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# Harnessing "Scale-Up and Spread" to Support Community Uptake of the *HoMBReS por un Cambio* Intervention for Spanish-Speaking Men: Implementation Science Lessons Learned by a CBPR Partnership

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## Abstract

Latinx men in the southern United States are affected disproportionately by HIV and other sexually transmitted infections (STIs). However, few evidence-based prevention interventions exist to promote health equity within this population. Developed by a well-established community-based participatory research partnership, the *HoMBReS por un Cambio* intervention decreases sexual risk among Spanish-speaking, predominately heterosexual Latinx men who are members of recreational soccer teams in the United States. Scale-up and spread, an implementation science framework, was used to study the implementation of this evidence-based community-level intervention within three community organizations that represent typical community-based providers of HIV and STI prevention interventions (i.e., an AIDS service organization, a Latinx-serving organization, and a county public health department). Archival and interview data were analyzed, and 24 themes emerged that mapped onto the 12 scale-up and spread constructs. Themes included the importance of strong and attentive leadership, problem-solving challenges early, an established relationship between innovation developers and implementers, organizational capacity able to effectively work with men, trust building, timelines and incremental deadlines, clear and simple guidance regarding all aspects of implementation, appreciating the context (e.g., immigration-related rhetoric, policies, and actions), recognizing men's competing priorities, and delineated supervision responsibilities. Scale-up and spread was a useful framework to understand multisite implementation of a sexual risk reduction intervention for Spanish-speaking, predominately heterosexual Latinx men. Further research is needed to identify how constructs, like those within scale-up and spread, affect the process across the implementation continuum, given that the uptake and implementation of an innovation is a process, not an event.

## Keywords

Immigrants, special populations, sexual health, sexuality, qualitative research, research, sexually transmitted diseases/infections, physiological and endocrine disorders, men's health interventions

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The burden of HIV is particularly heavy in the southern United States, which accounted for more than half of new HIV diagnoses in the United States during 2018. That same year, HIV diagnosis rates per 100,000 population were 15.7 in the South, compared to 10.0 in the Northeast, 9.3 in the West, and 7.2 in the Midwest (Centers for Disease Control and Prevention [CDC], 2019a). Latinx[1] populations in the United States continue to carry a disproportionate burden of the HIV epidemic. While progress has been made in HIV prevention in the United States, HIV diagnoses increased about 6% among Latinx persons from 2010 to 2017. In 2018, adult and adolescent Latinx persons made up 27% of the 38,832 new HIV diagnoses in the United States and dependent areas.

Furthermore, gonorrhea, chlamydia, and syphilis rates are two to four times higher among Latinx persons than among non-Latinx Whites (Centers for Disease Control and Prevention, 2019b). All southeastern states, including Alabama, Arkansas, Georgia, Florida, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia, have higher than the national rates of HIV, gonorrhea, chlamydia, and/or syphilis (Centers for Disease Control and Prevention, 2019a, 2019b).

Southeastern states have experienced large increases in Latinx populations since the 1990s, increasing by nearly 700% between 1990 and 2015 (U.S. Census Bureau, 2015). These states have become recent Latinx settlement destinations, resulting from rapid growth of the Latinx population within the past three decades, while states such as California, Arizona, New Mexico, Florida, and Texas have had well-established Latinx populations for multiple generations (Gilbert et al., 2016; Gill, 2010; Kochar et al., 2005; Massey, 2008; Painter, 2008).

The CDC has identified and prioritized various prevention strategies as "high-impact HIV prevention." High-impact HIV prevention strategies are proven, cost-effective, and scalable (Purcell et al., 2016). The primary goals of high-impact prevention are to prevent new infections, save life-years, and reduce disparities among populations disproportionately affected. High-impact prevention includes (a) HIV testing, which provides a potential entryway to other prevention options that include linkage to or reengagement and retention in care for those living with HIV, (b) prevention for persons with HIV through treatment as prevention and undetectable = untransmittable [U = U], (c) condom distribution, (d) policy and other structural initiatives, and more recently (e) preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) for those who are not living with HIV but who are at behavioral risk for contracting the disease (McCree et al., 2018; Purcell et al., 2016). Uptake by many populations, including Latinx populations, of these prevention strategies is suboptimal, and community organization staff have continually requested increased access to and support for implementing evidence-based interventions to reduce HIV and STI inequities among Latinx populations in the United States (Alvarez et al., 2009; Frasca, 2008). Thus, there is a need to increase the implementation of high-impact prevention strategies across the HIV prevention and care continua.

*HoMBReS por un Cambio* is an evidence-based community-level intervention designed to increase HIV and STI prevention behaviors among Spanish-speaking, predominately heterosexual Latinx men who are members of recreational soccer teams in the United States. This study aimed to examine the implementation process of the evidence-based *HoMBReS por un Cambio* intervention within three geographically distinct community organizations that represent typical community-based providers of HIV and STI prevention interventions (i.e., an AIDS service organization, a Latinx-serving organization, and a county public health department). Scale-up and spread (Goga & Muhe, 2011; Rubenstein et al., 2010; Yano, 2011; Yano et al., 2012) was used as the conceptual framework to understand intervention implementation.

## Methods

### *Community-Based Participatory Research*

Community-based participatory research (CBPR) was applied throughout all phases of this study by a long-standing and well-established partnership in North Carolina. CBPR is a collaborative approach that blends the experience of community members who are experts in their own real-world, lived experiences and their community's needs, priorities, and assets and that of representatives from community organizations who have broad experience based in service delivery, with sound science to promote health equity through deeper and more informed understanding of health-related phenomena and the identification of actions (e.g., interventions, programs, policies, institution, and system changes) that are more relevant, culturally congruent, and likely to be effective, sustained, and scalable, if warranted. Study designs, including those used to evaluate these actions that are informed by multiple perspectives may be more authentic to the community and to the ways that community members naturally convene, interact, and take action. Interventions, for example, may be more innovative and recruitment benchmarks, including enrollment and retention rates, may be higher. Measurement may be more precise and data collection may be more acceptable, complete, and meaningful. Analysis and interpretation of findings may be more accurate. Sustainability and meaningful dissemination of findings may be more likely. Moreover, working *with* rather than merely *in* communities, partners

may strengthen a community's overall capacity to problem-solve through participation in the research process (Clinical and Translational Science Awards Consortium Community Engagement Key Function Committee Task Force on the Principles of Community Engagement, 2011; Committee to Review the Clinical and Translational Science Awards Program at the National Center for Advancing Translational Sciences, & Institute of Medicine, 2013; Kost et al., 2017; Rhodes, 2014).

Members of the CBPR partnership involved in this study included community members from Latinx and non-Latinx communities; representatives from local service and health-focused organizations, for example, public health departments (local and state levels); other community organizations (including Latinx soccer leagues and teams, Latinx-serving organizations, and HIV-serving organizations, and local foundations); staff at local businesses, including a video production company and *tiendas* (Latinx grocers); clinic providers and staff; scientists from CDC; and researchers from universities.

## *The* HoMBReS por un Cambio *Intervention*

*HoMBReS por un Cambio* is an intervention designed by a CBPR partnership to increase HIV and STI prevention behaviors among Spanish-speaking Latinx men. Based on the original *HoMBReS* intervention, which is included in the CDC *Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention* (https://www.cdc.gov/hiv/research/interventionresearch/compendium/index.html) as a best-evidence community-level intervention, it harnesses the existing social networks of recreational soccer teams and incorporates community health workers, known as *Navegantes*. *Navegantes* are chosen because they are lay, natural helpers to whom other community members turn for advice, emotional support, and tangible aid. With special training in peer navigation and ongoing support, they become sources of reliable HIV and STI information and resources within their existing social networks. The training curriculum is divided into four modules. The first module provides general information about the intervention and the magnitude of HIV and STIs in the Latinx community, "breaks the ice" to help men feel comfortable talking about sex and sexuality, and explores the roles of *Navegantes*. The second module focuses on learning how to protect oneself and one's partner. Module 3 focuses on men's sociocultural experience as men, and how values, norms, attitudes, and expectancies around gender, masculinity, and being a man influence risk and protective behaviors. Module 4 focuses on reviewing information learned, practicing helping relationships among men, and distributing materials used throughout intervention implementation. Each site was to recruit, train, and support eight *Navegantes* from eight different soccer teams. These eight *Navegantes* in turn were to work with eight local recreational soccer teams (18–22 teammates each).

While the original *HoMBReS* intervention was developed, tested, and shown to be effective, using a CBPR approach (Rhodes et al., 2009, 2006), the partnership revised it in five key ways. First, HIV and STI epidemiologic data were updated throughout the curriculum and video vignettes (components of the intervention used to trigger discussions). Second, because members of the partnership concluded that the intervention did not sufficiently address HIV and STI through a social justice lens, content and activities were added that linked HIV and STI disparities among Latinx populations with upstream health inequities. Third, during previous *HoMBReS* implementation, *Navegantes* reported that they wanted to use video vignettes, which had been used in their own training, in their work with members of their social networks (Vissman et al., 2009). Three video vignettes were rewritten and produced for broad use within the community. These vignettes included *Negociando el Uso del Condón* (Negotiating Condom Use); *Haciéndose Las Pruebas* (Getting Tested); and *Viviendo con el VIH* (Living With HIV). The vignettes were developed by the CBPR partnership and focused on men's lived experiences. For example, the Negotiating Condom Use vignette included a man negotiating condom use with a woman who thinks that either he is being unfaithful or he assumes she has HIV or an STI herself. All actors were local Latinx men. The Getting Tested vignette followed the experience of a Latinx man accessing and obtaining screening for HIV and STIs at a public health department. The Living With HIV vignette highlighted the experiences of a local Latinx heterosexual man living with HIV.

Fourth, despite the successes of the *HoMBReS* intervention, qualitative data collected previously suggested that *Navegantes* needed more training in having discussions around sex and sexual health (Vissman et al., 2009). Activities were augmented across the *Navegante* training modules that allowed *Navegantes* to incrementally practice (as homework) introducing the themes of HIV and STIs in natural settings (e.g., conversations with friends), helping friends (e.g., peer navigation), and addressing common attitudes and beliefs that compromise Latinx men's health. A *temas del mes* (theme of the month) component was added. This component was designed to help guide *Navegante*-led topics and activities each month throughout the 12-month intervention implementation period. For example, in the first month, an inauguration ceremony is held for each *Navegante* with his team to celebrate his training and affirm his availability to assist his teammates. In subsequent months, *Navegantes* focused on various topics with their teammates including

**Table 1.** Outline of the *HoMBReS por un Cambio* Intervention Curriculum for *Navegantes*.

| Module | Activities |
|---|---|
| **1. General information about *HoMBReS por un Cambio* and an introduction to sexual health** | 1. Introduction to the program; ice breaker; and the purpose of *HoMBReS por un Cambio*<br>2. Establishing ground rules for working together<br>3. Information about and the magnitude of HIV and STIs within the Latinx community<br>4. Find someone who activity<br>5. HIV and STIs<br>6. Sexual health vocabulary<br>7. Practicing your roles as *Navegantes* |
| **2. Protecting oneself and one's partners** | 1. Review of Module 1<br>2. Learning and practicing the correct use of a condom with condom use simulator<br>3. Practical advice: What one should and should not do when using a condom<br>4. Condom use steps<br>5. Negotiating condom use (DVD)<br>6. Internal condom use<br>7. Other ways to prevent HIV and STIs<br>8. Why some people use condoms and others don't<br>9. Talking about condom use with other men<br>10. Homework (Examples of different types of condoms) |
| **3. Cultural values and health** | 1. Review of Module 2<br>2. What does it mean to be a man?<br>3. How do cultural values affect men's behavior?<br>4. Confronting attitudes and beliefs that affect our health<br>5. Overcoming obstacles to accessing health services (DVD)<br>6. Learning how to help our friends and team mates effectively: Using the APOYO card (Rhodes, Daniel, et al., 2013) |
| **4. Overall review** | 1. Review of Module 3<br>2. *Navegante* role playing<br>3. *Navegante roles*<br>4. Review of the modes of transmission and prevention of HIV and STIs<br>5. Distinguishing the myths and realities about HIV and STIs<br>6. Living with HIV (DVD)<br>7. Evaluation of the *HoMBReS por un Cambio program*<br>8. Document your work using the Activity Log<br>9. How to use the theme of the month<br>10. Other ways this program will be evaluated<br>11. Final conclusions and materials distribution, including identification badges, DVDs, DVD players, *Navegante* bags with logos of all organizations, t-shirts, hats, STI prevention brochures, locally developed condom use brochures, condoms, and lube<br>12. Graduation and certificate distribution |

*Note*. STI = sexually transmitted infection.

HIV, chlamydia, gonorrhea, syphilis, and herpes. The final *HoMBReS por un Cambio Navegante* training curriculum is outlined in Table 1.

## *Implementation Toolkit*

Although the training guide and curriculum were well developed and included detailed checklists to ensure every detail associated with implementation was addressed, an Implementation Toolkit was developed to facilitate intervention uptake and implementation within the real world of practice, outside a research study, and within organizations with different strengths and experiences in terms of men's sexual health and Latinx populations. It included (a) an introduction to using the Toolkit, (b) a summary of the intervention and the evidence underlying it, (c) an outline of staffing, budget, and facilities needed to implement the intervention, (d) an explanation of the role of the *Navegante* in risk reduction, (e) HIV and STI information, including prevalence and incidence, transmission, prevention, testing, treatment, and care, (f) information on the immigration context and its impact on Latinx persons, (g) hints to maximizing cross-cultural collaborations, (h) tips to building trust and successfully working with Latinx recreational soccer leagues, (i) instructions for using the training curriculum, (j) guidelines on how to identify and access local resources for screening and treatment, (k) protocols to

maintain participant safety and confidentiality, (l) directions and materials for fidelity and impact measurement, and (m) ideas to prepare for sustainability.

The Toolkit included appendices to support implementation including a sample project coordinator job description; a sample *Navegante* recruitment flyer in both Spanish and English; talking points to "sell" the project during *Navegante* recruitment; templates for materials for *Navegante* training sessions, such as an appointment card reminder for the next session, certificate of *Navegante* training completion, and *Navegante* identification badge; sample confidentiality agreements; and guidance on using Excel to make lists, tables, and charts to track participants and enter and analyze simple evaluation data.

### Scale-Up and Spread

After the enhancement of the intervention and development of the Toolkit, the partnership used scale-up and spread (Goga & Muhe, 2011; Rubenstein et al., 2010; Yano, 2011; Yano et al., 2012), a conceptual framework informed by diffusion and social normative theories (McQuail, 1987; Rogers, 2003; Tabak et al., 2012), to systematically uncover the supports needed to promote and improve implementation of *HoMBReS por un Cambio* within the three distinct organizations. Scale-up and spread provides a framework for implementing the implementation processes of an innovation. Constructs of scale-up and spread are (a) strong organizational leadership and commitment to the innovation, (b) believability of evidence supporting the innovation, (c) existence of a champion, (d) organizational capacity, (e) well-trained workforce (e.g., project coordinators), (f) engagement and commitment of stakeholders, (g) detailed and staged guidance, (h) role modeling, (i) thorough planning, (j) easy and timely access to resources, (k) understanding of and planning for different contexts, and (l) ongoing evaluation and quality improvement (Goga & Muhe, 2011; Rubenstein et al., 2010; Yano, 2011; Yano et al., 2012).

### Data Collection and Analysis

Two sources of data were used to explore implementation across the three organizations: (a) archival data and (b) individual and small-group in-depth interviews. Archival data included partnership meeting notes, progress reports, conference presentations, and notes from biweekly meetings between the Wake Forest School of Medicine (WFSM) partners and each organization. Interviews were conducted with a sample of project staff and leadership at each organization, including project coordinators ($n = 3$), project coordinator supervisors ($n = 3$), executive directors/county public health department directors ($n = 3$), financial managers ($n = 3$), development directors ($n = 3$), and board members ($n = 4$) at each organization at two time points, between 2016and 2018, during project implementation and after implementation had ceased. Intervention implementation lasted 12 months. Interview data were collected by trained interviewers who were recognized experts in and published broadly on innovative approaches to both qualitative research and CBPR. See Table 2 for a list of sample abbreviated items from the interview guide that was used for both individual and small-group interviews.

After each interview, the interviewers read through their notes and formulated initial impressions. Archival and in-depth interview data were triangulated iteratively. Archival materials for the same organization were reviewed simultaneously to ensure a thorough contextual understanding of each interview conducted at the same organization. Constant comparison (Miles & Huberman, 1994) was used to analyze data. Constant comparison combines qualitative coding with simultaneous comparison; initial observations are continually refined throughout data collection and analysis. The aim was to identify themes and subsequently map them onto scale-up and spread constructs, as appropriate, not to quantify participant or site experiences. Each analyst developed a matrix to identify similarities and differences within and across data collection time points (during and after intervention implementation), site, and participant categories (project coordinator, project coordinator supervisor, executive director/county public health department director, financial manager, development director, and board member) (Miles & Huberman, 1994). Although data were collected at two time points, the aim was not to identify change over time. Rather, the aim was to gain an understanding of the implementation process of an evidence-based community-level intervention by uncovering themes that provide insight into the implementation of the intervention, using a novel implementation science framework. Based on these matrices, each analyst developed preliminary themes. After preliminary themes were developed, the analysts came together, discussed, and reconciled final themes. These themes were subsequently mapped onto the constructs of scale-up and spread. The CBPR partnership refined and validated findings using an approach that included three empowerment-based meetings (Rhodes et al., 2011) to review themes and their placement within scale-up and spread constructs, discussion, refinement, and interpretation.

Human subject approval and oversight was provided by the Wake Forest School of Medicine Institutional Review Board (IRB), approval #00022676. Signed informed consent from each participant was obtained.

## Results

We identified 24 themes that are organized and presented by scale-up and spread constructs. Illustrative quotations are provided (Table 3).

**Table 2.** Abbreviated Sample Items From the In-Depth Interview Guide.

| |
|---|
| **Background** |
| What your role in this organization? |
| What was the impetus for being involved with this intervention/project? |
| **Organizational Fit** |
| What would you say are the top 3-5 priorities of the organization? |
| Compared to other priorities, how high a priority is HIV prevention? |
| Compared to other priorities, how high a priority is Latinx health? |
| Compared to other priorities, how high a priority is Latinx sexual health? |
| What are the programs and services currently offered by the organization? |
| Tell me about your organization's experience working with men. |
| Tell me about programs specifically offered for Latinx men. |
| What initiatives does your organization have to improve Latinx men's health? |
| What initiatives does your organization have to improve Latinx men's sexual health? |
| **Leadership and Commitment** |
| How was the decision made to implement *HoMBReS por un Cambio*? |
| Whose decision was it? |
| How was support within your organization garnered for implementation? |
| How was support outside of your organization garnered for implementation? |
| **Believability of the Evidence** |
| What are your thoughts about the underlying evidence around *HoMBReS por un Cambio*? |
| How confident were you in obtaining risk reduction outcomes? |
| **Organizational Capacity** |
| What resources/supports/capacities did your organization have to support work on Latinx men's sexual health? |
| What did your organization do to prepare to work with Latinx men's sexual health? |
| **Through Planning** |
| What supports were needed to implement *HoMBReS por un Cambio*? |
| What supports were needed? |
| What challenges to implementation did you experience? |
| How were they migrated? |
| What concerns do you have about *HoMBReS por un Cambio* as an intervention? |
| What strengths do you see? |
| How were decisions made? |
| **Well-Trained Workforce** |
| What drew you to your role? |
| What additional support or training might you have needed? |
| How sustainable is this intervention/project? |
| How do you think this intervention/project or its activities will be funded down the road? |
| **Evaluation** |
| How would you define success for this intervention/project? |
| How could these successes be best measured or documented? |
| How would you know whether your goals and objectives were met, how would you suggest it be evaluated? |
| What mechanisms currently exist for evaluation? |

## *Strong Organizational Leadership and Commitment to Innovation*

Across organizational types, strong and attentive leadership and commitment to implementing the *HoMBReS por un Cambio* intervention were identified as critical to identifying challenges and problem-solving solutions in a timely manner. Stakeholders, including staff and participants, became discouraged when challenges were not addressed immediately. For example, in one organization, the project coordinator had difficulty engaging the soccer league. He reported that he did not feel that he had the support and resources of his organization, and thus he became discouraged and the project was increasingly delayed and less successful. Thus, although organization staff were interested in implementing the intervention (e.g., the innovation), the organization lacked leadership and commitment.

## *Believability of the Evidence Supporting the Innovation*

Second, staff at all organizations reported having great confidence in the intervention and its underlying evidence base. Staff also viewed the intervention curriculum as meaningful

**Table 3.** Scale-Up and Spread Constructs, Themes, and Illustrative Quotations.

**Strong organizational leadership and commitment to innovation**

1) Need for strong and attentive supervision to problem solve before challenges grow and/or discourage staff, stakeholders, and participants

"We were slow; our organization was challenged early on, and it brought down the motivation of everyone involved like the coordinator and the soccer league."*

**Believability of evidence supporting the innovation**

2) Intervention was viewed as strong, evidence based, and meaningful

3) History built with the WFSM partners supported confidence in the intervention

"[Our site] has been working with [the WFSM team] for over a decade on different interventions. We have seen our work together be successful and grow. We have wanted to implement *HoMBReS* for many years so this was a special opportunity for us."*

**Existence of a champion**

4) A champion existed at each organization, but the project coordinator must also be a champion

"What do I think was key? My own enthusiasm [as the project coordinator]. I had to work with everyone to move this intervention forward. I had to do a lot of convincing and a lot of cheerleading."*

5) Commitment of a soccer league champion was critical

"It goes without saying that the soccer teams have to be onboard."*

**Organizational capacity**

6) All organizations had limited experience and capacity working closely with heterosexual men

"I really hate to say this, but this project has taught our organization that we need to increase our capacity to work with men. We work with them, but we really work with families, and that is different. We didn't know this about ourselves when we started this work together."*

7) Security guard and sign-in requirements at the entrances of the buildings that housed some organizations were barriers to men's participation

8) Flexibility at organizations was important

"We changed a number of policies at [our organization] to facilitate this work."*

**Well-trained workforce (e.g., project coordinators)**

9) Difficult to find qualified men who can work with other men; project coordinator must have documentation that allows him to work in the US, meet education requirements, have reliable transportation/valid driver's license, and be bilingual (in most cases)

10) Competing with higher paying jobs

"There are so many challenges to finding the right coordinator to do this work. I'd say it is particularly difficult given that some ideal coordinators can't legally work in the US. The other issue we faced is that men can find another higher paying job, and most have already."*

**Engagement and commitment of stakeholders**

11) Building relationships with soccer leagues took time

12) Many Latinx men are not accustomed to participating in health-related programming

"Getting men to think about their health was really a battle that our team had to overcome. They didn't want to participate in something health related; maybe they would have if we had included their families."*

13) Many Latinx men, particularly heterosexual men, held stigmatized attitudes about HIV and STIs

"I know [the Wake Forest team] has had lots of success working with Latino men around issues of sex and HIV. But this seemed hard, in our case, in our community. HIV is still viewed as a gay disease, and that's unfortunate, I hate to say it, but it is true."*

14) Discussions of sexual health were seen as taboo among some Latinx men

**Detailed and staged guidance**

15) Timelines with short-term objectives and incremental deadlines are necessary for implementation success

"I appreciated the freedom we have been given, but trust me, as an organization, we need to hear about expectations, benchmarks, deadlines, and deliverables, often."*

16) Difficult to teach and to learn how to build trust

"Sometimes we take trust for granted, but building rapport with groups, like the local soccer teams, that we haven't previously [built rapport with], is really much harder than presumed."*

**Role modeling**

17) Onsite role modeling is critical

"We sometimes needed more onsite support. We needed someone from the team [at WFSM or from other sites] who knows how to do the work, like recruitment, who has done it before."*

**Thorough planning**

18) Clear and useful materials including the Implementation Toolkit are critical to successful implementation

"The materials for implementation were useful and comprehensive."*

*(continued)*

**Table 3. (continued)**

| |
|---|
| **Easy and timely access to resources** |
| 19) Implementation Toolkit was identified as useful |
| 20) Organization-specific approval processes created obstacles to beginning implementation |
| "We have many layers for approvals to work in partnership, well, not really in partnership. Partnership is fine, but if there is any exchange of money or materials or resources, things get dicey."* |
| **Understanding of and planning for different contexts** |
| 21) Urgency of concrete office activities and responsibilities for project coordinator can take precedence over long-term and more abstract field work in the community |
| "I know it was tough for the coordinator to leave the office and face the community sometimes. This is hard work. It can be easier to get involved with what is going on in the office. There's always something to do, some type of drama here."* |
| 22) Anti-immigration rhetoric dramatically reduced community trust, buy-in, enrollment, participation, and retention |
| "This country has become so anti-Latino. It makes everything we do in the community not just a little bit but a lot harder."* |
| 23) Latinx men have competing priorities, that include affordable housing, food security, and immigration |
| **Ongoing evaluation and quality improvement** |
| 24) Organizations did not provide consistent guidance and supervision for project implementation locally; they assumed that the WFSM partners were providing supervision |
| "We are all busy, but you know the saying, trust then verify. I think a bit more supervision from the Wake [Forest] team would have been useful so we didn't fall behind."* |

*Note*. *Because of the sample size and to maintain participant privacy, attribution of quotations by organization or by role is not provided. WFSM = Wake Forest School of Medicine.

for their local population of Latinx men. At the same time, they reported that the history of working collaboratively with the WFSM partners over many years and over multiple studies related to HIV, STI, and immigration policy contributed heavily to their confidence in the intervention.

## *Existence of a Champion*

While the importance of having an intraorganizational champion was highlighted, it was noted that the project coordinator, the staff member in the field ensuring intervention implementation, must also be a champion. It was the project coordinator who was responsible for moving intervention implementation forward, including *Navegante* recruitment, training, and support. Further, the soccer league had to have a champion, someone within the league who was committed to the intervention and would prioritize its implementation.

## *Organizational Capacity*

Another theme that emerged was that staff at each organization had limited experience and capacity working closely with adult heterosexual men. While men are involved in some limited programming at each organization, programing that includes men is typically family based—men participate with their female partners and/or female partners and children. One organization had experience implementing programs for and conducting research with gay, bisexual, and other men who have sex with men (GBMSM) but did not have experience working with adult heterosexual men beyond simple and infrequent service delivery (e.g., walk-in HIV testing).

Two organizations had structural barriers that impeded their ability to work with Latinx men; they had security guards at their entrances. These security guards were identified as barriers because of the fear related to discrimination based on real or perceived race/ethnicity and/or immigration status. Many Latinx persons, including Latinx men, are understandably fearful of engaging with systems and processes that may risk interactions with law enforcement and potential profiling. Furthermore, one organization was housed in a building that had a sign-in process for visitors entering the building; this sign-in process was identified as a barrier for men to engage with the organization.

Organization flexibility emerged as critical to intervention implementation. Because recreational soccer league and team meetings, practices, and games tend to occur in the evenings and on weekends, organizations had to develop policies and procedures that allowed staff to work outside of the office and outside of typical office hours (i.e., 9 a.m.–5 p.m.) on a regular basis. While staff from organizations reported that they may host activities and events outside of typical office hours, they also reported that this is an exception, not a rule. Organizations had to develop new policies related to supervision, mileage, safety, and flex/comp time.

## *Well-Trained Workforce*

Staff at the three organizations reported difficulty finding qualified men to serve as project coordinators and to be trained to work with other men. Hiring a project coordinator who was similar to the population of Latinx men who participate in recreational soccer teams was

identified as an important component of the intervention. It was difficult to find potential project coordinators who had documentation to permit U.S. employment, the requisite educational attainment, reliable transportation and/or a valid driver's license, and bilingual language skills. Those who met requirements could often find higher paying jobs elsewhere.

### *Engagement and Commitment of Stakeholders*

Building relationships with soccer leagues and teams took time. The original *HoMBReS* intervention was implemented after 2 years of trust building and formative research conducted though CBPR approaches (Rhodes, Duck, Alonzo, Downs, & Aronson, 2013). However, in this implementation study, soccer leagues and teams were new to partnership, and the three organizations had either no or very limited relationships with Latinx recreational soccer leagues and teams. Thus, it took a great deal of time to build the foundational relationships with the soccer leagues and teams before planning for intervention implementation. This included trust building and raising soccer team member awareness about the impact of HIV and STIs.

Moreover, many Latinx men were not accustomed to participating in health-related programming. They were less concerned about HIV and STIs and had many other priorities, including upstream social determinants of health such as affordable housing, food security, job training, occupational safety, and immigration as well as child health. Many Latinx men held negative attitudes about HIV and STIs; HIV and STIs were seen as "gay" diseases or disease affecting those who are "promiscuous." Finally, sexual health was seen as a taboo topic among some Latinx men that made implementation difficult. Thus, many men did not want to participate in sexual health–related activities.

### *Detailed and Staged Guidance*

Another theme that emerged was the importance of timelines and benchmarks. While the WFSM partners wanted each staff member from each organization to work at the individual's own pace; staff reported a need for more defined timelines and incremental deliverables. Despite the acknowledged usefulness of the Toolkit, it was difficult for each organization to conduct some of the more abstract tasks associated with implementation. For example, building trust with soccer leagues and teams was a module within the Toolkit, but trust building is difficult to teach and to learn. It takes great creativity, trial and error, relationship building, and time in the field.

### *Role Modeling*

The importance of onsite role modeling was also highlighted. Although WFSM partners met with each organization (typically by conference call) every 2 weeks during intervention preimplementation planning, implementation, and evaluation to provide guidance and support, staff at each organization indicated that they needed and wanted more onsite guidance. Staff reported the value of vicarious learning and role modeling and suggested that it would have been beneficial if the partners who had experience in intervention-related activities such as recruitment, implementation, and data collection had spent more time working with staff and in the field coaching the project coordinator at each organization.

### *Thorough Planning*

It emerged that planning materials were critical to successful implementation. Interview participants noted that the checklists that were included in the *Navegante* training curriculum for each module were comprehensive and helped them organize phases of the study including intervention planning, implementation, and evaluation.

### *Easy and Timely Access to Resources*

The Toolkit was identified as particularly useful. It was stored in the cloud and easily accessible to each organization. With clear organization and lay language, it had information for all levels of organization staff. Executive directors, supervisors, and project coordinators could find what they needed to understand the context of the intervention and the steps and tasks involved in its implementation.

An identified challenge was related to establishing the subcontract with the participating public health department. Because the local County Board of Health had to approve the acceptance of funding through a subcontract with WFSM, the project was delayed substantially given the bureaucratic process required. Health department staff were eager to implement, but policy and regulation barriers were nearly insurmountable.

### *Understanding of and Planning for Different Contexts*

A challenge faced by each organization included what an interviewee referred to as "the tyranny of the urgent." Each day, the project coordinator faced urgent and concrete office-based activities and responsibilities that tended to take precedence over long-term and more abstract fieldwork of trust building, recruitment, data collection, training and supporting *Navegantes*, and supporting *temas del*

*mes* sessions. These activities did not seem as urgent as helping colleagues in the office with assisting clients who walked in the door, Spanish-language translations, planning special events, fundraising, and so forth.

Anti-immigration rhetoric, policies, and actions, which have increased dramatically across the United States over the past few years, dramatically reduced community trust, buy-in, and participation during intervention implementation. The pervasive social–political environment and negative messaging related to immigration and the movement to enforce and make immigration laws stricter has had a profound impact on trust and ease in which Latinx persons feel comfortable moving about communities and doing other things besides the essential (e.g., work and meeting the basic needs of themselves and their families; Mann-Jackson et al., 2018). These contextual issues highlight the critical nature of community-engaged work and the importance of advocacy for health promotion and social justice.

### *Ongoing Evaluation and Quality Improvement*

There was limited guidance and supervision to ensure timely completion of tasks related to planning and implementation and mechanisms for quality improvement. Staff from organizations assumed that the WFSM partners were providing supervision and feedback to the project coordinator, and the WFSM partners assumed that staff from the organizations were providing guidance. Being clear about roles is necessary because capacities can change quickly. Further, a change in organization leadership can fully halt CBPR studies (Rhodes et al., 2014); thus, revisiting roles over time may be warranted.

## Discussion

Scale-up and spread was a useful implementation science framework to explore the uptake and implementation of the *HoMBReS por un Cambio* intervention to promote sexual health risk reduction behaviors among Spanish-speaking, predominately heterosexual Latinx men who are members of recreational soccer leagues and teams in the United States. In this study, 24 themes emerged that mapped onto the 12 constructs of scale-up and spread. Identified as critical to the implementation process included strong and attentive supervision to identify and problem-solve challenges before they jeopardize implementation success. However, there must be clarity regarding who is responsible for supervision. In this study, there was some confusion among sites about whether the individual site, the university-based research team, or the CBPR partnership was responsible for project coordinator supervision and implementation of the intervention in the field.

Furthermore, much of the believability of the evidence supporting *HoMBReS por un Cambio* was attributed to a history of working together through CBPR. The WFSM team that was involved in the development of the intervention and this implementation study had been working in partnership with each of the organizations involved for over a decade and had a solid reputation based on previous successes (Rhodes, 2012; Rhodes, Alonzo, et al., 2018; Rhodes, Duck, Alonzo, Daniel, et al., 2013; Rhodes et al., 2017, 2014, 2016; Rhodes, Tanner, et al., 2018). This history was identified as contributing to intervention uptake and implementation at each organization. Not all innovations designed to promote health equity will have this level of support and the foundation of confidence by those responsible for implementing an innovation.

While the importance of a champion within a leadership role to ensure uptake and implementation is well documented, the person with "boots on the ground" must be a champion. The *HoMBReS por un Cambio* project coordinator must not only be Latinx, fluent in Spanish, authorized to work in the United States, and have a valid driver's license, but he must be enthusiastic and committed to the innovation and its implementation.

Of course, organizational capacity was identified as critical, but findings suggested that community organizations may have limited expertise working with Latinx men. Men experience profound disparities and at the individual and community levels, it is imperative to overcome the barriers that limit men's engagement with resources that could reduce these disparities. These barriers are not entirely in the control of staff within organizations; traditional notions of gender and masculinity, for example, have been identified as contributing to men's hesitation to seek and ask for help when needed (Daniel-Ulloa et al., 2017; Rhodes et al., 2007). Organizations could benefit from better understanding men's needs, priorities, and preferred ways of convening and getting things done and developing men-focused programming. CBPR will be essential to this work.

Onsite role modeling for organization staff by those experienced in working with Latinx men and implementing *HoMBReS por un Cambio* emerged as critical. Often organization staff identify the challenges related to improved health and well-being among communities and populations but they lack sufficient previous experiences and resources to effectively address them successfully. Having ongoing and direct guidance from someone with more experience that aligns with activities associated with implementing the innovation can contribute to its successful implementation.

Work remains to be done in terms of reducing negative preconceived notions, attitudes, and biases about sex, sexuality, and same sex attraction, behavior, and

orientations among Latinx men and within communities and at the population level. These notions, attitudes, and biases are detrimental for those holding them as well as their peers.

Immigration issues emerged as affecting implementation. Many communities and populations, including Latinx men, are subject to increased racial profiling based on assumptions about race/ethnicity, nationality, and immigration status. This profiling profoundly and understandably affects perceived safety and willingness to access all types of existing services that communities and populations need and are eligible for (Rhodes et al., 2015). In the case of *HoMBReS por un Cambio*, this context affected its uptake and implementation; Latinx men were hesitant to participate in the study and the study timeline was tight in terms of trust building.

Finally, this study highlighted the importance of a comprehensive Toolkit in supporting uptake and implementation of the *HoMBReS por un Cambio* intervention. This Toolkit was designed to meet the needs of all levels of the organization including leadership, development managers, and other staff to ensure successful uptake and implementation and support sustainability as warranted.

### *Scale-Up and Spread*

Successful and broad implementation of innovations (such as *HoMBReS por un Cambio*) is critical to increasing health equity. There has been a call for research to develop and explore comprehensive and efficient frameworks to promote the uptake and implementation of innovations across disciplines with careful attention to the unique aspects of different innovations, settings (including community settings), and diverse end users (Moullin et al., 2015). Scale-up and spread is a promising theory-based implementation framework with clear and distinct constructs. However, the framework has not been widely used, and more research is needed to better operationalize the constructs within community-based settings. Research is also needed to identify how constructs function across the implementation continuum because the implementation of an innovation, like *HoMBReS por un Cambio*, is a process, not an event. There are components along the implementation continuum that must be better understood and articulated as an innovation is implemented. These components include the characteristics of the innovation itself (e.g., whether at the individual, community, institutional system, or policy level), the phases/stages of implementation (what it takes to implement the specific innovation), the context in which the implementation is to occur, influencing facilitators and barriers, strategies applied to promote uptake and implementation, and types and levels of evaluation and feedback loops.

### *Limitations*

While this study included multiple organizations, only one organization of each type was included; this study included an AIDS service organization, a Latinx-serving organization, and a county public health department. Studies that included more organizations of each type could differentiate themes by organization type; however, this study provides preliminary data to guide implementation of evidence-based interventions designed to promote health equity in real-world practice.

This study was also conducted before the widespread promotion and availability of PrEP for populations at increased risk for HIV. Given the successes of interventions that harness the strengths of natural helping through community health workers, lay health advisors, and peer navigators (Eng et al., 2009), enhancements of this intervention could be made to include PrEP as another option to reduce HIV risk. However, PrEP does not protect against other STIs, which are a priority among Latinx men.

## Conclusions

While CBPR ensured that *HoMBReS por un Cambio* reflected the real-world, lived experiences of Spanish-speaking, predominantly heterosexual Latinx men, much work was necessary to ensure uptake and implementation in communities and within organizations that were new to the intervention. Furthermore, particular attention must be paid to establishing rapport and trust with communities that are marginalized, better defining the roles and responsibilities of champions, and including onsite coaching to ensure efficient and effective implementation of an innovation like *HoMBReS por un Cambio*.

Scale-up and spread was a useful framework to identify factors that support and guide uptake and implementation of a carefully tailored intervention designed to promote men's health. Innovations, such as *HoMBReS por un Cambio*, which bolster positive and reframe negative sociocultural values and expectations of gender, masculinity, and what it means to be a man must be implemented broadly. However, implementation can be difficult, and research is needed to improve uptake and implementation. There are no panaceas to the challenges associated with uptake and implementation of innovations designed to promote health equity; however, existing frameworks like scale-up and spread are promising and could benefit from further exploration.

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## Note

1. Latinx is a gender-neutral term used in lieu of Latina and Latino (Martinez & Rhodes, 2020).

## References

Alvarez, M. E., Jakhmola, P., Painter, T. M., Taillepierre, J. D., Romaguera, R. A., Herbst, J. H., & Wolitski, R. J. (2009). Summary of comments and recommendations from the CDC consultation on the HIV/AIDS epidemic and prevention in the Hispanic/Latino community. *AIDS Education and Prevention, 21*(5 Suppl), 7–18. doi: 10.1521/aeap.2009.21.5_supp.7

Centers for Disease Control and Prevention. (2019a). HIV surveillance supplemental report 2019. US Department of Health and Human Services, https://www.cdc.gov/hiv/images/library/infographics/continuum-infographic.png

Centers for Disease Control and Prevention. (2019b). *Sexually transmitted disease surveillance, 2018*. US Department of Health and Human Services.

Clinical and Translational Science Awards Consortium Community Engagement Key Function Committee Task Force on the Principles of Community Engagement. (2011). *Principles of community engagement* (2nd ed.). Department of Health and Human Services.

Committee to Review the Clinical and Translational Science Awards Program at the National Center for Advancing Translational Sciences, & Institute of Medicine. (2013). *The CTSA program at NIH: Opportunities for advancing clinical and translational research*. doi: NBK144067.10.17226/18323 [doi]. National Academies Press.

Daniel-Ulloa, J., Sun, C., & Rhodes, S. D. (2017). The intersection between masculinity and health among rural immigrant Latino men. *International Journal of Men's Health*, *16*(1), 84–95.

Eng, E., Rhodes, S. D., & Parker, E. A. (2009). Natural helper models to enhance a community's health and competence. In R. J. DiClemente, R. A. Crosby, & M. C. Kegler (Eds.), *Emerging theories in health promotion practice and research* (Vol. 2, pp. 303–330). Jossey-Bass.

Frasca, T. (2008). *Shaping the new response: HIV/AIDS and Latinos in the deep south*. Latino Commission on AIDS.

Gilbert, P. A., Barrington, C., Rhodes, S. D., & Eng, E. (2016). Saliendo Adelante: Stressors and coping strategies among immigrant Latino men who have sex with men in a non-traditional settlement state. *American Journal of Men's Health*, *10*(6), 515–525.

Gill, H. (2010). *The Latino migration experience in North Carolina: New roots in the old north state*. University of North Carolina.

Goga, A. E., & Muhe, L. M. (2011). Global challenges with scale-up of the integrated management of childhood illness strategy: Results of a multi-country survey. *BMC Public Health*, *11*, 503. doi: 10.1186/1471-2458-11-503

Kochar, R., Suro, R., & Tafoya, S. (2005). The new Latino south: The context and consequences of rapid popuation growth. *Pew Research Center*. http://www.pewhispanic.org/2005/07/26/the-new-latino-south/

Kost, R. G., Leinberger-Jabari, A., Evering, T. H., Holt, P. R., Neville-Williams, M., Vasquez, K. S., Coller, B. S., & Tobin, J. N. (2017). Helping basic scientists engage with community partners to enrich and accelerate translational research. *Academic Medicine*, *92*(3), 374–379. doi: 10.1097/acm.0000000000001200

Mann-Jackson, L., Song, E. Y., Tanner, A. E., Alonzo, J., Linton, J. M., & Rhodes, S. D. (2018). The health impact of experiences of discrimination, violence, and immigration enforcement among Latino men in a new settlement state. *American Journal of Men's Health*, *12*(6), 1937–1947. doi: 10.1177/1557988318785091 [doi]

Martinez, A. D., & Rhodes, S. D. (2020). Introduction: Disentangling language and the social determinants of Latinx health in the United States. In A. D. Martinez & S. D. Rhodes (Eds.), *New and emerging issues in Latinx health* (pp. 1–15). Springer.

Massey, D. (2008). *New faces in new places: The changing geography of American immigration*. Russell Sage Foundation.

McCree, D. H., Walker, T., DiNenno, E., Hoots, B., Valverde, E., Ocfemia, M. C. B., Heitgerd, J., Stallworth, J. A., Ferro, B., Santana, A., German, E. J., & Harris, N. (2018). A programmatic approach to address increasing HIV diagnoses among Hispanic/Latino MSM, 2010–2014. *Preventive Medicine*, *114*, 64–71. doi: 10.1016/j.ypmed.2018.06.007

McQuail, D. (1987). *Mass communication theory: An introduction* (2nd ed.). Sage.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Sage Publications.

Moullin, J. C., Sabater-Hernandez, D., Fernandez-Llimos, F., & Benrimoj, S. I. (2015). A systematic review of implementation frameworks of innovations in healthcare and resulting generic implementation framework. *Health Research and Policy Systems*, *13*, 16. doi: 10.1186/s12961-015-0005-z [doi]

Painter, T. M. (2008). Connecting the dots: When the risks of HIV/STD infection appear high but the burden of infection is not known–the case of male Latino migrants in the southern United States. *AIDS and Behavior*, *12*(2), 213–226. doi: 10.1007/s10461-007-9220-0

Purcell, D. W., McCray, E., & Mermin, J. (2016). The shift to high-impact HIV prevention by health departments in the United States. *Public Health Reports*, *131*(1), 7–10. doi: 10.1177/003335491613100104 [doi]

Rhodes, S. D. (2012). Demonstrated effectiveness and potential of CBPR for preventing HIV in Latino populations. In K. C. Organista (Ed.), *HIV prevention with Latinos: Theory, research, and practice* (pp. 83–102). Oxford.

Rhodes, S. D. (2014). Authentic engagement and community-based participatory research for public health and medicine. In S. D. Rhodes (Ed.), *Innovations in HIV prevention research and practice through community engagement* (pp. 1–10). Springer.

Rhodes, S. D., Alonzo, J., Mann Jackson, L., Tanner, A. E., Vissman, A. T., Martinez, O., Rodriguez-Celedon, R., Garcia, J. M., Arellano Hall, J. E., Song, E. Y., Eng, E., & Reboussin, B. A. (2018). Selling the product: Strategies to increase recruitment and retention of Spanish-speaking Latinos in biomedical research. *Journal of Clinical and Translational Science*, *2*(3), 147–155.

Rhodes, S. D., Daniel, J., Alonzo, J., Duck, S., Garcia, M., Downs, M., Hergenrather, K. C., Alegría-Ortega, J., Miller, C., Boeving Allen, A., Gilbert, P. A., & Marsiglia, F. F. (2013). A systematic community-based participatory approach to refining an evidence-based community-level intervention: The HOLA intervention for Latino men who have sex with men. *Health Promotion Practice*, *14*(4), 607–616.

Rhodes, S. D., Duck, S., Alonzo, J., Daniel, J., & Aronson, R. E. (2013). Using community-based participatory research to prevent HIV disparities: Assumptions and opportunities identified by the Latino partnership. *Journal of Acquired Immunodeficiency Syndromes*, *63*(Supplement 1), S32–S35.

Rhodes, S. D., Duck, S., Alonzo, J., Downs, M., & Aronson, R. E. (2013). Intervention trials in community-based participatory research. In D. Blumenthal, R. J. DiClemente, R. L. Braithwaite, & S. Smith (Eds.), *Community-based participatory research: Issues, methods, and translation to practice* (pp. 157–180). Springer.

Rhodes, S. D., Eng, E., Hergenrather, K. C., Remnitz, I. M., Arceo, R., Montano, J., & Alegria-Ortega, J. (2007). Exploring Latino men's HIV risk using community-based participatory research. *American Journal of Health Behavior*, *31*(2), 146–158.

Rhodes, S. D., Hergenrather, K. C., Bloom, F. R., Leichliter, J. S., & Montano, J. (2009). Outcomes from a community-based, participatory lay health adviser HIV/STD prevention intervention for recently arrived immigrant Latino men in rural North Carolina. *AIDS Education and Prevention, 21*(5 Suppl), 103–108. doi: 10.1521/aeap.2009.21.5_supp.103

Rhodes, S. D., Hergenrather, K. C., Montano, J., Remnitz, I. M., Arceo, R., Bloom, F. R., Leichliter, J. S., & Bowden, W. P. (2006). Using community-based participatory research to develop an intervention to reduce HIV and STD infections among Latino men. *AIDS Education and Prevention*, *18*(5), 375–389.

Rhodes, S. D., Hergenrather, K. C., Vissman, A. T., Stowers, J., Davis, A. B., Hannah, A., Alonzo, J., & Marsiglia, F. F. (2011). Boys must be men, and men must have sex with women: A qualitative CBPR study to explore sexual risk among African American, Latino, and white gay men and MSM. *American Journal of Men's Health*, *5*(2), 140–151.

Rhodes, S. D., Mann, L., Alonzo, J., Downs, M., Abraham, C., Miller, C., Stowers, J., Ramsey, B., Simán, F. M., Song, E., Vissman, A. T., Eng, E., & Reboussin, B. A. (2014). CBPR to prevent HIV within ethnic, sexual, and gender minority communities: Successes with long-term sustainability. In S. D. Rhodes (Ed.), *Innovations in HIV prevention research and practice through community engagement* (pp. 135–160). Springer.

Rhodes, S. D., Mann, L., Simán, F. M., Song, E., Alonzo, J., Downs, M., Lawlor, E., Martinez, O., Sun, C. J., O'Brien, M. C., Reboussin, B. A., & Hall, M. A. (2015). The impact of local immigration enforcement policies on the health of immigrant Hispanics/Latinos in the United States. *American Journal of Public Health*, *105*(2), 329–337.

Rhodes, S. D., Mann-Jackson, L., Alonzo, J., Siman, F. M., Vissman, A. T., Nall, J., Abraham, C., Aronson, R. E., & Tanner, A. E. (2017). The ENGAGED for CHANGE process for developing interventions to reduce health disparities. *AIDS Education and Prevention*, *29*(6), 491–502.

Rhodes, S. D., McCoy, T. P., Tanner, A. E., Stowers, J., Bachmann, L. H., Nguyen, A. L., & Ross, M. W. (2016). Using social media to increase HIV testing among gay and bisexual men, other MSM, and transgender persons: Outcomes from a randomized community trial. *Clinical Infectious Diseases*, *62*(11), 1450–1453. doi: 10.1093/cid/ciw127

Rhodes, S. D., Tanner, A. E., Mann-Jackson, L., Alonzo, A., Siman, F. M., Song, E. Y., Bell, J., Irby, M. B., Vissman, A. T., & Aronson, R. E. (2018). Promoting community and population health in public health and medicine: A stepwise guide to initiating and conducting community-engaged research. *Journal of Health Disparities Research and Practice*, *11*(3), 16–31.

Rogers, E. M. (2003). *Diffusion of innovations* (5th ed.). The Free Press.

Rubenstein, L. V., Chaney, E. F., Ober, S., Felker, B., Sherman, S. E., Lanto, A., & Vivell, S. (2010). Using evidence-based quality improvement methods for translating depression collaborative care research into practice. *Family, Systems, and Health*, *28*(2), 91–113. doi: 10.1037/a0020302

Tabak, R. G., Khoong, E. C., Chambers, D. A., & Brownson, R. C. (2012). Bridging research and practice: Models for dissemination and implementation research. *American Journal of Preventive Medicine*, *43*(3), 337–350. doi: 10.1016/j.amepre.2012.05.024

U. S. Census Bureau. (2015). *Hispanic or Latino origin 2015 American Community Survey 1-year estimates*. http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_1YR_B03003&prodType=table

Vissman, A. T., Eng, E., Aronson, R. E., Bloom, F. R., Leichliter, J. S., Montaño, J., & Rhodes, S. D. (2009). What do men who serve as lay health advisors really do? Immigrant Latino men share their experiences as *Navegantes* to prevent HIV. *AIDS Education and Prevention*, *21*(3), 220–232.

Yano, E. M. (2011). Scale-up and spread. *Training Institute for Dissemination and Implementation Research in Health*. http://conferences.thehillgroup.com/OBSSRinstitutes/TIDIRH2011/agenda.html

Yano, E. M., Green, L. W., Glanz, K., Ayanian, J. Z., Mittman, B. S., Chollette, V., & Rubenstein, L. V. (2012). Implementation and spread of interventions into the multilevel context of routine practice and policy: Implications for the cancer care continuum. *Journal of the National Cancer Institute Monograph*, *2012*(44), 86–99. doi: 10.1093/jncimonographs/lgs004