TEEN PREGNANCY PREVENTION FOR UNDOCUMENTED LATINX YOUTH: STRATEGIES TO IMPROVE ACCESS TO HEALTHCARE EDUCATION

By

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(Under the Direction of Pamela Orpinas)

ABSTRACT

Teen pregnancy rates among Latinx youth are more than two times greater than Caucasian adolescents. Because undocumented or under-documented Latinx adolescents have less access to reproductive healthcare and education than those with documentation, pregnancy rates among undocumented Latinx adolescents may be higher than those with documentation. Given the numerous barriers affecting undocumented Latinx youth, these adolescents often face many challenges in making informed decisions regarding reproductive health and sexual activity. The goal of this study is to improve the sexual health and well-being of undocumented Latinx adolescents through additional health education materials for teen pregnancy prevention programs for Latinx youth.

This study had two objectives. The first objective was to identify the challenges to reproductive health experienced by undocumented Latinx adolescents from the perspectives of community members, parents, and youth in the Latinx community. The second objective was to develop and test educational materials that address those challenges. A total of 21 semi-structured interviews were conducted to address the first objective. From these interviews, four themes emerged. 1) Discussing sexual and

reproductive health is uncomfortable, and health educators do not consider the Latinx cultural context. 2) Few services provide care regardless of immigration status. 3) Adults need accurate information and skills to talk with youth about sexual health. 4) Undocumented Latinx youth need access to multilingual materials. These four themes informed four corresponding tools. These tools consist of an activity to address machista and sexual and reproductive health terminology and facilitate the interaction with the educator, 2) a resource to create a healthcare guide for undocumented Latinx youth, 3) information in English and Spanish to assist parents' discussion of sex with their children, and 4) resources to assist individuals communicating with Latinx non-English speakers. The activities were sent back to the participants for feedback, which was incorporated into the content. The tools created can assist facilitators, parents, and youth with accessing safe sexual and reproductive healthcare.

INDEX WORDS: Teen Pregnancy Prevention, Latinx, Sexual and Reproductive Health Education, Adolescent Health

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DEDICATION

To undocumented Latinx youth. May you receive access to the care that you deserve.

We are fighting for you.

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To God, the glory is yours. You have been the greatest source of my strength, carrying me through it all. The obstacles were many, yet your grace was sufficient even in the darkness. Know that I will use these gifts you have blessed me with to continue to do your work, ever pushing towards the “peace which transcends all understanding" (Philippians 4:7).

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

LIST OF BOXES

CHAPTER 1:

INTRODUCTION

Lack of reproductive healthcare access and education in the United States is a severe problem for Latinx adolescents. Cost of care and difficulty getting to clinic locations contribute to this problem (Rangel Gómez et al., 2019); however, even when Latinx adolescents participate in healthcare visits, they are less likely to receive the same standard of care as Caucasian youth (Galloway et al., 2017a). These challenges, paired with socio-cultural values, help explain how adolescent pregnancy rates among Latinxs are more than twice that of Caucasian adolescents (Centers for Disease Control and Prevention, 2019). Undocumented Latinx adolescents have less access to reproductive healthcare and education than those with documentation (Patino, 2017). As such, pregnancy rates among undocumented Latinx adolescents may be higher than those with documentation. Moreover, as recent politics have used the topic of *illegal* immigration as a token for attracting voters, increasing hesitance in seeking health access and education due to fear of detainment is common (Artiga & Diaz, 2019).

No standard sexual health curriculums apply to all adolescents in the United States. This lack of uniformity has affected the emerging adult population, resulting in varying sex and reproductive health understandings. An adolescent pregnancy rate of more than twice that of any other developed nation may be a consequence of this lack of an evidence-based standardized curriculum (Pew Research Center, 2017). Latinx adolescents count for the greatest number of these pregnancies.

Inadequate reproductive healthcare access and education affect the entire healthcare industry, not just the individual. To date, approximately 10.7 million undocumented immigrants live in the United States. An estimated 45% of them are uninsured, five times more than US citizens (Artiga & Diaz, 2019). Due to lack of healthcare coverage, many undocumented individuals do not seek reproductive or other healthcare until a situation becomes dire (DuBard & Massing, 2007). The high number of undocumented and uninsured individuals seeking care via the emergency department strains the healthcare system. These visits are more costly than preventive care. Furthermore, the health of undocumented and uninsured individuals suffers because they do not have access to affordable care to prevent the progression of treatable conditions (Hacker et al., 2015; Urrutia-Rojas et al., 2006; Viladrich, 2012).

1.1 Definition of Latinx and Adolescence

The Latinx community comprises persons from over 30 countries who speak over 400 languages (Simons & Fennig, 2018). While differences exist among this population, numerous cultural practices and beliefs unite them. The terms Latino and Hispanic are often used interchangeably in the United States. However, scholars note distinct differences. Latino refers to individuals who have immigrated from or are descendants of Latin American immigrants, including Central and South America. Hispanic refers to individuals descended from a location conquered by the Spaniards, where post-colonialization, the people still speak Spanish. While some nations are both Latino and Hispanic, countries like Brazil and Guyana cannot be categorized as Hispanic because Spanish is not their primary language. Despite the language differentiation, many cultural

ideals related to a familial and communal structure are similar to neighboring Spanish-speaking countries, classifying them as Latino but not Hispanic (Marcus, 2020).

Latinx is a newer term used to describe persons of Latin descent. In Spanish, the endings of ‘o’ and ‘a’ usually refer to masculine and feminine objects, respectively. Almost all nouns and adjectives in the Spanish language have a male or female identity. Historically, the masculine form precedes phrases containing masculine and feminine objects. In recent years of understanding the fluidity of gender, the term *Latinx* has emerged as a non-binary form of describing Latin descendants of all genders (Rodriguez, 2019; Steinmetz, 2018). Due to its novelty, this term has not yet been translated or accepted across all settings and generations; it is mainly used in academic settings and among younger persons (Kaur, 2020).

Adolescence refers to a phase of life that depicts a person’s transition from childhood into adulthood (Curtis, 2015; Sawyer et al., 2018). The Centers for Disease Control and Prevention (CDC) defines *adolescence* as the developmental period when a person is between 10 and 19 years (Centers for Disease Control and Prevention, 2019). The World Health Organization, however, defines adolescence as the onset of puberty to maturation, which varies for each individual and usually carries into the early- to mid-twenties (World Health Organization, 2016).

1.2 Undocumented Latinx in the United States

The vast majority of undocumented persons (73%) in the United States are Latinx. Of this population, two-thirds (65%) are born in Mexico. Most of the undocumented Latinx population has lived in the United States since the 1990s and immigrated as young adults (Pew Research Center, 2017). Despite having higher

employment rates than their peers with legal documentation status, undocumented Latinx individuals often struggle to receive basic healthcare (Artiga & Diaz, 2019; Hacker et al., 2015 & Zallman, 2015). Less than 30% of undocumented immigrants receive private health insurance from their employers (American College of Obstetricians and Gynecologists, 2015). Other means of obtaining coverage are limited as well. Under the Affordable Care Act, undocumented persons cannot apply for healthcare through the Marketplace or government-assisted programs such as Medicaid (Majerol et al., 2015).

In 2016, a quarter of a million children were born to undocumented persons in the United States (Passel et al., 2018). While the exact number is unavailable, the literature posits that most of these births were to undocumented Latinx adolescents. The birth rate for Latinx teens was 28.9 births per 100,000 women in 2017. This rate is over twice that of Caucasian adolescents and the second-highest of any ethnic group in the United States (Centers for Disease Control and Prevention, 2019; Pew Research Center, 2017). Despite the high teen pregnancy rate in the Latinx community, obtaining reproductive healthcare, namely prenatal healthcare for these adolescents, is challenging.

While sexually transmitted infection (STI) rates among Latinx adolescents are significantly higher than among Caucasian youth, information concerning the rates of STIs among undocumented Latinx youth is scarce (Cardoza et al., 2012). Undocumented Latinx adolescents have less access to sexual and reproductive healthcare and education than their documented peers. As such, STI rates among Latinx youth are likely greater than or equal to the rates of Caucasian adolescents.

1.3 The State of Sexual and Reproductive Health

Sexual and reproductive health is one of the least discussed healthcare topics, even though it concerns all individuals and is directly related to other areas of health (Kilfoyle et al., 2016). The World Health Organization defines reproductive health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes" (World Health Organization, 2020). This definition includes healthcare and education concerning the reproductive system, pregnancy, and sexual activity. In the United States, reproductive health as a whole is a concern. Likely due to the fewer options for access and education, risks associated with reproductive health, the incidence of sexual and reproductive-related illnesses, and mortality are higher in the United States than in most other industrialized nations (Finer & Philbin, 2013). Stratifying by age group, adolescents account for the largest number of sexual and reproductive health concerns in the United States.

Sexual initiation and engagement in risky sex behaviors typically begin during adolescence (Abma & Martinez, 2017; Halpern & Haydon, 2012; Sieving et al., 2012). Risky sexual behaviors are actions that increase the likelihood of an individual contracting an STI or having an unplanned pregnancy, such as using drugs or engaging in sex with many partners. Risky sexual behaviors among adolescents have been an ongoing concern globally and within the United States (United Nations Department of Economic and Social Affairs Population Division, 2019). The onset of sexual activity at this stage is a normal part of development. Adolescents, however, are more likely to engage in risky sexual behaviors that warrant cause for concern (Pringle et al., 2017). Adolescent

pregnancy, or teen pregnancy, is a serious problem in the United States associated with adverse health outcomes and social disadvantages (Harden et al., 2009 & Oakley, 2009). Despite national success in lowering teenage pregnancy rates over the last two decades, much work is still required. The United States has the highest adolescent pregnancy rate of all industrialized nations (Sedgh et al., 2015 Eilers & Singh, 2015; World Bank Group, 2019). While the concern about pregnancy is valid, researchers and clinicians worry about additional reproductive health problems such as STIs.

STIs are an ongoing problem among adolescents. Within the past five years, half of new STIs have occurred in individuals between 15 and 24 years (Satterwhite et al., 2013). Nearly 62% of chlamydial infection cases reported in the United States were among adolescents aged 15-24. Similarly, rates of Gonorrhea among adolescents increased by 30% and Syphilis by 45% from 2014 to 2018 (Centers for Disease Control and Prevention, 2018). These increases in STIs are associated with several factors discussed in more detail in the next chapter, yet the primary issue stems from inadequate health education and barriers to healthcare access (Sieving et al., 2012; Upchurch et al., 2004).

Undocumented Latinxs too often do not have the option to access reproductive care, including regular exams and meetings with providers. Lack of access has been associated with reduced sexual and reproductive health literacy (Kilfoyle et al., 2016). Approximately 1.8 million undocumented youth live in the United States; most identify as Latinx (Krogstad et al., 2019). As undocumented individuals, these adolescents are at a disadvantage when pursuing reproductive care.

1.4 The Present Study

Given the number of barriers affecting undocumented Latinx youth, these adolescents often have challenges making informed decisions regarding reproductive health and sexual activity. Teen pregnancy prevention programs effectively increase reproductive knowledge in populations of need and decrease early sexual activity among adolescents (Boonstra, 2002; Farb & Margolis, 2016; Goesling et al., 2014). While many teen pregnancy prevention programs exist, CDC has deemed 45 as gold-standard. Researchers have evaluated and validated these top-tier programs in multiple populations and under various conditions. Despite these gold-standard interventions' strengths, only two are tailored toward Latinx youth. This disparity is a concern, considering the high incidence of adolescent pregnancy among the Latinx population. Unfortunately, neither of the gold standard teen pregnancy prevention programs for Latinx adolescents directly addresses the needs of undocumented Latinx youth; this research addresses this missing component. The goal of this study is to improve the sexual health and well-being of undocumented Latinx adolescents through the creation of additional health materials specifically designed for this population.

The objectives of this study are:

1. Examine the reproductive health challenges experienced by undocumented Latinx adolescents from the perspective of community members, parents, and youth in the Latinx community.
2. Based on the information obtained, design new health education materials to address undocumented Latinx adolescents' sexual and reproductive health needs.

3. Finalize the developed materials by evaluating content for relevance, ease of use, engagement, and comprehensiveness.

Chapter 1 provided an overview of the population and a study description. Available literature concerning undocumented Latinx youth is reviewed in Chapter 2. This study has the potential to further interventionists' and health education professionals' understanding of the sexual and reproductive health education needs.

CHAPTER 2:

LITERATURE REVIEW

This chapter covers topics related to studying sexual and reproductive health among undocumented Latinx adolescents. This chapter is composed of four sections. The first section discusses factors associated with risky sexual behaviors. The second section covers external challenges associated with risky sexual behavior and pregnancy among undocumented Latinx adolescents. The third section focuses on internal influences among this population. The final section examines the need for evidence-based teen pregnancy prevention programs for undocumented Latinx youth.

2.1 Factors Associated with Risky Sexual Behaviors and Pregnancy

Risky sexual behaviors include actions such as engaging in unprotected sex, exchanging sex for money or other goods, or having multiple sexual partners (or with someone who has multiple sexual partners). It also encompasses having sex under the influence of drugs or alcohol (or with someone under the influence of drugs or alcohol) (University of Michigan, 2020).

These behaviors are associated with an increased risk of adverse outcomes, such as having an unwanted pregnancy and being infected with an STI (Cooper et al., 1998, p. 1536). This section discusses eight risk factors: drug and alcohol use, low self-esteem, lack of sexual health knowledge, early sex initiation, adolescent victimization, single-parent households, poor school performance, and poverty.

Drug and Alcohol Use

The association among adolescent risky sexual behaviors, pregnancy, and drug and alcohol use is strong. Adolescents who engage in risky sexual behaviors early are also at increased risk for having more sexual partners and unprotected sex (Ritchwood et al., 2017). Those who use drugs and alcohol are more likely to become pregnant than those who do not (Substance Abuse and Mental Health Services Administration (SAMHSA), 2006). Even more so, drug and alcohol users are more likely to experience multiple adolescent pregnancies (Pfitzner et al., 2003). As many studies have yielded similar findings, researchers have examined the association among adolescent risky sexual behaviors, pregnancy, and drug and alcohol use from a neurological lens.

Neurological components, such as the frontal cortex and the limbic system, contribute to the connection between risky sexual behaviors and drug and alcohol use in adolescents (Bryan et al., 2016). The frontal cortex in the brain is associated with decision-making, yet it does not fully develop until after adolescence. This lack of development suggests that adolescents may be less able to make rational decisions than older youth (Ritchwood et al., 2017). In addition, the limbic system, which controls emotion, is more developed during adolescence. This development means youth can generally identify with and tap into their emotional mind, allowing it to dictate the actions of the body (Riggs & Greenberg, 2019). Both the frontal cortex and limbic system play significant roles in the continued development of the human brain. By understanding how neurological components work together, researchers can find methods to aid populations that engage in risky behaviors, like adolescents.

Low Self-Esteem

Low self-esteem is a risk factor for pregnancy and risky sexual behaviors among adolescents. Teens with lower self-esteem are more likely to agree to having sex or engaging in nonvoluntary sex than those with higher self-esteem (Bryan et al., 2016; Commendador, 2010; Jackman & MacPhee, 2017)). Researchers have found a relationship between low self-esteem, incorrect condom use, and inability to refuse sex (Nelson et al., 2017; Robinson, 2014). Raising low self-esteem during adolescence could help prevent youths from engaging in risky sexual behaviors.

Lack of Sexual Health Knowledge

Many pregnant teens report having insufficient knowledge of sexual and reproductive health. Less than 10% of adolescents between the ages of 13 and 18 receive adequate sexual health guidance from their care providers (Hoopes et al., 2017). Adolescents generally struggle with relaying sexual or reproductive health information to providers. The most common problems associated with receiving sexual and reproductive health assistance among adolescents were a lack of trust and fear of judgment (Hoopes et al., 2017). With providers traditionally being allotted about 15 minutes per patient, it is often challenging for patients to build a relationship with a provider to request sexual or reproductive health information. This situation is particularly problematic for adolescents. Of those adolescents who do discuss sex with their providers, the communication lasts for less than a minute on average (Pew Research Center, 2017). In this short time, topics are unlikely to be discussed thoroughly, nor do adolescents have enough time for questions or feedback. Introducing sexual and reproductive health information prior to the onset of intercourse is essential for healthy development. Doing

so allows individuals to understand their bodies and helps them make informed decisions about sex in the future, potentially reducing risky sexual behaviors (Alcalde & Quelopana, 2013).

Insufficient sexual and reproductive information can lead to adverse health outcomes such as adolescent pregnancy and STIs (Salam et al., 2016). Interventions containing comprehensive information on sexual and reproductive health have resulted in lower teen pregnancy rates (Jones et al., 2014; Lassi et al., 2015; Tebb et al., 2018). Within the United States, scholars have debated the best way to deliver sexual and reproductive health information to adolescents, with some groups believing that abstinence-only education is just as effective as a full sexual and reproductive health education curriculum that includes teachings about safe sex practices. Historically, this conversation has been at the forefront of many political battles – where more conservative groups favor limiting discussion around safe sex practices as they believe a comprehensive curriculum encourages sexual intercourse (Kramer, 2019). However, a systematic review comparing abstinence-only education with comprehensive sexual health education found that abstinence-only programs were ineffective at preventing teen pregnancy, as they often omit or provide misleading information to program recipients (Lassi et al., 2015).

Due to culture and religion, adolescent sexual health education in the Latinx community may not include as much detail as traditional comprehensive sexual health education programs. Parents and religious community members often prefer abstinence-only programs that leave youth uninformed, making them more likely to contract an STI or become pregnant (Castro et al., 2010). Multiple studies found that many Latinx parents

felt that the discussion of safe sex practices encouraged their children to engage in intercourse, despite research findings that show the contrary (Cabral, 2018; Deptula et al., 2010; Frankel, 2012; Guilamo-Ramos & Bouris, 2008). The absence of comprehensive programs in these communities creates opportunities for misinformation for Latinx youth.

Early Initiation of Sexual Intercourse

Early initiation of sexual intercourse is also associated with risky sexual behaviors and teen pregnancy. The age most related to early sexual initiation is 15, as most states and the District of Columbia recognize 16 as the age of consent. (Adams & East, 1999; Pringle et al., 2017; Silva et al., 2016). The National Conference of State Legislatures estimates that one in four adolescents will become pregnant in America before age 20 (National Conference of State Legislatures, 2021). Teenagers who have sexual intercourse at a younger age are more likely to become pregnant or impregnate someone else (Finer & Philbin, 2013). In addition, the age of initiation is associated with more frequent sexual occurrences, which in turn increases the likelihood of pregnancy (Conduct Problems Prevention Research Group, 2014; Reese et al., 2013).

Premature sex initiation among the Latinx population is slightly different when considering the cultural perspective on sex in general. A survey distributed by CDC found that Latinx adolescents were two times more likely to engage in sex before 13 when compared to their Caucasian peers (Centers for Disease Control and Prevention, 2014). While some scholars argue that the family structure and strict faith are protective factors, acculturation to the "American" culture strongly influences premature sex initiation and risky sexual behaviors among Latinx adolescents. The sexually delinquent imagery shown in American media has influenced attitudes toward sexual encounters and

drug and alcohol use (M. Ma et al., 2014). When addressing risk factors associated with risky sex behaviors and pregnancy in Latinx adolescents, premature sex initiation is critical to the discussion, as it is mentioned by researchers such as Cabral et al. (2018) in reference to this ethnic group.

Adolescent Victimization

An adolescent who has been the victim of sexual assault is more likely to engage in risky sexual behaviors (Goldberg et al., 2016). The Department of Health and Human Services estimates that a child is sexually assaulted in the United States every nine minutes (U.S. Department of Health and Human Services, 2018). Each instance of abuse can influence adolescent victims' psychological and physical well-being (U.S. Department of Health and Human Services, 2020). A study focusing on risky sexual behavior in adolescents who were victims of rape found that survivors were nearly two times more likely to engage in impulsive sexual behaviors and have sex with uncommitted partners. Moreover, female rape survivors were more likely to engage in sex as a form of coping and self-affirmation (Layh et al., 2020). A meta-analysis studying the association between child sexual abuse and adolescent pregnancy found that adolescents who experienced sexual abuse were more than twice as likely to become pregnant before age 20 (Noll et al., 2009). While several informative studies show the connection between victimization and risky sexual behavior, many do not include Latinx youth.

Statistics on current Latinx adolescent sexual assault rates are few in the United States. Perhaps the most comprehensive measure that examines risky sexual behaviors in adolescents is the Centers for Disease Control and Prevention's Youth Risk Behavior

Survey (Centers for Disease Control and Prevention, 2021). In the 2019 Youth Risk Behavior Survey, 8% of Latinx teen respondents (12% of females and 4% of males) reported being raped in their lifetime. Further, 18% of Latinx females and 6% of Latinx males reported experiencing sexual violence (Centers for Disease Control and Prevention, 2021). Additional research focusing on Latinx adolescent sexual assault is needed to provide the most comprehensive view of this problem.

Sexual assault is grossly underreported among the undocumented Latinx population. Undocumented adolescents are more likely than their documented peers to become victims of sexual assault (Tanzola, 2019). From 2015 to 2018, the Office of Refugee Resettlement received more than 4,500 sexual assault complaints from 1,000 detained children. Most of these complaints were against staff who were with them daily (Gonzales, 2019). Most of the available data on sexual assault among undocumented Latinxs is outdated and usually consists of rates that combine women and girls. Migrant women traveling to cross the border into the United States reported being sexually assaulted so often that before leaving their homes, it became common practice to take birth control pills to prevent pregnancy during the journey (Fernandez, 2019). Data related to victimization among undocumented male Latinx adolescents are limited. Because the research on undocumented Latinx adolescent sexual assault in males is scarce, social scientists can only infer that the behaviors exhibited by teenage victims of other ethnicities or ages somewhat mirror that of the individuals in this population. A more accurate depiction of sexual assault within this vulnerable population should be available as research continues.

Single-Parent Households

One of the most researched aspects of adolescent risky sexual behaviors and family life is upbringing in single-parent households (Killoren & Deutsch, 2014). While single parents can provide adequate direction, some teens may be disadvantaged regarding parental guidance for sexual health education and resources. Living with a single parent has been associated with more frequent risky sexual behaviors and higher teen pregnancy rates (Brent, 2002; Marroquin, 2021). In studies examining the impact of familial function on adolescent sexual decision-making, teens who lived with one parent were more likely to have engaged in sexual intercourse when compared to their peers in two-parent homes (Haglund & Fehring, 2010; Widman et al., 2016; Young et al., 2004). The differences between the two family types could be attributed to reduced parental monitoring, communication, and support. These disadvantages often exist in the form of a parent who cannot spend as much time with the child because of work or other responsibilities usually shared in two-parent households (Deptula et al., 2010; Tolou-Shams et al., 2018).

The stress associated with financial challenges in single-parent households can also influence the relationship with their children. Adolescents living in single-parent homes are more likely to live in poverty, a risk factor for adolescent pregnancy and risky sexual behaviors. These individuals are also less likely to receive quality education due to financial reasons, which influences risky sexual behaviors in adolescents (Orihuela et al., 2020).

Literature discussing the impact of single- or two-parent households on risky sexual behaviors among Latinx adolescents and undocumented Latinx adolescents is not

widely available. In an analysis of familial processes and household structure, Pain (2020) considered the impact of the ethnicity of single-parent households on risky adolescent sexual behavior. She found that adolescents who lived in two-parent Latinx homes were more likely to use condoms correctly and not have sex with strangers than their peers in single-parent homes.

Poor School Performance

Pregnancy and risky sexual behaviors are related to low academic performance. Students who engage in risky sexual behaviors are more likely to have behavioral problems at school (Gubbels et al., 2019). These individuals are also more likely to have excessive or chronic absences and tardiness when they do attend (Elfenbein & Felice, 2003). Excessive school absence and early disengagement are also related to future teen pregnancy (Yunzal-Butler et al., 2020). Furthermore, underperformance in school is associated with lower self-esteem and reduced overall self-efficacy, two risk factors associated with teenage pregnancy (Z. Ma et al., 2014; Rosenthal et al., 1991). The relationship between school performance, adolescent risky sexual behaviors, and pregnancy is stronger in underrepresented and immigrant groups (Alcalde & Quelopana, 2013).

Academic performance is related to risky sexual behaviors and adolescent pregnancy in Latinx communities. Studies assessing school disengagement and dropout rates found that teens who had dropped out of school became pregnant earlier than their peers, especially Hispanic youth (Bustamante et al., 2019; Gubbels et al., 2019). Other researchers posit that the initiation of sexual intercourse was significantly associated with lower grade point averages among male and female Latinx students. Interestingly, this

phenomenon was not observed by the Caucasian or African American youth in the study (Whitworth & Paik, 2019).

The literature on the school performance of undocumented Latinx adolescents and its impact on sexual behavior is limited. As such, it is difficult for researchers to fully understand the influence of documentation status on an already complex topic without observing and collecting data on this population.

Poverty

Poverty is linked to many adverse health outcomes, including diabetes, hypertension, cancer, and poor sexual and reproductive health (McBride Murry et al., 2011). Researchers focusing on the association between poverty and sexual and reproductive health explain that the general lack of access to health-related resources for impoverished youth contributes to the problem. Further, students who live in poverty are also more likely to attend schools in low-income areas, which typically have less access to health education (Berman et al., 2018). Adolescents who live in households below the federal poverty level are more likely to become pregnant when compared to adolescents from homes above that level. The cycle of poverty often continues as the children born to adolescent mothers in poverty often remain in poverty (Garwood et al., 2015). Even when the couple does not want to have a child in this economic situation, impoverished adolescents are less likely to obtain emergency contraception after unprotected sex or find access to abortion providers (Miller, 1997).

Similar to contraception access, adolescents raised in poverty areas are more likely to contract an STI than those living in higher-income homes (Harling et al., 2013). Additionally, because of the lack of healthcare access, STI transmission is a big concern

in impoverished communities. Commonly, individuals transmit the infections over multiple encounters between individuals from the same group before being completely treated (Chandra-Mouli et al., 2014). In the United States, approximately 16% of Latinx families live at or below the federal poverty level (U.S. Census Bureau, 2021). The percentage of undocumented Latinx families that live below the poverty line is unknown. Researchers need additional data to understand the STI rates in impoverished undocumented Latinx areas.

In summary: Risk factors viewed from a syndemic perspective

A synergistic epidemic or syndemic occurs when individuals are affected by the compounding effects of disease and social conditions (Tsai & Venkataramani, 2016). Singer et al.'s (2017) framework on syndemic theory states that biosocial connections can be analyzed using interactions between diseases and social interactions. This process was observed during the COVID-19 pandemic. The presence of the disease was exacerbated when factors such as ethnicity, lower socioeconomic status, and low education were considered. Using this context, researchers understand that factors often affecting vulnerable groups are not isolated events. A syndemic has the potential to (and often does) worsen negative health outcomes, especially in populations with multiple disparities (Wilson et al., 2014).

Scholars have used syndemic approaches to explain complications associated with unplanned pregnancies in youth and Latinx groups (Hill et al., 2019; Hill et al., 2022; Martinez, Ickovics, et al., 2018; Martinez, Kershaw, et al., 2018). For example, the syndemic impact of STIs and unplanned pregnancies is clear, given the statistics associated with poverty, lack of sexual health knowledge, low self-esteem, and drug and

alcohol use. Each of these factors is related to the other. Poverty is related to low school performance and single-parent households (Coyle et al., 2004; Lloyd, 2007; Z. Ma et al., 2014; Young et al., 2004; Yunzal-Butler et al., 2020). Early initiation of sexual intercourse is linked to lack of sexual health knowledge, low self-esteem, and adolescent victimization (Çakar & Tagay, 2017; Jackman & MacPhee, 2017; Kim et al., 2018; Nelson et al., 2017; Robinson & Frank, 1994). Victimization is related to drug and alcohol use (Conduct Problems Prevention Research Group, 2014; Kim et al., 2018; Santelli et al., 2001; Thompson et al., 2012). Regardless of the presence of one, or multiple factors, researchers have found that undocumented Latinx Adolescents' experiences with said factors are more severe. Undocumented Latinx adolescents encounter a more difficult health trajectory than their Caucasian peers due to health and social inequality (Rangel Gómez et al., 2019). By understanding this impact, researchers can better develop more tailored approaches to negative outcomes in reproductive health and other health avenues.

The following section discusses challenges associated with sexual behavior among undocumented Latinx adolescents.

2.2 Undocumented Latinx Youth Sexual Behavioral Challenges

Undocumented Latinx adolescents in the United States have many challenges contributing to having (or not having) sex. Four sections address these challenges: healthcare access, cost of care, pregnancy complications, and the threat of detainment or deportation. Each section explains these challenges and their association with sexual behavior among undocumented Latinx adolescents.

Healthcare Access

Lack of healthcare access is associated with reduced sexual and reproductive health comprehension (Kilfoyle et al., 2016). As undocumented individuals, Latinx adolescents are at a disadvantage when trying to get reproductive healthcare and education. Adolescents who do not receive the necessary medical information from a healthcare provider often pursue answers from friends or social media (Epstein et al., 2014), which may contain misinformation.

Access to reproductive healthcare services, including prenatal healthcare for these adolescents, is also frequently problematic. As it stands, data on reproductive health services provided to undocumented Latinx adolescents is scarce. However, this lack of access results in unplanned births in the community. In 2016, a quarter of a million children were born to undocumented persons in the United States (Passel et al., 2018). While the exact number is unavailable, researchers estimate that most of these births were from undocumented Latinx adolescents (Korinek & Smith, 2011; Passel et al., 2018). The absence of adequate preventative reproductive care has contributed to the high observed birth rates (Alcalde & Quelopana, 2013; Fortuna et al., 2019; Galloway et al., 2017b; Olcón & Gulbas, 2018).

Cost of Healthcare

Paying for prenatal care out of pocket is often extremely difficult for undocumented families. Undocumented Latinx are less likely to seek reproductive and prenatal care due to the cost (Pedraza et al., 2017). The average cost to deliver a baby in the United States for insured patients is $13,811. This cost does not include a birth with complications or special circumstances (like a cesarean section), prenatal care,

medications, or other needs during childbirth such as hospital stay or additional tests. Most undocumented Latinx are uninsured, so their cost is even higher (Johnson et al., 2020). Meanwhile, the median annual income for an entire undocumented household was $36,000 (Pew Research Center, 2017).

Because undocumented Latinx youth are not eligible for government-assisted programs like the Children's Health Insurance Program, they must seek other means of financially covering care. Often, undocumented Latinx adolescents seek prenatal assistance through community health centers, low-income Maternal and Child Health Services, or Disproportionate Share Hospitals if they are available in their communities (American College of Obstetricians and Gynecologists, 2015; Fuentes-Afflick et al., 2006). Non-profit organizations and community programs cannot offer many services as funding has significantly decreased over the past decade (American College of Obstetricians and Gynecologists, 2015). In 2009, pregnant undocumented Latinx teens could apply for the Children's Health Insurance Program on behalf of their fetuses and receive basic prenatal care. This act, however, has been amended to cover only lawful residents (Centers for Medicare and Medicaid Services 2019; Families USA, 2010). Due to the Emergency Medical Treatment and Labor Act, undocumented Latinx adolescents can receive labor and delivery care at low or no cost. The coverage does not include prenatal or postpartum care (Centers for Medicare and Medicaid Services 2012).

A common assumption is that healthcare access and education inequities among Latinxs exist solely due to immigrant documentation status. This assumption is incorrect. Immigrants who are United States citizens or authorized permanent residents are still less likely to receive basic health needs than citizens born in the United States. This disparity

often results from inadequate healthcare access in immigrant areas. Providers located in areas with a higher density of immigrants are often few. If they are present, specialized care is rare (Ku & Matani, 2001). Additionally, documented immigrants in the United States do not become eligible for government programs such as Medicaid or the Children's Health Insurance Program until five years after being authorized as permanent residents. Among those eligible for Medicaid or Children's Health Insurance Program, an estimated four million remain uninsured (Ambegaokar; Majerol et al., 2015 2015).

Pregnancy Complications

Complications can occur in any pregnancy; however, adolescents and undocumented Latinx females are more likely to have health problems while pregnant (Berk et al., 2000; de Azevedo et al., 2015). Adolescents are more likely to experience health complications such as preeclampsia, preterm delivery, and infant mortality than adults (Kawakita et al., 2016; Neal et al., 2018). Similarly, undocumented Latinx females are more likely to experience anemia, fetal distress, excessive bleeding, and other labor complications when compared to Caucasian women (Reed, 2005). Despite the number of pregnancy-related concerns in their community, undocumented Latinx women are less likely to pursue prenatal assistance until the problem has significantly progressed (American College of Obstetricians and Gynecologists, 2015). The delay in the pursuit of care causes both physical and financial strain. A review of health spending in 2007 found that much funding spent during the fiscal year was attributed to emergency pregnancy-related complications of undocumented women (DuBard & Massing, 2007).

Threat of Detainment or Deportation

The fear of being detained or deported is a reoccurring thought for many undocumented immigrants that hinders them from seeking healthcare. Overall, 39% of the 62.1 million Latinxs in the United States report worrying about deportation (Moslimani, 2022). Considering parents specifically, Becerra (2016) found that nearly all participants in her study feared deportation and familial separation. These worries did not just exist in those without documentation, as 57% of parents with permanent resident status and 22% of Latinx US citizen parents also reported fear of familial separation and deportation. According to the Annual Report of Immigration Enforcement Actions, Immigrant Customs Enforcement arrested 150,000 undocumented persons in the United States in 2017. When considering both Immigrant Customs Enforcement arrests and apprehensions from the United States Border Patrol, the United States detained 323,591 undocumented persons in 2017. Of those individuals, more than 86% (>278,000) were members of the Latinx community (Office of Immigration Statistics, 2019).

Pregnant undocumented females are more likely to experience stress and anxiety than their native-born counterparts due to fear of detainment or deportation (Korinek & Smith, 2011). If detained and placed in a detention center, the quality of prenatal care received could be substandard (Ohta & Long, 2019). The American Civil Liberties Union (American Civil Liberties Union, 2012)released a statement addressing the poor conditions of undocumented persons in the 200 detention centers nationwide. Within the document, the ACLU mentions the lack of prenatal care provided to detainees, stating that Immigrant Customs Enforcement must offer adequate prenatal care access, including “medical exams, lab, and diagnostic tests, and counseling” (American Civil Liberties

Union, 2012). While Immigrant Customs Enforcement suggested that new policies have been implemented, no such changes have been observed or reported (American College of Obstetricians and Gynecologists, 2015). In addition to lack of care, an infant born to a mother in Immigrant Customs Enforcement detention is placed into the foster care system if a documented family member is not available to take legal custody of the American citizen (American Immigration Council, 2019).

2.3 Socio-cultural Influences among Undocumented Latinx Adolescents

In the present study, socio-cultural influences are aspects of an undocumented Latinx adolescent's lifeworld that contribute to attitudes toward risky sexual behaviors or pregnancy. This section explores the impact of three sociocultural influences: family and familial structure, religiosity, and gender stereotyping.

Family and Familial Structure

The Latinx family is a tight-knit and centralized unit. This close collective structure, also known as *familismo,* may influence adolescents to make more conservative decisions concerning risky sexual behaviors and pregnancy (Cabrera et al., 2019). Among the undocumented Latinx family, *familismo* is often more restricted. An essential factor encouraging the *familismo* of the Latinx family unit is living in their own micro-communities. Many Latinx families work together through specific companies or family businesses. Latinx families also tend to live together. In the United States, Latinx families are more likely to reside in multi-generational housing or family compounds (Allison & Bencomo, 2015; Landale et al., 2006). Latinx families prefer to engage in extracurricular activities together, such as attending church or other communal events. With increasing attention to the undocumented population and the threat of detainment or deportation, it is

plausible that undocumented Latinx families maintain an even closer circle than documented relatives.

Among Latinx families, fact-based conversations concerning sex are less likely to occur than discussing abstinence (Murphy-Erby et al., 2011). This finding is particularly true in conversations with young women compared to young males. While the literature posits that abstinence-only education is less effective than comprehensive sex education, many Latinx families are unwilling to talk to children about sex. Some see this type of communication as an endorsement of premarital sex (Lescano et al., 2009). A disparity still exists for adolescents who can consult with their parents on this topic. Because Latinx populations are more likely to have lower levels of health literacy than their Caucasian counterparts, they are sometimes unable to provide accurate information even if they are open to discussing it with their children (Ghaddar et al., 2012).

Religiosity

Religiosity refers to the impact of faith on individuals or groups on how they live their lives, including sexuality (Hirsch, 2008). Due to the Spanish colonization of many Latinx countries in the 16th century, many Latinx populations identify with the Roman Catholic faith. The religious principles of Catholicism have a strong influence on sexual and reproductive health in this community. The Catholic Church disapproves of sex before marriage. Catholicism also heavily encourages the value of human life. As such, the church also considers contraception a sin. Perhaps the gravest disavowal of the Catholic Church is abortion. Their doctrine posits that life begins at conception, and any interruption of that life is morally reprehensible. These factors directly impact the Latinx family unit and the cultural attitudes toward sex (Ellison et al., 2005).

Gender Stereotyping

In addition to religious practices, the cultural implications of the *machismo* and *marianismo* gender stereotypes may also influence sexual health. The *machismo* gender role, which has existed for centuries, is based on the treatment of Native Indian women by the Spanish conquistadores (Paz, 1985). The origin of *machismo* explains how this role emphasized the importance of virility through multiple sexual relationships. The men forcibly housed women to be on standby for their sexual needs. Men were to assert themselves through violence and demanded servitude from all women, including family members and elders (Neira et al., 2018; Stevens, 1973). Today, the *machismo* gender role has evolved and is mainly associated with exaggerated ideas of tradition, sexuality, and at times, aggressiveness. This hyper-masculine attitude occurs most often in male-female relationships as a rite of passage for an adolescent male 'becoming' a man (Cianelli et al., 2008; Nuñez et al., 2016; Villegas et al., 2010; Wood & Price, 1997). This gender role can negatively impact an adolescent male's relationships, especially considering the historical and encouraged lack of respect for women and girls.

The *marianismo* gender role is a docile, submissive, virgin-like female emulating the Virgin Mary. Women are encouraged not to pursue sexual pleasure, as it was associated with prostitution and blasphemy. Sex should be reserved for procreation or the male's pleasure (Wood & Price, 1997). While children were encouraged to revere their mothers, others were not required to acknowledge her. Today, women who practice *marianismo* roles are encouraged to focus on family, respect, and a cheerful disposition. These nurturers rarely, if ever, consider their wants or needs as a priority (Castillo et al., 2010; Piña-Watson et al., 2014; Rodriguez et al., 2013). This gender role can impact an

adolescent female's perception of self-worth and understanding of healthy personal and romantic relationships.

2.4 Need for Evidence-Based Teen Pregnancy Prevention in Latinx Youth

The adverse health outcomes and barriers associated with pregnancy among undocumented Latinx adolescents highlight the need for preventative measures to reduce teen pregnancies in this group. Research has demonstrated the effectiveness of teen pregnancy prevention programs in reducing pregnancy among adolescents (Solomon-Fears, 2016). Evidence-based teen pregnancy prevention programs refer to those interventions evaluated and deemed gold-standard by the Office of Adolescent Health (Office of Adolescent Health, 2019), the Office of Population Affairs, and the Centers for Disease Control and Prevention (CDC). Some of these government-funded programs have also reduced risky sexual behaviors and STIs among adolescents.

Over time, interventions may require updating to include variables not present at the time of their creation. Continuous review is necessary for any intervention to ensure the information presented is up-to-date and applicable to the study population. Adaptations for behavioral interventions enable investigators to alter once-proven studies to consider more current components. The key to adapting effective interventions is to maintain the fidelity of the interventions' objectives. Moore and colleagues(2013) highlight five main adaptation areas: content, cultural relevance, dosage, participants, and procedures. In 2018, a systematic review revealed that altering overlapping components is the most common adaptation performed on evidence-based interventions. (Escoffery et al., 2018).

While there are some resources for Latinx adolescents to adequately address the complex background of the undocumented Latinx adolescent experience, there is a specific need for culturally and situationally appropriate reproductive health and pregnancy prevention education. To date, there is no gold standard teen pregnancy prevention program for providing comprehensive sexual and reproductive health education for the undocumented Latinx population. Given the size and need of this population, developing materials to address undocumented Latinx adolescents directly can benefit the participants and the entire community. The four adaptations of intervention discussed in this section are content, cultural relevance, dosage, and participant.

Changing intervention **content** can include updating statistics, adjusting the program structure, or integrating other approaches. In Escoffery and colleagues' (2018) systematic review, 100% of the studies modified some components of the original curriculum's content. The most common form of content change in evidence-based interventions is adding additional elements (Child and Family Research Institute-UT Austin, 2016; Escoffery et al., 2018). Adapted from the Oregon Model Parent Management Training, Pinna's intervention tailored materials to reflect the language used by military members and their families. The study included multiple cultural modifications and added effective parenting and military deployment materials to their intervention (Pinna et al., 2017 & Gewirtz, 2017).

Cultural relevance in adaptation focuses on changing an intervention to aid the priority population better. This type of adaptation can range from translating an intervention to another language to changing the study's setting (Moore et al., 2013). In

Escoffery and team's (2018) review, three-fourths of the evidence-based intervention adaptations mentioned cultural modifications. Cultural adaptations conducted for the population of interest can make interventions more feasible and effective than providing the original program (Baumann et al., 2015). Lewin et al. (2015) used cultural modification in their study assessing positive co-parenting techniques. Initially conducted in an adult population, Lewin et al.'s adaptation applied the validated curriculum to low-income minority teen parents. Changes in the curriculum included strategies for engaging teenagers and changing modules to be more relatable to a minority audience.

Dosage adaptations refer to changing the length of intervention sessions, the number of intervention sessions, or both (Child and Family Research Institute-UT Austin, 2016). These changes add or reduce the length of an intervention, both of which have consequences. Reducing the length of an evidence-based intervention can eliminate the opportunity to conduct in-depth discussions (a key reoccurring intervention component) or perform interactive activities. Adding time to an intervention can discourage recruitment as participants may not attend sessions for the required time (Breitenstein et al., 2016). Investigators of a family-based intervention adaptation found that participants were more likely to enroll and stay in interventions with fewer sessions (Kumpfer et al., 2002). Over half of the studies in the systematic review included altering intervention dosage (Escoffery et al., 2018).

Participant adaptations refer to interventions applied to populations different from the original study. Investigators who want to examine an evidence-based intervention for different persons may consider participant adaptation. Members of these populations typically share similar characteristics such as geographic location, age, or

health condition (Chambers & Norton, 2016). One example of participant adaptation is Ma et al.'s (2014) intervention to encourage physical activity in an obese population; the authors adapted the program from an evidence-based intervention developed to promote physical activity among people with diabetes. Participant adaptations are particularly useful in understanding the experiences of certain groups. Escoffery and the team (2018) found that four of five study adaptations included population changes.

Latinx adolescents, especially undocumented ones, have challenges in receiving adequate sexual and reproductive health access and education. Chapter 2 reviewed risky sexual behaviors of undocumented Latinx youth, the health disparities experienced by this group, and the cultural implications that scholars and practitioners must consider to provide adequate health education. While it is clear that undocumented Latinx youth need better sexual and reproductive health access and education, types of materials and strategies for delivery have yet to be determined.

CHAPTER 3:

METHODS

The purpose of the present study is to identify the sexual and reproductive health education needs of undocumented Latinx adolescents by interviewing Latinx community members, parents, and youth and developing strategies to address those needs. This study consisted of three phases. In Phase 1, I conducted individual semi-structured interviews about needs concerning sexual and reproductive health. In Phase 2, I developed sexual and reproductive health materials tailored to undocumented Latinx adolescents that address the problems identified in the first phase. Lastly, in Phase 3, I evaluated the new reproductive health materials for comprehension, ease of use, engagement, and relevance to identified themes. With this information, I finalized the materials.

3.1 Phase 1: Individual semi-structured interviews

The objective of Phase 1 was to examine the reproductive health challenges experienced by undocumented Latinx adolescents from the perspective of community members, parents, and youth in the Latinx community using the guide on reflective interviewing brought forth by Roulston (2010). Findings from this phase informed Phase 2 of the study.

Study sample

The study sample consisted of 21 participants from three groups associated with undocumented Latinx teens: community members, parents, and Latinx youth. For this study, **community members** refer to individuals with an invested interest and experience

in helping undocumented Latinx youth navigate the health system or other avenues regarding sexual health. These individuals were invited because they were part of or currently live (or have lived) in a primarily Latinx community or provide services to Latinx adolescents (e.g., social workers, physicians, health educators). In this study, participants' ages ranged from 21-37 years. **Parents** refer to biological or legal guardians of a Latinx adolescent aged 10-26 years. Participants in this group ranged from 31 to 45 years of age. **Youth** refers to Latinx adolescents 18-26 years old. In the present study, these participants were between 19 and 26 years old. While individuals were placed in single groups, it was not uncommon for them to be in multiple groups (e.g., a community member who is also a parent). Interviews began in September 2022 and continued until November 2022. The length of each interview ranged from 15 minutes to 55 minutes.

Those who did not speak English or Spanish or did not have the ability or time to sit and participate in a 30- 45-minute interview were excluded from the study. Participants were not required to disclose their documentation status but needed to be able to discuss issues that undocumented Latinx adolescents face.

Procedures

Participants were identified and invited by contacting local health champions for undocumented Latinx communities and leveraging existing relationships with members of the Latinx community who had connections to undocumented groups. Requests for interviews or potential interviews were conducted via email. Given the population's vulnerability, snowball sampling was the primary form of recruitment. Snowball sampling refers to recruiting individuals from a group and then asking them to refer a participant (or participants) to take part in the study following their completion

(Goodman, 1961). Interviews were conducted in English and Spanish, based upon the request of the study participant. My research team consisted of three interviewers: two assistant researchers and myself. After completing the interview, participants receive a $25 gift card for their time. We digitally recorded all interviews using the Zoom platform. All interviews were transcribed using Trint (https://trint.com/). The accuracy of each transcription was reviewed by cross-referencing audio to each transcription. I translated Spanish material using DeepL (https://www.deepl.com/translator).

Interview Guide

Phase 1 explored the perspectives of members, parents, and youth within the Latinx community. In this phase, participants were asked about the associations between documentation status, ethnicity, reproductive healthcare access, and education in the community. Discussing personal information was not required.

The interview guide (Appendix A) was informed by research on healthcare access, teen pregnancy, and STI prevention in Latinx and undocumented communities. We invited participants to discuss the following topics:

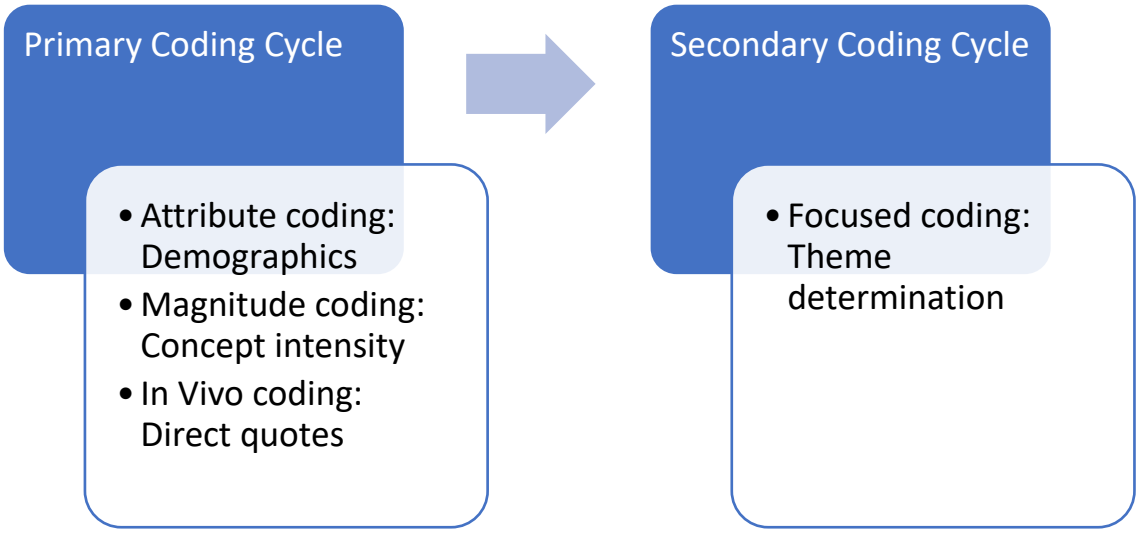
1. Concerns about sexual and reproductive healthcare knowledge and access for undocumented Latinx adolescents.
2. The needs for sexual and reproductive health education among undocumented Latinx adolescents.
3. Perspectives about materials or content that a comprehensive teen pregnancy prevention program for undocumented Latinx adolescents should include.

Data management and analysis

Interviews were transcribed, and the recordings were stored in an encrypted file. After the completion of the study, the recordings were destroyed. Transcripts from each interview did not include names but did include participant characteristics such as age, gender, and interview language. Identifying information was redacted during the transcription process.

Inductive coding was done to explore the data. Figure 3.1 outlines the two coding cycles. The primary or first cycle of coding included attribute coding (assess demographic information), magnitude coding (identify the intensity of concepts), and In Vivo coding (insert direct quotations from the transcript to group ideas). The secondary coding cycle incorporated focused coding (categorizing thematic categories by significance or rate of recurrence). I used thematic analyses to identify meaningful themes in the interview data (Schreier, 2012).

Figure 3.1 Coding Process



Using the interview transcripts, I developed a codebook (Appendix B). The development of a codebook simultaneously occurred with the process of thematic analysis. A codebook is a document used in qualitative inquiry where a researcher lists items related to the research question and explains them and the best practices for using them (DeCuir-Gunby et al., 2011). Codes consisted of items related to the study objective. Codes were defined based on their use in the transcripts. The codebook includes examples from the transcripts for each code. I conducted individual coding initially and then had a second researcher randomly code 33% of the interviews. Following their conclusion, we met, identified discrepancies, and revised the codebook as needed until we both agreed the final product was comprehensive. Data were analyzed using NVivo qualitative data analysis software (https://lumivero.com/products/nvivo/).

3.2 Phase 2: Material Development

The objective of Phase 2 was to design health education materials to address undocumented Latinx adolescents' sexual and reproductive health needs. After analyzing Phase 1 interviews, the themes were researched using peer-reviewed sources. Findings from this review were then used to develop health education materials for adolescents, parents, and facilitators/interventionists.

3.3 Phase 3: Finalizing Educational Materials

The objective of Phase 3 was to evaluate and finalize the new reproductive health materials by assessing them for comprehension, ease of use, engagement, and relevance to identified themes. Using a survey for each tool (four in total), I requested participant feedback concerning how well the materials responded to the themes found in Phase 1.

Study Sample

The final phase of this study included presenting the new materials to the community members, parents, and youth from Phase 1 who agreed to participate in this last section. To reduce participant burden, each participant was asked to review only one tool. I assigned participants to review the theme and corresponding tool that best matched the information they provided during their interview.

Survey

Following Phase 2, I developed a mixed-methods survey and sent requests electronically to the consenting participants from Phase 1. For each theme, participants responded to four close-ended questions followed by two open-ended questions. These four close-ended questions are:

1. Relevance. How relevant is the material to this theme?
2. Ease of use. How easy would it be for adolescents to use this material?
3. Engagement. How interesting and engaging is this material?
4. Comprehensiveness. How well does the material cover the needs of undocumented Latinx adolescents in relation to this theme?

The two open-ended questions were:

5. Please describe the most valuable and useful aspects of this material.
6. Please provide ideas to improve this material.

Completing this survey took participants approximately 15 minutes, and participants received a $25 gift card to thank them for their time.

Data Management and Analysis

. The survey was conducted using Qualtrics (https://www.qualtrics.com). Member checking was used as a form of material validity. Median scores were obtained using Microsoft Excel. Relevant suggestions in the open-ended questions were incorporated into the newly developed materials. Findings from the survey were organized by question and compiled.

Subjectivity Statement

This section introduces my background and experiences to explain my subjectivity to the present study. I approach this project as a 31-year-old African American doctoral student.

I take a special interest in working with the Latinx population. While I am not of Latinx descent, as an African American, I understand the complexities of being a minority in the United States of America. Historically, African Americans have experienced multiple atrocities, from enslavement to racism. These experiences have shaped the African American lifeworld, as many still are victims of prejudice today. Racism is a public health problem affecting individuals physically, mentally, and emotionally. By mistreating those who are different, the majority group feels powerful. Latinxs are also minorities in the United States, facing many challenges due to racism. While they did not experience slavery, the oppressive manner in which both groups have been treated still influences their health.

I further identify with this population as someone raised in the Catholic faith. As a 'cradle Catholic' (someone born into Catholicism), this religion was the first faith base I knew. In addition to regular mass, I attended Catholic school during elementary school,

and most of my classmates in religious education were Latinx. The structure and ideals presented by the Catholic church were norms in both their and my family's home. As such, I have understood Latinx's positionality from the faith perspective.

In addition to being a practicing Catholic, I also approach the present study as a parent. While my children are not yet in the stage of adolescence described in this research, I understand some of the challenges associated with parenting. I have also studied parent-child interactions and their influence on health outcomes.

CHAPTER 4:

RESULTS

This chapter presents the findings of the study and comprises three sections. The first section describes the participant descriptions and overview of the interviews. The second section presents the themes that emerged as well as the development of the educational materials. The third section explains the survey results and how the recommendations were incorporated into the activities.

4.1 Participant Descriptions and Interview Findings

Forty people were contacted to participate in this study. Ten were uninterested or had a time conflict, and nine did not meet the eligibility requirements for participation. Thus, the final sample consisted of 21 participants. Table 4.1 shows their demographic characteristics. Nearly all participants identified as Latinx (90.4%), except for one African American and one Caucasian respondent. Participants ranged from 19 to 45 years, with a mean age of 30.3. While participants were invited from across the country, most (76.2%) resided in the Southeastern United States. Only two men participated (9.5%) in this study. In some cases, participants could fit into more than one study group (e.g., participants were both parents and community members or youth and community members). When this occurred, they were sorted into the group they most identified with, leaving a nearly even distribution of participants across the three groups.

Table. 4.1 Participants' Demographic Characteristics (n=21)

Pseudonym	Sex	Interview Language	Age	Participant Type
1. Ana	F	English	31-36	Community Member
2. Beth	F	English	25-30	Community Member
3. Callie	F	English	18-24	Youth/ Community Member
4. Diana	F	English	18-24	Youth
5. Elena	F	English	37-42	Youth/Community Member
6. Flor	F	English	31-36	Parent
7. Giana	F	Spanish	43+	Parent/Community Member
8. Hadia	F	English	18-24	Youth
9. Isaac	M	English	31-36	Parent
10. Josefina	F	Spanish	25-30	Youth
11. Katerina	F	English	18-24	Youth
12. Laura	F	English	25-30	Community Member
13. Mariela	F	Spanish	43+	Parent/ Community Member
14. Nina	F	Spanish	37-42	Parent
15. Olivia	F	English	31-36	Parent
16. Paula	F	Spanish	37-42	Parent
17. Quena	F	Spanish	37-42	Parent
18. Rosa	F	English	25-30	Community Member
19. Silvia	F	English	25-30	Community Member
20. Tatiana	F	English	18-24	Youth
21. Umar	M	English	25-30	Youth

This section describes each study participant interviewed. After the interview, each individual stated their age and identifying gender. To increase anonymity, participants' ages were reported in ranges, and pseudonyms replaced actual names.

Ana was a college professor living in the southeastern United States. The information she provided in her interview made her experience working with Latinx youth very apparent. She had an extensive understanding of cultural components and issues concerning immigrant relations. Ana was a social worker by training with more than ten years of experience working with undocumented Latino adolescents. She also had experience working with Latino families in handling transitions related to trauma and

sexual abuse while crossing the United States border. During her interview, Ana expressed concern about barriers to sexual and reproductive health for undocumented Latinos, particularly the lack of parental knowledge and cultural implications of Latino society. She also had much to say about the low level of priority that sexual and reproductive health had in undocumented Latinx families. When asked about items that should be included in health materials for undocumented Latinx adolescents, Ana discussed the importance of ICE-free spaces to seek care.

Beth was a public health educator for a network of teen health clinics. She had experience working with adolescents aged 10-18 and focused primarily on reproductive health education. She provided a unique point-of-view as one of the few participants who did not identify as Latinx. During our conversation, the topic of language barriers frequently arose, a problem not often expressed by other participants. Beth expressed the need for both parents and adolescents to have access to places to receive safe reproductive healthcare. Despite her initial challenges in understanding Latino culture, she noted the importance of the newly developed health materials being culturally competent. She also made multiple suggestions of content based on her expertise, including the explanation of commonly misunderstood sexual and reproductive health terminology.

Callie was an undergraduate student in international relations and a peer health educator through her university in the Southeast. She spoke from the point of view of a youth and community member. Callie described her experiences helping her peers access reproductive healthcare and her opinions of Latinx youth's understanding of sexual and reproductive health. She noted how culture impacted Latinx youth from even accepting

sexual and reproductive health education materials and condoms or other contraceptives and how this was a disservice to a population that needed these resources. When asked what types of content should be included in health materials for undocumented Latinx adolescents, Callie stressed the importance of healthcare locations serving individuals regardless of documentation status.

Diana was an undergraduate student at a midwestern university. Her understanding of challenges related to sexual and reproductive health access for undocumented Latinx youth was limited. Her positionality spoke to the privilege of Latino youth with documentation, who consider themselves 'removed' from their undocumented peers. She explained how much Latino youth traditionally learn (or do not learn) about sex or reproductive health as adolescents and how that was detrimental to her as a young woman and other Latinx youth. She believed that the best resource that could be provided to undocumented Latinx youth is information on places that don't ask about documentation status.

Elena was a health educator who immigrated from Mexico to the United States as a child. Her experience as both a Latinx youth and a community member was unique, as she also self-identified as a 'privileged immigrant' who had never had to be concerned with documentation status since her parents migrated legally. As a health educator, she often worked with undocumented Latinx and provided several anecdotes concerning mothers and their attitudes toward sexual and reproductive health for their children, particularly the girls. She also provided personal insight into the sexual and reproductive healthcare needs of Latinx immigrants and how discussing these topics in academic and familial settings is often challenging. Her recommendation for health materials for

undocumented Latinx youth centered on material facilitation. She believed that the best resource for this group was to be taught by someone who looks like them and truly understands Latinx culture. She also expressed the need for materials in other dialects found in the Latinx community.

Flor was the parent of a daughter in middle school and a son in elementary school. Though she was born in the United States, her parents were originally from Mexico. Flor's approach to communicating with her daughter about sexual and reproductive health was open and honest. She talked about friends and family she knew who didn't practice the same principles and how it affected their children's lives. From her point of view, undocumented Latinx youth have just as much access to sexual and reproductive health education as their peers with documentation. She expressed that most Latinx youth know about the opportunities for undocumented Latinxs to access healthcare providers. When asked about what types of information should be included in health materials for this group, she suggested more guidance to accurate sexual and reproductive health web resources because of the amount of misinformation online.

Giana was a community member and parent in the Southeast. She had been involved in the community as a community health worker (*promotora de salud*) for several years. She had worked to connect the Latinx community in her area to needed resources and services. She was the mother of an adolescent male and could speak on current experiences and conversations surrounding sexual and reproductive health with her son. She also discussed the unique position of being a Latina mother to a son and the challenges associated with raising him to be responsible and knowledgeable. Giana provided insight into her experiences and observations of other Latinx community

members regarding sexual health. She highlighted the difficulty parents experience when providing their children with accurate and culturally relevant information.

Hadia, a recent high school graduate, provided an in-depth view of the current programs and strategies taught in schools in conservative states. She discussed her experiences with the lack of comprehensive sex education in middle and high school and how there is a need for health resources since sexual activity is common during that age. She also explained how cultural stereotypes like machismo and marianismo are still very present in Latinx families and impact how parents discuss sex with their children. As she prepares to enter nursing school, her experiences inspired her to pursue healthcare to serve her community. She feels that health materials are most needed for Latinx parents, as they greatly influence their child's decisions to engage in sex.

Isaac was the only father in the study. His position was also distinctive as the only Caucasian parent (foster) to an adolescent-aged undocumented Latina. Isaac discussed some challenges undocumented Latinx youth experienced and how difficult it was for an undocumented individual to obtain documentation in the United States. He also explained parents' difficulties when considering sexual and reproductive health access and education for their undocumented child. Perhaps the most impactful of these was cost. He mentioned how he was worried about his daughter becoming ill because she was not eligible to be covered under his health insurance. Isaac suggests that sexual and reproductive health materials must include cost-effective, safe care options for undocumented Latinx youth.

Josefina was a young woman who helped raise her adolescent age siblings. This experience included discussing sexual and reproductive health and similar topics with

them. She discussed concerns with undocumented Latinx youth being able to access reproductive care because of a lack of knowledge of options available. Josefina's career was in social work; she also provided bilingual services in Spanish and English to community members in her area. Because she was knowledgeable about local resources for the Latinx community and spoke about the lack of services available, she noted the need for safe and cost-effective reproductive care providers and learning centers.

Katerina, a master's student, discussed the social, economic, and health disadvantages in the Latinx community. She highlighted the need for a program to make resources more available to the immigrant Latino community to address gaps in knowledge and access to care. Katerina stated that Latino immigrants are likely to experience future adverse health outcomes because of a lack of knowledge. She mentioned the stigmatization of sex in Latino households making it difficult for youth to discuss their needs. While she was not asked about the perspective about content that should be included in reproductive health materials, Katerina expressed the need for parental involvement as well as access to free reproductive care.

Laura was a health educator from the southeast. She spoke of growing up in a Mexican household, and her family did not discuss sex and reproductive health. As an adult, these topics are still not mentioned in her family, even though her career involves teaching others about reproductive health and wellness. Laura discussed the challenges of finding culturally relevant health materials for her Latinx clients and the need for supporting materials for healthcare providers who may not know how to interact with undocumented Latinx clients. Laura stressed the importance of reproductive health

materials for undocumented Latinx youth, including LGBTQ+-friendly care resources and providers.

Mariela, the mother of an adolescent male and community leader, was heavily involved in advocacy and community organizing efforts in her local and regional community. She had extensive knowledge of the needs of the Latinx community as she has lived in the area for well over a decade. She mentioned her concerns about reproductive health resources in the area, the barriers Latinxs with and without documentation face, and the disconnect between bilingual services available and the community's actual use of those resources. Mariela also mentioned the need for culturally inclusive sexual and reproductive health education. Her recommendations for health education materials include consistent, easily attainable information.

Nina was a mother to several adolescents in the public school system. She discussed how her experience as a parent concerning sexual and reproductive health education provided through her local school system in the Southeastern United States. Nina was very open about her own experience when discussing sexual health with her adolescent son and the challenges that came along with that conversation. Additionally, she spoke about her own experiences surrounding sexual health and reproductive services and the conversations she had with her own parents, and how that influenced her parenting choices. Nina's suggestion for content for health education materials included supplemental items for parents to help explain what type of information they should be discussing with their adolescents.

Olivia was a community health advocate and parent who provided a unique positionality to the study. She discussed her experience growing up in a household where

sex and reproductive health were not addressed and how that is a common issue in the Latinx community. She also mentioned how this upbringing impacted her life as she became a mother at age 16. Olivia explained how her approach to parenting her now teen daughter was unconventional in many Latinx spaces but that there is a clear need for accurate information. However, she feels that by encouraging open and honest communication about sexual and reproductive health, her daughter can make more informed decisions than she did at her age. She felt that materials created for this study should include locations to receive low to no-cost healthcare and social/emotional support.

Paula lived in the Southeast, where she had been an active community member for over a decade. Paula talked about her experience as a mother of adolescents and a family member of a mixed-status household. She was open and willing to discuss her background and concerns as a mom of an undocumented adolescent and how knowledge and access to resources for that child might have been different from other Latinx adolescents. Paula believed that the health education materials for the study should include informative, easy-to-understand resources for Latinx youth. She also stressed the importance of finding locations that had experience helping undocumented youth.

Quena was a parent to two adolescents. She was very detailed and forthcoming about her experiences as a mother and as the daughter of immigrant parents. Quena spoke on stigma, shame, misinformation, and varying cultural beliefs surrounding sexual health and reproductive services, particularly the difference between the information she received as a child and the information she chose to deliver to her children. She had ideas

for sexual and reproductive health education resources, such as engaging workshops for youth and multilingual options for non-English speakers.

Rosa, an advocate, was passionate about serving and uplifting her community by organizing civic and leadership development for teens. She spoke about the influence of religion on Latinx culture and how that influenced teaching youth about sexual and reproductive health. She also discussed challenges with finding healthcare services for the Latinx youth and how mistrust is a big concern because of the historical treatment of Latinx regardless of documentation status. Rosa explained that while creating health materials for undocumented youth was needed, it was just as important to ensure there were incentives and engaging information.

Silvia was a nurse who had experience working with Latinxs with and without documentation in different capacities, such as interpreting. Her career allowed her to see the mistreatment of young Latinas in labor and older adults in the emergency room. She noted the need for educating Latinxs about their reproductive health. She emphasized that documents and programs should be culturally inclusive. Silvia also stressed the importance of educational materials for healthcare providers who work with undocumented Latinx.

Tatiana was a college student who gave insight into the cultural differences in sex education for Latinx families, especially growing up in a strict Catholic household. She spoke of the stigma associated with sex and reproductive health in general. Her perspective highlighted fear in the Latino immigrant community around the government due to the possibility of deportation and family separation. Tatiana believed there was a

great need for more education associated with birth control and abortion access for undocumented youth.

Umar was a military serviceman who grew up in the west. In his interview, he discussed the Latino experience in reproductive education in a state with a high Latino population. Umar noted that the state where he lived had materials specifically designed for the Latino community. He explained how his community silently acknowledges issues like language and migrant status. Doctors and nurses would give medical services to all people, no matter of migrant status, which encourages people to learn about and seek safe healthcare. Umar's suggestions for health education materials included information on access to locations for low-cost reproductive care.

4.2 Emergent Themes

This section describes the themes I found during the thematic analysis process of this study. Findings show that study participants shared similar perspectives, despite representing different groups (youth, parents, and community members). Following this step, I developed sexual and reproductive health materials to address each of the themes uncovered.

Using the coding process outlined in the methodology, I identified four themes and developed corresponding implications:

Theme 1: Discussing sexual and reproductive health is uncomfortable, and health educators do not consider the Latinx cultural context.

Discussions with adolescents involving sex and reproductive health can be difficult. Because of the complex relationship between Latinx culture, morality,

religiosity, and fear of detainment, the conversations surrounding sex and reproductive health can be even more challenging for undocumented Latinx youth.

Participants expressed their discomfort with conversations about sexual and reproductive health. Two related messages emerged from the interviews. First, education about sex and reproductive health in academic settings was uncomfortable for youth to discuss with adults. Second, there was an absence of sex and reproductive health conversations at home, aside from a simple "Don't do it" or passive shaming of peers known to have had sex or had gotten pregnant. Participants who experienced either or both of these situations stated neither instance helped them better understand reproductive health or make more informed decisions about sex.

In the Latinx culture, sex and reproductive health are not usually openly discussed within families. Because of this lack of communication, Latinx adolescents often felt uneasy when the topic was introduced in sex education classes or even in general conversations. Tatiana, a college student from the southeast, highlighted her experience,

> Walking into Health in seventh grade and being taught (about) STDs, you feel uncomfortable. Because one, for some Latinos, it's the first time they ever speak about this type of subject. And it's basically in front of strangers. You're surrounded by strangers (*long pause*). And you have a nurse, who you barely even see, tell you about condoms and how to put a condom on, and you feel uncomfortable. This is a very intimate topic. And to be in such a vulnerable state around people you don't feel comfortable around. It's just uncomfortable, to say the least!

Laura, a health educator who was raised in a Mexican household, shared a similar experience with feeling uncomfortable in a sex education class. She stated, "At schools with public education, programming was not that great. I didn't feel comfortable doing that (participating in the sexual education programs) because of my background at home."

In addition to the lack of comfort, participants expressed concern about the conflict between the course content and family values about sex and reproductive health. Because information was usually not facilitated in a culturally sensitive way, participants mentioned unease in receiving this information and confusion in determining which source (e.g., the teacher, their parents, the church) was correct. Laura talked about this challenge,

> Because most health materials are generalized, Latinx youth who do have a chance to come into contact with this information can feel confused about what to take in as new knowledge and what to reject, especially if it directly goes against cultural norms and religious teaching.

Tatiana had a comparable experience when learning about sex and reproductive health in school. She explained,

> We're confused because, at one point, we're at home being told, "Stay away from sex." Like sex is bad. But then, at school, we're being told, "Oh, use a condom." Or "Watch out for STDs." Or '" Get on birth control." And how do we know who to listen to?

Nina grew up in Mexico and immigrated to the United States as an adult. As a parent, she struggled with knowing how to talk to her children about sex. Because of her upbringing compared to American parents who were, in her observation, much more surrounded by the topics of sex and reproductive health. She provided her point of view,

> Those of us who come from more backward countries, like in our case Mexico, and we come from villages, it's much more difficult. Because I tell you, we didn't receive any orientation. So, as we're changing, as we're evolving, it costs. Evolution is difficult. Because for me as a mother who has never heard anything about it, it is very difficult for me. And the people who grew up here, well, they talk about it more openly because they already bring it by habit.

Several participants indicated that information on sex and reproductive health was either facilitated incorrectly or entirely missing from their education as an adolescent. Tatiana, a youth Latinx student, explained, “It's not taught- no other information is given

to people or young Latinos who want to be sexually active but don't know how to protect themselves." It can be hypothesized that these experiences are similar or more challenging for undocumented youth who sometimes may not always have access to reliable or consistent education (Patel & Saenz, 2017). When teaching about sex and reproductive health, facilitators need to know their students' demographic characteristics to tailor appropriate and comprehensible resources. Additionally, understanding the participants' community cultural norms is necessary so that materials are delivered respectfully.

When asked about the need for culturally relevant materials for Latinx youth, Laura—who immigrated to the United States as an adolescent—provided her insight, "Like with any educational material, it has to be very culturally responsive. …if it's meant to serve the community, then there should be somebody that's delivering it that looks and sounds like them. So, it's received better and accessible."

Culturally sensitive programming requires extensive research. Because of the unique experiences of Latinx youth, especially those undocumented, there is a need for health materials based on an in-depth understanding of Latinx culture.

Ana complained about the superficial adaptation of programming she witnessed in the field of social work, where she has seen the development of adolescent mental health materials for Latinx people,

> In the US, they will tweak it [health materials] for undocumented youth, particularly Latinos, and they'll just translate it identical more things regarding the statistics of the group. And [the idea is] "Okay, it's tailored, yay!" We'll make it more colorful and make it more attractive for that, for [Latinos]. And it's done.

She explains the advocacy she has had to do after witnessing this action, "We forget we have to step back. So, when it comes to sex and reproductive health, starting

with the [understanding and definitions of] words, let's just start with those words, what do they encompass?"

In response to these participants' perspectives, I developed Tool 1, *What about us? La Cultura Latina*. Box 4.1 summarizes this activity designed to increase youth's comfort in discussing sex and reproductive health.

Box 4.1 Educational materials for addressing Theme 1

What about us? La Cultura Latina

Purpose: Increase participants' comfort with discussing topics associated with sex and reproductive health by creating a safe space.

Content: In this activity, participants examine viewpoints on various sex and reproductive health topics and introduce the topic to the class as their comfort level allows. To create this safe space for expression, all responses are anonymous. The tool provides opportunities to ask questions related to both the course and address cultural beliefs about the terms discussed. In addition, the topics address parental and cultural expectations and norms. The proposed tool allows youth to express their thoughts and beliefs about sex and reproductive health without judgment. Suggestions for best practices in facilitator selection are also included.

Timing: Facilitators can use this tool while teaching a sex education curriculum and introduce it before discussing topics involving sex. Introducing this ad hoc tool before starting an intervention can make participants feel more comfortable because the facilitator understands their cultural norms.

Theme 2: Few services provide care regardless of immigration status.

Finding a care provider specializing in sexual and reproductive health and who easily interacts with young people can be difficult. Seeking the same type of care as an undocumented individual is significantly more challenging (Artiga & Diaz, 2019; Hacker et al., 2015; Patino, 2017). In this study, some participants complained about the lack of information about safe places to receive sexual and reproductive healthcare. This theme

has two central concepts. First, where can undocumented Latinos seek care without fear of detainment, and second, how can they pay for such care?

The fear of detainment often inhibits undocumented individuals from seeking healthcare. Callie is a college student and peer health educator who shared this sentiment,

> I've noticed a lot of migrants with their children completely avoid hospitals and health providers because there is a possibility of those providers whispering their migrant status to a police officer and could get them deported at the hospital. The conversation of you getting separated from your family is too much of a risk to you... that's just so bad. Pretty much in the US, in our state, if you are a migrant here, your health is even at stake because you could possibly get deported for that reason. So, if you break a leg, if you get sick, if you get a heart attack, or if you are giving birth, there's a possibility of possibly getting deported if you get a bad nurse... [that kind of] nurses would be openly racist and be like "Oh, you don't have those rights [to ask for care]."

Tatiana discussed a similar experience from a friend stating, "A young, undocumented Latina wouldn't want to go to a clinic to get on birth control because of fear that their name is going to pop up and they're going to get reported to ICE." In undocumented communities, sharing information related to their status can be dangerous. She continued explaining the anxiety associated with seeking care, "we're scared because you don't want to give them your phone number, address, or name. But that's what they ask for… you're scared to give them any type of information because you don't know how they're going to use it."

Diana had undocumented friends who also felt uncomfortable with going to a doctor. She said, "I've spoken with friends who are undocumented, and just the fear of even going to a doctor and getting caught [for asking for help] makes them not go." She says they try to take care of themselves and stay away from anything that would make them a target, "My friends who are undocumented say it's a 'keep your head down mentality,' like don't try it, keep under the radar."

For those willing to take the risk of seeking a healthcare provider, there is still the question of where they can afford to go. Healthcare costs, especially for uninsured patients, are generally prohibitive. Many participants identified cost as a barrier to seeking sexual and reproductive healthcare. Olivia is a health educator who became a mother as a teen. She observed, “I think not having insurance [is a big issue with immigrants]. Because, you know, everyone's [mindset] is always ‘toughing it out’ because we don't have money for X, Y, and Z. We cannot go to the doctor. It's going to cost us a lot.”

As the father to an undocumented adolescent, Isaac had insight into thoughts that parents have when dealing with the situation,

> We're very open with our child, and we [tell her], “Don't get sick. I mean, if you get sick, we'll figure it out but don't get sick,” because the financial reality of them getting sick is hundreds of dollars for one visit.

He explains how he seeks healthcare for his daughter, “Having an undocumented person living with me means the access to medical care comes down to clinics that will offer cheap-to-free care or emergency rooms. Finding and accessing clinics can be difficult, especially for minors.” Rosa, who works daily with Latinx teens, stated, “I wouldn't know what is available out there, [places] that are dedicated to giving and providing that service.”

Elena, who has worked with Latinas of varying statuses, commented on the multiple barriers to accessing sex and reproductive healthcare,

> The barriers they're facing are similar to just going to a primary care doctor with no insurance. And if you don't have insurance, there are very limited places where you can go. And the wait might be super long to be able to see if free or low-cost gynecologists exist [in their neighborhood].

In addition to cost, additional barriers to access include transportation and the service's hours of operation. Isaac explained,

> It's a financial issue. It's a transportation issue. It's a time issue. I mean… the reality for a lot of our immigrant and undocumented folks is they get paid by the hour. There is no paid time off. There is no leave. There are no breaks. And so when you go, and when you get there, how do you pay?

I created the Strategies to Create a Healthcare Resource Guide document in response to participant feedback concerning the need for safe health resources. This document is designed to alleviate difficulties in finding healthcare for undocumented Latinx youth. Box 4.2 summarizes this tool.

Box 4.2 Educational materials for addressing Theme 2

Strategies to Create a Healthcare Resource Guide

Purpose: Provide facilitators with best practices for developing a "Healthcare Resource Guide" specific to their community for undocumented Latinx youth.

Content: This tool aids facilitators in creating a resource guide to access medical facilities, care providers, social workers, and other sex and reproductive health-related resources. The guide consists of information on what information should be presented for each resource and where someone could find said information.

Timing: This facilitator tool is completed before starting a sexual health curriculum.

Theme 3: Adults need accurate information and skills to talk with youth about sexual health.

Adolescents who talk about sexual and reproductive health with their parents are more likely to abstain from sexual intercourse and make more informed decisions about safe sex when they do choose to have sex (Breitenstein et al., 2016; Cabral, 2018; Commendador, 2010). During the interview process, most parents and community

members expressed the need for accurate and healthy sexual and reproductive health conversations between parents and adolescents.

Some youths learn inaccurate or incomplete information about sex and reproductive health from their parents. Flor, a mother with a middle school daughter and a son in elementary school, provided her experience learning about sex, “It's what's passed down from generation to generation, from what your mom told you, what her mom told her… I feel they don't have the knowledge to pass down to the younger generations.” In most families, the ‘talk’ that is passed down is not enough. Rosa recalls her own experience ‘learning’ about sex and reproductive health from her parents, “[In my] family culture just says, 'Hey, don't get pregnant.' They don't really dive into how.”

Some parents may not teach their children about sex or reproductive health because they do not feel prepared to have this conversation. Some Latinx parents have had limited opportunities to seek information to share with their children. They were not taught these concepts; therefore, they struggle to share them with their children. Ana recalls talking with her mother about reproductive health as an adult, “My mom didn't know that there was a separate hole to pee from the one where you actually get your menstruation. She had no idea that there were two. She thought it was just all one thing.” A recent high school graduate, Hadia shared her insight based on her experiences with friends and their parents,

> I think it's all about parents being educated on the topic [of sexual and reproductive health]. If they're not educated, then they can't teach their children. I feel like sometimes undocumented parents don't have that education because they're coming from a country that didn’t have [those options].

Some parents do not discuss sex with their children because they believe talking will encourage premature sex, which is seen negatively both culturally and religiously.

Raising a teenage boy, Giana shared her struggle with talking to her son about sex, "Sometimes we don't talk to our children about these issues of sex because we have the idea that, well, talking to them is going to push them to do it." Olivia's mother never taught her about sex and used fear and shame in place of information after she found out that she was sexually active,

> As far as my mom speaking about sex or any reproductive health or anything like that, she didn't; it was more about anger. When she found out I had had sex, she got really upset, and I was punished. She told me, "You know, no one's going to want you now because you're basically ruined."

Josefina, a health educator, felt her own experience discussing sex with her father incited fear, "My dad was always like, 'If you do something, you're going to regret it.' Or 'You're going to see what's going to happen.' That was always kind of scary for me." As a health educator, Elena works with Latinx mothers and provided this anecdote from her experience,

> There are not a lot of conversations with-between a lot of parents and their kids about how to have a healthy sexual discovery or experience or how to have sex responsibly. Because, again, it's all about abstinence. I've had conversations with women whose daughters were pregnant when they were teenagers. In hindsight, they regretted not having had better conversations with their kids about how to take care of themselves.

When parents did discuss sex and reproductive health with their child, the adolescent often felt embarrassment or shame that kept them from really comprehending the material. Josefina did not understand the importance of that information and how missing it directly impacted her life,

> I got pregnant very young. It scares me because I know that at the time when it was my turn [to talk with my child about sex and reproductive health], I felt like, "I don't want to listen because it's embarrassing, and I don't want to talk about it, I don't want to talk about sex with my parents because they are my parents."

Sometimes youth do not want to talk to their parents out of fear of getting into trouble. Ana shared, “It can be very taboo because I think there's a fear. If I ask my parents anything about sex and reproductive health, they automatically assume that I'm having sex." Because of an upbringing where she could not talk with her mother, parents like Olivia have chosen a different path when talking to their children, “I speak a lot with her about STDs and any questions that she might have. We've always made it a very open and safe space to speak about it [because] I was the teen mom.”

To address the concerns mentioned by study participants in Theme 3, I created *Healthy Sex Talks*. This tool contains resources to help adults facilitate conversations about sex and reproductive health. Box 4.3 summarizes this tool.

Box 4.3 Educational materials for addressing Theme 3

Healthy Sex Talks

Purpose: Encourage adults to engage in healthy and scientifically accurate conversations about sex and reproductive health with youth by using credible health resources.

Content: This tool consists of resources for parents to understand the benefits of openly discussing sex and reproductive health with their children. It also contains strategies for starting the conversation and ensuring their child feels safe and heard. It includes information for adolescents on starting a conversation with their parents and maintaining open communication when discussing this challenging topic.

Timing: This tool should be in conjunction with the intervention facilitation. It can also be used alone as a single resource.

Theme 4: Undocumented Latinx youth need access to multilingual materials.

Despite numerous Spanish speakers in the United States, health information is not always available in their language. This experience holds when considering sexual and reproductive health and education. Several participants discussed the challenge of

language barriers and how they had the potential to impact patient outcomes negatively. Two main ideas emerged from the study findings: barriers to accessing healthcare because of a lack of Spanish language resources and the limited consideration for those who spoke indigenous languages.

Some healthcare settings do display Spanish health education materials, such as pamphlets. However, participants often reported problems finding healthcare providers who spoke their language. Beth is a health educator at a free clinic for teens and explains, “That's one of the most common barriers that I have seen; they [patients] don't speak English, and then I don't speak Spanish. I can only understand a few words.” She continues,

> Some will come in with a family friend or parents or someone that will help fill out the information and interpret. But it is also an issue because if they're not telling that person all of the correct information, we can’t truly help them.

Elena has volunteered to interpret for other Spanish speakers and shares her experience,

> It's already awkward enough [to visit a gynecologist], and to have to use an interpreter is worse. I'm not a certified interpreter, but because there are not many in our town, I've been asked to interpret for community members, and it is not easy.

Silvia worked as an interpreter before becoming a nurse and explained how, in her daily tasks, Spanish-speaking patients were still disparaged, even when interpreters were available to assist,

> There's been stuff that I wish they [doctors] would ask. As an interpreter, you can't ask anything of your own. It has to be exactly what the patient and doctor are saying. Sometimes as I was interpreting, I know that what they [the patients] are saying kind of doesn't make sense [because they do not understand what is being asked], but the provider does not ask follow-up questions.

As more refugees from Latinx nations relocate to the United States, the language barrier is more difficult for those who do not speak English or Spanish. These individuals usually immigrate from smaller rural communities and speak the indigenous languages (or native dialects) of their region. Information collected on the indigenous languages of Latinx immigrants is scarce. In her position as a peer health educator, Callie, who speaks English and Spanish, shared her experience,

> In our county, we've had a very high increase in Latino groups that don't speak Spanish. They speak their native dialect. I feel even worse for them because they can't get any type of aid when they are going through something health related to sex or reproductive care. Also, if an adult can't even get it [care], a child isn't going to be able to get care or education.

Individuals who primarily speak native dialects from remote areas are a growing concern of healthcare professionals, as they are unsure of the best way to communicate and treat them. Ana has dealt with this situation often and explained, “I worked with youth from Guatemala. They spoke their native dialect and not English or Spanish. Working with them was difficult because there was a severe language barrier, and we didn't have any individuals that could translate.” Quena explained, “Language barriers count. Some people don't know how to speak English or Spanish. Not being able to communicate, [you have] that fear of going to places to get help, because they may think no one can understand them.”

When asked to elaborate on her thoughts about care access and language barriers, a frustrated Tatiana stated,

> How [do we get help in] the system that wasn't created for us? It's not supposed to benefit us. So many undocumented Latinos can't even ask for help because of the language barrier. It's frustrating to be in a country where people, like our parents basically went through hell to get to for no one to help us.

In response to participant feedback, I developed *Language Matters*. The purpose of this document is to help facilitators identify multilingual resources for Latinx youth. Box 4.4 summarizes this tool.

Box 4.4 Educational materials for addressing Theme 4

Language Matters

Purpose: Provide resources that produce multilingual content for undocumented Latinx youth.

Content: This resource is created to help facilitators find accurate resources to provide multilingual versions of health materials for Latinx youth. It includes both information on Spanish language options as well as some indigenous languages of Latin and South America.

Timing: This tool is designed for facilitator use during an intervention or health program. It also has utility as a single resource.

4.3 Participants' Feedback on Activities

The purpose of this study was to improve the sexual health and well-being of undocumented Latinx adolescents through the creation of additional health materials specifically designed for this population. To accomplish the study purpose, I interviewed stakeholders of the Latinx community to inquire about sexual and reproductive health needs and created materials based on the interviews. This section details the survey results distributed to the study participants following the creation of the health materials.

I asked all 21 participants to complete an anonymous survey. Each participant received one tool to review and was invited to complete the online survey. The tool for their review corresponded to the theme they spoke about most. Five participants were assigned to Activity 1 and five to Activity 2. Because Tool 3 has separate versions for

English and Spanish, seven participants were assigned to this section. Four participants were assigned to review Tool 4.

The participants answered six questions: four multiple-choice questions (relevance, ease of use, engagement, and comprehensiveness) and two open-ended questions (usefulness and suggestions for improvement). The response options ranged from *very* (4 points) to *not at all* (1 point). Participants opened the survey 16 times; nine surveys were completed (42.8%).

Relevance, Ease of Use, Engagement, and Comprehensiveness

Table 4.2 displays the results of the quantitative study findings. Overall, the study participants provided positive feedback on each of the tools. All participants indicated the materials presented were *very relevant* to the themes. Eight of the nine participants stated that the materials were *very easy to use*, and one believed they were *somewhat easy to use*. More than half of the participants reported the materials to be *very engaging*; the remaining four thought the materials were *somewhat engaging*. The final question regarding how well the materials covered the needs of undocumented Latinx adolescents yielded seven of nine *very helpful* responses and two *somewhat helpful* responses.

Table 4.2 Assessment of relevance, ease of use, engagement, and comprehensiveness

	Tool 1 (n=5) Mean	Tool 2 (n=1) Score	Tool 3 (n=1) Score	Tool 4 (n=2) Mean
Relevance	4.0	4.0	4.0	4.0
Ease of Use	4.0	4.0	3.0	3.5
Engagement	3.6	4.0	3.0	3.5
Comprehensiveness	3.6	4.0	4.0	4.0

Note: Responses range from 1 (*Not at all*—relevant, easy to use, engaging, comprehensive) to 4 (*Very*—relevant, easy to use, engaging, comprehensive).

Usefulness and Suggestions

Table 4.3 summarizes the qualitative findings from the survey (items 5 and 6). Feedback from study participants was positive, highlighting how useful these materials would be in real-world settings. The suggestions provided were few and included minor changes incorporated into the final tool, if applicable. Of the recommendations, four were incorporated into the tools. The first suggestion was to use 'Latine' interchangeably with 'Latinx.' While Latinx is an academic term, I specified in Tool 1 to encourage using the term most comfortable for the participants. The second suggestion stated information about appointment availability was missing in Tool 2. I included appointment availability in the document's hours of operation section. The third suggestion was to add a QR code at the end of each resource, which I added to Tool 2 as a note to facilitators. Reviewers provided two relevant suggestions for Tool 4: including information for those without internet access and adding one of the indigenous languages of Guatemala. The former was added as a note to facilitators, and the latter was incorporated by adding the most spoken indigenous language of Guatemala, K'iche. These tools are in Appendix C.

Table 4.3 Usefulness and Suggestions for Tools Developed

Tool	Usefulness	Suggestions
What about us? La Cultura Latina	- The exercise would be helpful to undocumented Latinx youth - Discussions of the definitions of cultural stereotypes would be beneficial - Open discussion spaces would make this exercise successful	- Use the term 'Latine' instead of 'Latinx' - Adopt the material into additional health topics - Develop additional materials for parents
Strategies to Create a Healthcare Resource Guide	- The guide is valuable, especially in the areas of cost, notes for safety, and languages spoken	- Include possible appointment information for each resource in the guide - Include information on churches - Create a QR code at the end of each resource
Healthy Sex Talks	- The tool contained several valuable resource options for Latinx parents	- N/A
Language Matters	- The content focused on indigenous Latinx languages - Information about medical interpretation would be very helpful to undocumented Latinx who are non-English speakers	- Provide information for individuals who do not have internet access - Include information on at least one of the indigenous languages from Guatemala

CHAPTER 5:

DISCUSSION

Over the past two decades, the Latinx population has increased from 13% to 19% in the United States, making Latinos the second largest ethnic group in the United States (Zong, 2022). It is estimated 13% of these individuals do not have sufficient documentation, making it challenging to receive care. Sexual and reproductive health care is often not considered essential to Latinx youth, especially undocumented Latinx adolescents, despite its significance (Gamboa, 2021). Latinx adolescents have higher rates of pregnancy and sexually transmitted infections than Caucasians. Because care is limited for undocumented Latinx adolescents, strategies are needed to educate this population (de Azevedo et al., 2015; Evans et al., 2020). The goal of this study was to address this disparity by creating health education tools to support undocumented Latinx adolescents. I accomplished this goal by interviewing Latinx community members, parents, and adolescents to understand the needs of this group, developing four tools to be used with undocumented Latinx youth and their families, and evaluating the materials to determine applicability.

This study advances working with Latinx groups in multiple ways. The tools developed have the potential to help undocumented youth, especially when used in conjunction with existing pregnancy prevention interventions. The Office of Adolescent Health identified 45 gold-standard teen pregnancy prevention programs in the United States. Within this list are only two programs for Latinx youth and only one focused on

comprehensive coverage, entitled *¡Cuídate!* (translated "Take Care of Yourself.") *¡Cuídate!* has been adapted for multiple groups and dosage periods; however, no studies have adapted the intervention for undocumented Latinx youth. In fact, one of the authors pointed out this need in the discussions for future research efforts (Villaruel, 2015). The tools developed as a result of this study could be used with this and other comprehensive sexual and reproductive health interventions, bridging the gap to access for undocumented youth.

The present study focused on sexual and reproductive health. Still, this is not a priority for many undocumented Latinx due to conflicting priorities, such as fear of deportation, general health, income, housing, and food access (Hacker et al., 2015). Public health practitioners and interventionists who conduct programming related to sexual and reproductive health should note that challenges may occur in recruiting and retaining participants for such programs. Strategies to address these challenges should include acknowledging them as potential influences on sexual and reproductive health and taking the time to research and understand the population. Doing so can build positive relationships and establish trust (Namageyo-Funa et al., 2014).

Some investigators have developed successful strategies to work with undocumented Latinx individuals. Calva and colleagues studied best practices for building relationships with Latinx communities by finding entry points, reducing the assessment burden, and engaging with community members and stakeholders to build a relationship of trust (Calva et al., 2020). Reidy et al. (2012)reviewed successful means of recruiting and retaining Latinx groups, citing in-person recruitment using gatekeepers, facilitators who speak the language and are bicultural, and childcare as the most

successful methods for finding and keeping study participants. These investigators' strategies can assist future researchers interested in working with the Latinx population.

5.1 The Proposed Tools

Often, there is a misconception that talking about sex with young people is a form of encouragement to have sex. The evidence, however, suggests the opposite; talking about sex with adolescents has been shown to encourage abstinence and safer sex behaviors among those who choose to engage (Flores & Barroso, 2017 ; Jaramillo et al., 2017; Kohler et al., 2008). Talking about sex is difficult for most people, and doing so with a stranger who does not understand the participants' values can worsen the situation. Tool 1 consisted of an activity designed for Latinx youth to encourage healthy dialogue about sexual and reproductive health terms. This tool explores beliefs related to Latinx culture, including the machista ideologies. It focused on demystifying these terms to encourage participants to reevaluate their perceptions of relationships in the future. I designed this activity to prepare young students to discuss uncomfortable topics by defining terminology and identifying the associated behaviors. Doing so can allow youth to build capacity and make more informed decisions in the future, especially in conjunction with supporting a comprehensive sexual education curriculum (Haberland & Rogow, 2015). When asked about interaction with health educators and facilitators, one participant noted, "to be like in such a vulnerable state around people, you don't feel comfortable around. It's just uncomfortable, to say the least." This activity can alleviate this feeling by helping participants become more comfortable interacting with facilitators in a non-threatening environment.

The regulations concerning immigration status and health are legally unclear. There is no consensus on whether HIPAA protects the immigration status of a patient. Policymakers created HIPAA to protect patient health information, and some adversaries argue that immigration status is unrelated to health (The Network for Public Health Law, 2019). I would disagree, as the literature shows that certain health conditions affect undocumented individuals more than peers with documentation (Artiga & Diaz, 2019; Ghavami et al., 2016; Pedraza et al., 2017; Tanzola, 2019). Tool 2 consists of strategies to create a resource document to help facilitators guide their population to safe healthcare options. The purpose of this tool was to help alleviate fear and address the challenges of seeking sexual and reproductive health care. Facilitators who use this tool can provide undocumented youth and their families with safe avenues to seek access to physicians and other healthcare providers who can inform and equip them with the necessary tools to pursue better health. Of all the tools developed, Tool 2 requires the most work for the facilitator, as it is a document that involves customization depending on the community's location. This tool received the most positive response from study participants. It was inspired by the Promotora Health Guide developed by Orpinas and colleagues (Matthew et al., 2020; Orpinas et al., 2021; Orpinas et al., 2020). The study examined promotoras' challenges when educating and caring for their communities; the health guide helped the promotoras identify care providers and other resources for the community members. These instructions can be adapted to create a similar guide for different populations.

Parents often struggle with how to discuss sex with their children. The discomfort experienced can come from difficulty introducing topics that were most likely not discussed with them during their childhood, worries about detailed explanations (e.g.,

How are babies made?), and even concerns about not knowing the most accurate information or the best way to answer sex-related questions. In some communities where religiosity is prevalent and deeply rooted, the concept of sexual and reproductive health can be pushed aside for the pressure of purity or power, depending on gender. In some religious or cultural groups, parents replicate the refusal to educate children about sex as generations reproduce and teach their children what they were (or were not) taught (Ashcraft & Murray, 2017). Study participants divulged that they did not receive accurate sex education because their parents did not know how to portray correct, scientifically accurate information. Tool 3 is a document that provides parents with links to accurate information and strategies to discuss sexual and reproductive health with their children. The English and Spanish versions allow the reader to choose their preferred language to read about strategies to introduce the information to their child. This resource has the power to engage and empower parents of undocumented Latinx adolescents, namely if access to care is challenging to find.

Each day, thousands of individuals cross the borders of the United States. The number of them who speak indigenous Latinx languages has also increased (Misra & DeChalus, 2019). While language barriers are already challenging for Spanish-English translation, persons who speak native dialects are particularly disadvantaged because finding others who speak their language is often rare (Paulino et al., 2019; Steinberg et al., 2016). Tool 4, Language Matters, provides translation and learning resources for individuals interested in communicating with speakers of Spanish and other indigenous Latinx languages. It provides courses for some of the most widely spoken native dialects in Latinx countries to enable public health practitioners and interventionists to learn

language basics to better care for this vulnerable population. Future work to include additional indigenous languages should be considered for healthcare providers and facilitators, especially as more individuals migrate to the United States. I highlighted native dialects most popular in Latinx countries closest to the United States border. Because there are so many other indigenous languages, educators should expand the language resources available depending on the priority population.

5.2 Study Limitations

This study has some limitations. Some individuals did not want to speak with us. This issue could have stemmed from fear of detainment or deportation, especially given that most of our participants were recruited from the southeast, a part of the United States with some of the most restrictive and harsh laws against undocumented Latinx individuals. Only two males participated in this study. The limited male perspective may have an influence on the study interviews. Attrition in Phase 3 was also a limitation. Loss to follow-up may have occurred due to the time between Phase 1 and Phase 3 of the study (5 months). Finally, the sample was small, which is common in qualitative studies that focus on long interviews to collect data.

5.3 Recommendations and Future Directions

The tools developed in this study can be an asset to youth, family members, and others who work with the Latinx community. Researchers interested in health materials for undocumented youth could benefit from the lessons learned in the present study. Working with undocumented Latinx youth presents some methodological challenges. Opportunity for contact proved difficult as some persons from this population may fear

speaking with an outsider. Thus, community gatekeepers are vital to the success of such research.

Only one father participated in this study; however, he did not identify as Latinx. As such, researchers who plan to work with Latinx parents should identify best practices for engaging both mothers and fathers. While mothers may be more willing to participate, fathers may be more challenging to reach due to factors such as work scheduling and possible disinterest. In addition, though not the purpose of the present study, the gravity of victimization should be considered when working with this population. Some interviewees discussed sexual harassment, sexual assault, and rape. Persons invested in working with undocumented Latinx youth should be sensitive to the possibility of these crimes.

This research can serve as a blueprint for further inquiry into this population's health needs and other undocumented groups in the United States. Working with vulnerable populations requires attention to detail and space for understanding and respect. The three-phased methodological approach I used allowed me as a researcher to understand multiple participant points of view and create more comprehensive health education materials. The opportunities to provide education through discussion, culturally respectful content, and resource information development are essential for migrant families, as many do not seek opportunities for care because they are unsure of where to go for help. Because the framework outlines each step I took during this process, researchers and practitioners could adapt the tools to other populations and health areas.

Access to healthcare should be a human right. While researchers and advocates provide strategies to bring care to the Latinx community, making policy changes should

be a priority. Findings from this and other studies should inform decisions to increase aid to build a better future for all. Policymakers and advocates should take actionable steps toward addressing the immigration crisis in the United States. As policy continues to be more inclusive toward United States immigrants, equitable health care and reduced socioeconomic disparities are possible.

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APPENDIX A: Interview Guide

Interview Guide 1: Latinx Community Member

Thank you for agreeing to speak with us. We'd like to ask a few questions about knowledge and access to sexual and reproductive healthcare for Latinx Adolescents. We understand that experiences may differ from person to person. You don't have to answer any question you don't want to**.**

1. Tell me about your connection to Latinx Adolescents.
    a. Probe: Have you had any experience with undocumented Latinx adolescents? If so, can you tell me about them?
2. From your experience, what do Latinx adolescents **know about sexual health**?
    a. Is it different for undocumented Latinx adolescents?
3. What have you noticed about Latinx adolescents' **knowledge of reproductive health services**?
    a. Is this different for undocumented Latinx adolescents?
4. What are the challenges you have observed for these young people in obtaining **access to sex education**?
    a. Probe: What are the biggest challenges for providers?
    b. Parents?
    c. Adolescents themselves?
5. What are the challenges that you have observed for these young people in obtaining **access to reproductive health services?**
    a. Probe: What are the biggest challenges for providers?
    b. Parents?
    c. Adolescents themselves?
6. What do undocumented Latinx adolescents most need in terms of sexual and reproductive health education?
    a. What resources are available?
7. What are your worries/ fears about Latinx adolescents and **access to sexual and reproductive health education?**
8. Is there anything more about the undocumented Latinx adolescent experience with sexual and reproductive health you want to tell us?

Thank you for taking the time to be part of this interview.

Interview Guide 2: Parents

Thank you for agreeing to speak with us. Some questions are about sensitive topics. You don't have to answer any question you don't want to**.**

1. Tell me about the experience of Latinx parents **discussing reproductive health** with their children**.**
    a. Probe: What are their feelings about discussing reproductive health with children?
2. Do you **discuss sexual and reproductive health** with your child? Tell me about your experience discussing sex with your child.
    a. Probe: What are your feelings about discussing sex with your child?
    b. Probe: What are your fears/ worries about discussing sex with your child?
3. What have you noticed about your child's **knowledge of sexual health?**
    a. Where does your child get sexual/reproductive health information?
4. What have you noticed about your child's knowledge of reproductive health services?
5. Do you believe that documented and undocumented Latinx adolescents have the **same access to sexual and reproductive health education?**
    a. Probe: If so/ If not, why?
6. Have you observed or heard of challenges for undocumented youth in obtaining access to sex education?
    a. Probe: If so, what are they?
7. Have you observed or heard of **challenges for undocumented youth in obtaining access** to reproductive health services?
    a. Probe: If so, what are they?
8. What do undocumented Latinx adolescents most need in terms of sexual and reproductive health education?
9. Is there anything more about undocumented Latinx adolescents' experiences with sexual and reproductive health you want to tell us?

Thank you for taking the time to be part of this interview.

Interview Guide 3: Latinx Youth

1. Thank you for agreeing to speak with us. Some questions are about sensitive topics. You don't have to answer any question you don't want to**.**
    a. Tell me about your experience learning about reproductive health?

    b. Tell me about your experience **learning about sex**?

    c. Tell me about your experience **accessing sexual and reproductive health education** from your healthcare professional (doctor, social worker, counselor, etc.)
2. Do you have any worries or fears about your access to reproductive health education?

    a. Do you believe that documented and undocumented Latinx adolescents have the same **access to sexual and reproductive health education?**
3. Probe: If so/ If not, why?

    a. Have you observed or heard of challenges for undocumented youth in obtaining access to sex education?
4. Probe: If so, what are they?

    a. Have you observed or heard of **challenges for undocumented youth in obtaining access** to reproductive health services?
5. Probe: If so, what are they?

    a. What do undocumented Latinx adolescents most need in terms of sexual and reproductive health education?

    b. Is there anything more about undocumented Latinx adolescents' experiences with sexual and reproductive health you want to tell us?

Thank you for taking the time to be part of this interview.

Appendix B: Study Codebook

Code	Description	Example
Lack of Access to Health Resources	Difficulty obtaining health goods and services, such as the ability to obtain insurance, visit a doctor or go to a clinic	"It's a financial issue. It's a transportation issue. It's a- it's a time issue. I mean, when do you take her when and apply the reality for a lot of our immigrant and undocumented folks is they get paid by the hour. There is no paid time off. There is no leave. There are no breaks. And so, when you go, and when you get there, how do you pay?"
Challenges Associated with Language	Direct or indirect references to the Spanish language (or other dialects native to Latinx countries, language-associated barriers, and other linguistic challenges	"Honestly, there's just so much going on in terms of - like most of the time they don't speak English, so trying to learn a new language, some of them don't even speak Spanish well. So, they'll speak like a native dialect. So that in itself is really difficult. "
Religious and Cultural Barriers	Direct or indirect references to elements related to Latinx customs, group values, beliefs, traditions, systems, and social organization	"I think that there's some there's some cultural and potentially religious things in play societally in potentially in the Latino community that that may change that specifically the Catholic view of contraceptives and the Catholic view of premarital relations. "
Lack of Sexual and Reproductive Health Knowledge	Direct and indirect mentions of understanding sex, reproductive anatomy, pregnancy, and other aspects related to overall sexual and reproductive health	"I took this P.E. and Health class during the summer, so it was only like one summer where they basically gave us a bracelet which said like, it's like, 'I won't until I do.' So basically, it's like scaring people into not having sex. "
Incorrect Information Due to Media Influence	Mentions of digital, tv, and social media about inaccurate sexual and reproductive health information	"There is either a) no education, b) a slight education which comes from social media and friends and friends' groups or d) the teaching of abstinence completely. "

Code	Description	Example
Challenges Due to Migration	References of immigration from Latinx countries into the United States, migration-related concerns, as well as associated government agencies such as Immigration Customs Enforcement	"And a lot of times they're coming in and reconnecting reunited with families that, they have not had contact with for three, four years at least. So that attachment isn't there."
Deportation	Includes discussion of the process of detainment and deportation in the United States	"They ask for your name and a phone number, but it's like you're scared to give them any type of information because you don't know how they're going to use it. It might come back to you."
Differences in Documentation	References of knowledge, access to healthcare and other resources, and how they differ between Latinx without documentation, Latinx with documentation, and other groups in the United States	"I think that sometimes undocumented Latinos don't have as many means or resources as those that are documented to get help. When it comes to those reproductive needs, or they may feel like they don't get as much help as people that are documented."
Trauma Due to Immigration	Includes worries, fears, and other emotional responses and feelings associated with migration, detainment, and deportation	"Generally, if you are undocumented and you're a migrant. The conversation of sex education is literally in the back end of everyone's mind because usually, your first conversation is, "Oh, I am now in the U.S., and look, I am now being treated very unfairly, varying from racism, general threats."
Sexual and Reproductive Health Education Needs	Mentions of both tangible and abstract needs for Latinx youth, parents, and community members about sexual and reproductive health, including ideas related to health material development	"They really need health education, health education before the STDs, health education before the pregnancy. So, a lot of the things could have been prevented, and they had known or had the knowledge of how to protect themselves."

Code	Description	Example
Parent/ Youth Interactions	Descriptions of parental understanding and interest related to discussing sexual and reproductive health with youth	"I feel like there is a lot of "oh, my kid would never" or "my child knows better." "So and so cannot or would never." Like there's a lot of like stuff like that. And then, you know, they'll be the first ones to have a teen pregnancy just because they didn't disclose that they weren't open with their children about it or whatever."
Parental Attitudes	Mentions of the positionality of parents related to discussions of sexual and reproductive health, including what and how adolescents learn about sexual and reproductive health	"Well, sometimes we don't talk to our children about these issues of sexual education because we have - sometimes not all of us and not always - the idea that, well, talking to them is what they're going to do. "
Youth Attitudes	Mentions of the positionality of adolescents related to learning about sexual and reproductive health	"So, it scares me because I know that at that time when it was my turn, I was like "I don't want to listen because it's embarrassing, and I don't want to talk about it, I don't want to talk about sex with my parents because they are my parents."
Poverty	Includes mentions of financial strain, low socioeconomic status, being poor or low income	"There might be the worry make the expenses right because the sex education piece might be free. But then, once you start talking about going to the doctor, that means money. That means insurance. That means having to find a ride. That means maybe having to take time off work and to find an interpreter who's going to take care of the little siblings and all of those complications."
Pregnancy	References of being pregnant, becoming pregnant, circumstances that influenced pregnancy, or situational anecdotes discussing pregnancy and childbirth	"I have two sisters who were teen moms. So, I knew how much they struggled. I knew that my mom had kids early, and I knew that I liked how much she struggled and all that like. "

Code	Description	Example
Unhealthy Relationship Attachment	Mentions of unhealthy romantic closeness or attachment	"They get embedded in this kind of 'undocumented culture' where it's like, "I just want to find a partner that kind of understands my struggle, and it's going to feel like a community," and they form romantic relationships and sexual relationships very, very young, right?"
Relationship Empowerment	Includes needs and strategies for uplifting and building capacity for developing and maintaining healthy romantic relationships and healthcare-related behaviors	"I really feel that hopefully maybe one day that, you know, somebody that's in a position as an educator or a manager, something that might be a Latina that can be a really, really great role model for them to make, kind of push them to kind of seek help a little bit more with our resources and our services."
Relationship Challenges	References to difficulties experienced in romantic relationships	" Like you wouldn't necessarily have to have sex with this person to be like, you belong. So, you wanted to say no? Like, how can you say no? How can we build up that confidence for you to be in that situation? "
Relationship with Healthcare Providers	References to challenges in communicating with healthcare providers, the dynamics of the patient-provider relationship, as well as situational anecdotes related to healthcare providers and access to sexual and reproductive health	" I've noticed a lot of migrants with their children completely avoid hospitals and health providers because there is a possibility of those providers whispering their migrant status to a police officer and could get them deported at the hospital. And again, if the conversation of you getting separated from your family is too much of a risk to you, then... that's just too bad. "

Appendix C: Themed Activities

Theme 1 Tool:
What about us? La Cultura Latina

Background and Purpose

Latinx youth have varying experiences; however, findings from Theme 1 highlighted some common challenges. Discussing sex and reproductive health in both formal and familial settings is often uncomfortable, and there is shame associated with asking questions deemed inappropriate. Thus, the purpose of this tool is to introduce the concepts of sex and reproductive health and discuss gender stereotypes with Latinx youth in a non-judgmental environment.

Facilitators can use this tool alongside sexual and reproductive health interventions for Latinx youth. This tool can also be used to discuss other health topics when the terms are changed. Note: While 'Latinx' is the term used by the authors to describe the population, identify and use the one appropriate for your population (for example, Hispanic, Latine, or Latina/Latino).

Learner Objectives for Facilitators

- **Identify** and explain gender stereotypes in the Latinx community.
- **Define** the terms sex and reproductive health.
- **Explain** the Latinx culture's values concerning sex, reproductive health, and machista ideologies.

Materials and Time

Materials: Index cards or half sheets of paper (five per participant and four for the facilitator), pens (one per participant)

Time: 30-45 minutes (can vary depending on conversation flow and number of participants)

Instructions for the Facilitator

1) Give each participant five index cards.

2) Ask participants to number each card from one to five on one side. On the back side, ask participants to write what their family, church, and community has taught them about:

    Card 1: Sex

    Card 2: Reproductive health

    Card 3: Machismo stereotype

    Card 4: Marianismo stereotype

3) On Card 5, ask participants to write any questions about the content.

4) Once finished, collect the cards and sort them by number.

5) Read 2-4 responses from each card, starting with Card 1. Follow up with the formal definition of each term.

    Card 1: Sex is the act of engaging in sexual intercourse.

    Card 2: Reproductive health refers to caring for the male and female reproductive systems, including the uterus, ovaries, vagina, penis, and testicles.

    Card 3: Machismo is a traditional stereotype of Latino men characterized by extreme masculinity (or manly behavior) and hypersexualization. Men are expected to be tough, aggressive, controlling, and womanizing and avoid anything that seems feminine.

    Card 4: Marianismo is a traditional stereotype of Latina women characterized by extreme feminine (or assumed woman-like) behaviors. Women are expected to be quiet, virgin-like, and submissive to a man's physical and emotional needs.

6) Lead discussions of findings for each card with the entire group, ask:

- How are these definitions similar?
- How are they different?
- Is there anything missing that we should talk about regarding this term? If so, what?
- Do you feel the term is relevant in the Latino community? If so, how?

7) Read each question on Card 5 and answer those questions as needed.

Suggested additional reading for facilitators

Sotelo, I. (2023).Machismo: The Traits and Impact of Traditional Masculinity. https://www.verywellmind.com/what-does-the-term-machismo-mean-6748458

Ixa Soleto describes the Machismo stereotype in-depth, including the history of where the stereotype came from, the characteristics of Machismo, and the impact this type of behavior has on the Latinx community.

Sotelo, I. (2022). What is 'Marianismo'? The traditional woman's role in Latinx culture. https://www.verywellmind.com/what-is-marianismo-6749521

Ixa Soleto explains the Marianismo gender stereotype, the desired traits of women in this role, and the impact these principles have on women's health and the Latinx community.

Theme 2 Tool:
Strategies to Create a Healthcare Resource Guide

Strategies to Create a Healthcare Resource Guide

Background and Purpose

Latinx youth without health insurance have difficulties obtaining reliable healthcare. Lack of documentation makes the process even more problematic. Some options are available for these individuals; however, it can be challenging to find these resources.

This tool will provide facilitators with a guide to best practices for finding health resources for Latinx youth, as well as an example. Facilitators should compile the resources into one document before the intervention begins and distribute it to participants. Thus, the purpose of this tool is to provide Latinx youth with multiple reproductive healthcare resources.

Learner Objectives for Facilitators

- **Identify** safe sex and reproductive health resources for undocumented Latino youth.
- **Explain** what makes a resource safe for undocumented persons.

Materials and Time

Materials: Computer, internet access, phone, pen

Time: Varies

Instructions for the Facilitator

1) Research the available providers for each section using recommendations from gatekeepers (known community supporters) and search engines. If possible, visit providers before listing them in the resource guide. The resource sections are:

Emergency Services. List emergency services in the area. Clients should use emergency services in severe cases or when no other options are available.

Clinics. Describe hospitals, urgent care facilities, and community clinics that provide general health assistance to all. This type of care is vital for individuals who need access to sex and reproductive care such as birth control, abortions, STI/HIV testing, and other health needs. In clinics, individuals typically have access to a doctor and nurse/nurse practitioner.

Counseling and Mental Health Services. Describe care providers specializing in mental health care, such as psychologists, psychiatrists, counselors, and other health professionals. Mental health care is usually provided in an office setting but can also be available in a clinic or hospital.

Consulates and Embassies. Provide information for consulates and embassies for Latino countries. These offices can assist individuals seeking visas or other immigration-based questions.

Domestic Violence and Abuse Resources. Provide information on resources for individuals who have experienced domestic violence and other types of abuse. Trained counselors or social workers usually provide services.

Legal Services. List information on legal resources and immigration services. These services are typically provided by lawyers, paralegals, and other legal aides.

Parenting Resources. Provide information related to raising children and general parenting knowledge. Services are usually provided by community health workers, public health practitioners, and healthcare providers.

Reproductive Health Specialists. Provide information about healthcare providers focusing on reproductive health, including pregnancy, for both males and females. Services are rendered by doctors or nurses/ nurse practitioners.

Sexual and Reproductive Health Educators. List contacts for individuals or organizations that provide information about safe sex practices, reproductive health, and sexually transmitted diseases, such as STIs and HIV. Services are usually provided by a community health worker (promotora), health educator, social worker, nurse, or nurse practitioner.

Transportation. Show the various forms of transportation available in the local area.

2) For each provider found, ask or confirm the following:

Name. Include alternative names the organization may be known by.

Services Provided. Start a list- What type of services are available for this organization (e.g., counseling, women's health, general sexual and reproductive health)? Ask- Do care providers ask patients for proof of documentation for records?

Address. Ask the provider if there are multiple locations, if so, list each location as a separate resource and differentiate it by location (e.g., ABC Teen Clinic-Knoxville Location.)

Hours of operation. Ask if there are evening or weekend options if none are listed. Also ask if appointments are available and/or required.

Contact number(s). Ask if text is an option for contact. Ask if email addresses are available as a form of communication. Ask- How does this location treat patients who may be under-documented?

Website. Conduct a search- Does this site have a Spanish option? If so, make sure to include that information. For easier access, include a QR code if available.

Point of contact. Ask if there is a best point of contact for future questions. This individual should be someone the facilitator has met with or spoken to directly, is regularly on-site, and is knowledgeable of the services provided.

Transportation notes. List bus, train, or other public transportation stops close to the location. Indicate whether free parking is available.

Cost and payment options. Ask if options for cash payments, sliding scales, and other financial assistance are available.

Languages spoken. Ask if multilingual staff are available during the entire

hours of operation or only during certain days/times. If staff are unavailable, ask how the organization serves non-English speakers?

Notes for safety. Write down any potential safety concerns? Is this an ICE hotspot? Is the neighborhood dangerous during certain times? List the date researched.

Date last confirmed. Write down the date that this information was last checked or updated.

3) After gathering the information, sort by section and compile it into a booklet.

4) Distribute booklets to participants as needed.

Suggestions for additional reading for facilitators

Castaneda, R. (2016, November 2). Where can undocumented immigrants go for Health Care? Where can Undocumented Immigrants Go for Health Care? https://health.usnews.com/wellness/articles/2016-11-02/where-can-undocumented- immigrants-go-for-health-care

This article provides information about health care for undocumented immigrants in the US. It lists some locations where individuals can seek care, regardless of documentation and a range of costs for being seen in the respective facilities.

Guerra-Reyes L, Palacios I, Ferstead A. Managing Precarity: Understanding Latinas' Sexual and Reproductive Care-Seeking in a Midwest Emergent Latino Community. Qualitative Health Research. 2021;31(5):871-886. doi:10.1177/1049732320984430

Within this article, sexual and reproductive care for Latinas is explored in the midwestern United States. The authors note many of the challenges for Latinas seeking care, provider attitudes toward Latinas accessing care, and opportunities for improvement.

Example Template

TEEN PREGNANCY RESOURCE CENTER

Services provided	Health screenings, STI testing, pregnancy counseling
Address	XXX XXXXXX Street City, ST ZIP CODE
Hours of operation	M-F 8a-5p; Sa 9a-12p; Appointments preferred
Contact number	XXX-XXX-XXXX
Website	https://www.xxxx.org
Point of Contact	Isabel Pereira
Transportation notes	On the #X bus line; free parking is available
Cost and payment options	Services are free
Languages spoken	English, Spanish
Notes for safety	ICE presence is heavy in this area of town
Date last confirmed	May 1, 2023

Theme 3 Tool:
Resources for Healthy Sex Talks

Resources for Healthy Sex Talks

Background and Purpose

Adults may experience challenges when discussing sex with youth. Conversations are often uncomfortable because of the sensitive nature of the topic. Additionally, these discussions are sometimes difficult as information may change over time, and some adults do not have current and accurate knowledge. This guide contains a compilation of resources to assist educators, parents, and other adults in facilitating a 'healthy sex talk' with Latino youth. The purpose of these resources is to provide adults with accurate information to promote sex and reproductive health discussions with Latino youth.

Learner Objectives for Facilitators

- **Identify** best practices for sex and reproductive health conversations with youth.
- **Explain** how to find up-to-date sexual and reproductive health information.

Resources

Advocates for Youth

Advocates for Youth provides access to comprehensive sexual and reproductive health information to adolescents, activists, and parents. The site contains health information, fact sheets, and newsletters on diverse topics such as religiosity and sex, access to safe abortion care, and LGBTQ+ resources.
https://www.advocatesforyouth.org/

Healthychildren.org

Healthyhchildren.org provides a wide range of developmental health resources from birth to young adulthood. The American Academy of Pediatrics, a group of more than 67,000 pediatricians across America, developed the content. The "Dating and Sex" webpage discusses adolescent sexual and reproductive health and includes additional resources for families and facilitators. The section "Adolescent Sexuality: Talk the Talk Before They Walk the Walk" provides specific strategies for talking with adolescents about sex.
https://www.healthychildren.org/English/ages-stages/teen/dating-sex/Pages/default.aspx

CDC – Sexual health information for parents

CDC's Division of Adolescent and School Health provides information about different types of birth control, positive parenting practices, and testing for sexually transmitted diseases.
https://www.cdc.gov/healthyyouth/healthservices/infobriefs/birth_control_information.htm

Parent-adolescent communication about sex in Latino families: A guide for practitioners (resource for facilitators)

Created by the National Campaign to Prevent Teen and Unplanned Pregnancy, this resource provides health educators and public health practitioners with strategies to educate Latino parents on how to talk with adolescents about sexual and reproductive health. Topics highlighted are health statistics about Latino sexual and reproductive health, best practices for timing communication with families, and strategies for establishing strong relationships with children.
https://www.hennepinhealthcare.org/wp-content/uploads/2018/09/apt-parent-adolescent-comm-sex.pdf

Plan Parenthood (for parents)

Plan Parenthood, a non-governmental organization, provides safe healthcare and comprehensive sexual and reproductive health education for all. It covers health topics from birth to adulthood and discusses strategies for parents to have healthy conversations with their children.

https://www.plannedparenthood.org/learn/parents

Power to Decide: Sexual health resources

Power to Decide educates parents and youth about sex and reproductive health. This website includes information about places to find care providers, access to safe abortion and contraceptives, and LGBTQ+ health resources. It also discusses policies that impact women's reproductive health.
https://powertodecide.org/sexual-health/resources-for-parents-champions-mentors/talkingispower

Sex education: Talking to your teen about sex

Created by staff at the Mayo Clinic, this resource for parents explains best practices for discussing sex and other reproductive health topics with teens. It provides icebreakers, talking points for parents, and strategies to recognize healthy and unhealthy relationships.
https://www.mayoclinic.org/healthy-lifestyle/sexual-health/in-depth/sex-education/art-20044034

Actividad del Tema 3:
Recursos para hablar sobre salud sexual

Recursos para hablar sobre salud sexual

Antecedentes y Propósito

Los adultos pueden tener dificultades para hablar sobre sexo con los jóvenes. Las conversaciones suelen ser incómodas debido a la naturaleza delicada del tema. Además, estas conversaciones a veces son difíciles, ya que la información cambia con el tiempo y algunos adultos no poseen información correcta. Esta guía contiene una recopilación de recursos para ayudar a padres, educadores y otros a facilitar una "conversación sobre salud sexual" con los jóvenes latinos. El propósito de estos recursos es proporcionar a los adultos información precisa para promover conversaciones sobre salud sexual y reproductiva con los jóvenes latinos.

Objetivo de Aprendizaje

- **Identificar** las mejores prácticas para las conversaciones sobre salud sexual y salud reproductiva con los jóvenes.
- **Explicar** cómo encontrar información actualizada sobre salud sexual y reproductiva.

Recursos

Healthychildren.org

Healthychildren.org es un sitio web que ofrece una amplia gama de recursos sobre el desarrollo saludable desde el nacimiento hasta la edad adulta joven. El contenido ha sido desarrollado por la Academia Americana de Pediatría, que agrupa a más de 67.000 pediatras de todo el país. La página “Saliendo con chicos o chicas y relaciones sexuales” trata de la salud sexual y reproductiva de los adolescentes e incluye recursos adicionales para las familias y los facilitadores. La sección “Sexualidad de los adolescentes: hable antes de que comiencen su propio camino” ofrece estrategias específicas para hablar de sexo con los adolescentes.

https://www.healthychildren.org/spanish/ages-stages/teen/dating-sex/paginas/default.aspx

Plan Parenthood (para padres)

Plan Parenthood es una organización no gubernamental creada para proporcionar asistencia de salud segura y educación integral sobre salud sexual y reproductiva para todos. Este recurso contiene artículos sobre temas de salud desde el nacimiento hasta la edad adulta, junto con estrategias para que los padres mantengan conversaciones saludables con sus hijos.

https://www.plannedparenthood.org/es/temas-de-salud/para-padres

Educación sexual: Cómo hablar sobre sexo con tu hijo adolescente

Creado por el personal de la Clínica Mayo, este recurso para padres incluye las mejores prácticas para hablar sobre sexo y otros temas de salud reproductiva con los adolescentes. El contenido ofrece ejercicios para romper el hielo, estrategias para abordar temas difíciles, y características de relaciones sanas y relaciones tóxicas.

https://www.mayoclinic.org/es-es/healthy-lifestyle/sexual-health/in-depth/sex-education/art-%2020044034

Theme 4 Tool:
Language Matters

Background and Purpose

Latinos represent 30 countries and more than 400 languages. While Spanish is the most widely spoken language among Latinos, native dialects or indigenous languages are common in some countries, especially in more rural areas. While developing a sexual and reproductive health curriculum, considering the accessibility of language to reach the greatest number of people is necessary. This resource contains guidance on best practices for providing language-accessible information to non-English-speaking Latinos. Thus, the tool aims to equip facilitators with strategies to make content multi-lingual and accurately search for multi-lingual sexual and reproductive health resources.

Learner Objective

- **Identify** resources to create multi-lingual content for non-English speaking Latinos.

Materials and Time

Materials: Computer, internet access, phone

Time: Varies

Facilitator Resources

The following items are language resources facilitators can use to assist non-English speakers with obtaining health support.

DeepL

DeepL is an online translation software that uses artificial intelligence to translate written content into more than 30 languages. While artificial intelligence is not perfect, it has greatly improved translation, especially for Spanish. DeepL is one of the most accurate translation software available. This resource has a free version and a paid 'pro' version.

Spanish speakers with internet access can use DeepL to express their concerns to care providers, and providers can use the same application to respond. DeepL currently does not have audio capabilities, so users would need to be able to type their requests. Additionally, currently, DeepL does not support native Latin dialects.

https://www.deepl.com/

https://www.deepl.com/es/translator

Google Translate

Google Translate is an online translation software that uses artificial intelligence to translate content into more than 130 languages. This resource is helpful for translating many languages. Google Translate offers Spanish translation and Quechua, Aymara, and Guaraní, indigenous languages native to Latin and South America. This resource also has audio- recording capabilities, so users can type and say their content. This feature is especially useful to users who speak a language but are unable to write that language.

Language Courses

Language courses are a resource that care providers can use to assist their patients better. This option requires more time and effort than the software and programs listed. However, language courses help providers understand exactly what is happening with their patients and also help patients feel understood and cared about by their providers. Some many free online services and applications teach languages, such as Duolingo (https://www.duolingo.com/), Mango

Languages (https://mangolanguages.com/), and Babbel (https://www.babbel.com/). In-person courses are another option that helps providers build relationships with members of their communities. Local community centers, colleges, and universities often hold language courses, many at low-to-no cost. While Spanish is the second most-spoken language in the United States, more assistance is needed to help speakers of indigenous languages such as:

Quechua- Quechua is one of Latin and South America's most widely spoken indigenous languages. Still used by 8-10 million people, Quechua is used in Peru, Bolivia, Ecuador, and Argentina (Luykx et al., 2016). The following universities offer Quechua courses for learners:

-The University of Georgia (https://lacsi.uga.edu/quechua-minor)

-University of Pennsylvania (https://web.sas.upenn.edu/quechua/study-quechua/)

-The Ohio State University (https://u.osu.edu/quechua/courses/)

-The University of Colorado Boulder (https://www.colorado.edu/lasc/quechua)

Nahuatl- Nahuatl is an indigenous language spoken by nearly 2 million individuals. It is the most spoken of 64 native dialects in Mexico and has existed since 7 C.E. (Rolstad, 2001). The universities listed offer courses in Nahuatl for interested participants:

-The University of Texas at Austin (https://tlahtolli.coerll.utexas.edu/)

-University of Michigan (https://ii.umich.edu/lacs/students/lacs-languages/nahuatl.html)

-Brown University (https://cls.brown.edu/languagesatbrown/wlc/nahuatl)

Aymara- Spoken in countries such as Bolivia, Chile, Peru, and Argentina, Aymara is an indigenous language native to South America. More than 2 million speak this dialect. The Ohio State University offers courses in Aymara: (https://clas.osu.edu/sites/clas.osu.edu/files/OSU_aymara_course_SUM14_0.pdf)

K'iche- K'iche is the most widely spoken Mayan language in Guatemala. Over 1 million individuals speak this indigenous language, and it is one of 23 Mayan dialects used in the country. The University of Texas at Austin offers a free course online that covers a range of common phrases and terms used in this language, in addition to more complex topics:

(https://tzij.coerll.utexas.edu/)

Medical Interpretation

Medical interpretation is a field where individuals who speak multiple languages translate medical information on behalf of a patient to a healthcare provider and vice-versa. In the past, interpreters were on-site personnel in the room with patients during their medical treatment. As the demand for medical interpretation has increased, virtual interpreters are becoming more common in healthcare settings.

Interpreters are common in large medical settings such as hospitals and urgent care facilities. Medical interpreters are required to receive certification before working. These certificate courses are offered at a number of colleges, such as the University of Georgia (https://www.georgiacenter.uga.edu/courses/languages/spanish-english-medical- interpreter)

In many healthcare settings, Spanish-speaking staff may be available to assist during exams if the physician needs to speak English. Medical interpretation is essential to non-English speaking patients. However, there are some challenges as interpreters can only directly translate patient and provider conversations, meaning items could get lost in translation. Additionally, translation services are only sometimes available in non-hospital settings.