, 2006; Rohrbach, Grana, Sussman & Valente, 2006). Miller and Shinn (2005) define organizational values as including the "values about what its members believe it ought to accomplish in the world and also about what its members think is good, local prevention practice for its target population" (Miller & Shinn, 2005, p. 172). As Miller (2001) illustrated, whether an agency adopts or faithfully implements an intervention reflects the degree of congruence between the new intervention and the organization's values.

As Dworkin et al (2008) suggest, HIV prevention service providers in CBOs may resist the DEBI program because they feel they have little choice whether or not to implement an EBI, and doubt the assertion that the interventions in the program are "the best" for their populations. Throughout the country, states differ in regard to the degree to which CBOs receiving public funds (e.g., from state departments of health) are required to implement evidence-based interventions, such as those included in the DEBI program. In Wisconsin, while the Wisconsin AIDS Program, the lead governmental agency responsible for coordinating the state's public health response to the AIDS/HIV epidemic, supports (through funding, technical assistance, and capacity building strategies) the implementation of DEBIs, it funds other prevention efforts at the CBO level, such as agency-developed Internet outreach. In this environment of support for DEBIs combined with the ability to develop and implement non-DEBI interventions, Wisconsin HIV prevention service providers can chose to implement DEBIs or seek alternative HIV prevention interventions. This article explores Wisconsin-based providers' perspectives on the DEBI program, including why providers decide whether to implement DEBIs, within the broader context of CBO service provision (e.g., treatment services for people living with HIVAIDS) and target populations. Critical to improving service provider uptake of these interventions is understanding the process by

which agencies adopt externally-developed interventions, barriers and facilitators to intervention adoption and dissemination, and how agencies modify, add to, or eliminate components of an intervention in response to the needs, resources, goals, and culture of the organization and target population.

Methods

Data collection

Since 2004, approximately 100 people in Wisconsin have been trained in six different effective behavioral HIV prevention interventions, as defined by the CDC's DEBI initiative, in Wisconsin. From 2008-2009 in-depth, semi-structured interviews were conducted with 22 service providers in Wisconsin who had either completed DEBI training or oversaw the implementation of a DEBI intervention at an agency, or both. Agency directors were contacted to verify the accuracy of the list of people from their agencies who had attended training, confirm that the individuals were still working at the agency, and obtain contact information in order to request an interview. The 35 agencies on the original list included 6 public health programs, which were excluded from the study. Of the remaining 29 agencies, 12 no longer implemented the DEBI; experienced staff turnover to an extent that those who were trained in the DEBI either were no longer working at the agency and could not be located, or could not be identified by current staff; merged with other organizations; or dissolved. Six agencies did not respond to any attempts to contact them (via phone and email) and 3 declined to participate in the study. In total, 8 agencies agreed to participate in the study. One constituted a comprehensive AIDS service organization that offered treatment, care, support, and prevention services to a broad population. The remainder of the organizations incorporated HIV prevention into a broader spectrum of programs and services targeting specific populations, such as the Hispanic community, LGBT youth and adults, and African American women (see Table 1).

Agency directors provided contact information for staff at their organizations who had attended DEBI training. These individuals were contacted directly; 22 of 23 people who were contacted to participate in the study agreed to participate. Directors and staff were assured that participation in the interview was voluntary and confidential, and written informed consent was obtained before the interview began. Approval for the study was obtained from the Institutional Review Board at the Medical College of Wisconsin. Interview participants held a variety of the positions in their respective organizations, including HIV prevention directors, organization directors, case managers, outreach workers, and prevention specialists. Of the 22 interview participants, 4 held director-level positions; 2 directors attended DEBI training in order to understand the intervention but none facilitated interventions at their agencies. Of the 18 interview participants in non-director positions who participated in training, 5 did not implement the target intervention. Of the 20 interview participants who attended training, 8 (40%) completed more than one DEBI training. DEBI trainings included SISTA (n=5), VOICES/VOCES (n=8), Street Smart (n=1), MPowerment (n=8), Many Men, Many Voices (n=5), and Safety Counts (n=3). With the exception of two people, all interviewees currently worked at the agencies. Therefore, unlike previous studies (e.g., Somlai et al 1999) that found the median number of years for

frontline service providers to hold their positions to be one, participants in this study worked in HIV prevention and service delivery for a median of eight years, with a range of one to more than 20 years.

All interviews were conducted by the first author and digitally recorded, and lasted between one and a half and three hours. Interviews were conducted at places and times convenient for the interviewee, including a private room at the person's place of employment and interview rooms at the Medical College of Wisconsin. The interviews were semi-structured, based on an interview guide with a set of topics to be covered during the interview depending on the individual's position in the agency (i.e., director or facilitator) but that allowed flexibility to probe participant responses and explore topics in greater depth (Bernard, 1995). Individuals in director level positions were asked questions regarding decision-making processes about how staff were selected for training, how resources were allocated for the DEBI intervention; background information about the organization's mission, goals, and size; agency-level preparations to implement the DEBI; and evaluation activities related to HIV prevention programs. Interviews with participants in intervention facilitator positions addressed overall perceptions of the quality, relevance, and effectiveness of the training and the intervention; motivations to attend training; opinions about the activities learned at the training; perceptions of implementation feasibility; barriers to implementation; and assessment of client reaction and receptivity to the new program. Interviews with both directors and facilitators addressed needs assessment information related to target populations, including perceptions of the scope and severity of HIV risk and DEBI program relevance; staff history with the organization; information about the organization itself and its current or past HIV prevention projects; and public policy that affects the work of the organization and/or interviewee. The same semi-structured interview guide was used for those individuals who implemented the intervention in which they were trained and those who did not implement the intervention.

Analysis

All interview recordings were transcribed verbatim and entered into a computer-based text file. Transcripts were then transferred to the software program MAXQDA, to be coded and sorted. Transcripts were analyzed by the first author for emergent themes using principles of grounded theory analysis (Strauss & Corbin, 1990). Transcripts were initially examined to identify primary coding categories, as well as the range of themes present within each category. Identified coding categories and themes were organized into a formal code book. Transcripts were then formally content coded. New themes that did not appear to fit into the original code book were discussed and modifications were made when appropriate. When suggested by associations, overlap, or diversions in the data, thematic categories were refined, merged, or subdivided.

Transcripts were first coded by gender, ethnicity, participant's title or role in the agency (e.g., director, paid staff, volunteer), population served by the agency (e.g., African American men, youth), DEBI training attended, agency type, and whether the agency implemented the intervention. Then, the documents were coded with text codes that reflected key analytical concepts, including motivations for participating in the DEBI

training, satisfaction with the training, perceived barriers to implementation, and opinions about the utility of the interventions and the DEBI program in general. Data analysis explored similarities and differences in organizational structure, scope, and purpose; and the relationship between these variables and perceptions of the DEBI program. Due to the small sample size, for this paper analysis focused on the interviews as a complete set; distinctions were not made between which DEBI training was attended. Also, because many of the interviewees participated in multiple DEBI trainings, resulting in implementation of some interventions and not others, the current analysis does not differentiate between implementers and non-implementers. Finally, because this article focuses on overall views of the DEBI program from the perspective of service providers, analysis did not focus on the different perspectives offered by directors and facilitators.

Results

Motivations for Training

In order to provide increasingly complex services to a greater diversity of clients, both volunteers and employees with educational backgrounds and work experiences in health fields and social service provision often require or seek additional training once they begin working in HIV/AIDS-related services. In their survey of 316 community-based organizations conducting HIV prevention, Richter et al (2000) found that respondents ranked the "ability to do my job better," "improving the overall prevention effectiveness of the CBO," "improving my ability to make purposeful choices when designing prevention strategies," and "networking with other participants" as the most significant benefits of attending training.

For participants in this study, DEBI intervention training existed as one of many training opportunities. In addition to DEBI interventions, training opportunities included "cultural competency" training to improve staff members' ability to work with specific populations, such as transgender individuals and ethnic minorities; HIV testing procedures; "HIV 101" training; counseling, testing, and referral; information about drug users; Hepatitis C education; HIV/AIDS treatment updates; and STD education. Diverse organizations sponsored these trainings, including the state department of public health, the CDC, pharmaceutical companies, and other local and national non-profit organizations. For many agencies and employees, the lack of prior experience with HIV prevention specifically necessitated additional training after new staff members came to the agency. The motivation to attend DEBI training centered on notions of general skill building, with no predefined commitment to implementing an intervention:

I got interested in that [DEBI] because of the population that we are working with. And I went to...gain more skills and get more information...for the way that I can understand more of this population...to find a way for them to talk about difficult topics, like sex and condoms. [JO05]

Other motivations for participating in DEBI training included the opportunity to improve communication skills, learn new approaches to talking with clients about HIV and related

issues, stay current with the latest developments in HIV prevention science, and obtain new materials and approaches to keep participants engaged in programs.

The prevention director of one agency described that she sent her staff to DEBI training because it potentially benefited the entire agency:

I try to have my staff all be cross trained as much as possible...I think it makes their job so much more interesting and there isn't a turnover. I think if you really empowered people and give them different skills and different things to do that—I just found people do much better. So whenever there is a new training and it comes up and it seems like it's applicable in any sense of what we are doing, I like to try and send as many people as I can for training because we seem to always incorporate it in some way. [JO14] Likewise, staff members were chosen to attend particular trainings based on the work they already performed and the possibility of improving their services:

We really looked at the job that they were doing, the job that they were paid to do and how these trainings would influence what they were doing or improve what they were doing, give them additional tools for it. [JO16]

Another prevention director observed, "I hate to pass up a training when its [here] or [nearby], not knowing when it's going to come up again. And even if it's something that we don't use very often, I think you just benefit. You certainly just pick up some ideas from things like that" (JO14).

In addition to DEBI training as a general skill-building opportunity, intervention facilitators and prevention directors used the DEBI program and other researcher-developed, prepackaged curricula to expand and improve their services. One agency, for example, had earlier developed its own prevention program that primarily consisted of condom demonstrations because "14 years ago that's what a lot of people did." Over time, however, their understanding of prevention has changed:

We need to have an evidence-based model...It's not enough for people to feel better. They have to really have gone through some change and know how to implement the change. And so that was true with the HIV prevention as well. And we started hearing about them [DEBIs]. And funders started talking about them...We just were really into the outcomes...every program has an outcome study...You couldn't just run programs out of your instinct and that you really had to have some kind of evidence-based model. [JO16]

Researcher-developed interventions included in the DEBI program offered an alternative to agency-developed programs and represent the potential for more effective prevention efforts:

[The DEBI] was scientifically based. I mean, here's one, probably one of very few programs that is actually scientifically proven to work to reduce the spread of the disease, and, I mean, really, that is what we are here for...We're just sort of hoping that we're doing something that's effective. We have no research to back up and say that our [agency-developed] program is actually reducing HIV...There is no proven study of it done. So, I think it's a

good program, but, are we really wasting our time doing it? Going out and doing outreach: is that really the best use of our time? Or, on the other hand, we have a program that's proven [the DEBI intervention—JO] so why are we not already doing that program? So let's find out about it and see if we can implement it. [JO10]

CBO staff also attended DEBI training because the agency had made the decision, often in cooperation with funding agencies, to transition to evidence-based interventions and implement specific DEBI interventions:

It was a SAMHSA [Substance Abuse and Mental Health Services Administration] grant. And we wanted to find a good strategy to provide SAMHSA in the application. Normally we would just do it for outreach kinds of activities, [but] they weren't funding those activities alone anymore. They also wanted an evaluated program to accompany the applications. And Safety Counts seemed to fit best with what we were doing in the streets, working with active drug users, and it was just a good model for us. [JO17]

In summary, motivations to attend DEBI training included the need for skill-building for particular individuals, expertise development at the agency level, and a recognition that the agency's time and resources might be better spent on a program with evidence of effectiveness gained through rigorous scientific research.

Criticism of the DEBI Program

While providers were motivated to attend DEBI training based on pressure from external funding agencies and intra-agency desires to improve skills and programs, facilitators and directors were also critical of the DEBI program. Many of the interventions included in the DEBI program were developed with a commitment to participatory research during intervention development (Dworkin et al., 2008). Moreover, the CDC incorporated multiple channels for community feedback into the process of packaging and disseminating these interventions (Collins et al., 2006). Despite these efforts for collaborative intervention development and dissemination, interview participants were critical of what they saw as the "top down" approach to dissemination. In particular, they pointed to the inability of community organizations to provide feedback on the interventions after they are packaged for dissemination through the DEBI program, and the lack of recognition of the potential value of their "homegrown" programs:

I had co-workers and friends in the community who were at other CBOs and their perception was that they were, their programs were devalued because they weren't evidence-based. And I think it's just a stylistic difference. There could have been a way to say, "You know, this is really, you need to be showing that you're evidence-based. Here are some DEBIs that may fit in with what you are doing. Umm and let's all work together to have the best stuff," and made it feel more cooperative as opposed to a top down edict. And it really felt like a top down edict to a lot of people. [JO06]

Another criticism of the program was that the information contained in the training was too basic and not reflective of providers' skills and experiences:

Well, I felt it [the DEBI training] was pretty basic HIV intervention. I'm not just talking about HIV—I'm talking about the other factors in people's lives that have to do with HIV. So not only did we get education in just HIV stuff, but then also got it on alcohol and drugs, on healthy relationships and some other stuff...So it was like hearing information that I already know and it was interesting to see other people's styles of facilitation and stuff like that, but at the same time, it was like, you could have just given me the curriculum and I could have read it in a day instead of sitting there for five. [JO01]

"Fit" and Utility of DEBI Interventions

While some of the agencies included in this study had been involved in HIV prevention for only a few years and others for a few decades, all the agencies had decades-long histories of working with their particular target populations. In addition, prevention and other agency staff often identified as members of the communities with which the agencies worked. In reflecting on the relevance of CDC's DEBI interventions for their target populations, some service providers enthusiastically concluded that, "It was a match made in heaven" (JO16). However, most study participants offered more ambivalent assessments of the "fit" between a particular DEBI and their target populations. One agency, for example, tried to adapt MPowerment, developed for gay men between 18 and 29 years of age, for even younger audiences. Based on almost 10 years experience working with youth, however, this provider pointed out that MPowerment was inappropriate for his client population, even though of all the DEBIs, it targeted the most similar population:

It doesn't transfer 100 percent to youth; it doesn't transfer 50 percent to youth, I don't think. Just because it is a different social environment, it's different avenues of where you can do outreach for it...Youth are a little more timid than a 25-year-old, bar-going queer guy. And to ask a 14 year-old youth who has just come out of the closet, who isn't sexually active yet to go get other gay guys and bring them to this group—it just doesn't transfer 100 percent. [JO22]

Other issues concerning "fit" and utility centered on language, style, and cultural relevance of an intervention for target groups. For example, the VOICES/VOCES intervention, developed for heterosexual African American and Latino men and women who visit STD clinics, includes a video with both Spanish and English into the same video. Staff members from several agencies noted that their populations were monolingual, and would benefit from all-Spanish or all-English videos (JO05, JO12). Others complained that the videos were out-dated, inducing laughter among intervention participants (JO03, JO14) and causing the facilitator to apologize for the video:

Well, [I] just address it in the beginning. [I] just say, "This is old. I'm sorry they haven't made anything new. You will notice everybody's hair looks crazy and their clothes look really old. But the message is important and that hasn't changed so just kind of listen to it." So they get the laughing over with and then you kind of just go on to the rest of it. [JO14]

Providers also questioned whether an evidence-based intervention, tested with populations in other cities and regions of the country, could be expected to work with their particular constituency, despite apparent similarities. For example, a staff member of one CBO

doubted that MPowerment, an intervention targeting young MSM, would apply to their constituency, LGBT youth, because the "LGBT community is much larger [here] than it was in places that they piloted MPowerment...So *that* wouldn't work for us" (JO02). A staff member at another organization doubted that an intervention could be successfully transferred into a new setting. She wanted more evidence that it would work for her agency and target population:

I think the biggest thing was...it would have been nice to see a little bit more research about how effective this was in predominately communities of color. You know, the basic principles, I think, all carry over, but there wasn't—they had none of the pilot sites where, you know, predominately communities of color. And at the time, our population was 65% youth of color...with like 55% of African American, and none of the pilot sites really had that same population. [JO11]

Likewise, providers often perceived their populations to be different enough from the populations with which the intervention was originally developed that it would not work in a new context:

[Y]ou can't take this program that works here...and then take it to San Antonio, because that's a whole different population, and expect for it to be successful. You can take it and look at it and see what parts you would change...You would look at first of all it's about finding out who your population is...Yes, you said you want to target women, well what kind of women and where are the women? And who—what are they listening to now, what do they believe now? And how do you develop packages or how do you develop components that are going to resemble something that they are going to believe in and give them additional information? [JO18]

Finally frontline service providers doubt that "the populations we serve can be as predictable as some of the DEBIs" (JO17).

Discussion

Community-based AIDS organizations view research as important to advance HIV prevention and improve HIV-related treatment and care (Flicker et al., 2009). However, CBOs often lack the resources, infrastructure, and staff expertise to develop and sustain research programs on their own, and therefore frequently rely on projects developed and initiated in academic settings. The CDC's DEBI program illustrates one model of dissemination of researcher-developed interventions. CBO directors and staff in this study recognized the need to implement evidence-based HIV prevention programs but attended DEBI training for diverse reasons. Service providers attended DEBI training as one of many opportunities for skill-building and professionalization of services. That is, in addition to providing the requisite information and materials for implementing a specific evidence-based intervention, DEBI training offered other potential benefits to organizations, employees, and clients. Because both directors and potential facilitators viewed DEBI intervention training as part of more generalized skill-building processes, agencies often sent staff to training without a previously developed commitment to fully implement the

intervention as packaged and disseminated in the DEBI program. This effort to increase the prevention skills and knowledge of staff in general contradicts recommendations that organizations develop implementation plans prior to attending training (Wingood & DiClemente, 2008).

While agencies saw the benefits of incorporating evidence-based interventions into their HIV prevention programming, they were also critical of the DEBI program in particular. For providers, the DEBI process, including intervention development, determination of effectiveness, and dissemination, failed to recognize the contributions CBOs have made to prevention. Providers did not oppose the notion of evidence-based interventions, or incorporating these interventions into their prevention programming. Rather, they questioned the transferability and applicability of this evidence to their particular constituencies and agencies. They invoked the need for more specific evidence that can speak to the diversity many providers encounter among their clients. From the perspectives of CBO staff, this sense of a target population unique from those with which the DEBI was originally developed stems from long and intimate knowledge of the communities in which they work. It can affect the process of implementation, often resulting in modification of the DEBI intervention. Interview participants' comments suggest that CBO have worked for decades to become intimately familiar with their constituencies and target populations, and this knowledge forms the basis for doubts and questions about DEBI interventions.

The results of this study offer several places where the DEBI program can be changed to improve its acceptance by community organizations, especially in the areas of adaptation and follow-up. Service providers indicated that many of the DEBIs needed to be adapted to fit their particular organizational context, address the needs of their target populations, and respond to diversity within their constituency. However, they also recognized that, in order for an intervention to be considered a DEBI and retain the label "effective," it must be implemented with fidelity. Clearer guidelines as to aspects of an intervention that can be changed to respond to agency and client needs, and still retain its effectiveness, should be developed. Guidance on adaptation versus fidelity could be improved through increased follow-up after training. In addition to providing an opportunity for providers to ask questions regarding the implementation process and possibilities for modification of the intervention, follow-up could also contribute to an increased sense of accountability to implement the intervention. Finally, increased engagement of providers in the development of HIV prevention interventions, the dissemination process, and discussions about adaptation and fidelity could improve provider willingness to participate in the DEBI program, and give them a greater sense of ownership in the program. It would speak to agencies' efforts to legitimize their work, and acknowledge that they are as professional and expert in HIV prevention techniques and risk groups as researchers and public health officials.

Limitations and Future Research

This study presents several limitations. First, some interview questions asked participants to recall training and subsequent implementation experiences several years after they were completed. Interviewees often had difficulty recalling specific details about the

implementation process, including how decisions were made regarding DEBI "fit," what aspects of the prevention intervention were retained and which were changed, and particular aspects of the training. Second, due to the small sample size, it is difficult to make conclusions regarding differences in attitudes towards the DEBI program relative to position in the agency (i.e., director or facilitator), their relationship to organizational identity, and whether an agency implemented the intervention in which they were trained. In addition, the study consisted of a convenience sample of agencies from one state, decreasing the ability of the findings to be generalized to CBOs in states with different requirements regarding funding and the implementation of evidence-based interventions. Finally, the interviewees participated in trainings for very different interventions, conducted by very different facilitators and in different settings. The small sample size and research design do not allow for the effects of particular facilitators or training experiences to be explored.

This research project offers insights into the process through which researcher-developed, evidence-based interventions are disseminated to community-based organizations and implemented by these agencies. Because adoption, implementation, and modification processes are influenced by organizational factors, it is worth exploring how factors including organizational philosophy, affect implementation of a single DEBI. This research would also benefit from studies that compare the perspectives of agency directors and direct service providers are prevention needs, decision-making process regarding program adoption and implementation, and what barriers and facilitators exist to adoption and implementation. Furthermore, understanding the research-to-practice process will be critical for improving the extent of intervention dissemination and the ability of frontline service providers to implement these interventions. Further study of the implementation process needs to compare the preparations different types of agencies make in order to implement a new intervention, understand what agencies do with these interventions (e.g., how they modify them) when they do implement them, and explore how adopting these interventions changes the services agencies provide and the populations they are able to serve.

Acknowledgments

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Table 1

Agency Typology

Location	Services Offered	Target Population	Number of Interview Participants	Implement DEBI (current or past)?
Large urban area	Social support, community programs, HIV prevention, CTR	LGBTQ youth and adults	3	Yes
Large urban area	HIV/STD prevention, Needle exchange, comprehensive health services	Hispanic youth and adults	4	Yes
Large urban area (primary office)	Comprehensive HIV/AIDS services, including treatment and care; case management; and prevention	HIV positive individuals, all at- risk populations	8	Yes
Suburban area	Workforce development, food and nutrition programs, mental health counseling, health education	Hispanic community, African Americans, Whites	1	Yes
Large urban area	HIV prevention, social services	African American women, runaway youth	3	Yes
Medium urban area	HIV testing, support groups, job seeking, court-involved youth services	Runaway/Homeless youth; LGBTQ Youth	1	Yes
Large urban area	Capacity building and support for LGBTQ organizations	LGBTQ Youth, transgender	1	Yes
Large urban area	Workforce development, immigration services, education, social services, childhood development	Hispanic community	1	Yes