questionnaire was employed to collect data on socio-demographics along with HIV-related baseline characteristics of the study participants. The full version of the self and parent report strengths and difficulties questionnaires (SDQ) was used for psychosocial well-being assessment. Data obtained were analysed using SPSS version 25. P-values < 0.05 were considered significant.

Results

- There were 196/330 (59.4%) females and 134/330 (40.6%), M: F = 1:1.5. The prevalence of psychosocial problems as defined by abnormal total difficulties scores (TDS) was 27.9% (HIV-infected) vs. 24.2% (controls); p = 0.417. The SDQ subgroup with the highest prevalence was the emotional problem scale and commoner amongst the adolescents as compared to the children. There were higher odds of psychosocial problems amongst the HIV-infected which were not statistically significant OR = 1.21, 95% CI: 0.74 - 1.98; p = 0.53. On Spearman’s correlation analysis, all assessed clinical and laboratory markers of HIV disease severity were not significant correlates of psychosocial problems (p > 0.05).

Conclusions

Although living with HIV infection may affect the psychosocial well-being of an individual, HIV does not distinctively increase susceptibility to psychosocial problems. The practice of routine psychometric screening of children and adolescents may be considered since the challenge affects a significant number of all presenting to the health care facility irrespective of their HIV status.

Abstracts

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SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS OF AUSTRALIAN MIGRANT AND REFUGEE YOUTH

Shanaya Napier-Raman, 1Michael O’Dwyer, 2Syeda Zakia Hossain, 3Mi-Ja-Zung Lee, 4Elias Mpofu, 4Tinashe Dune, 5Pranee Liamputtong. 1The University of Sydney; 2University of Western Sydney; 3University of North Texas; 4Western Sydney University; 5VinUniversity

Objectives: Migrant and refugee youth (MRY) in Australia face specific experiences that inform their sexual and reproductive health (SRH). Migrant and refugee communities experience poorer health outcomes, and have lower health service uptake than non-migrant counterparts. Additionally, youth are vulnerable to poor sexual health and compromised sexual and reproductive health rights (SRHR), with Australian youth being disproportionately represented in national STI rates. MRY specifically face both challenges related to belonging to marginalised migrant and refugee communities, as well as those faced by young people transitioning to adulthood. Our study aims were to use an online quantitative survey to 1) investigate MRY’s understanding of and experiences with SRHR; 2) identify the barriers and facilitators shaping SRH outcomes; and 3) examine sociological factors that influence SRHR needs, literacy, service utilisation and access.

Methods: An online survey was developed examining MRY sexual behaviour, knowledge and understanding, education, beliefs and attitudes, service utilisation and SRHR awareness. The survey was piloted with 9 MRY and revised according to feedback. A combination of multiple choice, Likert scale, and open-text questions were used. Respondents were MRY (n = 102) aged 15–26 years, of a migrant or refugee background, living in the Greater Western Sydney area. Snowball and purposeful sampling methods were used. Preliminary descriptive statistics were run on key demographic, sexual behaviour and service utilisation questions.

Results: Most participants (n = 72) identified as female, with 29 identifying as male and one as non-binary. Participants identified as children of a migrant or refugee (55.9%), migrants (30.4%), or refugees (11.8%). Only 29% of respondents always used contraception to prevent pregnancy and protection to prevent sexually transmitted infections (STIs). 36% of participants never used protection to prevent STIs. Reasons given for lack of use included not needing protection if on the contraceptive pill, partners not wanting to and expense. Awareness of SRH services was low, with 63.7% reporting being unaware of any services in their area. Only 2.9% felt that current services meet the SRH needs of MRY ‘very well’, while 16.7% felt that their needs were met ‘not well at all’. 45.1% were unaware if sexual and reproductive rights.

Conclusions: Preliminary results indicate compromised SRHR in key areas: inadequate contraceptive and protection use, lack of engagement with services, and lack of rights awareness. Findings show that some MRY lack understanding of the difference between contraceptive pills and barrier protection against STIs. This further suggests deficits in SRH education and knowledge. Results indicate that SRH services are failing to engage MRY and adequately support them. Lack of awareness of services, and the inadequacy of services MRY are aware of, significantly infringes on rights to access health care. Lack of rights knowledge also limits MRY ability to articulate and action their rights. Significant changes to services are necessary to ensure that MRY are aware of services and that these services actually meet MRY needs.

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DEVELOPING THE VIOLENCE TOOL TO ASSESS RISK OF VIOLENCE AND EXPLOITATION IN GIRLS AND YOUNG WOMEN PRESENTING TO THE EMERGENCY DEPARTMENT

Kate O’Loughlin, 1Anne-Lise Goddings, 2Rebecca Salter. 1Evelina Children’s Hospital; 2UCL Great Ormond Street Institute of Child Health; 3Imperial College Healthcare NHS Foundation Trust

Objectives: The female perspective must be considered in youth violence work to ensure a gendered approach when shaping policy and developing violence reduction intervention programmes that support girls and young women. Increasing numbers of girls and young women presenting to Emergency Departments (ED) have experienced violence- and exploitation-related issues. The risk of violence and exploitation for girls and young women is poorly identified by professionals in healthcare settings and there are a lack of screening tools to assist in assessing this risk. We have developed the VIOLENCE tool (table 1) to provide a structured framework for identifying risk of violence and exploitation for girls and young women and have conducted a scoping study to assess the feasibility of piloting this tool within the ED as part of a wider project to validate its use.

Our objectives included

1. To understand the relevance and importance of the VIOLENCE tool components to professionals working within acute medical settings
2. To understand ED-based professionals’ level of experience and training in assessing risk of violence and exploitation in girls and young women