**A narrative review of the impact of stigma and discrimination on**

**migrant adolescents living with HIV in fragile contexts in the East and Southern Africa region**

**Regional Inter-Agency Task Team-East and Southern Africa (RIATT-ESA)**

**2023**

**Acknowledgements**

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**Acronyms**

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| --- | --- |
| ACMSAIDSALWHIVARTCCABAEACEANNASOESAHCWHIVIOMLHRMSMOCHAOECDPEPFARPMTCT PrEPRIATT-ESASADC SRHSRHRUNFPAUNHCRUNICEFUSAIDWHOYPLWHIV | African Centre for Migration and SocietyAcquired immune deficiency syndromeAdolescents living with HIVAntiretroviral treatmentCoalition for Children affected by AIDSEast African CommunityEastern Africa National Networks of AIDS and Health Service OrganisationsEast and Southern AfricaHealth care workersHuman immunodeficiency virusInternational Organisation for MigrationLawyers for Human Rights Men who have sex with menOffice for the Coordination of Humanitarian AffairsOrganisation for Economic Co-operation and DevelopmentPresident's Emergency Plan for AIDS ReliefPrevention of mother to child transmissionPre-exposure prophylaxisEastern and Southern Africa Regional Inter-Agency Task Team on Children Affected by AIDSSouthern African Development CommunitySexual and reproductive healthSexual and reproductive health and rightsThe United Nations Population FundUnited Nations High Commissioner for RefugeesUnited Nations Children's FundU.S. Agency for International DevelopmentWorld hHealth OrganisationYoung people living with HIV |

**Executive Summary**

**Introduction and background**

This narrative literature review for RIATT-ESA is motivated by a need to influence advocacy and HIV programming for adolescent migrants living with HIV in East and Southern Africa. Migrant adolescents are one of the most vulnerable groups in the region and face significant barriers to accessing HIV prevention, testing and treatment. There is an urgent need to address the gaps and inequalities that this population faces in HIV prevention and care in order to meet the global goal of ending the AIDS epidemic by 2030.

Stigma and discrimination against migrants and refugees is one significant factor that contributes to their increased vulnerability to HIV and AIDS. This review, therefore, aims at providing a contextualised understanding of the impact of stigma on migrant adolescents living in fragile contexts in East and Southern Africa where there is an accumulation of risk and limited state or community capacity to mitigate this risk. The review uses an ‘intersectional stigma’ framework to make sense of the complex interactions between the various forms of stigma that adolescent migrants living with HIV experience and how these forms of stigma create discrimination at both an interpersonal and institutional level.

**Methodology**

The review used a narrative approach to identify emergent themes in peer-reviewed articles and some key global reports. Globally there is a dearth of research focussing on sexual and reproductive health and HIV issues with adolescents and even less on adolescent migrants. Given this lack of research, literature selected for this review includes reference to tangential evidence, relevant to migrant youth, on general SRH and HIV programming for adolescents in East and Southern Africa, adolescents living with HIV in Africa, SRH and HIV programming in ‘emergency’ or ‘humanitarian’ contexts, and research with adolescents living with HIV aged 10-24.

**Key themes from the literature**

The most relevant evidence shows that adolescent migrants living with HIV experience stigma related to being a migrant, being a child or young person, and being HIV-positive. In addition to this, girls and young women also experience stigma related to their gender, especially if they are mothers. Key populations such as young people engaging in sex work and members of the LGBTQI+ community also experience stigma related to their occupation and their sexuality or gender identity. Each of these sources of stigma interact with the others and can express themselves in discrimination at all levels of young migrants’ experiences. This discrimination has impacts on their ability to access HIV treatment and impacts on their mental wellbeing. This intersecting stigma is seldom acknowledged in the broader literature on adolescents, migrants, and HIV.

One key outcome of intersecting stigma is the range of emotional responses that impact on young migrants’ health-seeking behaviour. Fear is reported repeatedly in the literature as a barrier to testing, treatment-seeking and ART adherence. These fears are frequently a product of the realities of life as a refugee or migrant: living at close quarters with strangers, fears about contravening social or religious norms, or the fear of discovery by officials. This last fear is particularly significant as a barrier to health-seeking behaviour, especially for informal migrants, who make up the largest population of migrants in Southern Africa. The difficulties associated with accessing legal status and documentation in their destination country are linked to this issue. Not ‘belonging’, a lack of social support, and precarious shelter and income make living with HIV particularly difficult for migrants who report the overwhelming need to preserve secrecy which often results in loneliness. These factors compound the vulnerability that young migrants already experience as a result of being in unfamiliar places, and xenophobic attitudes among community members and health service providers in host countries.

Although there is limited literature that deals directly with the impacts of stigma on the health of migrant adolescents living with HIV, there is a broader literature on non-migrant adolescents living with HIV, which offers some important insights into the challenges faced by migrants. Adolescents living with HIV in Southern Africa face a high burden of depression, anxiety and suicidal ideation, which contribute to low quality of life and challenges with anti-retroviral treatment (ART) access and adherence. Similar impacts are observed in East Africa and other sub-Saharan African countries. There is also significant evidence that poor mental health is exacerbated by social exclusion and HIV stigma. Significantly, stigma is identified in a number of studies as a key factor influencing young people’s decisions around getting tested for HIV and progressing through the HIV treatment pathway. This frequently expresses itself as ‘anticipated stigma’ (which impacts the choice to test), especially among key populations such as men who have sex with men (MSM), female sex workers, and people who inject drugs. Experiences of stigma are also related to other negative outcomes such as lower school attendance and a lack of future orientation (a key aspect of resilience). If young people living with HIV in ‘normal’ family and home community settings experience the impact of stigma in the ways described above it is important to ask how much more migrant adolescents who experience multiple intersecting stigmas are affected.

One key context of relevance for this review is humanitarian settings such as refugee settlements. There is very little literature on young people and SRH in humanitarian settings, with particularly limited attention paid to the needs of young women living with HIV in frameworks and guidance for emergency settings. This is particularly significant because of the strong evidence that young women migrants have often experienced gender-based violence (GBV) in the conflict context they are escaping. They are also at high risk of exposure to GBV in refugee settlements and in the unstable urban environments in which many migrants find themselves in their destination countries.

The literature that exists on adult migrants living with HIV in East and Southern Africa identifies institutional stigma as a significant structural barrier to accessing health services. Migrants struggle to acquire documents regularising their presence in an arrival country due to xenophobic laws, policies and the attitudes of state officials. Stigma occurs in health centres themselves where health service providers refuse care to migrants due to their migrant status and/or lack of documentation. This is despite the fact that in South Africa, for example, there are protective policies and guidelines in place to ensure access to healthcare for all, including international migrants. As a result of this stigma and the enforced or chosen invisibility of migrants living on the margins of society, most migrants receiving treatment for HIV access the treatment through non-government sources. There is almost no research on how falling between this “citizen-state responsibility nexus” impacts on young people living with HIV and AIDS.

This structural stigma does not only operate at a national level. These structures of exclusion are linked to global migration policy discussions that are increasingly driven by the need for security in countries where incoming migration is high. Those promoting the right to health treatment for all worry that this securitisation approach will affect public health access generally. This is especially an issue in Southern Africa, which has high levels of migration and the largest population of people living with HIV globally. The WHO points to the need for integrated responses to the barriers to access to health by migrant populations, this needs to include action to address structural barriers.

**Recommendations for Programming**

The narrative review concludes with recommendations for RIATT-ESA as a network mandated to firstly, advocate for the rights of children and young people affected by HIV and AIDS, and second, to share evidence on best practice programming.

One of the main advocacy recommendations is for RIATT-ESA to use the significant relationship the network has built over time with governments in the region to join existing advocacy around the need to address documentation access and the growing possibility of statelessness of young migrants. Secondly, RIATT-ESA, with its connection to international and national NGOs working in the HIV and AIDS sector, is well placed to advocate for SRHR and HIV and AIDS youth programmes to include specific work with adolescent migrants.

The review includes a number of recommendations on the gaps in programming for migrant adolescents living with HIV. Among these is the need to provide confidential health services in places where migrant youth are known to live and work, for example mobile clinics. There is a particular need to develop ethical programmes that improve access and welcome to key populations such as adolescents from the LGBTQI+ community and sex workers to health services. There is evidence that engaging empathetic and trained adult lay counsellors from refugee and migrant communities would be a successful programme approach. Peer support groups also have some evidence of being an effective programme strategy. Delivering economic strengthening programming such as cash transfers alongside integrated care, which could include lay counsellors and peer support groups as well as health service staff, has been shown to be effective with young people living with HIV in community contexts. Given the economic precarity of most migrant youth this would be an important intervention to pilot for migrant adolescents.

Recommendations for research include the need for scientific mixed-method studies of the impact of stigma on young migrant adolescents living with HIV and AIDs and the socio-economic, cultural, and structural barriers to accessing SRHR. Alongside this it is important to carry out a mapping of organisations in the region working with young migrants and organisations working with young people around HIV and AIDS in geographical areas where migrant youth are found. This mapping would provide RIATT-ESA with the detail to develop a targeted advocacy strategy. There is also a need for rigorous evaluations of existing programmes working with migrants living with HIV. Research also needs to be done to map existing policy frameworks at both national and regional level and among INGOs. There is a particular need to examine policy that would inform the facilitation of cross border access to ART.

This review has identified a serious gap in the research around migration and HIV and AIDS generally and stigma related to HIV status. This gap limits both advocacy and programming for this particularly vulnerable population. RIATT-ESA with its links to regional and national NGOs and government institutions has an important potential role to play. The themes and emerging recommendations identified in this narrative review are an important first step for the Task Team to develop a strategy to address the myriad health needs and right’s barriers faced by young migrants.

# **1. Background and rationale**

RIATT-ESA is a multi-sector partnership of organisations that focus on the care and support of children affected by AIDS in East and Southern Africa. The task team, formed in 2006, includes regional political and economic bodies, civil society organisations, academics, donors, and UN agencies. The mandate of the task team includes advocating for evidence-based best-practice, and developing and sharing technical and programming information. As of 2023 the RIATT-ESA strategy incorporates ‘migration’ as a key theme for the task team.

The reason for the decision to focus on migration is based on significant global evidence (UNAIDS, 2022) that suggests that if the commitment to end AIDS by 2030 is to be met there is an urgent need to “address inequalities in HIV prevention, testing and treatment access and outcomes, and close the gaps that exist in specific localities and for certain groups” (p,17). Migrant adolescents in fragile contexts are one of the most vulnerable of these groups. East and Southern African (ESA) is home to 1.74 million adolescents living with HIV. This number represents 60 percent of migrant youth globally (UNICEF, 2021). Research has shown that AIDS-related illness is the leading cause of death among adolescents in the ESA region, which makes them key to achieving the global goal of ending the AIDS epidemic by 2030 (Toska et al., 2019).

The World Health Organisation’s (WHO) 2022 global review of refugee and migrant health presents a set of closely related findings. The review shows that refugees and migrants have poorer health outcomes generally and, with regard to HIV and AIDS, face “numerous social, economic, political and legal barriers that have resulted in delayed testing and higher risk for HIV transmission” (WHO, 2022, p. 130). These barriers also limit access to care and treatment. Stigma and discrimination against migrants and refugees is one significant factor that contributes to the increased vulnerability of refugees and migrants to HIV and AIDS (Embelton, 2022). Discrimination against migrants creates legal, social, and economic barriers to health care access. This compounds the existing stigma that already exists for people with HIV and AIDS and makes HIV testing, seeking treatment, and accessing care almost unimaginable for many young migrants (Logie, et al., 2021a). Gaining a contextualised understanding of the impact of stigma on migrant adolescents living in fragile contexts in East and Southern Africa is, therefore, an important priority for achieving the goals of RIATT-ESA.

# 2. Defining the scope of the review

While defining the focus of this review it is important to acknowledge that child and youth migration is a complex and multi-faceted issue (Save the Children, 2020; Save the Children 2022). Young migrants are not a homogenous group and can be differentiated by age, gender, and country of origin as well as by their legal status, whether they are accompanied by an adult or not, their reasons for migrating, and whether or not this choice was made by themselves or if they were forced to move by an adult for the purposes of exploitation, for example (Save the Children, 2020). This complexity is exacerbated by the widely varying representations of young migrants by states, NGOs and communities. For example, child migrants are often represented as victims and the term ‘child migrant’ is conflated with ‘trafficked child’ when these are in fact very different cases (Walker et al., 2020).

Due to this complexity, it is necessary to outline the terminology used in defining the focus of this review. First, although there is significant internal migration and displacement in fragile contexts (OECD, 2022) and a growing literature on the need to see internal and international migration as linked (Cirilo, et al., 2022), this review only focuses on cross-border migration. The reason for this is that children and young people who cross international borders are particularly vulnerable (IOM, 2013; Save the Children, 2019). Second, in this review the term ‘migrant’ refers both to those who may be identified as refugees and asylum seekers escaping conflict or persecution (UNHCR, 1951) as well as informal migrants who migrate to attend school or finding work, for example. ‘Migrant’ also refers to those young people who choose to move and those who are trafficked. ‘Trafficking’ refers to children who, whether by force or not, are moved for the purposes of exploitation (UNICEF, 2007). The term ‘migrant youth’ includes both those with and those without family or primary caregivers (often referred to as unaccompanied and separated children).

Third, in looking at the impact of HIV-related stigma on young migrants this review adopts the multi-layered understanding of stigma described in Kimera et al. (2020a) where both stigma mechanisms and outcomes are significant. An example of a stigma mechanism would be the belief that HIV-positive status denotes a moral blemish or deviance and that the health of the uninfected is threatened. An outcome of this is prejudice and enacted discrimination towards those living with HIV. One result of this discrimination is the experience of internalised stigma, which can have significant impacts on young people’s mental health. Mechanisms such as prejudice and outcomes of stigma such as discrimination can operate at all levels of the socio-ecological system (Bronfenbrenner, 1979) in which young people grow up: the level of individual well-being, interaction with the community, health systems and the legal and political environment.

Finally, in outlining the need for this review RIATT-ESA identified the urgent need to “adopt a more comprehensive approach by targeting those who are most vulnerable and those most difficult to reach, including those being affected by fragility and conflict” (RIATT-ESA, 2023, p. 2). The Organisation for Economic Co-operation and Development (OECD) defines fragile contexts as those countries where there is an accumulation and combination of risks because of context-specific underlying causes combined with insufficient coping capacity of the state, system, and/or communities to manage, absorb or mitigate those risks. 60 states have been identified by the OECD that meet these criteria (2022). This review focuses on migrants in East and Southern Africa most of whom originate in countries listed as fragile (e.g. Democratic Republic of Congo, Somalia and Zimbabwe). Some research from contexts not identified as fragile have also been included in the review as the places in these countries where migrants and refugees live are still characterised by an accumulation of risk and limited state or community capacity to mitigate this risk. An example of this is South Africa, the main destination country for migrants from fragile states in East and Southern Africa (Walls et al., 2015). Though South Africa is not listed as one of the 60 ‘fragile states’ (OECD, 2022) research (Vearey et al, 2017; Vearey, 2018) shows that the state is not only unable to mitigate risk for migrants but, in fact, adds to the risk through anti-migrant attitudes and bureaucracy.

Cross-border migrant children and youth living in fragile contexts in East and Southern Africa face significant stigma from all sectors and at all levels of the systems in which they live. They also encounter myriad contextual barriers to accessing testing, treatment and care. Given this fact, if the global aim to end AIDS by 2030 (UNAIDS, 2022) is to be met there is an urgent need to focus attention on migrant youth. This narrative review of research explores key concepts in the literature on the impact of stigma on adolescent migrants in fragile contexts in East and Southern Africa that can be used to inform an advocacy and learning strategy for RIATT-ESA to respond to the needs of this vulnerable group.

# 3. Objectives of the narrative review

* **Objective 1**: Improve understanding of the impact of stigma and discrimination on accessing HIV and Sexual and Reproductive Health (SRH) services for cross-border migrant adolescents in East and Southern Africa aged 10-24 living with HIV in fragile contexts, including migrants living in refugee settlements, urban settings, and border areas that have the characteristics of fragile contexts, though not necessarily in countries listed as fragile states.
* **Objective 2**: Improve understanding of the social and environmental determinants of demand for and access to HIV and SRH services amongst this population
* **Objective 3**: Improve understanding of the key human-rights-related barriers to accessing HIV and SRH services.
* **Objective 4**: Make recommendations about possible programming responses that would address the contextual risk factors and barriers to access of service for this population.

All of this is to inform RIATT-ESA’s development of a strategic plan to address the issue of stigma and discrimination experienced by migrant adolescents living with HIV and AIDS in the region.

# 4. Methodology

This review used a narrative approach (Ferrari, 2015), which is well suited to the initial exploratory phase of RIATT-ESA’s work. A narrative review identifies, discusses, and organises research on key concepts of relevance to the research objectives using a set of emergent themes and concepts (Patton, 1990). The reasons for selecting this review methodology are twofold. Firstly, a narrative review, because it allows for the emergence of themes, is particularly useful for informing the development of recommendations for programming – each theme can inform a recommendation. Second, the nature of the literature identified in the search provided little *direct* evidence on the specific topic identified by RIATT-ESA (see later discussion), but it did identify tangential evidence that may lend itself to the identification of themes that can then be used to inform RIATT-ESA’s advocacy and technical advice for programming. A narrative review does not use the full protocol of a systematic review, but it does require a transparent search strategy to be outlined at the outset (Collins & Fauser, 2005). This strategy is outlined below.

# 5. Search strategy

Peer-reviewed research articles published since 2009 were prioritised with some research reports from key global agencies (Coalition for Children affected by AIDS, IOM, UNFPA, UNICEF, USAID/PEPFAR, WHO). Data bases used for the search were Medline, PubMed, The Lancet, PsychINFO and Anthrosource. Reference lists of included studies and relevant reviews were also checked to identify additional studies.

Only five articles were identified on the specific topic of *“impact of stigma on accessing HIV and SRHR services for migrant adolescents living with HIV in fragile contexts”.* This was not unexpected as globally there is a dearth of research (Babatunde et al., 2014; Vreeman, 2017) focussing on sexual and reproductive and HIV health issues with adolescents generally and even less on adolescents living in fragile contexts (Mukondwa & Gonah, 2016; Ivanova, et al., 2018; Jennings, 2019; Scelcht et al., 2017). Given this lack of research the decision was made to use the fairly broad inclusion criteria described below:

* Research dealing with **at least two of the key concepts** in Objective 1.
* Research conducted in East or Southern Africa or with reference to low resource settings. A few articles that dealt directly with stigma and access to services from Europe have also been included.
* Research that looked at **general SRH and HIV evidence and programming for adolescents** in fragile contexts but not necessarily on adolescents living with HIV.
* Research around **adolescents living with HIV in Africa**. Research with adults that was seen as providing particularly useful insight for RIATT-ESA strategy development has also been included
* Research into **SRH and HIV programming in ‘emergency’ or ‘humanitarian’** contexts that applies to migrant adolescents in the refugee settlements in East and Southern Africa
* Research with **adolescents aged 10-24**.

An initial search through the data bases identified titles and abstracts of 692 records from peer-reviewed databases. These were screened with five articles identified as *directly* related to the review title and 50 that met our broader inclusion criteria.

# 6. The context of young cross-border migrants in East and Southern Africa

Before looking at what emerged from the review it is important to briefly describe a range of contexttual factors that influence the risk profile of cross-border adolescent migrants in East and Southern Africa (IOM 2021; IOM 2022). East Africa hosts a large number of refugee and asylum seekers in heavily populated refugee settlements. Refugee and asylum seekers are also found in major urban centres such as Nairobi, Dar es Salaam and Kampala. By the end of 2021 it is estimated that the East and Horn of Africa and the Great Lakes region hosted 4.9 million refugees and asylum seekers, as well as 11,7 million internally displaced people with Uganda as the host to the largest number of refugees (UNHCR, 2023). In addition to refugees there are large flows of migrants from and through East Africa that include a wide variety of forced and irregular migrants. These mixed migration flows typically follow one of three routes: the ‘Northern Route’ towards North Africa and often onwards to Europe; the ‘Southern Route’ towards South Africa; and the ‘Eastern Route’ towards Yemen and other parts of the Gulf (Mixed Migration Centre, 2023).

The Southern African region has some of the largest bilateral migration corridors in Africa with the majority of informal migrants found in South Africa. The majority of Southern African countries (except Lesotho, Swaziland and South Africa) have smaller refugee settlements than those found in East Africa. There are no refugee settlements in South Africa as it does not have an encampment policy for refugees and asylum seekers. As a result, the majority of informal migrants, refugees, and asylum seekers in South Africa are found in the Johannesburg/Pretoria conurbation in both inner city and township areas, with smaller populations found in the cities of Durban and Cape Town. In Southern Africa there are also migrant adolescents in small border towns such as Chipata in Zambia (on the Zambia/Malawi border), Ressano Garcia (Mozambique/South Africa border) and Musina (South Africa/Zimbabwe border). Migration in Southern Africa consists mostly of mixed and informal migration flows. Although the lack of accurate statistics makes it difficult to estimate the number of adolescents among this population the International Organisation for Migration (IOM) estimates (IOM, 2022) that 41% of migrants in the Southern African region are under 20.

Another important contextual factor is the mixture of reasons for migration among adolescents in both East and Southern Africa. Young migrants in refugee camps have almost all moved to escape conflict while irregular migrants mostly choose to move because of a lack of economic opportunity in their countries of origin (IOM 2022; Save the Children, 2020). When it comes to adolescent migrants—either refugees or irregular migrants—there are two further categories to be aware of: those who are living with caregivers and those who are unaccompanied. Importantly, none of the few research articles found on SRH and HIV and migrant adolescents differentiates between unaccompanied and family-based migrant adolescents even though being in a family is a significant protective factor (Bhana et al., 2016) and we know that being unaccompanied increases general social and structural risk (Magqibelo, et al., 2016) and by implication HIV risk.

Other factors such as gender and sexual orientation also affect young migrants’ exposure to risk. With a few exceptions (Save the Children, 2020 and Vedasco, 2013) migrant adolescents living in border areas and migrant girls who are mothers are, however, almost invisible even though there is research showing that early motherhood and HIV increases the vulnerability of adolescent mothers and their children (Toska, et al., 2019). ‘Young key populations’ such as sex workers and LGBTQ+ youth are also almost invisible in the literature on migration (Govender et al., 2021). To sum up, there is little known about SRH and HIV issues (including the impact of stigma) related to the most vulnerable populations of adolescent migrants.

Having set the context, this narrative review goes on to examine the themes that emerged from the selected literature to build an understanding of the *“impact of stigma on accessing HIV and SRHR services for migrant adolescents living with HIV in fragile contexts and the human-rights-related barriers to accessing HIV and SRHR services for this population”.*

# 7. Migrant adolescents, HIV and the impact of stigma

This section discusses the five articles identified that were directly related to the central themes and regions of interest for this review: being HIV-positive, the impact of stigma, adolescent migrants, and barriers to accessing services in East and Southern Africa.

A cross sectional study (Logie et al., 2019) and a set of qualitative studies (Logie et al., 2021 and Logie et al., 2021a; Temin, et al., 2021) with refugee youth in informal settlements in Kampala (Uganda), and Durban and Johannesburg (South Africa), make up four of the identified studies. All four studies describe how intersecting stigmas impact experiences of and perspectives towards HIV testing, treatment, and care. There are the stigmas related to being a migrant, being a child or young person, being HIV-positive and, for the young women, their gender. The intersection of all of these sources of stigma creates discrimination at all levels of young migrants’ experience at home, at school (if access is possible), in the community, amongst peers, and at an institutional level. The fifth article, Embelton et al., (2022), builds on an understanding of intersectional stigma by looking specifically at this concept in a series of case study on young people in different sub-Saharan African countries. The study describes how intersectional stigma operates across all social-ecological levels: the individual, interpersonal, community, organisational, and structural levels.

Before exploring these articles in more detail it may be useful to explain intersectional stigma using the framework presented in the Girls on the Move in Southern Africa study (Save the Children, 2020). The study outlines how migrant girls are stigmatised institutionally and socially because they are a

‘Triple anomaly’ to hegemonic social orders: as migrants, they are ‘out of place’ in the system of the nation-state; as females they are outside of the domestic domain assigned to them as their ‘natural’ place; and as children they are ‘unprotected’ by the institution of the family…This triple anomaly in relation to dominant norms of belonging, gender, and childhood powerfully restricts knowledge production and sustains their ‘invisibility’. (p. 26)

The intersection of all these forms of stigma increase the overall impact on adolescents’ mental health and makes social isolation more severe. At the institutional level, the stigma of service providers towards migrant youth living with HIV affects their access to treatment and acts as a barrier to accessing appropriate treatment and care. This is confirmed by a number of other studies (Mukondwa & Gonah, 2016; IOM 2010a; Šehović 2021).

The three studies by Logie et al., (2019, 2021 and 2021a) with young migrants in Kampala Uganda are some of the very few (globally) that mention ‘young key populations’ (Bekker & Hosek, 2015) of adolescent migrants such as those involved in frequent transactional sex or sex work, those struggling with drug addiction, those in conflict with the law, or those who identify as LGBTQI+ (especially pertinent in East Africa where homosexuality is illegal in the majority of countries). Govender et al. (2021) makes the point that such young people face

a high incidence of stigma, discrimination and violence, much of which is fuelled by criminalisation and other discriminatory laws and policies, as well as by highly stigmatising and exclusionary social, religious or cultural attitudes, beliefs or practices. As a result, many of these young people face the highest risks of acquiring HIV and the least access to HIV services and related interventions to either prevent HIV infection or to benefit from treatment care and support when they become HIV-positive (p. 17).

Despite this important point, these marginalised populations are almost completely invisible in the literature on adolescents, migrants, and HIV (Jennings, 2019). With reference to one of these ‘key populations’ (young women migrants who are sex workers) Walker and Galvin (2018) point out that migration of young women to urban areas is often (in policy documents, political statements, media and even in research) conflated with human trafficking and being a ‘sex worker’. There is significant evidence that the reality is much more complex (Palmary, 2009; Save the Children, 2020; Save the Children 2015). Most young women and girls (this does not include refugee and asylum seekers who have moved to escape conflict) choose to migrate because of the lack of economic opportunities in their home countries. Leaving their homes is a considered and logical choice in the face of the limited options available to them there.

The majority of young women and girls who cross borders are not trafficked but make use of familiar ‘safe’ routes, strategies and transportation, based on the advice of elders. In their country of destination a few may choose sex work but the majority work in the informal economy or domestic services. This is not to say that they do not face risks but the simplistic trope of the ‘trafficked migrant’ and ‘migrant-as-sex worker’ that dominates political discussion and policy in Southern Africa exists to the detriment of finding solutions to protection that are based on the lived reality of migrant young women.

The selected studies by Embelton et al. (2022), Logie et al. (2019, 2021 and 2021a), and Temin (2021) are some of the very few that reflect the more complex reality of migrant adolescents. The research, in its focus on stigma, looks at ‘fears’, for example. It shows how young people’s fear that being identified as HIV-positive can impact on their attempts to gain legal status in their destination country and the documentation that would allow them to access work and services. Steenberg’s (2020) study undertaken with adult HIV-positive migrants from Mozambique living in Johannesburg makes a similar point by exploring the deeply personal experiences of stigma. Using a life-history approach the study shows that stigma produces ‘loneliness’ and ‘secrecy’ which impacts on ‘disclosure’. “The net effect of these three processes is a silence which is detrimental to the social normalisation of HIV, treatment-seeking and clinical drug adherence” (p. 57).

For girls especially, the fear of “shame and blame” (Logie, et al., 2019 p. 88) from family members and others in the refugee community was strong. In the study by Logie, et al. (2019) girls described how the stigma attached to being sexually active and not the HIV-related stigma was what prevented them from testing and seeking out treatment and care. These young women linked the stigma attached to sexual activity in adolescence to social norms from their countries of origin and especially religion. Religion plays a big role in their everyday experiences as membership of religious communities is an important way of retaining cultural ties with communities and countries of origin.

Motherhood is yet another factor that contributes to the stigma experienced by migrant women and girls. Although they do not make reference to stigma directly, Save the Children (2020) and Jennings et al. (2019) highlight that adolescent migrant young women who are mothers are almost completely invisible in the literature on migration, adolescents and HIV. The small body of research (Sam-Agudu et al., 2020; Toska et al., 2019) on HIV-positive adolescent mothers (but not migrants) suggests that this is likely another level of stigma that young women migrants face.

In addition to the forms of stigma described above that intersect with their status as migrants, there are a range of factors directly related to the fact that these young people are in unfamiliar places that also have an impact on young people’s risk of exposure to HIV and their access to treatment and care. The first of these is the language barrier between migrants and health professionals that is raised by a number of other studies with migrant adults (Mukondwa & Gonah, 2016; Roxo et al., 2019; Steenberg, 2020; Vearey 2018). Although this is primarily a practical barrier to healthcare access, it is also linked to stigma. This is evidenced for example in the derogatory term used to identify foreigners in South Africa ‘kwerekwere’. This term is based on the sound of the language of migrants, an unrecognisable jumble of sounds which is represented as ‘kwerekwere’.

Logie et al. (2019, and 2021a) also point out that unstable housing and overcrowded living conditions (eight to ten people living in small, often curtained off, rooms are a characteristic of housing for migrants in Southern and East Africa). Overcrowded homes mean that young people have limited access to private spaces where they can self-test or take their treatment. The stigma related to their HIV status thus creates another risk factor. It is worth pointing out that unstable housing is identified globally as an important risk factor in seeking HIV care and adherence to HIV treatment (Aidala et al., 2016).

The discussion up to this point has focused “persons of vulnerability” (IOM, 2010b) and the ways in which stigma increases the risks and vulnerabilities of young migrants in the context of this review it is important to take into account another perspective that could inform strategy. IOM (2010b) makes the point that the most effective interventions to reduce the HIV vulnerability of migrants develop projects and programmes that target “places of vulnerability” as opposed to “persons of vulnerability” (p. 11). Spaces of vulnerability are those places where migrants live and work and pass through. They include “land border posts, ports, truck stops, construction sites, commercial farms, fishing communities, mines, migrant communities and urban informal settlements, migrant-sending sites, detention centres, and emergency settlements” (p. 11). This is an important point to keep in mind when looking at possible intervention strategies for migrant adolescents living with HIV. A number of qualitative studies with migrant adolescents (Clacherty, 2019; Save the Children 2020; Walker and Clacherty, 2023) highlight the central role that the particular spatial reality within which migrants live plays in the daily lives, problem-solving strategies, and choices made by young migrants.

The diagram below summarises some of the literature discussed above by adapting the ‘Health Stigma and Discrimination Framework’ from Logie et al., (2021a)to a context of Migrant adolescents living with HIV and how intersecting stigmas impact on their well-being.



**Figure 1: A framework for understanding intersectional stigma and it’s impact on migrant adolescents living with HIV in East and Southern Africa**

# 8. Evidence that HIV-positive adolescents experience negative impacts and how stigma exacerbates these impacts

This theme explores evidence on health issues faced by HIV-positive adolescents and how stigma impacts this. Though this literature deals with adolescents generally and not with *migrant* adolescents it provides significant evidence on the impact of stigma and tangential evidence that can be applied to understanding the mental health status and impact of stigma on *migrant* adolescents.

Rueda et al.’s (2016) work is important here even though it focusses on adults living with HIV because it is a metanalysis of 64 studies on mental health quality of life, physical health, social support, adherence to antiretroviral therapy, access to and usage of health/ social services and risk behaviours. The analysis “found significant associations between HIV-related stigma and higher rates of depression, lower social support and lower levels of adherence to antiretroviral medications and access to and usage of health and social services” (p. 1).

There is a also a fairly large body of work looking at adolescents, that is pertinent to this review and this is the focus of what follows. A systematic review by Dessauvagie (2020) looks at mental health amongst adolescents living with HIV in sub-Saharan Africa. The review highlights that adolescents living with HIV face a high burden of depression, anxiety and suicidal ideation, which contribute to low quality of life and challenges with anti-retroviral treatment (ART) access and adherence. There is also a small body of growing evidence from East and Southern Africa (Casale et al., 2015; Kamau et al., 2012; Musisi & Kinyanda 2009; Kim et al. 2015; & Crowley, 2022) that suggests the same mental health issues amongst HIV-positive adolescents. Rich et al.’s 2022 qualitative research with adolescents in Harare Zimbabwe is particularly useful in describing the experiences and impactsof HIV-related self stigma .

Desrosiers et al. (2020) in a systematic review of sexual and reproductive health (SRH) interventions in humanitarian settings, which is particularly relevant to the large number of migrant adolescents living in refugee settlements in East and Southern Africa, highlights the evidence for the increased risk of mental disorders amongst girls and young women living with HIV in humanitarian contexts.

Cluver et al. (2022) in a recent comprehensive review of systematic reviews, new randomised trials and cohort studies for adolescents living with and affected by HIV make the point that 90% of adolescents living with HIV live in sub-Saharan Africa. This review identifies a high adolescent mental health burden amongst this population, contributing to low quality of life and ART challenges. The authors also highlight poor access to mental health services because of lack of infrastructure and skilled providers. The review identifies stigma (both internal and external) as particularly damaging in adolescence as young people develop their sense of identity and begin to negotiate relationships in this stage of their life. Adolescent girls are identified as especially vulnerable because of compounding factors such as gender-based violence, early pregnancy and motherhood. The co-occurrence of these factors with HIV-positive status compounds stigma, which consequently reduces access to health, education, social support, and social services. It is useful to point out that *migrant* adolescent girls experience a further multiplication of vulnerability with the additional stigma of ‘being foreign’ (Save the Children, 2020) and the lack of access to general health care faced by migrants (WHO, 2020).

Alongside this is significant (Vreeman et al., 2017) evidence that poor mental health is exacerbated by social exclusion and HIV stigma. The global systematic review by Vreeman et al., which includes research from low resource settings, highlights evidence that mental health challenges and stigma result in delayed HIV testing and decreased treatment adherence. Of relevance to the RIATT-ESA review on migrant adolescents is the evidence from this systematic review (Vreeman et al., 2017) that an intersection of challenges such as low levels of self-efficacy, mental health disorders and “environmental challenges such as homelessness or a history of time in detention facilities” (p. 103) all work together to reduce treatment adherence. When looking at the evidence from a number of qualitative studies (Clacherty, 2019; Mann, 2010; Mann, 2012; Temin, 2021) among migrant children in East and Southern Africa about the high levels of housing instability and detention this evidence becomes particularly significant.

Williams et al. (2017), in a review of 24 qualitative and mixed-method studies that explore adolescent progression through the stages of HIV care in Sub-Saharan Africa, highlights that all 24 studies refer to “debilitating experiences with stigma” (p. 7). This stigma was experienced internally by adolescents as ‘anticipated stigma’ (which impacts the choice to test) and in actual external barriers to progression through testing, diagnosis, follow up on test results, care and adherence. The stigmatising experiences include ostracism from peers, community gossip, discrimination in school and lack of empathy from health care workers. Adherence is affected by social conditions that lead to stigma-related discrimination such as minimal privacy in the home or at school.

Sam-Agudu et al. (2020), in a comprehensive review of programming gaps and ethical issues in sub-Saharan Africa, also identify stigma as a major barrier to accessing care for infants, children and youth. The review also highlights the “ethical dilemma of how to develop and promote services that welcome key populations … [such as] men who have sex with men (MSM), female sex workers, and people who inject drugs” (p. 406).

Stigma is one of the major barriers to adolescent mothers accessing prevention of mother to child transmission (PMTCT). Sam-Agudu et al. also make the important point that creating programming that offers stigma-free testing and treatment is imperative given the data showing high HIV burden and asymptomatic sexually transmitted infections (STIs) and incident infection amongst youth in sub-Saharan Africa. The review identifies the priority need to reduce the stigma attached to being HIV-positive in humanitarian contexts especially, if youth are to access care. Finally, the point is made that young women and girls are a particular priority because of the high risk of sexual and gender-based violence in these contexts.

Adding to the understanding of how stigma plays out for adolescents living with HIV, Arseneault et al. (2008) describe what they call “bullying victimisation” arising from stigma as strongly linked with poor adolescent mental health. Boyes et al., (2019) also present evidence for a link between bullying in the family and depression and anxiety in South African HIV-positive adolescents. Being bullied for taking medication was also associated with depression in HIV-positive adolescents in Malawi (Kim et al., 2015).

In another study that explores stigma amongst HIV-positive adolescents in a rural area in South Africa Treves-Kagan et al. (2015) found that ‘anticipated stigma’ was the greatest barrier to care. HIV is still associated with promiscuity and infidelity and thus community members avoid being identified as HIV-positive. Accessing health services for testing and treatment were especially avoided by young men (who would have no other reason to go to the clinic as women do). This led to delays in testing, accessing care and adherence to medications.

Zungu et al. (2021), in a study that includes an exploration of drivers of ART non-adherence and sexual risk-taking among adolescents living with HIV in ESA highlight stigma and the discrimination that follows as among one of the main reasons for non-adherence.

For fear of unwanted disclosure, some adolescents and young adults may not adhere to medicines when they are in situations where they might be seen taking medicines such as in public, or even in social situations and with friends, family members or intimate partners. This issue may be compounded by fear of loss of material support in situations in which adolescents are also receiving material support from their partners and family or community members. (p. 249)

Additionally, qualitative studies by Kimera et.al. (2020 and 2020a) provide nuanced understanding of how stigma-related “fear, negative thoughts and self-devaluation” affect adolescents living with HIV in a rural area of western Uganda. Adolescents in this study describe active discrimination such as verbal abuse about being HIV-positive as well as exclusion from activities because they were seen as ‘ill’. For the young people in this study it was the isolation because peers and adults thought they would infect others that had the greatest effect on their willingness to stay at school and their feeling of fear amongst peers and in their community.

The study by Kimera et al. (2020) raises the important point that stigma associated with HIV affects shool attendance. Reactionary attitudes and behaviours from others at school as well as internalized stigma that resulted in fear, negative thoughts and self-devaluation were two of the biggest barriers identified by young people living with HIV in this research. Management of ART and illnesses in the contexts of school were also challenges young people reported. Migrant youth living with HIV would experience similar challenges as well as the additional barriers of the intersecting stigma of being a migrant. There are significant structural barriers to accessing school and further education that are discussed in the section on structural barriers below.

A particularly troubling finding in the Kimera et al. studies was the lack of future orientation (a key aspect of resilience). In one study (Kimera et al., 2020) “participants looked at their future as unfeasible due to their status and the associated stigma around it in their surroundings” (p. 12). They described how people around them saw their death as inevitable and so did not invest in them in any way. This imposed “limitations on their future outlooks and aspirations”(p. 12). From their perspective stigma would prevent any possibility of them having meaningful work or having a family in the future.

If young people living with HIV in ‘normal’ family and home community settings experience the impact of stigma in the ways described above it is important to ask how much more migrant adolescents who experience intersections of stigma far beyond those of young people living within their own communities are affected.

There is an important counter ‘voice’ that needs to be taken into account here, however. Research by Bhana et al. (2016) points ot the resilience of young people who live with HIV. Bhana et al. use data from a randomised control trial (RCT) of the VUKA Family programme in South Africa to examine positive outcomes in the face of adversity for HIV-positive adolescents. The article defines these positive outcomes as ‘resilience’ which is the ability to ‘bounce back’ in a context of adversity. The point is made that even if many studies show high rates of mental health disorder among HIV-positive adolescents there are “large proportions of youth” (p. 50) who display no risk outcomes. The article describes the factors that promote resilience, including higher caregiver education, greater caregiver supervision, social support-seeking behaviour, and, significantly for this review, lower self stigmatisation.

Bhana et al. also point out that “stressful life events” are associated with worse mental health outcomes and that parental involvement is a key factor that creates resilience. So, despite the fact that it is important to acknowledge young migrants’ resilience they are clearly at greater risk than adolescents living within families as many adolescent migrants, particularly the large number of informal migrants, have little contact with parents and almost all migrants have experienced stressful events at some point in their movement across borders (Clacherty, 2019; Save the Children, 2020). The fact though that this research explores the concept of resilience is important because it points to the need to understand vulnerable young people as agents and not just victims of their circumstances, a significant point to keep in mind when discussing programming (Boyden, 2009) with children made vulnerable by conflict and political instability because, as Boyden points out, even in times of conflict, children are not helpless victims but contribute to their own and to their families’ ability to cope.

# 9. Research on Stigma and HIV with migrants from Sub-Saharan Africa living outside Africa

Though the two qualitative studies (Arrey et al., 2014; Kunene, 2017) discussed below focus on the impact of stigma on adult migrants living with HIIV in Germany, Belgium and the USA, they offer important perspectives that help understand the dynamics of stigma among migrant populations.

Arrey et al. (2014 ) describe how the issue of disclosure dominates the experience of women migrants from Sub-Saharan Africa living in Belgium. A qualitative study shows that women disclose to health professionals alone (because they need treatment) and not to their families and community. What emerged from the study was that the main reason for non-disclosure is self-stigma crated by the taboo of the HIV disease in their sub-Saharan culture

The second study (Koku, 2010) looks at HIV-positive migrants living in the US and their experience of stigma, its impact on their lives, and the coping and resistance mechanisms they have adopted. Again what emerges is that experiences of, and responses to stigmatization are shaped largely by cultural and religious assumptions and perceptions about HIV learnt from their countries of origin. In similar vein, the qualitative study by Kuehne et al. (2018) with newly diagnosed migrant patients in Germany describes how it is stigma that leads to resistant to testing and late care. Interestingly the study shows that “living in communities that discussed HIV almost doubled the odds of having had an HIV test” (p14).

# 10. HIV and AIDS care in refugee humanitarian settings

There is a small but relevant body of literature on HIV and AIDS care in humanitarian settings and a small body of literature on refugee settlements which applies directly to the adolescents in refugee settlements in East and Southern Africa. Although the literature represents widely varying methodologies and works with a wide range of population groups (including adolescents and young women), a consistent theme in the work done in refugee settlements is stigma. This includes fear of stigma, actual stigma within families and institutions, and stigma as a barrier to accessing care.

Jennings et al. (2019) provide a systematic review of sexual and reproductive health (SRH) provision for adolescents in humanitarian settings globally. This review highlights the dearth of literature on young people and SRH in humanitarian settings. Only 14 peer-reviewed and grey literature articles (of high and medium quality) were identified. None of these focused on care for those living with HIV but rather on prevention of unintended pregnancies, prevention of HIV/STIs, and sexual and gender-based violence.

Roxo et al. (2019) in a scoping review on care for adolescent girls living with HIV in emergency settings reveals a similar pattern. Frameworks and guidance pay scant attention to the needs of young women living with HIV. This review suggests that services that focus on the very specific needs of adolescents and young women living with HIV are almost non-existent. The stigma of being HIV-positive is highlighted in a cross-sectional mixed method study (Ivanova et al., 2019) with adolescent girls in Nakivale refugee settlement in Uganda. The young women in this study showed high risk of exposure to GBV in their country of origin and in their present lives in the settlement, but very low levels of knowledge and almost no support-seeking from service providers. This is largely because girls describe their parents as their only potential source of health information and they feared discussing SRH issues with them because of the stigma attached to this. Especially in discussion with girls, parents saw any such discussion as proof that the girls were sexually active. Iyakaremye and Mukagatare’s (2016) qualitative research in Kigame refugee settlement in Rwanda with adolescent girls also highlights high levels of GBV and its complete under-reporting because of institutional stigma. The treatment adolescent girls by settlement officials is described as particularly stigmatising.

Two qualitative studies in Osire Refugee settlement with women in Namibia (Pinehas, et al., 2016) and in Nakivale refugee settlement in Uganda with adults living with HIV (O’Laughlin et al., 2013) explore the direct experience and health care needs as expressed by refugees themselves. What emerges is that concern about and time spent accessing basic needs dominates men and women’s lives with little physical and emotional time left for concerns such as HIV testing and treatment. Women refugees express their need for health care that does not stigmatise them but takes into account their human dignity and restores their hope (Pineas, et al., 2016). They ask for,

Measures to enhance their autonomy and freedom; skills training; certainty about their future; security with aid distribution; protection against stigmatization due to human immunodeficiency virus (HIV) infection; protection against abuse; and participation in reproductive health care (p. 139).

These two studies are important because they allowed for the direct participation of refugees in the research process. This meant that issues emerged that may not be seen as important by policy makers and researchers. For example, the prominance of concerns around basic needs and the need for care that provides ‘hope’ to emerge. They also highlight the need to promote the agency of those living in refugee settlements (and indeed in all migrant contexts) to identify and participate in care programming.

# 11. Adult migrants living with HIV and the impact of stigma in Southern Africa

As Vreeman (2017) and Adejumo et al. (2015) point out there is very little research on HIV-infected children and adolescents in sub-Saharan Africa. There is even less on migrant adolescents and adolescents in humanitarian contexts (Ivanova, et al., 2018; Jennings, 2019; Scelcht et al., 2017). As discussed above, marginalised populations of migrant adolescents such as young migrant sex workers and members of the LGBTQI+ community are almost completely invisible (Logie 2019). For this reason this review has included work from the more extensive literature which looks at the impact of stigma and barriers to accessing services for HIV-positive adults. Most of the work identified refers to Southern Africa.

There are a number of qualitative and quantitative studies and discussion papers on migration and HIV in Southern Africa and South Africa (e.g. White et al., 2020; Vearey 2009; Vearey, 2018) that point out two key characteristics of migration in the region. The first characteristic is that migration is irregular, placing migrants in a legally precarious position in the arrival country. The second chracteristic is that migration pathways are characterised by repeated movements across borders. Health services (particularly those related to ART treatment) in Southern African countries do not take these characteristics of movement into account and therefore limit migrants’ access to testing, treatment and care.

One of the main issues identified by the studies mentioned above is institutional stigma that acts as a barrier to access to health services. This stigma expresses itself at two levels. The first level is that migrants struggle to acquire documents regularising their presence in an arrival country due to xenephobic attitudes of state officials. The second level of stigma occurs in health centres themselves where health service providers refuse care to migrants due to their lack of documentation despite the fact that protective policies and guidelines exist within South Africa to ensure access to healthcare for all, including international migrants (Šehović, 2021). Veary (2018) discusses migrants in South Africa being denied access to healthcare by healthcare professionals asking them to produce an Identity Document.

Lack of legal status in the arrival country also means that migrant populations are forced to live on the margins of society. This often means that they will live in peripheral areas of cities and towns, engage in the informal economy, and often choose to avoid government health facilities in an attempt to remain invisible to the various parts of the state aparatus. In fact most migrants receiving treatment for HIV access the treatment through non-government sources (Vearey, 2008; Vearey, 2018). The (mostly qualitative) work with adolescent migrants (e.g. Clacherty, 2019; Mann, 2010; Save the Children, 2022; Verdasco, 2013; Walker and Clacherty 2023) suggests that this conscious invisibility is a characteristic of adolescent migrants, making programming and promotion of service access for this group more difficult.

Šehović explores this issue of structural stigma in the context of adolescents in East and Southern Africa highlighting that, “those without citizenship … are left outside of the citizen-state responsibility nexus” (p. 117). There is some useful research looking at addressing equitable access to sexual and reproductive health and rights (SRHR) across Southern Africa (ACMS, 2022a) but almost no research in East Africa on this issue. There has also been some civil society advocacy around this issue, but again, mostly in Southern Africa. There is almost no research on how falling between the citizen-state responsibility nexus impacts on young people living with HIV and AIDS. This research gap is particularly concerning because these everyday experiences of exclusion can have significant impacts on migrant adolescents wellbeing. A study by Kostelny & Ondoro (2016) conducted in the Horn of Africa with young people living in conflict and post conflict contexts makes a point that is directly applicable to young migrants in East and Southern Africa (Clacherty, 2019).

The assumption frequently made in conflict and postconflict settings is that the main psychosocial and mental health risks to children stem primarily from violence-related trauma experienced during the conflict. Although war trauma is important, some of the greatest psychosocial distress for children comes from the everyday stresses resulting from structural violence. (Kosteleny & Ondero, 2016. p. 226).

This structural stigma does not only opperate at a national level. These structures of exclusion are linked to global migration policy discussions that are increasingly driven by the need for security in countries where incoming migration is high. There is an increasing desire among the international community to follow a securitisation agenda that aims to restrict the movement of people. Evidence of this can be found in a recent global compact (WHO, 2019) that seeks to guide an international response to migration by focusing on securitisation. Those promoting the right to health treatment for all worry that this securitisation approach will affect public health access generally. This is particular an issue in Southern Africa, which has high levels of migration and the largest population of people living with HIV globally. This securitisation agenda may be founded in political policy agendas but it is often expressed as xenophobia (Vearey, 2018), particularly in South Africa. It has also led to an increased emphasis on documentation, which often results in increasing fears and incidence of detention and deportation (Clacherty, 2019; Save the Children, 2020). Both of these have obvious impacts on migrants’ access to HIV prevention, treatment and care.

The WHO (2022) points to the need for integrated responses to the barriers against access to health by migrant populations, this needs to include action to address structural barriers. One useful example of an integrated response to structural stigma and discrimination against migrants is the Migrant Health Forums (MHFs) set up in South Africa (ACMS, 2022a) by government and IOM as part of the SRHR-HIV knows No Borders programme. A review of the effectiveness and sustainability of the MHFs (ACMS 2022a) points to the need for ‘Whole of Government and Whole of Society’[[1]](#footnote-1) actions at provincial, national and regional levels to address underlying structural violence.

# 12. Research on appropriate programming for adolescent migrants living with HIV

There is a dearth of research on general issues related to HIV-infected children and adolescents in sub-Saharan Africa (Vreeman 2017) and even less research that looks at the impact of stigma on adolescents in humanitarian contexts and other vulnerable key populations of adolescents such as the LGBTQI+ community (Ivanova et al., 2018; Jennings, 2019; Logie 2019; Scelcht et al., 2017). It follows that there is little evidence base for effective programming for these populations. The table below presents programming recommendations drawn from the articles included in this review to broaden the scope of RIATT-ESA’s deliberation on strategy. The table includes recommendations for dealing with issues of stigma, increasing access to care and treatment, and improved health service provision. Some of these recommendations were initially suggested for migrant adolescents, others for migrant adult populations and/or non-migrant adolescents, but have been included here based on their applicability to migrant adolescents in the region.

Laurenzi et al., (2020) found three randomised control trials (RTC) targeting mental health burdens for adolescents living with HIV in sub-Saharan Africa. The research on mental health reviewed in an earlier section of this review suggests that mental health challenges are one of the main impacts of stigma. For this reason we have included two of the RTCs identified by Laurenzi et al. that were conducted in the ESA region at the top of the table below.

**Table 1: Summary of evidence on programming from articles reviewed**

| **Author****Year****Document Type** | **Study Setting** | **Type of Study** | **Target Population for research** | **Recommendations programming from review evidence**  |
| --- | --- | --- | --- | --- |
| Bhana et al.2014Peer-reviewed | South AfricaKwaZulu-natalUrbanClinical | Randomised controlled trial | Pre-adolescents aged 10-13 years and their families | **VUKA programme for HIV-positive adolescents** – developed by a multi-disciplinary team, focused around creative print materials and counsellor facilitation of discussion and problem-solving within and between families in multi-family groups. VUKA shows promise as a family-based prevention program for YPLWHIV to improve behavioral health outcomes such as adherence that can be effectively delivered by lay staff in public health clinics. Many aspects of the programme are not applicable to migrant adolescents living with HIV (due to the family focus and clinic focus) but it is one of the only ‘tested’ programmes so we recommend research to examine the core approaches used in Vuka to adapt them for migrant contexts—by exploring evidence of peer group intervnetions or the possibility of implementing this approach in mobile clinics at vulnerable spots like border posts, for instance.  |
| Willis et al. 2019 peer reviewed  | Zimbabwe | Randomised control trial  | Adolescents living with HIV | In the **Zvandiri programme** a model of differentiated service delivery for children, adolescents and young people, between the ages of 0 and 24years, living with HIV in Zimbabwe. Adolescents and young people living with HIV between the ages of 18 and 24 are trained and mentored as **peer counsellors**. These peer counsellors are known as **Community Adolescent Treatment Supporters (CATS)**. They provide **home and health-centre based support to other young people living with HIV**. The study showed the intervention **improved linkage and retention in care, adherence to ART and psychosocial well-being, self- esteem, and quality of life**.  |
| Bhana et al. 2020Peer reviewed  | Low and middle income countries | Systematic review  | Adolescents living with HIV or affected by HIV  | **Systematic review of mental health interventions for adolescents affected by or infected with HIV.** **Research** on what works to improve mental health in adolescents living with HIV in LMIC **is in its nascent stages**. **Family-based interventions** and **economic strengthening show promise**. Family-based interventions could be relevant for migrant adolescents living with families (e.g. many adolescents in refugee camps live with family, though it may not be their biological family). **Economic strengthening for families and unaccompanied migrants adolescents** would be relevant. Economic strengthening through cash transfers in migration contexts has a strong history in migration contexts, e.g. Danish Refugee Council, UNICEF and Red Cross/Crescent Society <https://emergency.drc.ngo/respond/cash-transfer-programming/?campaign>. <https://cash-hub.org/guidance-and-tools/cash-in-emergencies-toolkit/> <https://www.unicef.org/turkiye/en/conditional-cash-transfer-education-ccte-programme>There are fewer examples in urban informal migration contexts but they do exist e.g. https://odi.org/en/about/our-work/cash-transfers-for-refugees-the-economic-and-social-effects-of-a-programme-in-jordan/  |
| Cluver et al.2022Peer-reviewed | Global | Review of systematic reviews | Adolescents living with and affected by HIV – focus on improving mental health  | **Combinations of economic and social interventions** (known as ‘cash plus care’) aimed at reducing the burden of search for basic needs and create time and space for health concerns and consequent health-seeking behaviour. **Integrated primary care services (where service providers task-share) that target migrant populations where they live.** **Strengthening existing support systems** for migrant adolescents. This would include working with families (if they have them). |
| O’Brien et al.2010Peer-reviewed | Sub-Saharan AfricaConflict or post-conflictRural | Evaluation | Patients attending health facilities supported by MSF | **ART can be feasibly and effectively provided in conflict or post-conflict settings.** Needs simplified treatment and monitoring, programmatic adaptations for the conditions, and resources. Conflict and post-conflict communities are ‘on the move’. **Need for research** to explore adaptation **for use with migrant adolescents ‘on the move’ particularly young people in transit countries (e.g. Zambia) and in border areas.**  |
| Temin & Heck2020Peer-reviewed | Global | Comprehensive literature review | Adolescent girls aged 10 to 19 years | **Female mentor-led girl groups** can improve adolescent **girls’** attitudes, beliefs, knowledge, and awareness on health and gender. Particularly applicable to vulnerable sub-populations such as migrant girls. **Need for research on how the model could be applied** to migrant girls.  |
| Mutambo, Shumba & Hlongwana2019Peer-reviewed | GlobalResource constrained settings | Narrative literature review | Children in resource constrained settings | Evidence that a “child-centred care approach” that includes **child-participation which promotes resilience** would lead to positive health outcomes and resilience in children living with a communicable, highly stigmatised and chronic condition such as HIV. |
| Logi et al.2019Peer-reviewed | GlobalHumanitarian crises | Reflective report | Forcibly displaced people | Evidence shows that **self care interventions, such as HIV self-testing**  have been effective especially in humanitarian settings that lack sufficient trained health workers and inadequate health infrastructure**Trained and supported lay health workers (from the refugee and migrant community) are effective** in increasing uptake of sexual and reproductive health services in such conditions – increase capacity were few professional health workers.  |
| Ivanonva et al.2019 | Nakivale  | Cross sectional mised-methods | Refugee adolescents in refugee settlemnet  | **Peer-support as a preferred source of HIV self-testing services**. Social support can increase HIV testing. Gender differences in preferences for peer support – men may prefer male peers because of perceived authority and beliefs that they will respect confidentiality.  |
| Boyes et al. 2019Peer-reviewed  | South Africa | Correlation study  | HIV-positive adolescents | **Bullying and victimisation** based on stigma associated with most or all indicators of poor mental health. **There are evidence-based examples of reduction of bullying** – most **deal with the community in which HIV-positive adolescents live** e.g. school, community groups. Given other research (Logie et al. 2021) on the **importance of religious organisations** in the lives of migrants this may be one area of focus.  |
| Vearey 2008peer reviewed  | Johannesburg South Africa | Use of 2006 survey data  | Migrants  | **Selected recommendations for public sector to make sure migrants’ health rights are upheld: Appropriate training within the public healthcare sector** (especially among institutional managers) relating to the rights of all international migrants to access ART. **Need to educate and advocate to local and provincial health departments to apply national-level directives**, policies and values around access to health for migrants.  |
| Arrey et al.2014Peer reviewed | Belgium  | Qualitative | Women living with HIV  | **Discussing HIV increases the uptake of HIV testing and reduces stigma.** Prevention efforts focusing on conversation and de-stigmatisation. In the context of migrant adolescents these conversations could be created in places where migrant youth and adults gather. This would require **working with existing migrant support organisations and research into particular contexts.** Save the Children’s Children on the Move programmes in East and Southern Africa work in such environments and would be a place to pilot such an approach (Save the Children, 2020)  |
| Jennings et al.2019 | Global  | Systematic review | Adolescents including humanitarian settings  | Integration of **rights-based approaches to delivery of adolescent PMTCT** care is critically needed, in order to improve outcomes for these young women and their infants. |
| Treves Kagan et al. 2015peer reviewed | Rural South Africa | Rapid, community-based qualitative assessment  | High prevalence community | Researching **how stigma hinders engagement with care** and implementing interventions that specifically address those factors was shown to be important. There is a need to **ensuring patient confidentiality and create safe spaces** espcially for **men and youth** to access care. |
| Toska et al.  | Sub-Saharan Africa | Scoping review of evidence | Adolescent mothers affected by HIV | Highlights lessons from **a series of promising programmes** (little evidence on actual interventions) focused on supporting adolescent mothers through novel approaches. The approaches include **support groups and home visiting and aims include support with school reentry, economic empowerment and links to employment opportunities, psychosocial support and lifeskills.** A few examples of the use of digital technology.  |
| Williams et al.2017peer reviewed | Sub-Saharan Africa | Meta-ethnography  | Adolescents living with HIV | **Prioritise addressing psychosocial issues among adolescents to promote individual-level engagement with HIV care**. The self-efficacy of ALWHIV is recognized as a key facilitator of diagnosis, retention in care, and adherence to ART. However, its effect is **reliant on social conditions such as family environment, presence or absence of peer support, and the attitudes of HCWs working with youth**. Inclusion of supportive social interventions such as **community support groups**, **family counseling, and HIV/sexual and reproductive health education.** Research would be needed to explore how these interventions can be adapted to migrant contexts.  |
| Logie 2021 et al. study  | Kampala Uganda | Qualitative study | Urban migrant adolescents  | **Culturally and contextually relevant services** to optimise HIV and sexual health outcomes create a landscape where refugee/displaced youth can **easily navigate transportation, literacy and language issues, access outreach programmes, and manage privacy concerns** to access SRH services. **Relationships developed between HIV programmes and religious leaders** to offer contextually relevant services. **Gender transformative approaches** can address the traumatic, long-lasting impacts of SGBV in war to disrupt inequitable gender norms. **Nurturing trusting relationships between service providers and refugee** communities, and dismantling discrimination of all forms – gender, migrant and HIV status.  |
| Singh et al. 2018 | Humanitarian crisis settings  | Systematic review of qualitative and quantitative  | Women and girls  | Assesses the utilisation of services of SRH interventions from the onset of emergencies in low- and middle-income countries**. Peer-led** and **interpersonal education**, **mass media** campaigns, **community-based programming** and **three-tiered network of community-based reproductive and maternal health providers** increased service use. |
| Desrosiers et al.2014peer reviewed | Low and middle-income countries | Systematic review | Adolescents | Quality **research** is needed to determine **effective means to deliver services outside health facilities to reach marginalised or vulnerable adolescents.**  |
| Schlecht et al. 2017peer reviewed  | Syrian refugees in Lebanon, Somali refugees in Kobe Refugee camp Ethiopia, migrant communities from Myanmar in Thailand  | Series of qualitative and quantitative studies | Early adolescents (10-14) | Critical **need for SRH programmes for early adolescence (10-14).** These should include: sensitive care for survivors of sexual violence, menstrual hygiene management, life skills, and fertility education. **Humanitarian programs can better engage with parents, teachers, and community leaders** as partners in the development and implementation of programs. |
| Sam-Agudu et al. 2020peer reviewed | Sub Saharan Africa | Narrative review | Adolescents | Key ethical and programme issues underlying HIV prevention gaps for infants, children, and adolescents prevail. Need **for gender empowerment, improving access to and appropriateness of critical health services, rights-based policy and legislation, closing research gaps, and considering the values and preferences of young people for HIV prevention and treatment services**. Preferences of young people for HIV prevention and treatment services need to be considered. See Table 1 Annex 1 for more detailed recommendations. |
| Newton-Levinson et al.2016 | Sub-Saharan Africa | Systematic review | Adolescents 10-24 | The most **significant barriers to youth’s access to STI services are rooted in cultural norms and stigma**. Increasing adolescent access to STI services will require significant work to **address clinic systems and provider attitudes, especially with respect to protecting adolescent confidentiality**. Addressing barriers to STI services, moreover, will necessitate **addressing cultural norms related to adolescent sexuality**.  |
| Casale et al. 2019Peer reviewed  | Resource-scarce district in South Africa | Moderated mediation model tested through a survey  | Adolescents 10-19 | The survey tested the **effects of stigma on suicidal ideation and attempts**, both direct and mediated through depression and **direct and stress-buffering effects of social support** resources on depression and suicidal ideation and attempts, among 1053 HIV-positive 10-19-year-old adolescents.**Support group participation** contributed to stress-buffering effects moderating the direct and indirect relationships between stigma and suicidal thoughts and behaviour. |
| Njau et al. 2022peer reviewed | Dar es Salaam Tanzania | Development and piloting of an intervention that was based on evidence about efficacy in reduction of poor mental health indicators  | Adolescents living with HIV, health care providers, and caregivers.  | **NITUE intervention.** This Swahili word means “Help me offload,” reflecting the intervention’s aim, which is to provide relief from carrying a heavy load of depressive symptoms. The components of the NITUE intervention, which was **specifically designed to be culturally congruent** included incorporating **evidence-based mental health intervention components** that included **cognitive-behavioural therapy** and the **involvement of caregiver and healthcare provid**ers in the treatment. **Adolescent and adults participants perceived the intervention to be acceptable and beneficial**. Will be tested for feasibility and efficacy.  |
| Zungu et al.2012Peer reviewed Chapter in book  | ESA  | Narrative review chapter  | Adolescents living with HIV in ESA  | Evidence for the potential **of home-based and community care** interventions is presented in this review. Evidence also demonstrates that social protection, particularly **cash plus care** provisions in combination are effective. It explores different kinds of social protection including **cash transfers for basic needs and for transportation to clinics** and cash plus care models plus the costs and efficiencies of the different models of social protection.  |

# 13. Recommendations to inform RIATT-ESA’s strategy development

A general recommendation for RIATT-ESA is to use the WHO Global Action Plan on Promoting the Health of Refugees and Migrants, 2019–2023 as a foundation for the development of a strategic plan to address the needs of migrant adolescents living with HIV and AIDS (WHO, 2019). The ‘Priority Actions’ (p. 107) are particularly pertinent. These actions are presented in Annex 2 of this document. All of the specific recommendations below, which are informed by the research presented in this review, fit in with one or more of the priority areas identified in the WHO Global Action Plan.

***Recommendations for Programming***

Part of RIATT-ESA’s mandate is to develop and share technical and programming information. Given this, the recommendations below are designed to inform the RIATT-ESA strategic direction in this regard. The recommendations are based on a synthesis of the information in Table 1.

**Facilitating access to health services:** Evidence suggests that migrant adolescents generally, and those living with HIV and AIDS particularly, face myriad barriers to testing, treatment and care, many of which are created by the outcome of the stigma attached to HIV and AIDS, being a migrant, their gender, whether they are part of the LGBTQI+ community, sex workers or men who have sex with men. Some of these barriers are structural and are addressed in the section below on advocacy, but others could be addressed by adolescent migrant-health-specific programming without forgetting key populations. There is evidence from this review that the following programme approaches can improve health outcomes and reduce risk:

* Target ‘spaces of vulnerability’ where migrant children and youth are found such as border towns and urban gathering places such as markets. It is important that programmes working in these areas are contextually congruent with the lives young people live in these spaces, for example caring and confidential searching for young people who work to keep themselves invisible and meetings held in appropriate safe spaces. It is important to recognise that local NGOs working with migrants *can* identify such spaces and should, therefore, be included in such programming. For example, community facilitators from Save the Children South Africa and Mozambique work in such spaces already (Save 2020). Of course young people living in the many refugee settlements in East and Southern Africa face barriers particular to the wide range of cultural and physical characteristics of these spaces and these need to be explored by deep context analysis before programmes are implemented. Linked to this is the fact that research shows that a key barrier to access is the lack of transport. Mobile units that visit places where migrant youth are living and working are therefore important, though creativity is needed to make sure that the confidentiality of those living with HIV is protected.
* Developing strategies to overcome the significant language barriers by exploring the possibilities of using young interpreters, trained in the ethics of interpretation, in migrant-friendly health service spaces or mobile clinics.
* Use a holistic approach that includes testing for HIV, provision of pre-exposure prophylaxis (PrEP), information on sexual health, psychosocial support, and the development of support from the people young migrants live with, whether they are family, informal guardians or peer group.
* Train health staff on the rights of refugee and migrant youth to access health services to address xenophobia and the resultant discrimination.
* Take seriously the fear of lack of confidentiality that research suggests has a significant impact on health-seeking behaviour around SRH services, HIV prevention, testing and treatment. This is a particular issue in refugee settlement contexts because youth cannot choose to attend a clinic that is a distance away from their homes as young people are able to do in urban areas (Save the Children, 2020). Innovative programme strategies that provide private access to health services for youth are important. There is evidence that self-testing could be a useful tool in this regard as would helping young people find strategies for coping with the lack of privacy to take ARTs in crowded living spaces.
* Focus on creating male-friendly services that allow for privacy and confidentiality. Research suggests that young men, in contrast with young women, have no ‘excuse’ to attend a primary health clinic, so their attendance connotes HIV-positive status.
* Create integrated programmes where clinic nurses, community health workers, peer educators and social workers share tasks and work together.
* Focus on ethical programmes that improve access and welcome key populations such as adolescents from the LGBTQI+ community and sex workers to health services.

**Providing peer and adult support:** There is some robust evidence that interaction with and support from peers and supportive adults can play an important role in health-seeking behaviour, adherence to treatment and positive mental health outcomes for young people living with HIV and AIDS. Table 1 highlights such programmes which include:

* Creating opportunities for young people who live with HIV to talk about their lives with peers and supportive adults. This could be particularly effective in helping young people cope with the impact of stigma and discrimination.
* Using creative print and digital resources that provoke dialogue, problem-posing and problem-solving amongst young people and between them and family or caregivers.
* Working with empathetic and trained adult lay counsellors from refugee and migrant contexts can play an important role in giving practical and psychosocial support. These facilitators can also be used to enable the discussion groups described above. Facilitators need to be the same gender as the young people they are working with. These lay facilitators can also play the role of the ‘supportive adults’, which research suggests children and youth living with HIV need to cope with the mental health challenges related to stigma and discrimination as well as the impact of living with chronic illness.
* Engaging peer counsellors who also live with HIV and are migrants as well as creating peer support groups have some evidence of being effective programme strategies.
* Delivering economic strengthening programming has been shown to have an impact on mental health outcomes for youth living with HIV. The most effective of these seems to be what is described as ‘cash plus care’ where direct cash transfers are provided in a context of care from support groups (including peer support groups) and home visiting conducted by trained lay counsellors from the community, alongside care from health service staff. There is evidence of such programmes working in various migrant contexts (e.g. Aygün et al., 2021).

**Addressing stigma and discrimination in the community:** The above programming recommendations focus on young migrants themselves. There is also a need to develop interventions that seek to reduce stereotyping, prejudice and enacted discrimination in the communities where young migrants living with HIV work and live. Community leaders, religious leaders and groups, school teachers, and other influential stakeholders as well as the general community. Youth should also be included. Evidence-informed messaging targeting the stigma attached to HIV and AIDS needs to be developed. Alongside aiming for attitude and behaviour change around HIV and AIDS there should be specific messaging around migrants in order to change xenophobic attitudes and behaviour. Identifying existing organisations already doing such work in the countries in the region (e.g. Sonke Gender Justice[[2]](#footnote-2)) and finding ways to complement or work with them would be an important.

***Research***

This review makes it clear that more research into the lives of migrant adolescents living with HIV needs to be done.The focus of the research should be on gaps around understanding this population as well as in policy and programmatic interventions. This could include:

* A scientific mixed-method study of the impact of stigma on young migrant adolescents living with HIV and AIDs. The study needs to cover East and Southern Africa and all contexts in which young migrants are living and working such as inner-city areas, border towns, refugee camps and transit areas. Its focus should be socio-economic, cultural, and structural barriers to access to SRHR for this population. Such a research project would be ambitious but is necessary to inform advocacy and programming advice. In this regard RIATT-ESA, with its existing link to some tertiary institutions, is well placed to advocate for and seek out partnerships with universities in East and Southern Africa. Advocacy to donors such as the Welcome Trust and the Gates Foundation who fund such research would also be a useful contribution.
* The few existing interventions dealing with migrant youth *and* HIV and AIDS need rigorous evaluation on actual impact on targeted populations. The methodologies used for evaluations of such programmes has tended to use descriptive analysis rather than proving actual impact. For example, the HIV Knows no Borders, the SRHR programme of IOM and Save the Children East and Southern African Region final evaluation (IOM, 2020).
* Mapping of, firstly, organisations in the region working with young migrants and second, organisations working with young people around HIV and AIDS in geographical areas where migrant youth are found. Apart from understanding their reach and capacity, the research should focus on how migrant young people could be included in existing programming around HIV and AIDS and how issues of HIV stigma could be included in existing programmes working with young migrants.
* Mapping of civil society organisations already doing advocacy around challenges faced by migrants – some of these advocacy campaigns focus on health, for example in South Africa, Lawyers for Human Rights[[3]](#footnote-3), Section 27,[[4]](#footnote-4) and migrant health forums (ACMS, 2022a) and in the region, Sonke Gender Justice[[5]](#footnote-5), International Detention Coalition,[[6]](#footnote-6) and the Africa Refugee Network[[7]](#footnote-7) .
* Mapping of existing policy and policy processes in progress in the region at national levels, within IOM, UNHCR, United Nations Office for the Coordination of Humanitarian Affairs (OCHA) and funding partners such as Global Fund and PEPFAR. following this review the focus should be on how RIATT-ESA could lobby to include the migrant population in HIV strategic plans and finding funding proposals, for example. The advocacy should be done in partnership with civil society initiatives mentioned above.
* Research to explore SADC and EAC policy around strategies for managing treatment across borders: There is evidence in the review that there are strategies for managing adherence to treatment for migrating populations. Protocols that include provision for managing ART across borders are in process (Vearey, 2017). RIATT-ESA is well placed to lobby for policy progress and a focus on adolescent migrants.

***Advocacy***

Advocacy with legal and policy structures around the risks that ‘illegality’ creates for migrant adolescent living with HIV and consequently the risk of increased HIV prevalence in the regions would be important. Advocacy is also needed to simply recognise this ‘invisible’ group of migrants in legal and policy initiatives. The mapping research described above should precede any direct advocacy by RIATT-ESA to prevent duplication of effort.

* Existing advocacy has focussed on improving access for migrants in general (Vearey et al, 2017; ACMS, 2022). Where adolescent and child migrants have been the subjects of advocacy the focus has been on documentation and statelessness generally and in relation to access of all levels of education. For example, the Lawyers for Human Rights (LHR) and the Jesuit Refugee Institutes’ ‘This is home’ campaign in South Africa. RIATT-ESA should look to extend and influence such campaigns to include SRHR for migrant adolescents, especially for those young people living with HIV and AIDS and the impact of stigma on health-seeking in young migrant populations.
* Though there has been some civil society advocacy in East Africa, for example the recently formed Eastern Africa National Networks of AIDS and Health Service Organisations (EANNASO), advocacy in this region is generally less active than in Southern Africa. RIATT-ESA should explore supporting civil society advocacy in East Africa.
* RIATT-ESA has a long relationship with the Coalition for Children affected by AIDS (CCABA) that has a strong focus on donors. The coalition is an important potential advocacy partner. CCABA has placed little emphasis on migration issues but it has a prominent place in the advocacy environment around treatment and RIATT-ESA could work to place the issue of children affected by migration on their agenda.

# 14. Conclusion

This review has identified a serious gap in the research around migration and HIV and AIDS generally and stigma related to HIV status. There is almost no research on adolescent migrants who are living with HIV in East and Southern Africa. This limits both advocacy and programming for this particularly vulnerable population. RIATT-ESA with its links to regional and national NGOs and government institutions has an important potential role to play. Examining the themes and emerging recommendations identified in this narrative review will be an important first step for the Task Team to develop a strategy to address the myriad health needs and right’s barriers faced by young migrants.

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# Annex 1: Table of recommended programming gaps in HIV prevention among children and adolescents in sub Saharan Africa

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From: Sam-Agudu, N. A., Folayan, M. O., & Haire, B. G. (2020). Program implementation gaps and ethical issues

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# Annex 2: WHO 2019. Seventy-second World Health Assembly: Global action plan on promoting the health of refugees and migrants, 2019–2023 Annex 5: Priorities of the Global Action Plan.

**Priority 1. Promote the health of refugees and migrants through a mix of short-term and long-term public health interventions**

**Objectives**

30. To promote the physical and mental health of refugees and migrants by strengthening health care services, as appropriate and acceptable to country contexts and financial situations and in line with their national priorities and legal frameworks and competence, ensuring that essential components, such as vaccination of children and adults and the provision of health promotion, disease prevention, timely diagnosis and treatment, rehabilitation and palliative services for acute, chronic and infectious diseases, injuries, mental and behavioural disorders, and sexual and reproductive health care services for women, are addressed.

Options for the Secretariat in response to requests by Member States include:

(a) supporting enhanced coordination and collaboration in order to achieve the goal of universal health coverage and the principle of “leaving no one behind” and to develop emergency and humanitarian health responses based on humanitarian principles and the Sendai Framework for Disaster Risk Reduction 2015–2030 and building on WHO’s role as the lead agency for the Inter-Agency Standing Committee Global Health Cluster;

(b) supporting the preparation of public health responses to refugee and migrant arrivals, while continuing to meet the health needs of the existing migrant and refugee populations and of the receiving population, by ensuring that services for refugees and migrants are delivered through existing health systems to the largest possible extent;

(c) supporting: diagnostic capacity to detect, and responses to, communicable disease outbreaks, for instance through enhanced surveillance, strategic preparedness and administration of essential vaccines; and access to emergency health services and to medicines and medical products that are safe, effective, affordable, of high quality medicines and available to all – all these activities within comprehensive national health policies and strategies that are aligned with international legal responsibilities and commitments related to the International Health Regulations (2005), with attention to appropriate antibiotic use and prevention of antimicrobial resistance;

(d) supporting the development of national guidance, models and standards that are designed to underpin the prevention and management of communicable and noncommunicable diseases and mental health conditions: by focusing on risk groups, such as women and girls, unaccompanied and accompanied children, adolescents and youth, older persons, persons with disabilities, those with chronic illnesses, including tuberculosis and HIV infection, survivors of human trafficking, torture, trauma or violence, including sexual and other forms of gender-based violence; by conducting or strengthening areas including situation assessments, screening, diagnostics, treatment and prevention of gender-based violence; and by addressing risk factors such as tobacco and alcohol use and poor nutrition.

**Priority 2. Promote continuity and quality of essential health care, while developing, reinforcing and implementing occupational health and safety measures**

**Objectives**

31. To improve the quality, acceptability, availability and accessibility of health care services, for instance by overcoming physical, financial, information, linguistic and other cultural barriers, with particular attention to services for chronic conditions and mental health, which are often inadequately addressed or followed up during the migration and displacement process, and by working to prevent occupational and work-related diseases and injuries among refugee and migrant workers and their families by improving the coverage, accessibility and quality of occupational and primary health care services and social protection systems, in accordance with Member States’ national contexts, priorities and legal frameworks.1

Options for the Secretariat in response to requests by Member States include:

(a) supporting the development of quality essential health care services, on a continuing and long-term basis, that are grounded in functioning processes of referral to appropriate secondary and tertiary care services and service-delivery networks for refugees and migrants who require health care services, including access to continuing social and psychological care provision as needed;

(b) supporting cross-border dialogue and collaboration in order to improve the continuity and quality of care of refugees and migrants, in collaboration with the International Labour Organization, the International Organization for Migration, the Office of the United Nations High Commissioner for Refugees and other relevant partners, and to create uniform protocols for assuring the continuity of care and tracking of patients, thereby reducing loss to follow-up due to the movement of people;

(c) supporting the development of national action plans and policies, and strengthening institutional capacities for promoting the health of refugee and migrant workers and their families at international forums and in instruments for collaboration and mechanisms of social protection, including the development of tools, policy options, indicators and information materials in line with the provisions of resolution WHA60.26 (2007) on Worker’s health: global action plan.

Promotion of the improvement of working conditions is one of the functions of the Organization under Article 2(i) of its Constitution. In resolution WHA60.26 (2007) on Workers’ health: global plan of action the Health Assembly urged Member States to devise national policies and plans for implementation of the global plan of action on workers’ health and to work towards full coverage of all workers, including inter alia migrant and subcontracted workers, with essential interventions and basic occupational health services for primary prevention of occupational and work-related diseases and injuries.

**Priority 3. Advocate the mainstreaming of refugee and migrant health into global, regional and country agendas and the promotion of: refugee-sensitive and migrant sensitive health policies and legal and social protection; the health and well-being of refugee and migrant women, children and adolescents; gender equality and empowerment of refugee and migrant women and girls; and partnerships and intersectoral, intercountry and interagency coordination and collaboration mechanisms**

**Objectives**

32. To help to meet the health needs of refugees and migrants by preventing and mitigating the impact of gender-based inequality in health and access to health services throughout the migration and displacement process by advocating refugees’ and migrants’ right to the highest attainable standard of physical and mental health, in accordance with international human rights obligations and corresponding relevant international and regional instruments, and by working to lower or remove physical, financial, information and discrimination barriers to accessing health care services in synergy with WHO’s partners, including non-State actors.

Options for the Secretariat in response to requests by Member States include:

(a) supporting the development of strategies, plans and actions designed to strengthen national capacity to meet refugee and migrant health needs and rights, by means that include multisectoral approaches with key stakeholders and facilitation of technical assistance, strategic partnerships and communication;

(b) supporting the development and implementation of evidence-based public health approaches and the building of health care capacity for service provision, affordable and non- discriminatory access and reduced communication barriers, and training health care providers in culturally-sensitive service delivery and provisions for persons with disabilities;

(c) supporting ways of ensuring the provision of health care services, aligned with national legislation, including in the areas of sexual and reproductive health and reproductive rights for women, maternal and child health care, prenatal and postnatal care, family planning and provision of access for children in any situation to specific and specialized care and psychological support;

(d) supporting the development of recommendations and tools for the governance, management and delivery of health care services that address epidemiological factors, cultural and linguistic barriers, and legal, administrative and financial impediments to access, with the involvement of refugee and migrant health workers;

(e) supporting the identification and strengthening of health care skills within refugee and migrant populations through training and certification, in keeping with national legislation, standards and evaluation;

(f) supporting existing and as appropriate new global refugee and migration coordination arrangements with Member States, the United Nations, the International Labour Organization, the International Organization for Migration, the Office of the United Nations High Commissioner for Refugees, United Nations Network on Migration, other entities within the United Nations system, and organizations outside the United Nations system, including the International Red Cross and Red Crescent Movement, as well as other humanitarian and development actors, civil society and faith-based organizations;

(g) providing support for the strengthening of resource mobilization for flexible and multi-year funding to enable countries and communities to respond to the immediate, medium-term and long term health needs of refugees and migrants – in concert with actions to improve the health and well-being of receiving populations and communities and including the health needs of refugees and migrants in existing and new regional and global funding mechanisms;

(h) providing support for establishing or building on existing coordination mechanisms among countries that encourage and allow for exchange of information and implementation of joint actions that help to ensure the continuity of care;

(i) providing support for the development of intercountry surveillance tools and mechanisms for the exchange of data on the health of refugees and migrants and exchange of information on steps taken and methods used in collecting and analysing data disaggregated by age and gender to inform gender-responsive programmes and services;

(j) providing support to Member States for promoting optimal health, opportunities for improving health and achieving good health outcomes, especially for young people and women;

(k) providing support to strengthening the capacity and role of health providers in gender appropriate identification, management and referral of sexual and other forms of gender based violence, such as gender-based discrimination, trafficking, torture and gender-based abuse, as well as in enhanced protection against and prevention of sexual violence and female genital mutilation and in the provision of care and support for the prevention and treatment of sexually transmitted infections and of acute malnutrition;

(l) providing support to the implementation of the 10 recommendations of the United Nations’ High-Level Commission on Health Employment and Economic Growth, one of which explicitly calls for tackling gender concerns in the health reform process and the health labour market while assuring gender parity in the distribution of health workforces and the elimination of gender-based discrimination within the health workforce.

**Priority 4. Enhance capacity to tackle the social determinants of health and to accelerate progress towards achieving the Sustainable Development Goals, including universal health coverage**

**Objectives**

33. To ensure that the social determinants of refugees’ and migrants’ health are addressed through joint, coherent multisectoral actions in all public health policy responses based on all relevant Sustainable Development Goals, especially Goal 3 (Ensure healthy lives and promote well-being for all at all ages) and Goal 10 (Reduce inequality within and among countries), target 10.7 (Facilitate orderly, safe, and responsible migration and mobility of people, including through implementation of planned and well-managed migration policies).

Options for the Secretariat in response to requests by Member States include:

(a) supporting, in collaboration with the International Labour Organization, the International Organization for Migration, the Office of the United Nations High Commissioner for Refugees and other relevant partners, the implementation of guidance and assessment tools and the elaboration of country-specific fact sheets and standards in order to highlight and respond to social and economic factors relevant to refugee and migrant health, in the context of universal health coverage and the Sustainable Development Goals and based on partnerships and best practices;

(b) supporting the identification of relevant sectors and stakeholders that contribute to tackling social determinants of refugee and migrant health and to identifying specific areas for dialogue and joint actions on achieving universal health coverage;

(c) supporting the training of all personnel working with refugees and migrants on the social determinants of health and necessary policy responses and professional training for health workers, and ensuring that health planners and health care workers are offered support and knowledge-sharing in order to implement appropriate refugee- and migrant-sensitive health interventions that also provide affordable and equitable access to all people;

(d) strengthening the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, and reporting thereon.

**Priority 5. Strengthen health monitoring and health information systems Objectives**

34. To ensure that information and disaggregated data at global, regional and country levels are generated and that adequate, standardized, comparable records on the health of refugees and migrants are available to support policy-makers and decision-makers to develop more evidence-based policies, plans and interventions.

Options for the Secretariat in response to requests by Member States include:

(a) supporting work with Member States to develop and implement surveillance of the health of refugees and migrants as part of overall national health surveillance, and issue progress reports that include health-related data on refugees and migrants, disease-risk distribution and risk reduction, in the context of the Sustainable Development Goals, in collaboration and coordination with the International Labour Organization, the International Organization for Migration, the Office of the United Nations High Commissioner for Refugees;

(b) supporting work with Member States to develop, at country and local levels, disaggregated data on the health of refugees and migrants, including health-seeking behaviour and access to and the use of health care services;

(c) supporting the development, subject to national contexts and legal frameworks, of intercountry approaches to the generation of data and databases on health risks in countries of origin, transit and destination that can be shared, as well as portable health records and health cards, including the possibility of health cards for population groups in movement, thereby facilitating continuity of care.

**Priority 6. Support measures to improve evidence-based health communication and to counter misperceptions about migrant and refugee health**

**Objectives**

35. To provide accurate information and dispel fears and misperceptions among refugee, migrant and host populations about the health impacts of migration and displacement on refugee and migrant populations and on the health of local communities and health systems.

Options for the Secretariat in response to requests by Member States include:

(a) supporting the provision of appropriate, factual, timely, culturally-sensitive, user-friendly information on the human rights and health needs of refugees and migrants in order to counter exclusionary acts, such as stigmatization and discrimination;

(b) supporting advocacy, mass media and public education within the health sector to build support and promote wide participation among government, the public, and other stakeholders;

(c) supporting the preparation of a global report on the status of refugee and migrant health, in collaboration with the International Labour Organization, the International Organization for Migration, the Office of the United Nations High Commissioner for Refugees;

(d) supporting the organization, with the International Labour Organization, the International Organization for Migration, the Office of the United Nations High Commissioner for Refugees and other key stakeholders, of a global conference on refugee and migrant health, including the role of the global action plan, which would complement and not duplicate existing forums.

1. A ‘Whole of government approach’ includes integrated legal, policy and public service change to work towards common goals within national governments. A ‘whole of society’ is one that engages all stakeholders such as individuals, families, communities, NGOs, religious institutions, academia and the media (Ortenzi et al. 2022). [↑](#footnote-ref-1)
2. <https://genderjustice.org.za/> [↑](#footnote-ref-2)
3. https://www.lhr.org.za/lhr-programmes/refugee-and-migrant-rights-programme/ [↑](#footnote-ref-3)
4. <https://section27.org.za/category/right-to-access-healthcare/migrant-health/> [↑](#footnote-ref-4)
5. <https://genderjustice.org.za/project/policy-development-advocacy/migration-gender-and-health/> [↑](#footnote-ref-5)
6. <https://idcoalition.org/> [↑](#footnote-ref-6)
7. <https://www.globalrefugeenetwork.org/africa-region> [↑](#footnote-ref-7)