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Provider–client rapport in pre-exposure prophylaxis delivery: a qualitative analysis of provider and client experiences of an implementation science project in Kenya

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Abstract: *Daily oral pre-exposure prophylaxis (PrEP) is being incorporated into services frequented by adolescent girls and young women (AGYW) in sub-Saharan Africa who are at a significant risk of HIV. In non-PrEP studies, positive provider–client rapport has been shown to improve patient decision-making and use of medication in clinical care. We examined AGYW and healthcare provider (HCP) perspectives on the value of and strategies for building positive provider–client rapport. We conducted in-depth interviews from January 2018 to December 2019 with 38 AGYW and 15 HCPs from two family planning clinics in Kisumu, Kenya where PrEP was being delivered to AGYW as part of the Prevention Options for Women Evaluation Research (POWER) study. We used semi-structured interview guides and audio-recorded interviews with participant consent. Verbatim transcripts were analysed using thematic content analysis. HCPs and AGYW emphasised the importance of positive provider–client rapport to meet AGYW support needs in PrEP service delivery. HCPs described how they employed rapport-building strategies that strengthened AGYW PrEP uptake and continuation, including: (1) using friendly and non-judgmental tones; (2) maintaining client confidentiality (to build client trust); (3) adopting a conversational approach (to enable accurate risk assessment); (4) actively listening and tailoring counselling (to promote client knowledge, skills, and self-efficacy); and (5) supporting client agency. Positive provider–client relationships and negative experiences identified in this analysis have the potential to facilitate/deter AGYW from using PrEP while at risk. The strategies to enhance provider–client rapport identified in this study could be integrated into PrEP provider training and delivery practices.* DOI: 10.1080/26410397.2022.2095707

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Background

In 2020, there were approximately 37.7 million people living with HIV worldwide, and 1.5 million people became newly infected.[1] Adolescent girls and young women (AGYW) in sub-Saharan Africa (SSA) represent about 25% of all new HIV infections worldwide. In Kenya, AGYW aged 15–24 represent 42% of all new HIV infections.[2] HIV incidence has remained high among young women, in spite of the scale-up of multiple behavioural health promotion campaigns focused on delay in sexual debut, decreasing the number of sexual partners, and condom usage.[3] Gender norms and power dynamics negatively impact the degree to which women successfully employ these strategies.[4,5]

HIV pre-exposure prophylaxis (PrEP) is a daily oral medication that has been proven safe and effective in preventing HIV across multiple populations.[6–8] PrEP is an important prevention option for young women, potentially providing them more control over their sexual health than trying to ensure a male partner uses a condom or is adherent to HIV medications.[3,9,10]

The World Health Organization (WHO) has recommended PrEP for anyone at ongoing substantial risk of acquiring HIV and made PrEP a pillar of its HIV prevention strategy.[11] Subsequent to WHO recommendation, PrEP has been adopted into the HIV treatment and prevention guidelines in several countries in sub-Saharan Africa, including Kenya.[12] Kenya further developed a framework for implementing PrEP to all populations at high HIV risk, including AGYW.[13] Health care systems are adapting and considering different models to facilitate optimal PrEP scale-up to different populations.[14,15]

Since new HIV infections in sub-Saharan Africa disproportionately affect AGYW aged 15–24, diversifying delivery points is an important step in increasing young women's access to PrEP. To this end, PrEP is being made available through platforms routinely accessed by this population for their sexual and reproductive health (SRH) needs, such as antenatal care (ANC) and family planning (FP) clinics.[16] Although expanding PrEP to platforms that are conveniently located and accessible to AGYW is important for increasing access, this will only result in greater PrEP uptake and use during periods of ongoing HIV risk if AGYW are satisfied that their needs are being met in the services they receive there. Formative research and systematic reviews in multiple countries have described judgmental attitudes towards AGYW seeking reproductive health care, which negatively impacts their health-seeking behaviour.[17,18] To address this potential barrier, the WHO and several national governments have additionally recommended offering PrEP in settings that specialise in youth-friendly services.[13,19]

The WHO describes the characteristics and standards of a youth-friendly service clinic as one where: (1) the service providers are non-judgmental and considerate in their dealings with adolescents and youth and deliver the services in the right way; (2) the service delivery point provides and enables adolescents and youth to obtain the appropriate and effective health services they need; (3) the services offered are acceptable, appealing and respectful to adolescents and youth; (4) adolescents and youth are aware of the services being provided and feel able and willing to obtain the health services when they need them without discrimination.[20] Kenya's guidelines for provision of adolescent- and youth-friendly services echo these criteria, specifying that health care providers (HCPs) should "respect, protect, and fulfil adolescents' and youths' rights to information, privacy, confidentiality, non-discrimination, and non-judgmental attitudes".[21] Notably, WHO has provided guidelines that recommend upholding human rights principles i.e. ensuring informed consent and maintaining confidentiality when providing HIV prevention services for both post exposure prophylaxis (PEP) and cotrimoxazole for preventing HIV-related opportunistic infections.[22] Although helpful as guiding principles, these broad recommendations have yet to be explored within the context of actual PrEP provision to AGYW.

Research has shown that developing a positive provider–client rapport facilitates the delivery of patient-centred care,[23] including delivery of adolescent-friendly services.[24,25] Provider–client rapport has been defined as "a feeling of connectedness and emotional support" between providers and patients that is built through

specific behaviours that lead to "increased patient comfort (reduced anxiety), patient self-disclosure, and patient trust".[26,27] In studies of non-HIV service provision, positive provider–client rapport has been identified as important for driving greater patient involvement in health care decision-making and use of prescribed medication.[24,25] A recent scoping review of PrEP delivery to men who have sex with men highlighted the importance of provider–client rapport in supporting PrEP uptake and use during periods of ongoing HIV risk.[28] One of the key findings of this scoping review was that users were able to openly disclose their sexual behaviours when the providers created a positive rapport with them by ensuring openness, assuring privacy, and confidentiality and avoiding the use of stigmatising words during consultations. Provider–client rapport may play a similarly influential role in PrEP use among AGYW in Kenya, especially given negative cultural attitudes about young, unmarried women being sexually active.[29,30]

As PrEP is scaled up, new PrEP providers may benefit from empirical evidence of specific strategies for building provider–client rapport while delivering this relatively new HIV prevention technology to meet the needs of AGYW. This is a secondary analysis of data from two PrEP delivery sites in Kenya that participated in the Prevention Options for Women Evaluation Research (POWER) study. We describe AGYW and HCP perspectives on the value of and strategies for meeting AGYW support needs through building positive provider–client rapport.

Methods

Study setting

The Prevention Options for Women Evaluation Research (POWER) study was a prospective cohort implementation science study to evaluate PrEP delivery to AGYW in Kisumu, Kenya, and Cape Town and Johannesburg, South Africa. AGYW were eligible to receive PrEP through POWER if they were 16–25 years old, HIV negative, and sexually active. Initial HIV risk assessments were conducted by either an HIV testing services counsellor or a nurse, and further PrEP counselling was completed by a nurse if the AGYW decided to take PrEP. PrEP was offered as an option for HIV prevention in addition to other HIV prevention strategies as per the Kenyan guidelines. Participants could be in the study even if they refused to initiate PrEP at enrolment. Return visits were scheduled at one month and then every three months thereafter. At each follow-up visit, AGYW underwent HIV testing, HIV risk assessment, and PrEP use counselling.

Kisumu County has an HIV prevalence of 17.5%, and 28% of all new HIV infections occur among AGYW.[31] POWER delivered PrEP at two FP clinics in Kisumu: the Jaramogi Oginga Odinga Teaching and Referral Hospital and the Kisumu Medical Education Trust clinic. In both clinics, POWER staff worked with existing facility staff to establish a client flow that integrated PrEP into routine FP services. Clients seeking FP services were approached by the health care provider (HCP) as they received their services. They were asked if they were aware of HIV prevention services offered at the FP clinic. They were then informed about PrEP and asked if they were willing to learn more about PrEP and participate in the POWER study. Willing participants were screened for eligibility and provided informed consent. In accordance with Kenya national guidelines, PrEP was offered alongside HIV counselling and testing, risk-reduction messaging, provision of condoms and contraception, and syndromic assessment and treatment of sexually transmitted infections. Between August 2017 and October 2019, the two clinics enrolled 1000 AGYW into the study, of which 898 decided to initiate PrEP.

Data collection and analysis

This is a secondary data analysis of in-depth interviews conducted with AGYW and health care providers (HCPs). Interviews were conducted as part of the POWER parent study to further understanding of facilitators and barriers to provision of PrEP services to AGYW and of uptake and use of PrEP by AGYW.

AGYW interviews

Interviews with AGYW were conducted between January and November 2018 using a semi-structured interview guide. Purposive sampling was used to include AGYW from six non-mutually exclusive categories, including individuals who: initiated PrEP at enrolment; declined PrEP at enrolment; initiated PrEP at enrolment and continued using PrEP without breaks for at least 6 months; initiated PrEP at enrolment but subsequently had gaps in pill coverage due to a late or missed follow-up visit; took a break from PrEP lasting 30 days or more, and subsequently

re-started PrEP; and individuals who sero-converted. All interviews were conducted face-to-face in participants' preferred language by a Kenyan qualitative researcher with prior experience conducting qualitative research with AGYW participants of PrEP research studies, and who was not involved in PrEP provision. Interviews lasted between 60 and 120 minutes and were audio recorded, simultaneously translated and transcribed, and quality controlled by bilingual research assistants.

Transcripts were uploaded into Dedoose version 6.1.18 (SocioCultural Research Consultants, LLC, Los Angeles, California, USA) and analysed by three experienced qualitative researchers (authors SDR, GB, and GOM) who, though external to the POWER clinical care teams, were deeply familiar with POWER's PrEP delivery protocol, staff, and implementation progress at each study site due to their participation in routine project calls and frequent interactions with POWER staff. Throughout the analysis process, this team of analysts routinely met with the interviewer to ask clarifying questions and obtain her feedback on drafts of the codebook and emerging themes. The codebook included deductive codes based on an "end-user journey" framework (human-centred design) in addition to inductive codes. Interview transcripts were double-coded by at least two analysts, with coding discrepancies resolved via group discussion.

Health care provider interviews

We conducted in-depth interviews with HCPs between October and December 2019 to understand barriers and facilitators to PrEP implementation at FP clinics and strategies that HCPs used to integrate PrEP delivery into routine practice. Authors SDR and GB – both qualitative researchers with extensive content knowledge about PrEP delivery in Kenya – developed semi-structured interview guides that solicited information about HCPs' professional background and prior experience delivering PrEP; delivery practices and strategies used to reach AGYW and assist with PrEP decision-making, and support PrEP use during periods of ongoing HIV risk; and considerations for scaling up FP clinic-based PrEP delivery. We used purposive sampling to recruit HCPs of different roles and responsibilities in PrEP delivery. Eligible HCPs were contacted by the POWER Study Coordinator who informed them of the purpose of the interviews and that an external qualitative researcher with no prior relationship with the HCPs (author SDR) would contact them and interview them if they consented. All the interviews were conducted in English, either face-to-face in a private room or via phone call, audio recorded and transcribed verbatim.

Interview transcripts were uploaded to Atlas.ti version 8 (Scientific Software Development GmbH, Berlin, Germany) and analysed inductively by authors SDR and GB using thematic content analysis. Any questions about the interview content were addressed via consultation with the Study Coordinator or the Kenyan qualitative researcher who conducted the AGYW interviews. These two individuals also provided feedback on the codebook, which was developed and iteratively refined by authors SDR and GB. Thereafter, author SDR coded the transcripts, and author GB reviewed coded transcripts. Disagreements about code application were resolved through discussion.

Ethics approval and consent to participate

The overall POWER study protocol was approved by the Institutional Review Boards (IRB) of the University of Washington (UW) (STUDY00000950) on 23rd March 2017 and the Kenya Medical Research Institute (KEMRI) (SERU PROTOCOL NUMBER 3394) on 2nd February 2017. All interviews were carried out in accordance with guidelines and regulations approved by UW and KEMRI IRBs. All participants provided written signed informed consent before taking part in the interviews. Parental permission was obtained for minors aged 16 and 17 before they provided assent to participate in the study. To ensure confidentiality and privacy of data collected, interviews were conducted in a private room in the research clinic and all audio recordings and de-identified transcriptions were transferred to a secure server.

Results

We interviewed 15 HCPs, of whom 60% were female. The median age was 30 years old (IQR: 29–42), and about two-thirds were staff employed by the POWER study (Table 1). We interviewed 38 AGYWs among whom the median age was 21 (IQR 19–24). Of these, 21% (8/38) had multiple sexual partners, 55% (21/38) did not know the HIV

Table 1. Characteristics of interviewed health care providers and adolescent girls and young women

1. Health care providers	
Characteristic	**Number**
Health care providers interviewed	15
Median age (IQR)	30 (29–42)
Female	9 (60%)
POWER staff	10 (67%)
Primary role during POWER study	
Health care provider	10 (67%)
HIV testing services counsellor	3 (30%)
Clinician[1]	6 (60%)
Adherence counsellor	1 (10%)
Other key informant[2]	5 (33%)
2. Adolescent girls and young women	
Characteristic	**Number**
Adolescent girls and young women interviewed	38
Median age (IQR)	21 (19–24)
Single marital status	22 (58%)
Median number of living children	1 (0–1)
Multiple sexual partners	8 (21%)
Unknown partner HIV status	21 (55%)
Condom use	
Always	4 (11%)
Never	16 (42%)
Inconsistent	18 (47%)
Positive chlamydia/gonorrhea	10 (26%)
Partner has other sexual partners	
Yes	4 (11%)
No	2 (5%)
Don't know	32 (84%)
Breastfeeding	5 (13%)
Ever pregnant	25 (65%)

[1]Includes nurses and doctors/medical officers
[2]Includes individuals whose primary role in POWER focused on research activities (as opposed to direct service provision) as well as individuals who were not directly involved in POWER but who, through their involvement in PrEP delivery in the region, could potentially provide relevant information about Kenya's PrEP delivery landscape and/or PrEP delivery to Kenyan AGYW.
IQR – interquartile range.
POWER – prevention options for women evaluation research.

status of their partners, and 89% (34/38) either used condoms inconsistently or not at all (Table 1). Just over half were initial refusers (26%, 10/38) or non-continuous PrEP users (23%, 9/38). The complete breakdown of AGYW interviewees by participant category and the median duration that the interviewed participants were on PrEP for each category is shown in Table 2.

Six key themes emerged from our analysis, describing and characterising positive provider–client rapport perceived as supportive of meeting AGYW needs for PrEP counselling and use. Both HCP and AGYW described the need for HCW to use friendly and non-judgmental tones, provide assurances of confidentiality, use a conversational approach to counselling, employ active listening to tailor counselling, and support client agency. Below, we elaborate on each of these five themes.

Friendly and non-judgmental tones build AGYW trust to discuss PrEP

AGYW reported the need to be served in a friendly and non-judgmental tone to have a positive relationship with an HCP. AGYW explained that feeling welcomed and being treated kindly is foundational to having a good clinic experience and described how having a good clinic experience encouraged them to use PrEP when they knew they were at HIV risk.

"*They [the PrEP providers] were very polite and welcomed me during the counselling. … They said they would give [PrEP to] those who want to take it. They were talking nicely. You can easily decide to pick it [take PrEP].*" (AGYW 1)

AGYW expressed concerns about being judged for being sexually active and were appreciative of the

Table 2. Categories of adolescent girls and young women interviewed

Participant category	Definition	Number interviewed (n = 38)	Median duration on PrEP in days (interquartile range)
Initial refusers	Participants who declined PrEP at enrolment (but may or may not have started later)	10 (26%)	0
Non-continuous users	Participants who initiated PrEP at enrolment and had a recently scheduled month 3 or month 6 visit and pharmacy records indicate late (within 30 days of scheduled pick-up), missed (did not completely attend their next scheduled pick-up) or declined PrEP pill pick-up	9 (23%)	93 (86–150)
Continuous users	Participants who initiated PrEP at enrolment and continued PrEP use over 6-month period with no gaps in pill coverage based on pill dispensing records	7 (18%)	108 (93–120)
Initial acceptors	Participants who initiated PrEP at enrolment	6 (15%)	47 (42–47)
Special cases	Participants whose unique circumstances or perspectives stood out and whose experiences could inform PrEP delivery, including participants who sero-converted to HIV	4 (10%)	145 (70–188)
Restarters	Participants who initiated PrEP and pharmacy records show a break in PrEP use for more than 30 days before a PrEP pill pick-up at a later clinic visit	2 (5%)	118 (118–118)

non-judgmental attitudes of the HCP with whom they interacted.

"*We were talking about the [HIV] risk factors. I am not that old, and she [the PrEP provider] wasn't like, 'You are not supposed to be having sex now.' She said, 'You need to do this and that to protect yourself from this and that'.*" (AGYW 2)

AGYW also frequently reported that, prior to seeking out PrEP, they were fearful that they would not be well received at the clinic.

"*I was afraid to come here by myself. … I didn't even know how I was going to start [to ask for PrEP]. … I talked to the nurse, and she was just good, and she was also understanding. … It influenced me.*" (AGYW 12)

Although treating clients kindly and non-judgmentally is likely an important component of any successful client–provider relationship, HCPs felt it was especially important in the context of delivering PrEP to AGYW, because many members of this population experience strong pre-visit anxiety, knowing that the dominant social norms do not condone young, unmarried women being sexually active. To support AGYW's need for kind and non-judgmental treatment, HCPs reported being careful about the language they used when talking to AGYW.

"*Adolescents, young people … are a very special group. I can say that because they can just come to the clinic one time, and you just comment something in a negative manner, and you won't see this person again. They are gone.*" (HCP 1)

HCP participants reported making a concerted effort to make counselling sessions friendly and, during the sessions, to convey to the AGYW client that the reason why she is at HIV risk is less important than her recognition of that risk and the actions she takes to mitigate it (e.g. through uptake of combination HIV prevention interventions). AGYW, for their part, especially appreciated that HCPs did not make assumptions about them:

"*I don't know how to describe the counselling, but I can only say that I wasn't tensed at any moment. I didn't feel like she is judging me. She was like, 'Not everyone that takes PrEP is a prostitute.' You can only take PrEP because you are at a high risk even if you have one partner.*" (AGYW 2)

In addition to being non-judgmental about clients' sexual activity, HCP emphasised the importance of being non-judgmental about missed PrEP appointments. They described the importance of letting clients know they were cared about, which in some instances resulted in continuation or re-initiation of PrEP.

"*[If] they don't turn up … we'll follow up [by phone]: 'Hi, you were supposed to come last week. What happened?' in a friendly way. … We just tell them, 'If you're busy, just tell us.' And, 'Are you ok? Are you safe? … Any day you need PrEP, come'. So, you know, when you create rapport with a client – when you tell them about how you miss them, like you really need to see them – some respond.*" (HCP 3)

Some AGYW reported that their sense that the HCP genuinely cared about their well-being influenced their decision to initiate PrEP.

"*What encouraged me to take PrEP was that [at that] first [visit], I was welcomed well, and I was happy … The counsellors at the clinic told me how PrEP works, how it can help prevent HIV, and for sure they welcomed me well. And I decided to take PrEP from the way they counselled me.*" (AGYW 9)

Confidentiality is key

AGYW participants also identified confidentiality as a key need for establishing a positive relationship with HCPs. Noting that disclosure of sexual activity could pose a reputation risk to AGYW, both AGYW and HCP participants insisted that AGYW will only feel comfortable continuing to come to the clinic for PrEP if they trust that providers will keep their information confidential.

"*I was comfortable because I was told that everything is private and confidential, so whatever I talked about in there was not going to be discussed anywhere [else].*" (AGYW 2)

One strategy reported by HCP participants to fulfil AGYW's need for confidentiality included providing strong verbal assurance that all the information would be kept confidential:

"*We always ensure that we tell these clients that there is paramount privacy and confidentiality. They [the health care facility] have a youth-friendly clinic. That means they understand that youth need their space – a special space where they can be talked to, where they feel their issues are private*

and confidential. So, it is a safe place for these young women." (HCP 12)

Another strategy used to convey confidentiality was waiting to document the visit until after the client had left:

"*We usually avoid … asking the client [about their risk] then marking the RAST [risk assessment tool] … so that the client doesn't [think], 'There is an interview going on which might be used later to [identify] me*'." (HCP 6)

A conversational approach builds rapport and enables effective HIV risk assessment

Both AGYW and HCP identified the benefits of a conversational approach to PrEP counselling. AGYW highly valued the conversational nature of their clinical encounters with HCPs and appreciated being listened to and feeling recognised and understood as a "whole person", and not just queried about their sexual activity.

"*You know someone needs to ask how you are doing before getting down to business.*" (AGYW 13)

HCPs described soliciting information about the clients' living arrangements, social support networks, financial situations, and personal aspirations. They encouraged AGYW to be open and talk to them about anything and everything that could impact their PrEP use.

"*They [HCPs] welcome people well … I always tell them stories, even when I see something in the house [experience problems at home], I always tell them, and they do encourage me. Or even when I experience any problem, they always want me to tell them.*" (AGYW 14)

HCPs believed supporting this need and encouraging AGYW to speak freely and honestly about their life circumstances helped them to more effectively counsel clients based on their personal situations and to help them assess their HIV risk more accurately:

"*[How you counsel clients] is on a case-to-case scenario. … When a client comes, you tell them, 'Tell me something. Tell me about yourself. Where do you live?' You start asking some questions and then, 'How is your partner? How long have you been with him? How many children? Or are you trying to look for a baby?' Once you talk to someone, they'll open up. … From there, you can pick up and build momentum because you know every relationship is different. So based on that relationship, you'll know how to advise the client.*" (HCP 3)

HCPs also reported that, without an open conversation, meaningful HIV risk assessment was unlikely to happen. For example, several HCPs reported that some clients believed that having only one partner themselves was a sufficient HIV prevention method and did not consider the possibility that their partner could have other partners. Other HCPs reported that, when asked about their HIV risk, clients too frequently emphasised their *partner's* sexual relationships, rather than their own.

"*Most of the clients … view risk as someone putting you at risk, rather than you putting yourself at risk. For example, we have had … clients say that, 'I want to take PrEP because I don't trust my partner. So, he may be putting me at risk.' But then when you are collecting information [from the client,] you ask, 'How many sexual partners do you have?' Then she says, 'Three'.*" (HCP 12)

HCPs reported that successfully getting clients to open up and self-reflect on their HIV risk was a major driver of PrEP uptake and continued use during periods of ongoing HIV risk.

"*Those that we helped to identify their risks and knew that they were at higher risk adhered better to the medication compared to maybe those who, in their mind, told us that, 'I know I'm not at risk', and they stuck to that. … [Those clients] didn't adhere [use during period of ongoing HIV risk] well to their medication. Even their visits were so erratic. They would come, and they would disappear.*" (HCP 17)

HCPs felt that having a conversation with AGYW and understanding their needs, choices, and desires in life helped them to assess their HIV risk more accurately and to continue using PrEP during their periods of ongoing HIV risk:

"*PrEP is really about a conversation. It is about understanding someone's reproductive health and sexual choices, understanding their goals and aspirations, and helping them understand and adopt PrEP as a lifestyle choice for a period of time, if it … helps them meet those desires and aspirations.*" (HCP 13)

Active listening and tailored counselling promote PrEP knowledge, skills, and self-efficacy

AGYW and HCP participants identified the AGYW's need for counselling that was relevant to their

particular sexual health situation. HCPs reported fulfilling this need by actively listening to clients and tailoring their counselling messages. They explained that this enabled them to more effectively address misconceptions and increase AGYW knowledge, skills, and self-efficacy in their ability to take PrEP.

"*You talk to the clients [about] what is PrEP, why do you need PrEP, how do you take PrEP, what are the benefits of taking PrEP. They ask you all the questions. … Everybody has information – the wrong ones and the right ones – so if they come, you also have to listen to what they have [previously] heard about PrEP.*" (HCP 1)

For example, HCPs reported that prospective clients were sometimes surprised to learn that PrEP did not have to be taken for life, but rather could be taken during periods of risk, and that this information sometimes made the prospect of daily pill-taking less daunting.

AGYW frequently referenced other kinds of misinformation they had heard in the community making them fearful of PrEP, especially about the effects it would have on physical appearance:

"*They [friends] could talk about someone that they knew who was taking PrEP and now has big breasts. They could talk of how PrEP makes people to look like a grandmother. They said many things, and this instilled fear in me.*" (AGYW 4)

Both HCPs and AGYW emphasised the importance of hearing and trusting information from HCPs about what to expect while taking PrEP; this awareness strengthened AGYW capacity to continue with PrEP, especially during challenging times, such as while experiencing temporary side effects from PrEP.

"*I think what they really need is continuous reassurance because some of them start taking the PrEP and start having the side effects, but if you continue engaging them and telling them that, 'We talked about these side effects from the start, and it's going to be there for some few days or few weeks, then it will go away,' then you really encourage them to continue using it.*" (HCP 17)

"*I was told about the side effects before being given the drugs, and when I started feeling the side effects, I just decided to continue taking the drugs … because I was told the more I continue to take them, the side effects will disappear.*" (AGYW 5)

Actively listening to AGYWs' descriptions of their daily lives and the difficulties they encountered with taking daily medication enabled HCPs to customise their counselling messages to address specific challenges. For example, one PrEP client summarised how the HCP helped her to address a challenge she had remembered to take PrEP:

"*I would forget [to take PrEP]. I used to rely on the phone [alarm]. Sometimes I forget carrying my phone. Maybe the phone was in the bedroom while I was in the kitchen. [The] time for taking PrEP would easily pass without noticing; hence, missing my pill. … I had such concerns, but the nurse told me that in case I don't want to forget, I should have it [the PrEP pill] next to me while eating. When I finish eating, I will remember to take the pill.*" (AGYW 6)

AGYW participants frequently referenced the educational and skill-building support they received from HCPs and the important effect this had in increasing their motivation and confidence to take PrEP.

"*What encouraged me was how [the HIV testing services counsellor] was frank and explained to me about PrEP. She is the one who motivated me … [and] gave me the morale to continue with it. … It was just a talk that we had with her … on PrEP, on HIV.*" (AGYW 7)

"*[What makes it easier for me to take PrEP is] the motivation you get from the nurse, the information she gives me.*" (AGYW 16)

Supporting client agency promotes AGYW empowerment and effective PrEP use

Although HCPs provided encouragement to AGYW around PrEP uptake and continuation, they also emphasised the importance of clients making their own decisions about whether to take PrEP. AGYW participants reported feeling like it was *their* decision to take or not take PrEP.

"*They [the PrEP provider] actually told me when I am doing it [taking PrEP] for myself, I should be having that motivation. I am supposed to be thinking that I am doing it and that I am not doing this for any other person, but I am doing it for myself.*" (AGYW 8)

"*Actually, when they [HCP] tell you something, they are not forcing you to do it. You can accept or refuse, yeah … So, I normally come here with an open mind to learn and receive [inaudible] because actually when they tell you something, they are not forcing you to do it. You can accept or you can refuse, yeah … I am considering everything that I was told, I just want to take it when I feel I am ready.*" (AGYW 8)

HCPs emphasised the importance of showing their trust in clients' judgment by giving them the time to make up their own minds. They believed emphasising their clients' decision-making power encouraged them to self-reflect as to whether PrEP is really right for them.

"*[Providers] should not force [PrEP on clients]. They should just give them time because they are the ones who are going to take the drug. If you force them, they won't take it. They'll just pick the drug, maybe reach the road, and throw it away.*" (HCP 8)

HCPs also believed that AGYW who felt empowered to take charge of their health tended to have better uptake and continuation.

"*We tell them [clients], 'You are in charge of your health'. … And we also tell them that it's a personal decision. … Most of them, they resonate well with this because most of our young women, they come from places whereby they don't [usually] have decision-making power. But if you teach them how to make a decision [for themselves] and how to identify risk, they can. … It should not be like, 'The nurse is the one who told me to take PrEP', [but rather], 'I decided on my own. It is fit for me'.*" (HCP 3)

On the whole, AGYW participants expressed a strong sense of ownership and control over their decisions to take PrEP and that, in some cases, this also impacted their willingness to talk to other AGYW about HIV prevention.

"*Now I am an empowered girl and a free person. I know what PrEP is and I am using it. I am now free to talk to anyone about PrEP. I cannot fear about anybody. … I can speak with anyone because I am deeply inside PrEP, and I know why I am on PrEP. I am on PrEP so that I do not become sick. The disease [HIV] is caused by sex, and I must just talk about sex. I am not afraid because I can go and teach other people about PrEP. I do not fear anymore.*" (AGYW 4)

Perceived negative experiences by AGYW during their interaction with HCPs could lead to initial refusal to initiate PrEP and non-persistence among those who initiated PrEP

AGYW described a number of experiences that they perceived as negative during their interactions with HCPs. These experiences included miscommunication, limited information, unmet expectations and interaction with older providers.

Miscommunication from lack of openness could make AGYW disengage from PrEP use and PrEP services. One (non-persister) participant described her negative experience with the clinic staff that made her leave the clinic without refilling PrEP. She narrated how the clinic staff left her to wait for almost six hours since they had gone for a meeting in a different facility.

"*They told me to wait outside. They were going to do something in [name of a hospital] and later come back. They called me at around three o'clock but I told them that I won't come back because I stay far away. I had reached far by the time they called … I didn't like.*" (AGYW 22)

When detailed information is not given, participants fail to make a decision to initiate or not to initiate PrEP. One initial refuser highlighted communication and detailed information when asked what should be done to make her clinic experience better.

"*Communication … You need to explain things in details.*" (AGYW 34)

For some young women, their expectations need to be met for a positive clinic experience. When not met – for example through a breakdown in communication by not informing them in advance the kind of provider they will meet in their next service delivery point – this could prevent them from initiating PrEP. As explained below by this initial refuser, she expected to be served by female providers only to meet a male provider in the laboratory and she did not like it.

"*I met men instead of women waiting to collect my urine sample. I didn't like it … you must change the staff at the clinic. I cannot collect urine sample and give it to a boy.*" (AGYW 28)

For others, since they are young women, their expectation is to meet their female peers. Though older female providers are considered to be more experienced in providing counselling, young

women regard them as more like their parents, who have certain moral values around sexuality, and could feel uncomfortable revealing some details to them.

"*We need more young women and girls at the facility. If you meet a fellow girl, at least you will reason the same way. You know it is difficult reasoning with an older woman. Some older women will advise you that this is bad. At least we need young girls who are also using it.*" (AGYW 24)

Discussion

Our qualitative analysis highlighted the importance of positive provider–client rapport in AGYW clinical encounters for PrEP. Participants identified specific AGYW needs that must be fulfilled to foster a positive relationship between AGYW and HCPs. HCPs participants in the study – most of whom had extensive experience counselling Kenyan AGYW about PrEP – described the importance of building rapport with their AGYW clients by ensuring confidentiality of sexual behaviour information, using a conversational approach to information gathering and counselling, and empowering and supporting AGYW to make their own decisions about PrEP. This study also identified specific strategies and tactics that HCPs used to fulfil AGYWs' need for support. Overall, the support needs to be identified by AGYW, and strategies to support these needs employed by HCPs, largely align with established principles of adolescent- and youth-friendly service provision; however, our findings point to specific aspects of PrEP delivery that appear to increase the intensity with which these strategies needed to be deployed.

Health care providers emphasised that gaining client trust was foundational to fostering a productive provider–client rapport and that being keenly sensitive to AGYW reactions to perceived judgement was crucial to developing trust. Other research has similarly shown that adolescent patients may withhold information from HCPs when they feel that they will be judged,[32,33] rendering effective counselling challenging. Building trust may be even more critical for the provision of PrEP because, unlike other SRH services such as family planning, for which eligibility assessment only entails confirming that the client is sexually active and does not wish to become pregnant, PrEP eligibility includes an exploration of both clients' and their partners' behaviours, and risk assessment for a disease which remains highly stigmatised. As such, the "bar" for establishing trust is arguably higher for PrEP than other SRH services. Mistrust of HCPs has been identified as a major barrier to health service utilisation specifically among populations that can benefit from PrEP[34] and has the potential to negatively influence risk behaviours.[35] This could effectively exclude at-risk individuals from PrEP and violates the WHO guiding principles on the provision of HIV prevention services and avoiding the perpetuation of human rights violations.[22] Similarly, studies have reported anticipated negative treatment from HCPs as a frequent reason for disengaging in care in both antiretroviral treatment[36] and FP services.[37] HCP biases based on cultural norms resulting in stigmatising and discriminatory care toward AGYW have also been reported as a potential barrier for PrEP and FP provision.[38,39] Though HCPs may find it especially challenging to speak non-judgmentally about AGYW sexuality,[40,41] there is evidence that training can strengthen HCP communication skills, which can result in improved health outcomes.[42,43]

Participants in our study emphasised the importance of a conversational tone and active listening during the clinical consultation, rather than targeted questioning about sexual risk. A recent qualitative study of HCPs involved in PrEP delivery to young and older women in Kenya and South Africa noted that formal risk assessment tools with targeted questions could make PrEP users feel judged and the HCPs in this study had to fine-tune their risk assessment and counselling to make it more conversational, sensitive, and inclusive.[44] Understanding patients in the context of their own social world has been described as a fundamental characteristic of patient-centred care.[45] Evidence has shown that a patient's belief that their HCP is listening to them and is interested in them as a person facilitates health-promoting behaviour, such as recall of information from the clinical encounter, understanding of treatment recommendations, and improved medication use.[46–48] For HCPs, understanding how best to support client's PrEP use (daily pill-taking) is, arguably, more complicated than other SRH services that AGYW clients can obtain more discreetly (e.g. injectable contraception, one-time HIV testing); for some AGYW clients, adequately supporting their PrEP use may also require HCPs to solicit more in-depth details

about the client's life, such as whether she has disclosed her PrEP use to partners or parents with whom she lives. Time constraints may pose an initial challenge in providing such customised counselling; however, some evidence suggests that after a relatively lengthy initial visit, during which trust is established and significant information is exchanged, subsequent visits can be much shorter.[49–51] The attitudes and behaviours displayed by HCPs during the first clinical encounter are particularly important for strengthening (or weakening) clients' subsequent relationship with the health system.[52,53]

The HCPs in our study believed affirming AGYW agency and self-efficacy was important for promoting successful PrEP use during periods of ongoing HIV risk. Because PrEP is a relatively new HIV prevention intervention, AGYW clients may be less familiar with it than other SRH services and/or know fewer individuals whose positive experiences of PrEP provide reassurance that PrEP is safe and efficacious. As such, AGYW may require more intense HCP support when deciding whether and when PrEP is right for them, or to use other HIV prevention interventions that may be better suited to their particular situation. Studies have reported that clients' self-efficacy influences the actions they take, the amount of effort they exert, and the overall "grit" they possess to keep going in the face of obstacles, such as side effects, pill burden, social stigma, and the financial and opportunity costs of getting to the clinic for drug refills.[54,55] Research based on self-determination theory has similarly shown that an autonomy-supportive environment increases individuals' intrinsic motivation for sustained self-regulation of health behaviour and results in higher quality decision-making, greater perceived confidence, and better medication use.[56–58] In the provision of PrEP to young women, a qualitative study among AGYW in Kenya and South Africa noted that "Acceptance of PrEP can be facilitated when AGYW receive counselling and comprehensive information, in an easily understandable manner, while being afforded the agency to decide for themselves if PrEP is appropriate for them".[9]

We observed some differences across the groups of young women interviewed. While most participants who initiated and continued on PrEP described a positive relationship with their provider that enhanced their engagement in PrEP use, participants who did not initiate PrEP or stopped using PrEP at some point described negative experiences with HCPs. These experiences included miscommunication, limited information, unmet expectations, and interaction with older providers as the reasons behind their choice. Similar experiences have been described as potential barriers to PrEP uptake and continued use during periods of risk in other studies.[59,60]

Overall, our findings indicate that successful provision of PrEP to AGYW may require an intensification of existing adolescent- and youth-friendly service provision strategies.[20,21,61,62] Guidelines and training modules for adolescent- and youth-friendly service provision of contraceptive and HIV treatment services[63,64] should be modified specifically for PrEP, and include concrete examples of conversations between HCPs and clients that help build trust. Adolescent- and youth-friendly service delivery competencies should be taken into consideration when selecting providers to offer PrEP services to this priority population. Future research should investigate additional strategies for enhancing provider–client rapport within the context of PrEP provision to AGYW. Training packages, such as the one developed by the Optimizing Prevention Technology Introduction on Schedule (OPTIONS) Consortium, lay a good foundation upon which to build specific counselling and messaging techniques to enhance HCPs skills in trust-building.[65]

Limitations

This study draws exclusively on qualitative data and, therefore, may not quantitatively assess whether the identified rapport-building strategies affected clinical outcomes, such as PrEP continuation and ongoing HIV-negative status. However, our analysis uses rich data drawn from health care provider expertise and experience with delivering PrEP to nearly 1000 AGYW as a component of integrated SRH services, and our AGYW data affirms health care provider perspectives on the importance of building positive rapport. Second, our study was a secondary analysis of AGYW and HCP interviews. As such, some of the nuances of client–provider relationships for meeting AGYW needs related to PrEP use could not be fully explored. However our participants' consistent emphasis on the importance of a positive provider–client report suggests HCP capacity and strategies to cultivate this relationship are crucial to

providing quality PrEP services for AGYW and our results point to specific strategies used by our study participants which may be useful for other PrEP programmes. Lastly, our findings may be subject to social desirability bias. We tried to mitigate this risk by using interviewers who were completely external to the care teams and assuring participants of their confidentiality during the informed consent process.

Conclusion

Both positive provider–client relationships and negative experiences identified in this analysis have the potential to facilitate or bar AGYW from using PrEP during their periods of risk. Our findings point to several broader "value-adds" of positive client–provider relationships, such as improving the accuracy of HIV risk assessment, promoting self-efficacy and confidence in AGYW their decision-making, and potentially positively impacting future health-seeking behaviour. More research is needed to better understand whether and how client–provider relationships specifically relate to PrEP uptake, continuation, and discontinuation. The strategies to support this relationship identified in this analysis could be incorporated into AGYW PrEP training curricula and delivery practices.

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Role of authors

SR and GB designed and developed the health care provider interview guide. SR conducted interviews with health care providers in Kisumu. SR and AWK analyzed the data. VO, SR, GO, FM, and JO wrote the first draft of the manuscript and finalised it based on coauthor feedback. VO, FM, JO, JM, and RJ provided project administration support. CC and JMB acquired funding and, with EAB, conceptualised the larger POWER study. All authors read, reviewed, and approved the final manuscript.

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References

1. Mahy M, Marsh K, Sabin K, et al. HIV estimates through 2018: data for decision-making. Aids. 2019;33(Suppl 3): S203–S211. doi:10.1097/QAD.0000000000002321
2. National aids control council. 2020). World Aids Day Report. KENYA HIV PROGRESS INDICATORS. Published online 2020.
3. Celum CL, Delany-Moretlwe S, McConnell M, et al. Rethinking HIV prevention to prepare for oral PrEP implementation for young African women. J Int AIDS Soc. 2015;18:20227.
4. Ngure K, Thuo N, Ogello V, et al. Dynamic perceived HIV risk and sexual behaviors among young women enrolled in a PrEP trial in Kenya: a qualitative study. Front Reprod Heal. 2021;3:637869.
5. Madiba S, Ngwenya N. Cultural practices, gender inequality and inconsistent condom use increase vulnerability to HIV infection: narratives from married and cohabiting women in rural communities in Mpumalanga province, South Africa. Glob Health Action. 2017;10 (sup2):1341597.
6. Baeten JM, Donnell D, Ndase P, et al. Antiretroviral prophylaxis for HIV prevention in heterosexual men and women. N Engl J Med. 2012;367(5):399–410. doi:10.1056/NEJMoa1108524

7. Grant RM, Lama JR, Anderson PL, et al. Preexposure chemoprophylaxis for HIV prevention in men who have sex with men. N Engl J Med. 2010;363(27):2587–2599. doi:10.1056/nejmoa1011205
8. Choopanya K, Martin M, Suntharasamai P, et al. Antiretroviral prophylaxis for HIV infection in injecting drug users in Bangkok, Thailand (the Bangkok Tenofovir study): a randomised, double-blind, placebo-controlled phase 3 trial. Lancet. 2013;381. 2013 Elsevier Ltd:2083–2090. doi:10.1016/s0140-6736(13)61127-7
9. Rousseau E, Katz AWK, O'Rourke S, et al. Adolescent girls and young women's PrEP-user journey during an implementation science study in South Africa and Kenya. PLoS One. 2021;16(10):e0258542.
10. Bärnighausen KE, Matse S, Kennedy CE, et al. 'This is mine, this is for me': preexposure prophylaxis as a source of resilience among women in Eswatini. Aids. 2019;33:S45–S52.
11. World Health Organization. Policy brief: pre-exposure prophylaxis (PrEP): WHO expands recommendation on oral pre-exposure prophylaxis of HIV infection (PrEP). Geneva: WHO/HIV, 2015. [cited 2021 Mar 10]. Available from: https://www.who.int/hiv/pub/prep/en/
12. National AIDS & S T I Control Programme (NASCOP). Guidelines on use of antiretroviral drugs for treating and preventing HIV infection in Kenya 2018 Edition. [cited 2021 Mar 28]. Available from: https://www.nascop.or.ke/new-guidelines/
13. National AIDS and STI Control Program (NASCOP). Framework for the implementation of pre-exposure prophylaxis of HIV in Kenya. NASCOP, MOH: 2017. [cited 2021 Mar 28]. Available from: https://www.prepwatch.org/wp-content/uploads/2017/05/Kenya_PrEP_Implementation_Framework.pdf
14. Masyuko S, Mukui I, Njathi O, et al. Pre-exposure prophylaxis rollout in a national public sector program: the Kenyan case study. Sex Health. 2018;15(6):578–586. doi:10.1071/SH18090
15. Were DK, Musau A, Atkins K, et al. Health system adaptations and considerations to facilitate optimal oral pre-exposure prophylaxis scale-up in sub-Saharan Africa. Lancet HIV. 2021;8(8):e511–e520.
16. Mugwanya KK, Pintye J, Kinuthia J, et al. Integrating preexposure prophylaxis delivery in routine family planning clinics: a feasibility programmatic evaluation in Kenya. PLoS Med. 2019;16(9):e1002885. doi:10.1371/journal.pmed.1002885
17. Kim B, White K. How can health professionals enhance interpersonal communication with adolescents and young adults to improve health care outcomes?: systematic literature review. Int J Adolesc Youth. 2018;23(2):198–218. doi:10.1080/02673843.2017.1330696
18. Chandra-Mouli V, Plesons M, Barua A, et al. Adolescent sexual and reproductive health and rights: a stock-taking and call-to-action on the 25th anniversary of the international conference on population and development. Sex Reprod Heal Matters. 2019;27(1):336–339.
19. World Health Organization. WHO Implementation tool for pre-exposure prophylaxis (PrEP) of HIV infection: module 12: adolescents and young adults. No. WHO/CDS/HIV/18.13. World Health Organization, 2018. [cited 2021 April 22]. Available from: https://www.who.int/hiv/pub/prep/prep-implementation-tool/en/
20. World Health Organization. Making health services adolescent friendly: developing national quality standards for adolescent friendly health services. WHO, 2012. [cited 2021 March 22]. Available from: https://www.who.int/maternal_child_adolescent/documents/adolescent_friendly_services/en/
21. Kenya Ministry of Health. National guidelines for provision of adolescent youth-friendly services in Kenya. Second Edition. Nairobi: MOH, 2016. [cited 2021 March 27]. Available from: https://faces.ucsf.edu/sites/g/files/tkssra4711/f/YouthGuidelines2016.pdf
22. WHO TIM. Guidelines on post-exposure prophylaxis for HIV and the use of co-trimoxazole prophylaxis for HIV-related infections among adults, adolescents and children: recommendations for a public health approach. Published online 2014.
23. Sprague S. Relationship centered care. J S C Med Assoc. 2009;105(4):135–136.
24. Street RL. How clinician-patient communication contributes to health improvement: modeling pathways from talk to outcome. Patient Educ Couns. 2013;92(3):286–291. doi:10.1016/j.pec.2013.05.004
25. Oetzel J, Wilcox B, Avila M, et al. Patient-provider interaction, patient satisfaction, and health outcomes: testing explanatory models for people living with HIV/AIDS. AIDS Care. 2015;27(8):972–978. doi:10.1080/09540121.2015.1015478
26. Haider M. Global Public Health Communication: challenges, perspectives, and strategies. Published 2005. Available from: http://books.google.com/books?hl = en&lr = &id = B1vE_8exfB0C&pgis = 1
27. Norling G. Finding common ground : defining and measuring provider-patient rapport title of project researcher's name. Published online 2005.
28. Hillis A, Germain J, Hope V, et al. Pre-exposure prophylaxis (PrEP) for HIV prevention among men who have sex with men (MSM): a scoping review on PrEP service delivery and programming. AIDS Behav. 2020;24(11):3056–3070. doi:10.1007/s10461-020-02855-9
29. Jayaweera RT, Ngui FM, Hall KS, et al. Women's experiences with unplanned pregnancy and abortion in Kenya: a qualitative study. PLoS One. 2018;13(1):e0191412. doi:10.1371/journal.pone.0191412

30. Hall KS, Manu A, Morhe E, et al. Bad girl and unmet family planning need among Sub-Saharan African adolescents: the role of sexual and reproductive health stigma. Qual Res Med Healthc. 2018;2(1):55. doi:10.4081/qrmh.2018.7062
31. National AIDS Control Council. Kenya HIV County Profiles 2016. [cited 2021 March 29]. Available from: https://nacc.or.ke/kenya-hiv-county-profiles/
32. Levy AG, Scherer AM, Zikmund-Fisher BJ, et al. Prevalence of and factors associated with patient nondisclosure of medically relevant information to clinicians. JAMA Netw Open. 2018;1(7):e185293. doi:10.1001/jamanetworkopen.2018.5293
33. Beck RS, Daughtridge R, Sloane PD. Physician-patient communication in the primary care office: a systematic review. J Am Board Fam Pract. 2002;15(1):25–38.
34. Cahill S, Taylor SW, Elsesser SA, et al. Stigma, medical mistrust, and perceived racism may affect PrEP awareness and uptake in black compared to white gay and bisexual men in Jackson, Mississippi and Boston, Massachusetts. AIDS Care – Psychol Socio-Medical Asp AIDS/HIV. 2017;29(11):1351–1358. doi:10.1080/09540121.2017.1300633
35. Blair I V, Steiner JF, Havranek EP. Unconscious (implicit) bias and health disparities: where do we go from here? Perm J. 2011;15(2):71–78. Available from: http://www.ncbi.nlm.nih.gov/pubmed/21841929%0A. http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid = PMC3140753
36. Ayieko J, Brown L, Anthierens S, et al. "Hurdles on the path to 90-90-90 and beyond": qualitative analysis of barriers to engagement in HIV care among individuals in rural East Africa in the context of test-and-treat. PLoS One. 2018;13(8): e0202990. doi:10.1371/journal.pone.0202990
37. Askew I, Berer M. The contribution of sexual and reproductive health services to the fight against HIV/AIDS: a review. Reprod Health Matters. 2003;11(22):51–73. doi:10.1016/S0968-8080(03)22101-7
38. Pilgrim N, Jani N, Mathur S, et al. Provider perspectives on PrEP for adolescent girls and young women in Tanzania: the role of provider biases and quality of care. PLoS One. 2018;13(4):e0196280. doi:10.1371/journal.pone.0196280
39. Jonas K, Duby Z, Maruping K, et al. Perceptions of contraception services among recipients of a combination HIV-prevention interventions for adolescent girls and young women in South Africa: a qualitative study. Reprod Health. 2020;17(1):1–14.
40. Jonas K, Crutzen R, Krumeich A, et al. Healthcare workers' beliefs, motivations and behaviours affecting adequate provision of sexual and reproductive healthcare services to adolescents in Cape Town, South Africa: a qualitative study. BMC Health Serv Res. 2018;18(1):1–13. doi:10.1186/s12913-018-2917-0
41. Jonas K, Crutzen R, van den Borne B, et al. Healthcare workers' behaviors and personal determinants associated with providing adequate sexual and reproductive healthcare services in sub-Saharan Africa: a systematic review. BMC Pregnancy Childbirth. 2017;17(1):86. doi:10.1186/s12884-017-1268-x
42. Tavakoly Sany SB, Behzhad F, Ferns G, et al. Communication skills training for physicians improves health literacy and medical outcomes among patients with hypertension: a randomized controlled trial. BMC Health Serv Res. 2020;20(1):60. doi:10.1186/s12913-020-4901-8
43. Dwamena F, Holmes-Rovner M, Gaulden CM, et al. Interventions for providers to promote a patient-centred approach in clinical consultations. Cochrane Database Syst Rev. 2012;2012(12):14. doi:10.1002/14651858.CD003267.pub2
44. O'Malley G, Beima-Sofie KM, Roche SD, et al. Health care providers as agents of change: integrating PrEP With other sexual and reproductive health services for adolescent girls and young women. Front Reprod Heal. 2021;3:19. doi:10.3389/frph.2021.668672
45. Robinson JH, Callister LC, Berry JA, et al. Patient-centered care and adherence: definitions and applications to improve outcomes. J Am Acad Nurse Pract. 2008;20(12):600–607. doi:10.1111/j.1745-7599.2008.00360.x.
46. Berger ZD, Boss EF, Beach MC. Communication behaviors and patient autonomy in hospital care: a qualitative study. Patient Educ Couns. 2017;100(8):1473–1481. doi:10.1016/j.pec.2017.03.006
47. Flickinger TE, Saha S, Roter D, et al. Clinician empathy is associated with differences in patient-clinician communication behaviors and higher medication self-efficacy in HIV care. Patient Educ Couns. 2016;99(2):220–226. doi:10.1016/j.pec.2015.09.001
48. Visser LNC, Tollenaar MS, de Haes HCJM, et al. The value of physicians' affect-oriented communication for patients' recall of information. Patient Educ Couns. 2017;100(11):2116–2120. doi:10.1016/j.pec.2017.06.005
49. Kiwanuka F, Shayan SJ, Tolulope AA. Barriers to patient and family-centred care in adult intensive care units: a systematic review. Nurs Open. 2019;6(3):676–684. doi:10.1002/nop2.253
50. Alnasir FA, Jaradat A. Patient-centered care; physicians' view of obstacles against and ideas for implementation. Int J Med Res Heal Sci. 2016;5(4):161–168.
51. Macewan GH. The efforts of therapists in the first session to establish a therapeutic alliance (Ongepubliceerde masterproef van University of Massachusetts). 2009; (February).
52. Hall MA, Dugan E, Zheng B, et al. Trust in physicians and medical institutions: what is it, can it be measured, and does it matter? Milbank Q. 2001;79(4):613–639. doi:10.1111/1468-0009.00223

53. Dang BN, Westbrook RA, Njue SM, et al. Building trust and rapport early in the new doctor-patient relationship: a longitudinal qualitative study. BMC Med Educ. 2017;17 (1):1–10. doi:10.1186/s12909-017-0868-5
54. Bradley R, Browne B, Kelley H. Examining the influence of self-efficacy and self-regulation in online learning. Coll Stud J. 2017;51(4):518–530.
55. Bohart AC, Wade AG. The client in psychotherapy. Bergin Garfield's Handb Pyschotherapy Behav Chang. 2013;6:219–257.
56. Williams GC, Patrick H, Niemiec CP, et al. Reducing the health risks of diabetes: how self-determination theory may help improve medication adherence and quality of life. Diabetes Educ. 2009;35(3):484–492. doi:10.1177/0145721709333856
57. Martinez KA, Resnicow K, Williams GC, et al. Does physician communication style impact patient report of decision quality for breast cancer treatment? Patient Educ Couns. 2016;99(12):1947–1954. doi:10.1016/j.pec.2016.06.025
58. Ng JYY, Ntoumanis N, Thøgersen-Ntoumani C, et al. Self-determination theory applied to health contexts: a meta-analysis. Perspect Psychol Sci. 2012;7(4):325–340. doi:10.1177/1745691612447309
59. Were D, Musau A, Mutegi J, et al. Using a HIV prevention cascade for identifying missed opportunities in PrEP delivery in Kenya: results from a programmatic surveillance study. J Int AIDS Soc. 2020;23:e25537.
60. McClinton Appollis T, Duby Z, Jonas K, et al. Factors influencing adolescent girls and young women's participation in a combination HIV prevention intervention in South Africa. BMC Public Health. 2021;21 (1):1–17.
61. High-Impact Practices in Family Planning (HIPs). Adolescents: Improving Sexual and Reproductive Health of Young People: a Strategic Planning Guide. Washington, DC: USAID; 2015 Sep. Available from: https://www.fphighimpactpractices.org/guides/improving-sexual-and-reproductive-health-of-young-people/
62. Engender Health. Youth-friendly services: a manual for service providers-2002. [cited 2021 March 27]. Available from: https://www.engenderhealth.org/files/pubs/gender/yfs/yfs.pdf
63. Reif LK, Bertrand R, Benedict C, et al. Impact of a youth-friendly HIV clinic: 10 years of adolescent outcomes in Port-au-Prince, Haiti. J Int AIDS Soc. 2016;19(1):20859, doi:10.7448/IAS.19.1.20859
64. Rosenberg NE, Bhushan NL, Vansia D, et al. Comparing youth-friendly health services to the standard of care through "girl Power-Malawi": a quasi-experimental cohort study. J Acquir Immune Defic Syndr. 2018;79(4):458–466. doi:10.1097/QAI.0000000000001830
65. Optimizing Prevention Technology Introduction on Schedule (OPTIONS) Consortium. OPTIONS Provider Training Package: effective delivery of oral pre-exposure prophylaxis for adolescent girls and young women . OPTIONS Consortium, June 2019. [cited 2021 April 22]. Available from: https://www.prepwatch.org/resource/effective-delivery-oral-prep-agyw/

Résumé

En Afrique subsaharienne, la prophylaxie préexposition par voie orale (PrEP) quotidienne est intégrée dans les services fréquentés par les adolescentes et les jeunes femmes à risque important de contracter le VIH. Les études ne portant pas sur la PrEP ont montré qu'une relation positive entre le prestataire et le client améliore la prise de décision des patients et l'emploi des médicaments dans les soins cliniques. Nous avons examiné les perspectives des adolescentes et des jeunes femmes ainsi que des prestataires de soins de santé sur l'utilité de l'établissement de relations positives entre les prestataires et les clients et sur les stratégies pour y parvenir. Nous avons mené des entretiens approfondis avec 38 adolescentes et jeunes femmes et 15 prestataires de soins de santé de janvier 2018 à décembre 2019 dans deux centres de planification familiale à Kisumu, Kenya, où la PrEP était pratiquée sur les adolescentes et les jeunes femmes,

Resumen

La profilaxis oral previa a la exposición (PrEP) se está incorporando en servicios frecuentados por adolescentes y mujeres jóvenes (AMJ) en África subsahariana que corren un riesgo significativo de contraer VIH. En estudios no PrEP, se ha demostrado que una relación proveedor-usuaria positiva mejora la toma de decisiones de las pacientes y su uso del medicamento en la atención clínica. Examinamos las perspectivas de AMJ y de prestadores de servicios de salud (PSS) sobre el valor y las estrategias para construir una relación proveedor-usuaria positiva. Entre enero de 2018 y diciembre de 2019, realizamos entrevistas a profundidad con 38 AMJ y 15 PSS de dos clínicas de planificación familiar en Kisumu, Kenia, donde la PrEP se administraba a AMJ como parte del estudio de Opciones de Prevención para la Investigación de Evaluación de Mujeres (POWER, por sus siglas en inglés). Utilizamos guías de

dans le cadre de l'étude de recherche d'évaluation sur les options de prévention pour les femmes (POWER). Nous avons utilisé des guides d'entretien semi-structurés pour solliciter des informations et tous les entretiens ont fait l'objet d'un enregistrement audio avec le consentement des participants. Les transcriptions intégrales ont été traitées à l'aide d'une analyse de contenu thématique. Les prestataires de soins de santé de même que les adolescentes et les jeunes femmes ont souligné l'importance de relations positives entre le prestataire et le client pour satisfaire les besoins en soutien des adolescentes et des jeunes femmes lors de la PrEP. Les prestataires de soins de santé ont décrit comment ils soutenaient ces besoins par des stratégies d'établissement de relations qui renforçaient le recours des adolescentes et des jeunes femmes à la PrEP et la poursuite du traitement. Les besoins spécifiques de soutien pour les stratégies d'instauration des relations comprenaient: (1) l'utilisation d'un ton amical et non moralisateur; (2) le respect de la confidentialité des clients (pour gagner leur confiance); (3) l'adoption d'une approche de conversation (pour permettre d'évaluer correctement les risques); (4) une écoute active et des conseils sur mesure (pour promouvoir les connaissances, les compétences et l'auto-efficacité des clients); et (5) le soutien de l'autonomie des clients. Les relations positives entre prestataires et clients au même titre que les expériences négatives identifiées dans cette analyse ont le potentiel de faciliter ou d'empêcher les adolescentes et les jeunes femmes d'utiliser la PrEP pendant les périodes où elles sont à risque. Les stratégies pour améliorer les relations entre prestataires et clients identifiées dans cette étude pourraient être intégrées dans la formation et les pratiques des prestataires de la PrEP.

entrevistas semiestructuradas para solicitar información y grabamos en audio todas las entrevistas con el consentimiento de las participantes. Analizamos las transcripciones textuales utilizando análisis de contenido temático. Los PSS y las AMJ hicieron hincapié en la importancia de una relación proveedor-usuaria positiva para atender las necesidades de apoyo de las AMJ en la prestación de servicios de PrEP. Los PSS describieron cómo apoyaron esas necesidades por medio de estrategias de construcción de relaciones que fortalecieron la aceptación y continuación de PrEP por las AMJ. Ejemplos de necesidades de apoyo específicas en las estrategias de construcción de relaciones son: (1) utilizar tonos amigables y sin juzgar; (2) mantener la confidencialidad de las usuarias (para fomentar la confianza de las usuarias); (3) adoptar un enfoque conversacional (para permitir la evaluación precisa del riesgo); (4) escuchar activamente y personalizar la consejería (para promover los conocimientos, las habilidades y la autoeficacia de cada usuaria); y (5) apoyar la agencia de las usuarias. Tanto las relaciones positivas entre proveedores y usuarias como las experiencias negativas identificadas en este análisis tienen el potencial de facilitar o impedir que las AMJ utilicen la PrEP durante sus períodos de riesgo. Las estrategias para mejorar la relación proveedor-usuaria identificadas en este estudio podrían integrarse en la capacitación y en las prácticas de prestación de servicios de PrEP de los proveedores.