

Diagnosis Disclosure to Adolescent Living with HIV in Urban Areas of Rwanda

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DESCRIPTION

Globally, 1.65 million adolescents (10-19 years of age) were living with Human Immunodeficiency Virus (HIV) in 2018, of which 88% (1.46 million) were in sub-Saharan Africa. Improved coverage and access to Anti-retroviral Therapy (ART) have changed the epidemiology of the HIV epidemic as children and adolescents transition to adulthood. Despite significant gains in reducing HIV/AIDS-related mortality and new infections in other age groups, new HIV infections among adolescents show a rising trend in sub-Saharan Africa with a particularly higher rate in the Eastern and Southern Africa [1-5].

Disclosure of Human Immunodeficiency Virus (HIV) to infected adolescents is essential for both personal health maintenance and HIV prevention within the larger population [6]. Non-disclosure of HIV status has been identified as one of the potential barriers to optimum adherence especially adolescents. Like many other countries in the sub-Saharan region, Rwanda has significant number of adolescents infected by HIV, who have increased survival times, due to increased access to ART. Emphasis on the adolescent HIV has increased worldwide as ART treatment has greatly extended life expectancies of positive adolescents. Few evidence-based guidelines exist on optimal time to disclosure to an Adolescent Living with HIV (ALHIV); little is known about the medical effects to disclosure. I investigated whether or not disclosure is associated with improved medical outcomes in ALHIV. Prior work has tended to be qualitative, cross sectional and with emphasis on psychological outcome. This paper addresses the adolescent cohort retrospectively longitudinal, building upon what is already known about disclosure [7-12].

I performed retrospective, longitudinal clinical record reviews of ALHIV seen at Kigali Teaching Hospital, January 2015 and July 2018. Patient demographics and clinical outcomes were systematically extracted. I calculated changes in mean CD4 count, ART and Bactrim adherence before and after disclosure. Linear regression was used to assess for trends in those clinical outcomes associated with age of disclosure while controlling for potential confounding variables [13-19].

Seventy seven ALHIV (51 females, 26 males) were included; most entered care through outpatients department (76%). Nearly half were cared for by parents and 21% experienced a change in their primary care givers during the course of study. The mean time of study is 1.7 years; mean number of visits is 15.7. Mean disclosure age was 15.6 years. I found an increase in ART adherence percentage with disclosure from 0.723 to 0.947 with $p=0.0016$. Younger disclosure age was associated with significant higher mean of CD4 counts over the course of study ($p=0.0011$) and the trend toward a higher mean ART adherence percentage (0.061) [20-23].

CONCLUSION

ART adherence and improved immunologic status are both associated with disclosure of HIV infection to ALHIV. Disclosure of an HIV diagnosis to an adolescent is an important means to improve HIV care. Moreover the research suggests that continuous close contacts and periodic visit of adolescents with HIV is also a key aspect for improvement of care and I suggest that further researches should focus on extended measurement of their viral for long period of time and dietary awareness and improvement in adolescents with HIV.

The research also suggests more involvement of health care providers in preparing caregivers for the disclosure process; therefore highlight the need for the National HIV/AIDS/STI Control Program for continuous strengthening the involvement and training of healthcare providers in HIV diagnosis disclosure to infected adolescents, based on updated WHO recommendations.

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