GENEVA CHALLENGE 2025

PATH

Peer Action for Teen Health

Photo by Teen Health Clinic BCM

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ABSTRACT

Adolescent migrants around the world face significant challenges accessing accurate health information and emotional support due to language barriers, social isolation, and legal or financial exclusion. These challenges are universal across both high-income and low-income countries. Migrant teens are particularly vulnerable to misinformation, mental health risks, and risky behaviors due to a lack of culturally sensitive, age-appropriate health education. PATH (Peer Action for Teen Health) is a peer-led health education and support initiative for migrant adolescents aged 13-18, combining in-person mentorship with a web-based platform to promote well-being through culturally adapted learning and peer connection. The project recruits older migrant teens as trained “health navigators” to support newly arrived youth through group sessions focused on mental health, reproductive health, and nutrition. Each navigator uses a multilingual, visual toolkit to facilitate interactive learning, and open discussion. The PATH web platform complements these sessions by offering self-paced modules, downloadable toolkits, a digital health passport, and a moderated peer discussion space. Accessible via mobile phone or school devices, the platform ensures continuity for teens who may move frequently or face barriers to in-person participation. The pilot will run in Jakarta (Indonesia), San Diego (USA), and Melbourne (Australia)—three cities representing distinct migrant integration challenges. By combining peer mentorship with a digital resource hub, PATH offers a scalable, community-based solution to a universal development challenge. This project supports SDG 3 (Good Health and Well-being), SDG 4 (Quality Education), SDG 5 (Gender Equality), SDG 10 (Reduced Inequalities), and SDG 17 (Partnerships for the Goals).

Keywords: adolescent migrant, peer education, digital health, youth empowerment, mental health

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INTRODUCTION AND PROBLEM STATEMENT

1. The Global Challenge of Migrant Adolescent Health

Adolescence is a crucial stage of human development that involves rapid physical growth, emotional shifts, and evolving social identities. For migrant adolescents, this period becomes significantly more complex due to displacement, separation from familiar support systems, and limited access to basic services. According to the United Nations High Commissioner for Refugees (UNHCR), nearly 49 million forcibly displaced people are under the age of 18 (UNHCR 2024a). These adolescents are often caught in cycles of uncertainty that severely impact their health, education, and well-being.

Many migrant adolescents experience a range of health challenges that differ from those faced by their native-born peers. Language barriers, unfamiliarity with health systems, and the fear of legal repercussions often prevent them from seeking medical care. In many host countries, undocumented or asylum-seeking youth have no legal access to public healthcare services. As a result, treatable conditions remain undiagnosed or untreated. Research shows that adolescent migrants are more likely to suffer from mental health issues such as anxiety, depression, and post-traumatic stress, especially if they have fled conflict zones or experienced prolonged displacement (WHO 2023). Despite the urgency of these conditions, migrant youth rarely receive appropriate care due to a lack of culturally sensitive services and mental health stigma.

In addition to mental health concerns, adolescent migrants often lack access to sexual and reproductive health education. Cultural taboos, insufficient public programming, and exclusion from school-based health curricula contribute to misinformation and confusion around topics such as menstruation, contraception, and puberty (UNICEF 2022). Girls are especially vulnerable when they lack access to menstrual products, prenatal care, or protection against gender-based violence. Nutritional challenges also affect many migrant adolescents. Some experience food insecurity due to poverty, while others face difficulty accessing culturally appropriate and nutritious food. These factors contribute to malnutrition, anemia, and stunted growth, which can affect long-term development (UNHCR 2024b).

Migrant adolescents are also more vulnerable to both communicable and non-communicable diseases. Due to overcrowded housing, poor sanitation, and frequent movement between temporary accommodations, some of them face a heightened risk of infectious diseases such as tuberculosis, respiratory infections, and gastrointestinal illnesses.

In refugee camps and informal settlements, exposure to unsafe drinking water and inadequate hygiene further increase these risks. Additionally, migrant adolescents often not able to follow immunization schedules, which make them more susceptible to vaccine-preventable diseases such as measles or hepatitis. On the non-communicable side, adolescents who experience chronic stress and food insecurity may develop early signs of cardiovascular problems, metabolic disorders, and nutritional deficiencies. In urban settings where processed foods are more accessible than fresh produce, some migrant youth also face rising rates of obesity, even as others struggle with undernutrition. These conditions leave many adolescents vulnerable to long-term harm.

In 2019, the COVID-19 pandemic further widened the health gap for adolescent migrants. Many young people lost access to schools, social services, and in-person community programs. In addition, digital exclusion limited their ability to connect to remote learning or telehealth resources. Migrant teens without regular internet access or devices often fell behind academically and socially, increasing the risk of isolation and psychological distress (UNICEF 2021). These disruptions placed additional stress on families and caregivers, many of whom were already struggling to navigate unfamiliar systems.

Despite these structural challenges, migrant adolescents continue to demonstrate remarkable resilience and adaptability. Many take on caregiving responsibilities for siblings, contribute to household income, or act as translator for their families. Some of them also form strong peer networks, even in environment that lack institutional support. However, many health systems or programs still overlook this demographic. Global development efforts often focus on early childhood or adult populations and leaving adolescent migrants in a policy and programmatic gap (Kadir et al. 2018). More broadly, adolescents' health as a whole remains under-prioritized in global health strategies. While significant progress has been made in maternal and child health, adolescents are frequently treated as an afterthought or subsumed into broader youth categories, which fails to address their distinct physiological and psychological needs.

Addressing the health needs of migrant adolescents requires more than short-term relief or generalized programming. We need a youth-centered approaches that recognize the specific barriers migrant teens face and empower them through culturally relevant, accessible, and age-appropriate health education. Programs that center peer-to-peer learning, digital inclusion, and community-based mentorship offer promising avenues for improving health status and fostering long-term resilience.

2. Peer Empowerment and Health Equity

Peer relationships play a central role in adolescent development and act as a vital resource for migrant youth in navigating unfamiliar environments. The WHO states that peer groups are “among the most influential social networks in shaping health behavior during adolescence” (WHO 2021). Migrant teens often rely on peer networks to manage stress, form their identities, and respond to health information, especially when formal support systems are inaccessible.

Evidence indicates that peer-led health interventions can significantly improve health status in adolescents. A recent meta-analysis of school-based programs reports that peer-led interventions positively influence physical activity, diet, and emotional regulation by leveraging relatable role models (Brinsley et al. 2025). Additionally, peer facilitators in low- and middle-income countries have shown reductions in depressive symptoms and substance use through community-based initiatives (Rose-Clarke et al. 2019).

Despite their potential, few health programs actively position migrant adolescents as peer leaders and agents of change. A scoping review found that while peer-led approaches are common, they rarely prioritize migrant youth as leaders in health interventions (Chow et al. 2024). UNICEF emphasizes that adolescent participation must go beyond tokenism and be embedded meaningfully in program design (UNICEF 2021). Peer navigators who share migration experiences offer culturally and linguistically relevant guidance that can demystify health systems and correct misinformation. Systemic reviews in LMICs (Low- and Middle-Income Countries) confirm that peer-led mental health initiatives, when combined with appropriate training and support, yield positive with appropriate training and support, yield positive outcomes for youth (Chow et al. 2024). Digital platforms can further enhance these programs by providing continuity and connection for mobile adolescents.

In PATH, peer empowerment forms the core mechanism. By positioning migrant youth as both learners and leaders, as well as supporting them with a web-based platform, we aim to co-create health solutions grounded in lived experience. This ensures that migrant adolescents receive accurate, relevant, and empowering education while fostering mutual trust and resilience.

3. Migration and Adolescent Health in Jakarta, San Diego, and Melbourne

Jakarta, San Diego, and Melbourne each present distinct and interconnected challenges for adolescent migrants. In Jakarta, the capital city of Indonesia, thousands of refugees and internally displaced individuals live in urban limbo with limited access to education, healthcare, or formal employment. Although

Indonesia is not a signatory to the 1951 Refugee Convention, it hosts nearly 13,000 refugees, many of whom reside in Jakarta (UNHCR Indonesia 2023). Migrant youth in the city often struggle with daily stress, stigma in public services, and minimal access to teen or adolescent-friendly healthcare. UNFPA (United Nations Population Fund) has reported that young people in Indonesia face widespread barriers to accessing sexual and reproductive health services, while many adolescents in urban areas encounter judgement from healthcare providers (UNFPA 2014).

Picture 1. Refugees in Jakarta, Indonesia. Photo by Kompas

In San Diego, the city's long-standing history as a refugee resettlement hub makes it home to diverse populations that come from Central America, the Middle East, and sub-Saharan Africa. The region has been a host for over 600,000 refugees in the past decade, including many unaccompanied minors (County of San Diego 2018). In San Diego, programs like Refugee Health Assessment exist to offer new arrivals migrant appropriate screenings and limited follow-up care. However, adolescent migrants continue to face major barriers like language challenges, difficulty navigating the U.S. healthcare system, lack of insurance, and trauma-related mental health conditions (Morris et al. 2009).

Picture 2. Refugees and Immigrant in San Diego, USA. Photo by Times San Diego

Melbourne, as one of Australia's most multicultural cities, hosts large communities of young migrants and refugees from Afghanistan, Sudan, the Middle East, and Southeast Asia. The city offers a variety of settlement services and youth-oriented programs through organizations such as the Migrant Information Centre (MIC) Eastern Melbourne and the Multicultural Youth advocacy Network (MYAN). These programs provide English language training, mental health workshops, and social integration initiatives. Despite the support, migrant adolescents in Melbourne still experience isolation, identity conflicts, and gaps in culturally competent care (MYAN 2019; MIC 2025).

Picture 3. Immigrant Adolescents in MYAN Organization, Australia. Photo by MYAN

Demographic trends in each city show a strong presence of migrant adolescents. In Jakarta, almost half of Indonesia's 270 million population is under the age of 30, with a significant portion of adolescents moving to the capital for education or family reunification (UNFPA 2014). In San Diego, youth make up a substantial proportion of the resettled refugee population, especially among unaccompanied minors (County of San Diego 2018). In Melbourne, thousands of adolescents aged 12-15 participate in government-supported education and settlement programs tailored to multicultural communities (Melbourne AMEP 2024).

Migrant adolescents across these cities face similar challenges, including disrupted education, mental health concerns, and limited access to reproductive and preventive health services. In Jakarta, young migrants report being stigmatized or dismissed when seeking healthcare, especially for reproductive and psychological concerns (ALIGN 2019). In San Diego, adolescents often suffer from trauma stemming from both pre- and post-migration experiences which also compounded by difficulties understanding and accessing the healthcare system (Gullo et al. 2021). In Melbourne, even

though the structural support exists, young people frequently report feelings of invisibility, disconnected from their culture, and limited access or spaces for peer dialogue (MYAN 2019).

Based on these reasons, we selected Jakarta, San Diego, and Melbourne for piloting this project because they collectively represent three different migrant integration environments. These cities will be able to offer a dynamic testing ground for PATH, which allow us to refine the program's adaptability across varied social, legal, and cultural landscapes. This tri-city model strengthens our approach to developing a scalable, youth-led intervention that meets the need of migrant adolescent globally.

4. Problem Statement

Migrant adolescents face overlapping challenges in accessing health information, emotional support, and preventive care due to language barriers, social isolation, and limited-service accessibility. Existing health systems often fail to engage youth in ways that are resonant with their culture, age-appropriate, and peer-driven. Despite their growing presence in urban centers like Jakarta, San Diego, and Melbourne, adolescent migrants remain underrepresented in health programming. There is an urgent need for innovative, youth-led approaches that position these adolescents not only as service recipients but as health leaders capable of fostering resilience, equity, and belonging within their communities.

1. Intrapersonal Barriers: Knowledge Gaps and Stigma

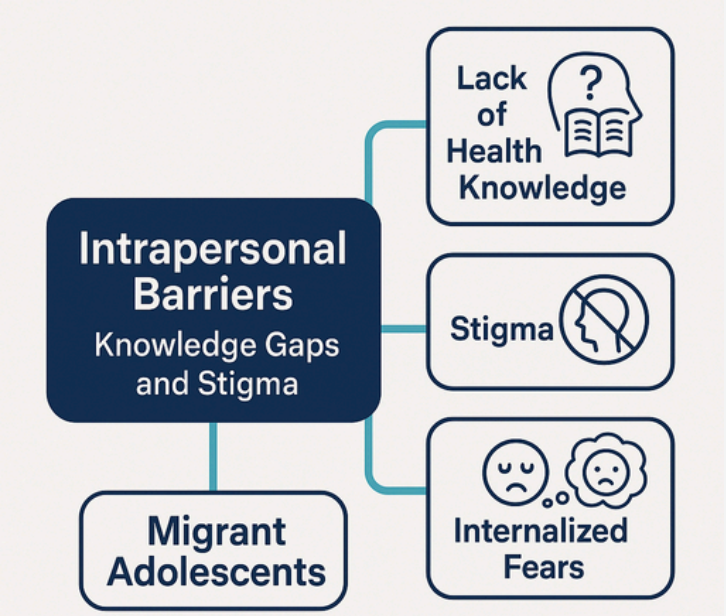

Figure 1. Intrapersonal Barriers Mind Map

Migrant adolescents frequently lack accurate health knowledge due to interrupted education and language barriers. One study found that displace adolescents in low- and middle-income countries had low level of sexual and reproductive health knowledge with only 40% could identify contraceptive methods and many had no formal education in the subject (Logie et al. 2024). In high-income settings, researchers noted that refugee youth "may not know where, how, or when to access sexual and reproductive health services," due to structural ignorance and information gaps (Aibangbee et al. 2024). These knowledge deficits hinder informed decision-making and expose teens to health risks in migration contexts.

Stigma further compounds these gaps. Adolescents in forced displacement and migrant communities often hesitate to seek reproductive or mental health support due to fear of judgement. A review on access to sexual and reproductive health services among forcibly displaced populations found that adolescents reported being delayed or turned away due to provide biases and stigma (Sawadogo et al. 2023). Similarly, global evidence shows that stigma and discrimination are "associated with adverse health outcomes" and significantly limit care-seeking among migrants and refugees (Cabieses et al. 2024). These internalized fears prevent teens from asking questions, disclosing symptoms, or seeking early treatment even though health services exist.

Migrant adolescents also experience intrapersonal stress from trauma, isolation, and identity conflict. A meta-ethnography of migrant young people in high-income countries highlights self-stigma, fear, and mistrust of services as major barriers to mental health care (Place et al. 2021). This internal turmoil is compounded by cultural norms that equate emotional distress with personal weakness, which lead many teens to suppress or ignore mental health symptoms. Without safe peer support or channels that culturally sensitive, these internal barriers escalate poor mental health condition, including anxiety and depression.

Finally, the lack of reliable digital and community-based resources deepens interpersonal barriers. In low-resource urban displacement settings, consistent internet access is rare, further isolating youth from potential education or self-help tools. This digital exclusion reinforces knowledge gaps and prevents adolescents from building self-efficacy or addressing stigma through education. As a result, many young migrants remain uninformed, fearful, and disengaged from life-saving health knowledge during a critical development stage.

2. Interpersonal Barriers: Language, Isolation, and Belonging

Figure 2. Interpersonal Barriers Mind Map

Language limitations often place migrant adolescents at a disadvantage when they try to engage with peers and access health services. A systematic review found that poor language proficiency correlates with higher rates of mental health issues, including anxiety, depression, and PTSD among migrants; longitudinal studies confirm that improved language skills over time help reduce these conditions (Montemitro et al. 2021). Study based on Australia showed that refugee adolescents with higher bilingual ability, such as proficient in both English and their native language reported significantly better psychological health and social connectedness (Mavisakalyan et al. 2025). Limited language skills often deepen social isolation and reduce feelings of belonging. In a 10-district study in British Columbia, first-generation refugee youth began adolescence with lower life satisfaction than non-immigrants but saw their emotional health improve significantly when peer belonging and positive school climate increased (Thomson et al. 2024). These findings show that social integration and peer support are powerful protective factors, yet lack of language skills can block access to such support.

At home, many migrant adolescents act as “language brokers,” translating family conversations with doctors or schools. While this role can empower youth, it also burdens them with adult responsibilities they often do not fully understand, which can contribute to increase stress and anxiety (Getrich 2025). This pressure can strain family relationships and exacerbate mental health challenges (McQuillan and Tse 2009). In addition to language barriers, migrant adolescents often feel marginalized by cultural or ethnic discrimination in schools and local institution. The loss of social support especially shortly after resettlement dramatically worsened refugees’ psychological well-being.

3. Organizational Level: Schools and Youth Centers

Schools and youth centers play a vital role in shaping the daily lives of migrant adolescents, yet many fail to provide the support these youth need to thrive. Migrant teens often navigate unfamiliar education systems, language barriers, and shifting cultural expectations with little guidance. When schools do not offer bilingual materials, flexible curricula, or spaces where migrant identities are affirmed, students can quickly disengage and feel unwelcome (Howard et al. 2024). In classrooms where mental health needs are overlooked and misunderstood, adolescents internalize stress and often remain silent about their struggles. Even when mental health services are available on school grounds, student may avoid them due to fear of stigma or prior experience with discrimination.

Youth centers are designed to be inclusive and supportive and supportive environments, and many already offer valuable services to adolescents. However, when it comes to engaging migrant youth, these institutions often face additional challenges. Staff may not always have access to training in trauma-informed care or culturally responsive practices, which can make it difficult to fully support displaced adolescents. Even well-established programs that promote resilience and health literacy, such as Peer Health Exchange and Friends for Life, which are recognized by the World Health Organization may not consistently tailor their content to address migration-related trauma or linguistic diversity (FRIENDS Program 2023; Peer Health Exchange 2024). As a result, youth who do not see their lived experiences reflected in programming may disengage or struggle to build trust.

To transform these environments, PATH integrates youth-led health navigation directly into schools and youth centers. This approach does not require building new institutions. It strengthens what already exists by valuing migrant youth as capable leaders and knowledge holders. With the right tools and partnerships, schools and youth centers can become spaces of healing, belonging, and empowerment, especially for migrant teens.

4. Community Level: Peer Dynamics and Cultural Fit

Adolescence is a period when peer acceptance becomes crucial to self-esteem and identity. For migrant teens, entering new communities often means navigating different social norms, language use, and behavioral expectations. These differences can lead to feelings of alienation and exclusion, particularly when cultural misunderstandings arise in peer groups. In schools and neighborhoods where local youth have limited exposure to diversity, migrant adolescents may face teasing, microaggressions, or outright bullying, which significantly impacts their mental health and sense of belonging (Ellis et al. 2010).

Gender roles and religious practices can further complicate peer dynamics. For instance, Muslim girls who wear hijabs or avoid certain extracurriculars due to religious beliefs may be seen as outsiders, making it harder to form friendships and engage fully in school life (Kohli 2006). At the same time, migrant youth often face pressure to assimilate quickly, which can create identity conflicts and generational tensions within their families.

When peer groups fail to offer understanding or inclusion, displaced teens may withdraw or seek validation in unsafe ways. That is why peer education and support models must consider cultural and spiritual values, not just shared age.

Programs that include culturally grounded mentorship or group dialogues especially those led by older migrant youth can help foster trust, mutual respect, and healing in community settings.

5. Digital Access and the Role of Technology

Technology can empower migrant adolescents by offering health information and emotional support whenever they need it. Smartphones allow teens to access mental health resources privately, and a systematic review confirmed that digital mental health tools are both acceptable and feasible for refugee populations, with many participants reporting satisfaction with the support they received (El-Haj-Mohamad et al. 2022). Such tools present flexible, stigma-free alternatives to in-person care, but only if youth have consistent access.

Unfortunately, many migrant adolescents cannot rely on smartphones or stable internet. In Indonesia, approximately 20 percent of students lack personal devices, and network connectivity remains a challenge in low-income urban areas (OECD 2021). In Australia, refugee teens often face digital exclusion because they cannot afford data plans, may lack digital skills, or find available content irrelevant, which lead to disengagement or missed opportunities (Alam and Imran 2015). Likewise, in the U.S., unaccompanied or undocumented minors often cannot purchase devices or maintain internet plans, forcing them to limit their online activity to public Wi-Fi or school computers (CLASP 2021).

To bridge this divide, PATH combines high-tech and low-tech strategies. We will build a mobile-first platform with offline features like downloadable modules and printable toolkits so that adolescents can engage even without internet. By blending digital and analog formats, PATH ensures equitable access to health education, building resilience rather than creating ne divides. In this way, our approach treats technology as a bridge, where we are amplifying reach without excluding those who lack devices or connectivity.

6. Looking Back and Moving Forward

Across intrapersonal, interpersonal, organizational. Community, and technological levels, migrant adolescents consistently face layered barriers to achieving health and well-being. Limited knowledge, language difficulties, social isolation, stigma, and lack of cultural fit are compounded by systematic gaps in schools, youth services, and digital infrastructure. Despite these challenges, migrant youth demonstrate resilience and creativity in seeking support, connection, and a sense of belonging. However, most existing interventions remain fragmented. Many focus on only one dimension, such as school-based education or mental health counseling without addressing the full ecosystem that shapes adolescent experiences. These siloed approach often fail to reso-

nate with the cultural, linguistic, and emotional needs of displaced youth, resulting in low engagement and limited impact.

Moving forward, there is a pressing need for holistic, youth-led models that are flexible, culturally responsive, and grounded in the realities of everyday life. A solution that bridges digital tools with human connection, peer support, and community knowledge can help close this gap. By empowering migrant youth as agents of change, we can co-create interventions that are sustainable inclusive, and globally adaptable.

1. About the PATH Project

The PATH project, which stands for Peer Action for Teen Health, is designed to address adolescent migrant health aged 13-18 through peer-led education and support. As described in earlier sections, migrant teens face unique challenges when it comes to health access, emotional support, and reliable information. These barriers often include language difficulties, social isolation, and a lack of culturally sensitive education. By building a peer-based support system, PATH will help teens connect with each other and take control of their own health and well-being. PATH seeks to create a peer-led, community-rooted model that empowers migrant adolescents as both learners and leaders. The project recruits older migrant teens who have already navigated the challenges of resettlement to serve as health navigators for newer arrivals. These trained peers will deliver interactive, culturally tailored health education sessions in schools, youth centers, and community hubs, focusing on three core areas: mental health, reproductive health, and nutrition.

Health navigators will receive training through a blended model of in-person workshops and online modules designed in collaboration with public health experts, youth educators, and migrant-led organizations. Once certified, these peer navigators will facilitate group sessions using a multilingual, visually rich toolkit that includes role-playing activities, storytelling, and interactive games. These tools are designed not only to educate but also to foster trust and shared experience, countering stigma and isolation.

A core feature of PATH is the introduction of a Youth Health Passport. It is a small, printable or app-based booklet where teens can track their own progress in areas such as hydration, iron-rich diet intake, physical activity, and emotional well-being. This self-monitoring tool, guided by peer navigators, encourages positive behavior change in an accessible and engaging way. To ensure sustainability and cultural fit, PATH will be implemented through partnership with local schools, refugee support organizations, and municipal youth offices. Each site—Jakarta, San Diego, and Melbourne—will adapt the content and delivery to reflect local languages, policies, and health needs while maintaining a shared framework and evaluation strategy. The web-based platform (accessible via direct link or QR code) will house multilingual resources, digital copies of the Health Passport, and a mentorship directory. This ensures that even those who relocate can stay connected and continue their health journeys.

We are trying to build PATH as more than intervention. We designed it to be a growing network of peer-led support that fosters belonging, builds leadership, and nurtures well-being. By centering migrant adolescents as experts in their own lives, the project bridges gaps in health access, cultivates resilience, and creates a replicable model for inclusive youth health education globally.

2. Implementation Plan

The PATH project uses a hybrid implementation strategy that combines online and offline activities to accommodate the diverse needs and realities of migrant adolescent. This design ensures that students with limited internet access can still participate, while also leveraging digital tools to scale learning, peer connection, and support. The dual pathways are interconnected and mutually reinforcing, building knowledge, skills, and emotional resilience.

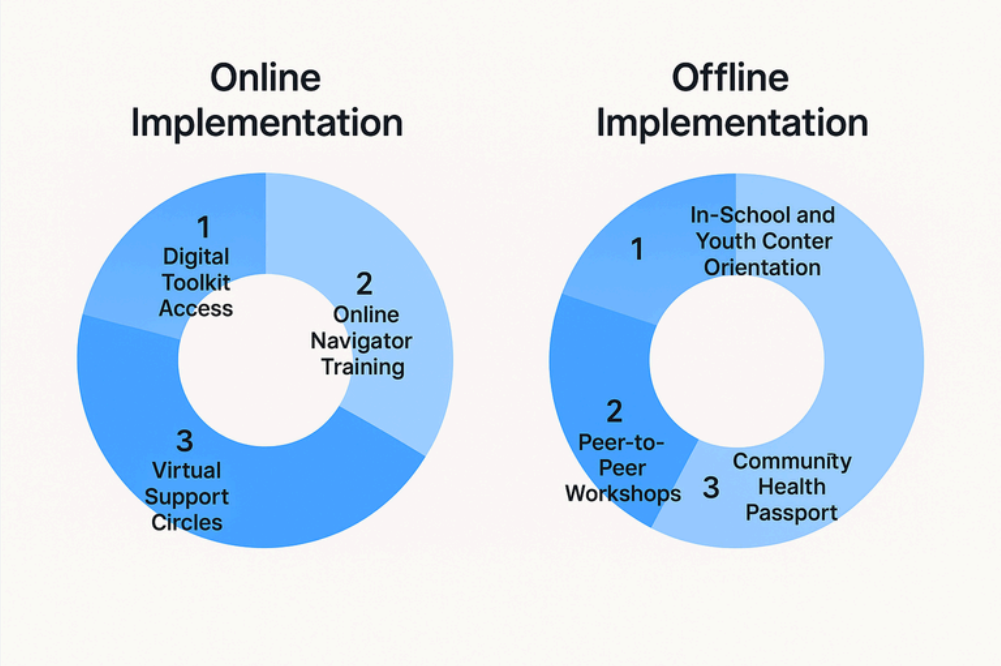

Figure 3. The Implementation Flow

1) Online Implementation

The online implementation of the PATH project is designed to ensure broad accessibility, flexibility, and cultural responsiveness for migrant adolescents. Recognizing the diversity of digital access across participants, the platform prioritizes low-bandwidth functionality and offers downloadable materials for offline use. By combining interactive learning, peer mentoring, and anonymous engagement tools, the digital pathway enables students to build health literacy and confidence in a safe and adaptable environment. The three key components of this online implementation are described below.

A. Digital Toolkit Access

Each student in the program will receive access to the PATH Digital Toolkit through a secure login. The toolkit is a web-based platform that can be opened via QR code or direct link. It is mobile-friendly and available in multiple languages. The toolkit includes:

- Visual learning modules on mental health, reproductive health, nutrition, and adolescent rights.
- Health knowledge games like myth-busting quizzes and scenario-based learning.
- Downloadable Youth Health Passport, which is a booklet that allows them to track behaviors daily. This includes:
  - Hydration (did I drink 6-8 glasses today?)
  - Iron-rich food intake (did I eat leafy greens, meat, or beans?)
  - Exercise (did I move for 30 minutes today?)
  - Mood and sleep tracking (how do I feel today?)
  - Reproductive health questions (am I prepared for my next period, or do I have questions?
- Messaging Space where youths can ask anonymous questions or request to speak with peer navigators.

Figure 4. PATH mobile web interface

B. Online Navigator Training

Older migrant adolescents who have integrated into the host school or community will be recruited and trained as peer health navigators. The training will be hosted on the digital platform and includes four key modules:

- Basic knowledge of adolescent health and development
- Communication and facilitation skills
- Trauma-informed care and emotional safety
- Instruction for using and guiding others through the Health Passport

After completing each module, navigators will take a quiz. Those who score at least 75% will receive a digital certificate. This ensures a baseline of knowledge and preparedness before supporting others.

C. Virtual Support Circles

Certified peer navigators will host virtual support circles once per two weeks using video conferencing tools like zoom or text-based platforms like WhatsApp for those with limited access. Each circle includes 4-6 participants and follows a guided format:

- Warm-up questions and check-in
- A focused discussion topic (e.g., managing stress or understanding consent)
- A myth-busting activity or mini quiz
- Reflection and encouragement for using the Youth Health Passport

These online groups give migrant teens a space to connect, share experiences, and feel heard.

2) Offline Implementation

While the digital platform ensures accessibility and continuity, the offline component of the PATH project emphasizes human connection, hands-on learning, and community-based support. These in-person activities are crucial for building trust, especially among adolescents who may have limited digital access or prefer face-to-face interaction. Through school-based sessions, peer-led workshops, and the use of tangible health-tracking tools, the offline pathway nurtures practical skills and emotional resilience. The following three components from the core of this approach.

A. In-School and Youth Center Orientation

The PATH program will begin with in-person orientation session held by school health educators, youth center facilitators, or trained staff from migrant-focused youth organizations. These sessions will take place in schools, youth centers, or community hubs, ensuring accessibility for adolescents both inside and outside formal education systems. The sessions will cover:

- The importance of adolescent mental health, reproductive health, and nutrition
- The structure and benefits of the PATH program
- The role of peer navigators and support circles
- How to access and navigate the digital toolkit

Participants will receive printed materials, including a visual summary of key health concepts and their personal Youth health Passport. By engaging trusted figures from schools and community-based organizations that specializes in working with displaced youth, the orientation can help to foster familiarity, cultural safety, and trust. This inclusive entry point ensures that both in-school and out-of-school migrant adolescents are prepared and supported to fully engage in the program.

B. Peer-to-Peer Workshops

Every two-week, peer navigator will lead interactive workshops in classrooms or youth centers. These sessions focus on key topics from the toolkit but are designed to be dynamic and fun. Activities include:

- Role-plays on real-life scenarios, such as asking for help or handling peer pressure.
- Myth-busting challenges using statements teens vote on and discuss
- Small group conversations where students share ideas and ask questions

These workshops help teens absorb knowledge through action and discussion. They also create a supportive social environment, reducing feelings of isolation.

C. Community Health Passport

Every participating teen receives a Youth Health Passport. Peer navigators will check in with participants during workshops or support circles to review progress and offer support. This tool is private but can be shared voluntarily during group reflection.

PROJECT PHASES

The PATH project will be implemented in five phases:

A. Phase 0: Preparation

In the preparation stage, we will develop the PATH Digital Toolkit, a web-based platform accessible through direct link or QR code. The toolkit will include multilingual health education modules, self-assessment activities, myth-busting games, downloadable mini-guides, and a messaging space for confidential support. We will also build the structure of the Youth Health Passport, which allows teens to track their behavior and health habits offline. At the same time, we will develop and test training modules for peer navigators in collaboration with educators and youth advocates. Preparation will also include partnerships with schools, refugee-serving youth centers, and community organizations.

B. Phase 1: Pilot Implementation

We will launch the pilot in three cities—Jakarta, Melbourne, and San Diego—to capture diverse migration contexts. Each city will begin implementation in two schools or youth centers, focusing on migrant adolescents between the ages of 13-18. The pilot will include:

- In-person orientation and distribution of printed materials
- Digital Toolkit rollout and online training access
- Recruitment and training of peer health navigators
- Formation of online and offline support circles
- Weekly in-school or community-based workshops

Throughout the pilot, we will conduct regular check-ins with educators, peer facilitators, and participants. Feedback will be gathered through brief surveys and reflection activities to understand the experiences and challenges across the three sites. The pilot will run for three months to evaluate feasibility, engagement, and the adaptability of digital and in-person tools across cultural and infrastructural settings.

C. Phase 2: Scaling Up

Following successful pilot evaluation, we will expand the PATH project within each city to 4-6 additional schools or youth organizations, ensuring a mix of urban, peri-urban, and underserved settings. This phase will retain the core components of the program but include adaptations based on pilot feedback, such as updated module content or different formats for workshops. We will introduce more peer navigators and formalize coordination with local government bodies, migrant service networks, and heath educators. A stronger monitoring and evaluation framework will be applied, using participation data,

behavioral tracking, and regular focus group reflections to assess impact and gaps.

D. Phase 3: Cross-City Integration and Policy Engagement

Once scaled in each location, the project will enter a cross-city integration phase. We will facilitate inter-city knowledge sharing through digital roundtables, youth-led presentations, and shared training updates. Migrant youth leaders and partner organizations will co-develop a summary report and policy brief to advocate for broader adoption of the PATH approach. In each city, we will present the findings to relevant government stakeholders (e.g., Ministries of Health or Education, local school boards, migrant affairs offices), positioning the PATH model as a scalable, rights-based solution for adolescent well-being.

E. Phase 4: Sustainability and Global Learning

To ensure long-term impact, we will integrate PATH into existing youth health programming by partnering with public schools, youth centers, and local NGOS. Peer navigators will continue to receive mentorship and may take on new leadership roles. We will advocate for PATH's inclusion in city or school-wide health education curricula. Annual youth-led gatherings and global webinars will support knowledge exchange beyond the original three cities and documentation of the project will be made available for replication in other regions facing similar challenges.

TIMELINE

We have developed a detailed timeline for PATH implementation across three cities (Jakarta, Melbourne, and San Diego), including preparatory work, local coordination, development and testing of the Digital Toolkit and Youth Health Passport, pilot activities, scaling up, cross-city collaboration, and policy engagement. Each activity has clear deadlines and assigned team responsibilities, which will ensure that the project stays on schedule.

Table 1. PATH Project Timeline

Phase	Activities	Team in Charge	2025	2026
Phase 0	Project Preparation	Core Team		
	Digital Toolkit development (UI/UX, modules, self-assessment tools)	Core, Digital, & Health Teams		
	Youth Health Passport prototype (offline tracking)	Core & Digital Teams		
	Peer navigator training module co-creation and pilot	Youth Engagement		
	Partnerships with schools and youth centers	Core, Partnership, & Local Teams		
Phase 1	Pilot implementation (2 sites per city)	Core & Local Teams		
	Orientation toolkit launch, and printed material distribution	Local Team		
	Peer navigator recruitment and training	Youth Engagement		
	Weekly workshops and support circles	Local Team		
	Monitoring and feedback collection	Core Team		

Phase	Activities	Team in Charge	2025	2026
Phase 2	Scaling Up (4-6 new sites per city)	All Teams		
	Expansion to additional schools/youth centers	Local Team		
	Integration of pilot feedback into updated content	Core & Youth Teams		
	Strengthened, monitoring, evaluation, and peer navigator expansion	Core Team		
Phase 3	Cross-City Integration & Policy Engagement	Core & Advocacy Team		
	Digital roundtables and inter-city youth forums	Core & Youth Teams		
	Co-creation of summary report and policy brief	Core & Advocacy Teams		
	Government and stakeholder presentations	Core & Advocacy Teams		
Phase 4	Sustainability & Global Learning	Core Team		
	Institutional partnerships for integration into curricula	Partnership Team		
	Annual youth-led gatherings and webminars	Youth Engagement		
	Open access documentation for replication	Digital Team		

BUDGET OVERVIEW

The total budget for **Phases 0 to 2** is estimated at **USD $62,750**, with costs expected to decrease in later phases as major materials and digital tools are already developed. This budget includes digital development, educational content, partnership building, in-person workshops, peer navigator training, and monitoring and evaluation.

Table 2. PATH Project Budget Overview

Deliverable/ Activity	Description	Costs (USD)
Digital Platform & Material Development		**25,000**
Digital Toolkit (platform build, multilingual modules, UI/UX)	Web-based toolkit with self-assessment, guides, games	15,000
Youth Health Passport (design + printable materials)	Offline behavior and health tracking tool	2,000
Peer navigator training modules	Digital and printable formats	2,000
Interactive animations & myth-busting games	Health education gamification	4,000
Partnerships & Local Coordination		**5,500**
Stakeholder consultations (school, NGOs, gov.)	MOUs, meetings, community co-design	1,000
Partnership setup with 10-18 school/youth sites	Initial pilot and scale-up partners	2,500
Logistics for QR codes, printing, distribution	Toolkit and passport materials	2,000
Pilot & Field Activities		**2,750**
In-person orientation and launch events	Food, space, materials	750

Deliverable/ Activity	Description	Costs (USD)
Peer navigator recruitment and support	Stipend, training sessions	1,000
Weekly workshops & support circles	Facilitators, snacks, handouts	1,000
Monitoring, Evaluation, and Learning		**9,500**
Baseline and endline participant assessment	Survey, reflection journals	2,000
Digital activity tracking and usage analytics	Toolkit engagement analysis	2,000
Feedback collection and reflection facilitation	Youth-led reporting activities	2,000
Cross-site analysis and summary reporting	Comparative learning	3,500
Personnel		**22,000**
Project Manager	Coordination and oversight	10,000
Partnership and Stakeholder Officer	Institutional relationships	7,000
Youth Engagement Officer	Peer navigator and youth support	5,000
TOTAL		**62,750**

GOALS, OUTCOMES, THEORY OF CHANGE, AND MONITORING

1. Goals

The goal of the PATH project is to improve health literacy, psychosocial well-being, and peer support systems among migrant adolescents (ages 13-18) through a culturally responsive, youth-led health education platform. By integrating digital tools with offline community engagement, PATH aims to reduce barriers to accurate health information and strengthen protective social networks.

2. Outcomes

Short-Term (within 1 year):

- Increased health knowledge and engagement among pilot participants
- Functional PATH Digital Toolkit and Youth health Passport in three cities
- Trained peer health navigators embedded in participating schools/ youth centers

Medium-Term (1-2 years):

- Expanded implementation across additional schools/youth organizations
- Strengthened capacity of local educators and youth leaders to support adolescent well-being
- Improved self-reported health behaviors and access to support among participants

Long-Term (3+ years):

- Institutional integration of PATH tools into youth health education programs
- Replication in new cities or migration contexts
- Policy recommendations adopted to support rights-based, participatory youth health approaches

3. Theory of Change

If we co-create an accessible and culturally grounded health education platform with migrant youth, and train peer health navigators to lead supportive in-person and digital activities, then migrant adolescents will be more likely to access reliable health information, feel connected to peers and trusted adults, and adopt healthier behaviors that improve both physical and mental well-being. Over time, this will lead to more equitable and youth-centered health systems across diverse migration contexts.

4. Monitoring

Monitoring will be continuous throughout all project phases, using both quantitative and qualitative methods. Key tools include:

- Baseline and endline assessments (surveys and self-evaluations)
- Digital analytics (module completion, platform engagement)
- Reflection journals and feedback from peer navigators
- Focus group discussion in each city
- Cross-city synthesis reports and a youth-led policy brief

The team in charge of monitoring will collaborate closely with youth participants to make sure that evaluation is participatory, ethical, and responsive to community needs.

SWOT ANALYSIS

The table below are describing the strengths, weaknesses, opportunities, and threats to PATH project.

Table 3. PATH Project SWOT Analysis

Strengths	Weaknesses
• Youth-led and participatory design ensures relevance and engagement • Digital and offline hybrid model increases accessibility and flexibility • Strong potential for cross-sector partnerships (schools, NGOs, health orgs) • Adaptable, culturally sensitive health content designed for migrant youth	• Limited resources for long-term platform maintenance beyond initial phases • Varying digital access and literacy across different city contexts • Peer navigator turnover may affect consistency of support • Requires careful moderation of the platform to maintain confidentiality and safety
Opportunities	**Threats**
• Potential for institutional adoption is schools and youth programs • Replication in other migration-affected regions or crises • Youth empowerment as change agents for health and equity	• Political shifts or restrictive migration policies may hinder implementation • Community mistrust due to prior negative experiences with systems • Digital fatigue or online misinformation can undermine engagement.

CONTRIBUTION TO THE SUSTAINABLE DEVELOPMENT GOALS (SDGS)

The PATH project directly contributes to the following Sustainable Development Goals:

SDG 3 "Good Health and Well-being"
This SDG aims to achieve healthy lives and promote well-being for all ages by 2030 (UNICEF 2025)

PATH enhances adolescent health literacy, mental health support, and access to accurate information, especially for migrant youth, who often face exclusion from formal health systems.

SDG 4 "Quality Education"
This SDG aims to achieve inclusive and equitable education and promote lifelong learning opportunities for all by 2030 (UNICEF 2025)

Through integration with schools and youth centers, PATH promotes inclusive, participatory health education and builds life skills in leadership, critical thinking, and digital literacy.

SDG 5 "Gender Equality"
This SDG aims to achieve gender equality and empower all women and girls by 2030 (UNICEF 2025)

By including modules on reproductive health, body autonomy, and consent, and by encouraging equal participation of all genders in peer navigator roles, PATH fosters gender equity among adolescent.

SDG 10 "Reduced Inequalities"
This SDG aims to reduced inequality within and among countries by 2030 (UNICEF 2025)

PATH targets migrant youth that often marginalized in both health and education systems and works to ensure their inclusion through tailored tools and youth-led advocacy.

SDG 17 "Partnerships for the Goals"
This SDG aims to strengthen the means of implementing sustainable development and revitalize the global partnership for sustainable development by 2030 (UNICEF 2025)

PATH is grounded in collaboration with schools, NGOs, government stakeholder, and youth groups, modeling how cross-sector partnerships can drive systemic change.

CONCLUSION AND FUTURE VISION

The PATH project offers an innovative and adaptable approach to advancing the health and well-being of migrant adolescents through participatory, youth-led education. By combining digital engagement with offline peer support, PATH bridges the gap between formal systems and the everyday realities faced by young migrants navigating new environments, unfamiliar health systems, and social exclusion.

What sets PATH apart is its emphasis on agency, cultural relevance, and community-building. Rather than treating migrant youth as passive recipients of care, PATH positions them as leaders, educators, and advocates in their own right. The development of the Digital Toolkit, Youth Health Passport, and peer navigator training creates a foundation for scalable and sustainable change, which is rooted in rights-based and inclusive values.

Looking ahead, our future vision is to see PATH integrated into school health programs, youth empowerment initiatives, and national adolescent health strategies in multiple countries. Through continued cross-city collaboration, youth-led knowledge exchange, and partnerships with government and civil society actors, PATH can evolve into a global model for health equity in migration contexts.

In an era where displacement, disinformation, and youth mental health challenges are on the rise, PATH offers a timely, hopeful, and action-oriented solution. It invests in young people not just as beneficiaries, but as catalysts for systemic change.

ANNEX

Annex 1. Team Members Full Profile

Ni Gusti Ayu Putu Intan Kumbayoni | Indonesia

Intan is a graduate student pursuing a Master of Applied Anthropology, focusing on Medical Anthropology, at the University of Maryland, College Park. Her research explores how structural, biological, and cultural factors shape health, with a focus on nutrition, infectious disease, and early-life development. Intan is committed to producing research that is both scientifically rigorous and meaningful to the communities it serves.

Yona Jessica Leony Detaq | Indonesia

Yona is a Master of Science student in Physics at the University of Melbourne. Her academic interests lie in exploring the fundamental principles of the physical world through research and innovation. Passionate about science communication and education, she aims to make complex ideas accessible and inspiring. Yona hopes to contribute to adavancing knowledge in physics while mentoring the next generation of scientists.

La Ode Musaldin | Indonesia

Aldin is pursuing a Master's degree in TESOL at Monash University, Australia. He is passionate about language education, with a focus on empowering learners through effective and inclusive English teaching. Aldin aims to contribute to education development in multilingual communities. His work reflects a strong commitment to cross-cultural understanding and language equity.

Annex 2. Youth Health Passport Prototype

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