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BMJ Open

Determinants of adherence and consequences of the transition from adolescence to adulthood among young people with severe haemophilia (TRANSHEMO): Study Protocol

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	Manuscripts

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ARTICLE SUMMARY

Abstract

Introduction: Severe haemophilia is a rare disease characterised by spontaneous bleedings from early childhood, which may lead to various complications especially in joints. It is nowadays possible to avoid these complications thanks to substitutive therapies for which the issue of adherence is major. The transition from adolescence to adulthood in young people with severe haemophilia is a critical period as it is associated with a high risk of lack of adherence to health care, which might have serious consequences on daily activities but also on quality of life.

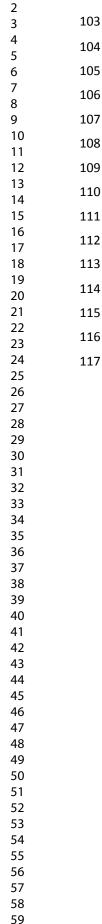
Methods and analysis: We present the protocol for a cross-sectional, observational, multicentric study to assess the impact of transition from adolescence into adulthood, especially on adherence to health care, among young people with severe haemophilia in France. This study in based on a mixed method, with two complementary and consecutive phases, comparing data from a group of adolescents (aged 14-17 years) to those from a group of young adults (aged 20-29 years). The quantitative phase focuses on the determinants (medical, organisational, socio-demographic and social, and psychosocial and behavioural factors) of adherence to health care (considered as a marker of the success of transition). The qualitative phase focuses on a more deeply assessment of the psychological mechanisms involved in the transition process for few patients. Eligible patients are contacted by the various Haemophilia Treatment Centres participating in the French national registry FranceCoag

Ethics and dissemination: The study was approved by the French Ethics Committee and by the French National Agency for Medicines and Health Products Safety (number: 2016-A01034-47). Study findings will be disseminated to the scientific and medical community in peer-reviewed journals and presented at scientific meetings. Results will be popularised to be communicated via the French association for people with haemophilia to participants and to the general public.

Adherence / Haemophilia / Transition / Adolescents / Young adults

- Trial registration number: NCT02866526

- Word count: 300
- - Keywords



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103 Strengths and limitations of this study

- 104 The comparison of experiences reported by adolescents compared to those reported by young 105 adults will allow to assess the impact of transition especially on adherence to health care 106 among young people with haemophilia (YPWH) through a cross-sectional study.
- 107 The backing of the French national registry FranceCoag will allow to assess the issue of 108 transition in a large population of YPWH.
 - 109 The mixed method of this study will bring original and complementary results by combining 110 quantitative and qualitative methods.
- 111 Determinants of adherence to health care considered as a marker of the success of transition will include classic factors (medical, organisational, and socio-demographic), but also more 112 113 original ones (social, psychosocial and behavioural).
- 114 Results will serve as the basis to propose recommendations and to develop interventions in 115 order to facilitate the transition process in YPWH. e the tran

Word count: 137 117

1 2		
3	118	INTRODUCTION
4 5	119	Haemophilia is a rare and inherited disorder (X-linked recessive transmission), affecting mainly males
6	120	(annual incidence: 1/5,000 male births).[1] It is characterized by bleedings due to a lack of clotting
7 8	121	factors (factor VIII (FVIII) for haemophilia A or factor IX (FIX) for haemophilia B). Bleedings often
9	122	start in early life, due to psychomotor skills acquisition. Seriousness of the symptoms depends on the
10 11	123	severity of the lack of FVIII/FIX. Severe haemophilia, defined by a biological activity of FVIII/FIX
12	124	lower than 1%, is characterized by spontaneous bleedings most frequently located into the joints
13 14	125	(haemarthroses) and into the muscles (haematoma). Natural history of untreated severe haemophilia is
15	126	marked by serious haemorrhagic events which compromise the vital prognosis. Insufficiently treated,
16 17	127	repetition of haemarthroses and haematoma results in invalidating motor disability.
17	128	It is nowadays possible to avoid these complications thanks to substitutive therapies for which the
19 20	129	issue of adherence is major, and to a lifelong regular clinical follow-up. Successive stages of the
20	130	disorder's care management have been described by Young,[2] including:
22	131	- The adolescence: independence and responsibility for disease management, self-advocacy and
23 24	132	disclosure, importance of treatment adherence, transfer of responsibilities from the caregivers
25	133	to the patient
26 27	134	- The adulthood: decide whether to continue prophylaxis, challenge of dealing with a chronic
28	135	disease and becoming one's own caregiver
29 30	136	The success of the transition from adolescence to adulthood may therefore be crucial in the
31	137	maintenance of adherence to care.
32 33	138	
34	139	In the context of chronic diseases, the process of transition may be more complicated, as affected
35 36	140	young people have to deal with a supplementary transition, from a paediatric health care system to an
37	141	adult one.[3, 4] Indeed, a successful transition involves a transfer of responsibilities from parents to
38 39	142	patients concerning the management of their health, the acquisition of the knowledge, abilities, and
40	143	self-reliance necessary to take on autonomy as well as the new roles people expect them to endorse as
41 42	144	adults.[5-8] Experiencing a difficult transition could be associated with a decrease in the level of
43	145	adherence to care, but it might also impair quality of life and the entry into adulthood.[9, 10] In the
44 45	146	framework of several chronic diseases (apart from haemorrhagic diseases), some studies highlighted
46	147	barriers or facilitators to successful transition, either associated to the young patients, or to their
47 48	148	parents, or to the various actors of the health care system.[11-14] Authors especially underlined
49	149	psychosocial factors such as knowledge, skills, beliefs, expectations, goals, relationships, fears, need
50 51	150	for control, emotional dependency, over-protectiveness, heightened awareness of health issues, lack of
52	151	trust in caregivers.[15-17]
53 54	152	
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In the specific context of haemophilia, some studies have been conducted to assess the issue of transition in young people with haemophilia (YPWH).[18] A study comparing quality of life in YPWH in pre-transition period with YPWH in post-transition period showed a lower quality of life and a higher level of distress in YPWH in post-transition period.[19] Some recommendations (involving patients, families, and caregivers) have been proposed to facilitate this process.[20-22] However, despite the setting up of some actions which have been shown to improve the disease specific knowledge, [23, 24] difficulties are still remaining, which may impair the health condition and the quality of life of YPWH.[25, 26] A study on the unmet needs reported by young adults highlighted psychological issues mainly related to independence achievement.[27] At the crucial age at which adolescents are often opposed or want to take their own decisions, maintaining the adherence to clinical follow-up and therapies is an important issue. Studies have shown a decrease in the level of adherence to the prescribed therapeutic regimen during transition (from 90% for the youngest patients (0-12 years) to 54% for those aged 13-18 years and to 36% for those aged 19-28 years; [28] 59% in another study in YPWH (13-25 years)[29]). This lower adherence might have serious consequences, such as haemarthroses which may impair daily activities but also quality of life. Some psychosocial factors of the maintenance of a high adherence have been highlighted, e.g. a greater perception of the need for prophylaxis than the concern over taking it, a positive expectancy of its effectiveness, a good social support, and a stronger emotional reaction to having haemophilia.[30] Even if some literature data exists on the issue of transition and its impact on adherence to health care

in the context of haemophilia, some limits may be discussed. The sample size of these studies is generally modest (below or about a hundred of patients).[30-32] An international larger study including 230 YPWH was conducted but all of them were young adults (aged 18-30 years), none were adolescents.[26] Adherence is usually assessed only through adherence to prophylactic treatment, which excludes YPWH under on-demand treatment.[30-32] None of these studies has been carried out in France where the features of the health care system are very specific. An international study showed that cost was a frequent reported barrier to prophylaxis (about 45% by both nurses from Haemophilia Treatment Centres and patients perspectives).[28] Thus, the assumption of all disease-related costs by the French social security system might influence the adherence to care. The backing of the French national registry FranceCoag[33] will allow to assess this issue in a large and exhaustive population of YPWH. This registry involves for more than 20 years French Haemophilia Treatment Centres (HTC), and it includes more than 10,000 patients (7,000 people with haemophilia (PWH), with 2,300 with severe haemophilia of all ages). Moreover, even if some psychological data have been related to the adherence to care, they are often analysed as independent factors. Taking into account the interdependence between these factors using adapted methods could bring original results. Finally, a mixed-design study combining quantitative and qualitative methods will allow to address in a global

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OBJECTIVES The main objective of this study is to assess the impact of transition from adolescence into adulthood especially on adherence to health care, among young people with severe haemophilia in France. The operational objectives of this study are: to compare the level of adherence in adolescents and in young adults (YA) to identify determinants (medical, organisational, socio-demographic and social, and _ psychosocial and behavioural factors) of the level of adherence in YPWH, to assess specific factors involved in suboptimal level of adherence in the sub-groups of adolescents on one hand and of YA on the other hand, to identify groups of patients (clusters) regarding both their level of adherence and their psychosocial characteristics, to examine trough a qualitative approach YPWH needs and expectations towards the health care system during the transition process, and to identify some ways to improve their global care.

2 3	206	METHODS/DESIGN
4 5	207	Study design
6	208	This study is designed as a multicentric (29 HTC from FranceCoag), observational, cross-sectional
7 8	209	study, based on a mixed method, with two complementary and consecutive phases:
9	210	- The quantitative phase focuses on the determinants of the level of adherence to health care
10 11	211	(considered as a marker of the success of transition), and compares data from a group of
12	212	adolescents to those from a group of YA,
13 14	213	- The qualitative phase focuses on a more deeply assessment of the psychological mechanisms
15	214	involved in the transition process for few patients selected from the quantitative phase.
16 17	215	
18 19	216	Participants O
20	217	Inclusion criteria
21 22	218	 Patients with severe A or B haemophilia (deficiency <1%)
23	219	 Patients affiliated to the French social security system and included in the FranceCoag registry
24 25	220	 Patients followed in one of the 29 participating HTC
26	221	- Patients aged 14-17 years (adolescents group), or aged 20-29 years (YA group)
27 28	222	- Adolescents authorised to participate by their parents or their legal representatives, or YA who
29	223	give their consent to participate in this study
30 31	224	
32	225	Non-inclusion criteria
33 34	226	 Vulnerable patients (adults under guardianship, pregnant or nursing women)
35	227	 Patients with reading and writing difficulties
36 37	228	
38	229	Period of the study
39 40	230	The planned duration of the study is 30 months. Inclusions started in February 2017. The quantitative
41	231	phase will go on for 18 months, the qualitative phase will go on for 10 months, and the last two
42 43	232	months will focus on results valorisation.
44	233	
45 46	234	Quantitative phase
47	235	Main evaluation criterion
48 49	236	The main evaluation criterion is the adherence to clinical follow-up and prophylactic treatment (an
50	237	hypothesized marker of the success of transition into adulthood), which will be assessed via the
51 52	238	following items:
53	239	- number of follow-up visits in agreement with the recommended number over the last two
54 55	240	years,
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2 3	241	- number of prophylactic treatment injections in agreement with the recommended number over
4 5	242	the last three months (if applicable),
6	243	 number of haemorrhagic events over the last two years,
7 8	244	- physician-reported adherence to clinical follow-up and to prophylactic treatment (if
8 9	245	applicable),
10 11	246	- patient-reported adherence to clinical follow-up and to prophylactic treatment (if applicable).
12	247	Each item will be dichotomized, and a composite quantitative endpoint will be constructed taking into
13 14	248	account all these dichotomized items. This composite quantitative endpoint will in turn be
14	249	dichotomized to define adherent / non adherent participants (main evaluation criterion).
16 17	250	
17 18	251	Secondary evaluation criteria
19 20	252	Each item which is part of the composite endpoint as described hereinabove will be considered in an
20 21	253	independent manner as a secondary evaluation criterion.
22	254	
23 24	255	Explanatory collected data
25	256	Medical data
26 27	257	Medical data will include: deficit characterisation, diagnosis (age at diagnosis, circumstances of
28	258	diagnosis, family history), viral diseases (HIV, HBV, HCV), comorbidities (intracranial haemorrhage,
29 30	259	major orthopaedic interventions, major disability, cancer, other chronic pathology), previous and
31	260	current treatment.
32 33	261	
34	262	Organisational data (Haemophilia Treatment Centres-reported)
35 36	263	Organisational data will include: paediatric / adult / paediatric and adult HTC, physicians' speciality,
37	264	mean age of the transition from paediatric care to adult one, consultations dedicated to the transition,
38 39	265	common consultations with both paediatric and adult medical teams, specific tools set up to facilitate
40	266	the transition process (information leaflet, therapeutic patient education).
41 42	267	
43	268	Socio-demographic and social data
44 45	269	 Gender and age of family members, living situation,
46	270	- Socio-professional category, socio-economic status assessed by the Family Affluence
47 48	271	Scale),[34]
49	272	– Distance to the HTC (in km),
50 51	273	 Membership of French patients association for PWH (AFH),
52	274	- Family functioning (structure, organisation, and communication) assessed by the French
53 54	275	validated version of the 6-items Family Assessment Device,[35-37]
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Schooling and academic success evaluated by ad-hoc items (schooling type, level of education, academic difficulties), Relationships with the health care system assessed using ad-hoc items (satisfaction and expectations towards the health care system, participation in therapeutic patient education programme). Psychosocial and behavioural data Ouality of life will be assessed using the validated French version of the SF-12 generic scale.[38] Two sub-scores, mental health and physical health, will be calculated. The SF-12 allows assessing the quality of life of adults as well as adolescents (14+ years). Quality of life of adolescents will also be assessed by the validated French version of the 10-items Kidscreen Index, which explores the following domains: physical well-being, psychological well-being, autonomy and relations with parents and home life, peers and social support, and school environment.[39] Haemophilia-specific quality of life will be assessed in all participants using the validated French short version of the Haemo-Qol questionnaire.[40, 41] Time perspective will be assessed using the Past Negative (PN) and Future (F) subscales of the French validated version of the Zimbardo time perspective inventory.[42, 43] The PN subscale (9 items) reflects a pessimistic attitude towards the past and the experience and memory of traumatic life events. The F subscale (12 items) reflects an orientation towards future and an attitude of planning and achievement of objectives. To avoid the questionnaire being too long, we will not plan to assess the Past-Positive, Present-Hedonistic, and Present-Fatalistic subscales. Coping Strategies will be measured by the validated French version of the Brief-Cope

- Coping Strategies will be measured by the validated French version of the Brief-Cope
 scale[44, 45] which consists of 28 items assessing individuals' use of 14 coping strategies:
 self-distraction, active coping, denial, drug use, emotional social support seeking, instrumental
 social support seeking, behavioural disengagement, emotional expression, positive reframing,
 planning, humour, acceptation, religion, and self-blame.
 - Autonomy will be assessed using ad-hoc items only proposed in the YA questionnaire
 (financial independence from the parents, and living, management of health, dealing with
 administrative tasks, and taking holidays without the parents). The 15-items Noom validated
 questionnaire[46, 47] assessing attitudinal autonomy, emotional autonomy, and functional
 autonomy will be proposed to all participants (ad-hoc translation for this study).

Data collection procedure Main medical data will be extracted from the FranceCoag database, and completed by a short questionnaire filled in by the referent physician from each HTC. Organisational data will be completed by a medical representative from each HTC. Participants' self-reported data will be collected through a standardised booklet including several questionnaires (an adolescent version and a YA version). Survey documents (information sheet, informed consent and booklet) will be sent by post to eligible YPWH. If no response is received within 30 days, a reminder letter will be sent. A second reminder letter and all survey documents along will be sent two months later in case of no response. Sample size justification According to the exhaustive FranceCoag database and considering the specific inclusion criteria of the TRANSHEMO study (severe A or B haemophilia, patients aged 14-17 or 20-29 years, followed in one of the 29 participating HTC), 154 adolescents and 389 YA are eligible for this study. We hypothesised a difference of 20% between adolescents and YA regarding the main evaluation criterion (90% of adherence to health care in adolescents vs 70% in YA). Then, under the hypothesis of a non-response rate of 30%, and considering a bilateral alpha risk of 5%, the power of this study would reach 99%.[48, 49] Data Management A specific database will be created using EpiData software, and merged with the FranceCoag database. A process will be used to assign to each participant a unique anonymous number. A data quality control will be performed by a physician to limit data inconsistency. Analysis The analysis plan and the final report will be written according to the STROBE recommendations.[50, 51] All analyses will be performed using R software. All tests will be two-sided, and p < .05 will define statistical significance. Analysis populations The analysis populations will be the adolescents and the YA groups, among whom adherent and non-adherent patients will be identified. Descriptive analysis A descriptive analysis will first be performed. Qualitative variables will be presented as numbers and percentages, quantitative variables as means and standard deviations, or as medians and interquartile ranges. Subjective data will be described by their overall scores and their sub-scores.

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Reasons for non-inclusion will be listed. Included patients will be compared to non-included eligible
patients using basic socio-demographic and clinical data, available in the FranceCoag database.

Comparative analysis *Crude analysis* Adherence will first be described by groups (adolescents / YA) using classical indicators. The comparison of adherence between the two groups will be performed using chi-square test (or Fisher test depending on the expected numbers) for the main evaluation criterion and for all qualitative secondary evaluation criteria, and using Student t test (or Mann-Whitney test depending on normality of the distribution) for quantitative secondary evaluation criteria. Adjusted analysis In order to identify factors associated with adherence, bivariate and multivariate analyses will be performed. Potential determinants (medical, organisational, socio-demographic and social, psychosocial and behavioural factors) will be proposed as explanatory variables. Logistic regression models will be used for the main evaluation criterion and for all qualitative secondary evaluation criteria, and linear regression models will be used for quantitative secondary evaluation criteria. Each characteristic whose degree of significance will be lower than .20 will be considered for multivariate

analyses. A backward selection will be applied to retain only significantly associated characteristics. Multilevel models will be used to take into account organisational factors which are related to the centre. Structural equation modelling will be considered to take into account the collinearity and/or the complex relationships which might exist between explanatory individual characteristics (especially social, psychological and behavioural ones).[52-54]

- This analysis will first be performed in the overall population with a forced adjustment on the group
 (adolescent / YA). It will secondly be performed independently in each of the two groups.

Cluster analysis

In order to bring to light particular profiles of adherent / non adherent in adolescents on one hand, and
in YA on the other hand, an exploratory unsupervised classification analysis will be performed.[55,
56] This method which does not require any condition of validity will allow to gather patients with
similar profiles in homogeneous clusters.

- - 380 Qualitative phase

381 Data collection procedure

Few subjects (adolescents on one hand and YA on the other hand) who will have participated in the quantitative phase will be selected for this phase according to the following characteristics: adherent or not, and under prophylaxis or not. If they agree, they will be contacted to participate in research

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interviews conducted by a psychologist, at any place at their convenience (at home, at the HTC...).

386 The interviews will be individual, confidential, semi-structured, and tape-recorded.

The psychologist will start with a general question, then he/she will adopt a non-directive attitude and will allow the participant to spontaneously and freely broach the answers which they consider relevant. Then he/she will summarise the response and introduce more precise questions regarding the topics which will have not been covered spontaneously or sufficiently by the participant. He/she will seek to focus the interview on the participant's personal experiences, subjective perceptions, and expectancies.

Adolescents' interviews

The interview will begin with this general question: "How do you feel about coming into adulthood in a few years?"

After the spontaneous answer, the psychologist will make them talk about the following topics: the meaning they give to becoming a YA; their expectations towards their life (personal and professional) as future YA; their fears towards their entry into adulthood; their plan to care about their health as future YA.

Young adults' interviews

403 The interview will begin with this general question: "How do you feel about reaching adulthood404 during the last few years?"

After the spontaneous answer, the psychologist will make them talk about the following topics: the
meaning they give to becoming a YA; their experienced difficulties towards the acquisition of their
autonomy (especially concerning the management of their health) and the construction of their life
(personal and professional); the facilitators and barriers they identified during their transition process.

Then, to go further and broaden these qualitative data, the psychologist will show to these participants a summary of the adolescents' expectations towards adulthood (from the interviews conducted in adolescents, which therefore will be carried out and analysed before those in YA). The psychologist will then ask YA to assess: to what extent these perceptions match with their own expectations when they were adolescents; to assess to what extent these perceptions match with their current lives; and to indicate which issues regarding transition adolescents forget to mention.

416 Sample size justification

Four profiles will be identified from the two selected characteristics (adherent or not, and under
prophylaxis or not). On the basis of three interviews by profile, up to 12 adolescents and 12 YA will
be selected for the qualitative phase (enrolments until information is saturated).

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422 Data management

423 All interviews will be precisely and entirely transcribed, including the participants' hesitations and424 self-corrections.

426 Analysis

The psychologist will analyse adolescents' interviews on one hand and YA ones on the other hand, using Interpretative Phenomenological Analysis (IPA) method. This method allows to comprehend the participants' subjective experiences through the analysis they make of (and the meaning they give to) their feelings and states, as well as the specific events they are faced with. It makes possible to highlight sociocognitive processes by which personal experiences are assimilated to individuals' perceptions of both themselves and the world they live in.[57, 58]

IPA of an interview is made of four iterative stages. During the first stage, the psychologist will read the interview several times, annotating, summarising, paraphrasing, and commenting on what is interesting or significant. The second stage will consist in encoding those annotations to a slightly higher level of abstraction by theoretical and scientific elements: the psychologist will underline the themes addressed by the participant. At the third stage, the psychologist will try to connect these themes by grouping them into superordinate clusters while checking that the connections they make match the meaning of the participant's speech. The last stage of the analysis will consist in giving a scientific meaning to the established clusters.

The same method will be used for all participants within each group, with the permanent goal of improving the previously identified clusters. Each time a new element is identified, or each time a theme or a cluster is modified, the psychologist will get back to previously analysed interviews to ensure that the new model accounts for the speech of all participants.

Finally, when all interviews will have been analysed, a summary will be made, by underlining
similarities and differences between adolescents and YA regarding transition into adulthood and its
consequences on their lives.

Analyst triangulation will be performed,[59, 60] by involving two psychologists in reviewing the
findings in order to assess the reliability and validity of the obtained results. This triangulation may
also allow to develop a broader and deeper understanding of the results.

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452 DISCUSSION AND LIMITATIONS

453 Strengths and limitations of the database

As the issues concerning transition into adulthood may intrinsically depend on features of the health care system, we intend to explore the specific perceptions of YPWH in France, whose health care system model is specific. The support of the FranceCoag registry to this study is therefore an important strength. While the exhaustivity of inclusions in this registry might have been an issue for patients with moderate or minor haemophilia, the exhaustivity concerning patients with severe haemophilia is guaranteed since 2000. Even if five HTC over the 34 active ones (i.e. 15%) did not accept to participate in the TRANSHEMO study, the loss of eligible patients was small (only 4% of the eligible YPWH). The comparison of basic socio-demographic and medical data, available in the FranceCoag database, between included patients and non-included eligible patients will allow to discuss the representativeness of the included sample.

465 Strengths and limitations of the study design

The quantitative phase of this study is cross-sectional, while it would have been pertinent to design a longitudinal study to follow up YPWH during their transition. However, as this process is long,[2] it would have been very time consuming, with a high risk of lost to follow-up. We therefore chose to compare at a unique time the experiences of two groups regarding their status towards transition. If the results of the present cross-sectional study turned out to be singular, they could justify to secondly set a longitudinal study up.

The mixed study design,[61, 62] by combining quantitative and qualitative methods, will bring original results. The first quantitative phase will allow to adjust the second qualitative phase, by the targeted selection of participants (adherent / non adherent participants according to main evaluation criterion) and by bringing results to be discussed with participants. The qualitative phase will then allow to shed light on the results from the quantitative phase by a deeper analysis of participants' experiences. This qualitative phase could also be a starting point for a future longitudinal and quantitative study, by highlighting unexplored processes by the present quantitative phase.

480 Strengths and limitations of the endpoints

The main objective of the study is to assess the impact of transition from adolescence to adulthood, which we chose to measure by the level of adherence to health care. This choice is debatable, as maintaining a high level of adherence to care probably reflects only a part of the success of the transition process. However, this choice is justified by several arguments: (i) it is necessary to propose an endpoint which applies for both adolescents and YA, in order to be able to assess through a transversal study the potential impact of the transition on a common endpoint, (ii) a decrease of adherence during the transition process may be associated with clinical consequences (serious Page 19 of 27

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bleedings), which may impair physical and psychological quality of life in YPWH, (iii) this endpoint
allows to assess more specifically the impact of the supplementary transition experienced by YPWH, a
transition from a paediatric health care system to an adult one, and (iv) this endpoint may be accessible
for educational actions.

Adherence is a concept which might be defined by the agreement between the behaviour of a patient and the received recommendations or prescriptions.[63] We chose to assess adherence to prophylactic treatment, which is the commonly used evaluation criterion when assessing adherence in haemophilia[29, 30] but which would have been valid only for YPWH under prophylactic treatment. We therefore also chose to assess adherence to clinical follow-up, which is valid for all YPWH (even if the rhythm of visits might be different depending on their personal situation). Moreover, we chose to collect data on adherence through three sources of information: (i) data from the FranceCoag database (follow-up visits, injections of prophylactic treatment, haemorrhagic events), (ii) referent physician-reported data, and (iii) patient-reported data. A composite endpoint combining these items will allow to take into account the complexity of the assessment of adherence, in particular by mixing clinical and objective data with behavioural and subjective adherence-related data.

504 Strengths and limitations of the determinants

505 This study will assess more systematically psychosocial determinants of adherence to health care, 506 considered as a marker of the success of transition. Indeed, beyond the likely impacts of medical, 507 organisational, and socio-demographic factors, we expect this success to be moderated by lesser 508 known sociocognitive (time perspective), emotional (coping strategies), and family factors (family 509 functioning).

510 Time perspective refers to how individuals partition their experiences into distinct temporal categories 511 of past, present and future.[64] Particular temporal frames may be associated with well-being and 512 quality of life.[65] Indeed, focusing on a "past negative" time perspective may result in negative long-513 term adjustment and post-traumatic stress symptomology.[66] On the contrary, "future" time 514 perspective has been viewed as the more constructive time perspective.[65]

Moreover, people (patients and relatives) faced with a severe chronic childhood disease generally experience repeated stress reactions because the disease questions individuals about their beliefs, identity, priorities, and short-term and long-term goals.[67, 68] The coping strategies individuals implement to deal with these stress reactions have been studied. Studies show that an individual's inability to implement appropriate coping strategies, or the use of strategies targeting only emotional responses (instead of their cognitive antecedents), are responsible for emotional disorders and impaired familial and social relationships. On the contrary, long-term well-being may be facilitated by the use of coping strategies which allow people restructuring their concepts, beliefs, values, priorities, standards, and personal goals.[68-72]

Finally, growing into adulthood implies that young people gain autonomy, get independent and endorse the responsibilities falling to adults. This personal empowerment implies that they develop their own personal values and long-term goals (attitudinal autonomy) and implement effective strategies to achieve these goals (functional autonomy). However, this ability to develop autonomy depends on the capacity to maintain confidence in one's own values and goals (emotional autonomy).[46, 73] We assume the development of autonomy (especially emotional autonomy) largely depends on the family functioning: parenting style, cohesiveness, flexibility, roles management, and communication of emotion.[74-77]

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532 ETHICS

Informed written consent will be obtained for all participants prior to recruitment for the study. For
adolescents, consent will be obtained from their two parents or legal representatives. All data will be
analysed confidentially and anonymously.

The study was designed according to Good Clinical Practices, and all procedures will be in accordance
with the Declaration of Helsinki. The study was approved by the French Ethics Committee (Comité de
Protection des Personnes Sud Méditerranée V) on 8th November 2016 and by the French National
Agency for Medicines and Health Products Safety on 22th September 2016 (reference number ID
RCB: 2016-A01034-47). The protocol was registered in ClinicalTrials.gov (NCT02866526).

DISSEMINATION

This study will allow to comprehend what the impact of transition from adolescence to adulthood could be in YPWH in France, which is of particular interest in the global approach whose goal is to take care of all aspects of life in patients with chronic diseases.

This study will also allow to identify determinants of adherence, considered as a marker of a successful transition in YPWH. The assessment of social, psychosocial and behavioural data, will allow to describe the socio-cognitive processes which may facilitate or complicate adherence, while taking into account other factors, *i.e.* medical, organisational, and socio-demographic factors. The results obtained from the quantitative phase of the study will be enlightened by the analysis of the interviews conducted in the qualitative phase. This analysis will bring supplementary and complementary data which would not have been accessible via the analysis of the questionnaires, especially concerning expectations and fears about health, but also about personal and professional life. Singular results from this qualitative phase could be used to better design a future quantitative study on the issue of transition, by assessing complementary outcomes to those assessed in the present quantitative phase.

Results will allow to propose recommendations and to develop adapted and focused interventions to
compensate for YPWH difficulties, and thus optimize the adherence to the proposed follow-up and to
the prophylactic treatment, but also facilitate their entry in the adult life.

560 In order to assess the transferability of the results from the TRANSHEMO study in other contexts of 561 childhood chronic diseases in France, complementary projects could be proposed to assess the issue of 562 transition in young patients with rare and/or serious and/or chronic diseases. This approach would 563 allow to identify which issues are common to these diseases and which ones are specific to a disease, 564 including severe haemophilia. Common and specific actions could then be proposed to facilitate the 565 transition process and support young patients. BMJ Open: first published as 10.1136/bmjopen-2018-022409 on 25 July 2018. Downloaded from http://bmjopen.bmj.com/ on June 8, 2025 at Department GEZ-LTA Erasmushogeschool

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- **Authors' contributions** NR, ABA, KB, TL, HC, PA contributed to the design of this study and wrote this article. The investigators (LA, SB, CB, M-AB, CB-A, AB-D, SC, PC, SCD, EDR, DD, CF, BF, VG, JG, YG, BG, AH, AH, YH, TL, AL, AL, MM, SM, FM, GM, CN, PN, PN, CO, BP-P, BP, AR, AR, DR, PS, AS, CS, BT, MT, J-BV, SV, FV, AV-E, BW) of the French Haemophilia Treatment Centres contribute to enrol participants, they revised the manuscript and approved the final version. Members of steering committee (NR-D, VM, TS) contributed to the design of this study, they revised the manuscript and approved the final version. Acknowledgements The authors thank all collaborators who participate in the study: Kahéna AMICHI (AP-HM, France), Claire ARCE (AFH), Marie AUGAGNEUR (University Hospital of Brest, France), Linda BODET (University Hospital of Lyon, Hospital Edouard Herriot, France), Aurélie CADET (University Hospital of Reunion, Reunion Island, France), Amandine CELLI (University Hospital of Nantes, France), Carine CERATO-BLANC (University Hospital of Nice, France), Marie Agnès CHAMPIAT (University Hospital of Montpellier, France), Sylvie CHARBONNEAU (University Hospital of Tours, France), Céline CHENUEL (University Hospital of Nancy, France), Emilie COTTA (AFH), Guillaume DELAVAL (University Hospital of Caen, France), Stéphanie DELIENNE (University Hospital of Dijon, France), Jessica DOUAY (University Hospital of Limoges, France), Assia DOUICI (AP-HP, Hospital Bicêtre, France), Guillaume DRUGMANNE (University Hospital of Brest, France), Charlène DUPRE (Hospital of Chambery, France), Sylvie GERARD (University Hospital of Toulouse, France), Eva GLEIZES (University Hospital of Saint-Etienne, France), Isabelle GOESIN (University Hospital of Rennes, France), Nicolas GUERIN (University Hospital of Caen, France), Veronique HACKER (University Regional Hospital of Strasbourg, France), Havet IDDIR (University Hospital of Saint-Etienne, France), Stéphanie IMBERT (University Hospital of Bordeaux, France), Anne LECLERE (University Hospital of Reims, France), Sophie LE DORE (Hospital of Versailles, France), Anderson-Dieudonné LOUNDOU (AP-HM, France), Cécile MAIRE (University Hospital of Besancon, France), Catherine MARICHEZ (University Regional Hospital of Lille, France), Marcelline MATINGOU (AP-HP, Hospital Necker, France), Pascale PALAMARINGUE (University Hospital of Reims, France), Bénédicte PRADINES (University Regional Hospital of Lille, France), Laurence QUINIOU (Hospital of Versailles, France), Olivia RICK (University Regional Hospital of Strasbourg, France), Martine ROCHE (AP-HM, Children Hospital La Timone, France), Florence ROUSSEAU (University Hospital of Montpellier, France), Gwendoline ROY (University Hospital of Clermont-Ferrand, France), Isabelle SAVARY (University Hospital of Rouen, France), Pascale SENECHAL (University Hospital of Amiens, France), Maryse TAMBURRO (University Hospital of Reunion, Reunion Island, France).

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8 9	607	
10	608	Competing interests
11 12	609	None declared.
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Determinants of adherence and consequences of the transition from adolescence to adulthood among young people with severe haemophilia (TRANSHEMO): study protocol for a multicentric French national observational cross-sectional study.

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Primary Subject Heading :	Haematology (incl blood transfusion)
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Keywords:	Adherence, Haemophilia, Transition, Adolescents, Young adults



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2 3	1	TITLE
4 5	2	Determinants of adherence and consequences of the transition from adolescence to adulthood among
6	3	young people with severe haemophilia (TRANSHEMO): study protocol for a multicentric French
7 8	4	national observational cross-sectional study.
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72 ARTICLE SUMMARY

74 Abstract

75 Introduction: Severe haemophilia is a rare disease characterised by spontaneous bleeding from early 76 childhood, which may lead to various complications especially in joints. It is nowadays possible to 77 avoid these complications thanks to substitutive therapies for which the issue of adherence is major. 78 The transition from adolescence to adulthood in young people with severe haemophilia is a critical 79 period as it is associated with a high risk of lack of adherence to health care, which might have serious 80 consequences on daily activities but also on quality of life.

Methods and analysis: We present the protocol for a cross-sectional, observational, multicentric study to assess the differences between adolescents and young adults with severe haemophilia in France through the transition process, especially on adherence to health care. This study in based on a mixed methods design, with two complementary and consecutive phases, comparing data from a group of adolescents (aged 14-17 years) to those from a group of young adults (aged 20-29 years). The quantitative phase focuses on the determinants (medical, organisational, socio-demographic and social, and psychosocial and behavioural factors) of adherence to health care (considered as a marker of the success of transition). The qualitative phase explores participants' views in more depth to explain and refine the results from the quantitative phase. Eligible patients are contacted by the various Haemophilia Treatment Centres participating in the French national registry FranceCoag.

91 Ethics and dissemination: The study was approved by the French Ethics Committee and by the French 92 National Agency for Medicines and Health Products Safety (number: 2016-A01034-47). Study 93 findings will be disseminated to the scientific and medical community in peer-reviewed journals and 94 presented at scientific meetings. Results will be popularised to be communicated via the French 95 association for people with haemophilia to participants and to the general public.

Adherence / Haemophilia / Transition / Adolescents / Young adults

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 - 98 Word count: 299

- 100 Keywords

Strengths and limitations of this study This study will be the largest to assess the issue of transition from adolescence to adulthood among young people with haemophilia (PWH), and the first one in France where the features of the health care system are very specific. The cross-sectional design of the study comparing experiences reported by adolescents compared to those reported by young adults is a limitation, as it would have been pertinent to design a longitudinal study to follow up young PWH during their transition; however, as the transition process is long, it would have been very time consuming with a high risk of follow-up. This study will be based on an explanatory sequential mixed methods design, which will allow to bring complementary results by collecting and analysing quantitative and then qualitative data in two consecutive phases within one study. The main evaluation criterion of the quantitative phase will be the adherence to health care, a hypothesised marker of the success of transition, whose choice is debatable as it is a complex concept to measure and as it probably reflects only a part of the success of transition. Potential determinants will be selected according to the SMART theoretical model (Social-ecological model for adolescents and young adults readiness for transition), and will include both pre-existing objective factors and modifiable subjective factors (potential targets of intervention), whose associations with adherence to health care will be hypothesised from the quantitative phase, and more deeply explored and explained thanks to the qualitative phase. Word count: 248

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125	INTRODUCTION
126	Haemophilia is a rare and inherited disorder (X-linked recessive transmission), affecting mainly males
127	(annual incidence: 1/5,000 male births).[1] It is characterized by bleeding due to a lack of clotting
128	factors (factor VIII (FVIII) for haemophilia A or factor IX (FIX) for haemophilia B). Bleedings often
129	start in early life, due to psychomotor skills acquisition. Seriousness of the symptoms depends on the
130	severity of the lack of FVIII/FIX. Severe haemophilia, defined by a biological activity of FVIII/FIX
131	lower than 1%, is characterized by spontaneous bleedings most frequently located into the joints
132	(haemarthroses) and into the muscles (haematoma). Natural history of untreated severe haemophilia is
133	marked by serious haemorrhagic events which compromise the vital prognosis. Insufficiently treated,
134	repetition of haemarthroses and haematoma results in invalidating motor disability.
135	It is nowadays possible to avoid these complications thanks to substitutive therapies for which the
136	issue of adherence is major, and to a lifelong regular clinical follow-up. Successive stages of the
137	disorder's care management have been described by Young,[2] including:
138	- Adolescence: independence and responsibility for disease management, self-advocacy and
139	disclosure, importance of treatment adherence, transfer of responsibilities from the caregivers to
140	the patient
141	 Adulthood: decide whether to continue prophylaxis, challenge of dealing with a chronic disease
142	and becoming one's own caregiver
143	The success of the transition from adolescence to adulthood may therefore be crucial in the
144	maintenance of adherence to care.
145	
146	In the context of chronic diseases, the process of transition may be more complicated, as affected
147	young people have to deal with a supplementary transition, from a paediatric health care system to an
148	adult one.[3–6] Indeed, a successful transition involves a transfer of responsibilities from parents to
149	patients concerning the management of their health, the acquisition of the knowledge, abilities, and
149	self-reliance necessary to take on autonomy as well as the new roles people expect them to endorse as
150	adults.[7, 8] Experiencing a difficult transition could be associated with a decrease in the level of
151	adherence to care, but it might also impair quality of life and the entry into adulthood.[9, 10] In the
152	framework of several chronic diseases (apart from haemorrhagic diseases), some studies highlighted
153	barriers or facilitators to successful transition, either associated to the young patients, or to their
154 155	parents, or to the various actors of the health care system.[11–14] Authors especially underlined
156	psychosocial factors such as knowledge, skills, beliefs, expectations, goals, relationships, fears, need
157	for control, emotional dependency, over-protectiveness, heightened awareness of health issues, lack of
158	trust in caregivers.[13–16] The theoretical social-ecological model of AYA (adolescents and young
159	adults) readiness for transition (SMART),[17] by identifying both pre-existing objective factors (less
160	amenable to intervention, including socio-demographics/culture, access/insurance, health status/ris

neurocognition/IO) and inter-related components of patients, parents and providers (potential targets of intervention, including development, knowledge, skills/self-efficacy, beliefs/expectations, goals, relationships and psychosocial functioning), has been proposed as the ideal framework to identify determinants (barriers and facilitators) of transition in the context of serious paediatric illness conditions.[14] Some interventions have been designed to improve the transition of care, and a Cochrane review assessing their effectiveness found that transitional programs might slightly improve transitional readiness (self-management skills and knowledge), but that they led to little or no difference in health status, quality of life or well-being.[18] The identification of barriers and facilitators to successful transition may help to design target interventions in order to improve their overall effectiveness.

In the specific context of haemophilia, some studies have been conducted to assess the issue of transition in young people with haemophilia (PWH).[19] A study comparing quality of life in young PWH in pre-transition period with young PWH in post-transition period showed a lower quality of life and a higher level of distress in young PWH in post-transition period.[20] Some recommendations (involving patients, families, and caregivers) have been proposed to facilitate this process.[21–23] However, despite the setting up of some actions which have been shown to improve the disease specific knowledge. [24, 25] difficulties are still remaining, which may impair the health condition and the quality of life of young PWH.[26, 27] A study on the unmet needs reported by young adults highlighted psychological issues mainly related to independence achievement.[28] At the crucial age at which adolescents are often opposed or want to take their own decisions, maintaining the adherence to clinical follow-up and therapies is an important issue. A study conducted in young PWH (13-25 vears) found that 41% of them had no followed prescribed treatment.[29] Studies have shown a decrease in the level of adherence to the prescribed therapeutic regimen during transition. A study based on nurses-reported data found a decreasing level of adherence, from 90% for the youngest patients (0-12 years) to 54% for those aged 13-18 years and to 36% for those aged 19-28 years.[30] Caregiver or self-reported adherence assessment showed similar results, with a lower level of adherence in adults in comparison with paediatric patients (and among these latter, a lower level in adolescents in comparison with children).[31, 32] This lower adherence might have serious consequences, such as haemarthroses which may impair daily activities but also quality of life. A higher number of hemarthrosis was observed in less-adherent to prophylaxis patients aged 12 to 25 vears.[33] which was also observed when considering patients of all ages.[32, 34] Some psychosocial factors of the maintenance of a high adherence in young PWH have been highlighted, e.g. a greater perception of the need for prophylaxis than the concern over taking it, a positive expectancy of its effectiveness, a good social support, and a stronger emotional reaction to having haemophilia.[35] In the general framework of haemophilia (not focusing on the transition period), a review on determinants of adherence to prophylactic treatment identified both barriers (absence or infrequent

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symptoms, increasing age) and motivators (belief in necessity of treatment, goo tionship with the health care provider, experience of symptoms).[36] Another review identifi ve key types of adherence barriers: patient-related factors (including age), condition-related fac reatment-related factors, health-care system factors, and socioeconomic factors.[37]

Even if some literature data exists on the issue of transition and its impact on ad ce to health care in the context of haemophilia, some limits may be discussed. The sample si these studies is generally modest (below or about a hundred of patients).[35, 38, 39] An internal larger study including 230 young PWH was conducted but all of them were young adults (as -30 years), none were adolescents.[27] Adherence is usually assessed only through adherence to p actic treatment, which excludes young PWH under on-demand treatment.[35, 38, 39] None of studies has been carried out in France where the features of the health care system are very spe An international study showed that cost was a frequent reported barrier to prophylaxis (about 459 both nurses from Haemophilia Treatment Centres and patients perspectives).[30] Thus, the assu on of all disease-related costs by the French social security system might influence the adherence are. The backing of the French national registry FranceCoag[40] will allow to assess this issue in e and exhaustive population of young PWH. This registry involves for more than 20 years ch Haemophilia Treatment Centres (HTC), and it includes more than 10,000 patients (7,000 per with haemophilia (PWH), with 2,300 with severe haemophilia of all ages). Moreover, even if some sychological data have been related to the adherence to care, they are often analysed as independe tors. Taking into account the interdependence between these factors using adapted methods could g original results. Finally, an explanatory sequential mixed methods designed study combin quantitative and qualitative methods will allow to address in a global way the issue of transition ng young PWH, *i.e.* focusing not only on its facilitators and barriers but also, on all the ic concerns and difficulties young PWH may experience as they grow into adulthood.

OBJECTIVES The main objective of this study is to assess differences between adolescents and young adults with severe haemophilia in France, through the transition process, especially on adherence to health care. The operational objectives of this study are: to compare the level of adherence in adolescents and in young adults (YA) _ to identify determinants (medical, organisational, socio-demographic and social, and psychosocial and behavioural factors) of the level of adherence in young PWH, to assess specific factors involved in suboptimal level of adherence in the sub-groups of adolescents and YA, to identify groups of patients (clusters) regarding both their level of adherence and their psychosocial characteristics, to examine through a qualitative approach statistical results which would have been brought to light according to the quantitative objectives, and to identify some ways to improve adherence to health care in young PWH and their global care. **METHODS/DESIGN** Study design This study is designed as a multicentric (29 HTC from FranceCoag), observational, cross-sectional study, based on an explanatory sequential mixed methods design[41-47] with two complementary and consecutive phases: The quantitative phase focuses on the determinants of adherence to health care (considered as a marker of the success of transition), and compares data from a group of adolescents to those from a group of YA, in order to provide a general understanding of the issue of adherence in young PWH. The qualitative phase explores participants' views in more depth (few patients selected from the quantitative phase) to explain and refine the general understanding from the quantitative phase. Interpretation and discussion of the global results will be done by integrating the results of both phases of the study. **Participants** Inclusion criteria Patients with severe A or B haemophilia (deficiency <1%) Patients affiliated to the French social security system and included in the FranceCoag registry _ Patients followed in one of the 29 participating HTC _ Patients aged 14-17 years (adolescents group), or aged 20-29 years (YA group)

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2 3	257	- Adolescents authorised to participate by their parents or their legal representatives, or YA who
4 5	258	give their consent to participate in this study
5 6	259	
7	260	Non-inclusion criteria
8 9	261	- Vulnerable patients (adults under guardianship, pregnant or nursing women)
10	262	Patients with reading and writing difficulties (as data collection in the quantitative phase is mostly
11 12	263	based on participants' self-reported data collected through a booklet)
13	264	Period of the study
14 15	265	The planned duration of the study is 30 months. Inclusions started in February 2017. The quantitative
16	266	phase will go on for 18 months, the qualitative phase will go on for 10 months, and the last two
17 18	267	months will focus on integrating results from both phases, in order to provide a global interpretation
19 20	268	and discussion of the results of the study.
20 21	269	
22	270	Quantitative phase
23 24	271	Main evaluation criterion
25	272	The main evaluation criterion is the adherence to clinical follow-up and prophylactic treatment (a
26 27	273	hypothesized marker of the success of transition into adulthood), which will be assessed via the
28	274	following items:
29 30	275	- number of follow-up visits in agreement with the recommended number over the last two years,
31 32	276	- number of prophylactic treatment injections in agreement with the recommended number over the
32 33	277	last three months (if applicable),
34 35	278	 number of haemorrhagic events over the last two years,
36	279	- physician-reported adherence to clinical follow-up and to prophylactic treatment (if applicable),
37 38	280	– patient-reported adherence to clinical follow-up and to prophylactic treatment (if applicable).
39	281	Each item will be dichotomized, and a composite quantitative endpoint will be constructed taking into
40 41	282	account all these dichotomized items. This composite quantitative endpoint will in turn be
41	283	dichotomized to define adherent / non-adherent participants (main evaluation criterion).
43 44	284	
45	285	Secondary evaluation criteria
46 47	286	Each item which is part of the composite endpoint as described hereinabove will be considered in an
48	287	independent manner as a secondary evaluation criterion.
49 50	288	
51	289	Explanatory collected data
52 53	290	Medical data
54	291	Medical data will include: deficit characterisation, diagnosis (age at diagnosis, circumstances of
55 56	292	diagnosis, family history), viral diseases (HIV, HBV, HCV), comorbidities (intracranial haemorrhage,
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2	202	
3 4	293	major orthopaedic interventions, major disability, cancer, other chronic pathology), previous and
5	294	current treatment.
6 7	295	
8	296	Organisational data (Haemophilia Treatment Centres-reported)
9 10	297	Organisational data will include: paediatric / adult / paediatric and adult HTC, physicians' speciality,
10	298	mean age of the transition from paediatric care to adult one, consultations dedicated to the transition,
12	299	common consultations with both paediatric and adult medical teams, specific tools set up to facilitate
13 14	300	the transition process (information leaflet, therapeutic patient education).
15	301	
16 17	302	Socio-demographic and social data
18	303	 Gender and age of family members, living situation,
19 20	304	- Socio-professional category, socio-economic status assessed by the Family Affluence Scale),[48]
21	305	- Distance to the HTC (in km),
22 23	306	 Membership of French patients association for PWH (AFH),
24	307	- Family functioning (structure, organisation, and communication) assessed by the French validated
25 26	308	version of the 6-items Family Assessment Device,[49–51]
27	309	- Schooling and academic success evaluated by ad-hoc items (schooling type, level of education,
28 29	310	academic difficulties),
30	311	- Relationships with the health care system assessed using ad-hoc items (satisfaction and
31 32	312	expectations towards the health care system, participation in therapeutic patient education
33	313	programme).
34 35	314	programme).
36	315	Psychosocial and behavioural data
37 38	316	- Quality of life will be assessed using the validated French version of the SF-12 generic scale.[52]
39	317	Two sub-scores, mental health and physical health, will be calculated. The SF-12 allows assessing
40	318	the quality of life of adults as well as adolescents (14 + years).
41 42	319	– Quality of life of adolescents will also be assessed by the validated French version of
43	320	the 10-items Kidscreen Index, which explores the following domains: physical well-
44 45	321	being, psychological well-being, autonomy and relations with parents and home life,
46	322	peers and social support, and school environment.[53]
47 48	323	- Haemophilia-specific quality of life will be assessed in all participants using the
49	324	validated French short version of the Haemo-Qol questionnaire.[54, 55]
50 51	325	- Time perspective will be assessed using the Past Negative (PN) and Future (F) subscales of the
52	326	French validated version of the Zimbardo time perspective inventory.[56, 57] The PN subscale (9
53 54	327	items) reflects a pessimistic attitude towards the past and the experience and memory of traumatic
55	328	life events. The F subscale (12 items) reflects an orientation towards future and an attitude of
56 57		
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planning and achievement of objectives. To avoid the questionnaire being too long, we will not
 plan to assess the Past-Positive, Present-Hedonistic, and Present-Fatalistic subscales.
 Coping Strategies will be measured by the validated French version of the Brief-Cope scale[58,

59] which consists of 28 items assessing individuals' use of 14 coping strategies: self-distraction,
active coping, denial, drug use, emotional social support seeking, instrumental social support
seeking, behavioural disengagement, emotional expression, positive reframing, planning, humour,
acceptance, religion, and self-blame.

Autonomy will be assessed using ad-hoc items only proposed in the YA questionnaire (financial independence from the parents, and living, management of health, dealing with administrative tasks, and taking holidays without the parents). The 15-items Noom validated questionnaire[60, 61] assessing attitudinal autonomy, emotional autonomy, and functional autonomy will be proposed to all participants (ad-hoc translation for this study).

342 Data collection procedure

Main medical data will be extracted from the FranceCoag database, and completed by a short questionnaire filled in by the referent physician from each HTC. Organisational data will be completed by a medical representative from each HTC. Eligible participants will be identified and approached by the HTC team by which they are followed (approach either during a medical consultation, or by phone call, or by a personalised mail sent at their home). Survey documents (information sheet, informed consent form, booklet, and prepaid envelope) will then be sent by post to eligible young PWH. Participants' self-reported data will be collected through a standardised booklet including several questionnaires (an adolescent version and a YA version). Consent will be collected through the signature of the informed consent form by the parents or the legal representatives for adolescents, and by the signature of the YA directly for YA. Completed questionnaires as well as signed informed consent forms will be sent back by the participants via the supplied prepaid envelope. If no response is received within 30 days, a reminder letter will be sent. A second reminder letter and all survey documents along will be sent two months later in case of no response.

357 Sample size justification

According to the exhaustive FranceCoag database and considering the specific inclusion criteria of the TRANSHEMO study (severe A or B haemophilia, patients aged 14-17 or 20-29 years, followed in one of the 29 participating HTC), 154 adolescents and 389 YA are eligible for this study. We hypothesised a difference of 20% between adolescents and YA regarding the main evaluation criterion (90% of adherence to health care in adolescents vs 70% in YA). Then, under the hypothesis of a non-response rate of 30%, and considering a bilateral alpha risk of 5%, the power of this study would reach 99%.[62, 63]

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366	Data Management
367	A specific database will be created using EpiData software, and merged with the FranceCoag
368	database. A process will be used to assign to each participant a unique anonymous number. A data
369	quality control will be performed by a physician to limit data inconsistency.
370	
371	Analysis
372	The analysis plan and the final report will be written according to the STROBE recommendations.[64,
373	65] All analyses will be performed using R software. All tests will be two-sided, and p<.05 will define
374	statistical significance.
375	
376	Analysis populations
377	The analysis populations will be the adolescents and the YA groups, among whom adherent and non-
378	adherent patients will be identified.
379	
380	Descriptive analysis
381	A descriptive analysis will first be performed. Qualitative variables will be presented as numbers and
382	percentages, quantitative variables as means and standard deviations, or as medians and interquartile
383	ranges. Subjective data will be described by their overall scores and their sub-scores.
384	Reasons for non-inclusion will be listed. Included patients will be compared to non-included eligible
385	patients using basic socio-demographic and clinical data, available in the FranceCoag database.
386	
387	Comparative analysis
388	Crude analysis
389	Adherence will first be described by groups (adolescents / YA) using classical indicators. The
390	comparison of adherence between the two groups will be performed using chi-square test (or Fisher
391	test depending on the expected numbers) for the main evaluation criterion and for all qualitative
392	secondary evaluation criteria, and using Student t test (or Mann-Whitney test depending on normality
393	of the distribution) for quantitative secondary evaluation criteria.
394	
395	Adjusted analysis
396	In order to identify factors associated with adherence, bivariate and multivariate analyses will be
397	performed. Potential determinants (medical, organisational, socio-demographic and social,
398	psychosocial and behavioural factors) will be proposed as explanatory variables. Logistic regression
399	models will be used for the main evaluation criterion and for all qualitative secondary evaluation
400	criteria, and linear regression models will be used for quantitative secondary evaluation criteria. Each
401	characteristic whose degree of significance will be lower than .20 will be considered for multivariate
402	analyses. A backward selection will be applied to retain only significantly associated characteristics.
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403 Multilevel models will be used to take into account organisational factors which are related to the 404 centre. Structural equation modelling will be considered to take into account the collinearity and/or the 405 complex relationships which might exist between explanatory individual characteristics (especially 406 social, psychological and behavioural ones).[66–68]

407 This analysis will first be performed in the overall population with a forced adjustment on the group408 (adolescent / YA). It will secondly be performed independently in each of the two groups.

Cluster analysis

In order to bring to light particular profiles of adherent / non-adherent in adolescents and in YA, an
exploratory unsupervised classification analysis will be performed.[69, 70] This method which does
not require any condition of validity will allow to gather patients with similar profiles in homogeneous
clusters.

Qualitative phase

417 Data collection procedure

Few subjects (adolescents on one hand and YA on the other hand) who will have participated in the quantitative phase will be selected for this phase according to the following characteristics (assessed from the quantitative phase): adherent or not, and under prophylaxis or not. If they agree, they will be contacted to participate in research interviews conducted by a psychologist, at any place at their convenience (at home, at the HTC...). The interviews will be individual, confidential, semi-structured, and tape-recorded. The psychologist will be blind to the responses in the questionnaires of the participant, and to his/her status adherent / non-adherent as defined according to the main evaluation criterion of the quantitative phase.

The psychologist will start with a general question, then he/she will adopt a non-directive attitude and will allow the participant to spontaneously and freely broach the answers which they consider relevant. Then he/she will summarise the response and introduce more precise questions regarding the topics which will have not been covered spontaneously or sufficiently by the participant. He/she will seek to focus the interview on the participant's personal experiences, subjective perceptions, and expectancies, in order to understand if the patient is adherent / non-adherent and the possible determinants of this adherence. The interview guide will be refined from the findings from the quantitative phase, in order to collect more specifically data about potential determinants and adherence to health care brought to light from the quantitative phase.

Adolescents' interviews

The interview will begin with this general question: "How do you feel about coming into adulthood ina few years?"

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After the spontaneous answer, the psychologist will encourage them to talk about the following topics: the meaning they give to becoming a YA; their expectations towards their life (personal and professional) as future YA; their plan to care about their health as future YA; their fears towards their entry into adulthood.

Young adults' interviews

445 The interview will begin with this general question: "How do you feel about reaching adulthood 446 during the last few years?"

After the spontaneous answer, the psychologist will encourage them to talk about the following topics:
the meaning they give to becoming a YA; their experienced difficulties towards the acquisition of their
autonomy (especially concerning the management of their health) and the construction of their life
(personal and professional); the facilitators and barriers they identified during their transition process.

Then, to go further and broaden these qualitative data, the psychologist will show to these participants a summary of the adolescents' expectations towards adulthood (from the interviews conducted in adolescents, which therefore will be carried out and analysed before those in YA). The psychologist will then ask YA to assess: to what extent these perceptions match with their own expectations when they were adolescents; to assess to what extent these perceptions match with their current lives; and to indicate which issues regarding transition adolescents forget to mention.

458 Sample size justification

Four profiles will be identified from the two selected characteristics (adherent or not, and under
prophylaxis or not). On the basis of three interviews by profile, up to 12 adolescents and 12 YA will
be selected for the qualitative phase (enrolments until information is saturated).

463 Data management

All interviews will be precisely and entirely transcribed, including the participants' hesitations andself-corrections.

467 Analysis

The psychologist will analyse adolescents' interviews on one hand and YA ones on the other hand, using Interpretative Phenomenological Analysis (IPA) method. This method allows to comprehend the participants' subjective experiences through the analysis they make of (and the meaning they give to) their feelings and states, as well as the specific events they are faced with. It makes possible to highlight sociocognitive processes by which personal experiences are assimilated to individuals' perceptions of both themselves and the world they live in.[71, 72]

474 IPA of an interview is made of four iterative stages. During the first stage, the psychologist will read475 the interview several times, annotating, summarising, paraphrasing, and commenting on what is

476 interesting or significant. The second stage will consist in encoding those annotations to a slightly
477 higher level of abstraction by theoretical and scientific elements: the psychologist will underline the
478 themes addressed by the participant. At the third stage, the psychologist will try to connect these
479 themes by grouping them into superordinate clusters while checking that the connections they make
480 match the meaning of the participant's speech. The last stage of the analysis will consist in giving a
481 scientific meaning to the established clusters.

The same method will be used for all participants within each group, with the permanent goal of improving the previously identified clusters. Each time a new element is identified, or each time a theme or a cluster is modified, the psychologist will get back to previously analysed interviews to ensure that the new model accounts for the speech of all participants.

According to the interpretation of each interview, the psychologist will have to determine the status
adherent / non-adherent of each participant. Thus, the identified clusters of themes will be put in
perspective with the psychologist-determined status towards adherence, in order to propose a model
describing the relationships between adherence to health care and its determinants.

Finally, when all interviews will have been analysed, a summary will be made, by underlining
similarities and differences between adolescents and YA regarding adherence to health care and its
determinants, and transition into adulthood and its consequences on their lives.

Analyst triangulation will be performed,[73, 74] by involving two psychologists in reviewing the
findings in order to assess the reliability and validity of the obtained results. This triangulation may
also allow to develop a broader and deeper understanding of the results.

497 Interpretation

Interpretation and discussion of the global results of the study will be done by integrating the results of both phases of the study. From participants who will have been considered consistently according to both quantitative and qualitative phases either as adherent or as non-adherent, hypothesized associations between potential determinants and adherence from the quantitative phase will be therefore confirmed or infirmed thanks to the results of the qualitative phase. Thus, combining the quantitative and qualitative findings will help explain the results of the statistical results, which underscores the elaborating purpose for a mixed-methods sequential explanatory design. [45, 75] Participants who will not have been considered consistently either as adherent or as non-adherent will allow to discuss representations and beliefs about adherence in the context of haemophilia, and the relevance of this outcome to assess the success of transition through quantitative studies.

509 Patient and public involvement

510 The development of the research question, study design and outcome measures involved interpretation
511 of literature, professional experience reported through the clinicians, nurses, and psychologists
512 working in the various Haemophilia Treatment Centres participating in the French national registry

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FranceCoag, and patients' priorities and experience reported through the French association patients association for PWH (AFH) that is member of the steering committee of the study. Patients will not be directly involved in the recruitment, but the AFH will regularly communicate about the study (internet, newsletters, social networks, magazine...) to inform eligible participants in order to maximise the recruitment. Results will be popularised to be communicated via the AFH to participants and to the general public.

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519 DISCUSSION AND LIMITATIONS

520 Strengths and limitations of the database

As the issues concerning transition into adulthood may intrinsically depend on features of the health care system, we intend to explore the specific perceptions of young PWH in France, whose health care system model is specific. The support of the FranceCoag registry to this study is therefore an important strength. While the exhaustivity of inclusions in this registry might have been an issue for patients with moderate or minor haemophilia, the exhaustivity concerning patients with severe haemophilia is guaranteed since 2000. Even if five HTC over the 34 active ones (i.e. 15%) did not accept to participate in the TRANSHEMO study, the loss of eligible patients was small (only 4% of the eligible young PWH). The comparison of basic socio-demographic and medical data, available in the FranceCoag database, between included patients and non-included eligible patients will allow to discuss the representativeness of the included sample. Moreover, the implication of clinicians, nurses, psychologists, and clinical research associates in both the clinical follow-up of patients and this study via their participation in the FranceCoag registry will help to maximise the recruitment and limit the risk of dropouts for this study. The French patients association for PWH (AFH), member of the steering committee of the FranceCoag registry, will also regularly communicate about the study (internet, newsletters, social networks, magazine...) to inform eligible participants in order to maximise the recruitment.

538 Strengths and limitations of the study design

The quantitative phase of this study is cross-sectional, while it would have been pertinent to design a longitudinal study to follow up young PWH during their transition. However, as this process is long,[2] it would have been very time consuming, with a high risk of lost to follow-up. We therefore chose to compare at a unique time the experiences of two groups regarding their status towards transition. If the results of the present cross-sectional study turned out to be singular, they could justify to secondly set a longitudinal study up.

The explanatory sequential mixed methods design, [41–47] by combining quantitative and qualitative methods, will bring original results. The first quantitative phase will allow to adjust the second qualitative phase, by the targeted selection of participants (adherent / non-adherent participants according to main evaluation criterion) and by bringing results to be discussed with participants. The qualitative phase will then allow to shed light on the results from the quantitative phase (based on self-reported questionnaires data) by a deeper analysis of participants' experiences collected through interviews conducted by a psychologist, especially for psychosocial and behavioural factors which will have emerged from the quantitative phase. This qualitative phase could also be a starting point for a future longitudinal and quantitative study, by highlighting unexplored processes by the present quantitative phase. The step of integration and mixing of the results from both phases of the study will

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allow to more fully answer the question of adherence to health care through the period of transition to adulthood in the context of severe haemophilia, and to develop a more robust and meaningful picture of this issue. Combining the quantitative and qualitative findings will help on one hand to explain relationships between adherence to health care and its determinants, and on the other hand to discuss representations and beliefs about adherence, a quantitative outcome which was considered as a marker of the success of transition.

Strengths and limitations of the endpoints

The main objective of the study is to assess the potential impact of transition from adolescence to adulthood, which we chose to measure by the level of adherence to health care. This choice is debatable, as maintaining a high level of adherence to care probably reflects only a part of the success of the transition process. However, this choice is justified by several arguments: (i) it is necessary to propose an endpoint which applies for both adolescents and YA, in order to be able to assess through a transversal study the potential impact of the transition on a common endpoint, (ii) a decrease of adherence during the transition process may be associated with clinical consequences (serious bleedings), [32–34] which may impair physical and psychological quality of life in young PWH, (iii) this endpoint allows to assess more specifically the potential impact of the supplementary transition experienced by young PWH, a transition from a paediatric health care system to an adult one, (iv) this endpoint was in the top five of health care transition outcomes identified by a Delphi process with an interdisciplinary group of medical and psychosocial professionals, [76] and (v) this endpoint may be accessible for educational actions. Adherence is a concept which might be defined by the agreement between the behaviour of a patient and the received recommendations or prescriptions.[77] We chose to assess adherence to prophylactic treatment, which is the commonly used evaluation criterion when assessing adherence in haemophilia[29, 35] but which would have been valid only for young PWH under prophylactic treatment. We therefore also chose to assess adherence to clinical follow-up, which is valid for all young PWH (even if the rhythm of visits might be different depending on their personal situation). Moreover, we chose to collect data on adherence through three sources of information: (i) data from the FranceCoag database (follow-up visits, injections of prophylactic treatment, haemorrhagic events), (ii) referent physician-reported data, and (iii) patient-reported data. A composite endpoint combining these items will allow to take into account the complexity of the assessment of adherence, in particular by mixing clinical and objective data with behavioural and subjective adherence-related data. The dichotomisation of this composite endpoint to define adherent and nonadherent young PWH will lead to a loss of variability in the data, but this choice will allow to get more accessible data and results. As the issue of variability is sensitive, each secondary endpoint (i.e., each variable included in the composite endpoint) will be analysed according to its original response format (binary, semi-quantitative, quantitative), independently of each other.

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590 Strengths and limitations of the determinants

In this study, the choice of the determinants to be assessed (determinants of adherence to health care, considered as a marker of the success of transition) was based on literature data in the context of haemophilia,[35–37] and this choice was consistent with the theoretical SMART model.[17] This model proposes both potential barriers and facilitators, but also both pre-existing and modifiable factors, more amenable to intervention, including beliefs/expectations related-factors (time perspective) and psychosocial functioning related-factors (coping strategies and family functioning).

597 Time perspective refers to how individuals partition their experiences into distinct temporal categories 598 of past, present and future.[78] Particular temporal frames may be associated with well-being and 599 quality of life.[79] Indeed, focusing on a "past negative" time perspective may result in negative long-600 term adjustment and post-traumatic stress symptomology.[80] On the contrary, "future" time 601 perspective has been viewed as the more constructive time perspective.[79]

Moreover, people (patients and relatives) faced with a severe chronic childhood disease generally experience repeated stress reactions because the disease questions individuals about their beliefs, identity, priorities, and short-term and long-term goals.[81, 82] The coping strategies individuals implement to deal with these stress reactions have been studied. Studies show that an individual's inability to implement appropriate coping strategies, or the use of strategies targeting only emotional responses (instead of their cognitive antecedents), are responsible for emotional disorders and impaired familial and social relationships. On the contrary, long-term well-being may be facilitated by the use of coping strategies which allow people restructuring their concepts, beliefs, values, priorities, standards, and personal goals.[82-86]

Finally, growing into adulthood implies that young people gain autonomy, get independent and endorse the responsibilities falling to adults. This personal empowerment implies that they develop their own personal values and long-term goals (attitudinal autonomy) and implement effective strategies to achieve these goals (functional autonomy). However, this ability to develop autonomy depends on the capacity to maintain confidence in one's own values and goals (emotional autonomy).[60, 87] We assume the development of autonomy (especially emotional autonomy) largely depends on the family functioning: parenting style, cohesiveness, flexibility, roles management, and communication of emotion.[49, 88–90]

619 ETHICS

620 Informed written consent will be obtained for all participants prior to recruitment for the study. For
621 adolescents, consent will be obtained from their two parents or legal representatives. All data will be
622 analysed confidentially and anonymously.

The study was designed according to Good Clinical Practices, and all procedures will be in accordance
with the Declaration of Helsinki. The study was approved by the French Ethics Committee (Comité de
Protection des Personnes Sud Méditerranée V) on 8th November 2016 and by the French National
Agency for Medicines and Health Products Safety on 22th September 2016 (reference number ID
RCB: 2016-A01034-47). The protocol was registered in ClinicalTrials.gov (NCT02866526).

DISSEMINATION

This study will allow to comprehend what the potential impact of transition from adolescence to
adulthood could be in young PWH in France, which is of particular interest in the global approach
whose goal is to take care of all aspects of life in patients with chronic diseases.

This study will also allow to identify determinants of adherence, considered as a marker of a successful transition in young PWH. The assessment of social, psychosocial and behavioural data, will allow to describe the socio-cognitive processes which may facilitate or complicate adherence, while taking into account other factors, *i.e.* medical, organisational, and socio-demographic factors. The results obtained from the quantitative phase of the study will be enlightened by the analysis of the interviews conducted in the qualitative phase. This analysis will bring supplementary and complementary data which would not have been accessible via the analysis of the questionnaires, especially concerning expectations and fears about health, but also about personal and professional life. Singular results from this qualitative phase could be used to better design a future quantitative study on the issue of transition, by assessing complementary outcomes to those assessed in the present quantitative phase.

Results will allow to propose recommendations and to develop interventions to compensate for young PWH difficulties, and thus optimize the adherence to the proposed follow-up and to the prophylactic treatment, but also facilitate their entry in the adult life. The effectiveness of such transitional programs could be improved by targeting specific patients at risk of difficulties (especially lack of adherence to health care) through the transition process, or by targeting specific needs expressed by young PWH in the present study.[18]

In order to assess the transferability of the results from the TRANSHEMO study in other contexts of
childhood chronic diseases in France, complementary projects could be proposed to assess the issue of
transition in young patients with rare and/or serious and/or chronic diseases. This approach would
allow to identify which issues are common to these diseases and which ones are specific to a disease,

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2 3	654	including severe haemophilia. Common and specific actions could then be proposed to facilitate the
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NR, ABA, KB, TL, HC, PA contributed to the design of this study and wrote this article. The investigators (LA, SB, CB, M-AB, CB-A, AB-D, SC, PC, SCD, EDR, DD, CF, BF, VG, JG, YG, BG, AH, AH, YH, TL, AL, AL, MM, SM, FM, GM, CN, PN, PN, CO, BP-P, BP, AR, AR, DR, PS, AS, CS, BT, MT, J-BV, SV, FV, AV-E, BW) of the French Haemophilia Treatment Centres contribute to enrol participants, they revised the manuscript and approved the final version. Members of steering committee (NR-D, VM, TS) contributed to the design of this study, they revised the manuscript and approved the final version. Acknowledgements The authors thank all collaborators who participate in the study: Tafat AIT CHEKDHIDH (Hospital of Montmorency, France), Kahéna AMICHI (AP-HM, France), Claire ARCE (AFH), Marie AUGAGNEUR (University Hospital of Brest, France), Thérèse AURIOL-VIGNE (AP-HM, France), Lynda BENDJEMAR (Hospital of Montmorency, France), Linda BODET (University Hospital of Lyon, Hospital Edouard Herriot, France), Aurélie CADET (University Hospital of Reunion, Reunion Island, France), Amandine CELLI (University Hospital of Nantes, France), Carine CERATO-BLANC (University Hospital of Nice, France), Marie Agnès CHAMPIAT (University Hospital of Montpellier, France), Sylvie CHARBONNEAU (University Hospital of Tours, France), Céline CHENUEL (University Hospital of Nancy, France), Emilie COTTA (AFH), Alix COUROUAU (Hospital of Chambery, France), Guillaume DELAVAL (University Hospital of Caen, France), Stéphanie DELIENNE (University Hospital of Dijon, France), Jean DHORNE (AP-HM, France), Jessica DOUAY (University Hospital of Limoges, France), Assia DOUICI (AP-HP, Hospital Bicêtre, France), Guillaume DRUGMANNE (University Hospital of Brest, France), Charlène DUPRE (Hospital of Chambery, France), Sylvie GERARD (University Hospital of Toulouse, France), Eva GLEIZES (University Hospital of Saint-Etienne, France), Isabelle GOESIN (University Hospital of Rennes, France), Nicolas GUERIN (University Hospital of Caen, France), Veronique HACKER (University Regional Hospital of Strasbourg, France), Hayet IDDIR (University Hospital of Saint-Etienne, France), Stéphanie IMBERT (University Hospital of Bordeaux, France), Amal KORTEBI (University Hospital of Brest, France), Anne LECLERE (University Hospital of Reims, France), Sophie LE DORE (Hospital of Versailles, France), Anderson-Dieudonné LOUNDOU (AP-HM, France), Cécile MAIRE (University Hospital of Besancon, France), Catherine MARICHEZ (University Regional Hospital of Lille, France), Marcelline MATINGOU (AP-HP, Hospital Necker, France), Pascale PALAMARINGUE (University Hospital of Reims, France), Bénédicte PRADINES (University Regional Hospital of Lille, France), Laurence QUINIOU (Hospital of Versailles, France), Paola RAMIREZ (AP-HM, France), Olivia RICK (University Regional Hospital of Strasbourg, France), Martine ROCHE (AP-HM, Children Hospital La Timone, France), Florence ROUSSEAU (University Hospital of Montpellier, France), Gwendoline ROY (University Hospital of Clermont-

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Determinants of adherence and consequences of the transition from adolescence to adulthood among young people with severe haemophilia (TRANSHEMO): study protocol for a multicentric French national observational cross-sectional study.

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TITLE

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national observational cross-sectional study.

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Determinants of adherence and consequences of the transition from adolescence to adulthood among young people with severe haemophilia (TRANSHEMO): study protocol for a multicentric French

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ARTICLE SUMMARY

75 Abstract

76 Introduction: Severe haemophilia is a rare disease characterised by spontaneous bleeding from early 77 childhood, which may lead to various complications especially in joints. It is nowadays possible to 78 avoid these complications thanks to substitutive therapies for which the issue of adherence is major. 79 The transition from adolescence to adulthood in young people with severe haemophilia is a critical 80 period as it is associated with a high risk of lack of adherence to health care, which might have serious 81 consequences on daily activities but also on quality of life.

Methods and analysis: We present the protocol for a cross-sectional, observational, multicentric study to assess the differences between adolescents and young adults with severe haemophilia in France through the transition process, especially on adherence to health care. This study in based on a mixed methods design, with two complementary and consecutive phases, comparing data from a group of adolescents (aged 14-17 years) to those from a group of young adults (aged 20-29 years). The quantitative phase focuses on the determinants (medical, organisational, socio-demographic and social, and psychosocial and behavioural factors) of adherence to health care (considered as a marker of the success of transition). The qualitative phase explores participants' views in more depth to explain and refine the results from the quantitative phase. Eligible patients are contacted by the various Haemophilia Treatment Centres participating in the French national registry FranceCoag.

92 Ethics and dissemination: The study was approved by the French Ethics Committee and by the French 93 National Agency for Medicines and Health Products Safety (number: 2016-A01034-47). Study 94 findings will be disseminated to the scientific and medical community in peer-reviewed journals and 95 presented at scientific meetings. Results will be popularised to be communicated via the French 96 association for people with haemophilia to participants and to the general public.

Adherence / Haemophilia / Transition / Adolescents / Young adults

- 97 Trial registration number: NCT02866526
 - 99 Word count: 299

- 101 Keywords

- Strengths and limitations of this study This study will be the largest to assess the issue of transition from adolescence to adulthood _ among young people with haemophilia (PWH), and the first one in France where the features of the health care system are very specific. The cross-sectional design of the study comparing experiences reported by adolescents compared to those reported by young adults is a limitation, as it would have been pertinent to design a longitudinal study to follow up young PWH during their transition; however, as the transition process is long, it would have been very time consuming with a high risk of follow-up. This study will be based on an explanatory sequential mixed methods design, which will allow to bring complementary results by collecting and analysing quantitative and then qualitative data in two consecutive phases within one study. The main evaluation criterion of the quantitative phase will be the adherence to health care, a hypothesised marker of the success of transition, whose choice is debatable as it is a complex concept to measure and as it probably reflects only a part of the success of transition. Potential determinants will be selected according to the SMART theoretical model (Social-ecological model for adolescents and young adults readiness for transition), and will include both pre-existing objective factors and modifiable subjective factors (potential targets of intervention), whose associations with adherence to health care will be hypothesised from the quantitative phase, and more deeply explored and explained thanks to the qualitative phase. Word count: 248

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126 INTRODUCTION

Haemophilia is a rare and inherited disorder (X-linked recessive transmission), affecting mainly males (annual incidence: 1/5,000 male births).[1] It is characterized by bleeding due to a lack of clotting factors (factor VIII (FVIII) for haemophilia A or factor IX (FIX) for haemophilia B). Bleedings often start in early life, due to psychomotor skills acquisition. Seriousness of the symptoms depends on the severity of the lack of FVIII/FIX. Severe haemophilia, defined by a biological activity of FVIII/FIX lower than 1%, is characterized by spontaneous bleedings most frequently located into the joints (haemarthroses) and into the muscles (haematoma). Natural history of untreated severe haemophilia is marked by serious haemorrhagic events which compromise the vital prognosis. Insufficiently treated, repetition of haemarthroses and haematoma results in invalidating motor disability.

137 It is nowadays possible to avoid these complications thanks to substitutive therapies for which the
138 issue of adherence is major, and to a lifelong regular clinical follow-up. Successive stages of the
139 disorder's care management have been described by Young,[2] including:

Adolescence: independence and responsibility for disease management, self-advocacy and
 disclosure, importance of treatment adherence, transfer of responsibilities from the caregivers to
 the patient

143 – Adulthood: decide whether to continue prophylaxis, challenge of dealing with a chronic disease
 144 and becoming one's own caregiver

145 The success of the transition from adolescence to adulthood may therefore be crucial in the 146 maintenance of adherence to care.

In the context of chronic diseases, the process of transition may be more complicated, as affected young people have to deal with a supplementary transition, from a paediatric health care system to an adult one.[3-6] Indeed, a successful transition involves a transfer of responsibilities from parents to patients concerning the management of their health, the acquisition of the knowledge, abilities, and self-reliance necessary to take on autonomy as well as the new roles people expect them to endorse as adults.[7, 8] Experiencing a difficult transition could be associated with a decrease in the level of adherence to care, but it might also impair quality of life and the entry into adulthood. [9, 10] In the framework of several chronic diseases (apart from haemorrhagic diseases), some studies highlighted barriers or facilitators to successful transition, either associated to the young patients, or to their parents, or to the various actors of the health care system.[11–14] Authors especially underlined psychosocial factors such as knowledge, skills, beliefs, expectations, goals, relationships, fears, need for control, emotional dependency, over-protectiveness, heightened awareness of health issues, lack of trust in caregivers.[13-16] The theoretical social-ecological model of AYA (adolescents and young adults) readiness for transition (SMART),[17] by identifying both pre-existing objective factors (less amenable to intervention, including socio-demographics/culture, access/insurance, health status/risk,

neurocognition/IO) and inter-related components of patients, parents and providers (potential targets of intervention, including development, knowledge, skills/self-efficacy, beliefs/expectations, goals, relationships and psychosocial functioning), has been proposed as the ideal framework to identify determinants (barriers and facilitators) of transition in the context of serious paediatric illness conditions.[14] Some interventions have been designed to improve the transition of care, and a Cochrane review assessing their effectiveness found that transitional programs might slightly improve transitional readiness (self-management skills and knowledge), but that they led to little or no difference in health status, quality of life or well-being.[18] The identification of barriers and facilitators to successful transition may help to design target interventions in order to improve their overall effectiveness.

In the specific context of haemophilia, some studies have been conducted to assess the issue of transition in young people with haemophilia (PWH).[19] A study comparing quality of life in young PWH in pre-transition period with young PWH in post-transition period showed a lower quality of life and a higher level of distress in young PWH in post-transition period.[20] Some recommendations (involving patients, families, and caregivers) have been proposed to facilitate this process.[21–23] However, despite the setting up of some actions which have been shown to improve the disease specific knowledge. [24, 25] difficulties are still remaining, which may impair the health condition and the quality of life of young PWH.[26, 27] A study on the unmet needs reported by young adults highlighted psychological issues mainly related to independence achievement.[28] At the crucial age at which adolescents are often opposed or want to take their own decisions, maintaining the adherence to clinical follow-up and therapies is an important issue. A study conducted in young PWH (13-25 vears) found that 41% of them had no followed prescribed treatment.[29] Studies have shown a decrease in the level of adherence to the prescribed therapeutic regimen during transition. A study based on nurses-reported data found a decreasing level of adherence, from 90% for the youngest patients (0-12 years) to 54% for those aged 13-18 years and to 36% for those aged 19-28 years.[30] Caregiver or self-reported adherence assessment showed similar results, with a lower level of adherence in adults in comparison with paediatric patients (and among these latter, a lower level in adolescents in comparison with children).[31, 32] This lower adherence might have serious consequences, such as haemarthroses which may impair daily activities but also quality of life. A higher number of hemarthrosis was observed in less-adherent to prophylaxis patients aged 12 to 25 vears.[33] which was also observed when considering patients of all ages.[32, 34] Some psychosocial factors of the maintenance of a high adherence in young PWH have been highlighted, e.g. a greater perception of the need for prophylaxis than the concern over taking it, a positive expectancy of its effectiveness, a good social support, and a stronger emotional reaction to having haemophilia.[35] In the general framework of haemophilia (not focusing on the transition period), a review on determinants of adherence to prophylactic treatment identified both barriers (absence or infrequent

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symptoms, increasing age) and motivators (belief in necessity of treatment, good relationship with the health care provider, experience of symptoms).[36] Another review identified five key types of adherence barriers: patient-related factors (including age), condition-related factors, treatment-related factors, health-care system factors, and socioeconomic factors.[37]

Even if some literature data exists on the issue of transition and its impact on adherence to health care in the context of haemophilia, some limits may be discussed. The sample size of these studies is generally modest (below or about a hundred of patients) [35, 38, 39] An international larger study including 230 young PWH was conducted but all of them were young adults (aged 18-30 years), none were adolescents.[27] Adherence is usually assessed only through adherence to prophylactic treatment, which excludes young PWH under on-demand treatment. [35, 38, 39] None of these studies has been carried out in France where the features of the health care system are very specific. An international study showed that cost was a frequent reported barrier to prophylaxis (about 45% by both nurses from Haemophilia Treatment Centres and patients perspectives).[30] Thus, the assumption of all diseaserelated costs by the French social security system might influence the adherence to care. The backing of the French national registry FranceCoag[40] will allow to assess this issue in a large and exhaustive population of young PWH. This registry involves for more than 20 years French Haemophilia Treatment Centres (HTC), and it includes more than 10,000 patients (7,000 people with haemophilia (PWH), with 2,300 with severe haemophilia of all ages). Moreover, even if some psychological data have been related to the adherence to care, they are often analysed as independent factors. Taking into account the interdependence between these factors using adapted methods could bring original results. Finally, an explanatory sequential mixed methods designed study combining quantitative and qualitative methods will allow to address in a global way the issue of transition among young PWH. *i.e.* focusing not only on its facilitators and barriers but also, on all the specific concerns and difficulties young PWH may experience as they grow into adulthood.

225	OBJECTIVES
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227	The main objective of this study is to assess differences between adolescents and young adults w
228	severe haemophilia in France, through the transition process, especially on adherence to health care.
229	The operational objectives of this study are:
230	- to compare the level of adherence in adolescents and in young adults (YA)
231	- to identify determinants (medical, organisational, socio-demographic and social, and psychosoc
232	and behavioural factors) of the level of adherence in young PWH,
233	- to assess specific factors involved in suboptimal level of adherence in the sub-groups
234	adolescents and YA,
235	- to identify groups of patients (clusters) regarding both their level of adherence and the
236	psychosocial characteristics,
237	- to examine through a qualitative approach statistical results which would have been brough
238	light according to the quantitative objectives, and to identify some ways to improve adherence
239	health care in young PWH and their global care.
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241	METHODS/DESIGN
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243	Study design
244	This study is designed as a multicentric (29 HTC from FranceCoag), observational, cross-section
245	study, based on an explanatory sequential mixed methods design,[41-47] with two complement
246	and consecutive phases:
247	- The quantitative phase focuses on the determinants of adherence to health care (considered a
248	marker of the success of transition), and compares data from a group of adolescents to those fi
249	a group of YA, in order to provide a general understanding of the issue of adherence in you
250	PWH,
251	The qualitative phase explores participants' views in more depth (few patients selected from
252	quantitative phase) to explain and refine the general understanding from the quantitative phase
253	Interpretation and discussion of the global results will be done by integrating the results of both pha
254	of the study.
255	
256	Participants
257	Inclusion criteria
258	 Patients with severe A or B haemophilia (deficiency <1%)
	- Patients affiliated to the French social security system and included in the FranceCoag registry
259	rulents annucled to the French social security system and included in the FranceCoug registry

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2 3	261	- Patients aged 14-17 years (adolescents group), or aged 20-29 years (YA group)
4 5	262	- Adolescents authorised to participate by their parents or their legal representatives, or YA who
6	263	give their consent to participate in this study
7	264	
8 9	265	Non-inclusion criteria
10 11	266	- Vulnerable patients (adults under guardianship, pregnant or nursing women)
12	267	Patients with reading and writing difficulties (as data collection in the quantitative phase is mostly
13 14	268	based on participants' self-reported data collected through a booklet)
14	269	Period of the study
16 17	270	The planned duration of the study is 30 months. Inclusions started in February 2017. The quantitative
17 18	271	phase will go on for 18 months, the qualitative phase will go on for 10 months, and the last two
19	272	months will focus on integrating results from both phases, in order to provide a global interpretation
20 21	273	and discussion of the results of the study.
22	274	
23 24	275	Quantitative phase
25	276	Main evaluation criterion
26 27	277	The main evaluation criterion is the adherence to clinical follow-up and prophylactic treatment (a
28	278	hypothesized marker of the success of transition into adulthood), which will be assessed via the
29 30	279	following items:
31	280	– number of follow-up visits in agreement with the recommended number over the last two years,
32 33	281	- number of prophylactic treatment injections in agreement with the recommended number over the
34	282	last three months (if applicable),
35 36	283	 number of haemorrhagic events over the last two years,
37	284	– physician-reported adherence to clinical follow-up and to prophylactic treatment (if applicable),
38 39	285	– patient-reported adherence to clinical follow-up and to prophylactic treatment (if applicable).
40	286	Each item will be dichotomized, and a composite quantitative endpoint will be constructed taking into
41 42	287	account all these dichotomized items. This composite quantitative endpoint will in turn be
43	288	dichotomized to define adherent / non-adherent participants (main evaluation criterion).
44 45	289	
46	290	Secondary evaluation criteria
47 48	291	Each item which is part of the composite endpoint as described hereinabove will be considered in an
49	292	independent manner as a secondary evaluation criterion.
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25 Explanatory collected data 76 Medical data will include: deficit characterisation, diagnosis (age at diagnosis, circumstances of diagnosis, dimuly history), viral diseases (HIV, HBV, HCV), comorbidities (intracranial haemorrhage, major onthopaedic interventions, major disability, cancer, other chronic pathology), previous and current treatment. 70 Organisational data (Haemophila Treatment Catres-reported) 71 Organisational data (Intercophila Treatment Catres-reported) 72 Organisational data (Intercophila Treatment Catres-reported) 73 Organisational data (Intercophila Treatment Catres-reported) 74 Organisational data (Intercophila Treatment Catres-reported) 75 Organisational data will include: paediatric care to adult one, consultations dedicated to the transition, common consultations with both paediatric and adult ITIC, physicians' speciality, mean age of the transition process (information leaflet, therapeutic patient education). 76 Socio-ordenographic and social data 76 Socio-professional category, socio-economic status assessed by the Family Affluence Scale), [48] 71 Distance to the HTIC (in Mn). 72 Membership of French patients association for PWI1 (AFII), 73 Schooling and academic success evaluated by ad-hoc items (schooling type, level of education, academic difficulties). 74 Relationships with the health care system assessed using	1		
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57 58 59		330	validated French short version of the Haemo-Qol questionnaire.[54, 55]
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Time perspective will be assessed using the Past Negative (PN) and Future (F) subscales of the
 French validated version of the Zimbardo time perspective inventory.[56, 57] The PN subscale (9
 items) reflects a pessimistic attitude towards the past and the experience and memory of traumatic
 life events. The F subscale (12 items) reflects an orientation towards future and an attitude of
 planning and achievement of objectives. To avoid the questionnaire being too long, we will not
 plan to assess the Past-Positive, Present-Hedonistic, and Present-Fatalistic subscales.

Coping Strategies will be measured by the validated French version of the Brief-Cope scale[58,
 59] which consists of 28 items assessing individuals' use of 14 coping strategies: self-distraction,
 active coping, denial, drug use, emotional social support seeking, instrumental social support
 seeking, behavioural disengagement, emotional expression, positive reframing, planning, humour,
 acceptance, religion, and self-blame.

Autonomy will be assessed using ad-hoc items only proposed in the YA questionnaire (financial independence from the parents, and living, management of health, dealing with administrative tasks, and taking holidays without the parents). The 15-items Noom validated questionnaire[60, 61] assessing attitudinal autonomy, emotional autonomy, and functional autonomy will be proposed to all participants (ad-hoc translation for this study).

Data collection procedure

Main medical data will be extracted from the FranceCoag database, and completed by a short questionnaire filled in by the referent physician from each HTC. Organisational data will be completed by a medical representative from each HTC. Eligible participants will be identified and approached by the HTC team by which they are followed (approach either during a medical consultation, or by phone call, or by a personalised mail sent at their home). Survey documents (information sheet, informed consent form, booklet, and prepaid envelope) will then be sent by post to eligible young PWH. Participants' self-reported data will be collected through a standardised booklet including several questionnaires (an adolescent version and a YA version). Consent will be collected through the signature of the informed consent form by the parents or the legal representatives for adolescents, and by the signature of the YA directly for YA. Completed questionnaires as well as signed informed consent forms will be sent back by the participants via the supplied prepaid envelope. If no response is received within 30 days, a reminder letter will be sent. A second reminder letter and all survey documents along will be sent two months later in case of no response.

Sample size justification

According to the exhaustive FranceCoag database and considering the specific inclusion criteria of the TRANSHEMO study (severe A or B haemophilia, patients aged 14-17 or 20-29 years, followed in one of the 29 participating HTC), 154 adolescents and 389 YA are eligible for this study. We hypothesised a difference of 20% between adolescents and YA regarding the main evaluation criterion (90% of

adherence to health care in adolescents vs 70% in YA). Then, under the hypothesis of a non-response rate of 30%, and considering a bilateral alpha risk of 5%, the power of this study would reach 99%.[62, 63] Data Management A specific database will be created using EpiData software, and merged with the FranceCoag database. A process will be used to assign to each participant a unique anonymous number. A data quality control will be performed by a physician to limit data inconsistency. Analysis The analysis plan and the final report will be written according to the STROBE recommendations.[64, 65] All analyses will be performed using R software. All tests will be two-sided, and p<.05 will define statistical significance. Analysis populations The analysis populations will be the adolescents and the YA groups, among whom adherent and non-adherent patients will be identified. Descriptive analysis A descriptive analysis will first be performed. Qualitative variables will be presented as numbers and percentages, quantitative variables as means and standard deviations, or as medians and interquartile ranges. Subjective data will be described by their overall scores and their sub-scores. Reasons for non-inclusion will be listed. Included patients will be compared to non-included eligible patients using basic socio-demographic and clinical data, available in the FranceCoag database. *Comparative analysis* Crude analysis Adherence will first be described by groups (adolescents / YA) using classical indicators. The comparison of adherence between the two groups will be performed using chi-square test (or Fisher test depending on the expected numbers) for the main evaluation criterion and for all qualitative secondary evaluation criteria, and using Student t test (or Mann-Whitney test depending on normality of the distribution) for quantitative secondary evaluation criteria. Adjusted analysis In order to identify factors associated with adherence, bivariate and multivariate analyses will be performed. Potential determinants (medical, organisational, socio-demographic and social, psychosocial and behavioural factors) will be proposed as explanatory variables. Logistic regression For peer review only - http://bmjopen.bmj.com/site/about/guidelines.xhtml

models will be used for the main evaluation criterion and for all qualitative secondary evaluation criteria, and linear regression models will be used for quantitative secondary evaluation criteria. Each characteristic whose degree of significance will be lower than .20 will be considered for multivariate analyses. A backward selection will be applied to retain only significantly associated characteristics. Multilevel models will be used to take into account organisational factors which are related to the centre. Structural equation modelling will be considered to take into account the collinearity and/or the complex relationships which might exist between explanatory individual characteristics (especially social, psychological and behavioural ones).[66–68]

413 This analysis will first be performed in the overall population with a forced adjustment on the group414 (adolescent / YA). It will secondly be performed independently in each of the two groups.

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Cluster analysis

In order to bring to light particular profiles of adherent / non-adherent in adolescents and in YA, an
exploratory unsupervised classification analysis will be performed.[69, 70] This method which does
not require any condition of validity will allow to gather patients with similar profiles in homogeneous
clusters.

422 Qualitative phase

423 Data collection procedure

Few subjects (adolescents on one hand and YA on the other hand) who will have participated in the quantitative phase will be selected for this phase according to the following characteristics (assessed from the quantitative phase): adherent or not, and under prophylaxis or not. If they agree, they will be contacted to participate in research interviews conducted by a psychologist, at any place at their convenience (at home, at the HTC...). The interviews will be individual, confidential, semi-structured, and tape-recorded. The psychologist will be blind to the responses in the questionnaires of the participant, and to his/her status adherent / non-adherent as defined according to the main evaluation criterion of the quantitative phase.

The psychologist will start with a general question, then he/she will adopt a non-directive attitude and will allow the participant to spontaneously and freely broach the answers which they consider relevant. Then he/she will summarise the response and introduce more precise questions regarding the topics which will have not been covered spontaneously or sufficiently by the participant. He/she will seek to focus the interview on the participant's personal experiences, subjective perceptions, and expectancies, in order to understand if the patient is adherent / non-adherent and the possible determinants of this adherence. The interview guide will be refined from the findings from the quantitative phase, in order to collect more specifically data about potential determinants and adherence to health care brought to light from the quantitative phase.

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Adolescents' interviews The interview will begin with this general question: "How do you feel about coming into adulthood in a few years?" After the spontaneous answer, the psychologist will encourage them to talk about the following topics: the meaning they give to becoming a YA; their expectations towards their life (personal and professional) as future YA; their plan to care about their health as future YA; their fears towards their entry into adulthood. Young adults' interviews The interview will begin with this general question: "How do you feel about reaching adulthood during the last few years?" After the spontaneous answer, the psychologist will encourage them to talk about the following topics: the meaning they give to becoming a YA; their experienced difficulties towards the acquisition of their autonomy (especially concerning the management of their health) and the construction of their life (personal and professional); the facilitators and barriers they identified during their transition process. Then, to go further and broaden these qualitative data, the psychologist will show to these participants a summary of the adolescents' expectations towards adulthood (from the interviews conducted in adolescents, which therefore will be carried out and analysed before those in YA). The psychologist will then ask YA to assess: to what extent these perceptions match with their own expectations when they were adolescents; to assess to what extent these perceptions match with their current lives; and to indicate which issues regarding transition adolescents forget to mention. Sample size justification Four profiles will be identified from the two selected characteristics (adherent or not, and under prophylaxis or not). On the basis of three interviews by profile, up to 12 adolescents and 12 YA will be selected for the qualitative phase (enrolments until information is saturated). Data Management All interviews will be precisely and entirely transcribed, including the participants' hesitations and self-corrections. Analysis The psychologist will analyse adolescents' interviews on one hand and YA ones on the other hand, using Interpretative Phenomenological Analysis (IPA) method. This method allows to comprehend the participants' subjective experiences through the analysis they make of (and the meaning they give to) their feelings and states, as well as the specific events they are faced with. It makes possible to

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- highlight sociocognitive processes by which personal experiences are assimilated to individuals'
 perceptions of both themselves and the world they live in.[71, 72]
 IPA of an interview is made of four iterative stages. During the first stage, the psychologist will read
 the interview several times, annotating, summarising, paraphrasing, and commenting on what is
 - 482 interesting or significant. The second stage will consist in encoding those annotations to a slightly 483 higher level of abstraction by theoretical and scientific elements: the psychologist will underline the 484 themes addressed by the participant. At the third stage, the psychologist will try to connect these 485 themes by grouping them into superordinate clusters while checking that the connections they make 486 match the meaning of the participant's speech. The last stage of the analysis will consist in giving a 487 scientific meaning to the established clusters.
 - The same method will be used for all participants within each group, with the permanent goal of improving the previously identified clusters. Each time a new element is identified, or each time a theme or a cluster is modified, the psychologist will get back to previously analysed interviews to ensure that the new model accounts for the speech of all participants.
- According to the interpretation of each interview, the psychologist will have to determine the status
 adherent / non-adherent of each participant. Thus, the identified clusters of themes will be put in
 perspective with the psychologist-determined status towards adherence, in order to propose a model
 describing the relationships between adherence to health care and its determinants.
- 496 Finally, when all interviews will have been analysed, a summary will be made, by underlining
 497 similarities and differences between adolescents and YA regarding adherence to health care and its
 498 determinants, and transition into adulthood and its consequences on their lives.
 - Analyst triangulation will be performed,[73, 74] by involving two psychologists in reviewing the
 findings in order to assess the reliability and validity of the obtained results. This triangulation may
 also allow to develop a broader and deeper understanding of the results.

503 Interpretation

Interpretation and discussion of the global results of the study will be done by integrating the results of both phases of the study. From participants who will have been considered consistently according to both quantitative and qualitative phases either as adherent or as non-adherent, hypothesized associations between potential determinants and adherence from the quantitative phase will be therefore confirmed or infirmed thanks to the results of the qualitative phase. Thus, combining the quantitative and qualitative findings will help explain the results of the statistical results, which underscores the elaborating purpose for a mixed-methods sequential explanatory design. [45, 75] Participants who will not have been considered consistently either as adherent or as non-adherent will allow to discuss representations and beliefs about adherence in the context of haemophilia, and the relevance of this outcome to assess the success of transition through quantitative studies.

Patient and public involvement

The development of the research question, study design and outcome measures involved interpretation of literature, professional experience reported through the clinicians, nurses, and psychologists working in the various Haemophilia Treatment Centres participating in the French national registry FranceCoag, and patients' priorities and experience reported through the French association patients association for PWH (AFH) that is member of the steering committee of the study. Patients will not be directly involved in the recruitment, but the AFH will regularly communicate about the study (internet, newsletters, social networks, magazine...) to inform eligible participants in order to maximise the recruitment. Results will be popularised to be communicated via the AFH to participants and to the general public. or oper teries only

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526 DISCUSSION AND LIMITATIONS

528 Strengths and limitations of the database

As the issues concerning transition into adulthood may intrinsically depend on features of the health care system, we intend to explore the specific perceptions of young PWH in France, whose health care system model is specific. The support of the FranceCoag registry to this study is therefore an important strength. While the exhaustivity of inclusions in this registry might have been an issue for patients with moderate or minor haemophilia, the exhaustivity concerning patients with severe haemophilia is guaranteed since 2000. Even if five HTC over the 34 active ones (i.e. 15%) did not accept to participate in the TRANSHEMO study, the loss of eligible patients was small (only 4% of the eligible young PWH). The comparison of basic socio-demographic and medical data, available in the FranceCoag database, between included patients and non-included eligible patients will allow to discuss the representativeness of the included sample. Moreover, the implication of clinicians, nurses, psychologists, and clinical research associates in both the clinical follow-up of patients and this study via their participation in the FranceCoag registry will help to maximise the recruitment and limit the risk of dropouts for this study. The French patients association for PWH (AFH), member of the steering committee of the FranceCoag registry, will also regularly communicate about the study (internet, newsletters, social networks, magazine...) to inform eligible participants in order to maximise the recruitment.

546 Strengths and limitations of the study design

547 The quantitative phase of this study is cross-sectional, while it would have been pertinent to design a 548 longitudinal study to follow up young PWH during their transition. However, as this process is 549 long,[2] it would have been very time consuming, with a high risk of lost to follow-up. We therefore 550 chose to compare at a unique time the experiences of two groups regarding their status towards 551 transition. If the results of the present cross-sectional study turned out to be singular, they could justify 552 to secondly set a longitudinal study up.

The explanatory sequential mixed methods design, [41–47] by combining quantitative and qualitative methods, will bring original results. The first quantitative phase will allow to adjust the second qualitative phase, by the targeted selection of participants (adherent / non-adherent participants according to main evaluation criterion) and by bringing results to be discussed with participants. The qualitative phase will then allow to shed light on the results from the quantitative phase (based on self-reported questionnaires data) by a deeper analysis of participants' experiences collected through interviews conducted by a psychologist, especially for psychosocial and behavioural factors which will have emerged from the quantitative phase. This qualitative phase could also be a starting point for a future longitudinal and quantitative study, by highlighting unexplored processes by the present quantitative phase. The step of integration and mixing of the results from both phases of the study will

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allow to more fully answer the question of adherence to health care through the period of transition to adulthood in the context of severe haemophilia, and to develop a more robust and meaningful picture of this issue. Combining the quantitative and qualitative findings will help both to explain relationships between adherence to health care and its determinants, and to discuss representations and beliefs about adherence, a quantitative outcome which was considered as a marker of the success of transition.

570 Strengths and limitations of the endpoints

The main objective of the study is to assess the potential impact of transition from adolescence to adulthood, which we chose to measure by the level of adherence to health care. This choice is debatable, as maintaining a high level of adherence to care probably reflects only a part of the success of the transition process. However, this choice is justified by several arguments: (i) it is necessary to propose an endpoint which applies for both adolescents and YA, in order to be able to assess through a transversal study the potential impact of the transition on a common endpoint, (ii) a decrease of adherence during the transition process may be associated with clinical consequences (serious bleedings), [32–34] which may impair physical and psychological quality of life in young PWH, (iii) this endpoint allows to assess more specifically the potential impact of the supplementary transition experienced by young PWH, a transition from a paediatric health care system to an adult one, (iv) this endpoint was in the top five of health care transition outcomes identified by a Delphi process with an interdisciplinary group of medical and psychosocial professionals, [76] and (v) this endpoint may be accessible for educational actions. Adherence is a concept which might be defined by the agreement between the behaviour of a patient and the received recommendations or prescriptions.[77] We chose to assess adherence to prophylactic treatment, which is the commonly used evaluation criterion when assessing adherence in haemophilia[29, 35] but which would have been valid only for young PWH under prophylactic treatment. We therefore also chose to assess adherence to clinical follow-up, which is valid for all young PWH (even if the rhythm of visits might be different depending on their personal situation). Moreover, we chose to collect data on adherence through three sources of information: (i) data from the FranceCoag database (follow-up visits, injections of prophylactic treatment, haemorrhagic events), (ii) referent physician-reported data, and (iii) patient-reported data. A composite endpoint combining these items will allow to take into account the complexity of the assessment of adherence, in particular by mixing clinical and objective data with behavioural and subjective adherence-related data. The dichotomisation of this composite endpoint to define adherent and non-adherent young PWH will lead to a loss of variability in the data, but this choice will allow to get more accessible data and results. As the issue of variability is sensitive, each secondary endpoint (i.e., each variable included in the composite endpoint) will be analysed according to its original response format (binary, semi-quantitative, quantitative), independently of each other.

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600 Strengths and limitations of the determinants

In this study, the choice of the determinants to be assessed (determinants of adherence to health care, considered as a marker of the success of transition) was based on literature data in the context of haemophilia,[35–37] and this choice was consistent with the theoretical SMART model.[17] This model proposes both potential barriers and facilitators, but also both pre-existing and modifiable factors, more amenable to intervention, including beliefs/expectations related-factors (time perspective) and psychosocial functioning related-factors (coping strategies and family functioning).

Time perspective refers to how individuals partition their experiences into distinct temporal categories of past, present and future.[78] Particular temporal frames may be associated with well-being and quality of life.[79] Indeed, focusing on a "past negative" time perspective may result in negative longterm adjustment and post-traumatic stress symptomology.[80] On the contrary, "future" time perspective has been viewed as the more constructive time perspective.[79]

612 Moreover, people (patients and relatives) faced with a severe chronic childhood disease generally 613 experience repeated stress reactions because the disease questions individuals about their beliefs, 614 identity, priorities, and short-term and long-term goals.[81, 82] The coping strategies individuals 615 implement to deal with these stress reactions have been studied. Studies show that an individual's 616 inability to implement appropriate coping strategies, or the use of strategies targeting only emotional responses (instead of their cognitive antecedents), are responsible for emotional disorders and 617 618 impaired familial and social relationships. On the contrary, long-term well-being may be facilitated by 619 the use of coping strategies which allow people restructuring their concepts, beliefs, values, priorities, 620 standards, and personal goals.[82-86]

Finally, growing into adulthood implies that young people gain autonomy, get independent and 621 622 endorse the responsibilities falling to adults. This personal empowerment implies that they develop 623 their own personal values and long-term goals (attitudinal autonomy) and implement effective 624 strategies to achieve these goals (functional autonomy). However, this ability to develop autonomy 625 depends on the capacity to maintain confidence in one's own values and goals (emotional 626 autonomy).[60, 87] We assume the development of autonomy (especially emotional autonomy) 627 largely depends on the family functioning: parenting style, cohesiveness, flexibility, roles 628 management, and communication of emotion.[49, 88-90]

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630 ETHICS

Informed written consent will be obtained for all participants prior to recruitment for the study. For
adolescents, consent will be obtained from their two parents or from their legal representatives, in line
with the French laws and regulations. All data will be analysed confidentially and anonymously.

The study was designed according to Good Clinical Practices, and all procedures will be in accordance with the Declaration of Helsinki. The study was approved by the French Ethics Committee (Comité de Protection des Personnes Sud Méditerranée V) on 8th November 2016 and by the French National Agency for Medicines and Health Products Safety on 22th September 2016 (reference number ID RCB: 2016-A01034-47). Data collection, recording, and analysis process was approved by the French Data Protection Authority (CNIL, Commission Nationale de l'Informatique et des Libertés, authorisation number 918045), and this approval was in line with the General Data Protection Regulation principles. The protocol was registered in ClinicalTrials.gov (NCT02866526).

DISSEMINATION

This study will allow to comprehend what the potential impact of transition from adolescence to
adulthood could be in young PWH in France, which is of particular interest in the global approach
whose goal is to take care of all aspects of life in patients with chronic diseases.

This study will also allow to identify determinants of adherence, considered as a marker of a successful transition in young PWH. The assessment of social, psychosocial and behavioural data, will allow to describe the socio-cognitive processes which may facilitate or complicate adherence, while taking into account other factors, *i.e.* medical, organisational, and socio-demographic factors. The results obtained from the quantitative phase of the study will be enlightened by the analysis of the interviews conducted in the qualitative phase. This analysis will bring supplementary and complementary data which would not have been accessible via the analysis of the questionnaires, especially concerning expectations and fears about health, but also about personal and professional life. Singular results from this qualitative phase could be used to better design a future quantitative study on the issue of transition, by assessing complementary outcomes to those assessed in the present quantitative phase.

Results will allow to propose recommendations and to develop interventions to compensate for young PWH difficulties, and thus optimize the adherence to the proposed follow-up and to the prophylactic treatment, but also facilitate their entry in the adult life. The effectiveness of such transitional programs could be improved by targeting specific patients at risk of difficulties (especially lack of adherence to health care) through the transition process, or by targeting specific needs expressed by young PWH in the present study.[18]

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In order to assess the transferability of the results from the TRANSHEMO study in other contexts of 666 667 childhood chronic diseases in France, complementary projects could be proposed to assess the issue of 668 transition in young patients with rare and/or serious and/or chronic diseases. This approach would 669 allow to identify which issues are common to these diseases and which ones are specific to a disease, 670 including severe haemophilia. Common and specific actions could then be proposed to facilitate the rt ye 671 transition process and support young patients. 672

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673 Authors' contributions

- 674 NR, ABA, KB, TL, HC, PA contributed to the design of this study and wrote this article.
- 675 The investigators (LA, SB, CB, M-AB, CB-A, AB-D, SC, PC, SCD, EDR, DD, CF, BF, VG, JG, YG,
- 676 BG, AH, AH, YH, TL, AL, AL, MM, SM, FM, GM, CN, PN, CO, BP-P, BP, AR, AR, DR, PS,
- 677 AS, CS, BT, MT, J-BV, SV, FV, AV-E, BW) of the French Haemophilia Treatment Centres
- 678 contribute to enrol participants, they revised the manuscript and approved the final version.
- 679 Members of steering committee (NR-D, VM, TS) contributed to the design of this study, they revised680 the manuscript and approved the final version.

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