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Disclosure and Quality of Life of People Living with the HIV/AIDS under HAART in Kinshasa, DR Congo

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Abstract

Background: The disclosure of the serological statute is not very current in the handling of People Living with the HIV/AIDS (PLWHA) in Kinshasa, in Democratic Republic of Congo whereas this practice influences on the Quality of Life (QoL).

Objective: To value the quality of life of the PLWHA under HAART having revealed or no their serological statute in Kinshasa, Democratic Republic of Congo.

Methods: The scale of the life quality, MOS SF-36, has been used in a survey transverse, descriptive and analytic track of the 8 December 2014 at 6 March 2015 by 677 patients followed to AMO-Congo, PODI Est and Center. The variables of interest were the data sociodemographic and the disclosure of the serological statute. These data were analyzed by SPSS 21. The Chi-squared test permitted to value the associations in the doorstep of statistical significance of $p \leq 0.05$.

Results: The middle age of topics was of 47.46 years ± 10.21. The feminine sex predominated with 76%, either a sex ratio of 3F/1M. 75% of the PLWHA had a bad QDV. 64% had not revealed their serological statute. 71% of the PLWHA were lone, 97% were instructed and 60% frequented the independent churches.

There was a meaningful association between the quality of life on the one hand and on the other hand, age ($p=0.018$), the sex ($p<0.001$), the matrimonial statute ($p<0.001$) and the disclosure of the serological statute ($p=0.006$).

Conclusion: The PLWHA under HAART in Kinshasa have a bad quality of life. This one is bound to the non-disclosure of the serological statute, to the advanced age, to the feminine sex and to the solitude.

Keywords: PLWHA; HAART; Quality of life; Disclosure and Kinshasa

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Introduction

The beginning of all handling of the patients touched by the HIV begins with the tracking. Yet, the impact of the announcement can provoke a psychic downfall of which the no one will stand up than progressively in the best of the situations [1,2].

The bad psychosocial support, the condemnation, the mistreatment and the discrimination associated to the infection to HIV constitute major obstacles to the prevention of new infections, to the attenuation of the impact of the illness, to the supply of a good beginning of all handling and a good quality of life of the PLWHA [2,3].

The disclosure of the serological statute is one of the factors of attenuation of the psychic tension and guarantee for a QOL. Though, the question of confidentiality always remains actuality in the field of the HIV/AIDS [3,4].

To share information on his/her/its serological statute is especially difficult for the PLWHA; because, the sociocultural connotations of the epidemic implying these revelations risk disrupting the relations with the spouse, and with the setting, what could aggravate the pejorative social effects of the attack by the HIV [5].

The people who want "to share" their statute choose the recipients of this information after assessment of the risks according to various factors as the confidence, the pre-existing help relation, the stability of the conjugal bond, or the capacity to bring a support [6].

A survey in France reveals that the PLWHA that had improved their QOL observed their treatment in general better and had an undetectable viral load [1]. Otherwise, the project Togolese PLWHA 2011-2012 had improved the QOL of the 30 PLWHA through the education to the treatments, the visits at home and the positive prevention [7,8].

To Senegal, in spite of a better accessibility in the HAART, the improvement of the QOL of the PLWHA is not always very paid, because the majority of the PLWHA hides their statute to their direct setting and don't accept to testify publicly of it, fearing the pejorative consequences of which they are victims in the society [9]. In DRC, databank doesn't exist on the disclosure and the QOL of the PLWHA under HAART. To value the quality of life of the PLWHA under HAART having revealed or no their serological statute in Kinshasa, Democratic Republic of Congo.

Methods

This transverse and descriptive survey has been achieved from December 8, 2014 to March 6, 2015 within the structures of ACS/AMO-Congo (Actions communal AIDS and Better Future for the Orphans in Congo), those of Physicians without borders and Station of distribution of the Antiretroviral (MSF/PODI) is and Center in Kinshasa, in DRC.

It was about a sample of suitability of 677 consistent PLWHA in ambulatory in the aforementioned structures. HIV-positive individuals aged 18 years and over on ART for at least 6 months were included in this study. HIV-positive individuals with antecedents of psychiatric unrests, not having resided in Kinshasa since at least 6 months and having interrupted the treatment during the survey have been excluded of this survey.

The cards of ad hoc investigation contained the data sociodemographic as well as those on the disclosure of the serological statute [10]. The MOS SF-36 valued the QoL of the PLWHA under HAART in Kinshasa. The ad hoc survey cards contained sociodemographic data as well as data on the disclosure of serological status [10]. The MOS SF-36 evaluated the QoL of PLWHA on ARVs in Kinshasa.

For operational definitions, it was agreed that:

- Age groups initially had six classes (<20, 21-30, 31-40, 41-50, 51-60 and >60); then, to facilitate statistical calculations, these brackets were grouped in two, that is, 40 years and 40 years, taking into account the average age of the subjects (47.46 years ± 10.21). This average age contained the most represented age group in this study.
- Yes: Concerns PLWHA who have disclosed their HIV status; that is, for the patient to share his HIV status with a confidant or with third parties.
- No: concerns PLWHA who have not disclosed their HIV status; that is to say, the fact, for the patient, not to share his HIV status with a confidant or with third parties.
- Educated: Any subject having a level of study ranging from primary to postgraduate.
- Un-educated: Any subject who has not studied or who has not been on the school bench.
- PLWHA living in a union: Any subject officially married or living in a common-law or common-law relationship **(Figure 1)**.
- Solitary: Any subject not living in a union, that is to say singles, divorced, separated and widowed.
- Traditional religion: Concerned the Catholic, Protestant, Kimbanguist and Islamic religious denominations.
- Independent religion: Concerned the so-called revival churches and others.

The MOS SF-36 is a scale of self-evaluation of the QOL bound to health valuing 8 measurements of health: the physical functioning (PF), the social role functioning (SF), the bodily pain (BP), the general health perceptions (GH), the vitality (VT), the emotional role functioning (RE), physical role functioning (PR) and the mental health (MH) [11].

For the interpretation of the results of the MOS SF-36, two synthetic scores have been calculated of which a physical health score and one of mental health [11]. To clear the level of the QOL, one considered each of the components summarized psychic or

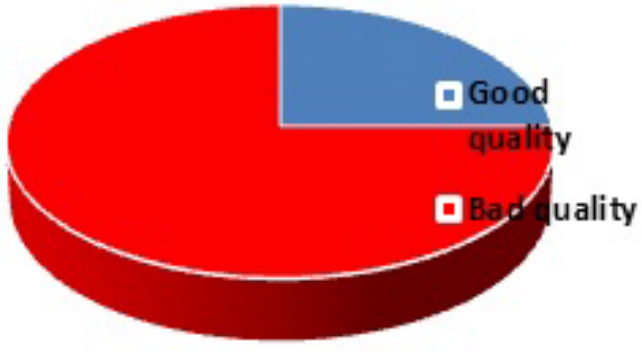

Figure 1 Quality of life of the PLWHA under HAART in Kinshasa.

physical. All patients having one of the two affected components or the two had a bad quality of life.

The research was conducted as follows: The investigator was present at the consultations to go to the interview; informed opinion was required from PLHIV in advance; the respondent completed the ad hoc survey form in which he provided sociodemographic and serostatus data prior to the MOS SF-36 application anonymously.

Data have been seized on computer thanks to the Software MS Excel 2010 and have been analyzed on SPSS 21. The analyses consisted in the production of the frequencies, to the calculation of measures of central tendency and scattering and to the crossing of interest variables. The test of Khi2 and the exact test of Fisher have been used to search for the association between the dichotomic variables. The statistical significance doorstep has been fixed to 0.05.

Results

Table 1 reveals that the topics aged of 40 years or more (p=0.018), of feminine sex (p<0.001) and lone (p<0.001) revealed less their serological statute.

Figure 1 demonstrates that 75% of the PLWHA under HAART had a bad quality of life.

Table 2 reveals that PLWHA under HAART in Kinshasa aged 40 or over (p=0.018), female (p <0.001) and solitaries (p<0.001) had a bad quality of life.

Table 1 Characteristic sociodemographic and disclosure.

Characteristic sociodemographic	Disclosure						
	Yes	%	No	%	Total	%	P
Age groups							
<40	52	7.6	102	15.0	154	22.7	0.018
≥ 40	191	28.3	332	49.1	523	77.3	
Sex							
Masculine	89	13.2	72	10.6	161	23.8	<0.001
Feminine	154	22.7	362	53.5	516	76.2	
School level							
Without instruction	5	0.7	13	1.9	18	2.7	0.62
Educated	238	35.2	421	62.2	659	97.3	
Matrimoniale status							
Lives alone (Lone)	73	10.8	406	60.0	479	70.8	<0.001
Lives in couple	170	25.1	28	4.1	198	29.2	
Religion							
Traditional religion	97	14.3	176	26.0	273	40.3	0.979
Independent religion	146	21.6	258	38.1	404	59.6	
Total	243	35.9	434	64.1	677	100	-

Table 2 Quality of life of the PLWHA under HAART and Characteristic sociodemographic.

Characteristic sociodemographic	Quality of life			
	Good n (%)	Bad n (%)	Total (%)	P
Age groups				
< 40	52 (7.6)	102 (15.0)	154 (22.7)	0.018
≥ 40	191 (28.3)	332 (49.1)	523 (77.3)	
Sex				
Masculine	89 (13.2)	72 (10.6)	161 (23.8)	<0.001
Feminine	154 (22.7)	362 (53.5)	516 (76.2)	
School level				
Without instruction	5 (0.7)	13 (1.9)	18 (2.7)	0.620
Educated	238 (35.2)	421 (62.2)	659 (97.3)	
Matrimonial status				
Lives alone (Lone)	73 (10.8)	406 (60.0)	479 (70.8)	<0.001
Lives in couple	170 (25.1)	28 (4.1)	198 (29.2)	
Religion				
Traditional religion	97 (14.3)	176 (26.0)	273 (40.3)	0.979
Independent religion	146 (21.6)	258 (38.1)	404 (59.7)	
Total	243 (35.9)	434 (64.1)	677 (100)	-

Table 3 Quality of life and disclosure of the serological statute.

Parameters of the HIV	Quality of life			
	Good n(%)	Bad n(%)	Total	P
Disclosure				
Having disclosing	61 (9.0)	182 (26.9)	243 (35.9)	0.006
Not disclosing	108 (16.0)	326 (48.1)	434 (64.1)	
Total	169 (25.0)	508 (75.0)	677 (100)	-

Table 3 reveals that the non-disclosure of the serological statute (p=0.006) was associated to the bad quality of life of the PLWHA under HAART in Kinshasa.

Discussion

The present study found that 75% of PLHIV had a poor quality of life. These results are similar to the multi-center ASTRA study in the United Kingdom, where HIV-positive subjects have a lower quality of life compared to HIV-negative subjects. This is because HIV-positive people experienced strong feelings of anxiety and depression [12].

Nevertheless, these results contrast with those of Rakotoarivelo and MJ Essi where the overall score of good quality of life was respectively 94% and 74.23% [13,14]. This could be explained on the one hand by the difference in scale used and the nature of the study, and on the other hand by the fact that these patients already benefited from an important psychosocial management.

The average age of PLWHA was 47.46 ± 10.21 years, with extremes of up to 60 years. PLHIV over the age of 40 had a poor quality of life. This observation was close to that of Arugwiru [11].

This age, in Africa, coincides with social success, sexual and professional activity. Being chronically ill at this age brings despair, anxiety and exposure to depression [15]. Indeed, this could be explained by the fact that this age is that of full professional and sexual activity. Revealing one's HIV status would lead to stigmatization and rejection.

The sex ratio was 3F/1H. This joins the study [11,16]. This feminization can be explained by the large surface of the genital tract favoring contact with the virus [15]. The practice of polygamy in Africa and the socio-economic vulnerability in African societies forcing women into prostitution may also affect the feminization of the population concerned [17]. Sexual violence in sub-Saharan Africa fostered by armed conflict also contributes to this feminization [18].

The present study showed that 64% of PLHIV did not disclose their HIV status. This non-disclosure was associated with older age, female gender and loneliness.

Female PHAs were less likely to disclose their HIV status. In African societies, women occupy a second-class position. Confessing one's HIV status would expose them to more rejection. These data are, however, contrary to the study by Diarra and Moumouni, where PLHIV who did not disclose their HIV status were predominantly male [3]. This difference could be explained by the nature of the samples.

Indeed, women experience more discrimination, stigma and abuse than men in HIV/AIDS. On the other hand, African women have higher physical and cognitive impairments and a lower socio-economic status than men [3,4,19,20].

Loneliness is a factor favoring mental pathologies, including depression, a condition that is not conducive to disclosure [21]. It is a factor of poor quality of life [14,15,22]. It is at the base of anxiety states, severe immune depression, opportunistic diseases, even depression [15].

Indeed, hiding his HIV status is very common in HIV/AIDS because confessions carry a high risk of disclosure of the diagnosis around him, but also keeping the secret maintains phenomena of guilt, anxiety with respect to HIV/AIDS sexual partner. This double secret is often accompanied by anxiety or depression [23].

Conclusion

People living with the human immunodeficiency virus in Kinshasa have a poor quality of life. This is related to the non-disclosure of HIV status, advanced age, female gender and loneliness. Thus, the notion of disclosure of HIV status should be considered a priority in the care of people living with HIV/AIDS on antiretrovirals.

References

1 Carrieri P, Spire B, Duran S, Katlama C, Peyramond D, et al. (2003) Health-related quality of life after 1 year of highly active antiretroviral therapy. J Acquir Immune Defic Syndr 32: 38-47.

2 Lang JP (2009) Psychiatry, HIV and Hepatitis C. 1st Edition. Elsevier Masson, p: 272.

3 Diarra A, Moumouni A, Moha M, Issaka O, Ousseini A et al. (2009) The daily experience of people living with HIV in Niamey. Studies and works of LASDEL, N°80.

4 Law No. 18/012 of July 9, 2018, amending and supplementing Law No. 08/011 of July 14, 2008 on the Protection of the Rights of PLWHA and Affected Persons (2018) Official Gazette of the DRC, Kinshasa, pp: 9-12.

5 Loukid M, Hilali K (2014) The issue of sharing the HIV status of people living with HIV in Morocco, p: 52.

6 Wong LH, Rooyen HV, Modiba P, Richter L, Gray G, et al. (2009) Test and tell: Correlates and consequences of testing and disclosure of HIV status in South Africa. J Acquir Immune Defic Syndr 50: 215-22.

7 PLWHA project (2012) Improving the living conditions of 30 PLWHA identified in Adamavo, Togo, Togolese Republic. p: 2.

8 Policy and strategies for caring for people living with HIV/AIDS (2014) Mauritania, p: 71.

9 Khoudia Sow (2002) Sharing information on his HIV status in a context of polygamy, Paris, ANRS, Social Sciences and AIDS Collection. 406: 219-28.

10 HIV non-disclosure and the criminal law: A summary of two recent decisions of the Supreme Court of Canada (2012) Toronto: Canadian HIV/AIDS Legal Network; p: 9.

11 Leplège A, Ecosse E, Coste J, Pouchot J, Perneger T (2001) The MOS

SF-36 questionnaire: User manual and interpretation guide of the scores of the SF-36, Paris, INSTEM Publishing.

12 Lopes M, Olfson M, Rabkin J, Hasin DS, Alegria AA, et al (2012) Gender, HIV status, and psychiatric disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions. J Clin Psychiatry 73: 384-91.

13 Rakotoarivelo R, Ramanalimanana P, Andrianasolo R, Razafimahefa SH, Randria MJD (2011) Assessment of the quality of life of people living with the human immunodeficiency virus in Antananarivo, Medicine of Black Africa, APIDPM tropical health, 5802 ; pp: 100-4.

14 Essi MJ, Kamto E, Billong CS, Ntoné F, Njoya O (2014) Evaluation of the quality of life of people living with HIV at Edéa. J Med Pharm 4: 409-15.

15 Muilu PJ, Mananga LG, Mampunza MMS (2017) Evaluation of the quality of life of people living with HIV/AIDS: Antiretrovirals in Kinshasa. European University Publishing. p: 28.

16 Mondjibaye FD (2013) Hygiene measures taken by PLWHA to improve their quality of life; Catholic University of Central Africa. p: 28.

17 National Guide for the treatment of HIV Infection with antiretrovirals in adolescents and adults (2005) PNLS, DRC. p: 6.

18 Jennifer K, Pam D (2007) Sexual Violence and Transmission of HIV/AIDS, Forced Migration Review, RMF 27.

19 Kathleen H (2007) Disclose your HIV status: The key to effective contraception. Family Health International. 24: 19-23.

20 Prado-Jean A, Nubukpo P, Druet-Cabanac M, Preux PM, Clément JP (2010) Psychiatry of the elderly: Epidemiology of psychiatric disorders., Medicine-Sciences. Flammarion. 603: 12-21.

21 Canadian AIDS Society (2014) Talk about depression, anxiety and HIV/AIDS. 52: 3-7.

22 Coudray M (2017) Living with HIV-AIDS today: The fear of rejection, the weight of loneliness. Psychologies - Shop.

23 British Columbia (2009) Longevity and quality of life of the HIV-infected patient once the infection is under control. The 18th Annual Canadian Conference on HIV/AIDS Research.