Published in final edited form as:

J Health Commun. 2018 ; 23(6): 591–596. doi:10.1080/10810730.2018.1493061.

The Perspective of HIV Providers in Western Kenya on Provider-Patient Relationships

JUDDY WACHIRA^{1,2}, BECKY GENBERG³, CATHERINE KAFU², BEATRICE KOECH²,
JACQUELINE AKINYI², REGINA K. OWINO², MICHAEL BARTON LAWS⁴, IRA B. WILSON⁴,
and PAULA BRAITSTEIN⁵

¹School of Medicine, Moi University, Eldoret, Kenya

²Academic Model Providing Access to Healthcare (AMPATH) Partnership, Eldoret, Kenya

³Bloomberg School of Public Health, Johns Hopkins University, Baltimore, MD, USA

⁴Department of Health Services, Policy & Practice, Brown University, Providence, RI, USA

⁵Dalla Lana School of Public Health, University of Toronto, Toronto, Ontario, Canada

Abstract

Enhancing effective adherence dialogue with HIV patients in an environment that promotes good provider-patient relationships, is key to optimizing the benefits of antiretroviral therapy (ART). The study examines the perspectives of HIV providers in western Kenya on provider-patient relationships. Sixty healthcare providers were sampled using convenience sampling methods from three Academic Model for Providing Access to Healthcare (AMPATH) sites (one urban and two rural). In-depth interviews conducted in either Swahili or English were audio recorded, transcribed, and translated into English. Content analysis was performed after thematic coding. Providers perceived that they had good relationships with most patients, and tended to identify negative patient attributes as the source of poor provider-patient relationships. Providers preferred patients who adhered to treatment guidelines. They did not like patients who challenged their authority, and did not see it as their responsibility to find more effective ways of interacting with patients who they found difficult. Structural barriers to collaborative physician-patient relationships included noncontinuity of relationships, lack of specific appointment times, high provider-patient ratio, and management of provider fatigue and job dissatisfaction. There is need for HIV care programs to identify culturally appropriate interventions to enhance better provider-patient relationship.

Background

Kenya, along with other sub-Saharan African countries, has made tremendous strides in the delivery of antiretroviral therapy (ART) to HIV-infected persons (Blaizot et al., 2016; Kelly & Wilson, 2015; Odhiambo, Kellogg, & Kim, 2014). ART coverage in Kenya increased from 64% in 2008 to 80% in 2013 (NACC, 2014). Despite this achievement, poor adherence

and high loss to follow-up (LTFU) rates along the cascade of HIV care (Hassan et al., 2012; Karcher, Omondi, Odera, Kunz, & Harms, 2007; Mann et al., 2013; Mûnene & Ekman, 2015; Ochieng-Ooko et al., 2010) reduce the effectiveness of these efforts. These challenges have been attributed to various individual, social, and structural factors (Fox & Rosen, 2010; Merten et al., 2010; Ochieng-Ooko et al., 2010; Posse, Meheus, Van Asten, Van Der Ven, & Baltussen, 2008; Reda & Biadgilign, 2012; Vreeman et al., 2009). Initiating effective adherence dialogue with HIV patients, and incorporating tailored interventions along the continuum of HIV care, are essential to optimize the benefits of HIV care.

Patient engagement in care, which entails patient involvement in decisions regarding their treatment, has been shown to promote better HIV medication and clinic adherence (Mûnene & Ekman, 2015). For HIV patients to be engaged, high quality provider-patient communication and relationship dynamics must be fostered and maintained (Flickinger, Saha, Moore, & Beach, 2013). In Kenya, poor provider-patient communication and relationship difficulties have been documented as barriers to optimal HIV care (Geng et al., 2015; Gourlay, Birdthistle, Mburu, Iorpenda, & Wringe, 2013; Gourlay et al., 2014; Posse et al., 2008; Wachira et al., 2014), yet very few studies in the region have focused on the role of provider and patient interactions in promoting HIV care (Wachira, Middlestadt, Reece, Peng, & Braitstein, 2013, 2014). These studies do not explore how Kenyan providers and patients experience and conceptualize provider-patient communication and relationships. Understanding providers' and patients' expectations during clinical encounters is essential to developing appropriate interventions to promote better provider-patient interactions in the context of HIV care delivery.

We therefore used qualitative methods to better understand these mutual expectations. In this article we examine providers' perspectives on the factors that contribute to poor provider-patient relationships. We focused on the following research questions: 1) What are the perceptions of providers about HIV patients? 2) How do providers perceive and experience provider-patient relationship?

Methods

Study Setting

The study was conducted within Academic Model for Providing Access to Healthcare (AMPATH) a partnership between Moi Teaching and Referral Hospital (MTRH), Moi University, and a consortium of North-American Universities focused on delivering HIV care in western Kenya (Tierney et al., 2007). We targeted three AMPATH care sites: MTRH, Webuye, and Busia consisting of 15,147, 4,043, and 7,185 active patients, respectively (as of March 2018). The clinician to patient ratio is 1:297-MTRH, 1:450-Webuye and 1:553-Busia. These sites represent urban (MTRH) and rural (Webuye and Busia) clinics.

Participants

We sampled all providers seeing patients with HIV, including clinicians (comparable to a physician assistant in the U.S.), nurses, counselors, and support workers (social workers, nutritionists, and psychosocial/outreach workers).

Study Design

We conducted this qualitative study using in-depth interviews between September 2014 and November 2015. Our sample size was based on achieving data saturation point, which was attained at 60 providers. We recruited a convenience sample of providers at the three study sites.

Human Subjects Protection

We obtained ethical approval from the Moi Teaching and Referral Hospital Institutional Research and Ethics Committee as well as the Brown University Institutional Review Board. Written consent was obtained from all participants. All interview sessions were conducted in private rooms and no names were used during the interview sessions, thus ensuring confidentiality.

Study Procedure

We conducted in-depth interviews with all 60 enrolled subjects in either English or Swahili (based on the participants preference) using a semi-structured interview guide. The interview guide was developed to explore physician-patient relationship and communication dynamics and included the following domains: 1) provider perceptions about HIV patients, 2) provider-patient communication, 3) provider-patient relationship, 4) barriers and facilitators to HIV care. The guide was first developed in English, translated into Swahili, and back-translated to English for consistency. It was pretested with a sample of four providers and revised accordingly. Socio-demographic information including age, gender, educational level, provider type, and duration working in HIV care was also collected. Trained and experienced research assistants from Kenya, identified the target groups at AMPATH health facilities and informed them about the study. All those who were approached agreed to participate in the study and provided written consent. They then conducted the audio recorded interviews that took approximately 1 hour. Participants were provided with transport reimbursement of Kenya Shillings (KES) 500, equivalent to USD 5.

Data Analyses

Audio recordings were transcribed verbatim. The four interviews conducted in Swahili were translated to English then back translated to Swahili by a native Swahili-English speaking translator. Transcripts were imported into NVivo 8™ (QSR International) for coding and analysis. For validation, three investigators (JW CK and BG) conducted independent coding and identification of themes on 12 transcripts. These three investigators met regularly to discuss and agree on emerging and conflicting codes while revising the codebook. In addition, experts in provider-patient communication were consulted on the codebook. Once the codebook was finalized and consistency achieved, two additional trained research assistants assisted with coding. Thematic analysis (Fereday & Muir-Cochrane, 2006) was used, with data coded under one or more themes. During analysis, new themes were identified and added to preexisting categories upon consultation and agreement by the analysis team. Data were scrutinized for differences and similarities within themes. The final write-up consisted of summaries, interpretations and textual excerpts.

Results

Table 1 shows the distribution of interview sessions per site and provider type. Most participants were female 43 (71.7%) and the median age was 38 years. On average participants had worked in HIV care for 7.7 years.

We present findings according to the following main categories of themes that emerged from our analyses: 1) Characteristics used to recall and identify patients (in addition to information in the medical record); 2) Interpretation of passive vs. active patient behaviors; 3) Factors perceived to contribute to poor provider patient relationship.

Characteristics Used to Identify and Recall Patients

Because patients do not consistently see the same provider, the question of whether providers are familiar with individual patients and how they remember patients was a consistent theme.

Physical features were mentioned as the most common way of recognizing patients, beyond recalling patients' names. Shorter duration of patient treatment at the site, and high patient volumes, were factors that providers reported made it difficult for them to recognize patients. However, providers easily recalled patients who asked a lot of questions or presented with unique social or health issues.

(Nurse): And then there are also those who have unique experiences... Maybe they came with issues or when you first enrolled them, they cried. They may have been so bitter, so you kind of remember them. Or there are those whose adherence was poor and now they have improved...you kind of remember them.

Patients with formal occupations, mainly those that are highly valued in the society including police officers and teachers, were also easily recognized by some providers.

Interpretation of Passive Vs. Active Patient Behaviors

Providers tended to report good relationships with their patients. Passive or quiet patients were often perceived negatively. For example, patients who did not ask questions during a clinical encounter were viewed as disengaged, secretive, to have a bad attitude, or to have a psychological problem. Most providers did not feel that it was part of their professional responsibility to actively engage their patients to identify issues and problems; rather, they expected patients to be forthcoming when necessary. Some of these patients were identified as patients enrolling in care for the first time or who are being observed by a new clinician.

(Clinical Officer): They are not open especially the new patients or those who were seen by a different clinician. ... When you ask them a question, they provide a direct answer and stop at that. They don't care explaining or giving extra information that you may need. So at times it's difficult to manage them.

Other health providers appear to conclude that some of these patients were perceiving stigma, in denial, or having a mental illnesses.

(Nurse): The other issue could be stigma. HIV patients especially if those who have not accepted their status... You don't know what they are actually feeling. You might even think some of them are psychotic.

On the other hand, some providers were content with timid patients, as long as they perceived that they were following the assigned treatment recommendation.

Active patients who asked a lot of questions elicited positive impressions. Providers perceived that inquisitiveness communicated that the patient understood the provider, had confidence in the provider, wanted to know more about their health issues, were making good progress, and were ready to receive care. However, providers felt very pressed for time because of high patient volume, and did not generally want to spend time on issues perceived to be nonrelevant. Depending on the clinic day, providers reported that a clinician sees between 25 and 40 patients a day.

(Clinical officer): Provided they are meaningful questions. You know there are those who will ask you questions just to frustrate you.

Factors Perceived to Contribute to Poor Provider-Patient Relationship

More patient than provider-related factors were cited by providers.

Rude Patients—Patients that providers had difficulty interacting with were often described as “rude,” including those who did not adhere to treatment recommendations. Providers felt that some patients project their guilt for not adhering to their treatment regimen, by being rude, and often understood the health providers’ firmness about adherence with treatment guidelines as quarrelling. Some providers mentioned that they more often perceived patients as rude when they were fatigued.

(Nurse): Some clients already feel guilty that they are not adhering to treatment.. they come with an attitude. ... When you question them some perceive that as quarrelling.

Irritating Patients—Providers characterized other patients as “irritating.” These were patients who had a negative attitude towards their providers; were impatient, demanding, or intimidating; presented with stories about HIV risk behaviors the providers had heard many times; and expressing a preference for certain providers. Some providers expected patients to be aware that providers are often distracted during clinical encounters, and that distractions and interruptions were an expected part of a provider’s role and duties.

(Clinical Officer): There was a time I had a client here and I was somehow on the phone and a message came through. I think maybe I was waiting for something [important])... so I was tempted to check (the message)? And then the patient said, “Leave that phone and talk with me first.”

Nonadherent Patients—Providers often expressed that patient nonadherence contributed to their sense of a poor patient-provider relationship. This included both nonadherence with ART and the use of alcohol. Providers stated that their efforts to be strict with patients about

these issues were often interpreted as quarrelling, and felt that some patients only wanted to receive positive feedback.

(Clinical Officer): Of course the routine defaulters. I don't think we can be friends. If you have defaulted your TB/HIV treatment for 3 or 4 times. I'm not an angel! At some point I feel like you are not serious.

Patients Late on their Appointment Day—The expectation is that patients will arrive first thing in the morning on their appointment day, and wait in line to be seen, whenever that may be. It was reported that those patients who arrive at the clinic in the afternoon and are seen late in the day, receive compromised care due to provider fatigue.

(Nurse): There are some who say we are harsh. You know at times we tell them to come early (by 8 am) when the doctor's mind is still fresh. When they come late (after 2pm) they get their prescription. We might not even greet them.

Distrust When Providers and Patients are in the Same Social Network—Patients who are within the same social network as their providers had the most difficult time establishing trust due to fear of disclosure. Some providers avoid interacting with such patients.

(Clinical Officer): And if there is a patient that I would not like to see is someone who is close to me like this family friend of mine... One day I saw a family friend on the queue. When he saw me he did not feel so good. He felt that he had been exposed and that his secret was out. I did not want to observe him because I could have asked so many questions and yet he is my good friend.

The following factors were associated with the health providers:

Poor Provider Communication Skills—Providers also acknowledged that poor provider communication especially among patients who did not adhere to their treatment recommendations including keeping clinic appointments and medication adherence contributes to disagreements provider and patients.

(Outreach worker): When they (referring to patients) come late, they fear being quarreled by either the doctors, clinical officers, or nurses. You know some of them (clinical team) do not know how to address patients. Instead of providing patients with the right information, they quarrel.

Job Dissatisfaction—Job dissatisfaction was viewed as a factor influencing provider-patient interactions. Job motivation was not only regarded as monetary benefits such as salary increment and performance-based incentives but included having regular update meetings and provision of tea during breaks.

(Clinical officer): Like you see previously staff would get lunch but nowadays they don't and that demotivates us. It is really demoralizing... Staff also thought salaries will be increased, but nothing has been done (giggles). Things such as the PBI (performance based

incentives) went with the wind. It has actually decreased staff motivation. Previously we used to be called for meetings severally, but nowadays the meetings are no longer there. We don't get updates.

Provider Fatigue—Provider fatigue was associated with high patient volume and it was cited that by 2 pm providers were too tired to offer quality care.

(Clinical Officer): What I can say is, what spoils the relationship between a patient and a doctor is burnout (i.e. fatigue). For instance I have been working from 8am this morning and it's now 2pm in the afternoon and patients are still flowing in. So the rest of those (patients) who will come in (after 2pm) I will not have patience because of fatigue. Fatigue alters clinicians' moods and even concentration.

Discussion

Three main findings emerged from our work: 1) providers preferred patients who adhered to treatment guidelines regardless of the patients' behavior during clinical encounters, 2) providers favored more social power than patient, and 3) the healthcare system presented structural barriers that influenced how providers perceived and interacted with patients.

Providers' preference for patients perceived to adhere to their providers' recommendations raises concerns over how providers can help nonadherent patients overcome the barriers they face and become adherent. Providers did not perceive nonadherent patients as vulnerable and needing more of their attention, and did not see it as their responsibility to find ways of interacting more effectively with these patients. Even as providers continue to foster good provider-patient relationships with adherent patients, establishing a stronger provider-patient relationship with nonadherent patients may be critical in assisting these patients overcome the challenges they face with adherence.

The principle of patient rights and autonomy is gaining more emphasis in sub-Saharan Africa (Rowe & Moodley, 2013), and has been articulated in the Kenyan medical professional code of ethics (Board, 2012). We observed, however, that providers thought that patients who expected their complete attention were irritating. As previously reported in the region (Bain, Dierickx, & Hens, 2015; Donatus, 2011; Gourlay et al., 2014), providers expressed preference for a care model in which they had more social power than patients, and expected patients to respect this hierarchy. This paternalist approach to care has raised ethical concerns regarding the professional culture of Kenyan HIV providers (Bain et al., 2015; Donatus, 2011). It may also limit patient engagement out of fear of possibly receiving compromised care, as noted in some developed countries (Adams, Elwyn, Légaré, & Frosch, 2012; Frosch, May, Rendle, Tietbohl, & Elwyn, 2012). Studies that further explore both providers' and patients' expectations of each other are required to better inform provider-patient communication and relationship approaches.

In high-income countries, patient-centered care is now recommended as the optimal approach to engaging patients in care (Epstein & Street, 2011; Rathert, Wyrwich, & Boren, 2012). But even in these settings patient-centered care can be difficult to achieve (Pilnick & Dingwall, 2011). How to implement patient-centered care in settings that have historically

been highly physician-centered, and where other sociocultural factors are working against it, remains a challenge. Our findings reveal the need for a deeper understanding of what constitutes patient-centered care in a Kenyan context in order to inform policy and practice. This should be combined with efforts to empower patients on their rights and how best to engage in care by applying culturally innovative approaches (Garcia-Williams, Brinsley-Rainisch, Schillie, & Sinkowitz-Cochran, 2010) within a committed healthcare management system (Joseph-Williams, Elwyn, & Edwards, 2014).

Amid efforts to scale up HIV care in sub-Saharan Africa, health facilities in this region continue to grapple with limited capital and human resources (Blacklock et al., 2016; Zachariah et al., 2009). Provider burnout, an outcome of these constraints, was reported, and has been shown to significantly lower the capacity of providers to engage with their patients (Halbesleben & Rathert, 2008). This is further compounded by patients interacting with multiple providers during the course of care. Generally, patients have been reported to experience continuity in care by directly receiving information, having confidence and security in the care system, and establishing a relationship with a trusted clinician who supports continuity (Haggerty, Roberge, Freeman, & Beaulieu, 2013). Task shifting should be considered as a measure to address low provider-patient ratio (Callaghan, Ford, & Schneider, 2010). In addition, finding better ways of providing continuity or having a provider whom the patient trusts to help them navigate care, even as they interact with multiple providers, is critical (Haggerty et al., 2013).

Miscommunication between providers and nonadherent patients was reported by the providers we interviewed. Capacity building and on-the-job training for providers on effective communication skills in the context of high patient volume is urgently needed. Also critical is sustaining staff motivation to promote a conducive and productive working environment (Blacklock et al., 2016; Zachariah et al., 2009). In developed countries, commitment from the top leadership, clear communication strategies, sustained staff satisfaction and capacity building, incentives, and a culture of change and learning (Luxford, Safran, & Delbanco, 2011) have been identified as fundamental to patient-centered care. These attributes could be extended and contextualized for this Kenyan setting.

Our study is not without limitations. Provider-patient relationship is dyadic yet this report focuses only on the providers' perspective. Additional research on the patient perspective is forthcoming. The study findings may not be generalizable to the wider Kenyan population since the AMPATH program offers a unique HIV care setting that may not be a reflection of other HIV care programs in Kenya. Despite these limitations, our findings provide valuable insight to the perceptions of providers on the factors that contribute to poor provider-patient relationship in Kenya. This is critical for informing HIV care programs in the region on approaches to enhance positive provider-patient relationships and adherence.

Conclusion

Providers' preference for adherent patients, their tendency for a more authoritarian approach to patient care, and their lack of skill in working more effectively with patients who they find difficult suggest a need for more awareness and capacity building approaches to enhance

better provider-patient relationships. This should be combined with efforts to empower patients on their role during clinical encounters. In addition, structural elements such as provider-patient ratio, management of provider fatigue, continuity of care, and provider motivation should be considered to ensure that providers work in a conducive and productive environment. Additional studies that explore appropriate and contextualized interventions, considering both the providers and patients relationship expectations as well as existing health system challenges, are urgently needed in this setting.

Acknowledgments

The authors would like to thank all the study participants for taking part in the study. We would also like to acknowledge the data entry personnel, data managers, administrative and clerical staff, for enabling the management, interpretation, and publication of these data. We are also grateful to the AMPATH clinical and administrative staff, for their dedication in caring for patients, and their attentiveness in accurately recording their patients' data. This research was supported in part by a grant to the AMPATH Partnership from the United States Agency for International Development as part of the President's Emergency Plan for AIDS Relief (PEPFAR), and the National Institute of Mental Health (K01MH099966, PI: Genberg). Dr. Wilson was supported by a K24 grant, (2K24MH092242). The contents of this study are the sole responsibility of AMPATH and do not necessarily reflect the views of USAID or the United States Government.

Funding

This work was supported by the National Institute of Mental Health [K01MH099966]; National Institutes of Health [2K24MH092242];

References

- Adams JR , Elwyn G , Légaré F , & Frosch DL (2012). Communicating with physicians about medical decisions: A reluctance to disagree. *Archives of Internal Medicine*, 172(15), 1184–1186. doi: 10.1001/archinternmed.2012.2360 [PubMed: 22777319]
- Bain LE , Dierickx K , & Hens K (2015). Ethical issues surrounding the provider initiated opt-Out prenatal HIV screening practice in Sub-Saharan Africa: A literature review. *BMC Medical Ethics*, 16(1), 1. doi:10.1186/s12910-015-0068-y [PubMed: 25576996]
- Blacklock C , Gonçalves Bradley DC , Mickan S , Willcox M , Roberts N , Bergström A , & Mant D (2016). Impact of contextual factors on the effect of interventions to improve health worker performance in Sub-Saharan Africa: Review of randomised clinical trials. *PLoS ONE*, 11(1), e0145206. doi:10.1371/journal.pone.0145206 [PubMed: 26731097]
- Blaizot S , Maman D , Riche B , Mukui I , Kirubi B , Ecochard R , & Etard J-F (2016). Potential impact of multiple interventions on HIV incidence in a hyperendemic region in Western Kenya: A modelling study. *BMC Infectious Diseases*, 16(1), 1–10. doi:10.1186/s12879-016-1520-4 [PubMed: 26729246]
- Board MP and D. (2012). The code of professional conduct and discipline-6th Edition. Nairobi, Kenya: Medical Practitioners and Dentists Board Retrieved from <https://drive.google.com/file/d/0B2F38kJEeTT3RFFGcEE2M2i3M1E/view>
- Callaghan M , Ford N , & Schneider H (2010). A systematic review of task- shifting for HIV treatment and care in Africa. *Human Resources for Health*, 8(1), 1–9. doi:10.1186/1478-4491-8-8 [PubMed: 20205749]
- Donatus G (2011). Ethical issues in health care in Kenya. A critical analysis of healthcare stakeholders. *Research Journal of Finance and Accounting*, 2(3), 122–139.
- Epstein RM , & Street RL (2011). The values and value of patient-centered care. *The Annals of Family Medicine*, 9(2), 100–103. doi:10.1370/afm.1239 [PubMed: 21403134]
- Fereday J , & Muir-Cochrane E (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*, 5(1), 80–92. doi:10.1063/1.2011295

- Flickinger TE , Saha S , Moore RD , & Beach MC (2013). Higher quality communication and relationships are associated with improved patient engagement in HIV care. *Journal of Acquired Immune Deficiency Syndromes* (1999), 63(3), 362. doi:10.1097/QAI.0b013e318295b86a [PubMed: 23591637]
- Fox MP , & Rosen S (2010). Patient retention in antiretroviral therapy programs up to three years on treatment in sub-Saharan Africa, 2007–2009: Systematic review. *Tropical Medicine & International Health*, 15(s1), 1–15. doi:10.1111/j.1365-3156.2010.02508.x
- Frosch DL , May SG , Rendle KAS , Tietbohl C , & Elwyn G (2012). Authoritarian physicians and patients' fear of being labeled “difficult” among key obstacles to shared decision making. *Health Affairs*, 31(5), 1030–1038. doi:10.1377/hlthaff.2011.0576 [PubMed: 22566443]
- Garcia-Williams A , Brinsley-Rainisch K , Schillie S , & Sinkowitz-Cochran R (2010). To ask or not to ask?: The results of a formative assessment of a video empowering patients to ask their health care providers to perform hand hygiene. *Journal of Patient Safety*, 6(2), 80–85. doi:10.1097/PTS.0b013e3181cb43c9 [PubMed: 22130348]
- Geng EH , Odeny TA , Lyamuya R , Nakiwogga-Muwanga A , Diero L , Bwana M , ... Bukusi E (2015). Retention in care and patient-reported reasons for undocumented transfer or stopping care among HIV-infected patients on antiretroviral therapy in Eastern Africa: Application of a sampling-based approach. *Clinical Infectious Diseases*, 62, civ1004.
- Gourlay A , Birdthistle I , Mburu G , Iorpenda K , & Wringe A (2013). Barriers and facilitating factors to the uptake of antiretroviral drugs for prevention of mother-to-child transmission of HIV in sub-Saharan Africa: A systematic review. *Journal of the International AIDS Society*, 16(1), 18588. doi: 10.7448/IAS.16.1.18588 [PubMed: 23870277]
- Gourlay A , Wringe A , Birdthistle I , Mshana G , Michael D , & Urassa M (2014). “It Is Like That, We Didn't Understand Each Other”: Exploring the influence of patient-provider interactions on prevention of mother-to-child transmission of HIV service use in rural Tanzania. *PLoS ONE*, 9(9), e106325. doi:10.1371/journal.pone.0106325 [PubMed: 25180575]
- Haggerty JL , Roberge D , Freeman GK , & Beaulieu C (2013). Experienced continuity of care when patients see multiple clinicians: A qualitative metasummary. *The Annals of Family Medicine*, 11(3), 262–271. doi:10.1370/afm.1499 [PubMed: 23690327]
- Halbesleben JRB , & Rathert C (2008). Linking physician burnout and patient outcomes: Exploring the dyadic relationship between physicians and patients. *Health Care Management Review*, 33(1), 29–39. doi:10.1097/01.hmr.0000304493.87898.72 [PubMed: 18091442]
- Hassan AS , Fielding KL , Thuo NM , Nabwera HM , Sanders EJ , & Berkley JA (2012). Early loss to follow-up of recently diagnosed HIV-infected adults from routine pre-ART care in a rural district hospital in Kenya: A cohort study. *Tropical Medicine & International Health*, 17(1), 82–93. doi: 10.1111/j.1365-3156.2011.02889.x [PubMed: 22943164]
- Joseph-Williams N , Elwyn G , & Edwards A (2014). Knowledge is not power for patients: A systematic review and thematic synthesis of patient-reported barriers and facilitators to shared decision making. *Patient Education and Counseling*, 94(3), 291–309. doi:10.1016/j.pec.2013.10.031 [PubMed: 24305642]
- Karcher H , Omondi A , Odera J , Kunz A , & Harms G (2007). Risk factors for treatment denial and loss to follow-up in an antiretroviral treatment cohort in Kenya. *Tropical Medicine & International Health*, 12(5), 687–694. doi:10.1111/j.1365-3156.2007.01830.x [PubMed: 17445136]
- Kelly SL , & Wilson DP (2015). HIV cascade monitoring and simple modeling reveal potential for reductions in HIV incidence. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 69(3), 257–263. doi:10.1097/QAI.0000000000000655 [PubMed: 25886932]
- Luxford K , Safran DG , & Delbanco T (2011). Promoting patient-centered care: A qualitative study of facilitators and barriers in healthcare organizations with a reputation for improving the patient experience. *International Journal for Quality in Health Care*, 23(5), 510–515. Retrieved from <http://intqhc.oxfordjournals.org/content/23/5/510.abstract> [PubMed: 21586433]
- Mann M , Diero L , Kemboi E , Mambo F , Rono M , Injera W , ... Sidle J (2013). Antiretroviral treatment interruptions induced by the Kenyan postelection crisis are associated with virological failure. *Journal of Acquired Immune Deficiency Syndromes* (1999), 64(2), 220. doi:10.1097/QAI.0b013e31829ec485 [PubMed: 24047971]

- Merten S , Kenter E , McKenzie O , Musheke M , Ntalasha H , & Martin-Hilber A (2010). Patient-reported barriers and drivers of adherence to antiretrovirals in sub-Saharan Africa: A meta-ethnography. *Tropical Medicine & International Health*, 15(s1), 16–33. doi:10.1111/j.1365-3156.2010.02510.x [PubMed: 20586957]
- Mûnene E , & Ekman B (2015). Association between patient engagement in HIV care and antiretroviral therapy medication adherence: Cross-sectional evidence from a regional HIV care center in Kenya. *AIDS Care*, 27(3), 378–386. doi:10.1080/09540121.2014.963020 [PubMed: 25298265]
- NACC. (2014). Kenya AIDS response progress report 2014: Progress towards zero. Nairobi, Kenya: Author Retrieved from http://www.unaids.org/sites/default/files/country/documents/KEN_narrative_report_2014.pdf
- Ochieng-Ooko V , Ochieng D , Sidle JE , Holdsworth M , Wools-Kaloustian K , Siika AM , ... Braitstein P (2010). Influence of gender on loss to follow-up in a large HIV treatment programme in western Kenya. *Bulletin of the World Health Organization*, 88(9), 681–688. doi:10.2471/BLT.09.064329 [PubMed: 20865073]
- Odiambo JO , Kellogg TA , & Kim AA (2014). Antiretroviral treatment scale-up among persons living with HIV in Kenya: Results from a nationally representative survey. *Journal of Acquired Immune Deficiency Syndromes* (1999), 66(Suppl 1), S116. doi:10.1097/QAI.0000000000000122 [PubMed: 24732815]
- Pilnick A , & Dingwall R (2011). On the remarkable persistence of asymmetry in doctor/patient interaction: A critical review. *Social Science and Medicine*, 72(8), 1374–1382. doi:10.1016/j.socscimed.2011.02.033 [PubMed: 21454003]
- Posse M , Meheus F , Van Asten H , Van Der Ven A , & Baltussen R (2008). Barriers to access to antiretroviral treatment in developing countries: A review Obstacles à l'accès aux traitements antirétroviraux: Une revue des récentes études dans les pays en développement Barreras al acceso al tratamiento antirretroviral: Una revis. *Tropical Medicine & International Health*, 13(7), 904–913. doi:10.1111/j.1365-3156.2008.02091.x [PubMed: 18466183]
- Rathert C , Wyrwich MD , & Boren SA (2012). Patient-centered care and outcomes: A systematic review of the literature. *Medical Care Research and Review*. doi:10.1177/1077558712465774
- Reda AA , & Biadgilign S (2012). Determinants of adherence to anti-retroviral therapy among HIV-infected patients in Africa. *AIDS Research and Treatment*, 2012, 1–8.
- Rowe K , & Moodley K (2013). Patients as consumers of health care in South Africa: The ethical and legal implications. *BMC Medical Ethics*, 14(1), 15. doi:10.1186/1472-6939-14-15 [PubMed: 23514130]
- Tierney WM , Rotich JK , Hannan TJ , Siika AM , Biondich PG , Mamlin BW , ... Sidle JE (2007). The AMPATH medical record system: Creating, implementing, and sustaining an electronic medical record system to support HIV/AIDS care in western Kenya. *Studies in Health Technology and Informatics*, 129(1), 372. [PubMed: 17911742]
- Vreeman RC , Nyandiko WM , Ayaya SO , Walumbe EG , Marrero DG , & Inui TS (2009). Factors sustaining pediatric adherence to antiretroviral therapy in western Kenya. *Qualitative Health Research*, 19(12), 1716–1729. doi:10.1177/1049732309353047 [PubMed: 19949221]
- Wachira J , Middlestadt S , Reece M , Peng C-YJ , & Braitstein P (2013). Psychometric assessment of a physician-patient communication behaviors scale: The perspective of adult HIV patients in Kenya. *AIDS Research and Treatment*, 2013, 1–10. doi:10.1155/2013/706191
- Wachira J , Middlestadt S , Reece M , Peng C-YJ , & Braitstein P (2014). Physician communication behaviors from the perspective of adult HIV patients in Kenya. *International Journal for Quality in Health Care*, 26(2), 190–197. doi:10.1093/intqhc/mzu004 [PubMed: 24519123]
- Wachira J , Naanyu V , Genberg B , Koech B , Akinyi J , Kamene R , ... Braitstein P (2014). Health facility barriers to HIV linkage and retention in Western Kenya. *BMC Health Services Research*, 14(1), 646. doi:10.1186/s12913-014-0646-6 [PubMed: 25523349]
- Zachariah R , Ford N , Philips M , Lynch S , Massaquoi M , Janssens V , & Harries AD (2009). Task shifting in HIV/AIDS: Opportunities, challenges and proposed actions for sub-Saharan Africa. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 103(6), 549–558. doi:10.1016/j.trstmh.2008.09.019 [PubMed: 18992905]

Table 1.

Distribution of participants by site and provider type

Provider type	Sites			Total
	MTRH	Webuye	Busia	
Clinical officers	8	4	4	16
Nurses	11	3	4	18
HIV counselor	3	2	2	7
Support workers	8	6	5	19
Total				60