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Barriers to Provider-Delivered Sexual Behavior Counseling for Youth Living with HIV/AIDS in the Democratic Republic of the Congo

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Abstract

Aims—The study aimed to understand providers' role in delivering HIV transmission prevention counseling to youth living with HIV (YLWH).

Methods—We conducted 14 in-depth interviews with providers in Kinshasa, DRC.

Results—Providers' lack of knowledge and comfort in talking to youth about sex because of cultural and religious beliefs about sexuality, coupled with confusion about legal issues related to youth and contraception, made it difficult for them to effectively counsel youth.

Implications for practice and policy—In order for providers to deliver effective prevention counseling to YLWH, clinics should follow adolescent-friendly clinic standards, provide counseling in an adolescent-friendly style, and institute an effective referral system for additional prevention services.

Conclusion—HIV prevention services can be improved through the creation of an adolescent-friendly environment and by providing "values clarification" and skill-based trainings so that providers are able to assess the role of their own beliefs and learn new skills.

Keywords

Provider-delivered Counseling; Positive Prevention; Low-resource Settings; Youth Living with HIV/AIDS

INTRODUCTION

Youth Living with HIV/AIDS in the DRC

Worldwide, nearly five million youth ages 15–24 currently live with HIV, and each year close to 900,000 new HIV infections occur among youth (UNAIDS, 2010). About 80% of

YLWH or four million live in sub-Saharan Africa (UNAIDS, 2010). In the Democratic Republic of the Congo (DRC) over 60% of the population is under twenty years of age and the prevalence of HIV among youth aged 15–24 is 0.8% overall and 1.4% in Kinshasa, the capital (Ministry of Planning Democratic Republic of the Congo, 2007). Formative research conducted in Kinshasa with close to 200 YLWH aged 14–24 found that over half of the young women and a quarter of the young men had already had sexual intercourse, with only 53% of young women and 67% of young men reporting using a condom at their most recent sexual encounter (Behets & Pettifor 2008). Therefore, this population is at risk of transmitting the virus to their partners through unprotected sex. This illustrates the importance of effective HIV prevention programs for people living with HIV/AIDS (PLWH) – also called Positive Prevention – and specifically for YLWH in this type of low-resource environment (Morin et al., 2007).

Effective Positive Prevention Strategies

Positive Prevention programs are important to reduce new infections and to ensure PLWH remain healthy (Indyk & Golub, 2006; Kennedy, Medley, Sweat, & O'Reilly, 2010). In 2009, the Global Network for People Living with HIV and The Joint United Nations Program on HIV/AIDS developed an expanded Positive Prevention strategy entitled, “Positive Health, Dignity and Prevention” that stressed the role that such programs played in maintaining the health of HIV-positive individuals in addition to preventing the further spread of HIV to others, within a human rights framework (Global Network of People Living with HIV & UNAIDS, 2009). In the context of Positive Prevention interventions such as the “Seek, Test, Treat, and Retain” approach, behavioral measures to prevent sexual transmission of the virus play an important role in combination prevention strategies (Dodd, Garnett, & Hallett, 2010; Montague, Vuylsteke, & Buve, 2011). Furthermore, recent findings that early initiation of antiretroviral (ARV) treatment by PLWH can prevent the spread of HIV to their sexual partners are promising (Cohen et al., 2011), but will only be effective if the PLWH are adherent to their medications and if their viral loads remain undetectable. Positive Prevention behavioral interventions can reach populations before they are eligible for treatment, and can also help keep individuals engaged once they are receiving treatment (Walensky, 2009). One important delivery mechanism for Positive Prevention is provider-delivered counseling.

The World Health Organization has suggested that to be effective, comprehensive provider-delivered sexual prevention counseling for PLWH in low-resource countries should include: psychosocial counseling, an assessment of possible HIV transmission behaviors, risk reduction counseling, counseling to improve condom use skills and access to condoms, family planning counseling and provision, and counseling on the prevention of mother to child transmission. For those programs specifically targeting youth, counseling should be provided within the context of adolescent development and sexuality (World Health Organization, 2008). Recent recommendations for improving Positive Prevention interventions in sub-Saharan Africa suggest that health care provider attitudes, beliefs, and inabilities to discuss sex with their patients should be priority targets for intervention (Bunnell, Mermin, & De Cock, 2006).

To our knowledge only one peer-reviewed publication has focused specifically on provider-delivered Positive Prevention counseling for PLWH in sub-Saharan Africa outside of routine Voluntary Counseling and Testing (Peltzer & Ndlovu, 2005). This was a qualitative study conducted with 15 medical providers who treated HIV positive adults living in Limpopo, South Africa. The study reported that the majority of providers did not make prevention counseling with their patients a priority during medical visits; however, those providers with a “collaborative” patient-provider interaction style were more likely to deliver prevention counseling in addition to their clinical services as compared to those providers with a more

“consultant” style (Peltzer & Ndlovu, 2005). However, there are no peer-reviewed studies that have looked specifically at the unique experiences of provider-delivered Positive Prevention counseling with YLWH in sub-Saharan Africa, nor in other low-resource settings. This study aims to fill this gap by qualitatively exploring how providers’ attitudes and perceptions of YLWH sexual behavior may influence the HIV transmission risk prevention counseling that they deliver for YLWH, ages 15 to 24 in a low-resource setting, in this case Kinshasa, DRC.

METHODS

Study Overview

We aimed to inform the development of a holistic Positive Prevention counseling program that addresses the developmental needs of YLWH ages 15–24 in Kinshasa DRC and helps them cope with their HIV infection in the context of their emerging independence and sexuality. This paper describes interviews with health care providers conducted to better understand their perceived role in delivering prevention counseling to YLWH.

Study Site

A family-centered HIV care and treatment program at a pediatric hospital in Kinshasa was the site of this study. The program provides comprehensive HIV medical care (including ARV treatment) and psychosocial support to children and their parents and guardians, as well as other household members. As of April 2012, the program had served more than 2,146 HIV-positive patients including 191 YLWH aged 15–24. Youth at the study site were likely infected through various infectious routes (perinatally, parenterally, or sexually) and HIV acquisition mode was mostly unknown (Behets & Pettifor 2008). At the study site medical doctors, counselors, and PLWH volunteers deliver basic positive prevention messages via peer support groups and individual one-on-one counseling. The individual counseling sessions are conducted on an ad hoc basis between youth and providers and peer groups meet once a month. There is some fluidity between provider roles at the site, with counselors providing adherence support in addition to psychosocial support, while medical doctors discuss some aspects of prevention with the YLWH in addition to providing treatment (Chalachala, Parker, Pettifor & Behets 2010).

Data Collection

The first author conducted face-to-face, semi-structured, in-depth interviews (IDIs) in French with all fourteen of the health care providers working at the HIV care and treatment program. To be eligible participants had to: 1) be a health care provider at the clinic; 2) have direct contact with YLWH patients aged 15–24; and 3) agree to be digitally recorded. Written informed consent was obtained before the interview. Interviews were conducted in a private conference room and lasted from 1–2 hours. All interviews were digitally-recorded, transcribed verbatim and analyzed within Atlas-ti version 5.2. The interview guide was developed based on an extensive review of the literature on effective provider-delivered positive prevention counseling and barriers to provider-delivered counseling. The interview guide assessed the following topic areas: providers’ definitions and perceptions of psychosocial support, HIV prevention, and high-risk sexual behavior for YLWH; providers’ experiences imparting psychosocial support and HIV prevention counseling to YLWH; perceptions, attitudes, and beliefs related to HIV prevention counseling for YLWH; perceived roles and responsibilities in providing HIV prevention information to YLWH; and personal comfort level and confidence in dealing with HIV prevention with YLWH.

Participant Demographics

The health care providers that participated in this study included counselors, nurses, doctors, nutritionists, and PLWH volunteers. Volunteers are responsible for conducting home visits with patients at the clinic and have been trained in basic psychosocial support techniques. Nine of the participants were women and six were men. Ages ranged from 34–52 and participants had worked directly with YLWH for an average of 5 years (See Table 1 for participant demographics).

Data Analysis

The first author conducted qualitative content analysis using a post-positivist/realist epistemological paradigm (Grbich, 2007; Hsieh & Shannon, 2005; Ulin, Robinson, & Tolley, 2005). This paradigm allows for the assumption that the social world is created through symbolic meaning such that the meaning given to data is derived from perceptions, experience, and actions within a specific context (Ulin et al., 2005). The first author spent three months at the study site and throughout this research study used the insights gained during the time in country to critically reflect on her role as researcher in carrying out the data collection, in interpreting the data, and in writing up the manuscript (Elliott, 2005; Saldaña, 2009). The first author followed five interrelated steps for the data analysis: reading, coding, displaying, reducing, and Interpreting (Miles & Huberman, 1994; Ulin et al., 2005). For the first step of *reading* the first author immersed herself in the data, read all of the transcripts multiple times, and began to develop questions about the data and identify preliminary emergent themes. For the second step of *coding*, the first author developed an initial codebook with topical codes based on questions from the IDI guide. She conducted an initial round of coding, assigning topical codes to sections of text so that the text could be more easily and meaningfully searched and extracted. Next, she formulated thematic codes (those based on general themes related to the interview questions) and identified emergent codes (codes developed based on new concepts and ideas not directly linked to the interview questions) and combined and separated codes as needed. The revised codes were then applied during a second round of coding. In order to ensure that codes were being applied in accordance with codebook definitions, 20% (three) of the transcripts were randomly selected and independently coded by another researcher. Any discrepancies in the coding were assessed and resolved as needed and adjustments to code applications made. Next, the first author produced code reports for the final 40 codes. For the third step, *displaying*, code summaries were developed for each of the final codes in order to identify key sub-themes within each code and to examine the evidence supporting these sub-themes. In the fourth step, *reducing*, key elements and themes began to form and essential concepts and relationships between the different themes and sub-themes began to come together to provide a more holistic view of the data. Finally, during the fifth step of *interpretation* the first author attempted to identify and explain the core meaning of the data and synthesized and communicated the findings through the process of writing up and presenting the data. As the question guide was developed based on the review of literature on effective provider-delivered Positive Prevention counseling, this helped to guide the analysis of study data. The interpretation process involved multiple re-writes and the re-organization of themes and sub-themes to most accurately reflect both the participants' perspectives and the essential meaning of the data.

RESULTS

An environment of cultural, religious and legal constraints

When asked what role providers saw in delivering HIV prevention information to YLWH, all of the health care providers felt strongly that their role included delivering sexual behavior counseling to YLWH. Interestingly, all types of providers including doctors,

nurses, counselors, and PLWH volunteers, shared many of the same views and beliefs and there were no clear distinguishing characteristics in their responses to the questions in the interview guide. Providers' views of the sexuality of adolescents were reflective of those of the local culture. For example, many providers viewed youth sexual relationships as unstable, spontaneous, and short-lived. They believed youth had sex only out of curiosity or for sexual pleasure. Providers did not value the sexual relationships of adolescents because they did not occur within the context of a marital relationship. Most providers deemed youth too young to have sexual relationships and were not confident that youth could have sex without putting themselves at risk. These views led providers to at times deny the existence of sexual activity and sexual desire among the YLWH, avoid discussion of sexual behavior, and denigrate those sexual relationships of which they were aware.

Providers described a cultural environment in which discussing adolescent sexual behaviors was "taboo". Providers felt that this environment discouraged youth from talking about sexual behavior. Likewise, while providers said they wanted to broach the topic of sex with YLWH, they reported that their cultural context constrained them from seeking out sensitive sexual information from youth and from providing more extensive sexual behavior counseling and services.

"Prevention for youth infected by HIV is still a challenge, especially in our country where sexuality is considered a taboo...you start to realize that this taboo consists, our taboo consists of a trap for the domain of prevention." - IDI 212

It is important to note that while providers considered sexual discussions with youth culturally inappropriate, within other spheres of Congolese life, such as in popular music or in private discussions between adults, sexuality is discussed freely. Providers also acknowledged a conflict between their religious beliefs and prevention strategies, such as condom use, as reflected in the following quote.

"Here, my religion says that a young person should not have sex before marriage and using a condom is already a sin...communicating with children on condom use, to teach them that, you find that you are sinning yourself, you are pushing them to sin, you push them to sin. So you are participating in their sin, that's why we tell them to abstain, that they have to wait until marriage, but we give, we go beyond religion because it is better to prevent than heal, it is a type of prevention, we tell them that they have to use condoms for those that are already sexually active." - IDI 110

In addition, providers described confusion regarding their legal and professional ethical obligations to provide YLWH prevention counseling and services.

"The laws need to be clear. To know is it permitted for providers in our context to offer condoms? That I think needs to be clarified. We need to clarify the laws that exist...already we know that we can't offer family planning but is it ok to offer condoms?" - IDI 209

In combination these perceived cultural, religious and legal constraints led to three primary impediments to effective provider-delivered sexual behavior counseling for YLWH: 1) providers' limited knowledge of youth sexual behavior; 2) providers' failure to create an environment where youth can speak openly about sexual behavior and; 3) providers' delivery of prevention services primarily limited to abstinence only counseling messages to the exclusion of other prevention services, such as access to condoms and family planning. These impediments are discussed in detail below.

Providers' Limited Knowledge of YLWH's Sexual Behavior

The majority of providers expressed the view that they had no idea how many of the YLWH were currently sexually active. When asked by the interviewer to estimate the percentage of sexually active YLWH, the responses ranged from 5% to 100% with most responses between 30% and 60%. Providers made assumptions about who was sexually active based on external cues, such as makeup or revealing clothing among young women.

"One time when we were speaking...she had a clothing style that was a bit sexy and she liked short skirts and she liked showing her bra, her cleavage, things like that so during our meetings I asked her the question if she had ever known a man." - IDI 203

Medical cues such as being pregnant, having a sexually transmitted infection (STI), or a recurrence of Tuberculosis (considered by providers a sign of non-adherence to medications and thus risky behaviors) were also used by providers to broach the topic of the youth's sexual behavior. Pregnancy was by far the most common medical cue described by providers. One provider mentioned that the only "proof" providers had of sexual activity was pregnancy. Relying on these external and medical cues contributed to providers practicing counseling in a reactive and selective rather than a proactive or preventive way. In the case below, a provider uses a young women's loss of her infant as an opportunity to counsel the youth on safe sex.

"Unfortunately the child died...since she was really shocked by the death of her daughter, I, we, I took advantage of the situation that day...and I began to speak with her..., 'what do you plan on doing, continuing with this sexual activity without protection?'" - IDI 105

Therefore, external cues were used to trigger counseling with the youth as providers did not have any other information to help inform the need for counseling. None of the providers described external cues for young men and many admitted that they were unaware as to whether male youth were having sex. These gender differences in how providers assessed youth sexual activity led to providers limiting their minimal sexual behavior counseling to primarily young women. One provider, after discussing how external cues are used to determine who might be sexually active, spoke about the problems associated with this approach.

"She could talk too much and not be sexually active, she could explain herself well but not be sexually active and another could be calm and she is the one who is sexually active so you can't judge appearances to know who is sexually active and who is not...A boy, you can't know if he is sexually active, because there are no signs, there are no external signs that show that he is sexually active unless he tells you." - IDI 102

The above quote indicates that there was some level of understanding amongst a minority of the providers that the strategy of relying on external cues to guide prevention counseling may not be effective. It is clear that providers did not have an adequate foundation of information on YLWH sexual activity; however, they made assumptions based on the limited information they did have.

"Well, it's difficult to know [if the youth are sexually active] because the majority deny it, after all, we don't ask them questions openly either" -IDI 212

The consequence of the providers' limited knowledge of youth sexual behavior is that they therefore had no systematic means of determining which youth were at risk and thus they did not know where to direct their more intensive prevention counseling efforts.

Providers' Failure to Create an Environment Where Youth Can Speak Openly About Sexual Behavior

Providers acknowledged that they did not have a complete understanding of YLWH sexual behavior. They overwhelmingly attributed this to the lack of willingness on the part of YLWH to admit sexual activity and felt that this precluded a real understanding of YLWH sexual behavior. Some providers believed youth refused to open up or even lied to them because of shame related to the lack of acceptance of youth sexual activity outside of marital relationships in their culture.

"They (the youth) are really closed, if there are some that speak they are rare – maybe two or three but it is really rare...Because they aren't married they are single, adolescents, if they do that, they are cheating and when you are cheating, you don't announce it, when you are cheating you hide it." - IDI 102

Providers assumed youth shared their belief that adolescent sexual relationships were not acceptable behavior and thus felt this explained why youth did not admit to having sex. However, youth may not have felt comfortable sharing this information with providers because they were aware that providers did not condone adolescents having sex. A few providers felt that youth did not share sexual information because the YLWH considered them as "parental" figures and did not want to disappoint them. Providers in general appeared uncomfortable discussing specific sexual behaviors with youth or posing direct questions and instead insisted their role was to provide information to the youth but not to inquire about their sexual behaviors.

"I only give counsel without demanding whether or not she has had sex or not I just give counsel." - IDI 113

Providers believed that direct questioning related to sexual behavior was not an effective way of learning about youth sexual behavior. As providers were uneasy posing pointed questions to the youth about their sexual behavior, they described using less direct ways to provide counseling. Providers attempted to use humor to approach the sensitive topic of sexual behavior including joking about the youth having a boyfriend or girlfriend to "relax the atmosphere".

"You watch the girl grow and develop secondary sexual characteristics and you can weave in certain questions...at times you pose questions like you were joking. Like how is your boyfriend? She responds 'doctor I don't have a boyfriend!' You see she responds directly that she doesn't have a boyfriend and that directly blocks you...she says 'no I don't have a boyfriend.' 'Oh good, that's good, continue like that.' And you provide prevention counseling". - IDI 203

As soon as she responded that she did not have a boyfriend, the provider gave positive encouragement, clearly acknowledging that the youth responded with the "right" answer. In some cases, providers described delivering directive and reprimanding counseling to youth. These reprimands were usually given in response to a medical cue, for example when a young girl showed up at the clinic pregnant, as in the case below, or with an STI.

"It's like the condom has nothing to do with you...So you are sabotaging yourself, you are not using them, now you have two children with two different fathers that don't support you, you live with your parents, it's good, your parents are still alive but one day when your parents won't be there anymore, you won't be able to study, you see, to sleep with men it's a real pleasure for you, tomorrow when the men learn that you are seropositive they will abandon you with the children and what will become of you?" - IDI 107

Providers felt frustrated that even though they had spent time counseling youth on prevention strategies, they felt the youth were not listening to them. In their frustration they scolded the youth and continued to communicate the same messages repeatedly. This seemed to create an environment where youth may have felt judged and scolded resulting in youth feeling uncomfortable expressing their real needs.

Providers' Delivery of Prevention Services Limited to Abstinence Only Counseling Messages to the Exclusion of Other Prevention Services

Counseling Messages—The providers' counseling stressed the importance of YLWH protecting themselves from re-infection and protecting others from becoming infected based on the different modes of transmission. Providers concentrated their counseling mainly on modes of transmission not related to sexual behavior, such as blood transfusions or the re-use of razor blades, rather than discussing more sensitive topics related to sex. Providers encouraged abstinence in their counseling as they believed that was the only means to ensure that youth were not putting themselves and others at risk. Providers believed that once youth became sexually active it was very difficult for YLWH to control their behavior and to practice safe sex.

"Abstinence is better for protecting the youth....so that these youth don't put themselves in situations that could bring them down, that could push them to have another type of sexual life"- IDI 108

Providers' beliefs on adolescent sexual behavior also influenced their counseling related to fidelity.

"An adolescent that's not married, he would be faithful to whom?"- IDI 102

Providers did not consider the promotion of "faithfulness" to be relevant for the types of relationships engaged in by YLWH. Providers did at times communicate messages related to condom use; primarily for youth already sexually active who the providers believed could not control their sexual urges. Providers appeared to choose what they may have considered a middle ground between the importance of prevention and the cultural, religious, and legal context in which they worked — they offered condom use to YLWH as a potential strategy targeted to a selected group of youth but did not encourage it for all youth and in many cases discouraged it. Condoms were recommended as a preventive last resort. During the interviews, a few providers said that they "promoted" condoms but then quickly corrected themselves to say that they "offer" condoms as a possible option. Most providers felt strongly that they did not want to come across as promoting engagement in sexual activity through encouraging the use of condoms, but rather they wanted to provide the information and allow the youth to make decisions as to how they would use this information. However, this led them to deliver mixed messages, as in the quote below, and thus they potentially missed the opportunity to effectively counsel youth on condom use.

"So, I give the counsel, 'stop with this life! But if you end up doing it you must wear a condom. You must require condoms even if the person refuses you tell the person: I don't know you, I don't know your serostatus, you don't know my serostatus either, protect yourself and I too will protect myself. That's the ideal – like that you will protect yourself and others but I'm not asking you to do that, me, I'm counseling you to be abstinent'." - IDI 212

This quote is particularly illuminating as the provider delivers the message of condom use as a preventive strategy, but couches this counsel within a firm request that the youth not follow this guidance but instead remain abstinent. Therefore, while providers believed they were counseling youth on safe sex and condom use, they were not aware that the way the information was presented may have influenced youth condom use decisions.

Access to Condoms—Providers reported that condoms were available in the pharmacy and that a system had been put in place for providers to write condom prescriptions for patients. However, after probing it became clear that the majority of providers were not comfortable prescribing condoms to YLWH.

“Well I don’t know if someone else has given them, but me, personally, I’ve never offered them, no one has ever asked me and I’ve never offered.” - IDI 102

As condoms at the clinic were available only at the pharmacy, providers were unaware if YLWH were accessing condoms. However, many stated that they believed it was unlikely that youth were accessing condoms due to the shame involved in requesting condoms. Many providers were aware that by not accessing condoms in the clinic, YLWH were at greater risk and some proposed ideas for how the situation could be rectified. Some suggested putting condom distribution boxes in the bathrooms at the clinic or including condoms with each prescription of medications, whether or not condoms were requested. In contrast to other areas of their counseling, providers acknowledged that the clinic environment impeded youth from learning about and using condoms. However, the providers struggled to find ways to adapt their counseling messages and create an open dialogue with youth within a context of what they saw as legal, ethical, and moral barriers.

Family Planning—Similarly, the majority of providers were adamant that family planning, like condoms, was not appropriate for YLWH to prevent unwanted pregnancies or mother-to-child transmission. Youth were not referred to the clinic’s designated family planning nurse unless they were married or had already given birth to a child. Most providers felt that adolescent sexual relationships were fleeting as opposed to more stable marital relationships and this may have contributed to their not recommending these services for YLWH. These providers felt that there was no need for family planning services for youth, as their understanding was that this was only indicated for couples having sex regularly.

“So the difference is that often for young women we don’t focus on family planning like that, because sexual activity for young women is not the same as sexual activity for adult women...It’s different; adolescents who do that do it for sexual pleasure or do it only occasionally”- IDI 101

Many providers felt that it was the youth’s responsibility to request family planning services; however, few ever did. In one case when a young girl who had previously been pregnant approached a provider to inquire about family planning options, she was told that it was not appropriate.

“And so she came here and said she wanted family planning. Me, I said ‘you aren’t married, when you want family planning it is to continue without condoms so you are not doing anything special. It’s true you will avoid getting pregnant, but re-infection, you won’t avoid that with family planning. You are a girl, you are younger than 18 and you aren’t even married why do you want to do family planning?’”- IDI 107

Even the fact that the young woman had already been pregnant was not sufficient for the provider to offer family planning counseling. This provider felt that using family planning would lead the young woman to have unprotected sex and therefore put herself at risk of re-infection, and thus prioritized this potential risk over the risk of an unwanted pregnancy or mother-to-child transmission. A few of the providers mentioned believing that it was illegal to provide family planning counseling to youth under the age of 18 in the DRC and that family planning required the permission of the male husband or partner. This further complicated the ability of providers to deliver family planning services to youth.

DISCUSSION

Providers believed it was their role to deliver Positive Prevention counseling and felt the counseling they were providing was in the youths' best interest. However, they were unable to effectively counsel youth and create an environment where youth felt comfortable talking with their providers about HIV or sexual health. This was primarily due to providers' lack of knowledge and comfort talking to youth about sex and their confusion about their legal obligations related to youth and contraception.

This seriously compromised the delivery of comprehensive adolescent counseling and services. Counseling, when provided rarely went beyond the discussion of whether or not the youth had a boyfriend or girlfriend, yet providers believed that this act of casual inquiry served as prevention counseling. Few youth admitted to having a partner, and thus for the majority of YLWH this was the extent of prevention counseling they received. Likewise, providers did not adapt the counseling to the individual needs of each youth and delivered highly general and didactic counseling, targeted only to those youth they assumed to be at most risk. As a result, the counseling that was provided was likely ineffective in helping youth remain sexually healthy.

In a study on contraceptive use by South African adolescents, the inability of nurses to recognize their views of adolescent sexuality as a barrier to services was recognized, similar to themes revealed in our study (Wood & Jewkes, 2006). In the same study, nurses felt that youth requesting contraception was equivalent to a public admission of having sex and was therefore not encouraged and thus perpetuated the negative view of adolescent sexual behavior. Providers at the study site in Kinshasa were similarly hindered by their views of adolescent sexual behavior and this led to reduced effectiveness of the counseling and services they were able to provide. Recent research on Positive Prevention has pointed to the importance of focusing on provider attitudes and beliefs to improve programs, in addition to the administrative or logistical issues most frequently cited in studies based in the U.S. (Gilliam & Straub, 2009; Koester et al., 2007; Myers et al., 2007; Patel et al., 2009). Effective potential mechanisms to address provider attitudes and beliefs that may get in the way of effective prevention counseling are "values clarification" trainings. These trainings can help providers become aware of how their beliefs and assumptions can negatively influence prevention counseling. They can also help providers address the disconnect between their perceptions of the impacts of their counseling and the actual effects of their counseling. "Values clarification" training generally includes three components: 1) self-reflection to uncover the providers attitudes, beliefs, prejudices and fears and how these may cause barriers to prevention counseling; 2) contextualization of the counseling in the context of public health by helping providers fully understand the need for such services and their own role implementing the services; and 3) sensitization of providers to their youth patients' rights, needs, and specific individual circumstances (Reproductive Health and HIV Research Unit, 2005). "Values clarification" interventions have been shown to have a positive impact on provider attitudes and beliefs in a variety of settings (Turner, Hyman, & Gabriel, 2008).

Studies in the U.S., Brazil, and South Africa have also shown that providers tended to focus their counseling on PLWH that they perceived to be at higher risk or presented with clinical prompts, such as an STI or pregnancy (Drainoni, Dekker, Lee-Hood, Boehmer, & Relf, 2009; Fehringer et al., 2006; Peltzer & Ndlovu, 2005; Wilkinson et al., 2006). Thus, in order to ensure that prevention counseling is reaching all youth, and is not dependent on external cues, clinics should develop systematic guidelines recommending that providers engage *all* youth in discussions related to their sexual behavior and screen these young patients for HIV transmission risk and counsel them on sexual risk, condom use, disclosure to sexual partners, treatment adherence, and mental health.

Providers placed blame on youth reticence and societal norms and taboos rather than considering alternative reasons why youth were unable to engage in discussions of sexual behavior with medical providers. There was no acknowledgement that providers may be contributing to an environment in which YLWH did not feel safe to share their feelings and experiences related to sexual behavior, and that this is something that could be rectified with improved counseling. This was most likely due to the providers' entrenchment within their own cultural norms and attitudes. The institutionalized, authoritative style of providing care that pervades sub-Saharan African medical institutions may have also contributed to challenges providers faced in creating an environment conducive to open discussions of adolescent sexual behavior (Woods et al., 2006). Patients were not encouraged to take an active role in discussions, which left little room for dialogue about prevention of transmission (Chalachala, Parker, Pettifor & Behets 2010; Kim, Odallo, Thuo, & Kols, 1999). To improve patient-provider relationships and create a more open environment, providers could be trained to dialogue more collaboratively with patients. This training could help providers learn effective methods to: 1) explore patient feelings about sexual activity, 2) use youth's existing knowledge of HIV as a means of engagement, 3) address barriers identified by the youth for safe sex, 4) understand youth's perceptions that could influence high-risk sexual behaviors, and 5) give tools to youth to plan for safer sex (Pinto, 2001). While providers were not asked directly if they would be open to changing their counseling behaviors, when asked about areas in which they would like further training, many suggested prevention counseling techniques specific to youths' developmental stage and psychological state. This supports the possibility that if given the appropriate training, providers in this context could effectively adapt their counseling to the specific needs of these youth.

Providers' delivery of counseling messages were not comprehensive in nature and were primarily abstinence only messages. Similarly, a few studies in the U.S. showed a decrease in delivery of Positive Prevention counseling and provision of services at those clinics where providers reported signs of high "fatalism" or believed that counseling would have no impact (Myers et al., 2007; Steward, Koester, Myers, & Morin, 2006). This corresponds to our findings that many providers focused primarily on abstinence and refused to provide condoms and family planning services because, among other reasons, they were not confident YLWH engaging in sexual behavior could follow more nuanced counseling messages. It is only once providers have a greater understanding of youth sexual behavior and trust that youth are capable of following prevention counseling that their counseling and services may be improved.

The lack of clear information and guidance concerning legal and ethical issues surrounding the provision of prevention counseling and services to YLWH also contributed to the delivery of limited sexual behavior counseling. In order to address this issue, clinic administrators can consider becoming aware of how local and national laws affect what providers can and cannot discuss in the context of services for youth. For example, while there was previously a 1958 law in the DRC that outlawed family planning due to the government's aim of increasing the population, this law is no longer enforced and had specific exceptions for health reasons (Kashamuka Mwandagaliwa, 2010). Providing relevant legal and medical ethics information to providers through clinic-level policies and through specific training for providers working with youth would help address this challenge.

In order for providers to deliver effective prevention counseling to YLWH, clinics could consider following adolescent-friendly clinic standards, providing counseling in an adolescent-friendly style, and instituting an effective referral system for prevention services. Current best practices for adolescent-friendly clinics include: 1) comfortable surroundings;

2) short wait times; 3) policies and processes that support the rights of youth; 4) youth involvement in design and continuing feedback; and 5) systems in place to train staff to provide effective adolescent-friendly services (Dickson-Tetteh, Pettifor, & Moleko, 2001; Senderowitz, Hainsworth, & Solter, 2003). Ongoing counseling trainings could teach providers how to: 1) create an atmosphere of empathy and active listening; 2) exhibit patience and encourage trust; 3) create a confidential atmosphere; 4) use a direct and explicit style; and 5) allow adolescent patients to verbalize their understanding of HIV, clarify misconceptions, and fill in gaps in knowledge (The Pennsylvania/MidAtlantic AIDS Education and Training Center, 2006). One possible counseling technique that incorporates many of these elements is Motivational Interviewing which has been shown to reduce risk behavior when applied to YLWH in the American context (Chen, Murphy, Naar-King, & Parsons, 2011). Finally, a referral system could be instituted that formalizes the process of referring YLWH patients to appropriate prevention services.

In the context of human resource shortages and overburdened staff in low-resource settings, adolescent-friendly systems can help make providing services to YLWH a multi-disciplinary team effort. If providers are able to provide adolescent-friendly clinical care they can more effectively respond to YLWH prevention needs by focusing on providing appropriate care and treatment while making referrals to counselors or trained PLWH volunteers for access to condoms, family planning, and more extensive HIV transmission prevention counseling. This analysis has highlighted barriers to effective prevention counseling that may exist in low resource settings and thus provides insight into how training and skill-building of providers can be tailored to the unique challenges of these settings. Lessons learned from this analysis can help to improve Positive Prevention behavioral interventions in low-resource contexts so that YLWH are reached before they are eligible for treatment and so that they remain engaged once they are receiving treatment.

Limitations

Providers may have presented a more positive picture about their commitment to Positive Prevention than is actually the case. However, providers were informed that there were no right or wrong answers to any of the questions and that their responses would be confidential and were encouraged to be candid in their responses. In addition, these providers are not representative of all providers working with YLWH in the DRC. They reflect a specific population of health care providers working in an HIV care and treatment program at a pediatric hospital in Kinshasa. Despite these limitations, this study provides an important new understanding of the barriers to provider-delivered prevention counseling for YLWH.

Conclusion

HIV prevention services for YLWH can be improved through the creation of a more adolescent-friendly environment as well as by providing “values clarification” and skill-based trainings so that providers are able to assess the role of their own beliefs as well as learn new skills. This may give providers the confidence and skills they need to improve the prevention services provided to YLWH and the ability to confront the constraints of their work environment.

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Table 1

Participant Demographics, n=14

Job Title	Gender	Age	Time working with YLWH
Nurse/Psychosocial Counselor	Female	48	7 years
Nurse/Psychosocial Counselor	Female	52	2 years
Nurse	Female	35	9 years
Doctor	Female	36	5 years
Nurse	Female	49	10 years
Doctor	Female	36	2 months
Nutritionist	Female	39	5 years
PLWH Volunteer	Female	47	1 years
PLWH Volunteer	Female	34	2 years
Doctor	Male	36	6 years
Nurse	Male	41	7 years
Doctor	Male	47	5 years
Psychosocial Counselor	Male	39	3 years
Doctor	Male	46	7 years