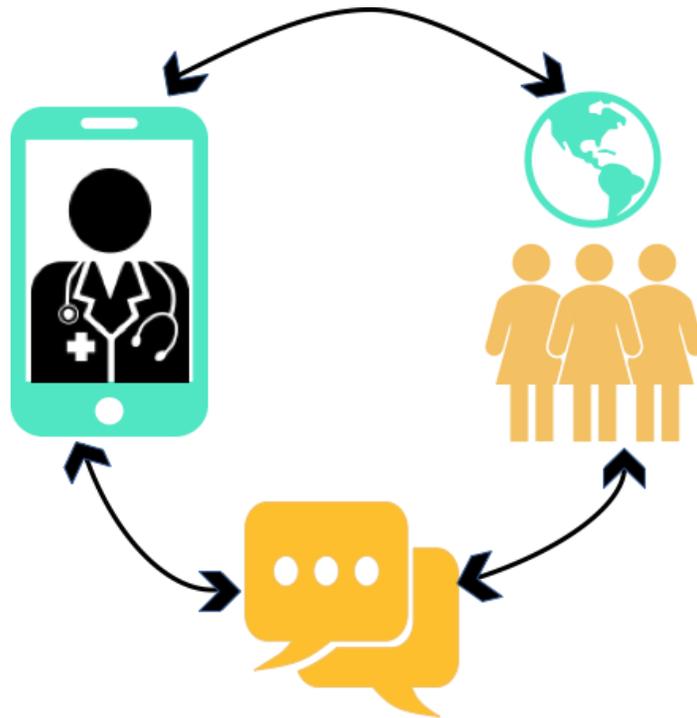




# MI ASISTENTE DE SALUD SEXUAL Y REPRODUCTIVA





# Mi Asistente de Salud Sexual y Reproductiva

Over the past decade, the number of adolescent girls migrating from the Northern Triangle (El Salvador, Guatemala, and Honduras) to the United States has dramatically increased. The particular sexual and reproductive health (SRH) needs of this population are often unmet, and once adolescents reach the U.S., they encounter multiple legal and economic barriers when accessing any form of healthcare. Mi Asistente de Salud Sexual y Reproductiva (MiA) aim to remedy some of these issues. Our proposal address the SRH needs of Northern Triangle adolescent girls through a three-pronged approach: an mHealth application for mobile delivery of SRH services, a system of community ambassadors, and a peer-to-peer mentorship program. All three prongs comes together to delicer SRH information and services in a culturally appropriate and sensitive manner.

## Meet the Team



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**Leah Crenson** is a Master's candidate at the Fletcher School of Law and Diplomacy where she is concentrating in Global Health and Gender Analysis in International Development. Prior to the Fletcher School, Leah worked as a Disaster Operations Specialist at USAID/Office of U.S. Foreign Disaster Assistance, and as a Monitoring and Program Officer at AGE Africa, a Malawi-based NGO focusing on girls' secondary education and life skills. She is currently consulting for a company opening a health clinic in rural Rwanda, and providing training on community sexual and reproductive health and Ebola prevention.



**Andrea Cerda Campero** is a recent graduate from the Fletcher School of Law and Diplomacy, where she concentrated in Development Economics and International Business Relations. Prior to Fletcher, Andrea worked at The Estée Lauder Companies in Mexico City, where she headed communications and corporate social responsibility for M.A.C Cosmetics. Andrea was in charge of managing the M.A.C AIDS Fund and worked with local NGOs and government agencies to develop HIV/AIDS prevention and treatment programs. Andrea wrote her MA thesis on the rise of teenage fertility rates in Mexico from 2006 to 2012.

## **Table of Contents:**

1. Executive Summary	2
2. Background	2
3. Problem Statement	5
4. Solution Overview	5
5. mHealth: MiA Application	6
6. Mentorship Program	10
7. Community Ambassadors	12
8. Implementation Considerations	14
9. Conclusion	17

## 1. Executive Summary

Over the past decade, the number of adolescent girls migrating from the Northern Triangle (a region comprising El Salvador, Guatemala, and Honduras) to the United States has dramatically increased. Many of them have experienced some form of gender-based violence (GBV) either in their home countries or during their migration journey through Mexico. The particular sexual and reproductive health (SRH) needs of this population are often unmet, and once adolescents reach the U.S., they encounter multiple legal and economic barriers when accessing any form of healthcare.

Mi Asistente de Salud Sexual y Reproductiva (MiA) (My Sexual and Reproductive Healthcare Assistant) aims to remedy some of these issues. Our proposal addresses the SRH needs of Northern Triangle adolescent girls through a three-pronged approach. MiA consists of an mHealth application for mobile delivery of SRH services, a system of community ambassadors, and a peer-to-peer mentorship program. All three prongs of our solution come together to deliver SRH information and services in a culturally appropriate and sensitive manner. It considers privacy and capitalizes on the current resources available in the target communities.

MiA has the potential of preventing and treating sexually transmitted infections (STIs) and other infections among teenage immigrants arriving from the Northern Triangle. It can also prevent unwanted pregnancies and refer pregnant teenagers to the appropriate prenatal care services. In addition, MiA can help survivors of GBV by referring them to the corresponding legal, medical, and counseling services.

Equally important, through its rights-based approach, our proposal has the potential of empowering Northern Triangle teenage girls. MiA can support them in their right to make individual decisions about their SRH, as well as in their right to have access to quality, non-discriminatory services.

Finally, MiA has the flexibility to be scaled up, by adding more services and widening the populations served, including boys and LGBTQIA individuals, within our pilot communities. It also has the ability to be scaled out, by adapting the services to help new communities. MiA will help ensure that sexual and reproductive health can be accessed by all of those who need it.

## 2. Background

The following section provides background information that was crucial to determining the MiA approach. This analysis touches on recent migration trends and on the socioeconomic context that is making hundreds of Central American women flee their home countries. Further, it briefly describes some of the experiences in the migration journey that can potentially affect the SRH of adolescent girls attempting to cross the U.S.- Mexico border. This section also analyzes the general SRH needs and beliefs of teenagers back in the Northern Triangle. Finally, it briefly describes key characteristics of the Northern Triangle immigrant population already established in the U.S.

### 2.1 The New Face of Migration

Over the past two decades, the face of migration along the United States- Mexico border has drastically changed. According to data from U.S. Customs and Border Protection, up to 2000, Mexican citizens made up approximately 98 per cent of the immigrants apprehended at the border. In contrast, apprehended

immigrants from the Northern Triangle — a region comprising Guatemala, Honduras, and El Salvador — were only 1 per cent. Today, individuals from the Northern Triangle make up approximately 50 per cent of the total immigrants apprehended at the U.S.- Mexico border.<sup>i</sup>

A declining birth rate, a stable economy, and the U.S. border buildup have all contributed to the decrease in irregular migration from Mexico. However, migration from the Northern Triangle has simultaneously picked up. This has brought along a new set of challenges for policymakers as not only Central American men, but also women and children are seeking to cross the border with hopes of a better future.<sup>ii</sup> While female migrants averaged around 13 per cent of all Mexican migrants apprehended by the U.S. Border Patrol between Fiscal Year(FY) 1995 to FY2017, women from the Northern Triangle averaged between 20 and 32 per cent. In FY2018, these numbers have increased even more, with women constituting approximately 42 per cent of all apprehended Northern Triangle immigrants in 2017.<sup>iii</sup>

There are a number of factors which explain the surge of irregular migration of women from the Northern Triangle to the United States. According to a 2017 report from Doctors Without Borders (MSF), these countries are experiencing “unprecedented levels of violence outside a war zone” and that “citizens are murdered with impunity, kidnappings and extortion are daily occurrences. Non-state actors perpetuate insecurity and forcibly recruit individuals into their ranks, and use sexual violence as a tool of intimidation and control.”<sup>iv</sup> Episodes of lethal domestic violence also contribute to women fleeing their households and filing asylum claims before American immigration judges. According to a 2014 report by the United Nations High Commissioner for Refugees (UNHCR), underage girls in the Northern Triangle are particularly vulnerable to gender-based violence (GBV.) In 2014, the number of young girls captured at the U.S.-Mexico border increased by 77 per cent compared to the previous year.<sup>v</sup>

Furthermore, recent droughts and devastating rainfalls have provoked food insecurity and severe poverty for subsistence farmers in Central America. According to the United Nations (U.N.), small scale farmers along the Dry Corridor that runs through Guatemala, El Salvador, and Honduras lost more than half of their maize and bean crops in 2018. UN officials claim that more than 2 million people are at risk of going hungry.<sup>vi</sup> The economic insecurity caused by environmental degradation has intensified violence as societies have become more stressed and unstable. Consequently, thousands of Central Americans, young women included, are abandoning their farms and migrating to the United States.<sup>vii</sup>

## 2.2 The Journey

In recent years, migrants from the Northern Triangle have organized into caravans, seeking safety by traveling to the U.S. border openly together.<sup>viii</sup> However, caravans by no means guarantee a safe journey for the hundreds of Central American women traveling through Mexico to reach the U.S. border. The migration process for many of these women involves paying exorbitant fees to smugglers, being held in detention centers, and becoming victims of extortion, abduction, and physical and sexual violence. Given the frequency of sexual violence, many women from the Northern Triangle take contraceptives before migrating to avoid pregnancy from rape by smugglers, armed criminal groups, or locals. However, contraception does not protect migrant women from sexually transmitted infections (STIs) or other health risks, and they often do not report or seek medical attention for sexual and GBV.<sup>ix</sup>

## 2.3 Sexual and Reproductive Health (SRH) in the Northern Triangle

To appropriately address the SRH needs of young female immigrants from the Northern Triangle, it is important to understand the SRH beliefs, education, and available services back in their home countries.

According to reports from the Guttmacher Institute and from the World Bank, young women in the Northern Triangle (specifically those who are 15-to-19 years old) face physical, social, and economic barriers to meeting their SRH needs. Adolescent girls face high levels of unmet needs for contraception, unplanned pregnancies, unsafe abortions, STIs, violence, discrimination on the basis of sexual orientation, and maternal mortality.

Even though awareness of contraceptive methods is high among adolescents in the Northern Triangle, unmet needs for contraception (i.e. wanting to delay pregnancy for the next two years, but not using a method) is high among those who are sexually active and have never been married. Abortion laws are very restrictive in the Northern Triangle. In Honduras and El Salvador, abortion is prohibited even when the mother's life is in danger. Selling, distributing, or using emergency contraception carries the same punishment as performing or obtaining an abortion. Unmet needs for contraceptive methods and restrictive abortion legislation all contribute to high rates of teenage fertility rates in the region.<sup>x</sup>

In addition, some married women have little or no agency over their SRH decisions. According to the Guttmacher Institute, about one fifth of 15-to-19-year-old married women in Honduras are not involved in their healthcare decisions.<sup>xi</sup> In Guatemala, more than half of married women reported needing permission from their husbands before using contraceptive methods.<sup>xii</sup>

Moreover, the SRH services available in the Northern Triangle are often directed to women adults. Many doctors and nurses are not trained for sharing information and providing services to youths in a sensitive and engaging way. Additionally, Public SRH services for minors often lack privacy as underage individuals must have parental consent for STI testing and are often served in the same room as other clients. Given the high social stigma on young, sexually active, unmarried women, this presents a key barrier for them when trying to access SRH services.<sup>xiii</sup>

Furthermore, according to the Guttmacher Institute, school is where most young girls in the Northern Triangle learn about their SRH and rights. However, the quality of schooling and the low levels of secondary and high school education among teenage girls in the region have raised concerns. In particular, the low levels of awareness and engagement regarding sexual and reproductive health rights (SRHR).<sup>xiv</sup> In a study carried out in El Salvador by the World Bank, adolescents questioned the validity of some SRHR principles recognized by the international community. For example, they thought that the right to sexual pleasure did not exist and that sexual pleasure should not be promoted given that it leads to promiscuity and the spread of STIs. Adolescents questioned the right to sexual diversity.

Finally, adolescent girls in the Northern Triangle claim to be deeply concerned that their right to report sexual abuse is not guaranteed and enforced.<sup>xv</sup>

#### 2.4 Central American Immigrants in the U.S.

According to a 2015 report from the Pew Research Center, of the three million Northern Triangle immigrants living in the U.S., approximately 55% lived in unauthorized status. Along with New York and California, Texas is among the top states of residence for Northern Triangle immigrants (15% of total immigrants from El Salvador, 8% from Guatemala, and 17% from Honduras). Nearly half of immigrants from the Northern Triangle in the U.S. are women. In addition, the report finds that, on average, 72% of immigrants from the Northern Triangle have lived in the U.S. ten years or more and that 60% of their households include children. Most of these children are U.S citizens.

Furthermore, education levels among Northern Triangle immigrants are relatively low. Most unauthorized immigrants from this region have not completed high school, 60%, compared with 48% of lawful Northern Triangle immigrants. Educational attainment is notably higher among U.S. born residents with Central American roots.

Finally, the report finds that only a third of Northern Triangle immigrants are proficient in English and that English proficiency tends to be higher for immigrants with a lawful status.<sup>xvi</sup>

### 3. Problem Statement

Adolescent girls, ages 12 to 18, who have recently migrated from the Northern Triangle to the United States as refugees, asylum-seekers, or undocumented immigrants have unmet sexual and reproductive health needs. These needs arise/are intensified from their intersecting social, economic, and legal circumstances.

### 4. Solution Overview

#### 4.1 Our Approach

Our current analysis is constrained to the limitations of a desk review as we were not able to speak to people going through this resettlement process and facing the challenges of accessing SRH. However, based on our research, we attempted to understand the wants, fears, concerns, and needs of our target population through human-centered design thinking. We walked through the journey of a girl encountering her SRH from the ages of 12 to 18 and then we considered when and how SRH plays a role in a girl's life during the process of migrating and resettling from Central America to the US. We considered what resources are available, how culture and religion play a role, the role of the persistent fear of deportation, language barriers, legal restrictions or opportunities, the role of potential trauma and sexual and/or gender based violence during and after the migration process, and many other factors to inform our design thinking process.

Because the US is a UN donor country, UN agencies like UNFPA don't provide services in the United States. There are still, however, huge populations of individuals in need of these services that are falling through the cracks. Our goal is to leave no one behind in the pursuit of the human right of healthcare, especially the often forgotten about population of migrants, who are assumed to have their needs met once they arrive in a high-income country, but which is commonly not the case. We chose to focus our attention on vulnerable populations already within the United States because we believe it is necessary to think globally and act locally. We must first address issues at home before expanding outward. We also recognize that this health issue is exacerbated by the current political climate and politicization of SRHR domestically and globally and therefore requires urgent attention.

We have chosen to narrow our initial focus to the state of Texas because it is a border state and holds some of the highest populations of immigrants from the Northern Triangle in the US. Additionally, it is a state with relatively restrictive laws and conservative culture on the issue of SRHR. We believe it will

be easier to expand MiA in the future if our baseline efforts are equipped for legal and cultural push-back.

In order to best engage and serve the needs of our target population, we viewed this health challenge with an interdisciplinary lens. Our proposed intervention incorporates healthcare, education, technology, law, gender studies, and the theory and practice of development assistance

#### 4.2 Overview

We have devised a 3-pronged approach to reaching as much our target population as possible and giving them access to information, support, and services for their SRH. The different prongs of our solution are integrated and overlap to reinforce the desired outcome of each activity: the mhealth platform, the mentorship program, and the community ambassadors.

**Figure 1. MiA: overlapping activities for reinforced outcomes.**



## 5. mHealth: MiA Application

### 5.1 Why This Solution

A study from the Guttmacher Institute, part of a growing body of literature on the importance of informed consent on reproductive healthcare, finds that informed consent requires women are able to access “complete, accurate and unbiased information.”<sup>xvii</sup> Such informed SRH is crucial for women of reproductive age, but our target population –adolescent, immigrant girls-- faces multiple access challenges. One primary challenge surrounds the availability of SRH services for both documented and undocumented immigrants.

Immigrant women do not access existing services because of cost-prohibitive insurance plans, limited availability of information on how to access these services, and perspectives on using these services based on immigration status.<sup>xviii</sup>

Adolescent girls' in the Northern Triangle also face social, legal and cultural barriers that hinder their access to SRH services. While the legal challenges shift after immigration to the United States, cultural and social barriers likely remain. For example, in Guatemala and Honduras, unmet need for contraception is high among adolescent girls aged 15-19, despite the fact that awareness of contraceptive methods is also high. About one fifth of married women in Guatemala report having no involvement in their health care decisions, including family planning, and there is a prohibitive stigma against premarital sex in Honduras and Guatemala. In some Northern Triangle countries, minors require parental approval for STI testing. We aim to help adolescent girls overcome these social, legal and cultural barriers, as well as the compounding access challenges associated with immigration into Texas.

Telehealth is a broad term covering multiple modalities of enhancing health care, public health and health education, including live video consultation, mobile health (mHealth), remote patient monitoring, and store-and-forward programs. We will be focusing on mHealth, which is the provision of health care services via mobile devices.<sup>xix</sup> While the health component of mHealth is a broad term, mHealth is "generally viewed as a driving force in transforming health-care delivery, making some elements of health care faster, better, more accessible and cheaper."<sup>xx</sup> In the United States, mHealth improves access for patients in both urban and rural areas and helps to reduce the health provider shortage by expanding the reach and capacity of physicians.<sup>xxi</sup> We plan to harness mHealth capabilities specifically focusing on the quality and accessibility of SRH care for adolescent girls' who have recently immigrated to the US.

## 5.2 Strategic Implementation

Our telehealth initiative aims to circumvent some of the barriers to adolescent immigrant girls' access to SRH services by providing discreetly accessible, rights-based, SRH education, counselling and referral pathways. Mobile device use is increasing globally and "four of every 5 citizens in developed countries and 1 of every 2 citizens in developing countries have a mobile phone subscription."<sup>xxii</sup> Of those with mobile phones, individuals in our target population (15-24 years old) are most likely to own a smartphone.

Given the increasing global prevalence of smartphones,<sup>xxiii</sup> we will design an app-based text messaging service to deliver critical message campaigns on issues affecting adolescent girl SRH, provide rights-based counselling on accessing existing services, and provide referral suggestions based on type of service provided and location. Our referral system is key, because it helps ensure that our efforts are not undermining or duplicating existing initiatives. It is our goal that adolescent girls who've recently migrated from Central America have easy access to safe and accurate sexual and reproductive health and rights-based information. Often, there are already programs or organizations in place that can best offer these services, and in those instances, we would rather connect our target population to those services than compete. A key strength of our program is our model of adaptability based on these needs and existing resources available to each community we serve. The mHealth services will not provide clinical services and diagnoses, but will provide an option for ordering birth control and over the counter SRH supplies. These services will be compliant with the more rigid state regulations of telemedicine.

Our mHealth application, MiA, will be a free service, available to all with smartphone access, promoted within immigrant communities by community volunteers who will also be able to assist users without their

own smartphone. Due to the many factors requiring discretion in accessing SRH health services, our application will have a discreet design that is not readily identifiable as targeting SRH. Similarly, text messages from the health and rights-based education campaign will be sent from “Mia” in order to look like messages are conversations with a friend.

This free service will eliminate any cost barriers our target population may have—for example, many are not eligible for free and inexpensive health insurance as Medicaid is unavailable, and the Children’s Health Insurance Program is not available within their first five years of legal residency.<sup>xxiv</sup> Undocumented immigrants are largely barred from public coverage. The application will provide generic rights-based education to all users, without requiring them to log into an account, thus assuaging any concerns about disclosing their immigration status while seeking information. Rights-based information will include generic rights to SRH within Texas, as well as information based on immigration status. For example, without logging in, users will be able to determine the laws around how a hypothetical undocumented adolescent girl could access emergency reproductive health care.

Adolescent girls wishing to opt into the rights and SRH curriculum to be disseminated via text campaign will need to log in to access that service, but will not be required to disclose their immigration status in order to log in. All messages from the curriculum will be disseminated using an encrypted server to ensure privacy. The goal of this text message curriculum is to increase the quality of information that adolescent girls receive about SRH and reduce access challenges for those who are unable to access health services due to the sensitivity surrounding cultural norms, immigration status or other barriers.

The SRH curriculum will be based on World Health Organization recommendations on adolescent SRHR and will contain different weekly modules on topics that can be adapted based on the information gaps revealed in the needs assessment. Weekly module topics will include: comprehensive sexuality education provision, contraception counselling, antenatal, intrapartum and postnatal care, sexually transmitted infections prevention and care, HIV prevention and care, menstrual hygiene, sexual and gender-based violence prevention, support and care, and harmful traditional practices prevention.

For each weekly topic, users who opt into the text campaigns will receive a text message highlighting one or two key facts for each topic. Key facts will highlight only the most critical underlying message contained in each module, so that users are more likely to retain the most important information. Users will be given the option to reply “YES” to the initial message in order to receive more information. Users will also have the option to log into the application for more information on each module topic, in addition to or in lieu of receiving additional information via text message. Each module on the application will also have the opportunity for users to test their knowledge on individual topics and dispel some common myths.

Application users who create accounts to log in will also be able to request access to birth control and over the counter medication related to SRH (such as for a yeast infection), delivered via community ambassadors. Birth control will be prescribed by remote physicians who will work approximately 50 hours per week, monitoring information and medication requests from application users.

### 5.3 Module 1 Sample: Topic - Contraceptives: Condoms

#### App Content:

- SMS text message key fact(s)
- Swipe through screens for more information
- Quiz to test knowledge
- Truth or Myth game

**Key Fact:** Latex, plastic and non-latex condoms are highly effective at preventing pregnancy, and the only birth control that can protect against STIs

#### Additional Information:

- How effective are condoms?
- How to use a male and female condom
- Where to get condoms
- What are the benefits of condoms?
- What are the disadvantages of condoms?

Figure 2: Sample Module – MiA Application Mockup



## 6. Mentorship Program

### 6.1 Why this Solution

As we've previously identified, there is an unmet need for adolescent girls who've recently immigrated to the US in accessing accurate information, delivered in a supportive manner, regarding their SRHR. Unfortunately, many students are not receiving this information in schools. In 2009 Texas removed the health education requirement to graduate from high school. Between 2007 and 2016 the number of schools not offering any sex education increased from 2.3% to 25.1% and in 2016 58.3% of Texas schools taught abstinence-only.<sup>xxv</sup> Because this need is so relevant and necessary, it is essential to deliver information in a supportive, culturally-sensitive way that is as easy as possible to access. One strategy that has been proven to be particularly effective, is school-based mentorship programs<sup>xxvi</sup>. Mentors, particularly ones who are familiar with and sensitive to the backgrounds of their mentees, can play a significantly positive role in the acclimatization and feeling of support for adolescents.<sup>xxvii</sup> Research shows that mentoring, including school-based and community-based mentoring programs, for first generation immigrant and refugee youth can promote academic and social engagement and assist in acculturation and integration.<sup>xxviii</sup>

We have additionally identified that there is an under-utilized resource of university and graduate students who can serve as volunteer mentors. This is an ideal target population of mentors because they are academically invested in issues such as public health, psychology, gender studies, law, and social welfare and are often seeking practical exposure. The UT Austin Refugee Student Mentor Program, for example, pairs university students who have middle-eastern foreign language skills with recent refugee students from the Middle East in Austin public schools.<sup>xxix</sup> It is a valuable support system for students to have a mentor who shows interest in them, understands their culture, and has experience navigating the American school system. It is likewise a mutually beneficial relationship for the mentor who has the opportunity to apply their studies in a practical way, remain connected with a community they care about, and broaden their understanding of the lived experiences of recent migrant youth.

The most common ways that teens learn about issues related to sex are through peers and media. A mentor program would be an opportunity to supply teens with accurate information and media resources, which they will hopefully also share with their peers, to improve the accuracy of SRH information being circulated. There will also be the added benefits of connecting our target population with mentors to support and guide them through the process of acclimating to the United States.

### 6.2 Strategic Implementation

As a result of Plyler v. Doe (1982),<sup>xxx</sup> undocumented immigrants are legally entitled to primary and secondary public education in the United States. Additionally, districts are strongly discouraged from requesting social security numbers, but if they do they must inform parents that disclosure is voluntary, provide the legal basis for why it is being requested, and explain how the number will be used.<sup>xxxi</sup> Based on the assumption that girls 12-18 are often travelling to the United States without a visa, at least partially for the purpose of accessing education, we can assume that a sizeable portion of this population is enrolled in school, although no specific data on rates of enrollment for undocumented teens is available.

Based on these assumptions and considerations, we believe the best way to link refugee, asylum seeking, and undocumented teens with mentors is through an after-school program, conducted in Spanish, targeted at recent migrants, that focuses on health, and highlights SRH. This after-school program could be conducted in two ways, either in the school building immediately following school or in a community recreation center. The advantage of the in-school option is its ability to capture the large population of recent migrants who are enrolled in school. The advantage of the community center option is that it doesn't require the school's approval, it has the potential to capture teenagers who are not enrolled in school, and it could be co-led by the university mentors and the community ambassador. However, the community center option has the drawback of potentially being more inconvenient by being in a separate location and the possibility of there not being a local community center, or one that is well maintained. Both options could be valuable and based on the needs assessment and ongoing evaluation, either one can be offered per community.

We have decided to make this program more broadly focused on health education in the hopes that this will be more likely to be accepted by a school in a conservative region of the country and by parents from conservative countries themselves. We have also decided to target this program more broadly at "recent migrants" because this population could all benefit from this program and in the hope that casting a wider net will be more likely to capture a larger proportion of our target population.

The most common ways that teens learn about issues related to sex are through peers and media. These after-school health programs would be an opportunity to supply teens with accurate information and media resources, which they will hopefully also share with their peers, to improve the accuracy of SRH information being circulated. There will also be the added benefits of connecting our target population with mentors to support and guide them through the process of acclimating to the United States.

In a mentorship intervention, it is important to share helpful and accurate information, but it is also important to build a relationship based on trust. Therefore the model of this program will be a brief 10 minute presentation on a health topic, followed by answering any anonymous questions that have been submitted to the mentors throughout the week, and the remainder of the time the mentors will spend time with the students, playing, talking, helping with homework where they can, and building a relationship. This program is an essential component of our solution to bridging the information gap on SRHR to adolescent recent immigrants.

This mentor program will target Spanish-speaking girls ages 12-18. Given the success of this program, it may expand to either include boys or have a separate space for boys. We are hoping this program will reach the most vulnerable populations of recent migrants, including undocumented immigrants, refugees, and asylum seekers. In addition to general SRH education, the information discussed in this program will highlight particular concerns of these groups, including GBV, sexual and domestic assault, gang violence, coercion for sex in exchange for goods or services, trauma of displacement, cultural and academic acclimation, and bullying.

## 7. Community Ambassadors

### 7.1 Why this Solution

While the mHealth Application will reach a broad audience, we want to make sure our initial target population, adolescent girls who have recently migrated to the US, know about and are able to use our service. For this reason, we would complement the application with a community ambassador program. Community ambassadors are based off the community health worker system. According to Torres et al., community health workers are “community outreach programs or practices delivered by front-line health workers who are members of the communities they serve.”<sup>xxxii</sup> Along the same vein, our community ambassadors will be volunteers who live and/or work within the target community. These will be people who are involved and trusted within the community and want to improve the health and wellbeing of the people there. They would be given training in basic health information, including a focus on SRH. These community ambassadors would serve as a liaison between our services and the local population. Their main job is to link our target population with the services we provide. In this sense, they are a type of referral service. The community ambassadors will be on-the-ground and working to create a safer and healthier environment for adolescent girls. Because privacy and lack of familial support around these issues may be a hindrance to accessing care, we believe a community ambassador system will help ensure that the most vulnerable populations are able to reach the service.

Being in a new place can be isolating, especially when someone may not know the language or have any networks. When SRH needs are added into the mix, which may be off-limits in their home culture, adolescent girls are at risk of neglecting the care they need, finding incorrect information from peers or the media, and seeking out informal, and possibly dangerous, means of care. However, a real person, one that the target population trusts or relates to and can speak the same language, can help give the encouragement and support needed to access reliable and private care through the application. Community ambassadors are the link between the healthcare services found in our application and the local community.

According to Wells et. al, community health workers who share a similar cultural background with the populations they serve, and specifically for refugees and immigrants, are better able to respond to that population’s needs.<sup>xxxiii</sup> Therefore, ideally, our community ambassadors would be female and have immigrated to the US from a Central American country, helping them relate to the girls who may be using the service. However, we are open to having anyone become a community ambassador that is enthusiastic about improving SRH in the community and can speak both English and Spanish. These can include people that work in the schools or other community centers.

Having a trusted community member recommend our service will give it more credibility within the community, allowing for an in-person dialogue and the ability to address any hesitations that may arise. These community ambassadors will not be afraid to speak candidly about SRH, but because they are part of the community, understand the concerns people there have about this often-taboo topic. Therefore, community ambassadors will be trained to carefully toe the line between pushing a more progressive reproductive health agenda and maintaining their position within the community. For this reason, community ambassadors will be given general health training for adolescent girls, including on topics such

as hygiene and healthy relationships, so they can continue to work and live within the community and not become isolated, themselves.

These community ambassadors would serve a different role than both the telehealth application and the peer-to-peer mentors. The telehealth application reaches a broader audience and can be used by anyone with a smartphone, regardless of their demographic background; the community ambassadors, however, will be targeting specific populations in a particular area. Additionally, health applications have been shown to have high drop-out rates, meaning that many users delete the app from their phones or mobile devices.<sup>xxxiv</sup> Community ambassadors can help keep up usage of our app, by referring new and existing clients to the app and helping clients use the app even if they are unable to keep it on their own phones for privacy issues. The peer-to-peer mentors, while also an in-person resource, would not necessarily have any prior connection with the community; the ambassador, on the other hand, are deeply invested in the location and population. Additionally, the community ambassadors would be a one-on-one resource, while the peer-to-peer mentors may give information to groups of students. All three components work together to create an inclusive and targeted intervention.

## 7.2 Strategic Implementation

Before becoming a community ambassador, the people selected will go through a core competencies training program on general adolescent health, as well as, specific SRH. They are also trained on the various components of our service, including the mHealth application and the peer-to-peer groups. They will then be trained to notice warning signs for domestic violence, sexual abuse, PTSD, and more. This training will be useful for being able to recognize the most at-risk populations in need of care. With this, they will be able to connect the target population to the specific aspects of our service that fit their needs.

Additionally, the community ambassadors will be trained on the importance of privacy. Fear of losing privacy may be one of the most salient factors for adolescent girls in deciding not to access care. The girls that the service is targeting may not be comfortable talking about their health issues to someone they know or are part of the community. This may be from fear of culturally-conservative communities learning of their use of the service or for the desire to hide their immigration status and fear of potential deportation from the country. The community ambassador must know how to be discreet in handling these cases and approaching the girls. Along a similar vein, these community ambassadors will learn how to be non-judgmental and supportive in their referrals.

The community ambassadors will also receive training on choice. Their main job is to be a referral service and an emotional support option. They must understand the importance of the girls' agency in deciding if, when, and how to access our services. According to Islam et. al, besides trust, treating individuals with respect was one of the most important characteristics for a community health worker.<sup>xxxv</sup> One of our service's main goals is to empower the people using the service, which means that respecting their choice in deciding to use the application is crucial.

The community ambassadors will have a phone provided by the organization to allow girls to use if they desire. Adolescent girls may not have a smartphone or private line of communication to use for this type of application. The ambassadors will be able to provide the tools to connect the girls to the service and allow them to retain a level of privacy from family or friends. The community ambassadors will have a unique login to the application that allows the information from each use will be cleared immediately after logging out.

The community ambassadors will also be given a stock of basic, over-the-counter health supplies. This would include things like treatment for yeast infections, pregnancy tests, condoms, emergency contraception, and more. The community ambassadors would be able to give these supplies to girls in need directly or the girls can be given a referral by the application to go see the community ambassador to be given the supplies in a more timely and private manner than by mail.

The community ambassadors will also help with design, monitoring and evaluation (M&E) of the service. They will provide initial input and, throughout the pilot process and afterwards, feedback on the effectiveness of the application, what types of services need to be added or changed, and how to more effectively target the most vulnerable populations. Because they are on-the-ground, part of the community, and interacting directly with the beneficiaries, they know the best practices and can help incorporate these into the service. With their help, we can ensure that our services are tailored to reach those who otherwise might not be able to or feel comfortable with using them.

There is no limit on how many community ambassadors there can be in one place. We believe 3-5 ambassadors should be sufficient per community, but can adjust based on their feedback and overall sizes of the areas we work in. Because we want the application to reach a larger audience, we do not expect every user to also consult community ambassadors. Community ambassadors will be chosen through application and interview. There will also be a nomination option for community members to highlight people they think would be effective community ambassadors. We would provide a per diem for the community ambassadors and would require they fill in a timesheet and inventory record for our M&E and logistical planning.

## 8. Implementation Considerations

### 8.1 Limitations

Limitation	Expected Challenges	Mitigating Factors
Community Nuances	Each community is different and has different norms and nuances. These differences will require detailed knowledge of each specific community.	We plan to complete needs assessments in conjunction with community leaders in each location, conduct external evaluations to ensure program effectiveness and move forward with malleable curricula/community ambassador selection.
Female-only Approach	The proposed project aim to fulfill SRH needs and rights of women, and does so from a female-centric approach, without engaging men in the community for a more thorough approach.	Our goal is to scale this project to include the SRH needs and rights of men/boys as well. We also plan to engage in behavior change communication with men/boys to open awareness and understanding of girls SRH needs.

Legal and Resource Differences	We hope to scale up this project by implementing in more and more communities, chosen based on available data and needs assessments. Each of these communities will have different state/local-level laws as well as available resources.	We plan to scale slowly, on a case-by-case basis in order to have a full understanding of the legal opportunities and restrictions. The flexibility of our proposal and curriculum will allow us to adapt to each context.
People on the Margins	Our community-centered program runs the risk of missing people on the margins of the central American immigrant community (such as those who have only recently arrived).	We plan to communicate regularly with community ambassadors to see which individuals we may be missing. We also remain hopeful that those who are not engaged in communities are attending school and can access after-school programs.
Quality of Care	Our three-pronged approach offers limited medical/tele-medicine services, and as such most medical services will follow referral pathways. Once referred, we will not be able to influence the quality of care.	We will implement a participant feedback system within our mHealth application such that users can report concerns about their experiences.
Immigration Status Sensitivity	The immigration status of undocumented immigrants and asylum seekers can be sensitive in this political climate. Any program to their benefit could risk accidentally exposing immigration status.	To mitigate this risk, the rights-based education searches on the application will be anonymous and will not require logging into the application. Additionally, the after-school program and community ambassadors program is broadly targeted at recent migrants, and does not pinpoint any one category of migrant. Telehealth consultations and prescription model will help reduce the fear migrants may have of going to health centers

## 8.2 Business Plan: Cost category percent of final budget

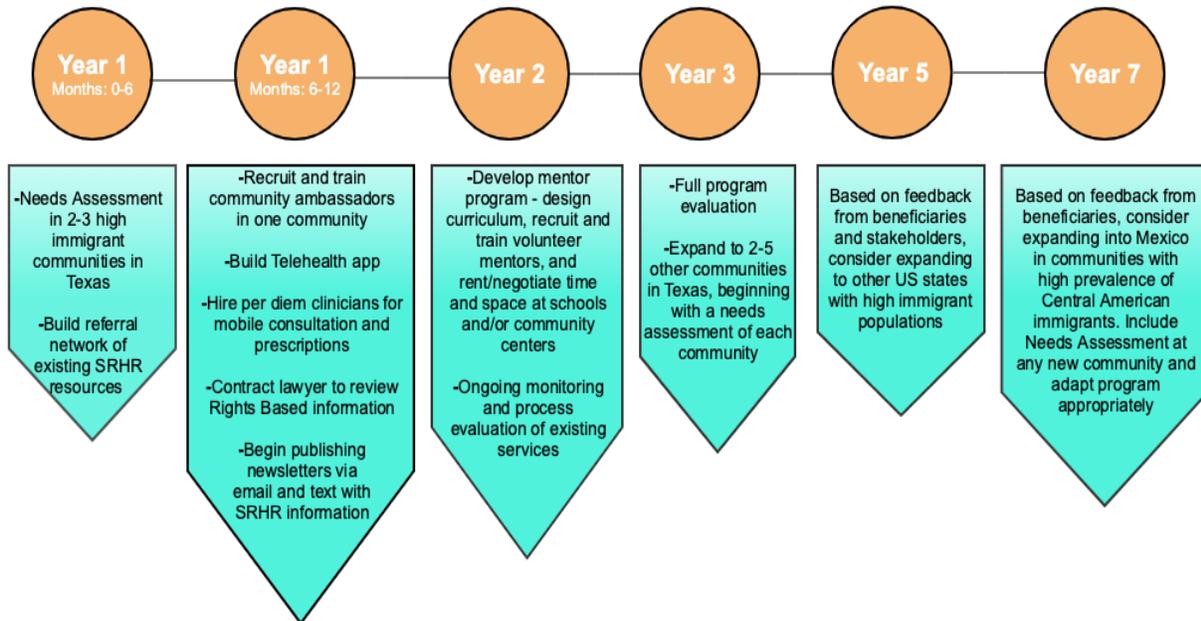
Description	mHealth	Community Ambassadors	Mentors Program
External Evaluation in year 1 and year 3	2%	3%	3%
Application Development/Maintenance	4%		
Physician consultation/FP prescription – 50 hours/week	36%		
Needs assessment/internal monitoring	2%	2%	2%
Office/Program Supplies	5%	5%	5%
Smart Phones – 1 for each community ambassador		9.5%	
Community Ambassador SRH supplies		13%	
Immigration lawyer – Contract basis	8.5%		
<b>Totals:</b>	<b>57.5%</b>	<b>32.5%</b>	<b>10%</b>

## 8.3 Future Plans:

The goal of MiA is to improve equitable access to quality SRH services and rights based information for adolescent girls who have immigrated from the Northern Triangle to the US as refugees, asylum seekers, or undocumented immigrants. In order to do this, it is essential to consider that within this target population, there is a huge range of needs and concerns and that each community we will work with is unique. Given this consideration, any future scaling or expansion of our program will be based on needs assessments and feedback from evaluations. With these prerequisites in mind, some potential options for scaling this program include:

- Expanding our services to:
  - other communities in Texas cities
  - other states in the United States
  - Mexico, still targeting immigrants from the Northern Triangle
  - any community in Latin America with high immigrant populations, for example countries surrounding Venezuela

- Expanding our target population to include:
  - any and all Spanish-speaking adolescents who've recently immigrated, not necessarily from the Northern Triangle and including those of different visa status
  - adolescent boys
  - Gender non-binary adolescents and more explicitly address the needs of the LGBTQIA community



## 9. Conclusion

Adolescent girls from the Northern Triangle migrating to the US are particularly vulnerable when it comes to SRH. Their journey makes often makes it imperative that they connect with SRH resources, but their migrant status and cultural background also make it extremely difficult to access these resources. MiA aims to help remedy some of these issues. Our interdisciplinary, three-pronged approach brings together an mHealth application for mobile devices, a peer-to-peer mentorship program, and a system of community ambassadors. All three prongs of our approach come together to deliver SRH information and services in a culturally appropriate and sensitive manner. Each part uses Spanish as their language of service. Our solution takes into account the legal and economic barriers for migrant adolescent girls when accessing health care. It considers privacy and capitalizes on the current resources available in the target communities. MiA has the flexibility to be scaled up, by adding more services and widening the populations served, including boys and LGBTQIA individuals, within our pilot communities. It also has the ability to be scaled out, by adapting the services to help new communities. This will include those migrating from the Northern Triangle, those migrating from elsewhere, those migrating to other parts of Texas, and those migrating to other parts of the US. MiA will help ensure that SRH can be accessed by all of those who need it.

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- <sup>ii</sup> Leutert
- <sup>iii</sup> Leutert
- <sup>iv</sup> Medecines Sans Frontiers, "FORCED TO FLEE CENTRAL AMERICA'S NORTHERN TRIANGLE: A NEGLECTED HUMANITARIAN CRISIS" (Mexico City, 2017).
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- <sup>vi</sup> "Two Million Risk Hunger after Drought in Central America - U.N.," *Reuters*, September 7, 2018, <https://www.reuters.com/article/us-americas-drought-un-idUSKCN1LN2AY>.
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- <sup>xii</sup> "Sexual and Reproductive Health of Young Women in Honduras" (Guttmacher Institute, July 2014).
- <sup>xiii</sup> "Sexual and Reproductive Health Of Young Women in Guatemala" (Guttmacher Institute, April 2014).
- <sup>xiv</sup> Cortez, Revuelta, and Girola, "ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN EL SALVADOR."
- <sup>xv</sup> "Sexual and Reproductive Health of Young Women in Honduras."
- <sup>xvi</sup> Cortez, Revuelta, and Girola, "ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH IN EL SALVADOR."
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