THE UNIVERSITY OF CHICAGO

EXPLORING THE IMPLICATIONS OF SHIFTING HIV PREVENTION PRACTICE IDEOLOGIES ON THE WORK OF COMMUNITY-BASED ORGANIZATIONS: A RESOURCE DEPENDENCE PERSPECTIVE

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE SCHOOL OF SOCIAL SERVICE ADMINISTRATION
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

BY
KEITH ROMELL GREEN

CHICAGO, ILLINOIS
DECEMBER 2018

DEDICATION

This dissertation is dedicated to the memory of Charles Edward Clifton (1959 – 2004), my mentor and constant advocate, in life and in death.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACKNOWLEDGEMENTS

I firmly believe that my steps in life have always been ordered by the spirit of God, including those that led me to and supported me through this dissertation. That said, I must first acknowledge the spirit of God that resides within me for trusting me with this work and not allowing me to (totally) lose my mind in the process.

I must also acknowledge the host of individuals and institutions that God's spirit used to provide me with the spiritual, emotional, technical, and financial support to get to the finish line. To my mother (Deborah), my partner (Michael), and my community of family/friends across the world who are far too many to name, you all have been my rocks! You've kept me both grounded and uplifted all at once. Thank you!

To my committee (Jennifer, Alida, and Celeste), I can't even begin to express how grateful I am for the three of you. You've taught me what it means to be a scholar and, by perfect example, an educator and academic colleague. Thank you for your leadership, guidance, and patience with me. I may not be able to tell you how much I appreciate you, but I hope to show you through the application of everything that you all have taught me.

To my funders (the Agency for Healthcare Research and Quality, the University of Chicago School of Social Service Administration, the Center for Health and the Social Sciences, and the Center for Race Politics and Culture), thank you believing me and trusting me with the resources to get this done.

And, finally, to my SSA classmates. Thank you all for your role in helping to shape the awesome learning community that has molded me into the scholar that I am becoming. This isn't the end for us. It's only the beginning. Let's change the world together!

ABSTRACT

Antiretroviral (ARV)-based prevention approaches such as Treatment as Prevention (TasP) and Pre-Exposure Prophylaxis (PrEP), present unprecedented opportunities for stemming the HIV epidemic in the United States. However, current racial/ethnic disparities in both the PrEP and HIV Continuums of Care point to significant implementation problems and gaps in the diffusion and uptake of these interventions. Community-based organizations (CBOs) that offer HIV prevention programming are uniquely positioned to assist our nation's most vulnerable populations with accessing TasP and PrEP, which includes navigating their options under the Affordable Care Act (ACA). However, these prevention approaches represent a shift in HIV prevention practice ideologies, which requires significant change in the way that CBOs have historically approached HIV prevention.

The U.S. Centers for Disease Control and Prevention (CDC), which is the largest funder of HIV prevention services in the country, has long recognized CBOs as important partners in the domestic fight against HIV/AIDS. In response to changing trends in the epidemic over time, the CDC's HIV prevention program with CBOs has grown in size, scope, and complexity. Little is known, however, about the capacity of CBOs to support the shift in practice ideology at the CDC that prioritizes ARV-based prevention, or about how local variations in ACA implementation impact the ability of organizational staff to integrate such approaches into their existing programming.

Grounded in resource dependence and new institutional theories, this dissertation employed qualitative research methods and is organized around two primary aims. The first aim was to explore the impact of emerging ARV-based approaches on HIV prevention practice ideologies as they are communicated to CBOs from the CDC. To achieve this aim, I conducted a document analysis of Funding Opportunity Announcements (FOAs) and other reports issued by the CDC related to community-based HIV prevention between 2003 and 2013. The second aim was to examine—via semi-structured interviews with organizational leaders, frontline prevention workers, and public health officials in Atlanta, Baltimore, Memphis, and New Orleans—how a diverse mix of CBOs in four cities heavily impacted by HIV/AIDS and with differing ACA implementation strategies are responding to shifts in the CDC's program for community-based HIV prevention.

Two primary shifts in HIV prevention practice ideologies communicated to CBOs from the CDC are revealed through this analysis. First, in accordance with the Advancing HIV Prevention initiative announced in 2003, funded organizations were required to implement standardized evidence-based behavioral interventions as determined by the CDC—in contrast to locally developed models. Then, as antiretroviral-based prevention emerged and evolved over time, the CDC's program for community-based HIV prevention shifted from a primary focus on behavioral interventions to the inclusion of these biomedical approaches.

In addition to shifts in practice ideologies, the CDC has also increasingly acknowledged within its program for community-based prevention that disparities in HIV are driven by larger contextual factors, including social and economic inequalities. As such, the document analysis also revealed concurrent shifts in structural approaches to preventing HIV/AIDS, intended to address the role of social context as a compliment to individual-level outreach and intervention strategies. Such approaches included: (1) expanding community-based prevention efforts to include people living with HIV/AIDS (PLWHAs); (2) targeting prevention efforts towards disproportionately affected populations (e.g., gay/bisexual men, transgender women) in geographic regions where HIV prevalence is highest (e.g., the southern U.S.); and (3) addressing the social/economic determinants of health facing the most vulnerable populations (e.g., poverty, homelessness, unemployment, and racial discrimination).

Given the significant degree of dependence on the CDC for HIV prevention resources that exists among the CBOs included in this study, these changes created a great deal of coercive and mimetic isomorphic pressure within the organizational field. Many CBOs staff changed their organizational infrastructures and focus populations to comply with changes at the CDC, and/or engaged in loose or de-coupling strategies to appear to be in compliance with funding mandates, at times neglecting the true HIV prevention needs of the communities that they serve. And, while CBO staff overwhelmingly agree with and support the biomedical HIV prevention practice ideology, without additional resources and recommendations for evidence-based models for addressing the social and economic determinants of health, access to ARV-based prevention remains limited among the most vulnerable populations.

CHAPTER 1. Introduction and Review of Relevant Literature

Introduction

Since the onset of the human immunodeficiency virus (HIV) in the early 1980s, African Americans, Latinos, and gay/bisexual men of all races in the United States have been disproportionately affected (Cohen, 1999; DeCock, Jaffe, & Curran, 2011; Centers for Disease Control and Prevention [CDC], 2011). Antiretroviral (ARV)-based prevention approaches—such as Treatment as Prevention (TasP) and Pre-Exposure Prophylaxis (PrEP)—present unprecedented opportunities for curbing the domestic epidemic. However, current racial/ethnic disparities in both the HIV treatment and PrEP Continuums of Care point to significant implementation problems and gaps in the diffusion and uptake of these interventions (Bradley et al., 2014; Kelly et al., 2015), despite expanded access to healthcare options available under the Affordable Care Act (ACA) (Rosenbaum, 2011). This is particularly the case for Truvada, an antiretroviral medication approved for use as PrEP by the U.S. Food and Drug Administration in 2012 (CDC, 2012). A recent analysis suggests that, while two-thirds of the people who could benefit most from Truvada as PrEP are African American or Latino, members of these populations account for the smallest percentage of prescriptions filled to date (CDC, 2018).

AIDS Service Organizations (ASOs) and other community-based structures that provide HIV prevention services (collectively referred to hereafter as Community-Based Organizations or CBOs) are uniquely positioned to assist the populations most susceptible to HIV transmission and acquisition with accessing ARV-based prevention, perhaps for the first time. The grass-roots histories and credibility with marginalized populations that CBOs possess grant these organizations invaluable access to groups of people who may not be reachable via other organizational types or strategies (DeCock, Jaffe, & Curran, 2011). As such, the U.S. Centers for

Disease Control and Prevention (CDC) has long recognized CBOs as important partners in the domestic fight against HIV/AIDS (CDC, 2009).

While early efforts were financed primarily through private donations and utilized community volunteers to offset costs, HIV prevention within CBOs today is predominantly funded via government resources distributed through the CDC, both directly and indirectly by way of local health departments (Wilson & Moore, 2009). Currently, the CDC is the largest funder of community-based HIV prevention services in the U.S., awarding $44.2 million dollars directly to CBOs in FY2015 (Department of Health and Human Services [DHHS], 2016). As such, the CDC serves as the primary organizing body for the HIV prevention field, possessing the power to dictate both practice ideologies and service technologies through the control of vital resources that sustain and support the efforts of CBOs within it.

Hasenfeld (2010) defines an organization's practice ideology as the assumptions made regarding client attributes and about the most appropriate strategies for intervening. Service technologies, then, are tangible enactments of the organization's practice ideology (i.e., strategies or tools used in daily organizational work) (Hasenfeld, 2010). Historically, organizations within the HIV prevention field have been guided by a practice ideology based on the assumption that altering risky sexual and substance use behaviors would effectively reduce new infections (CDC, 2003; Black AIDS Institute, 2015). Service technologies prescribed under this ideology included evidence-based behavioral interventions, condom distribution, and needle exchange programs. More recently, ARV-based prevention approaches such as TasP and PrEP—which involve engaging, linking, and retaining clients in primary medical care to ensure uptake and adherence to medications—has gained prominence within the field. These prevention efforts are reflective of a biomedical prevention practice ideology that most HIV/AIDS-focused CBOs were not originally designed to support. It's one thing to facilitate group-level behavioral interventions and ensure that clients have access to condoms and/or clean needles; assisting marginalized populations with establishing and maintaining relationships with primary care providers, however, requires a different level of engagement that prevention-focused CBOs may not possess the skills, capacity, or even desire to assume. As a result, ARV-based prevention—coupled with varied implementation of the Affordable Care Act which includes state government decisions to expand Medicaid programs or not—present unique challenges and opportunities for CBOs. More specifically, the federal government's emphasis on ARV-based approaches—as evidenced by the CDC's "High-Impact Prevention" strategy (CDC, 2011), the National HIV/AIDS Strategy (Office of National AIDS Policy [ONAP], 2015), and the funding priorities of the National Institutes of Health's Office of AIDS Research (National Institutes of Health [NIH], 2015)—represent a shift in field-level prevention practice ideologies and related service technologies that CBO staff must grapple with as they strive to offer the most appropriate services to the communities they serve.

Little is known about the capacity of CBOs to support the shift in practice ideology that prioritizes ARV-based prevention, or about how local variations in ACA implementation impact the ability of organizational staff to integrate such approaches into their existing programming. However, considering racial/ethnic disparities in the PrEP and HIV Care Continuums (Bradley et al., 2014; Kelly et al., 2014) and the historic role of CBOs for providing HIV prevention services within the most vulnerable and marginalized communities, it is important to examine and understand organizational responses to such drastic institutional change and environmental complexity. Integrating resource dependence (Pfeffer & Salancik, 1978) and new institutional (Meyer and Rowan, 1977; DiMaggio and Powell, 1983) theories, this dissertation aims to illuminate these responses to inform public health guidelines and technical support models for assisting CBOs with effectively integrating ARV-based prevention.

Specific Aims

Employing qualitative research methods, this dissertation is organized around two primary aims. The first aim is to explore the impact of emerging ARV-based approaches on HIV prevention practice ideologies as they are communicated to CBOs from the CDC. To achieve this aim, I conducted a document analysis of Funding Opportunity Announcements and other reports issued by the CDC related to community-based HIV prevention between 2003 and 2013. The second aim is to examine—via semi-structured interviews with organizational leaders, frontline prevention workers, and public health officials in Atlanta, Baltimore, Memphis, and New Orleans—how a diverse mix of CBOs in four cities heavily impacted by HIV/AIDS and with differing ACA implementation strategies are responding to shifts in the CDC's program for community-based HIV prevention.

I begin with a review of relevant literature in the next section of this chapter, including a detailed history of the role of CBOs in domestic HIV prevention efforts. Then, in Chapter 2, I provide a comprehensive description of the methods that I employed to achieve the specific aims of this study. In Chapter 3, I present findings from the document analysis, detailing shifts in practice ideologies and service technologies as they have been communicated by the CDC from 2003 through 2013 (Aim 1). In addition to mandating standardized behavior-change technologies and the gradual foregrounding of ARV-based approaches, this analysis also revealed other important changes in the CDC's community-based HIV prevention program that advanced structural approaches for curbing the epidemic. These changes included: (1) expanding community-based prevention efforts to include People Living with HIV/AIDS (PLWHAs); (2) targeting efforts towards disparately affected populations (e.g., African American gay/bisexual men, transgender women) in geographic regions where HIV prevalence is highest (e.g., the southern United States); and (3) addressing the social/economic determinants of health that impact access to prevention services for the nation's most vulnerable populations (e.g., poverty, homelessness, unemployment, racial discrimination).

In Chapter 4, I trace and analyze how organizational leaders have responded to the shift in practice ideology that mandated standardized behavioral interventions, as well as structural changes within the CDC's program for community-based HIV prevention that required them to focus their efforts more intentionally on young MSM and transgender women of color. Then, in Chapter 5, I explore how CBO leaders and frontline prevention workers are responding to changes at the CDC that not only prioritize ARV-based approaches and disparately impacted populations, but also require them to address the social/economic determinants of health (Aim 2). I conclude in Chapter 6 with a discussion about the implications of these findings for HIV prevention policy and community-based efforts within disparately impacted communities, as well as for organizational theory within the social services.

The Evolution of Community-Based HIV Prevention

The CDC estimates that approximately 1.2 million Americans are currently living with HIV, although 15% (or 162,500 people) are unaware of their status (CDC, 2017). Moreover, while African Americans made up only about 12% of the U.S. population in 2016, members of this racial group accounted for 44% of new HIV diagnoses that year (CDC, 2017). Similarly, Latinos accounted for 25% of new diagnoses in 2016 but made up only about 18% of the nation's population (CDC, 2017). Although new diagnoses among white MSM declined by 10% from 2011 to 2015, African American and Latino MSM experienced 4% and 14% increases during this same time period, respectively (CDC, 2017). Regionally, HIV diagnoses rates in the South are the highest in the nation at 16.8 infections per 100,000 people, compared to 11.2 in the Northeast, 10.2 in the West, and 7.5 in the Midwest (CDC, 2017).

A number of theories, including social network and syndemic theories, have been put forth to explain these disparities. Social network theory posits that social characteristics (such as racial segregation), rather than the properties of individuals alone, shape the occurrence of sexual partnerships (Laumann, Gagnon, Michael, & Michaels, 1994). In turn, these characteristics restrict or exacerbate the pathways through which sexually transmitted infections such as HIV can be spread. Aside from epidemiological consequences, the social composition of sexual relationships also affects the type of behavior that occurs within them, making social structure a critical focus for intervention (Laumann, Gagnon, Michael, & Michaels, 1994). In contrast, syndemic theory supposes that a constellation of psychosocial issues—including substance abuse/misuse, intimate partner and community violence, depression, sexual compulsiveness, and stress—accrue across the lifespan (Singer, 1996; Stall, 2003; Dyer et al., 2012). As a result, each condition can amplify the negative impact of one or more other health problems, including HIV/AIDS (Singer, 1996; Stall, 2003; Dyer et al., 2012). This theory emphasizes the need for HIV prevention to assume a holistic approach that addresses the whole person, as opposed to a specific focus on sexual behavior and risk taking.

Both social network and syndemic theory also address the role of inequality in creating vulnerability to HIV (Laumann, Gagnon, Michael, & Michaels, 1994; Singer, 1996; Stall, 2003; Dyer et al., 2012). Indeed, research in the U.S. suggests that the leading drivers of HIV infection among African American MSM in particular are related to such factors as poverty, incarceration, and unemployment. (Millett et al, 2012). While substantial evidence has been gathered in support of both social network and syndemic theory (Laumann, Gagnon, Michael, & Michaels, 1994; Singer, 1996; Stall et al, 2003; Dyer et al., 2012), others have suggested that existing disparities are best explained by the initial response from the federal government to the emerging AIDS crisis in the early 1980's—a response that has been perceived as insufficient for curbing the spread of the disease in a timely manner (Shilts, 1987; Epstein, 1996; Adam, 2011). Due to the highly stigmatized characteristics of the populations originally known to be affected by HIV in the U.S. (e.g., gay men, commercial sex workers, and injection drug users), some suggest that the CDC was crippled by a lack of both political and financial support from the Reagan administration to address the developing AIDS crisis (DeCock, Jaffe, & Curran, 2011). As a result of this inadequate response, community-based advocacy groups and peer support systems—such as the Gay Men's Health Crisis in New York City and Test Positive Aware Network in Chicago—emerged. Over time, these organizations evolved into what have become known as AIDS Service Organizations (ASOs), many of which remain on the front lines of today's fight against HIV/AIDS. ASOs and a host of other organizations offer a variety of prevention and support services within vulnerable communities that continue to be disproportionately affected by HIV yet marginalized from healthcare systems due to stigma, discrimination, and other factors (e.g., lack of access to affordable healthcare).

The Organizational Field of HIV Prevention

Given the increasing role of the CDC in shaping practice ideologies and the service technologies employed within CBOs, this dissertation integrates resource dependence (Pfeffer & Salancik, 1978) and new institutional theories (Meyer and Rowan, 1977; DiMaggio and Powell, 1983) to explore how these organizations have responded to changes in the CDC's program for community-based HIV prevention over time and, more specifically, the introduction of ARV-based approaches. Pfeffer and Salancik (1978) contend that organizations survive to the extent that they are effective. Effectiveness, these scholars contend, results from an organization's ability to successfully manage the demands of its environment, particularly those of the various interest groups that it depends on for resources (Pfeffer & Salancik, 1978). Thus, resource dependence theory attempts to explain how organizations navigate environmental demands to acquire the political and economic resources necessary for maintaining effectiveness (Pfeffer & Salancik, 1978).

From this perspective, history and network structure are presumed to be essential for understanding how and why organizations differ from one another. Specifically, the degree of power that an organization has for managing environmental demands is considered to be a direct result of the "particularities of their interdependence" and their location within social space—dynamic processes that evolve over time (Pfeffer & Salanick, 1978, p. xiii). Scholars employing a resource dependence perspective among human service organizations attempt to operationalize the strategies adopted by organizational leaders for learning about and attending to their environments, as well as how they select and process information to give meaning to competing demands. For organizations that provide HIV prevention services, a resource dependence approach is important for understanding how the growing influence of the CDC—as the largest funder of community-based efforts today—impacts service delivery within our nation's most vulnerable communities. For example, the demands placed upon CBOs in the wake of the CDC's "High Impact Prevention" strategy (CDC, 2011c) which specifically calls for the integration of ARV-based approaches, may be in conflict with the actual prevention needs and demands of the communities that these organizations serve.

New Institutional Theory (NIT) developed in response to rational and functionalist theories (such as resource dependence) that overemphasized individual/organizational actor choice and underemphasized environmental and cultural constraints. From this perspective, the decisions that CBO leaders make in response to the CDC's growing influence over prevention services are not simply based on resource dependence. Rather, these decisions are essentially made for them as a result of a variety of other forces operating within the organizational environment. This includes but is not limited to advances in prevention practice technologies as well as shifts in the populations most disparately impacted by HIV—factors that have contributed to changes within the CDC's program for community-based efforts but also directly affect service delivery patters within CBOs. Thus, NIT posits that organizational policies and service delivery patterns are the product of "taken-for-granted social prescriptions"—such as the need to focus prevention efforts on the most disparately impacted populations using the latest and most effective service technologies—that unconsciously guide the behavior of organizational actors (Battilana, 2006, p. 656).

Young (1986) defines social institutions as "recognized practices consisting of easily identifiable roles, coupled with collections of rules or conventions governing relationships among the occupants of those roles" (p. 107). Institutionalization occurs when these rules and practices become "infused with value beyond the technical requirements of the task at hand" (Selznick, 1957, p. 17). An organizational field, then, consists of those organizations that, "in the aggregate, constitute a recognized area of institutional life" (e.g. healthcare organizations, LGBT community centers, ASOs) (DiMaggio & Powell, 1983, p. 148). In order to achieve and maintain legitimacy as organizational fields become more institutionalized, DiMaggio and Powell (1983) suggest that there is a tendency among individual organizations to reproduce existing structures. As a result, organizations within any particular field eventually come to resemble each other with regards to such characteristics as structure and service technologies, which may cause organizational leaders to make decisions that are not always in line with either efficiency or effectiveness.

DiMaggio and Powell (1983) define this process of homogenization within organizational fields as isomorphism, suggesting three mechanisms through which it occurs—coercive, mimetic, and normative. Coercive isomorphism stems from political influences within the field (e.g., regulations, social policies) and the need for organizations to maintain legitimacy in order to effectively secure and maintain vital resources (DiMaggio and Powell, 1983). Mimetic isomorphism, these scholars contend, arises from standard responses to uncertainty within the organizational environment and results from leader's decisions to imitate structures and processes that they perceive to be effective (DiMaggio and Powell, 1983). Finally, DiMaggio and Powell (1983) offer that normative isomorphism is associated with professionalization, which results in the diffusion of particular practice ideologies and service technologies within an organizational field.

An intricate mix of isomorphic processes, combined with advances in both prevention technologies and surveillance techniques, have likely played a role in structuring the organizational field of HIV prevention. Although exact numbers are difficult to estimate, hundreds of organizations employing thousands of individuals across the country make up the field today (Black AIDS Institute, 2015). These organizations extend prevention services to our nation's most vulnerable and marginalized communities that may not otherwise have access to information or resources for preventing and/or managing the disease. This includes AIDS Service Organizations (ASOs) that have historically provided support services for people living with HIV/AIDS, such as treatment adherence/management programs, peer support groups, and case management. Other organizations, such as Federally Qualified Health Centers (FQHCs), provide primary and preventative care to all people regardless of their ability to pay. Reproductive health centers, substance abuse treatment facilities, and faith-based entities have also offered a variety of prevention services throughout the years to compliment the work of their primary missions. In addition, organizations that have historically focused on social programming and advocacy on behalf of LGBT (Lesbian, Gay, Bisexual, Transgender) communities have been important players in providing HIV/AIDS prevention and support services, with many expanding or changing their focus altogether over the years to address the needs of their affected constituents (Adam, 2011). While some of these organizations offer primary medical services in addition to prevention and support services—or have transitioned to FQHCs as ARV-based approaches have gained prominence within the field—most do not. Rather, they exist as entities with identities that are distinct from other types of healthcare organizations.

Likely as a result of mimetic isomorphism (DiMaggio & Powell, 1983)—which has led organizations across the country to assume similar structures, practice ideologies, and service technologies—HIV prevention within CBOs has historically focused on raising awareness about the various modes of viral transmission and on disseminating prevention and treatment information within vulnerable communities (Adam, 2011; CDC, 2003). In addition, many of these organizations provide HIV testing and a variety of interventions designed to evoke behavior change. To expand the reach of HIV prevention efforts across the nation, the CDC began establishing formal partnerships with CBOs in the late 1980s. Subsequently, through a competitive grant-making process, the CDC has entered into cooperative agreements with hundreds of CBOs for the provision of HIV prevention services over the past 30 years. In addition, other CBOs have been indirectly funded by way of contractual agreements with state and local health departments that are financially supported by the CDC. Such contracting has likely resulted in a great deal of coercive isomorphism within the field, redefining and shaping CBO practice ideologies and service technologies over time (CDC, 2009; DiMaggio & Powell, 1983).

Considering that the CDC is currently the largest funder of HIV prevention services in the U.S., the influence that this agency has over practice ideologies and related service technologies employed within CBOs cannot be overstated. As such, it is important to understand how CBOs have responded to prescriptions from the CDC to maintain both legitimacy and independence. Oliver (1991) suggests that these responses will vary—from conforming to resistant, passive to active, preconscious to controlling, impotent to influential, and from habitual to opportunistic—depending on the degree of institutional pressures toward conformity that are exerted over these organizations. Meyer and Rowan (1977) offer that when dominant institutional norms are perceived to be ineffective, inefficient, or contrary to organizational values, they will only be partially adapted by organizational actors. As such, these so called "rational myths" become ceremonially displayed in formal structure but not reflected in the day-to-day operations of the organization, a process referred to as decoupling (Meyer & Rowan, 1977). Decoupling occurs when the formal and informal structures of an organization are not totally in line with each other (Meyer & Rowan, 1977). In addition to decoupling, formal and informal organizational structures may also be loosely or partially coupled, depending on the situation and relationship of the organization to the source of the institutional norms in question. Little is known about the extent to which leaders and frontline staff within CBOs engage in decoupling/loose coupling processes to maintain independence and autonomy, while appearing to be compliant with various changes within the CDC's program for HIV prevention. Moreover, very little information exists regarding the implications of such actions for prevention efforts within disparately affected communities.

Shifting Institutional Norms within the Organizational Field of HIV Prevention

A considerable amount of research has been conducted and published over the years on various approaches to HIV prevention (e.g., behavioral interventions, treatment as prevention). However, not much attention has been given to the organizational context within which interventions are delivered, or to the ways in which CBO leaders and frontline prevention staff concur and comply with practice ideologies communicated from funders. In response to changing trends in the epidemic over time, including demographic shifts and advancements in

HIV testing and treatment approaches, the CDC's program for HIV prevention with CBOs has grown in size, scope, and complexity over the years (CDC, 2009). Moreover, changes in presidential administrations and in Congress have come with varying attitudes and beliefs about how and why HIV continues to be a public health problem in the United States, even in the absence of scientific evidence to support such views (Scott, 2009). For example, upon taking office in 2001, President George W. Bush's administration began laying the groundwork for significant changes within the HIV prevention field. Driven by both conservative values and scientific advancements of the times, prevention policy under the Bush administration privileged expanded HIV testing and secondary prevention approaches (focused on reducing risky behaviors of PLWHAs) over condom promotion and locally-developed interventions for HIV-negative individuals—strategies that were previously considered hallmarks of community-based efforts in the domestic fight against HIV/AIDS (Scott, 2009).

Abstinence-based prevention education also came to prominence during this era. Guided by the demands of the administration, the U.S. Department of Health and Human Services (HHS) and the CDC embarked upon what has been described as a "war against condoms," publicly attacking the empirical evidence demonstrating the efficacy of this widely-used prevention tool (Scott, 2009). According to U.S. Global AIDS Coordinator Randall Tobias, rising HIV infection rates around the world was proof that existing prevention approaches relying on condoms had not been effective (Human Rights Watch, 2004). As a result, the CDC pulled a condom fact sheet from its website, replacing it with one that emphasized abstinence while lacking information about condom use and efficacy (Scott, 2009; Human Rights Watch, 2004).

The implications of such actions for community-based HIV prevention were potentially disastrous, likely further perpetuating disparities within marginalized communities. Meanwhile, advances in HIV treatment were improving the lifespan and overall quality of life for PLWHAs. In the mid-1990s, the U.S. Food and Drug Administration approved several drugs in a new class of antiretroviral medications known as Protease Inhibitors (PIs) (Sifris & Myhre, 2017). Shortly thereafter, clinical trials demonstrated that combining these drugs with nucleoside reverse transcriptase inhibitors (NNRTIs) (referred to as Highly Active Antiretroviral Therapy or HAART) drastically reduced viral replication and immune system depletion in PLWHAs (Hammer et al., 1997). As a result, PLWHAs who had access to these medications were afforded the opportunity to live longer, healthier lives and the perception of HIV as a death sentence began to subside.

More recently, two major ARV-based interventions have significantly impacted both HIV treatment and prevention. Research has demonstrated that effective treatment with HAART that results in viral suppression among PLWHAs virtually eliminates the possibility of transmitting the virus to an uninfected sexual partner (Das, Chu, Santos, Scheer, Vittinghoff, McFarland, & Colfax, 2010; Donnell et al., 2010; Cohen et al., 2011). These findings have led to prevention strategies that employ targeted outreach approaches using advanced testing technologies to detect undiagnosed, acute HIV infection among disparately affected populations and encourage/facilitate prompt initiation of HAART (Granich, Gilks, Dye, DeCock, & Williams, 2009; CDC, 2011).

In addition, studies have shown that some ARVs can be effectively used as prevention strategies if consumed by HIV-negative individuals either before or after exposure to the virus. For example, Post-Exposure Prophylaxis (PEP) requires that persons who have potentially been exposed to HIV—through such contact as a needle-stick in a health care setting or from unprotected sex with a person of unknown HIV status—be prescribed and strictly adhere to specific ARVs for a period of time immediately following the exposure, significantly reducing the likely of seroconversion (Khan et al., 2001; Van Der Ende, Regez, Schreij, Van Der Meer, & Danner, 2002). In contrast, Pre-Exposure Prophylaxis (PrEP) requires daily consumption of Truvada (a particular ARV) and can be beneficial for individuals who may consistently be at high risk of exposure to the virus (e.g. HIV-negative partners in serodiscordant intimate relationships, commercial sex workers, and injection drug users). Several recent studies have found Truvada as PrEP to be highly effective at circumventing infection when participants adhere to the prescribed regimen (Grant et al. 2010; Thigpen et al., 2012; Baeten et al., 2012; Choopanya et al., 2013).

Significance

In 2010, with guidance and input from a variety of community advocacy groups and service organizations, the White House issued the nation's first comprehensive coordinated plan for addressing the domestic HIV epidemic. Known as the National HIV/AIDS Strategy (NHAS), the primary goals of the strategy were to: (1) reduce new HIV infections; (2) increase access to care and improve health outcomes for people living with HIV; and (3) reduce HIV-related health disparities (ONAP, 2015). In accordance with the NHAS, the CDC's Division of HIV/AIDS Prevention announced a "High-Impact Prevention" (HIP) approach to reducing new infections in the U.S (CDC, 2011). HIP called for the use of combinations of "scientifically proven, cost-effective, and scalable interventions" focused on the most vulnerable populations in geographic areas where HIV prevalence is highest (CDC, 2015). Both behavioral and ARV-based prevention technologies (including TasP and PrEP) were represented among the recommended interventions included as part of the HIP strategy, reflecting the profound scientific advances that had been made in HIV prevention during recent years.

The Patient Protection and Affordable Care Act (ACA) extended access to ARV-based treatment and prevention to many Americans who might otherwise be unable to afford it. Signed into law by President Barack Obama in 2010, the ACA was designed to make affordable, quality health insurance available to all citizens (Rosenbaum, 2011). Specifically, the ACA: (1) gave states the option and financial support to expand their Medicaid programs to cover all adults under age 65 with income up to 133% of the federal poverty line; (2) established the "Health Insurance Marketplace," a virtual repository for information about insurance plans and a portal for purchasing health care; and (3) made subsidies available to low-income citizens for support with paying premiums and other out-of-pocket costs (Patient Protection and Affordable Care Act, 2010). Regional differences in the implementation of this legislation may have implications for the diffusion and uptake of ARV-based interventions, however, particularly among marginalized populations who could benefit most from them. For example, during the conceptualization of this dissertation, 19 states had opted out of expanding their Medicaid programs under the ACA (Kaiser Family Foundation, 2018). Moreover, while a number of insurers and Medicaid plans cover ARVs for both prevention and treatment, many have stipulations regarding reimbursement for specific ARVs and premiums or co-pays that threaten to sustain differential access to these medications (Kaiser Family Foundation, 2018).

CBOs can play an important role in assisting our nation's most vulnerable citizens with understanding their healthcare options under the ACA and accessing ARV-based prevention when appropriate. However, integrating ARV-based approaches requires change in the way that these organizations have traditionally approached prevention, particularly with high-risk HIV-negative individuals (referred to hereafter as HRNs). Although risk reduction and behavior-change technologies remain at the forefront, High-Impact Prevention emphasizes the need to educate both PLWHAs and HRNs about ARV-based approaches, while also connecting/retaining appropriate candidates in routine medical care (CDC, 2011). As such, ARV-based prevention requires CBOs to interface with the healthcare sector in ways that may not necessarily be considered pertinent to the missions and goals of these organizations (e.g., assisting clients with making medical appointments, developing “linkage agreements” with primary care providers).

Additionally, while the potential of ARV-based prevention for curbing the U.S. HIV/AIDS epidemic is promising, the extent to which the practice ideology associated with these service technologies is compatible with or creates complexity within HIV/AIDS service organizations is also unclear. More specifically, little is known about how prevention strategies focused primarily on getting drugs into bodies—rather than altering high-risk behaviors or disrupting patterns of inequality within disparately impacted communities—are in alignment with the missions and histories of U.S. CBOs. In addition, not much is known about how the organizational structures of CBOs have been forced to transform to adequately accommodate ARV-based approaches, or how such transformation impacts the availability of other prevention strategies on the ground. Information is also lacking about whether the decisions that CBO leaders and frontline staff are making with regards to integrating ARV-based prevention into their existing programming are sincere or involve some level of decoupling (Meyer & Rowan, 1977). Such decoupling could have severe implications for dissemination and uptake of ARV-based prevention, given the historic role of CBOs in engaging the nation’s most vulnerable populations into prevention services.

Furthermore, given the complicated nature of ARV-based prevention, CBO staff must make an ongoing effort to stay abreast of rapidly evolving medical advancements to be able to appropriately link their client populations to them. Data from a recent survey of the U.S. HIV prevention workforce suggest that HIV science and treatment literacy among CBO employees is disturbingly low (Black AIDS Institute, 2015). On average, respondents answered approximately 64% of the basic HIV science-related survey questions correctly, with no significant differences in knowledge observed when controlling for factors such as race and education. Additionally, the average scores on the HIV treatment-related questions and on questions that focused on ARV-based prevention were 56% and 46% respectively, with answers from many respondents indicating a lack of belief in the efficacy of technologies such as PrEP (Black AIDS Institute, 2015). While there is currently a movement within the field to explore the acceptability and feasibility of HIV workforce certification (a form of normative isomorphism), these findings allude to additional challenges that CBOs face with incorporating ARV-based prevention. More specifically, these data suggest that ARV-based interventions may be implemented unevenly across the nation (Black AIDS Institute, 2015).

Given the CDC's influence over community-based HIV prevention, as the largest funder within the field, it is important to understand how the increasing emphasis on ARV-based approaches has impacted the focus of CBOs. In the following chapters, I illuminate how HIV prevention practice ideologies and resulting service technologies communicated by the CDC have evolved in the wake of ARV-based approaches. I also describe and analyze how CBO leaders and frontline workers are responding to shifts in the CDC's community-based HIV prevention program to incorporate these technologies into their existing programming. Developing such an understanding is important for three primary reasons. First, understanding the nature of shifts in practice ideologies and service technologies may assist CBOs with constructing their responses to these changes, potentially improving dissemination and uptake of ARV-based prevention. Second, acquiring this knowledge can assist public health officials with structuring more efficient protocols and procedures for supporting CBOs with integrating these prevention approaches. Finally, this information offers insight into organizational responses to resource dependence in the field of HIV/AIDS, illuminating the strengths and weaknesses of current funding structures and their impact on prevention efforts within the most vulnerable communities.

CHAPTER 2. Research Design and Methods

Employing a two-phase study design, this dissertation utilizes qualitative research methods to explore and describe the impact of evolving HIV prevention practice ideologies communicated to CBOs from the CDC. More specifically, I traced shifts in practice ideologies by conducting document analysis of Funding Opportunity Announcements (FOAs) and other relevant texts issued by the CDC related to community-based HIV prevention since the emergence of "treatment as prevention" approaches in 2003 (Aim 1). Next, I analyzed and documented the strategies currently being employed by CBO leaders and frontline staff in response to shifting practice ideologies that prioritize ARV-based prevention (Aim 2). To accomplish this, I conducted a 2x2 comparative case analysis that involved in-depth interviews with CBO staff and public health officials in four metropolitan areas with demographic profiles reflective of domestic HIV disparities and with differential access to affordable healthcare options under the ACA—Atlanta, Baltimore, Memphis, and New Orleans.

Phase I: Document Analysis

Through a competitive grant-making process, community-based organizations across the country are contracted to provide HIV prevention services directly through the CDC and/or indirectly by way of local health departments. To understand how prevention practice ideologies have been communicated from the CDC to CBOs both before and after the emergence of ARV-based approaches (Aim 1), I conducted a document analysis of FOAs issued from the CDC for community-based prevention efforts between 2003 and 2013 (n=6). The year 2003 was significant as a starting point because it coincides with the introduction of "prevention with positives" approaches, which resulted in significant protocol changes for service delivery within CDC-funded CBOs (CDC, 2003). My cut-off point was 2013 because it is the year that the last FOA for community-based HIV prevention was issued by the CDC prior to the start of data collection for this dissertation. I also analyzed other documents referenced in these FOAs that provide background and context for changes to the CDCs community-based prevention program (n=4), including the Advancing HIV Prevention Initiative (API) and the National HIV/AIDS Strategy (NHAS). Table 1 provides a comprehensive list of documents included in this analysis.

Table 1. List of Documents Analyzed

Document Name	**Year Issued**
Advancing HIV Prevention Initiative	2003
FOA #04-064: CDC HIV Prevention Projects for Community-Based Organizations	2004
FOA #06-618: CDC HIV Prevention Projects for Young Men of Color who have Sex with Men and Young Transgender Persons of Color	2006
FOA #08-803: CDC HIV Prevention Projects for the Commonwealth of Puerto Rico and the U.S. Virgin Islands	2008
FOA #10-103: CDC HIV Prevention Projects for Community-Based Organizations	2009
CDC HIV Prevention Strategic Plan	2010
National HIV/AIDS Strategy (NHAS)	2010
FOA #11-1113: CDC HIV Prevention Projects for Young Men of Color who have Sex with Men and Young Transgender Persons of Color	2011
High Impact Prevention Approach	2011
FOA #13-1301: CDC HIV Prevention Projects for the Commonwealth of Puerto Rico and the U.S. Virgin Islands	2013

Data Collection and Analysis

I obtained relevant FOAs from the program leader of the Community-Based Organization Initiative in the Division of HIV/AIDS Prevention at the CDC. Additional documents that provide context for the CDC’s rationale for various shifts in prevention policy (i.e., practice ideologies and service technologies), which guided FOAs during this period, were obtained from searches of the CDC website and other online sources. These documents included reports concerning the Advancing HIV Prevention Initiative and the High-Impact Prevention Strategy, as well as CDC HIV Prevention Strategic Plans and the National HIV/AIDS Strategy.

I analyzed these documents via an iterative and systematic process, employing a slightly modified approach to the document analysis method outlined by Glenn Bowen (2009). Bowen's (2009) approach entails "finding, selecting, appraising (making sense of), and synthesizing" data contained in documents (p. 28). This process produces excerpts, quotations, and/or entire passages that are then organized into major themes, categories, and case examples specifically through content analysis (Bowen, 2009). While Bowen (2009) calls for a "skimming" of the documents prior to more in-depth analysis, I bypassed this step and moved directly to reading and interpreting the documents as I acquired them. This decision was made to allow for a more comprehensive understanding of the FOAs, and of the practice ideologies communicated through them, to emerge prior to conducting interviews within the field.

After reading each FOA, I constructed analytic memos that entailed concise reviews of key findings from these documents (Saldana, 2014). These memos were guided by analytic questions that stemmed from the first aim of this dissertation—to explore the impact of emerging ARV-based approaches on HIV prevention practice ideologies as they are communicated to CBOs from the CDC. These questions included: (1) What is the stated purpose/objective of this FOA?; (2) What federal programs/policies guide the activities to be funded under this FOA?; (3) What are the HIV prevention practice ideologies communicated through this FOA?; (4) How do the practice ideologies communicated through this FOA differ from those communicated in previous FOAs?; (5) What interventions are sanctioned under this FOA and how do they differ from those of previous FOAs?; (6) How much money is made available for community-based prevention under this FOA?; and (7) How are funds allocated across the various funding categories within the FOA? Similarly, I constructed analytic memos after reading each of the other relevant documents, guided by the following questions: (1) What is the purpose of this document?; (2) How does this document contribute to community-based HIV prevention practice ideologies?; (3) What interventions are sanctioned in this document, if any?; (4) What is the rationale/evidence provided to justify sanctioned interventions in this document?; and (5) How do interventions sanctioned in this document differ from those previously sanctioned?

Concurrently, I coded and analyzed the analytic memos via Dedoose, an online qualitative software program that allows coders to identify important thematic units (e.g., frequently occurring explanatory or interpretive statements) (Saldana, 2014). I derived a codebook based on these memos and utilized the analytic functions of Dedoose to explore salient themes that were emerging. These themes included: (1) the types of practice ideologies being communicated by the CDC; (2) how practice ideologies communicated by the CDC were being operationalized; and (3) the federal government's attitudes, beliefs, and values that undergirded changes in practice ideologies over time.

Preliminary findings of this document analysis were incorporated into the semi-structured interview guides employed in the second phase of this study (see Appendices G, H, and I). These findings informed additional questions related to how CBO leaders and frontline staff in the selected cities interpret and enact HIV prevention practice ideologies as they are communicated by the CDC, as well as how local health department interpretations impact their ability to incorporate ARV-based approaches into routine prevention activities. The final results from this document analysis are outlined in Chapter 3 of this dissertation.

Phase II: Comparative Case Analysis

To understand how organizational leaders and frontline staff within CBOs are responding to shifts in practice ideologies brought about by the emergence of ARV-based prevention, as well as how these responses vary in geographic regions with differential access to affordable healthcare options under the ACA (Aim 2), I employed a 2x2 comparative case study design (Kaarbo & Beasley, 1999) for the second phase of this dissertation. The case study method was ideal for answering my research questions, as it allowed for empirical examination of this real-world phenomenon within its naturally occurring context, without directly manipulating either the phenomenon or the context (Kaarbo & Beasley, 1999). Cities included in this analysis—Atlanta, Baltimore, Memphis, and New Orleans—were selected based upon their status as geographic areas with some of the highest annual HIV incidence rates in the nation (CDC, 2015). Population demographics (U.S. Census Bureau, 2015abcd) and local politics regarding ACA implementation (particularly Medicaid expansion) (Kaiser Family Foundation, 2018) were also used as determining variables. In general, African Americans and Latinos comprise at least 50% of the total population in each of these cities (U.S. Census Bureau, 2015abcd), and members of these racial/ethnic groups also consistently account for the majority of new HIV infections diagnosed each year (CDC, 2015; CDC, 2017).

Rationale for Selecting Cases

In the most recent national surveillance data available during the conception of this dissertation, seven geographic areas were identified as “hardest hit” by HIV/AIDS based on new infection rates per capita (CDC, 2015). These areas included Atlanta, GA; Miami, FL; Washington DC; Baton Rouge, LA; New Orleans, LA; Baltimore, MD; and Memphis, TN. Of these seven regions, expanded Medicaid options are currently available in Washington, DC, Baton Rouge, New Orleans, and Baltimore (Kaiser Family Foundation, 2018). Table 2 shows each of the 7 cities and their respective state’s decisions regarding Medicaid expansion, as well as general demographic information.

I used an inductive approach to narrow down the cities that would be included in the comparative case analysis of this dissertation. Given the unique nature of Washington DC—it is technically not a city and, thus, not governed by the policies of any particular state—I excluded it from my analysis. Instead, I selected Baltimore and New Orleans for inclusion as cities where HIV infection rates are high and state Medicaid programs are being expanded (CDC, 2015; Kaiser Family Foundation, 2018). I selected New Orleans over Baton Rouge because of its greater concentration of African American and Latino residents (65.7% versus 50.1%, respectively) (U.S. Census Bureau, 2015de). Medicaid programs are not being expanded in any of the other states where the "hardest hit" regions are located. Of those regions, Memphis and Atlanta have demographic profiles relatively similar to Baltimore and New Orleans, specifically with regards to proportions of African American and Latino residents (U.S. Census Bureau, 2015cabd). As such, I also selected these cities (Memphis and Atlanta) for inclusion. (See Table 2.

Procedures for Selecting Organizations for Inclusion

After determining the cities that would serve as cases for my analysis, I developed a preliminary list of organizations offering HIV prevention services in each city as a sampling frame. Three different organizational types are predominantly represented in each city including AIDS Service Organizations (ASOs), Federally Qualified Health Centers (FQHCs), and LGBT-focused organizations. To ensure a diverse sample, I employed purposive sampling (Kirs & Miller, 1986) to select up to four organizations per city for inclusion in this study, including up to two ASOs wherever possible and one each of the other organizational types. This approach was intended to ensure that I had an appropriately diverse set of organizations to sample from in each of the target cities. Organizations were eligible for inclusion if they were funded by any source to provide HIV prevention services. Table 3 lists the characteristics of the final sample of selected organizations.

Table 2. Demographic Profiles of Cities with Highest Concentrations of New HIV Infections

	General Population	African American Population	Latino Population	Expanding Medicaid?
Atlanta, GA	447,841	54.0%	5.2%	No
Miami, FL	417, 650	19.2%	70.0%	No
Washington DC	658,893	50.7%	9.1%	Yes
Baton Rouge, LA	229,426	54.57%	3.3%	No
New Orleans, LA	378,715	60.2%	5.3%	No
Baltimore, MD	622,104	63.7%	4.2%	Yes
Memphis, TN	653,450	63.3%	6.5%	No

(U.S. Census Bureau, 2015.; "Status of State Action," 2010)

Recruitment and Consent

Prior to collecting data, this study was granted expedited review and approved by the University of Chicago School of Social Service Administration Institutional Review Board. Throughout the duration of the study, I complied with all required procedures to ensure responsible conduct of the research. I travelled to and spent approximately two weeks in each of the selected cities to conduct interviews. In each city, I was hosted by an individual with some connection to the HIV prevention field whom I know from my professional/personal contacts. My hosts assisted me with making contact with potential participants and provided background information on the city's HIV prevention landscape. It should be noted, however, that none of these hosts were employed at any of the organizations that were ultimately included in this study.

I made initial contact with public health administrators from each jurisdiction and with leaders from selected organizations (e.g., executive directors, prevention program coordinators) via email. This correspondence informed prospective participants of the overall purpose of the study and asked if they would be interested in being interviewed (see Appendix A and B for Recruitment Scripts). If the individual expressed interest, I arranged a telephone call to discuss the study purpose and procedures in greater detail. During the initial conversation with interested organizational leaders, I also obtained permission to approach the organization's frontline prevention workers (FPWs) to gauge their interest in participating as well. If permission was granted, I contacted FPWs separately to invite them to participate. I informed these individuals that their participation in the study would be blinded from the organizational leader and that their right to refuse participation would not affect their employment in any way (see Appendix C). Prior to the interviews, I obtained oral informed consent from each participant, given that risks associated with participation were minimal and no personal information was being solicited (see Appendices D, E, and F for consent documents). I began the informed consent process with a thorough description of the study purpose, the procedures to be followed, and the risks/benefits associated with participation.

Table 3. Characteristics of Organizations Selected for Inclusion

	Atlanta	Baltimore	Memphis	New Orleans	Total
ASO	3	2	2	1	8
CBO	1		1		2
Faith-Based Organization				1	1
FQHC				1	1
LGBT Organization		1	1		2
University program		1		1	2
Total	4	4	4	4	16

Each public health administrator that I contacted in the four selected cities agreed to be interviewed. Government funded community-based HIV prevention efforts in Memphis and New Orleans are managed primarily by these cities' respective state health departments. Therefore, interviews were conducted with administrators who oversee these programs for the state. Similarly, Atlanta's prevention efforts are managed by the Fulton County Health Department and, thus, the HIV program manager for this department was also interviewed. In addition, I contacted, consented and interviewed PrEP program coordinators in the city/county health departments where these positions had been created (Atlanta and Baltimore). Although the Louisiana State Health Department did not have a designated PrEP coordinator, they do have a health equity and development supervisor who works closely with the prevention manager to implement PrEP programming in New Orleans. Both administrators agreed to participate via a joint interview.

Procedures for In-Depth Interviews with Public Health Administrators

I conducted a total of 11 interviews with public health administrators (n=12 as one interview was with 2 administrators). In most cases, depending on the structure of the local health department, I interviewed the HIV prevention program director/coordinator as well as the person directly responsible for PrEP programming in the selected city. The protocol for these interviews was informed by data from the document analysis conducted in Phase 1 of this study and explored: (1) how these individuals perceive and interpret HIV prevention practice ideologies as they are communicated by the CDC; (2) the administrators perceptions of their employing institution's perceptions of these ideologies; (3) how they communicate these practice ideologies to CBOs; and (4) region-specific barriers to PrEP implementation (see Appendix G). In most instances, these interviews took place at the participant's place of employment; a smaller number were conducted at other locations such as cafes, based on the participant's preference and availability. Interviews with public health administrators lasted for approximately 60-90 minutes and were digitally audio recorded.

Procedures for In-Depth Interviews with Executive Directors/Prevention Program Coordinators

I conducted in-depth interviews with a total of 18 CBO leaders (one from each organization selected and two from two organizations in New Orleans). Only one executive director approached in Atlanta declined to participate, due to timing of the interview conflicting with a Fulton County budget crisis that organizational staff were scrambling to deal with at the time. Another executive director in New Orleans agreed to participate but was ultimately unable to due to scheduling conflicts. The protocol for interviews with organizational leaders was informed by data from both the document analysis conducted in Phase 1 and data from interviews with public health administrators. These interviews explored: (1) how organizational leaders interpret and enact HIV prevention practice ideologies as they are communicated by the CDC; (2) these leader's perceptions of these ideologies; (3) their perceptions of their staff's perceptions of these practice ideologies; and (4) how local health department interpretations of these ideologies and ACA implementation strategies impact their ability to incorporate ARV-based prevention into existing prevention programming (see Appendix H). Additionally, I asked questions pertaining to attributes of the selected organizations (e.g., budget, number of prevention staff, time in existence) to understand how responses to shifting prevention practice ideologies may vary by organizational type in different cities. Interviews were conducted at the participant's host organization, lasted for 60-90 minutes, and were digitally recorded for later transcription. Participants received a $25 cash research incentive as compensation for their time.

Procedures for In-Depth Interviews with Frontline Prevention Staff

In addition to interviews with organizational leaders, I conducted group interviews (Frey & Fontana, 1991) with a total of 27 frontline prevention workers (approximately two from each organization). These interviews were conducted in small groups, as opposed to individually or in larger focus groups, because of the limited number of these workers that were available at any given organization. Additionally, this method allowed for variations in perspectives and attitudes to emerge in an environment where participants could naturally correct each other's interpretations of reality (Frey & Fontana, 1991). Consistent with Aim 2, which seeks to explore how a diverse mix of CBOs are responding to shifts in HIV prevention practice ideologies that have occurred since the onset of ARV-based approaches, the protocol for these interviews focused on understanding: (1) how these individuals interpret and enact HIV prevention practice ideologies as they are communicated by the CDC; (2) their perceptions of these ideologies; (3) their perceptions of their organizational leaders' perceptions of these ideologies; and (4) how local health department and organizational leaders' interpretations of these ideologies impact their ability to integrate ARV-based prevention on the ground. Group interviews were conducted at the participants' host organization and lasted for approximately 60-90 minutes. Participants received a $20 cash research incentive as compensation for their time.

Data Analysis for In-Depth Qualitative Interviews

Digital audio recordings of each interview were transcribed and de-identified to protect the confidentiality of participants. Interview transcripts were then analyzed via a modified version of Systematic Text Condensation (STC) (Malterud, 2012). STC is a descriptive and explorative method for thematic cross-case analysis of different types of qualitative data, including analysis of historical documents and in-depth interviews (Malterud, 2012). This method prescribes "analytic reduction with specified shifts between decontextualization and recontextualization," which is particularly important for comparative case analyses such as this dissertation (Matlerud, 2012, p. 796). More specifically, STC allowed me to move intentionally between analysis of the selected organizations as both unique analytic units and as collective groupings based on various organizational attributes (e.g., type, size, and location).

Matlerud (2012) outlines a four-step process for STC: (1) total impression – from chaos to themes; (2) identifying and sorting meaning units – from themes to codes; (3) condensation – from code to meaning; and (4) synthesizing – from condensation to descriptions and concepts. Seeing that my research questions were derived primarily from my professional knowledge of and experience with the shift in HIV prevention practice ideologies that has foregrounded ARV-based prevention, as well as the document analysis conducted in Phase I, many of the themes that I expected to uncover from my data were structurally pre-determined. Therefore, I engaged a modified version of Matlerud's (2012) protocol for STC for this Phase, conducting a step-wise analysis of the data that involved reading small groups of 3-4 interview transcripts at a time and constructing analytic memos from them as data collection was ongoing. During this stage, in line with Malterud's (2012) method, I made a conscious effort to bracket the preconceptions that I held about the data, while also acknowledging the interpretive position that was pre-determined by my research questions and professional experience. As such, these memos were organized according to my predetermined themes which included: (1) how participants in the selected cities interpret and respond to HIV prevention practice ideologies communicated by the CDC; (2) how these responses vary based upon the individual's role/position within the organization; (3) how local health department interpretations of these ideologies affect organizational responses; and (4) how organizational responses vary based on attributes of the organization and ACA implementation context. Relevant quotes were extracted from the transcripts and included in the analytic memos in anticipation of coding and further analysis via Dedoose.

Engaging this process in this way allowed for me to revise my semi-structured interview guides between interviews as necessary based on emerging themes. Once all of the interviews were conducted and analytic memos created from each transcript, I uploaded the memos to Dedoose. Expounding upon the codebook developed during Phase I, I then coded the memos according to the process outlined by Malterud (2012). This process included identifying, classifying, and sorting codes based upon the previously identified themes (Malterud, 2012). While coding, names and features of the code groupings were elaborated from themes established during the first step of the analysis.

Next, I utilized the analytic functions of Dedoose to condense the data according to my codes, reducing it to a decontextualized selection of meaning units sorted as thematic code groups across individual interviews (Malterud, 2012). This step implied systematic abstraction of meaning units within the code groups that were established in the second step of the analysis. At this stage, each of the code groups was taken as an analytical unit for further abstraction by condensation of text (Malterud, 2012). Ultimately, the meaning units were compiled within each code group to demonstrate a diversity of nuances that described different aspects of meaning. Meaning units were then sorted into subgroups based upon my research questions and theoretical perspectives. From there, I reduced the content from each meaning unit into a preliminary narrative that Malterud (2012) refers to as a condensate—an artificial quotation intended to maintain the original terminology applied by participants. Finally, these narratives were re-contextualized to develop descriptions and concepts that provide credible stories that elucidate my research questions (Malterud, 2012). More specifically, I re-contextualized the narratives by exploring variations in the data based on organizational type and ACA implementation context. The re-contextualized narratives serve as the basis for Chapters 4 and 5 of this dissertation.

CHAPTER 3. Tracing Shifts in HIV Prevention Practice Ideologies Communicated by the CDC

Pfeffer and Salancik (1978) suggest that both organizational history and field structure are essential for understanding how and why organizations differ from one another. These variables are particularly important when analyzing the strategies employed by organizations for responding to changing environmental demands. For the organizational field of HIV prevention, acquiring knowledge about field structure and, more specifically, the CDC's growing influence over the practice ideologies that guide the work of CBOs is essential for understanding variations in organizational responses to changes in federally-funded community-based efforts over time. This includes how organizations have responded to the emergence of ARV-based approaches such as Treatment as Prevention (TasP) and Pre-Exposure Prophylaxis (PrEP), and the inclusion of these interventions within the CDC's program for community-based HIV prevention. The primary aim of this chapter is to illuminate and describe, through document analysis, the HIV prevention practice ideologies communicated to CBOs from the CDC between 2003 and 2013. Additionally, I explore the impact of advances in HIV prevention technologies and surveillance techniques on the CDC's program for community-based HIV prevention.

As an overview, two dominant HIV prevention practice ideologies are communicated from the CDC to CBOs via these documents—behavioral and biomedical. The behavioral prevention practice ideology is rooted in the notion that decreasing new HIV infections requires the reduction of risky sexual and drug use behaviors (e.g., condomless sex, sharing substance injecting equipment), employing service technologies designed to produce such change (e.g., evidence-based behavioral interventions, condom distribution, needle exchange). Conversely, the biomedical prevention practice ideology involves the promotion of intervention strategies that utilize antiretroviral medications—such as TasP, PEP, and PrEP—to reduce the risk of acquiring or transmitting the virus. Service technologies prescribed by this ideology include strategies for engaging, linking, and retaining appropriate candidates into primary medical care to support and encourage medication adherence.

Although HIV testing is a biomedical tool used to detect undiagnosed infection among those populations perceived to be at greatest risk, it is instrumental to both biomedical and behavioral ideologies. Specifically, the assumption about HIV testing is that increasing status awareness results in behavior change and allows for opportunities to connect appropriate candidates to primary medical care and other prevention approaches including TasP, PrEP, and behavioral interventions (CDC, 2003). Similarly, while condoms are also biomedical in nature, condom distribution is a service technology prescribed under the behavioral practice ideology of HIV prevention. This is based upon the assumption that increasing access to these highly effective biomedical tools will encourage their use among those who are potentially at risk.

Two primary shifts in HIV prevention practice ideologies communicated to CBOs from the CDC are revealed through this analysis. First, in accordance with the Advancing HIV Prevention initiative announced in 2003, funded organizations were required to implement standardized behavioral interventions as determined by the CDC—in contrast to interventions that were locally developed and had previously been permitted. Then, as antiretroviral-based prevention emerged and evolved over time, the CDC's program for community-based HIV prevention shifted from a primary focus on behavioral interventions to the inclusion of these biomedical approaches.

In addition to shifts in practice ideologies, the CDC has also increasingly acknowledged within its program for community-based prevention that disparities in HIV are driven by larger contextual factors, including social and economic inequalities. As such, the document analysis also revealed concurrent shifts in structural approaches to preventing HIV/AIDS, intended to address the role of social context as a compliment to individual-level outreach and intervention strategies (Auerbach & Hoppe, 2015). Such approaches included: (1) expanding community-based prevention efforts to include people living with HIV/AIDS (PLWHAs); (2) targeting prevention efforts towards disproportionately affected populations (e.g. gay/bisexual men, transgender women) in geographic regions where HIV prevalence is highest (e.g., the southern U.S.); and (3) addressing the social/economic determinants of health facing the most vulnerable populations (e.g., poverty, homelessness, unemployment, racial discrimination).

The following analysis spans and is organization around two presidential administrations—those of George W. Bush and Barack Obama. It reveals that the prevention practice ideologies and structural strategies illuminated cannot be disentangled from governmental politics in general and, more specifically, politics directly concerning HIV prevention. Such politics create a substantial amount of tension within the organizational environment to which CBOs must respond. For example, conservative values associated with the Bush administration advanced abstinence before marriage approaches to sexuality (although marriage was not a legal option for non-heterosexual couples at the time), while also attacking the science behind condom distribution efforts within disparately affected communities. More recently, state decisions around Medicaid expansion and stigma-related challenges at the local government level serve to both facilitate and limit the extent to which CBOs engage their most vulnerable clients into ARV-based prevention approaches.

The primary research questions that guided this analysis included: (1) how have advances in HIV testing, prevention, and treatment approaches influenced prevention practice ideologies over time?; and (2) how have the attitudes, values, and beliefs of federal and local government influenced these ideologies and their subsequent implementation? I conclude with a discussion about the implications of shifting practice ideologies and evolving structural approaches within the CDCs program for community-based HIV prevention on the organizational field and, more specifically, on the efforts of CBOs operating within it.

Community-Based HIV Prevention Under the Bush Administration

The Introduction of "Prevention with Positives" and Standardized Prevention Practices

In 2003—citing stable rates of HIV-associated morbidity and mortality across the country (primarily as a result of the advent of Highly Active Antiretroviral Therapy or HAART), as well as recent syphilis outbreaks among MSM, increasing HIV incidence among both MSM and heterosexuals, and strong prevention collaborations among heavily affected communities—the CDC announced a retooling of its HIV prevention efforts via the "Advancing HIV Prevention (AHP): New Strategies for a Changing Epidemic" initiative (CDC, 2003a). Four priority strategies were outlined as part of the AHP initiative: (1) make voluntary HIV testing a routine part of medical care; (2) implement new models for diagnosing HIV infections outside of medical settings; (3) prevent new infections by working with persons diagnosed with HIV and their partners; and (4) further decrease perinatal HIV transmission (CDC, 2003a). While strategies 1 and 4 were targeted towards primary medical settings, the other two priorities offer insight into the behavioral HIV prevention practice ideology as it is operationalized and communicated to CBOs via the CDC.

More specifically, the second strategy put forth under the AHP initiative called for the implementation of newer, more advanced testing technologies that can deliver same day HIV test results (also referred to as "rapid tests"). Previous models, which required clients to return within approximately 2 weeks to receive their results, were considered counterproductive to ensuring that people were aware of their status and, subsequently, changed their risk behaviors to avoid acquiring or transmitting the virus (CDC, 2003a). In other words, significant numbers of people who were being tested for HIV were simply not returning for their results. From a New

Table 4. Primary Impact of Documents Analyzed on Community-Based Prevention

Document Name	Year Issued	Primary Impact on Community-Based HIV Prevention
Advancing HIV Prevention Initiative	2003	Behavioral – introduced the notion of "prevention with positives" via behavioral interventions; introduced a standardized behavioral intervention requirement
FOA #04-064	2004	Operationalized shifts in the behavioral prevention practice ideology introduced in the Advancing HIV Prevention initiative Structural – focused prevention resources on racial/ethnic minorities and specific "high-risk" populations disparately impacted by HIV; no mention of gay men or anal sex as a risk factor.
FOA #06-618	2006	Structural – exclusive focus on YMSM and YTP of color; acknowledges and targets regional and population variation in disparately affected cities and populations
FOA #08-803	2008	Structural – operationalized shifts in the behavioral prevention practice ideology introduced via the Advancing HIV Prevention initiative within the Commonwealth of Puerto Rico and the U.S. Virgin Islands
FOA #10-103	2009	Behavioral – included additional resources for the CBO Monitoring and Evaluation project for the development, implementation, monitoring, and evaluation of community-based prevention programming Biomedical – encourages the integration of diagnostic and prevention services for other frequently co-occurring conditions Structural – acknowledges that HIV disparities are inextricably linked to a complex blend of social and economic determinants that must be addressed in order to eliminate them; introduced organizational goals/target numbers for specific prevention activities
CDC HIV Prevention Strategic Plan	2010	Biomedical/behavioral – promotes the use of newer HIV testing technologies that can detect acute infection Structural – promotes the need to address HIV stigma and discrimination through prevention programming
National HIV/AIDS Strategy (NHAS)	2010	Outlines goals for addressing the national HIV/AIDS epidemic that integrates each of the existing behavioral and biomedical HIV prevention practice ideologies as well as structural approaches
FOA #11-1113	2011	Operationalizes the goals of the NHAS by building the capacity of CBOs to implement programming that integrates each of the existing prevention practice ideologies and structural approaches
High Impact Prevention Approach	2011	Further operationalizes integrated prevention practice ideologies and structural approaches put forth in the NHAS by promoting the combination of "scientifically proven, cost-effective, and scalable interventions" focused on the most vulnerable populations in geographic areas where HIV prevalence is highest
FOA #13-1301	2013	Operationalizes High-Impact Prevention in the Commonwealth of Puerto Rico and the United States Virgin Islands Promotes a more holistic and comprehensive, health-focused HIV prevention framework that can reach the general public, populations at risk, and health care providers easier with the goal of facilitating "open and honest societal dialogue around sensitive issues that are critically important to address, including health equity, human sexuality, relationships, and sexual behavior"

Institutional Theory (NIT) perspective, encouraging CBOs to adopt this new testing technology created coercive isomorphic pressure within the field (DiMaggio and Powell, 1983), resulting in uniform testing standards across funded organizations. Consequently, such standards required a shift in the way that CBOs approached HIV testing. Not only did CBO staff need to be trained on how to use this new technology, they also needed to be prepared to deliver HIV test results on the same day that the test had been conducted (which, at the very least, impacts staff scheduling practices within these organizations).

The AHP initiative's third strategy—to prevent new infections by working with PLWHAs—was considered a novel approach for the times and represented a major shift in the behavioral HIV prevention practice ideology as communicated by the CDC. Up until that point, according to the Morbidity and Mortality Weekly Report (MMWR) in which the AHP initiative was announced, the CDC had targeted its prevention efforts primarily towards HIV negative individuals "by providing funding to state and local health departments and nongovernmental CBOs for programs aimed at reducing sexual and drug-using risk behavior" (CDC, 2003a). The AHP initiative acknowledged that PLWHAs modify their behavior to reduce the risk of transmitting the virus to uninfected partners, while also suggesting that ongoing prevention services may be required to assist with behavior change and maintenance. As such, the initiative called for increased efforts to identify and link undiagnosed individuals to: (1) ongoing medical and prevention services; (2) demonstration projects with local health departments and CBOs to provide prevention case management to PLWHAs; and (3) support for newer models of partner notification and referral services (CDC, 2003a).

These strategies expand the behavioral HIV prevention practice ideology beyond a sole focus on HIV-negative individuals to include PLWHAs. Additionally, the AHP initiative stated that CDC grantees would be required to employ standardized procedures for prevention interventions and evaluation activities—a requirement that had not previously been in place. It is important to note, however, that despite the mention of recent syphilis outbreaks among MSM, neither of the strategies outlined under the AHP was aimed at addressing this public health concern. This oversight reflects the lack of integrated services within the CDC's program for community-based prevention efforts during this period.

Operationalizing the Advancing HIV Prevention Initiative

The first Funding Opportunity Announcement (FOA) issued for community-based HIV prevention by the CDC following the announcement of the AHP initiative was FOA #04-064 (CDC, 2003b). The stated goals of this FOA were to: (1) reduce new HIV transmissions; (2) increase the proportion of individuals at high risk for HIV infection who receive appropriate prevention services; (3) reduce barriers to early diagnosis of HIV infection; (4) increase the proportion of individuals at high risk for HIV infection who become aware of their serostatus; (5) increase access to quality HIV medical care and ongoing prevention services for individuals living with HIV; (6) address high priorities identified by the state or local HIV prevention Community Planning Group (CPG); and (7) to complement HIV prevention activities and interventions supported by state and local health departments (CDC, 2003b). These goals were consistent with the aims of the Advancing HIV Prevention Initiative and the expansion of the behavioral prevention practice ideology to include PLWHAs, though not specifically focused on making voluntary testing a routine part of medical care or decreasing perinatal transmission (which are not considered staples of community-based HIV prevention).

Despite the nod to state and local prevention planning and implementation efforts, FOA #04-064 restricted fundable interventions to those sanctioned by the CDC, as alluded to in the AHP initiative (CDC, 2003ab). Funded organizations were required to adopt and tailor CDC procedures related to HIV prevention, including those outlined in the Replicating Effective

Programs (REP) and the Diffusion of Effective Behavioral Interventions (DEBI) projects. The REP project was launched in 1996 by the CDC to identify effective HIV/STD prevention interventions and to prepare them for dissemination (Collins, Harshbarger, Sawyer, & Hamdallah, 2006). Initiated in 2002 in support of the REP initiative, the DEBI project was a CDC-funded strategy for diffusing evidence-based, group- and community-level interventions to health departments and community-based organizations across the country (Collins et al., 2006). Similar to HIV testing standards placed upon funded organizations, Evidence-Based Interventions (EBIs) can be seen as coercive isomorphic pressures (DiMaggio & Powell, 1983) led by the CDC to ensure that funded prevention services will be based on scientific evidence. However, these interventions may require significant adaptation to account for regional and cultural differences in perceptions of risk, as well as localized social/economic determinants of health (e.g., poverty rate, median education level). Consequently, such adaptations come with the potential to compromise the core elements of the interventions, thereby reducing efficacy.

Regardless of this potential challenge, CBOs funded under FOA #04-064 were expected to use CDC procedures, including REP strategies and EBIs, to provide one or more of the following: (1) targeted outreach and either Health Education/Risk Reduction (HE/RR) or Counseling, Testing, and Referral (CTR) services for “high-risk” individuals; or (2) one or more of the following types of interventions: (a) prevention with individuals living with HIV and their sex or injecting drug-using partners who are HIV negative or unaware of their HIV status, (b) prevention for individuals at very high risk for HIV infection, or (c) Partner Counseling and Referral Services (PCRS) (CDC, 2003b). If proposing to provide CTR services, organizations were required to document that they had discussed the details of the proposed program with their local health department and agreed to follow their guidelines for these services, consistent with the goals of the FOA to respect state and local prevention planning and implementation efforts.

Awards under FOA #04-064 were renewable for up to 5 years, dependent upon availability of funds and the "best interest of the federal government" (CDC, 2003b). Funding being dependent upon availability and the best interest of the federal government was not new to the organizational field of HIV prevention or to social services in general. However, it is worth noting here because it suggests the vulnerability of community-based prevention funding under federal administrations that may possess hostile attitudes and beliefs regarding the value of such services and/or the populations for which they are chiefly designed.

Refining Target Populations and Geographic Regions

With regards to target populations, FOA #04-064 defined an individual at "high risk" for HIV infection as someone who "has had unprotected sex or shared drug injecting equipment in a high-prevalence setting or with a person who is living with HIV" (CDC, 2003b). A "high prevalence setting" was described as "a geographic location or community with an HIV sero-prevalence greater than or equal to one percent" (CDC, 2003b). Lastly, a person at "very high risk for HIV infection" was defined as someone who has: (a) had unprotected sex with a person who is living with HIV; (b) had unprotected sex in exchange for money or drugs; (c) had multiple (greater than five) or anonymous unprotected sex or needle-sharing partners; or (d) been diagnosed with a sexually transmitted disease (STD) (CDC, 2003b).

Acknowledging the disparate impact that HIV was continuing to have on communities of color, CBOs could apply for funding to: (A) provide HIV prevention services to members of racial/ethnic minority communities who are at high risk for HIV infection; or (B) provide HIV prevention services to members of groups at high risk for HIV infection (as defined above) regardless of their race/ethnicity (CDC, 2003b). These categories suggest a structural approach to HIV prevention within the CDC's program for community-based efforts that is aimed at addressing racial/ethnic disparities by directing resources towards disproportionately impacted communities and high risk populations, as opposed to a more general approach.

Organizations were required to demonstrate that they were physically located in the area(s) where services would be provided, or that they had provided services in the area for at least three years (CDC, 2003b). This requirement was based upon the assumption that community-based efforts are most effective when delivered by organizations that have experience working with target populations and/or are physically located within the geographic regions where services are delivered. Despite the disparate impact of HIV on gay men across the country outlined in the AHP initiative, however, and the FOAs stated focus on "populations that have traditionally suffered exclusion from mainstream interventions and agencies," there was no mention of sexual orientation or anal sex as a risk factor within the FOA (CDC, 2003b). Such an omission is likely reflective of conservative values within the Bush administration which perceived gay men (and certainly transgender women) as disposable and unworthy of government-funded prevention efforts.

In 2006, however, the CDC issued FOA #06-618 (CDC, 2006). The specific objectives of this FOA were virtually the same as #04-064 (CDC, 2003b) with one notable addition: increase outreach and education efforts to encourage young men of color who have sex with men (YMCSM) and young transgender persons of color (YTPOC) to know their HIV status (CDC, 2006). According to the FOA, young MSM and particularly YMCSM, were the largest group of young people affected by HIV at that time (CDC, 2006). Additionally, the FOA states that recent data from the National HIV Behavioral Surveillance System (established as part of the Advancing HIV Prevention initiative) indicated that HIV prevalence was 46% among black MSM, 21% among white MSM, and 17% among Latino MSM in 5 of the 17 participating cities

(CDC, 2006). Moreover, nearly half (48%) of the MSM surveyed who were HIV positive were previously unaware of their status (CDC, 2006).

Acknowledging that state and national data surveillance systems were not designed to categorize individuals as transgender, the FOA cited limited data available from the CDC for its focus on this population, which suggested heightened rates of infections among male-to-female (MTF) transgender persons (CDC, 2006). Specifically, a community network sample found HIV prevalence among transgender women and men to be 35% and 2%, respectively (CDC, 2006). Another study cited in the FOA estimated HIV incidence at 7.8% for MTF repeat testers at counseling and testing sites, the highest rate detected for any risk group at that time, according to the FOA (CDC, 2006).

To address these alarming statistics, the FOA suggested that “continual outreach and education are required as new generations replace those that benefited from earlier prevention efforts” (CDC, 2006). In addition, the FOA stated that “testing should be encouraged and prevention programs should improve methods for reaching persons unaware of their HIV status, especially those in populations disproportionately at risk” (CDC, 2006) Subsequently, the primary goal of FOA #06-6818 was to provide effective prevention services to YMCSM and YTPOC (up to age 24 years old) at high risk for infection or transmission, by funding nonprofit organizations to conduct select standardized programs that complement HIV prevention activities and interventions conducted by state and local health departments (CDC, 2006).

Different from FOA #04-064 (CDC, 2003b), which required organizations to demonstrate previous experience providing prevention services to the intended population and to be physically located in the area(s) where services would be provided, FOA #06-618 specified that funding would be limited to nonprofit organizations that had experience working with YMCSM and YTPOC within a list of specified Metropolitan Statistical Areas (including the four cities selected for this dissertation) (CDC, 2006). This restriction was likely included in response to data from the NHBS that highlighted disparate rates of undiagnosed HIV infection in particular geographic regions, introducing a structural approach to prevention that forced CBOs to acknowledge regional variations in both new infections and available resources within the field.

Funding for FOA #06-6818 was congressionally earmarked for CBOs through the Minority AIDS Initiative (MAI), which required that funds be used to enhance efforts to prevent the acquisition or transmission of HIV infections in racial and ethnic minority communities (CDC, 2006). Three specific funding categories were outlined in the FOA: (a) Effective Behavioral Interventions (EBIs) for high risk YMCSM and their partners; (b*)* EBIs for high risk YTPOC and their partners; and (c) demonstration projects for locally developed, theory-based HIV prevention program models targeting high risk YMCSM and their partners or YTPOC and their partners.

Refining Fundable Interventions

Under Categories A and B of FOA #06-608, CBOs were required to adapt CDC program models—including REP, DEBI and other activities supporting the Advancing HIV Prevention initiative—similar to the requirements outlined in FOA #04-064 (CDC, 2006; CDC, 2003b). More specifically, applicants were required to select one of the following EBIs for implementation with high risk individuals: Popular Opinion Leader (POL); MPowerment; Safety Counts; Many Men, Many Voices (3MV); Community Promise; Together Learning Choices (formerly Teens Linked to Care); Healthy Relationships; Street Smart; or Sisters Informing Sisters about Topics on AIDS (SISTA) (CDC, 2006). In addition, funded CBOs were mandated to implement one of the following Public Health Strategies for high-risk individuals: (a) Comprehensive Risk Counseling and Services (CRCS), formerly known as HIV Prevention Case Management (PCM), or (b) Counseling, Testing, and Referral (CTR) services (CDC, 2006).

It is important to note that interventions listed under Categories A and B included individual-level approaches targeting HIV-negative individuals as well as PLWHAs, in addition to some group- and community-level interventions that target both populations. This additional emphasis on prevention with positives was consistent with the shift in the behavioral HIV prevention practice ideology put forth in the AHP initiative (CDC, 2003a) and FOA #04-064 (CDC, 2003b). In contrast to FOA #04-064 (CDC, 2003b), however, FOA #06-6818 also mandated that all interventions include the promotion of abstinence, faithful monogamy and correct, consistent condom use (also referred to as the ABCs of HIV prevention) (CDC, 2006). Although this mandate suggested a shift in the Bush administration's position on condom promotion (as described in the Introduction and Review of Relevant Literature section of this dissertation), it also explicitly reemphasized conservative rhetoric about sex and sexuality within the behavioral HIV prevention practice ideology. As such, while this FOA resulted in coercive isomorphic pressure within the field (DiMaggio & Powell, 1983), requiring funded CBOs to employ specific EBIs to uniformly address HIV disparities among YMSM and YTPOC, it is also infused with conservative values that may directly conflict with how sexual behavior and relationships have emerged and are now celebrated among these populations.

Given the lack of available evidence-based interventions focused on YMCSM and YTPOC, CBOs could also apply under Category C of FOA #06-618 for funds to implement demonstration projects that could determine the feasibility and effectiveness of locally developed prevention programs (CDC, 2006). To be considered for funding, the proposed program had to be based on a behavior change theory and make use of additional behavior change strategies when appropriate (CDC, 2006). In addition, organizations were required to demonstrate a stable history of implementing the program and documentation of successful recruitment and retention of the target population for 12 months or more (CDC, 2006). In a way that FOA #04-064 (CDC, 2003b) did not, this additional funding opportunity acknowledged the value of “homegrown” interventions for addressing local and cultural barriers to prevention that may not be otherwise attended to through the implementation of nationally disseminated, pre-packaged models (CDC, 2006). Such consideration offers an example of a structural strategy that is critical to the behavioral HIV prevention practice ideology, as it validates the need and makes provision for localized community-based efforts directed at the most vulnerable populations regionally. However, the documentation required to demonstrate the theoretical foundations of the intervention and a stable history of implementation could unintentionally disqualify smaller CBOs that may not possess the capacity for such reporting/recordkeeping.

In February 2008, the CDC released the last FOA for community-based prevention to be issued under the Bush administration, FOA #08-803 (CDC, 2006). Consistent with the objectives of the AHP initiative (CDC, 2003b), the primary goal of this FOA was to fund community-based organizations in the Commonwealth of Puerto Rico and the U.S. Virgin Islands to: (1) implement selected, standardized HIV prevention models to complement HIV prevention activities and interventions conducted by state and local health departments by addressing high priorities identified by the state or local Community Planning Groups (CPGs); (2) administer effective HIV prevention services to persons at high risk for HIV infection or transmission; and (3) reduce barriers to early diagnosis of HIV infection and increase access to HIV testing and use of quality medical care, treatment, and ongoing prevention services (CDC, 2008).

The objectives of this FOA were similar to previous FOAs issued subsequent to the Advancing HIV Prevention Initiative (FOA #04-064 and FOA #06-618), with grantees being required to adapt and implement one EBI and at least one public health strategy (CDC, 2008; CDC, 2003b; CDC, 2006). Although no specific populations or “risk groups” were mentioned in the FOA, a Spanish language EBI (Modelo de Intervención Psicomédica) was included among the list of fundable interventions (CDC, 2008). The primary significance of FOA #08-803 to this analysis is that it further operationalized the shift in the behavioral HIV prevention practice ideology by sanctioning a culturally and linguistically responsive EBI for use in the stated regions. FOA #08-803 also built upon structural approaches to HIV prevention by expanding the priority geographic areas (and thus the target populations) of previous FOAs.

Summary of Community-Based Prevention under the Bush Administration

In sum, the reassessment and refocusing of HIV prevention efforts at the CDC in 2003 resulted in a major shift in the community-based HIV prevention practice ideology under the Bush administration. More specifically, the Advancing HIV Prevention initiative and the flagship FOA for community-based prevention (FOA #04064) that followed shifted the behavioral prevention practice ideology by requiring CBOs to adopt standardized interventions, in contrast to locally-developed programs (CDC, 2003b). While the FOA ensured that disparities in race were considered—revealing structural efforts to target prevention efforts among disparately affected populations—definitions of "high risk" and "very high risk" were broad and did not specifically highlight anal sex or mention gay men, the most severely impacted group in the United States (CDC, 2003b). This omission, likely the result of conservative values within the Bush administration, ignored such structural factors as stigma and homophobia that affect risk and access to prevention services for gay/bisexual men.

However, data from the NHBS and other sources that highlighted alarming disparities in HIV incidence and prevalence among YMCSM and YTPOC, as well as in the Commonwealth of Puerto Rico and the U.S. Virgin Islands, resulted in FOAs focused specifically on the prevention needs of these populations/regions (CDC, 2006; CDC, 2008). Although prevention activities funded under these FOAs mirrored those outlined in FOA #04-064 (CDC, 2003b), the focus on specific geographic regions with disparate rates of undiagnosed HIV infection among YMCSM and YTPOC was novel, reflecting a structural HIV prevention approach that acknowledged regional and population variance. By narrowing in on specific areas of the country and populations with the greatest prevention needs, the rationale was that targeted testing and secondary prevention strategies—guided by the integration of the behavioral prevention practice ideology and strategic structural efforts—would have a greater impact. Moreover, the intentional focus on YMCSM and YTPOC expanded the categories of populations considered to be at high risk for HIV infection beyond those outlined in FOA #04-064 (persons who have had unprotected sex or shared drug injecting equipment in a high-prevalence setting or with a person who is living with HIV) (CDC, 2003b). At the same time, the infusion of conservative values that stress abstinence and monogamy threatened to further stigmatize and marginalize these populations. More specifically, such rhetoric did not take into consideration the social/economic determinants of sexual relationships among YMSM and YTPOC (e.g., stigma, homophobia, discrimination), which could have significant implications for the delivery of effective prevention services within CBOs.

Community-Based HIV Prevention Under the Obama Administration

In 2008, the White House Office of National AIDS Policy (ONAP) began working on a national strategy to re-focus the country's response to the domestic HIV epidemic (ONAP, 2010). The following year, under the direction of President Barack Obama's administration, ONAP began hosting HIV/AIDS "community discussions" to hear directly from people affected by HIV about their experiences with the virus. ONAP also solicited strategic recommendations for developing a national strategy from these discussions and other outreach efforts. Recommendations from these community engagement activities called for a wide-scale and multifaceted HIV prevention campaign to engage the American public. In addition, prevention efforts targeting specific "high risk" populations (including MSM and transgender women) were also championed, reflecting the public's understanding of greater accuracy in HIV surveillance among diverse communities (ONAP, 2010).

In July 2009, the CDC issued its first FOA under the Obama administration, FOA #10-103 (CDC, 2009). Citing the disproportionate impact that HIV/AIDS was continuing to have on African Americans, Latinos, and gay/bisexual men of all races, the CDC explicitly sought to maintain the fundamental elements that had well served its program for community-based HIV prevention since the beginning, while enhancing the program by incorporating lessons learned from previous cycles (CDC, 2009). Specifically, the FOA made funds available for CBOs to develop and implement prevention programs in two categories: (a) services for members of racial/ethnic minority communities (e.g., African Americans, Latinos) at high risk for HIV infection, and (b) services for members of groups (e.g., MSM, transgender women, injection drug users, HIV-infected persons) at high risk for acquiring or transmitting HIV, regardless of race/ethnicity (CDC, 2009).

Organizations could apply to implement prevention programs that included behavioral interventions, HIV CTR (Counseling, Testing, and Referral) services, or both, in support of the HIV prevention priorities outlined in their respective jurisdiction's comprehensive HIV prevention plans (CDC, 2009). Despite this flexibility, CBOs were required to implement at least one EBI as part of their proposed activities (CDC, 2009). In addition, the FOA explicitly stated that EBIs could also be adapted to better meet the needs of the proposed target population if organizations could justify why an available intervention would not suffice without adaptation (CDC, 2009). Allowing CBOs the flexibility to modify EBIs as necessary represents a shift in the behavioral HIV prevention ideology, reflective of evolving structural approaches within the CDC's community-based program. More specifically, this flexibility suggests that the CDC acknowledged the limitations of existing service technologies (EBIs in particular) for addressing the myriad prevention needs that exist within affected communities. One size does not fit all in the case of HIV prevention and even a good fit may not be perfect. Therefore, by allowing flexibility with regard to implementation, this change was aimed at improving the responsiveness of the CDC's community-based HIV prevention program to more specific real-time needs on the ground.

Furthermore, FOA #10-103 also made clear that the CDC was invested in building the capacity of CBOs to conduct outcome monitoring of behavioral interventions by making additional funding available to support an optional CBO Monitoring and Evaluation Project (CDC, 2009). The purpose of this project was described as two-fold: (1) to improve the performance of CDC-funded CBOs delivering particular individual- or group level behavioral interventions (CLEAR; Many Men, Many Voices; Partnership for Health; RESPECT; SiHLE; Sister to Sister; START; Street Smart; or WILLOW) by monitoring changes in clients' self-reported HIV transmission risk behaviors after participating in the intervention; and (2) to assess implementation fidelity of these interventions within CBOs (CDC, 2009).

The interventions selected for monitoring and evaluation under this project were focused on both PLWHAs and HIV-negative individuals. Three of these interventions had been previously sanctioned under past FOAs (CLEAR; Many Men, Many Voices; and Street Smart). RESPECT focused on both male and female high-risk negatives, Sister to Sister on HIV-negative women, SiHLE on African American teens, and WILLOW on women living with HIV (CDC, 2009). START focused on individuals returning to communities after being incarcerated, while Partnership for Health is an intervention designed specifically for physicians who may be treating PLWHAs and/or individuals at high risk (CDC, 2009). No specific rationale was provided for why these particular interventions were chosen for monitoring and evaluation under this project. However, the inclusion of interventions that address the prevention needs of women, as well as issues of incarceration and patient/provider relations is indicative of evolving structural approaches within the CDC's program for community-based HIV prevention that extend beyond general prevention strategies and focus in on specific disparities and their underlying causes.

Additional evidence for evolving structural approaches can be found in the purpose section of FOA #10-103. Here, the CDC explicitly stated that it supported the promotion of "Program Collaboration and Service Integration (PCSI)," in line with the National Center for HIV, Viral Hepatitis, STD, and TB Prevention's (NCHHSTP) program imperative (CDC, 2009). The primary aim of PCSI was to promote "improved comprehensive services at the client level through enhanced collaboration at the health department jurisdictional level, as well as the applicant program level, thereby offering opportunities to: (1) increase efficiency, reduce redundancy, and eliminate missed opportunities; (2) increase flexibility and better adapt to overlapping epidemics and risk behaviors; and (3) improve operations through the use of shared data" (CDC, 2009). Citing disproportionate rates of tuberculosis, hepatitis B and C, and STDs among populations also disparately affected by HIV, FOA #10-103 encouraged the integration of diagnostic and prevention services for these commonly co-occurring infections for the first time (CDC, 2009).

From a structural prevention perspective, such integration acknowledges the interconnectedness of these infections as well as the systems that provide services to the populations most susceptible to them, including CBOs. Promoting program collaboration and service integration increases the likelihood that individuals who are unaware of their HIV positive status, as well as those who are aware but may not be engaged in primary medical care, will not fall through cracks within the public health infrastructure. Rather, any particular interaction with the system could potentially provide an opportunity for both HIV testing and linkage to these additional services. Moreover, FOA #10-103 acknowledged—for the first time in any FOA for community-based prevention issued since the Advancing HIV Prevention initiative (CDC, 2003b)—that these health disparities are "inextricably linked to a complex blend of social and economic determinants" (e.g., poverty, racism, and homophobia) that must be addressed in order to eliminate them (CDC, 2009). However, no additional funding categories were included in the FOA for CBOs to specifically address these determinants, and the CDC provided no recommendations for appropriate service technologies for doing so.

Game Changers in HIV Prevention

The year 2010 brought about a unique blend of both policy and biomedical advancements that significantly impacted community-based HIV prevention practice ideologies and structural approaches. In January 2010, the CDC added the following objectives to its HIV Prevention Strategic Plan (formerly referred to as the Advancing HIV Prevention initiative), to make urgent priorities of the current administration more explicit: (1) prevent new infections among MSM and African Americans; (2) address stigma and discrimination; (3) promote the use of rapid HIV tests; (4) address the role of acute infection in HIV transmission; and (5) increase routine HIV testing in medical settings (CDC, 2010). These additional objectives were in direct alignment with recommendations elicited through the aforementioned community discussions hosted by ONAP to inform a national strategy for combating the domestic epidemic. Moreover, they impacted HIV prevention practice ideologies and structural approaches in a number of ways.

First, while the focus on rapid HIV testing technologies and increasing routine testing in medical settings was not new for the CDC, addressing the role of acute infection in HIV transmission was. Newly infected individuals (or those within the acute stage of infection) have elevated HIV viral loads (Cohen, Shaw, McMichael, & Haynes, 2011). As a result, they are considerably more likely to transmit the virus to uninfected sexual partners. Advances in testing technologies allow for earlier detection of the virus which, in turn, allows for earlier behavioral intervention and linkage to primary medical services that include prompt initiation of ARV treatment for those found to be HIV-positive. Employing HIV testing strategies beyond raising status awareness for the purpose of stimulating behavior change—which had been the rationale for testing since the AHP initiative—situated this technology within both the behavioral and biomedical HIV prevention practice ideologies. More specifically, testing protocols focused in this fashion combined these ideologies based on the notion that earlier detection and intervention with both behavioral and biomedical (ARV-based) interventions would result in decreased rates of new infections. In addition, the charge to address stigma and discrimination through HIV prevention programming within the objectives of the strategic plan was novel, acknowledging the role that these variables play in sustaining HIV disparities. As such, this requirement expanded and further institutionalized the structural approaches to community-based HIV prevention originally put forth in FOA #10-103 (CDC, 2009).

In July 2010, the nation's first comprehensive coordinated plan for addressing the domestic HIV epidemic (the National HIV/AIDS Strategy or NHAS) was released (ONAP, 2010). The primary goals of the NHAS were to: (1) reduce new HIV infections; (2) increase access to care and improve health outcomes for people living with HIV; and (3) reduce HIV-related health disparities (ONAP, 2010). Additionally, the NHAS called for a more coordinated national response to the HIV epidemic and was released with an accompanying federal implementation plan that outlined specific steps to be taken by various federal agencies to support its high-level priorities (ONAP, 2010b). Recommended actions outlined in the implementation plan for reducing new HIV infections aligned with the existing behavioral prevention practice ideology and structural approaches by calling for: (1) the allocation of public funding to geographic areas and populations consistent with the epidemic (e.g. the southern U.S., gay/bisexual men, transgender women, black and Latino Americans); (2) enhanced program accountability; (3) the design and evaluation of innovative prevention strategies and combination approaches for preventing HIV in high risk communities; and (4) expanding access to effective prevention services (ONAP, 2010).

That same month (July 2010), what has been described as the biggest "game changer" in HIV prevention occurred. Investigators for the Pre-Exposure Prophylaxis Initiative (iPrEX) research study announced results from a multinational, phase III clinical trial demonstrating the safety and efficacy of daily oral antiretroviral medications (specifically tenofovir disoproxil fumarate and emtricitabine combined as the brand name drug Truvada) for preventing HIV infection among MSM exposed to the virus (Grant et al., 2010). More specifically, iPrEX found that men who took Truvada as indicated for prevention (once a day, 7 days a week) reduced their risk of acquiring HIV by up to 99% (Grant et al., 2010). As a result, the CDC issued interim guidance to health providers on prescribing Truvada as Pre-Exposure Prophylaxis (PrEP) for MSM (CDC, 2011a). Gilead Sciences, the maker of Truvada, also pursued approval from the FDA for the drug to be officially indicated for use as PrEP (as opposed to only being prescribed off label for prevention) (Gilead Sciences, Inc., 2012).

The landmark study demonstrating the effectiveness of Highly Active Antiretroviral Therapy (HAART) for reducing the potential for PLWHAs to transmit the virus to uninfected partners would not produce data until the following year (Cohen et al., 2012). However, hypothetical anecdotes within the field (based on the pharmacology of ARVs) suggested that reducing the amount of virus in an HIV-positive individual's blood stream also reduces infectiousness, establishing the biomedical HIV prevention practice ideology (which involves the promotion of testing technologies for detecting acute infections and prompt initiation of antiretroviral medications to reduce the risk of acquiring or transmitting the virus). Truvada as

PrEP, which also involves the use of antiretroviral medications to reduce acquisition of HIV, expands this ideology by including an intervention specific to HIV-negative individuals.

As previously mentioned, a deeper dive into data from the iPrEx trial revealed that, with appropriate adherence, Truvada as PrEP could be more effective than condoms for preventing HIV acquisition (Grant et al., 2010). Additional studies with other populations across the world would continue to provide evidence for this proof of concept (Thigpen et al., 2012; Baeten et al., 2012; Choopanya et al., 2013). It is important to note, however, that the iPrEX study combined behavioral interventions—including ongoing risk-reduction and PrEP medication adherence counseling—with Truvada to achieve the aforementioned results (Grant et al., 2010). Additionally, routine HIV testing was required to ensure that participants remained HIV-negative while taking Truvada as PrEP to avoid other potential complications. As such, adhering to a daily medication (and a routine testing schedule) to prevent HIV requires significant behavior change on the user's part. Moreover, a number of structural challenges exist to ensuring that those who could benefit most from this novel biomedical prevention strategy know that it exists and have unfettered access to it.

Institutionalizing the Biomedical HIV Prevention Practice Ideology

The first FOA issued from the CDC for community-based HIV prevention following the aforementioned advances in policy and treatment technologies was FOA# 11-1113 (CDC, 2011b). Similar to FOA #10-103 (CDC, 2009), the primary stated objective of this FOA was to support the development and implementation of effective community-based prevention programs (CDC, 2011b). However, in alignment with the targeted strategies outlined in the NHAS (ONAP, 2010a), this FOA was focused exclusively on programs that targeted YMCSM and YTPOC, as well as their partners at high risk of acquiring or transmitting HIV (CDC, 2011b). Also, different from the objectives of FOA #10-103 (CDC, 2009), FOA#11-1113 broadened the CDC's aim to build the capacity of funded CBOs to deliver “selected behavioral interventions or HIV CTR services to persons at high risk” (including structural interventions, outreach, and enhanced HIV testing to these populations) (CDC, 2011b). Additional objectives included: (1) increasing the number of YMCSM and YTPOC who are aware of their HIV status and linked to care, treatment and prevention services; and (2) ensuring the provision of HIV prevention and care services (CDC, 2011b). The objectives of this FOA advanced the biomedical HIV prevention practice ideology by institutionalizing practices for ensuring access to prevention and care services beyond knowing one’s HIV status for both PLWHAs and HIV-negative individuals, whereas previous linkage efforts had been focused exclusively on HIV-positive persons. This is likely a direct result of the aforementioned advances in biomedical prevention approaches for HIV-negative individuals.

Under FOA# 11-1113, CBOs were urged to request funding to implement “Comprehensive Prevention Programs” for YCMSM and YTPOC that support the HIV prevention priorities outlined in their respective jurisdiction’s comprehensive HIV prevention plan (CDC, 2011b). Applicants could apply for prevention activities under two categories: (Category A) prevention services for high risk YMCSM and their partners regardless of age, gender, and race/ethnicity; and (Category B) prevention services for high risk YTPOC and their partners regardless of age, gender, and race/ethnicity (CDC, 2011b). According to the FOA, a successful application would propose programs that consisted of the following components: (1) client recruitment; (2) enhanced HIV testing; (3) risk reduction interventions and services through the implementation of one of the following: Comprehensive Risk Counseling Services (CRCS) with the CLEAR EBI or an existing, locally developed, theory-based intervention; (4) condom distribution; and (5) a coordinated referral network (CDC, 2011b). Similar to each of the FOAs issued since #06-618 (CDC, 2006), FOA#11-1113 was limited to organizations that had experience working with and providing services to YMCSM and YTPOC in specified geographic areas, including the four cities that are the focus of this dissertation (CDC, 2011b).

For the first time ever, this FOA listed specific requirements for organizational targets related to various prevention activities (CDC, 2011b). For example, CBOs applying for Category A were required to provide enhanced HIV testing to a minimum of 600 to 1,000 YMCSM annually (CDC, 2011b). Category B required that 75 to 100 YTPOC receive these services (CDC, 2011b). In addition, HIV testing activities funded under both categories were required to reach and maintain a previously undiagnosed seropositivity rate of 4% on an annual basis (CDC, 2011b). These requirements were in line with previously instituted structural approaches within the CDC's program for community-based HIV prevention, making target populations/service priorities more explicit and tied directly to funding.

With regards to interventions, the FOA divided the target populations into three categories (medium-risk negative, high-risk negative, and HIV positive) and provided specific guidance on sanctioned interventions deemed appropriate for each category, also for the first time (CDC, 2011b). Congruent with the emerging biomedical HIV prevention practice ideology, both Pre- and Post-Exposure Prophylaxis (PrEP and PEP) were included among the list of recommended referral services (CDC, 2011b). It is important to note, however, that although PEP had been included in the proverbial HIV prevention toolbox since 2005 when the Department of Health and Human Services first issued clinical guidelines for prescribers (DHHS, 2016), FOA# 11-1113 includes the first mention of this ARV-based biomedical prevention tool in any FOA issued by the CDC for community-based efforts. This delayed mention can likely be attributed to two specific factors: (1) the substantial buzz generated about ARV-based prevention in general following the introduction of PrEP and (2) the potential for wider accessibility of PEP under the ACA.

In addition to providing linkage-to-care and treatment services for PLWHAs using evidence-based practice models (e.g., ARTAS, peer navigators), funded organizations were also require to make similar services available to HRNs, for the first time under any CDC FOA. CBOs were also required to provide follow-up support services to remove barriers to medical care (e.g. transportation and housing) (CDC, 2011b). Additionally, FOA# 11-1113 outlined specific targets for various prevention activities required for both PLWHAs and HRNs (CDC, 2011b). For example, if funded, CBOs were required to link a minimum of 70% of all identified HIV positive individuals to appropriate risk reduction interventions and strategies, including primary care (CDC, 2011b). CBOs were also required to distribute condoms to 100% of HIV positive and high-risk negative individuals (CDC, 2011b).

High Impact HIV Prevention

Shortly after the release of FOA #11-1113 (CDC, 2011b), the CDC officially announced its High-Impact Prevention (HIP) approach to reducing new HIV infections in the U.S. (CDC, 2011c), likely in response to the flood of previously described policy and biomedical advances that occurred in 2010. This strategy further institutionalized community-based prevention practice ideologies and structural approaches put forth in FOA #11-1113 (CDC, 2011b) by calling for the use of combinations of "scientifically proven, cost-effective, and scalable interventions" focused on the most vulnerable populations in geographic areas where HIV prevalence is highest (CDC, 2011c). In alignment with the National HIV/AIDS Strategy (ONAP, 2010a), focus populations included: (1) gay and bisexual men of all races; (2) African Americans; (3) Latinos; (4) injection-drug users; and (5) transgender individuals (CDC, 2011c). Interventions sanctioned under the HIP initiative were divided into 7 categories: (1) HIV testing and linkage to care; (2) antiretroviral therapy; (3) access to condoms and sterile syringes; (4) prevention programs for people living with HIV and their partners; (5) prevention programs for people at high risk of HIV infection (including PrEP); (6) substance abuse treatment; and (7) screening and treatment for other sexually transmitted infections (CDC, 2011b). It is important to note that, although injection-drug users have been listed as a target population in several of the FOAs and other documents that I analyzed, this is the first mention of access to sterile syringes for this population. This omission was likely due to the controversial nature of syringe-exchange programs and the long-standing ban on federal government funding to support them (which was briefly lifted in 2010 but recently reinstated) (Fisher, 2012).

In 2012, the CDC released FOA #13-1310 for comprehensive community-based prevention services in the Commonwealth of Puerto Rico and the United States Virgin Islands (CDC, 2012b). This was the first FOA to be released following the announcement of the HIP (CDC, 2011c) initiative and the last to be included in this analysis. The stated purpose of FOA #13-1310 was to implement comprehensive prevention programming to reduce morbidity, mortality, and related health disparities in the designated geographic areas (CDC, 2012b). Specifically, the FOA was intended to: (1) support the development and implementation of high impact, comprehensive community-based HIV prevention programs to achieve maximum impact on reducing new HIV infections via the provision of services to persons at high risk for transmitting and acquiring HIV in the specified regions; (2) increase the number of HIV-positive persons in the specified regions who are aware of their HIV status and linked to and re-engaged in care, treatment, and other essential support services; (3) build the capacity of CDC-funded CBOs to support the delivery of scalable, cost-effective, and evidence-based comprehensive community-based prevention programs; and (d) promote collaboration and coordination of HIV prevention (CDC, 2012b).

FOA #13-1301 was a competing continuation of FOA #08-803 and, thus, eligibility was limited to CBOs that were previously funded under that FOA (CDC, 2012b). Prevention activities funded under FOA #13-1301 mirrored those from FOA #11-1113 (CDC, 2011b), including organizational targets for HIV testing, condom distribution, and linkage to care services for both HIV-negative individuals and PLWHAs. Funded organizations were also required to develop a referral tracking system to determine and document successfully accessed referral services, as well as develop or enhance systems for providing client navigation services for PLWHAs and HRNs at all stages of care, treatment, prevention, and essential support services (CDC, 2012b). These requirements further operationalized the biomedical HIV prevention practice ideology by requiring CBOs to more thoroughly document and track referral services at all stages of care as opposed to simply at the initial linkage stage. Such requirements may be attributed to age and ethnic/racial disparities identified in the HIV Treatment Cascade, which suggests significant drop-off rates beyond the linkage stage for younger persons and for people of color (Bradley et al, 2014).

Summary of Community-Based Prevention under the Obama Administration

In sum, the advent of ARV-based prevention and federal policy initiatives such as the National HIV/AIDS Strategy and the Affordable Care Act resulted in substantial changes in community-based HIV prevention practice ideologies communicated to CBOs from the CDC under the Obama administration. A number of changes in structural approaches to HIV prevention at the community-level were also introduced during this period. To operationalize these changes in practice ideologies and approaches, three FOAs for community-based prevention were issued by the CDC from 2009 through 2013—FOAs #10-1003, #11-1113, and #13-1301.

FOA #10-103 impacted the behavioral HIV prevention practice ideology in two specific ways. First, the FOA expanded the variety of EBIs that CBOs could select from, while also allowing for flexibility in implementation to better respond to the prevention needs of local communities (CDC, 2009). Second, this FOA made funding available for a CBO Monitoring and Evaluation Project to support the development, implementation, monitoring, and evaluation of community-based prevention programming (CDC, 2009). In addition to previously sanctioned EBIs that focused on PLWHAs, MSM, and homeless youth, this project encouraged the evaluation of additional interventions that also focused on women (for the first time), as well as formerly incarcerated individuals and primary care providers that take care of PLWHAs (CDC, 2009). Finally, FOA #10-103 expanded structural prevention approaches by formally introducing the concepts of "Program Collaboration and Service Integration" (PCSI) and "social and economic determinants of health" into the field, requiring that funded organizations incorporate appropriate strategies for addressing these variables (CDC, 2009). However, implementing PCSI and offering programming that addresses social/economic determinants required CBOs to more intentionally approach prevention beyond the individual level by tackling the structural and systemic barriers that exist for their most vulnerable clients, which created additional demands to which these organizations were required to respond to. Despite this, these additional demands were not accompanied by increased resources for addressing these barriers, or recommendations for specific service technologies for doing so.

Issued in April 2011, shortly after the NHAS was released and the ACA signed into law, FOA #11-1113 was focused exclusively on providing comprehensive prevention programming to young MSM and transpersons of color (CDC, 2011b). This FOA operationalized the biomedical HIV prevention practice ideology introduced in the NHAS by requiring linkage to care activities for high-risk HIV-negative individuals for the first time, which included referrals to both PrEP and PEP (CDC, 2011b). In theory, the ACA would make these biomedical prevention tools available to all Americans regardless of their ability to pay for them. In addition, FOA #11-1113 advanced structural approaches to HIV prevention by putting forth organizational targets for particular services for the first time (CDC, 2011b)—resulting in coercive isomorphic pressure (DiMaggio & Powell, 1983) as CBOs needed to ensure that funded services were delivered to priority populations within the CDC's community-based prevention program in order to maintain funding.

In August of 2011, the prevention practice ideologies and structural approaches put forth in the NHAS and operationalized in FOA #11-1113 were further institutionalized in the CDC's High Impact HIV Prevention (HIP) Strategy (CDC, 2011c). HIP specifically outlined the CDC's plan for disseminating "scientifically proven, cost-effective, and scalable interventions" focused on the most vulnerable populations in geographic areas where HIV prevalence is highest (CDC, 2011c). In 2013, FOA# 13-1301 was released, the last to be issued under the Obama Administration (CDC, 2012b). This FOA operationalized community-based High-Impact HIV Prevention efforts in the Commonwealth of Puerto Rico and the United States Virgin Islands.

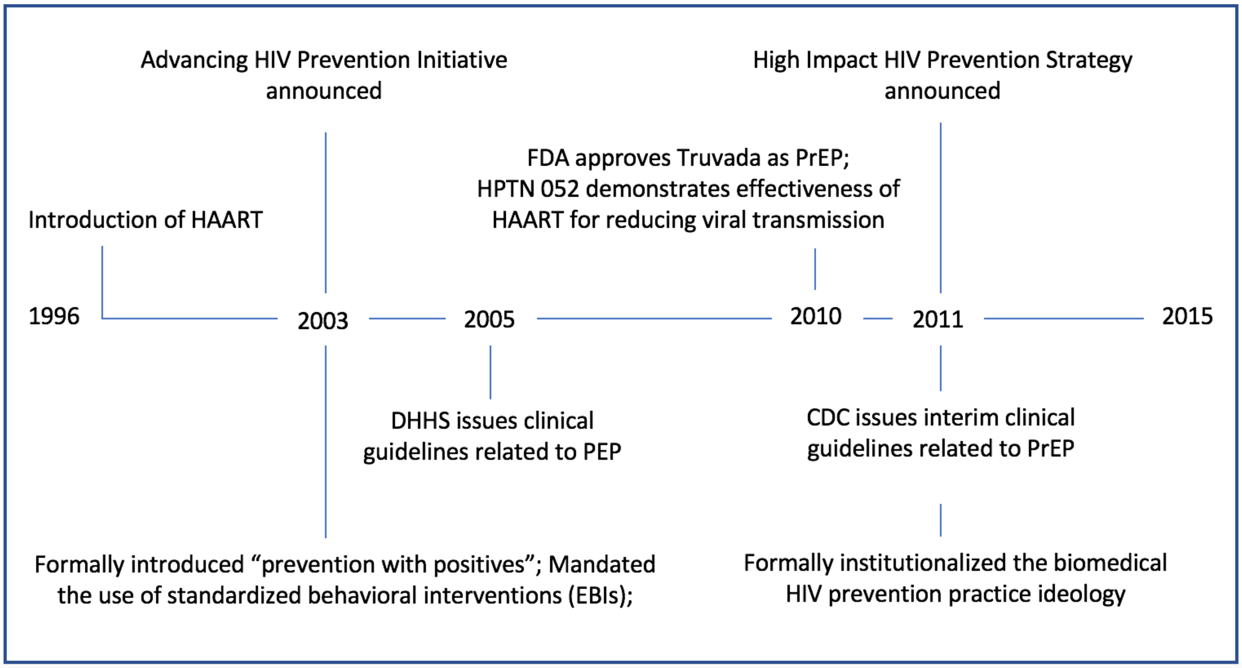
Discussion

Much has changed in the way of community-based HIV prevention since the days when information dissemination, locally-developed interventions, and condom distribution were the only tools available in communities dwindling from the havoc that AIDS was wreaking. More specifically, advances in prevention approaches and HIV surveillance strategies have expanded the CDC's program for community-based prevention, shifting practice ideologies and introducing structural approaches that have refined service delivery in a number of ways. In this chapter, I have documented and described HIV prevention practice ideologies as they have been communicated by the CDC since the Advancing HIV Prevention (AHP) initiative issued in 2003, illuminating how environmental demands placed upon CBOs from this particular funding source have accumulated over time. In short, this analysis revealed two primary shifts in HIV prevention practice ideologies communicated to CBOs from the CDC. As Figure 1 shows, funded organizations were first required to forgo locally-developed homegrown interventions and implement standardized behavioral interventions as determined by the CDC. Then, as antiretroviral-based prevention emerged and evolved, the CDC's program for community-based HIV prevention shifted from a primary focus on behavioral interventions to the inclusion of these biomedical approaches.

In addition to these shifts in practice ideologies, this analysis also revealed concurrent advances in structural approaches to preventing HIV/AIDS, as the CDC has increasingly acknowledged the impact of larger contextual factors (e.g., social and economic inequalities) for perpetuating disparities in HIV. These structural approaches included: (1) expanding community-based prevention efforts to include PLWHAs; (2) targeting efforts towards disproportionately affected populations (e.g. gay/bisexual men, transgender women) in geographic regions where HIV prevalence is highest (e.g., the southern U.S.); and (3) addressing the social/economic determinants of health facing the most vulnerable populations (e.g., poverty, homelessness, unemployment, racial discrimination).

According to the history of CDC-funded HIV prevention efforts outlined in the AHP, both behavioral prevention practice ideologies and structural approaches predate this initiative (CDC, 2003a). However, the AHP expanded the behavioral HIV prevention practice ideology by requiring CBOs to adopt rapid testing approaches and standardized behavioral interventions focused on HRNs and PLWHAs, for the first time (CDC, 2003a). The primary rationale offered in support of these priority strategies was grounded in the assumption that past prevention efforts supported by the CDC, focused primarily on reducing sexual and drug-injecting risk behaviors among HIV-negative individuals and utilizing testing technologies that required individuals to return for their results, were too broadly focused and generally ineffective (CDC. 2003a). Thus, an increased focus on raising HIV status awareness among "very high risk" individuals using rapid testing technologies, and an even stronger focus on those who tested positive through expanded testing initiatives, was believed to produce knowledge that would lead to "individual empowerment, preventative actions, and an overall reduction in transmission" (CDC, 2003a).

Figure 1: Timeline of Shifts in HIV Prevention Practice Ideologies



Evidence cited by the CDC in support of changes to the behavioral ideology that expanded its focus to PLWHAs was mixed. While some research demonstrated little or no change in behavior among individuals who became aware of their serostatus, studies that did show significant risk reductions involved substantial pre- and post-test counseling and, in some cases, long-term prevention case management (Wolitski et al., 2007). Moreover, these studies were focused on specific target populations (e.g., men who have sex with men, injection drug users) and not necessarily on disproportionately affected minority groups such as African Americans and Latinos. For example, Colfax et al. (2002) found that reducing the risk of secondary HIV transmission during the early seroconversion period requires enhanced efforts to both identify newly infected individuals as early as possible and to provide risk-reduction counseling more effectively throughout at least the first year after infection. However, the vast majority of the participants in this study were white (64%), with African Americans and Latinos accounting for 9% and 18% of the sample, respectively (Colfax et al., 2002). Changes in community-based prevention ideologies and practice based on evidence from studies that were not inclusive of the experiences of disproportionately impacted populations has significant implications for prevention policy implementation on the ground. More specifically, such changes may not address the true prevention needs of the most disparately affected communities. For example, sanctioned interventions under the Diffusion of Effective Behavioral Interventions (DEBI) program were ultimately determined to not be completely responsive to local community prevention needs following the CBO Monitoring and Evaluation Project in 2009, resulting in the de-emphasis of several EBIs in subsequent FOAs (CDC, 2009). This shift occurred despite the investment that CBOs had made in developing infrastructure to implement these interventions, which these organizations had been previously required to adopt in order to receive CDC funding.

In addition to changes in prevention technologies prescribed by the CDC in the AHP (e.g. testing types, interventions), a major shift in focus populations also occurred as the Center's program for HIV prevention has expanded over the years. Although there was no mention of gay/bisexual men or transgender women in the first FOA released after the AHP initiative (FOA #04-064), later FOAs would heavily emphasize the prevention needs of these populations. However, since these groups have been at the center of the epidemic since its emergence, their absence from the first FOA to follow the release of the Advancing HIV Prevention Initiative cannot be excused as a simple oversight. Rather, it should be interrogated as a potential compromise in the face of the various attitudes and beliefs that underscored conservative and liberal politics during the Bush administration, which ultimately defined the HIV prevention practice ideologies that guided the work of the field during those times. The implications of such a compromise, however, cannot be overstated. In the absence of an acknowledgement of the prevention needs of these populations within the CDC's program for community-based prevention, delays in addressing them would ultimately result in increased disparities in new infections.

Subsequently, FOA #06-618 issued in 2006 addressed this structural gap in prevention efforts by acknowledging the disparate impact of HIV/AIDS on young MSM and transpersons of color specifically, making funds available for CBOs to target and deliver services to these populations (CDC, 2006). In addition, this FOA intentionally focused prevention efforts in designated Metropolitan Statistical Areas (CDC, 2006), likely in response to data from the National HIV Behavioral Surveillance System (NHBS) that highlighted disparate rates of undiagnosed HIV infection in particular geographic regions. Then, in 2008, FOA #08-803, expanded the priority geographic areas within the CDC's program for community-based prevention (and thus the target populations) to the Commonwealth of Puerto Rico and the U.S. Virgin Islands, while also sanctioning a culturally and linguistically responsive EBI for use in these regions (CDC, 2008). These structural changes, which aimed to address the prevention needs of the populations for whom HIV disparately impacted in specific regions, likely resulted in a great deal of tension for CBOs. Whereas organizational targets were previously more broadly focused, with CBOs from anywhere in the country able to apply for CDC prevention dollars, organizations were now being required to target specific populations in pre-determined geographic areas (using CDC-sanctioned behavioral and biomedical interventions).

Acknowledging the consistently disparate rates of new HIV infections among African Americans and gay/bisexual men of all races, as well as the potential limitations of the REP and DEBI initiatives, FOA #10-103 issued in 2009 reinforced the behavioral HIV prevention practice ideology by supporting the development, implementation, monitoring, and evaluation of community-based prevention programming (CDC, 2009). This FOA also formally introduced the concept of “Program Collaboration and Service Integration (PCSI)” which called for the incorporation of screening services for other commonly co-occurring conditions, while also acknowledging the need for CBOs to address the “social and economic determinants” of health among disparately affected populations (CDC,2009). The promotion of these service delivery strategies placed additional demands on CBOs by requiring funded organizations to more intentionally approach HIV prevention beyond the behavioral and biomedical realms to address the structural and systemic barriers that exist to HIV prevention and treatment for their most vulnerable clients. However, no additional resources were made available for CBOs to address these variables, nor were there specific recommendations for service technologies to be employed. Such unsupported mandates should be interrogated as inauthentic, as CBOs are likely only to ceremonially incorporate them in the face of limited resources (Meyer & Rowan, 1977). As a result, the challenges that exist for these organization’s clients that are intended to be addressed via these structural changes (e.g., undiagnosed concurrent infections, poverty, incarceration) may continue to be neglected.

Despite this, PCSI and the call to address the social and economic determinants of health were further institutionalized within the National HIV/AIDS Strategy (ONAP, 2010a) and in the CDC’s High-Impact Prevention approach (CDC, 2011c). Although the NHAS implementation strategy does call for a more integrated federal response to the epidemic, it does not speak to such coordination with regards to CBOs (CDC, 2010b). Moreover, the inclusion of ARV-based prevention approaches such as PrEP, PEP, and TasP as critical elements of these public health strategies introduced a new biomedical prevention practice ideology into the field, creating additional environmental demands to which CBO staff must respond. In addition to providing HIV testing and standardized behavioral interventions, organizations were now required to engage, link and ultimately assist with retaining their client populations in ARV-based prevention. And, while the evidence in support of ARV-based prevention is strong, the extent to which the practice ideologies associated with these interventions are compatible with community values and perceptions regarding appropriate strategies for responding to the HIV epidemic is unknown. For instance, issues of homelessness and un/underemployment may take priority over ARV-based prevention for a CBOs most vulnerable clients. As such, the pressure to focus prevention efforts on these interventions may create tension between what CBO workers know to be the needs of their clients and the services they are funded to deliver by the CDC. Moreover, we know little about how variations in ACA implementation serve to support or create additional demands to which CBOs must grapple with in order to adopt the biomedical prevention practice ideology and extend access to ARV-based approaches to their client populations. In the following chapters, I explore how members of the HIV prevention workforce are responding to the major shifts in HIV prevention practice ideologies and structural approaches illuminated through this analysis.

CHAPTER 4. Organizational Responses to Shifts in the Behavioral HIV Prevention Practice Ideology and Focus Populations

Introduction

In the previous chapter, I traced the evolution of HIV prevention practice ideologies (and related service technologies) as they have been communicated to CBOs from the CDC since the Advancing HIV Prevention (AHP) initiative was announced in 2003. More specifically, I described how advances in both surveillance data systems and prevention technologies have resulted in two primary shifts in HIV prevention practice ideologies communicated to CBOs by the CDC: (1) the requirement for CBOs to implement standardized behavioral interventions and (2) the inclusion of ARV-based prevention approaches. In addition to these shifts in practice ideologies, this document analysis also revealed concurrent advances in structural approaches to preventing HIV/AIDS, as the CDC has increasingly acknowledged the impact of larger contextual factors (such as social and economic inequalities) for perpetuating disparities in HIV. These structural approaches included: (1) expanding community-based prevention efforts to include PLWHAs; (2) targeting efforts towards disproportionately affected populations (e.g. gay/bisexual men, transgender women) in geographic regions where HIV prevalence is highest (e.g., the southern U.S.); and (3) addressing the social/economic determinants of health facing the most vulnerable populations (e.g., poverty, homelessness, unemployment, racial discrimination).

In this chapter, I explore how organizational leaders within CBOs describe and have responded to the shift in HIV prevention practice ideology that required them to rethink and overhaul their behavior-change service technologies, as well as structural changes that impacted their organization's focus populations. I reveal through this analysis how resource dependence (Pfeffer & Salancik, 1978)—particularly reliance on the CDC as the predominant source for HIV prevention funding—has caused many of these organizations to drift away from their missions and to follow funding at the expense of actual prevention needs within the communities they serve.

About the Organizations

As previously explained, CBOs within the organizational field of HIV prevention emerged and evolved in response to federal government indifference and neglect of the emerging AIDS crisis within the most disparately affected communities (Shilts, 1987; DeCock, Jaffe, & Curran, 2011). While a variety of organizational types offer prevention services today, AIDS Service Organizations (ASOs) were established directly in response to such indifference and neglect. Historically, these organizations have provided support services for people living with HIV/AIDS, including treatment adherence/management programs, peer support groups, and case management (Shilts, 1987; Adam, 2011; DeCock, Jaffe, & Curran, 2011). Many have also been instrumental in advocacy efforts that have resulted in substantial political and technological advances within the field (Adam, 2011). In addition, a number of organizations that have historically focused on social programming and advocacy on behalf of LGBT (Lesbian, Gay, Bisexual, Transgender) communities have expanded or changed their focus altogether to meet the HIV/AIDS prevention needs of affected communities (Adam, 2011). Reproductive health centers, substance abuse treatment facilities, universities, and some faith-based entities have also offered a variety of prevention services throughout the years. While some of these organizations offer primary medical services in addition to prevention and support services (or have transitioned to Federally Qualified Health Centers as ARV-based approaches have gained prominence in the field), most do not. Rather, they exist as entities completely separate from other types of healthcare services. Federally Qualified Health Centers (FQHCs), on the other hand, do provide primary and preventative care to all people regardless of their ability to pay.

Although ASOs are intentionally over-represented in the sample for this study (n=8), a diverse mix of CBOs are included in the following analysis. This includes two reproductive health centers, two LGBT-focused organizations, two university programs, an FQHC, and one faith-based organization. While several organizational leaders cited private foundations and other funding sources that support their HIV prevention efforts, the CDC funds the vast majority of this work, either directly or indirectly by way of local health departments. As such, this analysis revealed very little variation in the ways that these organizations are responding to the demands placed upon them from the CDC, suggesting a great deal of passive conformity (Oliver, 1991) and/or decoupling (Meyer & Rowan, 1977) to maintain the appearance of compliance.

The implications of such passive conformity and decoupling are far-reaching, particularly considering the historic role of these organizations for attending to the HIV prevention needs of the most vulnerable and marginalized communities in the face of federal government indifference and neglect throughout the years (Shilts, 1987; DeCock, Jaffe, & Curran, 2011). While the potential of ARV-based prevention for curbing the U.S. HIV/AIDS epidemic is promising, practice ideologies and structural approaches communicated to CBOs from the CDC—particularly those focused on getting drugs into bodies rather than altering high-risk behaviors or disrupting patterns of inequality within disparately impacted communities—are oftentimes in conflict with the missions and histories of U.S. CBOs. As a result, progress towards dissemination and uptake of ARV-based prevention may be hindered. Furthermore, the true HIV prevention needs of the communities that these organizations serve (including access to comprehensive sexual/reproductive health services and affordable housing) continue to go unaddressed.

Responding to Shifts in Behavior-Change Technologies

As discussed in the previous chapter, the AHP initiative issued in 2003 expanded the CDC's program for community-based HIV prevention to include a focus on PLWHAs for the first time (CDC, 2003a). Previously, the CDC had targeted its prevention efforts primarily towards HIV negative individuals by providing funding to state and local health departments, as well as nongovernmental CBOs, for programs aimed at reducing sexual and drug-using risk behaviors (CDC, 2003). In addition, the AHP initiative called for funded CBOs to adopt standardized interventions under the REP and DEBI initiatives for both PLWHAs and high-risk negatives (HRNs) (CDC, 2003). The primary aim of the DEBI project was to diffuse evidence-based, group- and community-level HIV/STD behavior change interventions to health departments and community-based organizations across the country (Collins et al, 2006), a coercive strategy to ensure uniformity of prevention messaging across funded organizations (DiMaggio & Powell, 1983). Considering that many of these organizations were founded to provide social support services for PLWHAs, or had been doing so since the onset of the epidemic in the case of many LGBT organizations, this shift in focus populations within the CDC's community-based HIV prevention program was not so much of a stretch for them. These organizations were, in effect, already providing prevention services to this population in the form of condom distribution and education. However, the requirement to implement pre-packaged EBIs to be eligible to receive CDC funding created a great deal of tension for many of these CBOs.

Each of the organizations included in this study has been funded by the CDC to provide HIV prevention services at some point in their existence (either directly or indirectly by way of their local health department) and have consequently been required to implement EBIs. As a result, many of the organizational leaders across several sites and interviews possessed some degree of experience with these interventions and, thus, had a great deal to say about the limitations and challenges associated with adopting them. An executive leader from a New Orleans ASO, who transitioned into his current role after years in a career within an altogether different area of social service, raised a common issue related to EBI implementation—the limitations of generalizability:

> When I first arrived, the focus was more on evidence-based interventions. I had my little issues with that because I kinda felt that the interventions that were particularly being pushed by CDC weren't necessarily reflective of the populations that we service in particular. And I kinda wondered what populations they were using to actually pilot those particular programs.

While EBIs provide some assurance that prevention education delivered by CBOs will be based on scientific evidence and uniformly delivered, they are typically developed in very specific geographic regions with local members of target populations (Collins et al, 2006). As such, EBIs may require significant adaptation to account for regional and cultural differences in perceptions of risk or localized social/economic determinants of health, factors that organizational leaders suggest have not always been taken into consideration by the CDC. For example, according to the executive director of another ASO in New Orleans, these interventions have been developed in more liberal regions of the country where mindsets and challenges to effective prevention are considerably different:

> They mandate that you do it the way that they're doing it in Illinois. That ain't going to work in the South. They take D.C., New York, and Chicago, and that's how it's supposed to work all over everywhere. And I've seen stuff that works here…don't even work in Nevada. Because the mindset of people is different for the particular area that they're in. We're Bible Belt here. And we're governed by the church here. And, if the church still say you're committing a sin and you unclean and you gonna die 'cause you out there having oral sex behind a dumpster with a man…you know it gets more graphic than that [laughs]. But that's what those kids are thinking about. That's what those parents are thinking about. So, that's why they kick young MSM and transgenders out of their house because the church say it's a sin.

This organizational leader articulated a specific barrier to HIV prevention for MSM and transgender individuals that the EBIs being diffused during that period were not designed to address—the stronghold of religious ideology in the southern United States. To mitigate this, prevention efforts within these regions must be designed to explore individual-level behavior in context, while also addressing the impact that the environment has on sex and sexuality in order to stimulate change that results in decreases in new HIV infections. This level of intervention is certainly beyond the scope of most EBIs and potentially even the qualifications of interventionists within many CBOs as well.

These assessments of EBIs by organizational leaders underscore the need for the CDC's CBO Monitoring and Evaluation Project that was introduced in 2009 under FOA #10-103 (described in the previous chapter) (CDC, 2009). This project made funding available to improve the performance of funded organizations implementing EBIs and to assess the fidelity of a select group of these interventions. Moreover, CBO leaders' assessments provide support for the CDC's call to address the social and structural factors that contribute to HIV incidence and prevalence disparities among MSM and transgender individuals. Such efforts within the CDC's program for community-based HIV prevention were designed to ensure that sanctioned behavioral interventions were responsive to regional variations in social/economic determinants of health, including community norms and religious ideologies (CDC, 2009).

Organizational leaders also described technical issues and a lack of training on the nuances of EBIs as barriers to dissemination, further validating the need for additional support from the CDC for implementing them. When CBOs are not sufficiently funded to implement EBIs as they are designed, leaders are forced to make modifications that may impact both fidelity and efficacy, potentially hindering effective prevention efforts within the communities that they serve. For example, the executive director from New Orleans who is quoted above described the challenges associated with facilitating an EBI focused on homeless individuals and the organization's efforts to adapt the intervention to better accommodate the transient needs of this population:

> We used to do [an EBI] for homeless youth. And we had to adapt it to our youth because it didn't really fit, you know? A lot of the modules didn't really fit. Plus, they were in and out; they weren't staying there. So, we tried to make the modules sort of independent so that we could catch them when they're there, so they could do each of the modules over a year if they needed to.

This example offers further evidence of gaps between the design of EBIs and the actual needs of the clients that CBOs serve. In this instance, an EBI designed to address the prevention needs of homeless individuals neglected to take into consideration a key barrier to engaging and retaining members of this population—their transient nature. The intervention also offered nothing in the way of addressing the social and systemic issues within the city that perpetuate homelessness.

In addition to the lack of focus on social and systemic issues that serve as barriers to HIV prevention in disparately affected communities, organizational leaders also described the limitations of training offered by the CDC for effective implementation of DEBIs. For example, a prevention program coordinator from a Memphis ASO described the excitement of prevention workers throughout the city when a CDC capacity building specialist came to town to provide training on implementing the *d-up: Defend Yourself!* intervention, excitement that quickly began to wane as it became apparent that they did not possess all of the skills necessary to effectively implement the intervention:

> I remember when we had all these D-Up trainings where [a CDC capacity building specialist] came down and gave this training. And it was big. And our boys all across the city who were doing prevention, they came to the D-Up training and they were like, 'It was great.' And then he left. He went back home to eat spaghetti and be with his husband. But we were here like, 'Okay, now let's do this!' And then we were like, 'Okay, all we have to do is go out in the middle of the night and we need to look at all the friendship groups that are in the club.' So then, we get to the club and be like, 'How do we figure out who's friends with who? How do we know which friend is the friend that everybody listens to versus the most popular friend that everybody just wants to hang

> with?' Yeah…no! Nobody taught us this level of engagement. But it's in the book and we're supposed to be able to translate that. But it don't really happen.

This leader also discussed the costs associated with EBIs and the limited resources available for adopting them with fidelity:

> I went to California to train for Popular Opinion Leader. But then I got to L.A. and they were like, 'It's no way one person can do this.' And I was like, 'I'm the only person on my grant. Like, we only got so much money to do this and like half of that is my salary, so what?' And they were like, 'It's no way. So, you might as well give up now.'

Despite the sub-optimal level of resources awarded to the organization for implementing POL, this leader was still required by contract to make do with the funds that his organization had received, suggesting that loose coupling (Meyer & Rowan, 1977) may occur when CBOs are mandated to adapt these interventions without sufficient resources for doing so. Such loose coupling played out within this organization in the form of significant modifications to the intervention protocol that likely impacted its efficacy. However, as a result of the organization's dependence on CDC funding to not only support intervention implementation but also staffing costs (albeit insufficiently), this leader perceived that he had no choice but to proceed as contracted.

In New Orleans, the financial challenges associated with implementing EBIs have also been hampered by recovery efforts that are still underway in the aftermath of Hurricane Katrina, which occurred more than 10 years prior to the conception of this study. A researcher/prevention program director from the city described the challenges as such:

> DEBIs cost money to implement and are hard to implement in certain places post-Katrina. There's just not a lot of money out there; they cut it off at the knees with everything else. So yeah, we did do the DEBIs and stuff like that, but…we've had a really hard time putting it back together.

This leader described the regional challenges of implementing EBIs in the wake of a natural disaster that devastated the city's entire HIV prevention infrastructure. She also alluded to a common perception shared by other organizational leaders regarding HIV prevention practice ideologies and service technologies communicated by the CDC—as ARV-based prevention gained prominence within the field, the CDC is de-emphasizing the use of many of the EBIs that it previously sanctioned, as well as funding for implementing them (a perception that is not well supported in the document analysis described in the previous chapter). The executive director from an Atlanta ASO, however, affirmed this sentiment:

> Prevention, when I first started, was all of the behavioral interventions. So, Mpowerment, d-up, 3MV…so it was trying to change behaviors and change mindsets and also do a lot of condom distribution. So, that was a lot of my prevention then. Now prevention is more so medical. We still have condoms, but I feel like everyone wants to be moved to PrEP or treatment as prevention as the most effective prevention strategy for at-risk populations.

Regardless of the challenges associated with implementing EBIs and the perception that the CDC was beginning to move away from a vast majority of them, some organizational leaders did find value in interventions that had been designed with specific populations in mind. For example, some leaders had grown particularly fond of EBIs that focused specifically on black MSM (e.g., 3MV and d-up!), especially as they were afforded more flexibility by the CDC to adapt them to be more locally relevant. However, when asked about other funding sources to support the delivery of these interventions in the wake of the perception that the CDC was transitioning away from them, none of the organizational leaders interviewed described efforts to secure resources to continue to implement EBIs. This point illuminates an essential concern regarding prevention services within the field being funded primarily by the CDC—the impact of resource dependence (Pfeffer & Salancik, 1978). More specifically, as leaders within CBOs perceive that the CDC is de-emphasizing interventions that it once considered important, they willingly follow suit despite their organization’s investment and belief in some EBIs. For example, the organizational leader of an ASO in Atlanta that was once funded to implement both 3MV and d-up: *Defend Yourself!* was clear that other needs within the organization take precedence over securing resources to continue to implement EBIs:

> I think you can get it [resources to continue to implement EBIs] on the corporate side. But we're an organization that's still chasing dollars. When you get corporate money, it's unrestricted revenue. And that's the money that we use to fix the air conditioner [*the organization's air conditioner was out at the time of the intervie*w]…fix the roof. Our housing is unrestricted, so we need to pay the rent over there and keep the utilities on and furnish it and give [the participants] gift cards for food and things like that. So, it's just where your focus is. So, it's so many competing priorities right now that you gotta really figure out which way do you go.

Application to Theory

The shift in practice ideology within the CDC's program for community-based HIV prevention that required CBOs to adapt pre-packaged interventions can be viewed as an example of a coercive pressure that resulted in considerable isomorphism (DiMaggio & Powell, 1983) within the organizational field. More specifically, the requirement for CBOs to adapt EBIs was intended to ensure a uniform standard of prevention messaging across funded organizations. However, as these interventions became institutionalized within the field, they created a great deal of tension for organizations funded to implement them. Across several interviews and regardless of geographic location, organizational leaders were challenged by the lack of local population input and relevance of these interventions, as well as the limited training and resources made available from the CDC for implementing them with fidelity. In some cases, these factors resulted in unauthorized modifications to EBIs and, subsequently, a degree of loose coupling (Meyer & Rowan, 1977) within organizations to appear compliant with intervention protocols to maintain funding. Such modifications potentially compromised the fidelity of these interventions, ultimately defeating the primary purpose of the DEBI project (which was to ensure a uniform standard of prevention messaging in vulnerable communities).

In addition to the lack of local input and relevance of some EBIs, leaders also perceived that these interventions—which they had invested substantial time and resources into implementing over the years—were slowly being phased out by the CDC as ARV-based prevention (and newer EBIs designed to facilitate medication adherence) gained prominence within the field. This perception increased frustration among organizational leaders, who described constant change in the CDC's program for community-based HIV prevention over the years that did not take implementation challenges for CBOs or the comprehensive prevention needs of the communities that they serve into consideration. The executive director of a New Orleans ASO, with an extensive history within the field, summed up his experience with these changes in this way:

> I've been doing this for twenty-one years. Every five years, CDC changes what they do. By the time you've gotten the community accustomed to expect one thing, we have to retrain and retool them to expect something else. So, if you have a 5-year grant, the first 1½ years of the grant is to re-establish information, systems, trainings, everything all over again. And then when they say, 'It's not working,'…it's because of what they've instituted!

Moreover, despite the fact that a number of organizational leaders found value in some of the EBIs for meeting the HIV prevention needs of the client populations that they serve (even in the face of significant implementation challenges), none of these leaders described efforts to secure alternative funding sources to continue to offer these interventions. Considering that the CDC is the largest funder of prevention services in the U.S., and the vast majority of these organizations are solely dependent upon this source for their prevention programming, such responses reflect a disturbing degree of resource dependence (Pfeffer & Salancik, 1978) within the field. More specifically, CBOs go along with shifting practice ideologies and associated service technologies communicated to them from the CDC to maintain funding, at the expense of offering services that organizational staff believe to be most effective at producing behavior change among the populations that these organizations serve. Such resource dependence potentially limits the range of effective prevention programming available in marginalized communities, while also leaving CBOs unresponsive to the actual needs of their focus populations (e.g., combating religious ideology and the social/economic determinants of health).

Responding to Shifts in Focus Populations

In addition to the challenges that CBOs faced from the shift in practice ideology that required funded organizations to implement pre-packaged evidence-based interventions, leaders have also had to grapple with the gradual narrowing down of focus populations within the CDC's program for community-based prevention—from a general approach to an almost exclusive focus on young MSM and transgender women of color. In this section, I describe how organizational leaders, prevention staff and some health department officials perceived and have responded to this shift. In doing so, I illuminate how the call for CBOs to focus prevention efforts more specifically on black MSM and transgender women has led some leaders to adjust their organizational infrastructures in ways that challenged the boundaries of their stated missions, including making significant adjustments to their primary focus populations.

Many organizational leaders recognized the gradual changes in focus populations within the CDC's program for community-based prevention early on. For reasons that are not particularly clear from data collected for this dissertation, however, others did not (or possibly chose not to). An administrator within the Tennessee Department of Health described his efforts to educate and convince CBO leaders in Memphis to pay attention to the direction that the CDC was headed, admonishing them to reorganize their programming accordingly:

> I came into the health department in 2007 and we were doing four SISTA [*an EBI for women*] programs in Memphis. Zero things for MSM. There were no MSM who worked for agencies in Memphis. We were funding eight agencies back then in Memphis and said, 'Here's where the ship is going,' you know? 'We've gotta look at the data.' We kept bringing out the data and saying, 'Eighty percent of our cases are in men. We're doing no programs for men.' (laughs) And we were doing quite a few programs for youth as well, but a lot of it would be like 'Girls, Incorporated' or some things like that. But that's not where our new cases were coming from.

Although the gradual shift in focus populations was evident to this administrator, he described resistance from CBO leaders based on the populations that they had historically served. There are two plausible explanations for such resistance. The first would be to assume a degree of homophobia, transphobia, and discrimination among these organizational leaders that played out as intentional neglect of the rising rates of HIV infection among MSM and transgender women (and particularly those of color). A less sinister explanation would be to suggest a potential disconnect between the prevention needs observed by these leaders on the ground and those that have been identified by CDC officials based on epidemiological data. Although disparities were increasing among MSM in the city (and across the nation), these leaders still acknowledged and may have been reluctant to neglect the prevention needs of the women and young people that they were serving.

Although most of the organizational leaders interviewed for this study stated or implied that they understood the need for this shift based on emerging epidemiological data, the gradual exclusion of women from the CDC's program for community-based prevention was considered highly problematic to many. The executive director of a women's reproductive health and justice organization in Memphis describes the shift in this way:

> I've seen there be a focus on men and boys and it be expanded to trans-women. That's what I've seen change. But, we as a black community, we're still neglecting a whole population. Where do women and girls fall in this? Why is this not more like community-focused, right, cultural-focused, geographic-focused? Because it totally varies from place to place depending on what you're talking about.

This leader's statement illuminates the impact of shifting focus populations within the CDC's program for community-based prevention on the organizational field and particularly the resulting tension for CBOs that had historically served women. From a community perspective, she articulates the importance of considering regional as well as cultural variations in prevention needs that may not be addressed via such narrowly targeted efforts. Offering that sexual dynamics within black communities are more nuanced than the CDC recognizes and, as such, prevention efforts must be inclusive of women, this leader further elaborates:

> The HIV funding community has basically forgotten that the very men and boys that they are trying to help, the very trans people that they are trying to help, also sleep with us…

> are married to us! And this is not even the whole kinda “down low” thing, but there is a cultural kinda piece right here that’s not being included.

This statement reflects the frustration expressed from other leaders (described in the previous section) regarding the lack of local input into EBI development and the need for CBOs to adapt them to more effectively meet the needs of their client populations. Regional and cultural variation matter, according to this leader, and there may be severe implications for not considering these variables in HIV prevention programming and planning. For example, variation in sexual dynamics within and among any given community that are not addressed via EBIs or targeted prevention efforts may result in ineffective messaging and neglect of populations that are not considered to be at “highest risk” but are engaged in substantial risk behaviors with those who are. An HIV prevention program coordinator at an ASO in Atlanta described how this shift in focus populations unfolded in that city and, more specifically, the tension that it created for organizations that served women:

> When we first started, a lot of prevention was just based upon testing individuals and not necessarily with a focus on a particular population. It was more general testing, just getting it out to the public…and condoms, you know, that was kind of pretty much the main mantra of metro Atlanta. Then, if I identify those persons, hopefully get them into the resources necessary to start their care. And, as different information came out, focuses started getting a little bit more specific as far as targeted testing. African-American women started being the fastest growing demographic of becoming positive, so then the focus changed.

In addition to providing a detailed description of how the shift in focus populations at the CDC unfolded in Atlanta, this leader also relays a common misperception within the field about the rates of HIV infection among black women. Although incidence rates among black women have consistently been disproportionately higher than their white counterparts, in context, the numbers among this population have never eclipsed or even come remotely close to those among black MSM (CDC, 2017). Such erroneous misperceptions may explain why many leaders were initially reluctant to redirect their prevention efforts despite the emergence of data that could no longer justify allocating resources to sustain business as usual. In other words, it may not have been that they didn't necessarily want to believe or even address rising rates of HIV infection among black MSM and transwomen due to homophobia, transphobia and racial discrimination. Rather, it may be that they were receiving conflicting messages about the impact of HIV within the communities that they served, which created a great deal of tension on the ground (although the source of these conflicting messages is not immediately clear). Moreover, despite the fact that HIV was unquestionably impacting black MSM and transwomen at more severe rates, black cisgender women were still being disparately impacted as well (CDC, 2017).

This same organizational leader from Atlanta went on to suggest that public perceptions about black men on the "downlow" (i.e., men who do not disclose to their girlfriends or wives that they also have sex with men) were the dominant drivers of prevention messaging targeted towards black women before the CDC intervened by way of its funding streams and directives, which was affirmed by several other organizational leaders across sites. He also described challenges with helping African Americans move beyond the widely-held belief that HIV is a disease that exclusively affects gay men:

> Then 'downlow' became the popular term and trying to make individuals aware of that in regards to still protecting yourself and not being aware of what your partner's actual sexual behaviors were outside of your relationship. And, through all of this, the main focus within the African-American community, was still trying to get them to understand that this was not a gay disease. Even though gay men were the population that was mostly impacted.

These claims further validate the need for CDC intervention via its program for community-based HIV prevention to ensure accurate prevention information and messaging in marginalized communities. A program director for HIV prevention services offered at a university in Baltimore described the shift in focus populations and the undertone of the downlow phenomenon within that city in this way:

> There was very little messaging, at least in this area, about any real prevention efforts other than, 'Black women, we have to protect ourselves from downlow men.' So, this was very stigmatizing language, very hurtful language. And I think that type of messaging did more harm than good. And, ultimately, it didn't change anything, you know? What it did was vilify black men. And so, what it meant is that black men, no matter the sexual orientation, just weren't having conversations about HIV. 'Cause they didn't want to feel that stigma.

According to this leader, the misguided focus on downlow men served to further stigmatize gay/bisexual men, causing many of them to avoid HIV testing altogether. This resulted in a substantial amount of undiagnosed infection and, ultimately, disparate rates of new infections among this population. While this leader recognized and was intentional about the need to move beyond the downlow myth and attend to the true prevention needs of MSM in Baltimore (even in her role as an outreach worker at the time), she also cautioned against other unintended consequences of this shift in focus, including the decreased focus on black cisgender women who also continue to be disproportionately affected:

> My role as the outreach worker really was trying to figure out how to incorporate the LGBT conversation into it. Because it just wasn't happening. Unfortunately, however, what's happened is that once that down-low conversation stopped taking place, HIV in women conversations stopped happening, you know what I'm saying? It was like that was only the one lens they were addressing and talking to women about. Now that we're not doing that, HIV prevention in women is completely gone. So, that's been really disappointing.

This sentiment was shared by other leaders across a number of organizations. For example, a prevention program coordinator at a faith-based organization in New Orleans described the shift in focus populations as creating division among affected communities that is problematic, as it takes the emphasis off of people and becomes more about numbers:

> I think there's a big fight with funding because of the targets and the focus. Like, sometimes you can hear black women say, 'Well, what about us?' And then you hear MSM say, 'What about us? 'Cause all the funding is going here?' Versus looking at the fact that HIV is impacting everybody. The focus is on numbers more than it [is] on people…understanding the people. So, if you don't meet this number, that means you're not successful.

For some organizations, the shift in focus populations and requirements for reaching specific numbers within these groups (as mandated by their contracts with the CDC) has translated to an overall shift in the populations that they serve. This illuminates how organizations that have historically served women are responding to structural approaches within the CDC's program for community-based HIV prevention that have prioritized gay/bisexual men and transgender women, revealing both coercive and mimetic isomorphic processes (DiMaggio & Powell, 1983) that have resulted from resource dependence (Pfeffer & Salancik, 1978). For example, one AIDS service organization in Atlanta was originally founded with an exclusive focus on the needs of women. And, while some women still come through their doors, the organization's primary focus is now on MSM. The organization has shifted its focus to mimic other organizations that it perceives to be successful at complying with CDC strategies for ensuring that priority populations benefit from funded efforts. The deputy director from another organization in Atlanta that has historically served women described how trends in funding may actually push them to consider a similar move:

> We did not apply for some testing and counseling money because they had an algorithm that you needed to have. And we weren't pulling in those numbers for the algorithm for women. That's the new CDC kind of algorithm; 10 positives for every 1,000 tests. And so, this may keep us out of the running because, you know, the rates are dropping for women and so it is more difficult for us to find women.

This leader speaks to the specific organizational targets imposed by the CDC for prevention services funded under FOA #11-1113 (CDC, 2011b). In contrast, the executive director of a women's reproductive health and justice organization in Memphis described how she has resisted targeted prevention strategies prescribed by the CDC. More specifically, her organization has opted not to accept government funding for their prevention services, which allows them the freedom to approach service delivery with less restraint:

> For us, we center comprehensive reproductive and sexual health education, which also emphasizes HIV prevention and intervention. We also have to think about those types of

> dynamics and how sexual orientation also crosses. And so, I think we're just not talking enough about sex. We can't even get to the nuances of it all, right?

The prevention program coordinator from the aforementioned ASO in Atlanta that has completely rebranded itself from an organization that once focused exclusively on women to one that now primarily targets MSM elaborated on this sentiment. When critiquing the MSM label used by the CDC as a catch-all term for men who may not identify as gay or bisexual but engage in sexual relations with other men, he affirmed other leaders' statements that the shift in priority populations does not take the nuances of sexuality and sexual identity within communities of color into consideration, particularly as it relates to this population:

> Some people [*within the field*] still equate MSM with being gay. And I'm like, 'Those two are not the same. Let's be clear!' Most heterosexual men that may, somewhere along the lines, have sex with another man will still identify themselves as being…that DL concept, you know what I'm saying? So, let's not put those two together to make those synonymous with each other. Because then you're missing a population that's out there, and probably the most difficult population to engage in prevention type methods. Because they say, 'Well, I don't get down like that.'

From this leader's perspective (and as the literature suggests), gay identified men are more likely to be connected to the "gay community" and, therefore, the abundance of prevention resources that exist within it (Mustanski, Newcomb, Du Bois, Garcia & Grov, 2011). As such, these individuals are more likely to be aware of where to access prevention services than men who do not identify as gay. As another leader of an Atlanta ASO stated:

> Here in Atlanta, from my experience, if you are a young gay man, in some capacity, you know where to go get tested. You know where you can go get information. I mean AID Atlanta was synonymous with young gay men knowing that they can go there to get tested.

This leader went on to describe how she attempted to advocate on behalf of these men but the shift in focus (and therefore resources) was already well underway, forcing organizations to conform or risk losing vital funding sources:

> So, it came down to where I was like, 'Can we try to open it up?' But the money stuff started driving the narrative on how you would do your prevention methods. The CDC

> wanted specific types of testing instead of it being more general population to have a wider umbrella, then it put agencies or organizations in a pigeon hole to say, ‘Okay, well if this what I'm getting paid for, this is what my deliverable says, then that's what I have to focus on.’

Application to Theory

Taken together, my analysis indicates that coercive isomorphism (DiMaggio & Powell, 1983) brought about by the CDC’s program for community-based HIV prevention resulted in CBOs targeting and engaging specific numbers of MSM and transgender women (particularly of color) and a great deal of tension for these organizations on the ground. Worryingly, many organizational leaders expressed concern that this shift did not take sexual relationship dynamics within black communities into consideration and also neglected the nuances of sexual identity for some groups of MSM. Despite these concerns, some leaders restructured their organizations to focus more intentionally on MSM and transwomen, particularly those from CBOs that were once focused exclusively on HIV among black women. One of the leaders interviewed for this study had actually shifted her organization’s focus populations altogether to be in alignment with this structural change at the CDC, while another leader recently declined to apply for CDC funding because of her belief that her organization would not be able to achieve pre-determined targets related to black women.

Such responses suggest that both coercive and mimetic isomorphic processes (DiMaggio & Powell, 1983) are operating within the organizational field of HIV prevention, as a result of a substantial degree of resource dependence (Pfeffer & Salancik, 1978). To ensure that government funded HIV prevention services are reaching the most disparately affected populations in the nation (MSM and transgender women of color), the CDC instituted organizational targets into its program for community-based HIV prevention that required CBOs to engage specific numbers of members from these focus populations in order to maintain funding. Although organizational leaders expressed concern about the CDC’s shift in focus populations and the subsequent lack of attention being given to the impact that HIV continues to have on black women, there was very little discussion about efforts to push back against this. Citing limited availability of non-government resources for HIV prevention, many of these leaders have accepted their fate as it relates to this shift. In response, they have adjusted their organizational infrastructures accordingly, mimicking other CBOs that they perceived to be successfully aligned with the structural shift at the CDC, oftentimes without regard for their own organizational histories and missions. One executive director in Memphis, however, opted not to accept government funding for prevention in order to stay true to her organization's mission. This leader cited the need to more fully address the nuances of sexuality and sexual identity within black communities as her rationale for this decision, a point that was supported by other leaders interviewed for this study despite the fact that they continued to accept prevention funding from the CDC. As a result, she secured foundation funding to support her organization's HIV prevention programming, which was not bound by the limitations of practice ideologies or structural approaches dictated by the CDC. This example is important for understanding how organizational responses to environmental demands differ, as well as the strategies CBO leaders employ to ensure that the prevention practice ideologies of the organization remain community-centered and informed.

Discussion

In this chapter, I have analyzed and described organizational leaders' perceptions of and responses to the shift in practice ideology within the CDC's program for community-based HIV prevention that required them to adopt pre-packaged behavioral interventions (EBIs) in place of locally developed prevention programs. I have also described how these leaders have perceived and responded to structural shifts in CDC-funded HIV prevention programming—from a broad population approach to one that is more intentionally focused on MSM and transgender women of color in specific high prevalence geographic areas across the nation.

This analysis has revealed three main trends regarding the impact of these changes on the work of CBOs over time, further illuminating the extent to which resource dependence (Pfeffer & Salancik, 1978) operates among organizations within the field and drives prevention programming on the ground. First, leaders within these organizations have been challenged by the lack of local population input and relevance of pre-packaged evidence-based interventions, as well as limited training and resources made available from the CDC for implementing them with fidelity. Such disregard for local input and appropriate funding levels for EBIs perpetuated loose-coupling (Meyer & Rowan, 1977) among organizational leaders. More specifically, to be eligible to continue receiving funding for these interventions, leaders engaged in strategic efforts to appear to be incompliance with intervention protocols, which likely appeased program monitors but also impacted implementation fidelity on the ground.

Second, organizational leaders have had to grapple with the perception that the CDC is gradually beginning to de-emphasize these once heavily promoted and mandated evidence-based behavioral interventions, which they have been relatively passive about despite their acknowledgement of the value of some of them. For example, one leader was clear that other organizational priorities take precedence over efforts to secure secondary funding sources to continue to implement EBIs, highlighting the extent to which resource dependence (Pfeffer & Salacik, 1978) exists and impacts community-based prevention on the ground. Although some of these interventions may be both relevant and impactful within marginalized communities, this potential is negated because a large numbers of CBOs that provide HIV prevention services are no longer offering them.

Finally, while organizational leaders understood the need to focus more intentionally on MSM and transgender women based on epidemiological data, the gradual exclusion of cisgender women from the CDC's program for community-based HIV prevention forced many of them to expand their organization's primary target populations. As a result, at least one leader completely changed her organization's focus from exclusively serving women to offering services predominately for MSM and/or transgender women. At least one other leader interviewed for this study was strongly considering a similar move. These responses to the shift in priority populations within the CDC's program for community-based prevention further illuminate the high degree of resource dependence (Pfeffer & Salancik, 1978) operating among CBOs in the HIV prevention field, as the vast majority of prevention services offered within these organizations were solely funded by the CDC. Therefore, organizational leaders were reluctant to push back against these changes despite their perceptions of the actual needs of the communities that they serve.

The implications of these finding for the HIV prevention landscape are far-reaching. If CBOs recognize the value of EBIs focused on the populations most affected by HIV but discontinue their use because they perceive that the CDC is no longer invested in these interventions, there is the potential for limited prevention strategies being delivered on the ground that are not focused exclusively on ARV-based prevention. This is particularly worrisome because consistent condom use remains a challenge among all populations but takes on additional importance for individuals within sexual networks where there is a higher prevalence of HIV and greater potential for sexual partners to be unaware of their status and/or not virally suppressed. In addition, as a result of the de-emphasis of EBIs that are not focused exclusively on ARV-based approaches, prevention messaging within the most vulnerable communities may also become infused with misinformation and, potentially worse, religious or moral ideologies that further perpetuate cycles of risky sexual and drug-using behaviors.

Finally, the decision made by some leaders to restructure their organizations to focus more intentionally on MSM and transgender women to be in alignment with the CDC's shift in priority populations means that there will be fewer prevention resources available for cisgender women of color within vulnerable communities. Although incidence rates among cisgender women have declined significantly in the past 10 years, women of color are consistently more disproportionately impacted by HIV than their white counterparts (CDC, 2017). This gap in prevention services could result in the undoing of past progress made with respect to this population, creating yet another shift in epidemiological trends and, ultimately, additional shifts in the CDC's program for community-based HIV prevention services to which CBOs in the field will be forced to contend with.

In the next chapter, I explore how both leaders and frontline prevention staff within CBOs are responding to the introduction of the biomedical HIV prevention practice ideology as communicated by the CDC. I also describe how these individuals perceive and are responding to the CDC's call for their organizations to address the social/economic determinants of health. These findings offer additional evidence of isomorphic processes (DiMaggio & Powell, 1983) operating within the field, further problematizing resource dependence (Pfeffer & Salancik, 1978) and the implications of reliance on one primary source to fund prevention services within disparately affected communities.

CHAPTER 5. Organizational Responses to the Introduction of the Biomedical HIV Prevention Practice Ideology and the Call to Address the Social/Economic Determinants of Health

In the previous chapter, I explored how organizational leaders described and have responded to the shift in the behavioral HIV prevention practice ideology communicated from the CDC, which required them to adopt standardized evidence-based interventions (EBIs) focused on changing risk-related behaviors. I also examined how these leaders perceive and have responded to the inclusion of structural changes within the CDC's program for community-based HIV prevention that impacted the categories of populations that their organizations were funded to serve. This analysis illuminated the dangers of resource dependence (Pfeffer & Salancik, 1978)—and particularly reliance on the CDC as the sole funder of HIV prevention services—for the availability of effective community-based programming. More specifically, such resource dependence resulted in a great deal of isomorphic pressure (DiMaggio & Powell, 1983) throughout the field, forcing CBOs to narrowly focus prevention efforts on MSM and transgender women of color using standardized behavior-change focused EBIs, while neglecting the needs of black cisgender women and the nuances of community dynamics.

In this chapter, I describe organizational responses to the introduction of the biomedical HIV prevention practice ideology, which shifted community-based efforts from a primary focus on standardized behavior-changed focused EBIs to the inclusion of antiretroviral-based approaches (e.g., Treatment as Prevention, Pre- and Post-Exposure Prophylaxis). This shift required CBOs to engage/retain HIV-negative individuals in primary medical care for the first time. The following analysis explores how state decisions to expand their Medicaid programs (or not) is impacting this shift in prevention practice ideology. I also examine the role of CBOs in assisting marginalized populations with navigating health insurance, as well as the pros and cons of pursuing Federally Qualified Health Center status for these organizations. Additionally, I describe how organizational leaders and frontline prevention workers are responding to the call from the CDC to address social/economic determinants of health, illuminating the gaps in the social safety net that severely impact access to ARV-based prevention for our nation's most vulnerable citizens. Taken together, the findings described in this chapter further elucidate the impact of resource dependence and resulting isomorphic pressures on the ability of CBOs to meet the comprehensive needs of the populations that these organizations have been established to serve.

Responding to The Introduction of the Biomedical HIV Prevention Ideology

As previously stated, the introduction of the biomedical HIV prevention practice ideology, and particularly the focus on engaging HIV-negative individuals into ARV-based prevention approaches such as PrEP and TasP, presented new opportunities and challenges for community-based organizations. While many of these organizations had previously been involved in assisting people living with HIV/AIDS (PLWHAs) with accessing and staying in primary medical care via the Ryan White Care system, ARV-based prevention for high-risk negatives (HRNs) is a relatively new concept within the field. Moreover, passage of the Affordable Care Act, which gave states the option to expand their Medicaid programs to cover a broader range of low-income individuals and established the Health Insurance Marketplace (Patient Protection and Affordable Care Act, 2010), increased access to ARV-based prevention for these individuals. Despite increased access, however, CBO staff described a number of challenges associated with operationalizing the biomedical HIV prevention practice ideology. Such challenges include the decision by some states to not expand their Medicaid programs, a limited number of culturally-competent healthcare providers that accept Medicaid and other insurance plans available on the Marketplace, and client issues with understanding their insurance options and navigating the system. In this section, I describe these challenges and various organizational responses to them.

The Impact of State Decisions to Expand Medicaid or Not

As discussed in the previous chapter, the CDC's shift in focus to include PLWHAs in its program for community-based HIV prevention was not initially grounded in a practice ideology that involved the promotion of antiretrovirals to reduce transmission. Rather, it was rooted in a behavior change ideology based on the premise that PLWHAs who were aware of their status would take precaution to prevent transmitting the virus to uninfected partners (CDC, 2003). However, the evolution of antiretroviral-based prevention approaches such as Treatment as Prevention (TasP) and Pre-Exposure Prophylaxis (PrEP) introduced a biomedical HIV prevention practice ideology that, according to organizational leaders interviewed for this study, has ultimately resulted in the dominance of these interventions within the field over time. Each of these leaders spoke to this ideological shift within the field in some way, sharing both their personal perceptions and organizational responses to it. The deputy director of an ASO in Atlanta summarized this shift in these terms:

> So, as CDC started changing their recommendations…when they started moving away from all those kind of groups interventions and all and they started going into looking at viral load suppression for patients, we had to be there. So, as I always say, as an organization you have to see where things are going. You know, you can't predict the future, but you have to really say, 'Okay, you know what your community needs are,' you know? You've seen what's going on in the community. You see what things are going on in the federal level. You gotta kinda figure out where do you fit in all of those things.

In addition to the FOAs and other documents analyzed in the previous chapter, the CDC issued FOAs #15-1506 and #15-1509 in 2015 for health departments to implement community-based demonstrations projects designed to increase and support PrEP access and uptake in their respective jurisdictions, officially directing both focus and resources towards this ARV-based prevention approach. With the exception of Atlanta, each of the cities represented in this study were recipients of these awards. Moreover, many of the participating organizations were indirectly funded under these opportunities to participate in their local jurisdiction's demonstration project. Irrespective of the Atlanta exclusion, the vast majority of leaders interviewed for this study (regardless of organizational type) were similarly required to integrate promotion, linkage, and retention activities related to PrEP and other ARV-based approaches into their prevention programming as a result of the CDC's shift in focus and funding. Similar to the way that organizations adopted and are now moving away from EBIs based upon their perception that the CDC is de-emphasizing them, the widespread integration of supportive services for ARV-based prevention speaks to the substantial influence of government funding over community-based practice, particularly considering the CDCs status as the largest funder within the field. Such a substantial degree of government influence in this area further illuminates the challenges of resource dependence (Pfeffer & Salancik, 1978) on the availability of comprehensive prevention services within marginalized communities.

However, as can be expected, a state's decision to expand its Medicaid program or not has severe implications for access to ARV-based prevention approaches, which affects these organization's abilities to connect potential candidates to prescribing providers. This is especially the case for PrEP, considering that the Ryan White Care Act was designed and is in place to ensure that PLWHAs have access to primary medical services. Although Gilead Sciences—the manufacturer of Truvada—offers a drug assistance program that provides the medication at no cost to individuals below a certain income threshold, the absence of Medicaid expansion limits access to providers who must write prescriptions and monitor patients for potential complications. A prevention coordinator at a Memphis CBO summarized the general sentiment from leaders regarding the impact of non-expansion on PrEP access in states where it hasn't happened and likely won't:

> It's really horrible. It really makes it difficult. It's a huge challenge for resources… funding. Although Ryan White is one source of that, we know what Medicaid can do to provide assistance. And I think it's just…it's slowed a lot of things down. And you know, again, you're in the South. You're in a state like Tennessee. It's one of the states that truly needs it. Like, a city like Memphis where poverty is one of the highest in the nation. Medicaid…it just…it's almost like you have to prioritize and choose and Medicaid would have been very beneficial.

This leader alludes to the impact of poverty on healthcare access and the benefits that expanding Medicaid could have for improving access to ARV-based prevention for the most vulnerable populations. He also speaks to the challenges associated with social service delivery in impoverished regions where the needs of the poor become particularly politicized. Other organizational leaders in Memphis and Atlanta expressed a great deal of frustration directed towards their local government officials, describing the decision to not expand Medicaid as a racist attempt at undoing the legacy of the nation's first non-white president, Barack Obama. The executive director of a reproductive health and justice organization in Memphis put it this way:

> THEY messed up! And did Obamacare need some help? Yeah. Did we need to like totally re-vamp it in order to do it? No, could've fixed some things and amend it and then everybody gets to take credit. Dang! Or is it just because the black man name on it, it's too much? You can't have the black man's name connected to you getting your gallstones out? I mean, because that's what it really comes down to. It comes down to race. It comes down to racism. It comes down to stupidity. It comes down to, 'I wanna be first; you can't be first,' or whatever. It doesn't come down to people's health and wellness…[their] ability to live. It doesn't come down to any of that.

This same organizational leader also connects state decisions to not expand Medicaid to issues of classism, which further perpetuates gaps in healthcare access for our nation's most vulnerable citizens:

> Tennessee not expanding Medicaid and the Republicans still not having anything in place—well, what they trying to put in place, continuing to allow poor people to be further and further pushed out of that—it's about to be 'the haves and the have-nots.' You got some money, you might be able to get something. Might. You don't have any money, you can't get anything. It's not about healthcare. It's about controlling who has and who does not have. It's not about making sure that people are well.

These assertions speak to the values and assumptions within the general organizational environment that impact dissemination and uptake of ARV-based prevention and, more specifically, operationalization of the biomedical HIV prevention practice ideology. By choosing not to expand Medicaid for reasons that are not grounded in the benefits of doing so for our nation's most vulnerable citizens, politicians stifle effective community-based prevention and indirectly assume some responsibility for perpetuating health disparities in marginalized communities.

In Atlanta, the absence of Medicaid expansion is compounded by Fulton county's strained relationship with the CDC and the subsequent loss of prevention funding in recent years (particularly the previously mentioned 1506 and 1509 funding opportunities). In 2012, the city of Atlanta became one of 12 cities to be "directly funded" by the CDC—part of a national effort designed to bypass state government in order to ensure that the nation's most disparately impacted regions have more control over prevention resources to meet the needs of local populations. This decision was particularly important to the potential that PrEP could have for addressing HIV disparities among young MSM and transwomen of color in Atlanta because it removed a critical layer of bureaucracy at the state level. However, as a result of the Fulton county government's lack of infrastructure to properly manage such a large influx of funds from the CDC, millions of dollars were ultimately returned to the federal government due to underspending. The Fulton county public health administrator interviewed for this study described this added layer of complexity within the region in this way:

> When you look at how long CDC has been funding jurisdictions and directly funding cities, it is truly shameful that in 2012 Atlanta receives its first direct funding. With that being said, though, the CDC might say, 'Yeah, but let's look at what they've done with it in terms of not being able to spend all of the cooperative agreement each year.' But I also say the CDC has to take ownership of that because, as a brand new directly funded city, there should have been some assessment in Atlanta's capacity to directly fund prevention services. And, it clearly didn't happen.

CBOs in the region are already feeling the impact of these administrative challenges, as none of these organizations received funding in the most recent Fulton county HIV prevention funding cycle. However, large medical institutions such as Grady Health System and Emory University Healthcare were funded. Although the Fulton county public health administrator could not provide an explanation for this, many organizational leaders in the city offered that, as the biomedical prevention ideology gains traction within the field, the value of CBOs for engaging and helping to retain the most vulnerable populations in care is not recognized. As a result, funder investment in CBOs that have historically offered HIV prevention services has waned.

In light of their state's decision not to expand Medicaid, CBO leaders in Memphis and Atlanta described their city's efforts and infrastructure for connecting interested candidates to PrEP. At the time of my interviews with leaders in Memphis, there was only one provider in the city that could prescribe PrEP and monitor patients for side effects on an income-based sliding-scale. This provider is located in a section of town that is difficult to access via public transportation, limiting this option for many of the individuals that CBOs in the region are contracted to connect to PrEP under the state's demonstration project. Moreover, this clinic is part of a larger faith-based care network that, according to the prevention program coordinator at a Memphis CBO, forces clients to endure religious messaging while accessing services:

> We just need more options. Because this place may have cheap labs, but some people are not religious. They don't wanna hear church stuff when they go there. 'So, take care of my health. Don't try to force anything down my throat.'

In Atlanta, the Fulton County Health Department has established one of the first government-run PrEP clinics in the southern U.S., pulling from a variety of resources to be able to offer PrEP to interested candidates who might not otherwise be able to afford it. The Fulton County Health Department administrator interviewed for this study described the effort:

> We launched a PrEP clinic with no new money. This has really been one of those, you know, "everybody bring what little change you got to the table" models [laughs]. So, we are utilizing two of our staff who are full time in PrEP now. One is kinda coordinating all of the PrEP activities from the appointments and the doctor's schedules and all of those types of things. And then we have one disease intervention specialist who does all of the PrEP one-on-one activities. They are a tag team that's been phenomenal. And like all of the printed materials, educational materials, we cover the cost for that. So that's been the prevention department's contribution. The STD department has been paying for the STD screenings and the creatinine tests. And then we have had doctors from Emory who are volunteering their services to actually see clients and then also do the follow up with them. So, when I tell you it's been, "What you got? What can you bring? Bring that with you. What y'all got over there?" to try to make this clinic work.

This example suggests that public health officials perceive value in and are responding to the recent shift in HIV prevention practice ideology communicated by the CDC that prioritizes ARV-based prevention, while also illuminating the impact of resource dependence operating at the health department level. More specifically, to be in alignment with the evolving biomedical HIV prevention practice ideology, the Fulton County Health Department has established its own in-house PrEP clinic. Meanwhile, as a result of current funding challenges, support for community-based prevention efforts and the evidence-based behavioral interventions offered by these organizations has been virtually eliminated.

Similar to the environment in Memphis, however, the Fulton County PrEP clinic is one of only a small number of provider options in the city that can offer PrEP at little to no cost to patients who lack health insurance. Additionally, and also similar to the religious doctrine that candidates in Memphis are subjected to when accessing the city's only available sliding-scale option, potential PrEP candidates in Atlanta are confronted with the stigma associated with accessing sexual health services ervices at the local health department (i.e., people assume that you're coming to be treated for HIV or some other sexually transmitted infection). These challenges elucidate the impact of local contextual factors on the ability of CBOs to respond to the shift in HIV prevention practice ideologies communicated by the CDC that prioritize ARV-based prevention approaches and, more specifically, PrEP. Despite their efforts, a number of factors beyond the control of these organizations affect their ability to seamlessly connect their most vulnerable clients to ARV-based prevention. As such, these challenges affirm the need for HIV/AIDS-focused CBOs to exist and, more importantly, to offer programming that addresses the social/economic determinants of health that exist within vulnerable communities (including but not limited to stigma and dogmatic religious ideology).

In contrast to the woes of not expanding Medicaid described by organizational leaders in Memphis and Atlanta, leaders in Baltimore and New Orleans expressed a great deal of excitement about their state's decision to expand and its impact on improving access to ARV-based prevention. These leaders described their excitement with some reservation, however, in light of the country's current political climate and ongoing efforts to repeal the Affordable Care Act. The executive director of an ASO in Baltimore put it this way:

> Oh, it's fabulous! You know, I would say 95 percent of the people that are on PrEP in our programs are accessing PrEP because of Medicaid expansion. So, I've been on the edge of my seat here thinking, 'Oh my God, what are we gonna do if all of a sudden we don't have that anymore.

Although there are some limitations with regard to healthcare providers who accept Medicaid and are also culturally competent, PrEP candidates in expansion states have significantly more options for prescribers than those in non-expansion states. This is also the case for PLWHAs without health insurance who previously received their care primarily via providers made available to them through the Ryan White Care Act. These individuals are being transitioned to Medicaid and now have a larger pool of providers to choose from.

Challenges with Navigating Health Insurance

Organizational leaders from both expansion and non-expansion states described substantial obstacles to operationalizing the biomedical HIV prevention practice ideology that are associated with accessing health insurance on the Health Insurance Marketplace established under the Affordable Care Act (Patient Protection and Affordable Care Act, 2010). Although

FOA #15-1509 was designed to support state and local health departments (and thus CBOs) with developing and implementing comprehensive HIV prevention and care programming for MSM and transwomen of color, including health insurance navigation was optional (CDC, 2015b). Thus, while CBOs funded under this opportunity were expected to assist PrEP candidates with navigating barriers to access, the lack of structural support for this service was perceived by many organizational leaders as counterproductive. While describing the value of Medicaid expansion for assisting her organization's most marginalized clients with accessing ARV-based prevention, the executive director of an ASO in Baltimore also highlighted the critical role that CBOs play in assisting with health insurance navigation:

> Medicaid expansion has been amazing because we're used to working with the HIV-positive population and most of our clients were Ryan White clients. Now, most of them are insured. So, being in a Ryan White clinic, you have case managers and all these wonderful people that are going to make sure that everybody gets insurance. I think Medicaid expansion is great for prevention as well, but I think it's a matter of making sure that you're finding the population that needs these services so that you can help get them insurance if they're not already insured. But I think that just takes us back to the original challenges that we discussed and, that is, if you find them you should be ready to deliver all the services in one go. And that's what I think that we've been successful at in Baltimore in creating this peer navigator infrastructure. Those individuals need to be equipped to do insurance and do all that stuff with people.

This leader's comments highlight the value of prevention peer navigator models that combine navigation efforts for both PrEP and health insurance. At her organization, this leader was intentional about structuring navigator roles in this way under their 1506/1509 contracts, despite initially receiving pushback from the CDC:

> What we did in our organization from the upfront was that we made the qualifications for our peer navigator higher than the qualifications that some of the other groups did. And we got some pushback from CDC but, from our work with positives, we do a ton of work with positives…one of the main challenges with that population is that, even if they were insured, their insurance is lapsed and we need an outreach worker that can help navigate people through those systems.

This leader went on to describe some of the barriers to consistent healthcare access that exist for many of her organization's client populations—including navigating the healthcare system and having appropriate documentation for completing paperwork—as well as the value of navigators for assisting clients with overcoming them:

> We know from working with people that face barriers to being in healthcare that those challenges can be pretty deep. Even if you have an outreach worker that knows what to do with the client, the client is going to require some sort of documentation to eventually get their insurance. They're gonna need an address. When that insurance lapses, they need an address to receive the paperwork to kinda reinstate their insurance and all sorts of stuff. So, I think that those same barriers exist in the population that needs prevention services. And, you know, having some sort of a navigator or an outreach worker that can be linked to somebody and have that person who is in touch with them and is able to communicate with them…helps to keep them insured or to keep them engage in the healthcare.

As an AIDS service organization that has been working with PLWHAs for over 25 years, this leader relied on her history and experience with marginalized populations to effectively push back against the CDC to make adjustments to the proposed peer navigator model as she felt appropriate. This speaks to the notion that organizational history and identity impact how organization's respond to both resource dependence and coercive isomorphic pressures (Pfeffer & Salancik, 1978; DiMaggio & Powell, 1983). Newer organizations, or those without an extensive history of working with PLWHAs, may not have identified the need for integrated navigator models or possessed the type of standing within the field that this organization has to be able to successfully push back on behalf of their clients. Thus, while an integrated peer navigation model makes perfect sense to this leader with regard to removing obstacles to PrEP uptake for the most vulnerable populations, this model is not uniformly replicated across organizations that provide HIV prevention services.

Similar to the implications of resource dependence (Pfeffer & Salancik, 1978) among CBOs that provide HIV prevention services described in the previous chapter (e.g., limited effective behavioral interventions being implemented on the ground), when government funding is not available for CBOs to offer insurance navigation and/or organizational leaders don't perceive value in this job task because their state has not expanded Medicaid and there are limited options available on the Health Insurance Marketplace for their clients to choose from, these two types of navigation are not offered and access to PrEP is fettered. The deputy director of an ASO in Atlanta summarized the challenges of navigating the Marketplace for her organization's clients as such:

> We have people who, when they got on the ACA, they couldn't stay on the ACA in terms of if they don't have consistent income that can pay their premium. They drop in and out. You have periods of reenrollment. People like, 'When can I enroll, when can't I enroll,' you know? People don't have coverage that is sufficient because the premiums are high. And, you know, this is also amongst our own staff…whose insurance we pay for!

This leader affirms the need for integrated peer/health insurance navigator models for assisting clients with understanding their benefits (including subsidies available to help with the costs of premiums), enrollment periods, etc. More specifically, she highlights the need for frontline staff persons to at least be knowledgeable about the Marketplace, for the organization's clients as well as for themselves. If these individuals do not have the proper knowledge/skills to engage with the Marketplace for themselves, there can be no expectation that they will be able to effectively assist their organization's clients with doing so.

The executive director for a women's reproductive health and justice organization in Memphis suggested that, in addition to the difficulties with navigating the Marketplace, affordability remains a critical issue for their most vulnerable clients as a result of employment disparities and the absence of livable wage standards in the state:

> The Marketplace can come but…if you could [access it], you accessed it at a particular price. And, because there was the built-in piece around hardship, you might be able to get that for something that is more affordable. But, depending on what your hardship looked like, that's still a hardship because Tennessee won't move the minimum wage. And a lot of families – I mean, white, black, Latino…it don't even matter – the employment disparity is ridiculous if you only have the type of education that gets you from the factory down or the certification that you can be a CNA.

These organizational leaders suggest that the lack of access to affordable healthcare is an issue facing a broad range of citizens, including individuals within working families who lack the capacity to earn enough income to make ends meet and also afford to pay insurance premiums/deductibles. As such, the barriers to accessing healthcare go beyond expanding Medicaid or even healthcare legislation and reform. High rates of poverty and unemployment, as well as the lack of access to educational opportunities (which lead to employment advances) also play an important role, highlighting the need for social safety net programs such as Medicaid expansion and validating the CDC's call to address the social/economic determinants of health within its program for community-based prevention (which will be discussed in the next section).

Moreover, organizational leaders suggest that individuals who do possess the time and resources to make educated decisions about their healthcare plans may also be less likely to take advantage of community-based prevention services and, therefore, face a different set of challenges when engaging the healthcare system. More specifically, they may not be aware of all their prevention options, including PrEP and PEP, and may not know how to approach their providers about these interventions. The deputy director of an ASO in Atlanta described these challenges in this way:

> The people who are selecting their policies, they go through an enormous amount of research. And they talk to their doctors and they ask them if they're on the plan. And they have the support to go to the doctor and leave their job and to be off as long as it takes. But then they don't have the ability to ask the in-depth questions when they are in an office with a visit that is short term, you know? They don't go in and do all the things that we say. And don't let something be wrong…

While this leader described the benefits of ACA navigators for assisting these individuals, she is forced yet again to acknowledge the limitations of her staff and current resources for offering this additional service:

> It's like the more you need, the more you see that you don't have covered [and] the more out of pocket cost you have. And you don't know how to select a plan. And you don't have navigators that navigate you every year. And we drop in and out because our money is cyclical. So, I mean, these are new plans under this new form of the ACA. We gonna be dropped out so quick. Even if you have access to or are able to get in and had it, you drop out and you can't get back in with that same level of coverage. And this is just news that I'm learning about how to talk about it. And I'm not even doing Medicaid and

> insurance navigation because I can't. I'm not funded. And even if we tried to do it, because we just do everything, I don't have people who have the skill. They can't select their own policy.

This statement reinforces the dangers of resource dependence within the field (Pfeffer & Salancik, 1978), which impacts how CBOs respond to the introduction of the biomedical HIV prevention ideology communicated to them from the CDC. While this leader makes a strong case for CBOs to offer health insurance navigation to connect clients to ARV-based approaches, it is not a service that her organization provides because they are not funded to do so and there are currently no efforts underway to secure funding for this service in the near future. As such, when organizations are heavily or solely dependent upon one source for the resources necessary to provide essential services to their focus populations, but that particular funder does not support all of the necessary service technologies these organizations require to be effective, critical gaps remain in providing comprehensive HIV prevention within marginalized communities.

To Seek Federally Qualified Health Center Status or Not?

The gradual dominance of the biomedical HIV prevention practice ideology at the CDC—coupled with the significant degree of resource dependence within the field that has caused CBOs to continually adapt their infrastructures to be in alignment with subsequent funding requirements—has resulted in some of these organizations deciding to offer medical services on location. This includes pursuing funding to open “PrEP clinics” (which appear easier to come by than resources for continuing to offer effective behavioral interventions) and even transitioning to Federally Qualified Health Centers (FQHCs). The perceived benefits of offering primary medical services for the organization was expressed by several organizational leaders across sites, regardless of their state’s decision to expand Medicaid or not. Not only do leaders perceive that pursuing FQHC status makes them more attractive to government funders, but they are also lured in by the additional revenue streams associated with such a move. The executive director of an ASO in Atlanta—who was in the process of opening a PrEP clinic at his organization when I interviewed him for this study—described the benefits of doing so in this way:

> I think getting dollars for a PrEP clinic allows you to begin to build your infrastructure for a clinic. So, a gateway. So, understanding what your capacity is…because at the end of the day, when you think about a PrEP clinic, you ultimately are going to see people who are HIV-positive who are presenting for PrEP. So, you build your capacity for PrEP, you build your capacity to then provide HIV clinical services. So, I'm on board with that.

It is worth noting that this organizational leader perceived PrEP as a gateway for the organization to begin offering clinical services to PLWHAs. As previously mentioned, offering treatment approaches to this population, as well as the need for CBOs to be involved with engagement and retention services, is not new to the field. As such, this leader's comments suggest that the advent of PrEP is the tipping point that has secured the dominant position of the biomedical HIV prevention practice ideology within the field, forcing CBOs to acknowledge the need to adjust their organizational infrastructures to be able to accommodate all ARV-based approaches. This is consistent with responses to both coercive and mimetic isomorphic processes described by DiMaggio and Powell (1983). When organizational leaders are faced with new mandates from funders that cause uncertainty within their environments, they tend to replicate infrastructures that are favorable to funders and appear to be working for other organizations, whether in line with their stated missions or not.

While the option to transition to an FQHC was appealing to some leaders—because it would allow them to offer affordable primary medical care in additional to behavioral and social services that their organizations have historically provided—doing so presents an entirely different set of challenges for CBOs. The executive director of an ASO in New Orleans shared his thoughts on offering primary medical services and transitioning his organization to an FQHC:

> I kinda got my finger on the pulse of a lot of things happening by being on some national committees. There's a movement by the GOP-led Congress in the House to reduce

> funding across the board. I could work towards and spend that $200,000 to become a FQHC, but it's not guaranteed that I would be funded as a FQHC.

This leader offered that, not only do organizations have to consider the costs involved with securing FQHC status, but they must also contend with the same political challenges in the general task environment that impact Medicaid expansion and ultimately determine the success or failure of organizations that make the transition. Similar to the way that organizational leaders in non-expansion states discussed their government leaders' decisions around Medicaid expansion, this leader implies that race also plays a critical role in the requirements for attaining and maintaining FQHC status:

> Just like when in '87, '88, with Stonewall and all of that movement when the epidemic was starting and you had white groups protesting and trying to ensure that we got funding. They were throwing money at them. Once African American agencies and groups started participating, then they put more regulations in and made it more stringent. And, since they say now that HIV is a treatable disease, the shift in funding has happened. So, now that there are more minority entities trying to become FQHCs, suddenly the pool of money has diminished, and also there's more stringent requirements now. So, for us to transition to FQHC, where we already have six in the city, would be counter-productive. I mean, it would be even more competition. So, after sitting down, talking with staff, looking at the trends, there are other avenues that we could develop that, not being a FQHC, but providing certain services and coordinating with FQHCs in referrals, that is more beneficial than being a FQHC.

Comparing the early days of the gay liberation movement to the present-day fight against HIV/AIDS, this organizational leader alludes to the role that race plays in funding and support for community-based efforts, suggesting that there is a structural effort to undermine the work of minority-led and serving organizations. Such an assertion speaks to the dominant attitudes and beliefs about HIV/AIDS and those who are affected, as well as the political power of dominant groups to direct both scarce resources and service dynamics. More specifically, this leader suggests that when dominant groups are affected by a social problem, resources are effectively mobilized to address it. However, when minority populations are disparately affected by the same social issue, resources for addressing it become scarce. As such, minority-led organizations are at a disadvantage with respect to their ability to effectively provide critical services to the populations that they serve.

Moreover, this leader went on to describe the challenges associated with reimbursement for services under Medicaid. He suggested that caps on payment for eligible services and bureaucratic red tape related to the reimbursement process, coupled with stringent requirements for personnel-to-client ratios, makes the pursuit of FQHC status a risky move for CBOs. He stated that this is particularly the case in New Orleans, since there are already a number of FQHCs in the city (two of which were long-standing ASOs that recently converted to FQHC status):

> The problem is, they've changed the funding dynamics on Medicare/Medicaid. Instead of \$200, \$250, \$300 dollars for every cost, they've reduced it to \$175. So, they've changed that which means you would have to work three times harder to offset your cost.

Another organizational leader from New Orleans had recently led her organization through the process of transitioning to FQHC status because, as she puts it, she saw the "writing on the wall" with respect to the dominance of ARV-based prevention within the field. While she did not bring up challenges associated with the Medicaid reimbursement rate, she did state that it was more fiscally advantageous for the organization when they only offered clinical services as opposed to becoming an FQHC. Her rationale for this position stems from a rebate system that the organization was able to take advantage of as a result of the pharmacy services that it offers, which she described in this way:

> It was better fiscally for our organization [before we became an FQHC]. Well, it's kinda two-tiered. Since 2011, we had a contract with Priority Drugs [to provide pharmacy services]. So, we were eligible for what's called a 340b I.D. number. And that means, because we're serving a low-income population, the federal government allows us to pay for medications at a cheaper rate. So, if somebody has private insurance and they're getting their medications still through us, what happens is your organization will generate a rebate. And, that money helps you expand your services, and so that's what we did. So, that money I had been generating, I was able to open up my own pharmacy that way. But those are the kinds of things that you don't realize in the long run, how it affects your

> bottom line. On' the flip side, as a community health center, our reimbursement rate is greater for primary care visits.

This statement suggests that CBO leaders' decisions to seek FQHC status in response to the biomedical HIV prevention practice ideology are complicated and also affected by the extent to which these organizations are dependent upon limited resources to provide HIV prevention services. Transitioning to FQHC status comes with requirements that involve decreasing personnel-to-client ratios (which means increasing staff) but also with potential delays in funding. If these organizations do not possess the reserves or other funding sources to cover the expenses associated with such requirements and delays, they run the risk of falling into financial holes that could ultimately force them to close their doors, worsening the gaps in HIV prevention services available to the most vulnerable populations.

Application to Theory

The introduction of the biomedical HIV prevention practice ideology as communicated by the CDC has resulted in a considerable degree of tension within the organizational field to which CBOs must respond. Service technologies associated with this practice ideology involve engaging and retaining high-risk negatives (HRNs) in antiretroviral-based approaches, requiring these organizations to interact with the healthcare sector in novel ways. Given the current state of healthcare in the United States and particularly the politics associated with increasing access for marginalized populations—including state decisions to expand Medicaid or not, as well as the challenges associated with navigating the Health Insurance Marketplace—such interaction drastically impacts the ability of CBOs to effectively enact the biomedical prevention ideology. For example, in states where Medicaid programs are not being expanded, CBOs have limited options for connecting clients with prescribing providers. In addition, while expanded Medicaid options and the Health Insurance Marketplace serve to increase assess to ARV-based prevention, CBO staff interviewed for this study described significant barriers to assisting their client populations with navigating these options.

Similar to the challenges associated with requiring CBOs to adopt standardized evidence-based behavioral interventions without providing adequate resources and training for doing so, the CDC's program for community-based efforts has coercively pushed these organizations to enact the biomedical HIV prevention practice ideology in an environmental climate that does not entirely support it. Although some organizational leaders found value in and have implemented both PrEP and health insurance navigation models to assist marginalized clients with overcoming these barriers—with some CBOs strategically integrating the two models—others cite the lack of available resources from the CDC to support these roles as a significant obstacle. And, while the CDC has made funds available to health departments (and ultimately CBOs) for peer/PrEP navigation services via the #15-1506 and #15-1509 funding opportunities, the decision to include health insurance navigation specifically was optional. As a result, CBO leaders interviewed for this study were overwhelmingly on board with the biomedical HIV prevention practice ideology, however, only one of them engaged in advocacy to ensure that her organization would have the resources to offer this valuable service. Worryingly, none of the other organizational leaders described similar advocacy efforts or attempts to secure outside funding to provide health insurance navigation.

This lack of advocacy on behalf of the services that CBO personnel deem essential for ensuring access to ARV-based prevention further elucidates the implications of resource dependence (Pfeffer & Salancik, 1978) within the organizational field. Dependence upon the CDC as the primary funder of HIV prevention services within the field leads CBOs to go along with changes in the CDC's community-based prevention program, even in the absence of adequate resources and support for doing so. As a result, access to comprehensive HIV prevention in vulnerable communities remains limited. However, since there were no specific organizational targets for linking HRNs to ARV-based approaches outlined in any of the FOAs analyzed for this dissertation, and efforts funded through the #15-1506 (CDC, 2015a) and #15-1509 (CDC, 2015b) opportunities are simply demonstration projects, the loose- or de-coupling of organizational structures (Meyer & Rowan, 1977) to appear to be aligned with the biomedical prevention practice ideology were not observed. We can expect, however, that CBO personnel will engage in such behaviors if or when the CDC institutes organizational targets specifically related to this service (as they have with other prevention services such as HIV testing and linkage to care for PLWHAs).

In addition, while this analysis reveals that some CBOs have started PrEP clinics in response to the expansion of the biomedical HIV prevention practice ideology, others have transitioned their organizations to Federally Qualified Health Centers, illuminating mimetic isomorphism related to this shift in focus at the CDC ((DiMaggio and Powell, 1983). CBOs that had never considered offering primary medical services at their organizations are weighing the pros and cons of doing so, using other organizational models as a guide. In this study, I find that establishing PrEP clinics appeared to be an easier feat for these organizations than transitioning to FQHCs, largely due to resource availability and the fact that this decision is more in line with the missions of these social service organizations. Transitioning to an FQHC, however, comes with an additional set of challenges to be grappled with, including factors related to historical and environmental context (e.g., political and racially-motivated decisions related to resources for supporting FQHCs and Medicaid reimbursement).

Responding to the Call to Address Social/Economic Determinants of Health

In addition to the tension that organizational leaders faced as a result of the shift in focus populations within the CDC's program for community-based HIV prevention described in the previous chapter, CBOs have increasingly been tasked with addressing the social/economic determinants of health that impact access to services within priority populations (e.g., homelessness, poverty, incarceration, unemployment). By nature, the biomedical HIV prevention practice ideology—which requires CBOs to engage HRNs into primary medical care—also demands that these organizations confront and make an effort to address these variables. Organizational staff interviewed for this study, including leaders and frontline prevention workers, discussed their perceptions of and efforts for responding to this mandate.

While CBO staff overwhelmingly agreed with the need for the social/economic determinants of health to be addressed within the context of providing HIV prevention services, many of them felt that the CDC's requirement for them to do so was disingenuous. In the absence of additional resources for meeting the actual needs of their clients or support for tackling the larger systemic issues that impact them, both organizational leaders and frontline prevention staff felt that they were simply going through the motions with respect to this requirement. The director of prevention services at a university in Baltimore put it this way:

> There's been more of a focus on understanding social determinants of health, but it feels super superficial. It feels like people are just using like key words and catch phrases. People aren't actually addressing doing the actual work of dismantling systems of repression, particularly in healthcare systems. They just wanna say buzzwords. So that's kinda frustrating.

A number of CBO staff across sites affirmed that there appears to be no real effort or support from the CDC to actually address the myriad social/economic determinants of health affecting their most vulnerable clients, despite the call to do so via FOAs issued for community-based prevention and health department demonstration projects funded under FOA #15-1509 (CDC, 2015b). A frontline prevention worker at a Baltimore LGBT organization describe the challenges associated with engaging clients into PrEP within the context of these social/economic determinants:

> My issue with the PrEP thing, and it's the same issue when it comes to HIV treatment, you can't have a [client] talking about taking a pill every single day, when they can't find a job or don't have somewhere to sleep. There's no way that we can push PrEP on somebody. Now, we do it, we have those conversations… but you can't expect a [client] to sit there and take a pill every single day of PrEP when they're not even stable. We have to go back and look at what we did for HIV to get a lot of these people on HIV medication if we're going to push PrEP.

This prevention worker suggests that, in the same way that the Ryan Care Act was designed to provide wrap-around services to ensure that the most vulnerable PLWHAs could effectively access HIV treatment, a similar structure is necessary for connecting and retaining HRNs in ARV-based prevention. For example, resources must be made available for increasing the number of transitional housing units for HRNs. Instead, CBO staff describe a referral network established by their local health departments that does not effectively meet the needs of their client populations. A frontline prevention worker at a Baltimore ASO describes her frustration with such referral networks in this way:

> I've spoken to one of the members at the health department and I brought the concern. I'm like, 'Yall have yet to talk about housing. Y'all have yet to talk about all these resources that you're quick to tell somebody that we have. And then, we revert to our Resource Guide [provided by the health department] and there aren't as many as you think that you have or that you say that you have, and then there's stipulations on these kinda things. Your funding is going into PrEP but you're wasting the money because half of these people aren't ready to talk about PrEP when they're still trying to survive… trying to see the next day.

This statement speaks to larger systemic issues that are at the core of effective HIV prevention efforts targeted at HRNs and particularly MSM who are currently at the center of the CDC's program for community-based HIV prevention; our nation's social safety net is not designed to support healthy or "able-bodied" men. Such systemic issues severely impact implementation of the biomedical HIV prevention practice ideology on the ground, despite the CDC's call for CBOs to address them. Virtually all of the CBO staff interviewed for this study described collaborations with other social service organizations for assisting clients with meeting these additional needs. And, while some of these organizations have developed relationships with service providers that offer complimentary services and/or sought out additional funding to overcome this barrier (such as securing resources to establish housing and employment programs for young MSM and transpersons of color), the need is described as insurmountable in the face of high poverty rates within their respective cities. There are never enough beds to house everyone who presents with the need, or enough resources to support a client with limited education or work experience with finding gainful employment and securing affordable health insurance.

Finally, one of the most significant barriers to accessing ARV-based prevention described by CBO staff—which is indirectly related to social/economic determinants of health—is the lack of established relationships between healthcare personnel and members of marginalized communities. Beyond medical mistrust, which came up frequently in my interviews with CBO staff and is well documented in healthcare literature, many members of marginalized communities have no reference for what it means to have an ongoing relationship with a medical provider. CBO staff suggest that, beyond Medicaid expansion and the Health Insurance Marketplace, this lack of relationship is one of the primary barriers to PrEP access and uptake. The executive director of an LGBT organization in Baltimore summed up this barrier like this:

> Many of [our clients] don't have an ongoing relationship with a medical provider. So, it's one of those things where, yes, it's [Medicaid] available, but does it benefit you if you don't know that it's available, one? And then, two, if you don't know how or don't feel comfortable even accessing a medical provider. If you went three, or four, or five years without ever going to a hospital, which is the problem for men in general—regardless of where they fall in the spectrum of class, race, sexuality—men just believe they're invulnerable and avoid hospitals. So, in this case, the marginalized members of our community, they are really disconnected from having an ongoing relationship with a primary care physician or health physician in general. So, even that being the case, if they're not engaged in having a relationship with a healthcare provider then it's all for naught, 'cause they can't access it anyway.

Descriptions of this barrier suggest the need for CBOs to offer evidence-based models of patient/provider mediation as a standard feature of PrEP navigation. While the health department demonstration projects funder under FOA #1506 (CDC, 2015a) include a component that is focused on educating prescribers about PrEP, there was no requirement or additional financial support available for CBOs to be involved specifically with bridging the gap between primary healthcare providers and members of marginalized communities.

Application to Theory

From a theoretical perspective, the CDC's call for CBOs to address social/economic determinants of health did not result in coercive isomorphic pressures in the same way that other requirements described throughout this dissertation have. Prior to the #15-1509 health department demonstration projects (which were focused specifically on social determinants) (CDC, 2015b), there was no real guidance or specific organizational targets provided for CBOs within any of the FOAs issued for community-based HIV prevention. As a part of their applications, CBOs were simply required to document how they were currently addressing social/economic determinants (CDC, 2015b). Depending on the outcomes of these demonstration projects, however, this requirement could change in the future, creating both challenges and opportunity for CBOs.

CBO staff overwhelmingly recognized the value of the CDC's call for their organizations to be involved with addressing the social/economic determinants of health affecting their most vulnerable clients. However, in the absence of additional resources or recommendations for evidence-based models for doing so, they perceived the effort as disingenuous and their response to it can be summarized as "going through the motions." And, while some of these organizations have sought out other funding sources to address social and economic determinants—particularly the issue of homelessness which was pervasive in each of the included cities—others have not. As such, those organizational leaders who perceive this as an opportunity to more intentionally address the breadth of HIV prevention needs of the communities that they serve can be expected to push back against the CDC and demand appropriate resources for doing so (and hopefully pursue additional funding streams as well). Those leaders who perceive this as more of the same within the CDC may be especially challenged by this mandate and continue to "go through the motions," particularly as outcomes related to social and economic determinants become directly linked to funding. Based on the findings described in this dissertation so far, this will ultimately play out as loose- or decoupling strategies (Meyer & Rowan, 1977) that will allow for the organization to be in compliance with CDC requirements (or at least appear to be) without actually addressing the issues. As a result, however, effective HIV prevention may continue to be limited in marginalized communities.

Discussion

The introduction of the biomedical HIV prevention practice ideology as communicated by way of the CDC's program for community-based prevention, as well as the call for CBOs to be involved with addressing social and economic determinants of health, present unique challenges and opportunities for these organizations. The biomedical prevention practice ideology requires CBOs to play an active role in engaging and retaining high-risk HIV negative individuals (HRNs) into primary care for the first time. While many CBOs operating within the field have been involved with linkage and retention efforts for people living with HIV/AIDS (PLWHAs) for some time, this requirement represents somewhat of a crossroads for them. More specifically, it has coercively forced many organizational leaders to consider making the transition to Federally Qualified Health Centers or, at the very least, to begin offering primary medical services (a form of mimetic isomorphism) (DiMaggio and Powell, 1983).

The challenges associated with accessing ARV-prevention, even in the face of Medicaid expansion and the Health Insurance Marketplace, support the CDC's call for CBOs to be involved with addressing the social/economic determinants of health. In addition to the logistical issues related to securing and navigating health insurance, the lack of affordable housing and access to quality education and good-paying jobs are described by CBO staff as significant barriers to ARV-based prevention for their most vulnerable clients. In response, some organizations have instituted peer/PrEP navigator models to assist these clients with understanding both their health insurance and biomedical prevention options. CBO staff who assume these roles are also responsible for assisting vulnerable clients with navigating the various social/economic determinants that affect them. And, while such positions are increasingly being supported by the CDC, it is clear from my interviews with CBO staff that these efforts merely scratch the surface. Without additional resources and evidence-based models for truly addressing the structural issues that perpetuate social/economic determinants—including the limitations of our nation's social safety net and capitalist economy, as well as the atrocities of our criminal justice system—the call for CBOs to address these variables was perceived by many as simply superficial.

These findings highlight the need for CBOs that provide HIV prevention services to not only exist, but to reclaim their identities as staunch advocates for the true needs of their client populations in this new biomedical prevention era, despite the isomorphic pressures placed upon them by the CDC. While the potential of ARV-based prevention for curbing new HIV infections in marginalized communities is indeed great, the barriers to access for the most vulnerable members are equally huge, though not insurmountable. The CDC's acknowledgement of the need to address social/economic determinants is a step in the right direction; however, it is up to CBO staff to advocate on behalf of the communities that they serve to take it to ensure that the barriers to access are sufficiently tackled.

CHAPTER 6. Conclusion

The organizational field of HIV prevention emerged in response to the federal government's neglect of the AIDS crisis in the early 1980s, which decimated communities of affected individuals across the country (Shilts, 1987; DeCock, Jaffe, & Curran, 2011). Over time, the federal government has become the primary funder of HIV prevention services in the U.S., dictating both practice ideologies and the service technologies employed at organizations within the field. What are the implications, though, of dependence upon this same neglectful government for resources and effective models for fighting the epidemic today? The answer, in simple terms, is that the true needs of the most disparately affected communities continue to be overlooked.

In this dissertation, I have integrated resource dependence (Pfeffer & Salancik, 1978) and new institutional theories (Meyer and Rowan, 1977; DiMaggio and Powell, 1983) to explore how community-based organizations have responded to coercive isomorphic pressures within the CDC's program for community-based HIV prevention. In addition to mandating standardized behavior-change technologies and the gradual foregrounding of ARV-based approaches, this analysis has also revealed other important changes in the CDC's program for community-based HIV prevention efforts that advanced structural approaches for curbing the epidemic. These changes included: (1) expanding community-based prevention efforts to include People Living with HIV/AIDS (PLWHAs); (2) targeting efforts towards disproportionately affected populations (e.g. African American gay/bisexual men, transgender women) in geographic regions where HIV prevalence is highest (e.g., the southern United States); and (3) addressing the social/economic determinants of health facing the nation's most vulnerable populations (e.g., poverty, homelessness, unemployment, racial discrimination).

My interviews with CBO staff and public health administrators in four cities disparately affected by HIV—Atlanta, Baltimore, Memphis, and New Orleans—revealed a number of challenges and opportunities for CBOs as a result of these shifts. First, leaders within these organizations have been challenged by the lack of local population input and relevance of EBIs, as well as limited training and resources made available from the CDC for implementing these interventions with fidelity. This resulted in loose-coupling (Meyer & Rowan, 1977) among organizational actors, where leaders ceremonially proceeded with implementation but made modifications to intervention protocols in consideration of these limitations. Then in 2011, following the CDC's "CBO Monitoring and Evaluation project" designed to support the development, implementation, monitoring, and evaluation of community-based HIV prevention programming, these organizations were forced to grapple with the de-emphasis of a number of these interventions without regard for their investment in them over time. Despite finding value in some of EBIs that focused specifically on gender and sexual minorities—even in the absence of adequate resources for effective implementation from the CDC—organizational leaders did not always seek out other funding sources to continue offering them.

What has happened with the DEBI project over the years speaks to one of the primary challenges of resource dependence (Pfeffer & Salancik, 1978) within the organizational field of HIV prevention. Seen here as a coercive isomorphic pressure (DiMaggio and Powell, 1983) to ensure a CDC-defined standard of prevention education across the country, the DEBI project forced CBOs to adopt a particular service delivery model (without adequate financial or technical support for doing so). Then, once evaluated and presumed not to offer the biggest bang for the buck, the investment at the CDC began to shift and CBOs soon followed suit. The implications of this are two-fold. First, it is evidence of the loss of autonomy within CBOs over the years to have full control over the service technologies that they offer. More importantly, however, it leaves a gap in prevention services that both the CDC and CBOs agreed were effective at one point in time. Targeted, theory-based interventions focused on the prevention needs of all of the populations that CBOs serve are necessary, even if the CDC does not perceive enough value in them to fund them. Many of these interventions have been designed to address the whole person as opposed to the biological aspects of HIV prevention, approaches that are much more humanistic and holistic in nature. If these populations are not receiving such interventions at the very organizations created to provide them, then where else will they gain access?

At the same time, organizational leaders were grappling with a major structural shift in the CDC's program for community-based HIV prevention—the increased focused on gay/bisexual men and transgender women of color. While organizational leaders interviewed for this study generally agreed with the rationale for this shift, based on their understanding of the epidemiological data, they also felt strongly that the gradual exclusion of women within the CDC's community-based HIV prevention program was not responsive to sexual dynamics within the communities that they served. These leaders described more fluid forms of sexual expression and sexuality within black communities that is not confined to socially-constructed labels, thereby potentially missing opportunities to reach men who many not identify as gay/bisexual and their female sexual partners. While one organizational leader from a CBO that focused primarily on women refused to accept funding from the CDC to more effectively respond to such sexual dynamics, others shifted their focus populations to be in compliance.

This response further illuminates the highly problematic nature of resource dependence (Pfeffer & Salancik, 1978) within the organizational field of HIV prevention. Since the majority of leaders from organizations focused on women acquiesced to this shift, it creates yet another gap in community-based prevention that leaders in the field have identified. If CBOs that previously offered programming that attended to the needs of women in their communities are no longer doing so, where do these women now turn for these services? More importantly, what happens if incidence rates among this population were to rise again? Will the CDC shift its priorities yet again, forcing these organizations to readjust their infrastructures and turn away from YMSM and YTW of color? These are important questions that must be addressed if we are to truly see an end to the HIV/AIDS epidemic and achieve zero new infections in our lifetime.

The introduction of the biomedical HIV prevention practice ideology—which involved a shift from a primary focus on behavioral intervention to the inclusion of biomedical approaches—comes with both great opportunity and challenge for CBOs. For example, the biomedical HIV prevention practice ideology affords them these organizations the opportunity to be directly involved with addressing barriers to healthcare for the populations that they serve. In response to the introduction of this prevention practice ideology—which involves engaging and retaining priority populations in antiretroviral-based prevention—some CBOs are now offering primary care services. Moreover, a few leaders have transitioned their organizations to Federally Qualified Health Centers, while others are strongly weighing the pros and cons of this option. But will these changes be enough to increase uptake of ARV-based prevention, particularly PrEP, and actualize the primary goal of the National HIV/AIDS Strategy to ultimately bring about an end to the HIV epidemic? Or, are the challenges associated with accessing ARV-based prevention in the context of limited Medicaid expansion and access to affordable healthcare options too great to eventually maximize the potential of the biomedical HIV prevention ideology? More importantly, are ARV-based approaches such as PrEP even a priority for our nation's most vulnerable citizens?

While answers to the first two questions are yet to be determined, CBO staff interviewed for this study suggest that the answer to the last one is, no. In general, attending to the social and economic determinants of health affecting the most vulnerable client populations (e.g., poverty, discrimination, lack of access to quality healthcare) take precedence over ARV-based prevention for both CBO staff and the people that they serve. Moreover, the CDC's call for CBOs to address these social/economic determinants may be, in part, an acknowledgement of their own reservations regarding the potential of ARV-based prevention; without adequately addressing them, uptake of these interventions will continue to be fettered However, addressing social/economic determinants has historically been the real business of HIV/AIDS focused CBOs. ASOs emerged to take care of and provide social support for people living with/dying from HIV/AIDS (DeCock, Jaffe, & Curran, 2011). While offering primary medical services may seem like natural evolution for these organizations, what does it mean for leaders to express concern that the CDC's efforts to address social/economic determinants of health feels superficial to them?

If the resource dependence trends revealed through this dissertation continue, the answer to this question could be devastating for the communities most affected by HIV. More specifically, if the organizations that exist to serve them continue to make strides to comply with the biomedical HIV prevention practice ideology, while going along with what they perceive as the CDC's superficial efforts to address the true needs of vulnerable communities, disparities in HIV will persist. Members of these communities will seek out prevention services from these organizations, only to be offered a pill-a-day to prevent HIV that they may not be able to either access or adhere to. Moreover, they may not learn about other ways to effectively avoid contracting HIV, such as condom negotiation during sex work or sero-sorting/positioning to minimize risk. They also may not be provided with the tools to assist them with eliminating the real factors that put them at risk—such as homelessness which may drive them to sex work, or unemployment that has left them without health insurance.

In conclusion, this dissertation has illuminated the woes of resource dependence (Pfeffer & Salancik, 1978) within the organizational field of HIV prevention and has important implications for organizational practice, policy, and theory. With regards to practice, this dissertation has revealed that being solely dependent upon the CDC for essential prevention resources has led to both mission drift and, ultimately, neglect of the true needs within the communities that organizations within the field serve. To rectify this, CBOs must be made aware of the implications of resource dependence (Pfeffer & Salancik, 1978) and provided with technical support for diversifying their funding streams to be able to more adequately address the needs of the communities that they serve. Such technical support should not come from the CDC. Rather, it is important for foundations and other philanthropic entities to fund and provide such assistance, in order to ensure that CBOs regain and maintain their autonomy moving forward.

The policy implications of these findings are twofold. First, the call for CBOs to address the social and economic determinants of health without additional resources for doing so does in fact seem superficial. However, given the complicated nature and limitations of federal funding streams, it is not likely that additional resources will be provided from the CDC to more comprehensively address social/economic determinants. In light of this, the CDC should explore the extant research literature to make evidence-based recommendations and, in partnership with CBOs, evaluate any resulting programming to contribute to a practice-informed knowledge base on addressing the social/economic determinants of health.

From my interviews with CBO staff, however, it is clear that the CDC could not tackle this challenge on its own, which leads me to the second policy implication of this dissertation—our nation's social safety net requires rethinking and restructuring in order to address the HIV/AIDS crisis. CBO staff stated that it is virtually impossible to house "able-bodied" gay/bisexual males and transgender women, which are the primary target of the CDC's PrEP uptake efforts. This reality, however, is greater than PrEP. It is a reflection of how our country distinguishes between worthy and unworthy populations with regards to who receives certain social services. It is also counterproductive to the CDC's goal to increase PrEP uptake among these populations. Therefore, true change within these communities will require CBOs to advocate on behalf of changing this and other social systems which, unfortunately, is absent from the CDC's call to address the social/economic determinants of health (and likely beyond the scope of this government agency).

Finally, with regards to organizational theory, this dissertation has illuminated the impact of government resource dependence (Pfeffer & Salancik, 1978) within a field that emerged in response to government neglect. The ramifications of this, as previously described, is coercive and mimetic isomorphic pressure (DiMaggio and Powell, 1983) to conform to CDC practice ideologies. Such conformity ultimately results in the continued neglect of the true needs of the populations that CBOs were established to serve. Although the evolution of the organizational field of HIV/AIDS prevention may be a unique case study, other fields in which organizations have been largely dependent upon government resources may also be neglecting the needs of their focus populations as a result. This may ultimately result in the inefficient use of government resources and, more importantly, further perpetuation and worsening of the social problems that these resources are allocated for.

Limitations

While this dissertation describes organizational responses to changes within the CDCs program for community-based HIV prevention since 2003, it only includes CBOs from four of the nation's most disparately impacted cities. As a result, the findings outlined throughout cannot be generalized to the entire United States. However, heavy reliance on the CDC for HIV prevention funding is likely a common phenomenon among CBOs throughout the country, which may result in little variation in organizational responses regardless of location (particularly among CDC-funded CBOs).

In addition, this dissertation is not inclusive of every organization (or organizational type) that provides HIV prevention services in these cities, with ASOs representing over half of the sample. It is possible that very different response patterns may have emerged among different types of organizations. Future studies should make an effort to be more inclusive of all organizations that provide prevention services in cities under investigation, perhaps employing mixed-methods to be able to cover more ground.

Finally, with only two exceptions, each of the organizations included in this study was receiving CDC-funding for prevention services (either directly or indirectly by way of their local health departments) at the time that CBO staff were interviewed. The CEO of one of these organizations was intentional about not applying for/accepting funding from the CDC to be able to maintain control over the types of services offered as well as the content of prevention messaging. To better understand the variation in organizational responses to field-level changes, future studies should be inclusive of more organizations that are not funded by the CDC or have more of a variety of funding sources for prevention services. Understanding how these organizations have been able to sustain prevention programming in the absence of CDC funding, as well as the content of this programming, is important for documenting and disseminating best practices among CBOs.

REFERENCES

Adam, B.D. (2011). Epistemic fault lines in biomedical and social approaches to HIV prevention. *Journal of the International AIDS Society, 14*(S2), 1-9.

Auerbach, J.D. & Hoppe, T.A. (2015). Beyond "getting drugs into bodies": Social science perspectives on pre-exposure prophylaxis for HIV. *Journal of the International AIDS Society*, *18*(3), 1-5.

Baeten, J.M., Donnell, D., Ndase, P., Mugo, N.R., Campbell, J.D., Wangisi, J.,…Celum, C. (2012). Antiretroviral prophylaxis for HIV prevention in heterosexual men and women. *The New England Journal of Medicine*, *367*(5), 339-410.

Battilana, J. (2006). Agency and institution: The enabling role of individuals' social position. *Organization, 13*, 653-676.

Black AIDS Institute. (2014*). When we know better, we do better: The state of HIV/AIDS science and treatment literacy in the HIV/AIDS workforce in the Unites States*. Retrieved from www.blackaids.org/images/reports/15-know.pdf

Bowen, G. (2009). Document Analysis as a Qualitative Research Method. *Qualitative Research Journal*, 9(2), 27-40.

Bradley, H., Hall, H.I., Wolitski, R.J., Van Handel, M.M., Stone, A.E., LaFlam, M., …Valleroy, L.A. (2014). Vital signs: HIV diagnosis, care, and treatment among persons living with HIV—United States, 2011. *Morbidity and Mortality Weekly Report*, *63*(47), 1113-1117.

Choopanya, K., Martin, M., Suntharasamai, P., Sangkum, U., Mock, P.A., Leethochawalit, M.,…Vanichseni, S. (2013). Antiretroviral prophylaxis for HIV infection in injecting drug users in Bangkok, Thailand (the Bangkok Tenofovir Study): a randomized, double-blind, placebo-controlled phase 3 trial. *The Lancet*, *381*(9883), 2083-2090.

Cohen, C. J. (1999). *Boundaries of blackness: AIDS and the breakdown of the black community*. Chicago, IL: University of Chicago Press.

Cohen, M.S., Chen, Y.Q., McCauley, M., Gamble, T., Hosseinipour, M.C., Kumarasamy, N.,…Fleming, T.R. (2011) Prevention of HIV-1 infection with early antiretroviral therapy. *New England Journal of Medicine*, *365*(6), 439-505.

Collins, C., Harshbarger, C., Sawyer, R., Hamdallah, M. (2006). The Diffusion of Effective Behavioral Interventions Project: Development, Implementation, and Lessons Learned. *AIDS Education and Prevention* (Supplement A), 5-20.

Das, M., Chu, P.L., Santos, G.M., Scheer, S., Vittinghoff, E., McFarland, W., & Colfax, G. (2010). Decreases in community viral load are accompanied by reductions in new HIV infections in San Francisco. *PloS One, 5*(6), e11068.

DeCock, K.M., Jaffe, H.W., & Curran, J.W. (2011). Reflections on 30 years of AIDS. *Emerging Infections Diseases, 17*(6), 1044-1048.

DiMaggio, P.J. & Powell, W.W. (1983). The iron cage revisited: Institutional isomorphism and collective rationality in organizational fields. *American Sociological Review, 48*(2), 147-160.

Donnell, D., Baeten, J.M., Kiarie, J., Thomas, K.K., Stevens, W., Cohen, R.R.,…Celum, C. (2010). Heterosexual HIV-1 transmission after initiation of antiretroviral therapy: A prospective cohort analysis. *The Lancet*, *375*(9731), 2092-2098.

Dyer, T.P., Shoptaw, S., Guadamuz, T.E., Plankey, M., Uyen, K., Ostrow, D.,…Stall, R., (2012). Application of syndemic theory to black men who have sex with men in the Multicenter AIDS Cohort Study. *Journal of Urban Health, 89*(4), 697-707.

Epstein, S. (1996). *Impure science: AIDS, activism, and the politics of knowledge*. Berkeley: University of California Press.

Fisher, M. (2012, February 7). A history of the ban on federal funding for syringe exchange programs [Blog post]. Retrieved from https://www.csis.org/blogs/smart-global-health/history-ban-federal-funding-syringe-exchange-programs

Frey, J.H. & Fontana, A. (1991). The group interview in social research. *The Social Science Journal, 28*(2), 175-187.

Gilead Sciences, Inc. (2012, July 12). *U.S. Food and Drug Administration approves Gilead's Truvada for Reducing the Risk of Acquiring HIV* [Press release]. Retrieved from http://www.gilead.com/news/press-releases/2012/7/us-food-and-drug-administration-approves-gileads-truvada-for-reducing-the-risk-of-acquiring-hiv

Granich, R.M., Gilks, C.F., Dye, C., DeCock, K.M., & Willimas, B.G. (2009). Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission: a mathematical model. *The Lancet, 373*(9657), 48-57.

Grant, R.M., Lama, J.R., Anderson, P.L., Mcmahan, V., Liu, A.Y., Vargas, L.,…Glidden, D.V. (2010). Preexposure chemoprophylaxis for HIV prevention in men who have sex with men. *The New England Journal of Medicine, 363*(27), 2587-2599.

Hammer, S.M., Squires, K.E., Hughes, M.D., Grimes, J.M., Demeter, L.M., Currier, J.S.,…Cook, J.C. (1997). A controlled trial of two nucleoside analogues plus indinavir in persons with human immunodeficiency virus infection and CD4 cell counts of 200 per cubic millimeter or less. *New England Journal of Medicine, 337*(11), 725–33.

Hasenfeld, Y. (2010). *Human services as complex organizations, 2nd edition.* Thousand Oaks, CA: Sage Publications.

Human Rights Watch. (2004). *The United States' "war on condoms"*. Retrieved from http://www.hrw.org/backgrounder/hivaids/condoms1204/2.htm

Kaarbo, J. & Beasley, K. (1999). A Practical Guide to the Comparative Case Study Method in Political Psychology. *International Society of Political Psychology*, *20*(2), 369-391.

Kahn, J.O., Martin, J.N., Roland, M.E., Bamberger, J.D., Chesney, M., Chambers, D.,…Katz, M.H. (2001). Feasibility of postexposure prophylaxis (PEP) against human immunodeficiency virus infection after sexual or injection drug use exposure: The San Francisco PEP study. *Journal of Infectious Disease*, *183*(5), 707-714.

Kaiser Family Foundation. (2018, September 11). State of action on the Medicaid expansion decision. Retrieved from https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act

Kelly, C.F., Kahle, E., Siegler, A., Sanchez, T., Del Rio, C., Sullivan, P.S., & Rosenberg, E.S. (2015). Applying a PrEP continuum of care for men who have sex with men in Atlanta, GA. *Clinical Infectious Diseases, 61*(10), 1590-1597.

Kirs, J. & Miller, M.L. (1986). *Reliability and Validity in Qualitative Research*. Beverly Hills, CA: Sage Publications.

Laumann, E., Gagnon, J., Michael, R., & Michaels, S. (1994). *The social organization of sexuality*. Chicago: University of Chicago Press.

Malterud, K. (2012) Systematic text Condensation: A strategy for qualitative analysis. *Scandinavian Journal of Public Health, 40*, 795-805

Meyer, J.W. & Rowan, B. (1977). "Institutionalized organizations: Formal structure as myth and ceremony." *American Journal of Sociology, 83*(2), 340-363.

Millett, G.A., Peterson, J.L., Flores, S.A., Hart, T.A., Jeffries, W.L., Wilson, P.A.,…Remis, R.S. (2012). Comparisons of disparities and risks of HIV infection in black and other men who have sex with men in Canada, UK, and USA: A meta-analysis. *The Lancet, 380*, 341-348.

National Institutes of Health. (2015). NIH HIV/AIDS research priorities and guidelines for determining AIDS funding. Retrieved from https://grants.nih.gov/grants/guide/notice-files/NOT-OD-15-137.html

Office of National AIDS Policy. (2010a). *National HIV/AIDS Strategy for the United States*. Retrieved from https://obamawhitehouse.archives.gov/sites/default/files/uploads/NHAS.pdf

Office of National AIDS Policy. (2010b). *National HIV/AIDS Strategy Federal Implementation Plan*. Retrieved from https://obamawhitehouse.archives.gov/files/documents/nhas-implementation.pdf

Oliver, C. (1991). Strategic responses to institutional processes," *Academy of Management Review*, *16*, 145-179.

Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

Pfeffer, J. & Salancik, G. 1978. *The external control of organizations*. New York: Harper and Row.

Rosenbaum, S. (2011). The Patient Protection and Affordable Care Act: Implications for public health policy and practice. *Public Health Reports, 126*(1), 130-135

Saldana, J. (2014). *The Coding Manual for Qualitative Researchers, 2nd Edition*. Thousand Oaks, CA: Sage Publications.

Scott, W.R. (2001). *Institutions and organizations*. Thousand Oaks, CA: Sage Publications.

Selznick, P. (1957). *Leadership in administration*. New York, NY: Harper and Row.

Shilts, R. (1987). *And the band played on*. New York, NY: St. Martin's Griffin.

Sifris, D. & Myhre, J. (2017). When did HAART become ART? Change is about more than just semantics. Verywellhealth. Retrieved from https://www.verywellhealth.com/cart-hiv-combination-antiretroviral-therapy-48921

Singer, M, (1996). A dose of drugs, a touch of violence, a case of AIDS: Conceptualizing the SAVA syndemic. *Free Inquiry – Special Issue: Gangs, Drugs, & Violence, 24*(2), 99-110.

Stall, R., Mills, T.C., Williamson, J., Hart, T., Greenwood, G., Paul, J.,…Catania, J.A. (2003). Association of co-occurring psychosocial health problems and increased vulnerability to HIV/AIDS among urban men who have sex with men. *American Journal of Public Health, 93*(6), 939-942.

Thigpen, M.C., Kebaabetswe, P.M., Paxton, L.A., Smith, D.K., Rose, Charles, E., Segolodi, T.M.,…Brooks, J.T. (2012). Antiretroviral preexposure prophylaxis for heterosexual HIV transmission in Botswana. *The New England Journal of Medicine*, *367*(5), 423-34.

U.S. Census Bureau. (2015a). State and county QuickFacts: Atlanta (city), GA. Retrieved from http://quickfacts.census.gov/qfd/states/13/1304000.html

U.S. Census Bureau. (2015b). State and county QuickFacts: Baltimore (city), MD. Retrieved from http://quickfacts.census.gov/qfd/states/24/24510.html

U.S. Census Bureau. (2015c). State and county QuickFacts: Memphis (city), TN. Retrieved from http://quickfacts.census.gov/qfd/states/47/4748000.html

U.S. Census Bureau. (2015d). State and county QuickFacts: New Orleans (city), LA. Retrieved from http://quickfacts.census.gov/qfd/states/22/2255000.html

U.S. Census Bureau. (2015e). State and county QuickFacts: Baton Rouge (parish), LA. Retrieved from http://quickfacts.census.gov/qfd/states/22/22033.html

U.S. Centers for Disease Control and Prevention. (2003a). Advancing HIV prevention: new strategies for a changing epidemic. *Morbidity and Mortal Weekly Report*, *52*(15), 329-332.

U.S. Centers for Disease Control and Prevention. (2003b). *Human Immunodeficiency Virus (HIV) prevention projects for community-based organizations* (04064).

U.S. Centers for Disease Control and Prevention. (2006). *Human Immunodeficiency Virus (HIV) prevention projects for young men of color who have sex with men and young transgender persons of color* (PS06-618).

U.S. Centers for Disease Control and Prevention. (2008). *Human Immunodeficiency Virus (HIV) prevention projects for the Commonwealth of Puerto Rico and the United States Virgin Islands* (CDC-PS08-803).

U.S. Centers for Disease Control and Prevention. (2009). *Human Immunodeficiency Virus (HIV) prevention projects for community-based organizations* (CDC-RFA-PSA10-1003).

U.S. Centers for Disease Control and Prevention. (2010*). HIV strategic plan 2011-2015*. Retrieved from https://www.cdc.gov/hiv/pdf/policies_DHAP-strategic-plan.pdf

U.S. Centers for Disease Control and Prevention. (2011a). Interim guidance: Preexposure prophylaxis for the prevention of HIV infection in men who have sex with men. *Morbidity and Mortal Weekly Report*, *60*(03), 65-68.

U.S. Centers for Disease Control and Prevention. (2011b). *Human Immunodeficiency Virus (HIV) prevention projects for young men of color who have sex with men and young transgender persons of color* (CDC-RFA-PS11-1113).

U.S. Centers for Disease Control and Prevention. (2011c). *High-Impact Prevention: CDC's approach to reducing HIV infections in the United States*. Retrieved from http://www.cdc.gov/hiv/pdf/policies_NHPC_Booklet.pdf

U.S. Centers for Disease Control and Prevention. (2012, July 16). *CDC statement on FDA approval of drug for HIV prevention* [Press release]. Retrieved from https://www.cdc.gov/nchhstp/newsroom/2012/fda-approvesdrugstatement.html

U.S. Centers for Disease Control and Prevention. (2012b). *Human Immunodeficiency Virus (HIV) prevention projects for the Commonwealth of Puerto Rico and the United States Virgin Islands* (CDC-RFA-PS13-1310).

U.S. Centers for Disease Control and Prevention. (2015a). *Health department demonstration projects to reduce new HIV infections and improve engagement in HIV medical care among men who have sex with men (MSM) and transgender persons* (CDC-RFA-PS15-1506).

U.S. Centers for Disease Control and Prevention. (2015b). *Health department demonstration projects for comprehensive prevention, care, behavioral health, and social services for* *men who have sex with men of color at risk for and living with HIV infection* (CDC-RFA-PS15-1509).

U.S. Centers for Disease Control and Prevention. (2017). HIV Surveillance Report, 2016; vol. 28. Retrieved from https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2016-vol-28.pdf

U.S. Centers for Disease Control and Prevention. (2018, March 6). *HIV prevention pill not reaching most Americans who could benefit – especially people of color* [Press release]. Retrieved from https://www.cdc.gov/nchhstp/newsroom/2018/croi-2018-PrEP-press-release.html

U.S. Department of Health and Human Services. (2016). *Centers for Disease Control and Prevention: Justification of estimates for appropriation committees*. Retrieved from https://www.cdc.gov/budget/documents/fy2016/fy-2016-cdc-congressional-justification.pdf

Van Der Ende, M.E., Regez, R.M., Schreij, G., Van Der Meer, J.T.M., & Danner, S.A. (2002). Post-exposure prophylaxis. *International Journal of STD & AIDS, 13*(1), 30-34.

Wilson, P.A., & Moore, T.E. (2009). Public health responses to the HIV epidemic among black men who have sex with men: A qualitative study of US health departments and communities. *American Journal of Public Health*, *99*(6), 1013-1022.

Young, R.C. (1988). “Is population ecology a useful paradigm for the study of organizations?” *American Journal of Sociology, 94*, 1-23.

APPENDIX A. Public Health Administrator Recruitment Script

To be sent via email or read over the phone to potential study participants.

Hello, my name is Keith Green and I'm a doctoral candidate at the University of Chicago School of Social Service Administration. I am currently working on my dissertation study, which is interested in how the strategies employed by community-based organizations for incorporating antiretroviral (ARV)-based prevention approaches such as "treatment as prevention" and "pre-exposure prophylaxis" vary in geographic areas with differential access to affordable healthcare options under the Affordable Care Act.

To explore this topic, I am conducting a document analysis of Funding Opportunity Announcements (FOAs) issued from the U.S. Centers for Disease Control and Prevention for HIV between 2001 and 2016, as well as Request for Proposals (RFPs) from local health departments in Baltimore, Memphis, New Orleans, and Atlanta. In addition, I am conducting exploratory interviews with public health administrators in each of these cities and in-depth interviews with executive directors, prevention program administrators and frontline staff workers from CBOs that currently offer HIV prevention services. The results of the study will be used to inform public health policies and protocols for successfully integrating ARV-based approaches within CBOs and, thus, the successful dissemination and uptake of these essential prevention approaches.

I am reaching out to you because you are currently in the role of ___________________ at the ___________________ health department and I believe that your perspective will be critical in helping me to understand the local context for integrating ARV-based prevention within CBOs.

If you decide to participate, I will schedule a time for us to talk either on the phone or in person. I will ask you questions about the HIV prevention programming supported by your local health department, how expectations about prevention programming are communicated, and how implementation of the ACA affects the delivery of prevention programming throughout your state. I will be audio recording the interview so that I can have an accurate record of what was said. A written transcript of the audio file will be made, removing any information that could potentially identify you. The audio file will be destroyed within 2 weeks of the receipt and verification of the transcription, and written transcripts will be destroyed after 3 years of completion of the interview. What you tell me will be shared with my colleagues as a part of our data analysis plan; however, none of the information will be traceable to you. Your name and any other identifying information will not be known to anyone other than myself. This will help to protect your confidentiality and to create a safe and informative interview process.

Your decision to join this study is voluntary. This means that you are free to join this study or not. You may also drop out of the study at any time. There is no penalty for not joining. There is no penalty for dropping out. Your decision to join the study will not have any effect on your job or current position and information that you share in this study will never be shared with your employer or supervisor.

There is no direct benefit to participating in this study. However, the information you provide may produce insight that can assist public health administrators across the country with structuring efficient protocols related to the integration of ARV-based technologies within CBOs and, thus, the successful dissemination and uptake of these essential prevention approaches.

If you are interested in participating in this research, please contact me at 773-562-6872 or reply to this email. Should you have any questions or concerns regarding this study you may also contact the study principal investigator, Jennifer Mosley, at (773) 702-1250 or mosley@uchicago.edu. Many thanks for your consideration.

Sincerely,

Keith R. Green, MSW
Doctoral Candidate
University of Chicago School of Social Service Administration
969 E. 60th Street
Chicago, IL 60615

APPENDIX B. Organizational Leader Recruitment Script

To be sent via email or read over the phone to potential study participants.

Hello, my name is Keith Green and I'm a doctoral student at the University of Chicago School of Social Service Administration. I am currently working on a research study that is interested how the strategies employed by community-based organizations for incorporating antiretroviral prevention approaches such as "treatment as prevention" and "PrEP" vary in geographic areas with differential access to affordable healthcare options under the Affordable Care Act.

To explore this topic, I am conducting interviews with executive directors, program administrators, and frontline staff workers from CBOs that currently offer HIV prevention services in Baltimore, Memphis, New Orleans, and Atlanta. The results of the study will be used to inform public health policies and protocols for successfully integrating ARV-based approaches within CBOs and, thus, the successful dissemination and uptake of these essential prevention approaches.

I am reaching out to you because you are currently in the role of ___________________ at ___________________ (organization/institution), and I believe that your perspective will be critical in helping us to understand how these approaches are being integrated into existing prevention services offered by CBOs.

If you decide to participate, I will meet you at your organization to conduct a 60-90 minute interview. During the interview, I will ask you questions about the HIV prevention programming offered by your organization, how expectations about prevention programming are communicated to your organization by funders, and how implementation of the ACA affects the delivery of prevention programming within your organization. I will be audio recording the interview so that I can have an accurate record of what was said. A written transcript of the audio file will be made, removing any information that could potentially identify you or your organization. The audio file will be destroyed within 2 weeks of the receipt and verification of the transcription, and written transcripts will be destroyed after 3 years of completion of the interview. What you tell me will be shared with my colleagues as a part of our data analysis plan; however, none of the information will be traceable to you. Your name and any other identifying information will not be known to anyone other than myself. This will help to protect your confidentiality and to create a safe and informative interview process. I will also ask for your permission to approach members of your frontline prevention team to participate in a group interview that will explore similar topics.

You will be compensated $25 for your participation in this study. There is no direct benefit to participating in this study. However, the information you provide may produce insight that can assist public health administrators with structuring efficient protocols related to the integration of ARV-based technologies within CBOs and, thus, the successful dissemination and uptake of these essential prevention approaches.

If you are interested in participating in this research, please contact me at 773-562-6872 or reply to this email. Should you have any questions or concerns regarding this study you may also contact the study principal investigator, Jennifer Mosley, at (773) 702-1250 or mosley@uchicago.edu. Many thanks for your consideration.

Sincerely,

Keith R. Green, MSW
Doctoral Candidate
University of Chicago School of Social Service Administration
969 E. 60th Street
Chicago, IL 60615

APPENDIX C. Frontline Prevention Staff Recruitment Script

To be sent via email or read over the phone to potential study participants.

Hello, my name is Keith Green and I’m a doctoral student at the University of Chicago School of Social Service Administration. I am currently working on a research study that is interested how the strategies employed by community-based organizations for incorporating antiretroviral prevention approaches such as “treatment as prevention” and “PrEP” vary in geographic areas with differential access to affordable healthcare options under the Affordable Care Act.

To explore this topic, I am conducting interviews with executive directors, program administrators, and frontline staff workers from CBOs that currently offer HIV prevention services in Baltimore, Memphis, New Orleans, and Atlanta. The results of the study will be used to inform public health policies and protocols for successfully integrating ARV-based approaches within CBOs and, thus, the successful dissemination and uptake of these essential prevention approaches.

I am reaching out to you because you are currently in the role of ___________________ at ___________________ (organization/institution), and I believe that your perspective will be critical in helping us to understand how these approaches are being integrated into existing prevention services offered by CBOs.

If you decide to participate, I will meet you at your organization to conduct a 60-90 minute group interview with you and 1 or 2 of your co-workers. During the interview, I will ask you questions about the HIV prevention programming offered by your organization, how expectations about prevention programming are communicated to you, and how implementation of the ACA affects your ability to deliver prevention programming within your organization. I will be audio recording the interview so that I can have an accurate record of what was said. A written transcript of the audio file will be made, removing any information that could potentially identify you or your organization. The audio file will be destroyed within 2 weeks of the receipt and verification of the transcription, and written transcripts will be destroyed after 3 years of completion of the interview. What you tell me will be shared with my colleagues as a part of our data analysis plan; however, none of the information will be traceable to you. Your name and any other identifying information will not be known to anyone other than myself. This will help to protect your confidentiality and to create a safe and informative interview process.

Your decision to join this study is voluntary. This means that you are free to join this study or not. You may also drop out of the study at any time. There is no penalty for not joining. There is no penalty for dropping out. Your decision to join the study will not have any effect on your job or current position and information that you share in this study will never be shared with your employer or supervisor.

You will be compensated $20 for your participation in this study. There is no direct benefit to participating in this study. However, the information you provide may produce insight that can assist public health administrators with structuring efficient protocols related to the integration of ARV-based technologies within CBOs and, thus, the successful dissemination and uptake of these essential prevention approaches.

If you are interested in participating in this research, please contact me at 773-562-6872 or reply to this email. Should you have any questions or concerns regarding this study you may also contact the study principal investigator, Jennifer Mosley, at (773) 702-1250 or mosley@uchicago.edu. Many thanks for your consideration.

Sincerely,

Keith R. Green, MSW
Doctoral Candidate
University of Chicago School of Social Service Administration
969 E. 60th Street
Chicago, IL 60615

APPENDIX D. Public Health Official Consent Document

Introduction

The *HIV Prevention Logics Study* is a research study interested in understanding the impact of antiretroviral-based prevention approaches on the work of community-based organizations (CBOs). Additionally, this study is concerned with how strategies for incorporating these approaches vary in geographic areas with differential access to affordable healthcare options under the Affordable Care Act (ACA).

To explore these topics, I am conducting a document analysis of Funding Opportunity Announcements (FOAs) issued from the U.S. Centers for Disease Control and Prevention for HIV between 2001 and 2016, as well as Request for Proposals (RFPs) from local health departments in Baltimore, Memphis, New Orleans, and Atlanta. In addition, I am conducting exploratory interviews with public health administrators in each of these cities and in-depth interviews with executive directors, prevention program administrators and frontline staff workers from CBOs that currently offer HIV prevention services. The results of the study will be used to inform public health policies and protocols for successfully integrating ARV-based approaches within CBOs and, thus, the successful dissemination and uptake of these essential prevention approaches.

The purpose of this form is to give you information on the *HIV Prevention Logics Study*. I will review this form with you and give you a copy to keep. Please feel free to ask any questions that you might have. When I have answered all of your questions, you can decide if you want to join the study or not. This is called “informed consent”.

What will you do if you join this study?

If you join the study, you will participate in an interview that will last approximately 45-60 minutes. You will be asked questions about the HIV prevention programming supported by your local health department, how expectations about prevention programming are communicated, and how implementation of the ACA affects the delivery of prevention programming throughout your state.

Risks or Discomforts

You might feel uncomfortable or not qualified to answer some of the questions. You may skip any question that you don’t want to answer or take a break at any time. You also can withdraw from the study at any time. There is no penalty for not answering a question, taking a break, or withdrawing from the study.

There also is a potential risk of loss of confidentiality. However, the research team at the University of Chicago makes every effort to keep your information confidential. The steps we take to protect your confidentiality are described below.

Benefits

There is no direct benefit to participating in this study. However, the information you provide may produce insight that can assist public health administrators throughout the country with structuring efficient protocols related to the integration of ARV-based technologies within CBOs and, thus, the successful dissemination and uptake of these essential prevention approaches.

Confidentiality

Anything you say during this interview will be kept confidential. A written transcript will be made of the interview recording and your name will never appear on this transcription. We will destroy the recording of the interview after the transcript is made. We will keep all of the data on a password-protected server at the University of Chicago. We will destroy all of the data after 3 years of completion of the interview.

We will share the results of the study at conferences and in journal articles. Any results that we publish will be de-identified. This means that your name and any information that could identify you or your organization will never be written in any papers, presentation, or reports.

The only time I will tell someone what you say is if you tell us that you plan to hurt yourself or someone else. If I learn this information, I am required by law to report this to the right mental health or law enforcement agency. These reports are made so that people can get the help they need to stay safe. I try to do everything possible to keep what you say confidential but cannot promise your confidentiality in this type of situation.

Right to Refuse or Withdraw

Your decision to join this study is voluntary. This means that you are free to join this study or not. You may drop out of the study at any time. There is no penalty for not joining. There is no penalty for dropping out. Your decision to join the study will not have any effect on your job or current position.

Costs

There are no costs to you for joining this study other than your time.

Compensation

There is no compensation for participating in this study.

Who can you talk to about this study?

If you have any questions, you can contact the student research, Keith Green:

Keith Green, MSW
University of Chicago
School of Social Service Administration
969 E. 60th St., Chicago, IL 60637

Phone: 773-562-6872

Or you may contact Dr. Jennifer Mosley, the Principal Investigator of the *HIV Prevention Logics Study*:

Jennifer Mosley, PhD
University of Chicago
School of Social Service Administration
969 E. 60th St., Chicago, IL 60637
Phone: 773-702-1250
Email: mosley@uchicago.edu

Please leave a message with your name and telephone number or your email address. Say that you want to talk about the *HIV Prevention Logics Study.* Someone will return your message as soon as possible.

If you have comments about the research or questions about your rights as a research participant, you can contact the Social Service Administration/Chapin Hall Institutional Review Board (IRB) office at:

IRB Director
SSA/Chapin Hall IRB
969 East 60th Street
Chicago, IL 60637
(773) 834-0402

How can you join this study?

1. Please ask any questions you have about the study.
2. Contact Keith Green, MSW or Dr. Jennifer Mosley with any additional questions you have.
3. Give your verbal consent to the student researcher to join the study.
4. If you want, you can keep a copy of this form for your own records

APPENDIX E. Organizational Leader Consent Document

Introduction

The *HIV Prevention Logics Study* is a research study interested in understanding the impact of antiretroviral-based prevention approaches on the work of community-based organizations (CBOs). Additionally, this study is concerned with how strategies for incorporating these approaches vary in geographic areas with differential access to affordable healthcare options under the Affordable Care Act (ACA).

I will be conducting in-depth interviews with executive directors, program administrators, and frontline staff workers from CBOs that currently offer HIV prevention services in Baltimore, Memphis, New Orleans, and Atlanta. The results of the study will be used to inform public health policies and protocols for successfully integrating ARV-based approaches within CBOs and, thus, the successful dissemination and uptake of these essential prevention approaches.

The purpose of this form is to give you information on the *HIV Prevention Logics Study*. I will review this form with you and give you a copy to keep. Please feel free to ask any questions that you might have. When I have answered all of your questions, you can decide if you want to join the study or not. This is called “informed consent”.

What will you do if you join this study?

If you join the study, you will participate in a face-to-face interview that will last approximately 60-90 minutes. You will be asked questions about the HIV prevention programming offered by your organization, how expectations about prevention programming are communicated to your organization by funders, and how implementation of the ACA affects the delivery of prevention programming within your organization. The interview will be audio recorded and a written transcript of the recording will be produced.

Risks or Discomforts

You might feel uncomfortable or not qualified to answer some of the questions. You may skip any question that you don’t want to answer or take a break at any time. You also can withdraw from the study at any time. There is no penalty for not answering a question, taking a break, or withdrawing from the study.

There also is a potential risk of loss of confidentiality. However, the research team at the University of Chicago makes every effort to keep your information confidential. The steps we take to protect your confidentiality are described below.

Benefits

There is no direct benefit to participating in this study. However, the information you provide may produce insight that can assist public health administrators with structuring efficient protocols related to the integration of ARV-based technologies within CBOs and, thus, the successful dissemination and uptake of these essential prevention approaches.

Confidentiality

Anything you say during this interview will be kept confidential. A written transcript will be made of the interview recording and your name will never appear on this transcription. We will destroy the recording of the interview after the transcript is made. We will keep all of the data on a password-protected server at the University of Chicago. We will destroy all of the data after 6 years of completion of the interview.

We will share the results of the study at conferences and in journal articles. Any results that we publish will be de-identified. This means that your name and any information that could identify you or your organization will never be written in any papers, presentation, or reports.

The only time I will tell someone what you say is if you tell us that you plan to hurt yourself or someone else. If I learn this information, I am required by law to report this to the right mental health or law enforcement agency. These reports are made so that people can get the help they need to stay safe. I try to do everything possible to keep what you say confidential but cannot promise your confidentiality in this type of situation.

Right to Refuse or Withdraw

Your decision to join this study is voluntary. This means that you are free to join this study or not. You may drop out of the study at any time. There is no penalty for not joining. There is no penalty for dropping out. Your decision to join the study will not have any effect on your job or current position.

Costs

There are no costs to you for joining this study other than your time.

Compensation

For participation in this study you will receive $25 cash at the end of the interview. You do not have to answer all of the questions to receive the research incentive. I sincerely appreciate you for taking the time to speak with me.

Who can you talk to about this study?

If you have any questions, you can contact the student research, Keith Green:

Keith Green, MSW
University of Chicago
School of Social Service Administration
969 E. 60th St., Chicago, IL 60637
Phone: 773-562-6872

Or you may contact Dr. Jennifer Mosley, the Principal Investigator of the *HIV Prevention Logics Study*:

Jennifer Mosley, PhD
University of Chicago
School of Social Service Administration
969 E. 60th St., Chicago, IL 60637
Phone: 773-702-1250
Email: mosley@uchicago.edu

Please leave a message with your name and telephone number or your email address. Say that you want to talk about the *HIV Prevention Logics Study.* Someone will return your message as soon as possible.

If you have comments about the research or questions about your rights as a research participant, you can contact the Social Service Administration/Chapin Hall Institutional Review Board (IRB) office at:

IRB Director
SSA/Chapin Hall IRB
969 East 60th Street
Chicago, IL 60637
(773) 834-0402

How can you join this study?

1. Please ask any questions you have about the study.
2. Contact Keith Green, MSW or Dr. Jennifer Mosley with any additional questions you have.
3. Give your verbal consent to the student researcher to join the study.
4. If you want, you can keep a copy of this form for your own records

APPENDIX F. Frontline Prevention Staff Consent Document

Introduction

The *HIV Prevention Logics Study* is a research study interested in understanding the impact of antiretroviral-based prevention approaches on the work of community-based organizations (CBOs). Additionally, this study is concerned with how strategies for incorporating these approaches vary in geographic areas with differential access to affordable healthcare options under the Affordable Care Act (ACA).

I will be conducting in-depth interviews with executive directors and program administrators, as well as group interviews with frontline staff workers from CBOs that currently offer HIV prevention services in Baltimore, Memphis, New Orleans, and Atlanta. The results of the study will be used to inform public health policies and protocols for successfully integrating ARV-based approaches within CBOs and, thus, the successful dissemination and uptake of these essential prevention approaches.

The purpose of this form is to give you information on the *HIV Prevention Logics Study*. I will review this form with you and give you a copy to keep. Please feel free to ask any questions that you might have. When I have answered all of your questions, you can decide if you want to join the study or not. This is called "informed consent".

What will you do if you join this study?

If you join the study, you will participate in a face-to-face group interview with 2-3 other frontline prevention staff from your organization. The group interview will last approximately 60-90 minutes. You will be asked questions about the HIV prevention programming offered by your organization, how expectations about prevention programming are communicated to you, and how implementation of the ACA affects your ability to deliver prevention programming within your organization. The group interview will be audio recorded and a written transcript of the recording will be produced.

Risks or Discomforts

You might feel uncomfortable or not qualified to answer some of the questions. You may skip any question that you don't want to answer or take a break at any time. You also can withdraw from the study at any time. There is no penalty for not answering a question, taking a break, or withdrawing from the study.

There also is a potential risk of loss of confidentiality. However, the research team at the University of Chicago makes every effort to keep your information confidential. The steps we take to protect your confidentiality are described below.

Benefits

There is no direct benefit to participating in this study. However, the information you provide may produce insight that can assist public health administrators with structuring efficient protocols related to the integration of ARV-based technologies within CBOs and, thus, the successful dissemination and uptake of these essential prevention approaches.

Confidentiality

Anything you say during this group interview will be kept confidential. To protect your confidentiality and that of your co-workers, each participant will be asked not to divulge information that is discussed in this interview with other people and to sign a confidentiality agreement prior to the start of the interview. A written transcript will be made of the interview recording and your name will never appear on this transcription. We will destroy the recording of the interview after the transcript is made. We will keep all of the data on a password-protected server at the University of Chicago. We will destroy all of the data after 6 years of completion of the interview.

We will share the results of the study at conferences and in journal articles. Any results that we publish will be de-identified. This means that your name and any information that could identify you or your organization will never be written in any papers, presentation, or reports.

The only time I will tell someone what you say is if you tell us that you plan to hurt yourself or someone else. If I learn this information, I am required by law to report this to the right mental health or law enforcement agency. These reports are made so that people can get the help they need to stay safe. I try to do everything possible to keep what you say confidential but cannot promise your confidentiality in this type of situation.

Right to Refuse or Withdraw

Your decision to join this study is voluntary. This means that you are free to join this study or not. You may drop out of the study at any time. There is no penalty for not joining. There is no penalty for dropping out. Your decision to join the study will not have any effect on your job or current position.

Costs

There are no costs to you for joining this study other than your time.

Compensation

For participation in this study you will receive $20 cash at the end of the interview. You do not have to answer all of the questions to receive the research incentive. I sincerely appreciate you for taking the time to speak with me.

Who can you talk to about this study?

If you have any questions, you can contact the student research, Keith Green:

Keith Green, MSW
University of Chicago
School of Social Service Administration
969 E. 60th St., Chicago, IL 60637
Phone: 773-562-6872

Or you may contact Dr. Jennifer Mosley, the Principal Investigator of the *HIV Prevention Logics Study*:

Jennifer Mosley, PhD
University of Chicago
School of Social Service Administration
969 E. 60th St., Chicago, IL 60637
Phone: 773-702-1250
Email: mosley@uchicago.edu

Please leave a message with your name and telephone number or your email address. Say that you want to talk about the *HIV Prevention Logics Study.* Someone will return your message as soon as possible.

If you have comments about the research or questions about your rights as a research participant, you can contact the Social Service Administration/Chapin Hall Institutional Review Board (IRB) office at:

IRB Director
SSA/Chapin Hall IRB
969 East 60th Street
Chicago, IL 60637
(773) 834-0402

How can you join this study?

1. Please ask any questions you have about the study.
2. Contact Keith Green, MSW or Dr. Jennifer Mosley with any additional questions you Have.
3. Give your verbal consent to the student researcher to join the study.
4. If you want, you can keep a copy of this form for your own records

APPENDIX G. Guiding Questions for In-Depth Semi-Structured Interviews with Public Health Officials

Introduction

My name is Keith Green and I am a doctoral candidate at the University of Chicago School of Social Service Administration. In general, I am interested in how individuals from the communities most impacted by HIV gain access to antiretroviral (ARV)-based prevention strategies such as "treatment as prevention" and PrEP. Today, I would like to talk with you specifically about your experience with these interventions and learn about the efforts that are being employed by ______________________________ health department to incorporate them into the existing HIV prevention practices of community-based organizations in _______________________ city.

Confidentiality & Honesty statement
Thank you very much for agreeing to be interviewed for this research study. My intention is to create an environment where you feel that you can be as honest as possible with your responses to the questions that I am going to ask you. Please try to answer whatever feels comfortable. If there is something that makes you uncomfortable, please let me know. You can skip any question you want to. You can take a break at any time. You also can end the interview whenever you want. All of your comments are confidential.

With your permission, I will be audio recording the interview so that we can have an accurate record of what was said. A written transcript of the audio file will be made, removing any information that could potentially identify you. The audio file will be destroyed within two weeks of the written transcript being verified against the recording. Written transcripts will be kept on a password-protected server at the University of Chicago School of Social Service Administration and will be permanently destroyed after six years of completing the interview.

What you tell me today will be shared with my colleagues as a part of our data analysis plan; however, none of the information will be traceable to you. We plan to share the results of the study at conferences and in journal articles. Any results that we publish will be de-identified, meaning that your name and any information that could identify you will never be written in any papers, presentation, or reports. Your name and any other identifying information will not be known to anyone other than myself. This will help to protect your confidentiality and to create a safe and informative interview process.

Do you have any questions before we get started? Do I have your permission to begin audio recording this interview now?

1. Please describe how the _______________________ health department supports the HIV prevention work of community-based organizations (CBOs).
2. How is the support offered to CBOs by ________________________ health department for HIV prevention services funded?

3. How are the protocols/expectations for incorporating ARV-based prevention approaches into existing prevention practices communicated to CBOs?

4. What have you perceived to be the thoughts and opinions about ARV-based prevention approaches among CBOs that offer HIV prevention services in _________________________ city?
5. Please describe the challenges/barriers to incorporating ARV-based prevention approaches into the existing prevention services that are currently offered by in _________________________ city.
6. How does your state's decision to expand or not expand Medicaid impact access to ARV-based prevention approaches in __________________________ city?
    a. How does this decision impact the way that the __________________________ health department promotes/supports ARV-based prevention approaches?
7. How does the ______________________ health department's history and structure influence the way that ARV-based prevention approaches are incorporated into existing prevention practices throughout ___________________________ city?

APPENDIX H. Guiding Questions for In-Depth Semi-Structured Interviews with Executive Directors/Program Administrators

Introduction

My name is Keith Green and I am a doctoral candidate at the University of Chicago School of Social Service Administration. In general, I am interested in how individuals from the communities most impacted by HIV gain access to antiretroviral (ARV)-based prevention strategies such as "treatment as prevention" and PrEP. Today, I would like to talk with you specifically about your experience with these interventions and learn about how they are incorporated into the existing HIV prevention practices of ______________________________ organization.

Confidentiality & Honesty statement
Thank you very much for agreeing to be interviewed for this research study. My intention is to create an environment where you feel that you can be as honest as possible with your responses to the questions that I am going to ask you. Please try to answer whatever feels comfortable. If there is something that makes you uncomfortable, please let me know. You can skip any question you want to. You can take a break at any time. You also can end the interview whenever you want. All of your comments are confidential.

With your permission, I will be audio recording the interview so that we can have an accurate record of what was said. A written transcript of the audio file will be made, removing any information that could potentially identify you. The audio file will be destroyed within two weeks of the written transcript being verified against the recording. Written transcripts will be kept on a password-protected server at the University of Chicago School of Social Service Administration and will be permanently destroyed after six years of completing the interview.

What you tell me today will be shared with my colleagues as a part of our data analysis plan; however, none of the information will be traceable to you. We plan to share the results of the study at conferences and in journal articles. Any results that we publish will be de-identified, meaning that your name and any information that could identify you will never be written in any papers, presentation, or reports. Your name and any other identifying information will not be known to anyone other than myself. This will help to protect your confidentiality and to create a safe and informative interview process.

Do you have any questions before we get started? Do I have your permission to begin audio recording this interview now?

1. Please describe the HIV prevention services that are currently offered by (organization name).

2. How do ARV-based prevention approaches such as "treatment as prevention" and PrEP fit into HIV prevention services that are currently offered by (organization name)?

3. How is (organization name) funded to incorporate ARV-based prevention approaches into existing prevention practices?

4. How are the protocols/expectations for incorporating ARV-based prevention approaches into existing prevention practices communicated by funders? (Go through each prevention approach individually)

5. What have you perceived to be the thoughts and opinions about ARV-based prevention approaches among frontline HIV prevention staff within (organization name)?

6. (If interviewing a program administrator) What have you perceived to be the thoughts and opinions about ARV-based prevention approaches among senior management within (organization name)?

7. Please describe the challenges/barriers to incorporating ARV-based prevention approaches into the existing prevention services that are currently offered by (organization name).

8. What impact does your state's decision to expand or not expand Medicaid have on your client population's ability to access ARV-based prevention approaches?
    a. How does this decision impact the way that (organization name) incorporates ARV-based prevention approaches?

9. How does this organization's history and structure influence the way that ARV-based prevention approaches are incorporated into existing prevention practices?

APPENDIX I. Guiding Questions for In-Depth Semi-Structured Interviews with Frontline Prevention Staff

Introduction

My name is Keith Green and I am a doctoral candidate at the University of Chicago School of Social Service Administration. In general, I am interested in how individuals from the communities most impacted by HIV gain access to antiretroviral (ARV)-based prevention strategies such as "treatment as prevention" and PrEP. Today, I would like to talk with you and your co-workers specifically about your experiences with these interventions and learn about how they are incorporated into the existing HIV prevention practices of ______________________________ organization.

Confidentiality & Honesty statement
Thank you very much for agreeing to participate in a group interview for this research study. My intention is to create an environment where you feel that you can be as honest as possible with your responses to the questions that I am going to ask you. Please try to answer whatever feels comfortable. If there is something that makes you uncomfortable, please let me know. You can skip any question you want to. You can take a break at any time. You also can end the interview whenever you want. All of your comments are confidential.

With your permission, I will be audio recording the discussion so that we can have an accurate record of what was said. A written transcript of the audio file will be made, removing any information that could potentially identify you. The audio file will be destroyed within two weeks of the written transcript being verified against the recording. Written transcripts will be kept on a password-protected server at the University of Chicago School of Social Service Administration and will be permanently destroyed after six years of completing the interview.

What you tell me today will be shared with my colleagues as a part of our data analysis plan; however, none of the information will be traceable to you. We plan to share the results of the study at conferences and in journal articles. Any results that we publish will be de-identified, meaning that your name and any information that could identify you will never be written in any papers, presentation, or reports. Your name and any other identifying information will not be known to anyone other than myself. This will help to protect your confidentiality and to create a safe and informative interview process. As a reminder, we are asking everyone to keep what we say in the focus group private and not to share what is said today with anyone else. Do you have any questions so far?

We thought, as a general approach, we would pose a question and then whoever wants to answer can start talking. Everyone should feel free to "jump in" or talk more about any point that is being made. If you think you can offer an additional perspective on what the person is talking about, then please feel free make your point as well. The only thing we ask is not to talk over one another because it makes the recording difficult to hear.

Do you have any questions before we get started? Do I have your permission to begin audio recording this interview now?

1. Please describe the HIV prevention services that are currently offered by (organization name).

2. How do ARV-based prevention approaches such as “treatment as prevention” and PrEP fit into HIV prevention services that are currently offered by (organization name)?

3. How are the protocols/expectations for incorporating ARV-based prevention approaches into existing prevention practices communicated to you by senior management/program administrators? (Go through each prevention approach individually)

4. Can you explain to me how you determine if a client is a candidate for any of the previously mentioned ARV-based prevention approaches? (Go through each prevention approach individually)

5. After you have determined that a client is a candidate for a particular ARV-based prevention approach, what do you do next? (Go through each prevention approach individually)

6. After you have connected or referred a client to a medical provider, how do you follow up to ensure that the client is retained in care?

7. What have you perceived to be the thoughts and opinions about ARV-based prevention approaches among other frontline HIV prevention staff within (organization name)?

8. What have you perceived to be the thoughts and opinions about ARV-based prevention approaches among senior management within (organization name)?

9. Please describe the challenges/barriers to incorporating ARV-based prevention approaches into the existing prevention services currently offered by (organization name).

10. What impact does your state’s decision to expand or not expand Medicaid have on your client population’s ability to access ARV-based prevention approaches?

APPENDIX J. Group Interview Participant Confidentiality Agreement

Prior to beginning the group interview, we ask that you read and acknowledge your adherence to the following confidentiality agreement due to the potentially sensitive nature of the information that will be discussed.

By signing below and accepting the offered research compensation, I hereby agree to keep all information discussed in the group interview completely confidential and further agree not to disclose such information to any other party. I understand that the group interview will be audio recorded and that the audio recording will be used for research purposes only and will not be used publicly.

Signature: ____ Date: ____________________

Please print your name: ____