European Journal of Molecular & Clinical Medicine
ISSN 2515-8260 Volume 07, Issue 06, 2020

Factors That Affectsexual and Mental Health experienceperinatally-Acquired womenadolescents with HIV

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Abstract: The social, cultural and economic realities facing women and men with HIV are defined as well-being, but are challenged as well. Women and men with HIV are responsible for their sexual health with a sexual rights approach. Precise and accessible information is best provided through peer training and health care professionals trained in empathic approaches to sensitive matters to make informed choices and secure, enjoyable sexual relations. Young people living with HIV acquired perinatally require appropriate support in terms of sex and intercourse in advance of adulthood.HIV affects both sexes, but evidence shows that young women are especially vulnerable to sexual abuse and are more susceptible to sexual conduct to satisfy their daily needs of survival. This can lead to poor sexualand reproductive health (SRH). This paper examines young women's sex and relationship experiences with perinatally acquired HIV to learn how they can improve SRH care and related outcomes.A comprehensive case study approach has been implemented, in each case, a young woman (15–19 years), a caregiver and a service provider with perinatally diagnosed HIV

Keywords: Adolescents, HIV sexual transmission, Perinatally-acquired HIV, reproductive health, Sexual health, reproductive health

1. INTRODUCTION:

Several recent reports from the World Health Organization (WHO) highlight the fact that teens worldwide have no access to sufficient care for their health. These reports show that young people with certain health conditions, such as HIV, are struggling to achieve their rights to health care because of their stigmatized nature. The WHO has developed standards to support improvements in quality in adolescent health. One of these adolescents should be actively involved in decisions about their own care, and should participate in the planning and evaluation of services for their needs[1].

The healthcare administrators' understanding of needs and experiences of teens and their collaborators is a prerequisite to service improvement. The complexities of adolescence, particularly in terms of sexual health and relationships, are highly gendered and it is therefore important to understand the discrepancies between the needs and experiences of youths[2].

This paper reports the findings of research on the experience of looking for and receiving sexual and reproductive health care in Malawi, an impoverished resource country in South Africa, for women perinatally infected with HIV. A that number of children with HIV acquired perinatally tend to live in and after adolescence worldwide (and in Malawi). More than 2.1 million teenagers between 11 and 19 and 5.1 million young people between 15 and 24 years of age worldwide. In Malawi, almost 1.1 million people are estimated to live with HIV out of a total population of 15.4 million[3].

Around 11% are children and young people, and more than 91% have been perinatally infected with HIV. Because progress in anti-retroviral therapy (ART), HIV-positive young people have grown and become adults, a key part of their continued well-being is their sexual and reproduction health (SRH). Many young women in sub-Saharan Africa (also in Malawi) start sex with elderly partners at the age of 15 or older, often with whom they are unprotected. Unwanted pregnancies and sexually transmitted infections are the consequences of unprotected sex. This includes the potential for further HIV transmission and possible re-infection by new strains of HIV for young women with HIV.

This includes Unwanted pregnancy was reported in young women living in Malawi with perinatally infected HIV. Research has also shown that young women are especially vulnerable to sexual abuse. These questions pose a challenge to HIV services as to how to best meet the needs of young SRH women.In Africa, numerous leading feminist scholars argued that births are central to the identity of an African woman. Malawi is no exception in terms of the high value even for women living with HIV in their motherhood. Results from previous studies in Sub-Saharan Africa show that children's desires vary from 46% to 76%, particularly since ART has developed. Several factors affecting the wish of women for pregnancy and childbearing have been established[4].

These include increased appreciation of oneself, maintenance of sexual relations, pressuring sexual partners or family members to fulfil social and cultural needs and a strategic approach to building up one's own family particularly in situations of difficulties in adult relations with intimacy, trust and satisfaction. However, in all studies of women living with HIV, the younger age was shown to be a coherent predictor of fertility intentions[4].

In Malawi, this means that as many young women as their male counterparts, there are new HIV infections. Among the young women and one percent of young men 15–24 years of age, HIV prevalence is 4.9%. Given proof that young people living with HIV have high children's desires, most of the programs, in this particular community of women, don't directly discuss fertility desires. Therefore, it is important for sexual and reproductive care therapy to minimize risk that service providers recognize the socio-demographic factors that influence young women 's appetite for childbearing[4].

Research on the experiences of young women who develop HIV, especially in the sub-Saharan area, is limited. Existing studies have highlighted a number that have a negative impact on the ability of adolescents infected with HIV to access healthcare, social, cultural and social services.Many young women find it difficult to obtain contraception offered by adult services or adult services because the field of pre-marital sex is a cultural and social. Furthermore, there is evidence that health professionals have challenges to meet the distinctive needs of young women in the SRH sector[2].

This is due to service providers that are poorly equipped to talk to young people about sexual problems. As such, the needs for more information, open communication and friendly and flexible services are consistent with young people. Existing studies have drawn from mixed populations of men and women in sub-Saharan Africa and have thus been incapable of analysing gender problems with any accuracy. This study is complemented by a special focus on sexual / reproductive health and the experience of young women. Furthermore, the first research on this subject takes the Malawian background into clear consideration[5].

The need for adequate ageing for sex and relationship support is growing as the number of children with perinatally acquired HIV persists and is sexually successful. A variety of studies have shown that women are more likely to engage in sexual activity to meet their daily needs. As most adolescent’s report that they have little influence over negotiating safe sex or contraception, this results in poor sexual and reproductive health (SRH).Malawi 's HIV management services provide substantial support for the clinical needs of adolescents, but still face unprecedented challenges in meeting the SRH needs of this growing adult[5].

More than 2,000,000 teenagers from 11 to 15 and five million young people from 15 to 24 years live with HIV worldwide. In Malawi, nearly 8.8% of the population living with HIV is over 17 million. About 10% of those who live with HIV are children and young people with more than 90% of children who acquire HIV perinatally. Young women have higher prevalence of HIV (4.9% compared to 1%) than young men.Several studies indicate that women with perinatally acquired HIV are, for various reasons, often sexually active at an early age relative to their masculine equivalent. Socio-economic factors, service provision and service providers are the key elements in shaping the sexual experiences of teenagers. Gender and power relations are still the overarching theme throughout the entire knowledge community[6].

Most women with perinatal HIV have lost one or both parents in foster homes, raising their chances of living in poverty. Sexual activity is also used in this context to provide for survival or as an economic tool for a perfect lifestyle or modernity. In the context of HIV positive status, however, it becomes complicated, which is the result of tension between young women's sexual needs and economic and social realities and HIV prevention problems and the status of sexual partners[4]. A growing number of aleatory studies have shown that the ability of young women to take informed decisions in particular on sexual security and contraception has an impact on their ability to negotiate in relation to sex and sexual power inequality (in terms of experience of authority and control of sexual activity).

The sex with elderly and married men was most common. Male relations and economic dependence on men have reduced the autonomy of young people in sexual matters as they have given their older partners power and control positions in sex meetings. This increased the likelihood of teenagers being subject to unsafe practices such as unprotected sex as a guarantee against abandonment and keeping their sources of funding. As a result, protecting themselves and others is less likely and even when they have access to the appropriate information, they become more vulnerable. Such challenges remain a challenge for HIV providers to address the SRH needs of women adolescents[6].

While challenges are well documented elsewhere in discussing sexual problems with younger people. Likewise, it is culturally prohibited to talk about sex in Malawi before husband's marriage and parent's child because of fears of making young people too early on, or because sex is usually confined to families secretly. In this regard, studies show that the fact that adults do not want to be regarded as not compliant with social and cultural norms is an obstacle for the majority of young people to access contraceptive items.Similarly, a number of studies in Africa have shown that service providers and counsellors advise young people with perinatally acquired HIV to refrain from sex, otherwise adolescents will[7].

Health care professionals can adhere to the cultural rules by giving understated warning of possible adverse outcomes of sex rather than realistic SRH education, advice and help, and not by addressing sexual problems directly with young people. Moreover, most of the HIV management services are organized mainly for paediatric, adult and youth care[8]. Thus, young people who are no longer in paediatric care and who feel uneasy about adult services do not have programs to meet their unique needs. It may be assumed that perinatally HIV infected adolescents, despite their sexual needs, are not and should not be sexually active[4].

However, despite knowledge of children's risks and resistance from others in the community it remains strong for women adolescents to have children in the future and/or continue to have children. For example, a signal is that service providers in majority countries face challenges in the management of HIV and AIDS and efforts to prevention because patterns indicate poor preventive practice in the most teenage pregnancies among perinatally HIV infected women adolescents[9].

2. RESEARCH QUESTIONS

Question 1- What is Reproductive Health?
Question 2- What is the affect of sexual and Mental Health?
Question 3- What Acquired Women Adolescents with HIV?

3. REVIEW OF LITERATURE

Kapila A*, Chaudhary S, Sharma RB, Vashist H, Sisodia SS, Gupta A discussed about HIV/aids on a paper with title "a review: HIV aids" HIV / AIDS has been one of the most systematic diseases in the world ever. A lent virus that causes HIV infection and Aid is the human immunodeficiency virus (HIV). AIDS is a human condition that enables life-threatening pathogens and carcasses to grow by incremental immune system failure. The transmission of blood, sperm, vaginal fluid and breast milk leads to HIV infection[10]. HIV is present as free virus particles and viruses in infected immune cells within these corporal fluids. HIV infects vital cells such as CD4 T cells and macrophages into the human immune system. A variety of pathways, including proptosis of infected T cells, contribute to low T cells. HIV infection AIDS symptoms are mostly caused by conditions which usually do not develop in people with healthy immune systems. They are mostly opportunistic infections caused by bacteria, viruses, fungi and parasites that are usually controlled by the immune system elements damaging HIV. When a couple in which one person is infected use condoms regularly, the HIV infection risk is below 1% annually. It is clear that the standard of protection for women's condoms can be equal[11].

Elizabeth D Lowenthal, Sabrina Bakeera-Kitaka, TafireyiMarukutira, Jennifer Chapman, Kathryn Goldrath, Rashida A Ferranddiscussed about "Perinatally acquired HIV infection in adolescents" With the maturity of the HIV epidemic and the growth of antiretroviral therapy, children with HIV are adolescents. The growing number of HIV-acquired adolescents living in this area poses both unforeseen challenges and opportunities to learn about HIV infection pathogenesis. In this study they address developments in paediatric HIV epidemiology and the unique characteristics of HIV in sub-Saharan African adolescents. Longstanding immune infection leads to chronic clinical difficulties which cause serious morbidity and leads to a lack of immune system. In addition to addressing chronic disease, HIV-infected adolescents also need to deal with physical and psychological issues, adhere to medications and learn to negotiate sex while undergoing rapid development. Contexts Specify c strategies to identify the early cation in children of HIV infection and to establish a quick link to care. Age-specific sexual and reproductive health and psychological and educational and social care should be integrated into clinical HIV care. Health care professionals will need to be educated so they are able to understand, handle and provide access to quality treatment beyond expert service at low-level health facilities for the increasing numbers of children who live in adolescence[12].

Sen (2014) described the fact that women 's health today has been shaped by the confluence of the two major policy trends-evolution of healthcare reform policies and a strong articulation from the early 1990's of a human rights-based approach to health, emphasizing the laws and policies for an innovative and effective approach to health, in the after-2015 development agenda. The push for sexual and reproductive rights is an inclusive development to human rights for health that transcends the right to health services and addresses the rights of girls and women in relation to sexual autonomy, integrity and choice. The specific definition of the right to health is crucial in order to comply with, protect, and achieve the health of girls and women in law, policy and programs. However, the more common discussions about the right to health ghettoized this expanded understanding and was only partially covered by the Millennium Goals. The paper argues for the dual approach of putting SRHR effectively into the framework of the post-2015 development agenda. The

first is to establish it firmly in an inclusive approach to health rights. And the second is to propose a forward-looking agenda, based on the two decades of national implementation, with a focus on quality, equality, and responsibility in policies and programs. This will build on good practice and tackle key issues in the process for growth itself[13].

4. METHODOLOGY

The rate of poverty in Malawi and high HIV prevalence among women in comparison to men describe it. Women have little access to formal education and opportunities to produce income in Malawi. Similarly, many people who are perinatally infected with HIV have lost one or both parents and live with foster families, so there is a greater probability of living in poverty. Sexual practices are also used to attain modernity or an idealized lifestyle or as survival instruments. Nevertheless, the HIV programs are focused primarily around paediatric, adult and youth treatment. This could be an obstacle for young women, as they argue, to access the services needed and it does not conform to Malawi's national policy on sexual and reproductive health and rights, which promotes contraceptive use for all 15 and older people.

Three locations, all in Central Malawi, and all centres, Maziko, Chyembekezo and Yankho (pseudonyms), are established for the treatment of pediatric HIV. MazikoCenter in Malawi is in a city and runs 10 percent of all antiretroviral (ART) children who have begun treating children. Yankho Clinic is a rural Maziko Centre-affiliated facility.Chiyembekezo Centre is Malawi's first specialized care and assistance centre, including children. HIV treatment and support. The health systems of these three centres provide no concrete support for the transfer of young people from child to adult. Other services at the centres, which are held once a month, include counselling and teen club meetings. The main activities include: medical care (including the distribution of condoms), group discussions and games. Podiatrists, clinicians, nurses, counsellors and community volunteers are the staff involved in providing the care.

5. DESIGN

A case template was introduced for analysis. A qualitative case-studies approach was considered appropriate because a comprehensive overview was created and the experiences and needs of young women from different perspectives were fully understood and explained. -- case comprised a young woman, her designated caregiver and service provider with perinatally diagnosed HIV (15 – 19 years). The involvement of caregivers and service providers helped to understand young women's experiences in a diverse and in-depth way and enabled them to understand their needs and experiences within their broader lives and encounters with the medical system. The study was approved by the United Kingdom's Research and Ethics Committee in 2011 (C 09, 2011) of the University of Nottingham and in 2011 by the Malawi Review Board's College of Medicine Research and Ethics (P9/11/1124). Each of the three research sites has given written consent to participate in the study. The help services of the centres were referred to young women who became distressed or reported abuse.

6. SAMPLE

Purposeful sampling was done to recruit participants. The criteria included: Perinate women are exposed to HIV, (ii) know their status, (iii) attend a minimum of six months at the Centre, and (iv) be cognitively capable of completing data collection techniques. The criteria included were: The clinic approached participants face to face. At the Centres, health

practitioners approached both young women and their primary caregivers on an individual basis to encourage their participation in the research. They met the inclusion criteria.

The young women and their carers interested in taking part in the study were invited to meet the researcher, who talked in detail about what was involved in the study. The pair were recruited to the study after the researchers obtained their informed consent. Youths under the age of 18 may agree to be involved with parental permission in conjunction with them. The young woman and her caregiver had a chance to identify an operator who had been in constant contact with the lady for at least 6 months. The service providers who were involved in taking part in the study received consent. All participants received verbal and written consent to participate in the study. The consent form with a valid thumbprint was signed by participants who were analphabetic and the form was signed as a temoin by a medical professional.

7. INSTRUMENT

In order to achieve a sufficient number of complete cases, 7 young women from each HIV center and four women from rural facilities were recruited. Nevertheless, only 15 of these 21 young women (i.e. each of the cases consisting of a young adult, her caregiver and a service provider) were eventually able to represent 'complete cases.' The study therefore involved a total of 43 participants. The MazikoCentre was in four cases. The ChiyembekezoCentre was six cases and the District Hospital of Yankho was in four cases.

Therefore, ten cases from the urban environment were recruited and four from rural areas. Six adolescents fell off, for fear of being related to teenage status, as their caregivers were not able to engage in the study to provide full cases. The use of 'my story' books has been fully explained and participated in the sentence exercise by only young women whose carers also took part. They recognized that the scientist had worked in the clinic previously. This study was conducted with the older age of women who attended the centres (15 to 19 years old rather than 10 to 14 years old). The principal researcher (GM) is female and has worked in partnership with the HIV Management Centres. His past was as a professional nurse at the central hospital. Her doctoral studies were carried out at the time of study. She felt that this age group would be more open and experienced than younger adolescents on sexual questions. Furthermore, a large number of young women, including Malawians, in sub-Saharan Africa, start sex when they are 15 years old or non-cohabiting for material support or survival and these meetings are largely unsafe. This often leads to unforeseen pregnancies and early birth.

8. DATA COLLECTION

Data were collected between January and November 2012 following an initial observation period at the three sites to enhance their familiarization with settings and contexts. Data for 14 cases (i.e. 43 participants in total) were collected. The gathering of information included detailed and digitally recorded personal interviews using a theme guide. All interviews were performed by the lead investigator (GM) in Chichewa and were directly translated into English. The majority of the study participants chose to have their interviews at the centres rather than domestically.

Only four caregivers decided to conduct their home interviews. When interviews were held at participants' homes, other family members were asked to stay a distance, or to sit outside the house whenever they could, while the interview was under way to ensure confidentiality and privacy. "Can you tell me your story of developing HIV?" was this one open question posed in order to open interviews to teens, acreages and service providers. "Or can you tell

me your experience of caring for this young woman who is growing up with the virus or providing care?Teens were encouraged to explain the specific issues such as the life with HIV, the growth and the progress of a young woman with HIV and to recognize obstacles to cope with a positive HIV status.

Both providers and caregivers have been encouraged to focus their discussions more (rather than on themselves) on the case they were involved with. Other issues included a young woman 's main needs, key concerns / challenges in looking after a young woman who grew up with HIV, and the most important and practical solutions for her adult life. Speeds and samples. Developed as the interviews progressed to encourage participants to think more in depth and to facilitate transparency for the complexity and uniqueness of individual experiences and challenges as well as perceived needs for young ladies. The researchers were also helped by their familiarity and proximity with the study settings and their capacity to engage in regular talks in the local dialect. The "insider" viewpoint of the researcher made it possible to access more community events such as engaging in teen club meetings, which an outsider could not do. A technique called "my story book" was used in the interviews with teenagers. This is an innovative visual method to encourage open discussion on the sensitive topic and was particularly useful for low literacy participants. 'My story' books consist of images generated by the researchers and exercises to finish the sentence.

Images of young women from a similar ethnic group, to which participants were identified, were culturally sensitive. Young women were invited to show images that best suited their experiences, important needs and problems affecting their lives, future aspirations and priorities. They reflected on the relevance to their experiences, needs and challenges of the phrases selected for the sentence completion exercise. After completion of the book exercise "My Story," teenagers were invited to engage in an in-depth interview to reflect on their writing.

They were also requested to explain their pictures and their significance(s) with regard to HIV growth. 'My story' was tested in another facility offering HIV care in Malawi to determine its feasibility. Some of the adolescents had second follow-on interviews regarding problems stemming from initial interviews, which needed clarification but were not as structured or detailed as the initial ones. A frequent interview was done with a caregiver, a 21-year-old girl, who was disturbed by the essence of the connection to her aunt.

The distressed participant was referred for support services as the interview was conducted within the centre. A subject guide was accompanied by interviews with the caregivers and service providers. During the data collection phase, the researcher provided detailed field notes and the interview transcripts were simultaneously read to facilitate decisions on data saturation and continuous sampling. It took 30 minutes to 1/2 hours to conduct each interview.

9. DATA ANALYSIS

In the context of and on the basis of contextual, transferable findings, data analysis was a multi-stage process involving inductive themed analysis. It was necessary for each case to concentrate on individual accounts so that each case can be presented separately and held true to the case-study approach. Century-wide analysis of similitudes, differences, relationships and contradictions was then undertaken. QSR NVivo 10 was used as a tool for systematically identifying, sorting, coding, and categorizing case-by - case data. Themes were extracted from data and data were coded by the researcher (GM). Emerging issues were addressed as a team and with selected respondents to improve the rigor of the interpretive process. The researcher carried out a confirmation exercise for the participant in a meeting where everyone agreed that the data 's interpretation by the researcher was relevant to their personal experience.

10. RESULTS

The sample was heterogeneous for young women, caregivers and service providers. Six young women lived with either or both parents, two were married and were living with their husbands and six lived with either an aunt, uncle or sister, all of whom had died. Five young women still attended school (four at secondary school and one at primary school), one was in college, one was tertiary school, two dropped out of school (due to failed examinations and lack of fees).Five of the carers worked, six did not work and three did small business. They included nursing (7), medical (4) and social welfare (3), from various backgrounds. (See Table 1 of servicesproviders and caregivers).

The findings provide a nuanced picture of factors affecting the sexual activity of young people and related health studies. It also revealed significant differences in the meanings they have attributed to sexual relations and risk understanding among caregivers, service providers and young women. These issues were divided into four areas:

(i) Want to be 'normal';
(ii) Risk, health and sex: agendas that conflict;
(iii) Cultural silence: responsiveness to adolescent relationships and
(iv) Responding to health care: response from health services.

Table1: ServiceProviders and Caregivers

Category of participants	*Characteristics*	*Number*
Caregivers	*Age group (years)*	
	21–31	*5*
	32–41	*4*
	> 42	*8*
	Relationship to adolescent	
	Mother	*4*
	Father	*3*
	Sister	*3*
	Husband	*1*
	Aunt	*5*
	Uncle	*1*
Service providers	*Age range*	
	20–30	*3*
	31–40	*9*
	> 40	*4*
	Gender	
	Female	*9*
	Male	*6*
	Marital status	
	Married	*8*
	Single	*6*
	Paediatrician	*1*

11. DISCUSSION

This study presents an insight into key issues that affect the experience of SRH in the sub-Saharan African context of young women with HIV that grows perinatally. The results revealed the underlying motivations and wishes of young women who have led them to sexual relations. It was shown how complicated yet important such relationships are for the well-being of young people - both to provide a sense of 'natural' and social identity, love and to provide access to essential material and social capital. The findings show that young women, their caregivers and service providers understand these relations in very different ways, creating a cultural silence that acts as an obstacle to accessing contraception or open discussion of other possible health hazards. Finally, the study showed how young women 's needs cannot be met by their existing structure of service provision, HIV, SRH, and maternity care.

12. CONCLUSIONS

The challenges facing people living with HIV to achieve sexual health are in many ways similar to those facing all people living in vulnerable environments who relying on good health services and systems. Women and men with HIV must also be addressed in a way that supports, enables and does not discriminate against the increased vulnerability due to stigma, societal sensitivity and illness. In Africa and Malawi, HIV treatment also tends not to be adequately trained to address the emerging problems of adolescent SRH. Cultural normative expectations seem to be a critical intersection between cultural and social values that encourage until marriage sexual abstinence, the reality of pre-marital sex among young women, and the desire to use contraceptives. Improving information about SRH, advice, assistance and access to contraceptives can be carried out by means of relatively modest services innovations and training for adolescents who are living with perinatally acquired HIV. Consequently, it is critical that service providers network with prominent groups, community leaders and religious leaders to raise awareness of cultural issues that affect women's teenagers. The situation described in this study reveals the complexity of trying to implement SRHs in a resource-conservative society for young HIV positive women. This showed an image that is contradictory to the National SRH and Rights Policy of Malawi, which supports birth control for everyone aged 15 and older and stresses young people's access to safe and informed consent SRH services. HIV management in Malawi appears to be unable to effectively address the complex SRH issues facing young women. In the short to medium term, a few of the problems found in the report (e.g. gender discrimination or poverty) would be difficult to solve. Increased information, counselling, support and access to contraceptives does not however require significant new human or material resource investment for young HIV-positive women. Instead these challenges can be solved by fairly modest technology developments and preparation for employees. New training initiatives should involve young people, drawing on the findings of qualitative studies like this, to clearly identify where differences in values and understanding exist, the impact they have on services and to encourage debate and innovation in order to address some of the issues.

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