

**Purpose:** To explore narratives between caregivers and their children on HIV status, mental health, and stigma in Botswana.

**Methods:** Qualitative research was conducted using thematic analysis to explore the relationship between HIV status, mental health and stigma amongst youth and their caregivers in Botswana. Semi-structured interviews were conducted from January to February 2022 assessing attitudes towards these topics. Eligible participants were recruited from Stepping Stones International Botswana (SSI), an NGO in Mochudi, Botswana. The youth participants (ages 12–15) had variable HIV status and were considered vulnerable youth, accompanied by their caregivers to the interviews. Those younger than 12 and older than 25 without a caregiver were excluded from our sample.

**Results:** Preliminary caregiver narrative results show that they acknowledge mental illness, but struggle to define it. They were aware children engaged in risky behaviors like unprotected sex, but not willing to have conversations about it. Common codes used in the caregiver data analysis included insufficient interventions from a systems level, labeling mental health as “issues of young people”, parents’ personal discomfort discussing mental health, and a high level of cognitive dissonance- a distinct difference between their beliefs and actions about mental health. This was particularly distinct in conversations about caregivers’ beliefs about mental health and stigma- that they would not perpetuate bias against those with mental illness- but their actions ostracized those with mental illness from themselves. Preliminary youth narrative results show that they were better able to define mental health compared to their adult counterparts. Definitions are often within the contexts of stress and ongoing problems, recurring codes throughout the youth data. Many were not able to speak on their communication with their caregivers about these topics and other sensitive topics such as HIV. Many did not even know their HIV status indicating either a lack of communication with parents for perinatally infected youth, or youth deciding not to test themselves. Common codes among youth also include hesitancy to discuss mental health and observations of their parents’ words and actions in and around mental health. Both caregiver and youth shared a few common themes. Cognitive dissonance was a recurring code among the dyads. A common theme thus far surrounds a difficulty in defining stigma as it relates to their culture and community practices, both at the caregiver and the youth level. Children and caregivers both seem to be able to reference others who have experienced mental health issues, but rarely do they recognize it in themselves, or even in their immediate family.

**Conclusions:** Findings indicate that there may be a lack of systemic, harm-reductive support to educate caregivers on having conversations about mental health. Initial findings indicate a need for education and support for both parties on mental health. It is essential to use the views of this study to aid better understanding on the mental health and HIV/AIDs related needs of the youth in Botswana and their caregivers.

**Sources of Support:** International AIDS Society, CIPHER program, Center for AIDS Research PENN, PENN Mental Health and AIDS Research Center, Botswana Baylor Children’s Clinical Centre of Excellence.

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#### CREATING ADOLESCENT-CENTERED SEXUAL AND REPRODUCTIVE CARE FOR A MOBILE HEALTH UNIT

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**Purpose:** Exacerbated by the COVID-19 pandemic, adolescents from structurally marginalized communities face barriers to accessing sexual and reproductive health (SRH) care. Mobile health units (MHUs) may be effective in reaching these adolescents but few studies have assessed their feasibility in this population.

**Methods:** We assessed the feasibility of an MHU to provide SRH care to adolescents in community settings. Adolescents were invited to community demonstrations of hypothetical MHU care (“Demonstration events”). Adolescents completed surveys (demographics, likelihood of future MHU-based care, and access to health care) and staff documented field notes. We then partnered with adolescents, health care providers, and community leaders to create adolescent-centered SRH care for MHU delivery (“Clinical events”). Free and confidential services provided on the MHU included contraceptive care, condoms, testing for pregnancy, Neisseria gonorrhoea (GC), Chlamydia trachomatis (CT), Syphilis, and Human Immunodeficiency virus (HIV). Initially, we provided electronic prescriptions for contraception during MHU visits. We later designed a system to dispense contraception [i.e., emergency contraception (EC) for future use, combined hormonal oral contraceptives (CHOCs), patches and Medroxyprogesterone] in the MHU. After MHU care, adolescents completed surveys to report satisfaction while staff documented feedback through field notes.

**Results:** At 8 community “Demonstration events”, 98 teens (mean age 15.8 years, 67% female at birth, 17% Genderfluid/Non-Binary/Trans, 49% heterosexual, 24% Hispanic, 49% Black, 40% White) were enrolled. Most (70%) reported no previous vaginal/penile sex. Many (46%) had forgone needed health care in the previous year. Most (77%) said they were very/somewhat likely to get care on the MHU if available in the future and 82% would recommend it to friends. Most thought the MHU would be a great way to increase access to SRH care because it eliminated transportation obstacles and appointment delays. Many felt the MHU would provide adequate privacy and advised bringing the MHU to school or community events. Teens recommended collecting urine specimens in nearby restrooms and using a brown bag to transport them to the MHU. Utilizing their feedback, we partnered with teen-serving community organizations and schools to host the MHU. At two “Clinical events”, we provided care for five patients (4 biologic females, 1 biologic male). Accepted health services included condom provision (n=5) and, pregnancy (n=3), GC/CT (n=4), and Syphilis/HIV (n=2) testing. Two MHU patients received contraceptive prescriptions, one received contraception onsite (EC and CHOCs), and one with a positive CT test was contacted and treated. Four adolescents completed a post-care survey. All (100%) were very satisfied with MHU care and said they would recommend it to a friend. All (100%) agreed/strongly agreed they learned something new about SRH and reported the information was helpful. Field notes revealed patients communicated appreciation for the care, felt comfortable on the MHU, and found school-based SRH care acceptable. We plan to host five additional MHU “Clinical events” (Fall 2022).

**Conclusions:** As COVID-19 continues to negatively impact adolescent SRH care-seeking, our work offers key insights to customizing MHU-based SRH care to meet the unique needs of adolescents from structurally marginalized communities.

**Sources of Support:** Institutional expansion of NIH-funded KL2 program (RB), 3R21HD098086-02S1 (MM), K23HD098299 (KM).

## 51.

### ADVERSE CHILDHOOD EXPERIENCES AND MENTAL HEALTH

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**Purpose:** To assess whether adverse childhood experiences are related to mental health among youths aged 14–19 years in Switzerland.

**Methods:** Data were drawn from the Swiss mental health study carried out in summer 2021. Participants (n=1164, aged 14–19, 49.6% females) were asked whether they had ever suffered any of 11 adverse childhood experiences (ACE; e.g. You often felt unsupported, unloved and/or unprotected or You have experienced harassment or bullying at school). The ACE were added and divided in four groups: None (31.7%), One (27.4%), Two-three (24.0%) and Four or more (16.9%). Groups were compared on mental health issues (depression, anxiety and self-esteem) controlling for age, gender, family structure, relationship with mother, father and between parents, socioeconomic status (SES) and somatic health. All significant variables at the bivariate level ( $p < .05$ ) were included in a backward multinomial logistic regression using None as the reference category. Results are presented as relative risk ratios (RRR) with 95% confidence intervals.

**Results:** At the bivariate level, groups differed in gender (more females), family structure (parents not living together), relationship with mother, father and between parents, SES, somatic health and depression, anxiety, and self-esteem, with results being less positive as the number of ACE increased. At the multivariate level, those in the One group reported a worse relationship with their mother (RRR: 0.78 [0.64:0.94]) and father (0.79 [0.65:0.95]), lower SES (2.57 [1.00:6.63]) and more anxiety (3.69 [1.57:8.71]). Those in the Two-three group were more likely to be females (1.84 [1.06:3.20]), to report a worse relationship with their mother (0.78 [0.65:0.94]) and father (0.72 [0.60:0.86]) and between parents (0.85 [0.75:0.97]), and to be more depressed (2.37 [1.10:5.09]). Finally, those in the Four+ group were also more likely to be females (2.91 [1.35:6.26]), to report a worse relationship with their mother (0.63 [0.51:0.77]) and father (0.67 [0.55:0.82]) and between parents (0.83 [0.71:0.97]), and to report lower SES (3.36 [1.19:9.50]). They also reported more frequently anxiety (4.79 [2.00:11.49]) and lower self-esteem (2.34 [1.09:5.00]).

**Conclusions:** Adverse childhood experiences have a negative effect on youth mental health, especially anxiety that increases with the number of ACE. Females are more affected than males and there is a clear decline of their relationship with both their parents and between the parents independently of the family structure. Additionally, more ACE are observed in the lower SES segment. These results should give hints to clinicians on what to ask when doing the psychosocial interview. As ACE are evitable, such questions should be included in the anamnesis from early childhood, especially among vulnerable populations such as those living in the lower SES segment.

**Sources of Support:** UNICEF Switzerland and Liechtenstein.

## 52.

### ENGAGEMENT OF PEER EDUCATORS FROM INDIA'S NATIONAL ADOLESCENT HEALTH PROGRAMME DURING THE COVID-19 PANDEMIC RESPONSE

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**Purpose:** India's National Adolescent Health Program, Rashtriya Kishor Swasthya Karyakram (RKSK) is based on a continuum of care for adolescent health and development needs. The program adopts three implementation approaches: facility, community, and school-based for providing information, commodities, and services, with referral linkages through India's three-tier public health system. The community-based approach involves implementation of the Peer Education program at the village level, delivered by trained peer educators (PEs), who act as an important link between service providers and adolescents, parents, and the community. We conducted a study to understand the role of these PEs recruited and trained to deliver the Peer Education program to the COVID-19 response.

**Methods:** The study was conducted in two Indian states, Madhya Pradesh and Maharashtra (December 2021–March 2022). A snowball sampling technique was used to select the participants. In-depth interviews were conducted with stakeholders (n= 110, Maharashtra: 58, Madhya Pradesh: 54) engaged in the implementation of the peer education program at the state, district, block, and village levels. Focus group discussions were also conducted with adolescents enrolled under the PEs [n=16 FGDs (with 120 adolescents), Maharashtra: 8 (66 adolescents), Madhya Pradesh: 8 (54 adolescents)]. The data was coded and organized thematically using a sequential approach of deductive and inductive steps. The study was approved by the Institutional Ethics Committee of the Public Health Foundation of India.

**Results:** Our study found that PEs played a role beyond their program role and acted as a bridge to health services for adolescents during COVID-19. They supported the COVID-19 response and related activities for both adolescents and their communities in four ways: 1) sensitization of adolescents and community members to COVID-19 symptoms, appropriate behaviors, and vaccination by creating wall paintings, and interacting with adolescents through formal and informal sessions; 2) supported community health workers in conducting household surveys to screen patients for COVID-19 symptoms and contributed to the making and distribution of masks; 3) acted as a navigator for adolescents in accessing the health system by informing them about the closest health facility and in certain situations, accompanied adolescents to the health facilities; 4) helped with the online registration process of the beneficiaries and accompanied them to the COVID-19 vaccination sites, while also acting as role models by taking the first dose of the vaccine.

**Conclusions:** Despite their unpreparedness, PEs played an active role in the COVID-19 pandemic response, contributing assistance in several ways. Trained PEs can support adolescents and the community in meeting their needs and acting as a bridge to health services for adolescents during pandemics. To ensure sustainability of their work, it is imperative to further engage and build PEs' skills to