Science to Community

What providers think about HIV prevention: The Implicit Theory Project

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Main Findings

- HIV infection is not the greatest concern compared to bigger issues such as homelessness, drug abuse, unemployment, etc.
- Confidence, trust, unconditional support and providing a comfortable and safe space is key.
- Community-building helps clients move towards safer behaviors.
- Implicit theories are often based on provider's own behavior change experiences.

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Background

The Implicit Theory project was designed to capture how HIV prevention providers delivering services think behavior change in their clients happens, what we refer to as providers' implicit theories. This is important for many reasons. To begin with, the providers work directly with clients and were often peers of these clients. They are directly interacting with their clients and may be able to even witness when change has occurred. The providers' position as peer or former peer, as the practice of hiring from the community that one wants to serve is very popular among HIV prevention organizations, is also key. This position provides insight and familiarity about the context and complexities of clients' lives that is unique to providers. But the most compelling reason to capture this is that this is what providers are actually doing. Regardless of what researchers are studying or what funders are funding, we found that the providers we interviewed are out in the field acting on what they believe helps change behavior. Providers' implicit theories drive their services, and therefore, it's important to understand these implicit theories.

Purpose

The Implicit Theory Project is a formative research study about how HIV prevention providers think about the work they do, and, most importantly, what they believe about two important concepts in HIV prevention, namely, 1) what promotes risk behavior and 2) what facilitates behavior change. In our previous collaborative work we have seen that prevention workers often base their work on unarticulated notions of what comprises risk and behavior change. We call these unarticulated notions "implicit theories." By asking prevention workers to describe the rationale of their interventions, this project hopes to take these implicit theories and make them explicit. These provider-generated theories can be useful to CBOs, researchers and funders to help understand aspects of behavior change and circumstances that encourage HIV-related risk behaviors among at-risk populations.

Why this project?

More and more, funders are requiring CBOs to prove that their interventions are theory-based and to develop new interventions that are based on proven theories of behavior change. In our research and collaborative work we have seen that many CBOs are dissatisfied with proven behavior change theories and often just list them in grants for funding requirements. Too often, behavior change theory and other behavioral research does not take into account the knowledge and experience of prevention workers who are dealing directly with clients at risk. The typical research mode for members of the scientific community is to present, publish and disseminate their findings, as well as make recommendations for practice, paying little attention to knowledge that is constructed outside of laboratories or research environments.

Methods

Sample Selection

We conducted 20 in-depth interviews of HIV prevention workers from five CBOs in the San Francisco Bay Area. We selected the CBOs based on client population served, attempting to get a very diverse sample to reflect the diversity of the San Francisco Bay Area. We originally thought about comparing provider theories based on the community they worked with, but because the sample size was too small, this was not possible. This would be a good direction for future inquiry.

We contacted each CBO with a phone call and then set up a time to introduce ourselves and the study to the Executive Director and invite the agency to participate in the study. All five agencies approached agreed to participate. Then, two

members of the study team attended an agency staff meeting to describe the study process and solicit volunteers to be interviewed. We sought interviews from front-line providers, most of whom were community outreach workers or HIV test counselors. Participation was voluntary and we only interviewed those staff who volunteered. All interviews were consented and confidential.

The five CBOs served the following populations: urban gay and bisexual men, rural street youth, rural sex workers and rural gay and bisexual men, immigrants including Latino immigrants (youth and gay adults) and Asian and Pacific Islander immigrants (gay youth and gay and heterosexual adults) and urban sex workers and substance users. The CBOs provided the following range of programs: street based outreach to youth and adults, school-based education presentations, retreats and group interventions, individual one-on-one counseling and theatre interventions.

We used the CBO as a point of entry and a way to access the individual providers. We were not seeking the theories that the CBO itself operated under, but the implicit theories of the providers at the CBO. In our interview guide (discussed below) we included a question to help us distinguish between the theories and ideas of the providers versus the CBO. Participating CBOs were paid $200 to partially compensate for the stafftime lost due to our interviews.

Table 1
Implicit Theories Interview Guide

General Background:
- What brought you to HIV prevention work?
- Have you done HIV/AIDS prevention work in any other agency (when, for how long)

Experiences with this organization
- What brought you to the CBO where you are now?
- What do you do at your CBO?
- Has it been a good fit for you? In what ways (good fit/not good fit)?
- How do your ideas about HIV prevention compare with your agency's?

Client experiences
- Tell me about a rewarding experience (or two) when you felt you really helped a client?
- Tell me about a frustrating experience working with a client.
- What puts your clients at risk for HIV?
- What helps your clients reduce their risks for HIV?
- If you had the resources to do the programs you thought were useful, what would you do?

Analysis

There were two stages in the analysis. The first stage involved construction of an interview summary that reduced the interview transcript from around 50 pages to 4 pages (see Table 1 for the draft transcript guide). Two project team members (primary and secondary writers) were assigned to prepare the summary, one wrote the summary and the other collaborated. The entire team read each transcript in preparation for a discussion of the summary. The primary writer led a discussion of the transcript with the project team, which usually took about 1 1/2 to 2 hours. The purpose of the team discussion was to fill in gaps that the primary writer missed and to supplement the summary with additional information when appropriate.

In the second stage of analysis, the team read the summary and analyzed these data in the context of answering ten questions related to the provider's major approach to behavior change (see Table 2 for the list of questions). In discussing the answers to these questions, we constructed a map that captured the implicit theory of each provider that we interviewed. We then analyzed the maps, looking at each map individually, and then comparing them to each other, to determine patterns and themes. We presented the maps at a community forum where participants were invited, along with people who did not participate in the study, in order to protect confidentiality. Two agencies were represented at this forum. The study participants from the agencies agreed with the researcher's rendering of the map based on the participant's interview.

Table 2
Analysis Questions for Developing a Conceptual Map

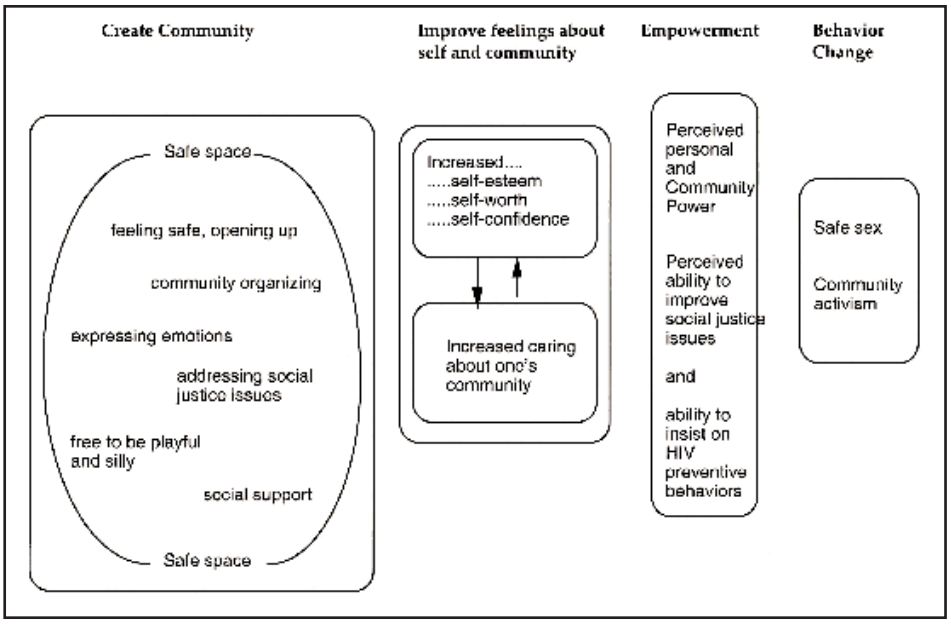
- What are the levels of focus of the participant's theory? At what level does the participant spend most of their time in their theory? For example: interpersonal, family, community, policy, etc. What is primary in their approach to explaining risk?
- How close to the mode of transmission is/are the intervention(s) that the participant thinks works?
- What is the catalyst for change? Please describe.
- What is the point of view from the service provider? How is change approached, from participant, provider or other?
- What are the contextual issues for the participant's clients? What's the connection with HIV? (poverty? homophobia?) Does he/she suggest a way to address this?
- What is the relationship to HIV in this community? How is HIV thought about in this community?
- What does the participant see as putting their clients at risk?
- Do their programs for change address their theories of risk?
- Do their theories of change address or target the client risk they identified?
- Is there something crucial to understanding the participant's theory of risk and risk reduction that is not captured above? Please describe.

Mapping Process

In order to understand and appreciate the prevention workers' implicit theories, we designed theory maps. We felt that a map was the most appropriate tool to fully describe the thought processes and logic of these theories. The maps varied greatly from theory to theory, although the outcome of the process was often safer sex or safer

Example: Implicit Theory Map

For a prevention worker who works with young gay and bisexual men of color, the emphasis is on community and individual empowerment. He believes that homophobia, racism and classism are an essential part of HIV prevention for this community. These larger societal factors disempower the young gay men and therefore they do not care about themselves or their community enough to practice safe sex. The way to begin to challenge this is to provide a safe space with peers for social support. This enables the participants to open up and share their lives with each other, to be honest, to make friends. Within this safe space, the group begins to examine larger social forces that impact their lives, such as racism, classism and homophobia to place the individual struggles of the group in a larger social context, and link larger social justice issues to personal experiences. This increases the group members individual self-esteem, self-worth and self-confidence and their concern and caring about their community, creating both individual and community empowerment. With these perceptions of personal and community power, the group begins to organize to address some of these larger structural issues and effect change in their own community (for example, organizing around homelessness of LGBTQ youth). At the same time, the individual empowerment leads the participants to insist on HIV preventive behaviors in sexual situations. The final result of this is that the young people will practice safe sex and participate in community activism to work against the larger societal factors that disempower young gay men.



behaviors. The maps allowed us to describe the path of theories, including what factors placed people at risk and what steps to progress through in order to reduce that risk. In constructing these maps, we organized the essential information of each prevention worker's theory into a type of flowchart with the necessary factors to encourage safer behaviors. See box above for an example of a map and narrative to describe the mechanism of prevention and behavior change.

Findings

Major Themes

In our project, we asked prevention workers about the work they did, and we interpreted what they said and extrapolated theories. We didn't find one unifying implicit theory that encompassed all of the prevention workers' ideas. It was even difficult to name and label each of the theory maps we developed. Instead, we arrived at common underlying themes that ran through most of the prevention workers' theories. The following four themes were found to be the most important in terms of how prevention workers envisioned the path to behavior change.

Key Issues

Self-esteem, empowerment. Many prevention workers believed that building client self-esteem was key to beginning to reduce risk of HIV transmission. They believed that their clients had to feel worthwhile before they could care about protecting themselves.

Confidence, trust, providing a comfortable and safe space, unconditional support. As many clients lived in hostile environments, being in a safe space where they could open up and discuss important emotional issues without fear of being judged was frequently reported as a key step before being able to learn about HIV prevention.

Community-building. Many prevention workers thought that it was crucial to build a sense of community for connecting to others, especially among populations who have been disenfranchised and are at high risk for HIV. Having a sense of community increased feelings of support and responsibility that built support for safer behaviors.

Communication about sex. Several participants cited the importance of learning how to communicate about sex—in society at large, as well as

with peers and with prospective sex partners. This was frequently reported as a necessary skill for risk reduction to take place.

Structural Issues

Almost all of the prevention workers interviewed mentioned larger structural issues as important factors in HIV prevention. These issues address the context in which risk taking and risk reduction was thought to occur. Some participants felt strongly that these had to be addressed in order to achieve behavior change. Others recognized that they were barriers to risk reduction, but felt that behavior change could be achieved by working around these issues.

Social Injustice including racism, homophobia, poverty, abuse, violence, and homelessness. These large-scale structural issues were seen as more important to address than smaller interpersonal issues that occurred down the road, such as condom use.

Cultural Constraints such as sexual taboos, gender issues and religion made it difficult for people to talk about sex and sexual issues, which made sexual risk reduction difficult.

Recommendations

Overall, we found that according to the prevention workers we interviewed, effective HIV prevention might not look like the traditional model of HIV prevention. Providers in this study have moved past the "AIDS 101 and a condom" mode of prevention and are tackling broader, more complex issues in their efforts to stem the HIV epidemic in their communities.

Recommendations to Funders

- **Be flexible about funding for HIV prevention programs**. Interventions can include components of housing assistance, community building, job training, etc.
- **Look for different measures of success**. Simply counting the number of condoms or needles distributed, or number of clients who attend a workshop doesn't cover all the ways agencies encourage and support behavior change.
- **Allow for funds for infrastructure**. Some activities require greater funding. Offering retreats, drop-in centers or extended hours for outreach helps attract clients. Rent, equipment and personnel funds are needed.

Recommendations to CBOs

Most of the providers had attempted to institute some kind of safe space or support system for clients:

- One agency offered **weekly dinners** where anyone could come and talk about any topic they desired.
- One agency offered **e-mail list exchanges** where they posted a description of what was offered at a small group meeting. Clients who were reluctant to show up at a meeting could still benefit from some of the information and post their own comments.
- One agency sponsored **overnight retreats** twice a year.
- One agency made use of **other existing safe spaces**, building a relationship with a drop-in center for street youth and starting outreach there.

Recommendations to Researchers

- **Study implicit theories** of prevention workers more rigorously, using qualitative and quantitative methods.
- Formalize and **test implicit theories** to add to the literature on behavior change theory.
- Consider **conducting trails of interventions that are not "traditional"** but address HIV in the larger context.
- Test theories to see if they hold true for **different communities**.

Materials Available
For information on the Implicit Theories Project see www.caps.ucsf.edu/ppt/Freedmanppt.html

Acknowledgements

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