

Traumatic grief in young people in Sub-Saharan Africa: a scoping review

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Aim: To identify relevant and pertinent themes and interventions within the literature relating to childhood traumatic grief, in order to provide a sound background of evidence for further research and service development.

Background: Childhood traumatic grief is caused when a significant person in a child's life dies under circumstances that they perceive to be traumatic. This can leave a child unable to return to the same level of physical and emotional functioning that he or she had prior to the death occurring. In Sub-Saharan Africa, there is an increased risk for childhood traumatic grief due to a high prevalence of orphanhood, environmental stressors, stigma, and abuse. This can have detrimental effects upon mental health.

Methods: The review followed the York methodology: identifying the purpose and agreeing on the strategy beforehand; identifying relevant sources/studies; selecting the studies; charting the data; and collating, summarizing, and reporting results.

Results and discussion: Interventions identified to prevent and/or manage traumatic grief included narrative exposure therapy, psychotherapy, mentoring, peer-group support, psycho-social support, a grief and loss therapy session, and memory boxes. Mental health remains neglected within service and policy development as well as in global health spending. The average amount expended on mental health services per person per year in low-income countries is less than \$0.25. Only 36% of people in low income countries are covered by a mental health policy, compared with 92% in high income countries.

Limitations: The sixth stage of the York methodology was omitted. Only papers written in English were included in the review.

Conclusion: Childhood traumatic grief in young people is an important issue within Sub-Saharan Africa and has relevance to the global mental health agenda.

Implications for nursing and health policy: With the HIV/AIDS pandemic continuing to threaten and the number of orphans estimated to rise, a number of recommendations developed from the literature are suggested.

Keywords: childhood traumatic grief, HIV/AIDS, interventions, mental health, orphans, scoping review, Sub-Saharan Africa, young people

Aim, rationale, and background

We aimed to identify relevant and pertinent themes within the literature relating to childhood traumatic grief (CTG) in order to provide a background of evidence for further research and service development. Both authors have been collaborating with colleagues in Sub-Saharan Africa (SSA) for a number of years and have come to understand some of the issues relating to CTG. This review encompasses how populations within SSA view and experience death, orphanhood, and traumatic grief.

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CTG is relatively underresearched in spite of its importance globally, and specifically to SSA.¹ It has been estimated that 14 million children have been singly or doubly orphaned in SSA due to human immunodeficiency virus (HIV) acquired immunodeficiency syndrome (AIDS), malaria, and tuberculosis-related deaths.² Furthermore, Thupayagale-Tshweneagae and Mokomane³ argue that the needs of adolescents orphaned by AIDS are seldom recognized or adequately addressed in policy and programs. According to Cluver and Gardner⁴ and Thupayagale-Tshweneagae et al,⁵ orphanhood increases the probability of a child developing posttraumatic stress disorder and depression. Despite these risk factors, mental health services remain underdeveloped and have been criticized for being unable to meet the needs of communities, particularly as mental health policies generally are limited.⁶ This review is particularly relevant for service providers, researchers, and stakeholders working in the field of child development, child and adolescent mental health, and global mental health.

We present key definitions, the methods used in the scoping review, and the themes that emerged from the literature. The themes are: traumatic grief in context; the significance to SSA of CTG; the influence of orphanhood upon mental health; community attitudes toward HIV/AIDS and orphanhood; cultural influences upon the expression of grief; diagnosing and managing CTG and its comorbidities; service and policy development in SSA; and formal and informal service provisions.

Key definitions

Traumatic grief

The terms “traumatic grief”, “complicated grief”, and “prolonged grief” are used interchangeably within Western literature; within this review, the term “traumatic grief” was chosen. CTG occurs when a significant person in a child’s life dies under circumstances that the child perceives to be traumatic.⁷

Young people

A young person was considered to be between the ages of 0–26 years.

Sub-Saharan Africa

Sub-Saharan Africa includes countries in western, eastern, and southern Africa, as defined by the United Nations.⁸

Formal sector

In this review, the formal sector included any statutory health service funded by the Ministry of Health.

Informal sector

In this review, the informal sector included any service that provides health and/or social care that is not funded through a statutory organization.

Methodology and methods

A scoping review was chosen, as it is primarily a way of summarizing a range of evidence in order to convey the breadth and depth of a field; it allows gaps within the literature to be identified and suggests future areas of research.⁹ This can increase awareness of a particular topic, which is a key issue for CTG. Importantly, scoping reviews are not intended to assess the quality of the existing literature although we comment briefly on this. We did not exclude studies on grounds of quality, not least because it would have eliminated the majority of studies but also because, as Sandelowski¹⁰ points out, there are wide variations in concepts of “the good” and in what constitutes “quality criteria”. A systematic scoping process employing the first five stages of the York methodology was used.¹¹ This included: identifying the purpose of the review and agreeing on the strategy beforehand; identifying relevant sources/studies; selecting the studies; charting the data; and finally, collating, summarizing, and reporting results. Both authors were involved in all stages, including independent abstract review, full article review, and data charting decisions. We had made provision to call upon colleagues willing to arbitrate where disagreement occurred, but this was not necessary. Although a sixth stage in the York methodology involves consulting with stakeholders, this stage was omitted even though some would argue that doing so might compromise methodological rigor.¹²

Search terms

The terms “grief”, “bereavement”, and “mourn” were chosen to relate to the traumatic grief aspect of the review. The term “traumatic” was not included because it did not yield any results. The terms “child”, “adolescent”, “young people”, and “youth” were included to represent the population group. The term “Africa” was chosen to include all studies within African countries. “Sub-Saharan Africa” was not used as it did not yield any results, but specific databases allowed synonyms of “Africa” to be included. The term “intervention” was not incorporated as it did not yield any results.

Sources searched

A total of six databases and eight global networks were searched, including: Allied and Complementary Medicine

(AMED), Applied Social Scientists Index and Abstracts (ASSIA), the Cumulative Index to Nursing and Allied Health Literature (CINAHL), the Excerpta Medica dataBASE (EMBASE), the Medical Literature, Analysis and Retrieval System Online (MEDLINE), PsycINFO, HOPEHIV, Orphans and Vulnerable Children (OVC), the Population Council, Save the Children, the Tropical Health Education Trust (THET), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Children's Fund (UNICEF), and the World Health Organization (WHO) (see Table 1).

Qualitative or quantitative empirical studies from any time period (up until March 2013) were included, as well as unpublished documents ("grey literature"), book chapters, reports, conference abstracts, theses, and dissertations, as this enabled all data relating to the topic to be identified and bias to be minimized. References and bibliographies of all included studies were searched for key terms in order to identify other studies that could not be accessed through databases. Studies presented in a language other than English were excluded due to time and financial constraints of translating papers, although none were identified.

Results and discussion

Childhood traumatic grief in context

CTG is a form of psychological trauma that differs from a typical grief response. It occurs when a significant person in a child's life dies under circumstances that the child perceives to be traumatic.⁷ This initiates a grieving process as well as a trauma response.¹³ Prigerson¹⁴ defines traumatic grief as

an inability to return to the level of physical and emotional functioning that one had prior to a death. Children may also experience secondary loss, such as changes to their lifestyle.¹⁵ While the grieving process is often misunderstood in terms of the child's level of understanding, Corr and Balk¹⁵ argued that very young children also will feel loss, even if they do not know the reason for it. Therefore, as children react to death, grief can manifest psychologically, physically, socially, or spiritually over different periods of time.

Beveridge¹⁶ reported that survival instincts are utilized during traumatic experiences, resulting in a psychophysiological response. Following a traumatic event, children may present with symptoms concurrent with Type I or Type II trauma.¹⁷ Type I trauma includes symptoms of denial, numbing, dissociation, and anger and is more prominent after a single unanticipated event has occurred. Type II trauma includes symptoms of detailed recall and misperceptions of an event that are often caused by recurrent exposure to traumatic circumstances, suggesting that children are able to anticipate a trauma and adapt. Terr¹⁷ also suggests that some children present with mixed type trauma (symptoms of Type I and Type II trauma), particularly if the trauma has involved an unexpected death. Hence, bereaved children may show symptoms concurrent with Type I trauma initially and over time develop symptoms of Type II trauma.

Traumatic grief is often associated with posttraumatic stress disorder, which is a term used to describe the reactions that manifest following a traumatic event that induces clinically significant distress or impairment. This may mani-

Table 1 Sources searched for formal and informal service provision

	Source	Initial search	Accepted	Excluded at a later date	Forward and reverse citation tracking	Included
Database	AMED	8	1	1	0	0
	ASSIA	7	0	0	0	0
	CINAHL	0	0	0	0	0
	EMBASE	70	3	2	0	1
	MEDLINE	63	4	3	2	2
	PsycINFO	150	4	3	0	1
Global network	HOPEHIV	14	0	0	0	0
	OVC	5	1	1	0	0
	Population Council	39	11	7	0	4
	Save the Children	22	0	0	0	0
	THET	17	1	1	0	0
	UNAIDS	357	0	0	0	0
	UNICEF	24	0	0	0	0
	WHO	6	0	0	0	0
	Further search	—	—	—	3	3
Total	14	782	25	18	5	11

Abbreviations: AMED, Allied and Complementary Medicine Database; ASSIA, Applied Social Scientists Index and Abstracts; CINAHL, Cumulative Index to Nursing and Allied Health Literature; EMBASE, Excerpta Medica dataBASE; MEDLINE, Medical Literature, Analysis and Retrieval System Online; OVC, Orphans and Vulnerable Children; THET, Tropical Health Education Trust; UNAIDS, Joint United Nations Programme on HIV/AIDS; UNICEF, United Nations Children's Fund; WHO, World Health Organization.

fest in children as repetitive reenactment of the trauma, nightmares, and disorganized or agitated behavior.¹⁸ Posttraumatic stress disorder is categorized as a mental disorder but can develop in people without prior mental health problems. Alternatively, these disorders can exist comorbidly with anxiety, attention deficit hyperactivity disorder, conduct disorder, and substance misuse, although these are often misdiagnosed as personality disorder, dissociative disorder, or phobic disorder.¹⁷

Traumatic grief has also been associated with psychosis – a psychiatric diagnosis that typically manifests within adulthood.¹⁹ Ross²⁰ developed the dissociation model, which suggests adults who have experienced a childhood trauma may present with symptoms similar to schizophrenia, although they are more likely to exhibit positive symptoms (hallucinations, delusional beliefs, thought disorders) than negative symptoms (poverty of speech, loss of motivation, blunted emotional affect). This implies that the traumatic event is a key factor of psychosis and that a diagnosis of dissociative psychosis as opposed to schizophrenia may be more appropriate. However, as traumatic grief, posttraumatic stress disorder and psychosis are Western psychiatric definitions, the transferability of these concepts to other cultures and contexts is questionable. They also provide only one explanation of the causal relationship between childhood trauma and mental health problems.²¹ Overall, CTG is a relatively new concept within the literature, and further work is still developing. The nature of trauma research has also been questioned on ethical grounds, due to difficulties gaining informed consent from traumatized participants and the potential for generating further distress.²²

The significance of childhood traumatic grief in Sub-Saharan Africa

In SSA in 2009, an estimated 14.8 million children (aged 0–17 years) had been orphaned due to AIDS,² with this figure predicted to rise in future years. The death of a parent or parental figure is one of the most stressful events a child can experience, and AIDS-related deaths are associated with traumatic grief.²³ If this occurs, there are pre-risk factors (previous life stressors), peri-risk factors (feeling loss of control), and post-risk factors (poor level of social support) that make a child more likely to experience mental health problems.²⁴

McDermott²⁵ indicated that there is a culture of silence regarding death and dying in SSA in the days immediately following the death of a parent. This results in young people being discouraged from mourning the death of their parents

externally. Wood et al²⁶ reported similar findings within SSA. This can leave young people physically and emotionally unprepared for death.²⁷ Van der Heijden and Swartz²⁸ discussed an intervention that broke the cultural silence and allowed young people to remember and grieve. This intervention was conducted by researchers from SSA, despite using an approach nonconcordant with cultural practices. This recognizes the importance of ensuring that local researchers are involved in service development to make sure that interventions are culturally sensitive, especially as expressions of grief can be different within Western countries²⁹ although, as Van der Heijden and Swartz²⁸ acknowledged, the social constructs of grief are yet to be explored.

Nevertheless, even when many risk factors are present, it is evident that some children remain resilient. Masten³⁰ suggested that disadvantaged children are more likely to be resilient to bereavement, particularly as they are likely to have experienced trauma historically.¹⁷ Although risk factors and resilience across different cultures and contexts have been widely researched, and while ethnographic data suggests that children in SSA and children residing in high-income countries have similar prevalence rates of mental health problems,³¹ research into the prevalence of CTG remains limited, particularly within low-income countries, making it difficult to assess the extent of this phenomenon within populations in SSA.

The influence of orphanhood upon mental health

The relationship between orphanhood and mental health can be categorized into contributing risk factors and presentation of mental distress. Gilborn et al³² identified contributing risk factors as illness within the family, limited access to health-care, and stigma and social isolation. This is in addition to molestation and rape, which were associated with depression and anxiety. Another risk factor reported within the findings involved community and sexually based violence.³² Specifically in South Africa, there is an exceptionally high rate of violent death. Despite these traumatic experiences, young people who have experienced many stressors were more likely to say they were able to cope with difficulties, compared with people who had experienced the least trauma. The orphan crisis can exacerbate problems within resource-poor communities, as 40% of HIV positive parents are fostering at least one child who is not their own.³³ This could portend pretraumatic risk factors. Gilborn et al³² also reported the risks associated with being an orphan of AIDS. This is because AIDS orphans have a higher propensity for negative mental health factors

compared with those orphaned from other causes.³⁴ Risk factors for the development of mental health problems have been widely researched within the literature, although risk factors and resilience are individual experiences and do not necessarily apply to whole populations.

Orphaned young people will often present with symptoms of anxiety, including feeling worried and overwhelmed. Mental distress might also present through anger, fear, guilt, and somatizations (physical symptoms from psychological cause). This includes headaches, nightmares, fatigue, and poor concentration.³⁵ Anxiety can also tend to manifest with an external focus, particularly upon social and economic contexts. By comparison, other young people will internalize anxiety, potentially leading to depression and lowered self-esteem. Conflicting evidence suggests AIDS orphans are more likely to internalize problems.³⁶ Hopelessness is also reported in some young people, although others are able to display some signs of optimism and report feeling happier.^{28,32} Within the intervention studies, older children tended to report greater confidence and self-esteem despite greater exposure to traumatic events. There does, however, appear to be a sex difference, with females reporting greater exposure to death, traumatic events, and daily stress compared with males. Consequently, females were more likely to show higher levels of psychosocial distress and lower psychosocial wellbeing than males.

Community attitudes toward HIV/AIDS and orphanhood in SSA

Denis and Makiwane³⁷ found that adults need to have a trusting relationship with members of a community before disclosing HIV status. Gilborn et al³² acknowledged that the majority of parents stated they have not talked directly to their children about HIV/AIDS in spite of older children viewing disclosure positively. One reason for reluctance to disclose HIV status is stigma, something directed toward women more than men. Even though HIV/AIDS is highly prevalent across SSA, it remains a taboo subject. Stigma is associated with negative mental health.³⁸ However, two interventions report a reduction in stigmatizing behavior through education.^{39,40}

Kayombo et al³⁵ found that young people who were orphaned experienced stigma from friends, family, and their community. Some children were also rejected by their relatives after the death of their parents for fear they might infect their own children. This could predispose to young people becoming homeless after they are orphaned. Idoniboye⁴¹ suggested that behavioral problems associated

with orphanhood can make it difficult for young people to be placed into a family, but conflicting research indicates that many standby guardians care for a child who is not their own.³³ Whereas some young people do not receive the support they need from adults and peers in order to deal with their traumatic stressors, one study found that 88% said they could ask an adult for help if they needed it and 90% had enjoyed spending time with their peers in the past month.³² Feeling supported by family, peers, and the wider community is a protective factor that reduces the probability of developing traumatic grief reactions or mental health problems.⁴² Attitudes about HIV disclosure and orphanhood need to be addressed, as stigma and bullying increases the likelihood of a young person developing a psychological disorder.⁴³ While acknowledging these studies, the literature pertaining to public perceptions of HIV/AIDS and orphanhood within SSA remains limited.

Cultural influences upon the expression of grief in SSA

One risk factor for traumatic grief involves the understanding and perception of death and dying, which differs among cultures and contexts.⁴⁴ Gilborn et al³³ suggested that for parents diagnosed with AIDS, the greatest concern is to ensure that their children have access to education, food, and clothing; emotional suffering was the least concerning factor expressed. This emphasizes how material needs are prioritized within SSA and aligns with Opperman,⁴⁵ who suggested that the risk for developing traumatic grief was elevated when material wealth was threatened. An intervention involving traditional healers, who would comfort orphans by telling them stories about other orphans who had managed to cope and gain achievement in life, allowed children space to remember and grieve. Although emotionally challenging, it was positive in that it encouraged the children to build a more optimistic attitude toward life as orphans.²⁸ It is acknowledged, however, that the social constructs of grief in the context of SSA are yet to be explored.

Diagnosing and managing childhood traumatic grief and comorbidities

Prigerson et al⁴⁶ make the observation that traumatic grief is not established as a clinical diagnosis within the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition. Melhem et al⁴⁷ suggest that this reflects the interlinked relationship between traumatic grief and the two main psychiatric sequelae, posttraumatic stress disorder and depression, despite evidence to suggest they are independent from each

other. As a result, guidelines on the management of traumatic grief are less clear within the literature, and its absence from the manual makes it difficult for health workers to identify and manage the issue. It is of interest to note that amongst the changes in the most recent update of the manual (the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, published in May 2013), a new diagnosis of “persistent complex bereavement related disorder” is proposed, together with a new diagnostic category of “trauma and stressor related disorders”.⁴⁸ These changes are not without their critics.

The Mental Health Gap Action Programme, launched by the World Health Organization in 2008, provides a diagnostic and treatment algorithm for a range of mental health problems in nonspecialist primary care settings; in one subsection of the manual, health workers are advised to ask if a person has been exposed to extreme stressors such as bereavement. The recommended guidelines are to support culturally appropriate mourning; mobilize social networks; provide psychological first aid in cases of extreme distress; and address physical needs. Additionally, health workers are encouraged to identify any other mental health problems and follow the recommended treatment plan within that subsection.³⁸ However, the Mental Health Gap Action Programme does not include specific information relating to the identification and treatment of traumatic grief in young people. This is an important omission because, although the majority of children who experience a traumatic event will demonstrate a typical trauma reaction, a minority of children will need psychological or pharmacological intervention.⁴⁹

According to Dyregrov,⁵⁰ who compared the processes in Europe and the United States for dealing with critical incident stress, debriefing should be the first intervention offered to a child after a traumatic event: this can be applied within different cultures and contexts and utilizes group therapy and leadership techniques. Following this, bereavement-focused cognitive-behavioral therapy can be implemented. In addition, general observations should be carried out for symptoms of traumatic grief, acute stress reaction, and posttraumatic stress disorder, although acute stress reaction and posttraumatic stress disorder should be managed before traumatic grief, but without avoiding discussion of the grief.¹⁹ If acute stress reaction or posttraumatic stress disorder is suspected, assessment tools can be utilized to make a formal diagnosis by measuring reactions to trauma⁵¹ and the severity of posttraumatic stress disorder symptoms.⁵² Interventions implemented to manage posttraumatic stress disorder include trauma-focused cognitive-behavioral

therapy and eye movement desensitization and reprocessing. Cognitive-behavioral therapy is an intervention that encourages an individual to challenge their thoughts, feelings, and behaviors over a set period of time.⁵³ Eye movement desensitization and reprocessing uses bilateral stimulation, mostly in the form of eye movements, to allow reprocessing of traumatic memories.⁵⁴ This is achieved by focusing upon specific images, negative sensations, and associated cognitions, and desensitizing these memories by introducing positive sensations and cognitions. These interventions must be appropriate in terms of age and developmental understanding and incorporate sensitive language to explain about death and grief.

Service and policy development in Sub-Saharan Africa

Globally, mental health remains neglected within service development,^{55,56} policy development,⁵⁷ and global health spending.⁵⁸ In terms of policy and service development, the average money spent on mental health services in low-income countries is less than \$0.25 per capita per year. This compares to global spending within mental health services that equates to \$1.63 per person per year and mental health expenditure per capita that is more than 200 times greater in high-income countries than in low-income countries.⁵⁵ In addition, only 36% of people residing in low-income countries are covered by a mental health policy, compared with 92% of people residing in high-income countries.⁵⁹ However, mental health is gaining status and credibility, with several low-income and middle-income countries now beginning to introduce policies and service provisions,⁶⁰ albeit that the budget allocated to these provisions continues to remain disproportionate to the scale of the problem.⁵⁸

Health worker shortages are a huge problem in SSA and can be attributed to a number of factors. Firstly, the existing work force is unable to work effectively, as 41% are estimated to be HIV positive.⁶¹ This is exacerbated by resource limitations.⁶² Secondly, many countries lack the financial means to train staff.⁶³ Maj⁶⁴ suggested there is a need for psychiatrists to be trained to a higher standard, to cover a wider area of the population and to adhere to psychosocial interventions. Thirdly, it is common practice for healthcare professionals to work in affluent geographical areas where health needs are not as severe.⁶³ Professional migration is often caused by push factors, including war, civil unrest, and economic deterioration, as well as pull factors, including salary, job satisfaction, and workplace environment.^{65,66} This has resulted in many professionals from SSA emigrating

to more affluent countries, adding to the burden of worker shortages in their own country.

Formal and informal service provisions and interventions

Specialist services

Schaal et al⁶⁷ evaluated the efficacy of narrative exposure therapy compared to interpersonal psychotherapy in a pilot randomized controlled trial with two groups of Rwandan genocide orphans. The outcomes measured included post-traumatic stress disorder and depressive symptomology. Narrative exposure therapy is a form of trauma-focused cognitive-behavioral therapy that is aimed at integrating emotional, cognitive, physiological, and sensory memories within the context of traumatic experiences. Interpersonal psychotherapy uses a series of techniques to manage post-traumatic stress disorder, depression, and interpersonal relationships and find ways of coping with these problems by helping individuals to gain insight into their difficulties. Participants in the narrative exposure therapy group received three individual therapy sessions and one grief session, while interpersonal psychotherapy participants also received four therapy sessions. At the 3-month posttest, no significant differences were found between any of the outcome measures, but at the 6-month follow up the proportion of participants in the narrative exposure therapy group who still had a diagnosis of posttraumatic stress disorder had decreased to 25%, compared with 71% of participants in the interpersonal psychotherapy group who still had a diagnosis of post-traumatic stress disorder ($P < 0.05$). This study showed that narrative exposure therapy constituted an effective treatment for traumatized survivors with symptoms of posttraumatic stress disorder and depression and was more effective than interpersonal psychotherapy in reducing the severity of symptoms.

An intervention delivered at a specialist level was reported by McDermott,²⁵ who evaluated the use of integrative long-term psychotherapy with an eleven-year-old girl from South Africa who had been abused and singly orphaned. This intervention was found to have a positive effect upon the child's mental health, as evidenced by a reduction in hypervigilance, an improvement in healthy play, and the development and maintenance of relationships with peers. In this study the intervention was delivered by a clinical psychologist, and in the study by Schaal et al⁶⁷ both narrative exposure therapy and interpersonal psychotherapy were conducted by health professionals with a psychology background. While this is positive in ensuring that interventions are appropriate and

evidenced based, it could also result in a lack of transferability to other contexts where health professionals are unavailable to implement these interventions. In both studies, interventions were confined to small participant numbers of 1–26 people. Before the results can be generalized, there is a need for larger-scale studies to be conducted in order to ascertain the effectiveness of the interventions on the wider population.

Non-specialist services

We found eight interventions that were delivered at a non-specialist service level by nonhealthcare professionals. All of these interventions aimed to provide psychosocial support to orphans and vulnerable youths. Apicella et al⁴⁰ evaluated a US-funded intervention program entitled “Reaching HIV/AIDS Affected People with Integrated Development Support (RAPIDS)”, which incorporated psychosocial support for young people aged 10–24 years in Zambia. The program leader delivered this intervention, which aimed to provide emotional and spiritual counseling to vulnerable young people and chronically ill people. An improvement in school attendance, skills for work, and material needs and a decrease in stigmatizing behaviors was observed following the intervention.

Chitiyo et al⁶⁸ evaluated the effectiveness of psychosocial support in improving school outcomes of children with special needs aged 10–14 years in Zimbabwe. Conducted by teachers at the school, this intervention included grief and bereavement counseling, ball games, and a buddy system and was considered to improve confidence, self-esteem, motivation, class work, and school attendance. Similarly, Gilborn et al³² compared the use of three intervention groups and a control group in orphans and vulnerable youths aged 14–20 years, also in Zimbabwe. These groups comprised: 1) youth exposed to community psychosocial support only; 2) youth exposed only to the Salvation Army Masiye Camp, a residential psychosocial support program; and 3) youth who attended Masiye Camp and went on to become a youth counselor or leader. The comparison group received none of the above. The community psychosocial support involved training teachers to recognize and respond to psychosocial distress among students; Kids' Clubs that met weekly for group recreation, socialization, and games; and group and individual counseling and problem solving. The Masiye Camp was a 10-day residential, faith-based program aimed at improving the psychosocial well-being of participants. The leader group consists of youth who attended Masiye Camp as campers and then became either Masiye Camp counselors

or community psychosocial-support youth leaders. Males who participated in the community psychosocial program were more likely than their comparison-group peers to report self-confidence (85% vs 77%, adjusted odds ratio [AOR] =1.85, 95% confidence interval [CI] =1.03–3.33; $P<0.05$). However, no other associations were identified between the community psychosocial support group and the comparison group. Males who attended Masiye Camp were significantly more likely than comparison-group males to report feeling confident in the last month (87% vs 77%, AOR =2.27, 95% CI =1.14–4.45; $P<0.05$). For males, the leadership experience was strongly associated with self-confidence (96% vs 77%, AOR =6.83, 95% CI =1.49–31.34, $P<0.05$).

Nelson et al³⁹ assessed the feasibility of training youth caregivers to provide HIV education and psychosocial support to orphans and vulnerable children aged 11–15 years in South African schools through counseling. This was found to improve the psychosocial wellbeing of participants through increased confidence and an improvement in school work.

Van der Heijden and Swartz²⁸ evaluated a Vhutshilo intervention that consisted of 13 education sessions, one being a grief and loss session for young people aged 10–13 years living in resource-poor communities in South Africa. The aim of this session was to provide a space for young people to talk about death and improve coping strategies. The grief and loss session was reported to be helpful, but some younger children found the session traumatic. As psychosocial support addresses both primary (psychological) and secondary (social) outcomes, the sustainability of these interventions could increase. This is important to address as interventions can manage the effects of traumatic grief but could increase discrimination within the community.

Three interventions were identified that reported an improvement in social connectedness by increasing adult support within mentorship programs and improving peer relationships. Brown et al⁶⁹ evaluated a mentorship program for young people aged 12–26 years in Rwanda who were doubly orphaned and heads of their households. This quasi-experimental study compared young people exposed to the mentorship program with those in a control group for a reduction in feelings of marginalization, grief, depression, and maltreatment. Mentoring involved regular home visits and the development of a therapeutic relationship. Findings revealed that adult mentorship mitigated the adverse psychosocial outcomes of orphanhood by reducing symptoms of depression ($P<0.009$) and levels of marginalization ($P<0.004$). The intervention did not significantly reduce

the feelings of grief and maltreatment in comparison to the control group.

Kumakech et al⁷⁰ evaluated a peer support group that assessed the influence of the intervention upon the psychosocial wellbeing of 10-year old and 15-year-old AIDS orphans in Uganda. Peer-group support involved young people participating in problem-solving exercises that related to specific issues in their lives. This intervention was found to be effective in decreasing psychological distress and reducing symptoms of depression, anxiety, and anger. Orphans who did not receive the intervention showed an increase in depression and anxiety. Denis and Makiwane³⁷ evaluated the use of memory boxes, which involved members of families compiling stories and important objects pertaining to their history in a box before an anticipated death. This intervention provided an opportunity for families to talk about life, death, and plans for the future in order to promote resilience in young people at risk for experiencing traumatic grief. Creating memory boxes was found to be a helpful process to implement when preparing for bereavement. However, the session required active participation, which was variable across the study.

Kayombo et al³⁵ evaluated the role of traditional healers in supporting orphans aged 3–19 years in Tanzania. Traditional healers live within communities at the grassroots level and are recognized for providing remedies for illnesses and diseases. In addition, those in this study were also caring for orphans of HIV/AIDS and even providing psychosocial support to help children cope with orphanhood. Psychological needs were met through the development of coping skills; social needs were addressed through acceptance and community integration; emotional needs were met through love, encouragement, and motivation; and physical needs were met through shelter, food, and school fees. The authors maintain that the role of traditional healers in caring for orphans needs to be recognized, and more resources should be provided to empower them and train them in basic psychosocial techniques so that orphans can be reintegrated into their communities without feeling stigmatized.

Quality of formal and informal service provision reporting

The intervention studies included in this paper (summarized in Table 2) that report existing services provisions were published between 2003 and 2010, implying research conducted within this field remains fairly recent. Despite the majority of interventions being carried out by local community providers, the findings have been published by authors who

Table 2 Summary of intervention studies

Study	Setting	Study design	Sample	Data collection	Data analysis	Ethics approval	Quality of data/reporting	Intervention(s)	Summary of findings
Apicella et al ⁴⁰ RAPIDS Evaluation Final Report; Population Council	Zambia	Cross-sectional observational study	1,500 households, 10–24 years of age	Qualitative and quantitative interviews	SPSS	Approved	Good	Psychosocial support	Improvement in education and skills for work during intervention; decrease in stigmatizing behaviors during intervention
Brown et al ⁴⁹ Population Council	Rwanda	Quasi-experimental study	593 people, 12–26 years of age	Questionnaire, interview	STATA	Approved	Average	Mentoring	Reduction in depressive symptoms ($P < 0.009$) and levels of marginalization ($P < 0.004$) at follow-up
Chitiyo et al ⁴⁸ Southern Illinois University, USA; Midlands AIDS Caring Organisation, Zimbabwe; Tennessee Technological University, USA	Zimbabwe	Experimental study	20 people, 10–14 years of age	Unstructured interviews, observation	Not stated	Not stated	Poor	Psychosocial support: counseling, playing games, buddy system, school fees, scripture union lessons	Improvement in confidence, self-esteem, motivation, class work, and school attendance at follow up
Denis and Makiwane ³⁷ University of KwaZulu-Natal, South Africa	South Africa	Pilot study	17 families	Interviews	Not stated	Not stated	Poor	Memory boxes	Helpful intervention for families preparing for bereavement
Gilborn et al ³² Horizons/Population Council; Regional Psychosocial Support Initiative; Catholic Relief Services	Zimbabwe	Cross-sectional observational study	1,258 people, 14–20 years of age	Survey	SPSS: Pearson's two-sided chi-square test, Student's t-test	Approved	Good	Psychosocial support	Psychosocial wellbeing increased during intervention
Kayombo et al ³⁵ Muhimbili University College of Health Sciences, Tanzania	Tanzania	Observational study	72 people, 3–19 years of age	Questionnaire, interviews	Coded and grouped into categories	Not stated	Average	Psychosocial support	Physical, psychological, emotional, and social needs of orphans are addressed during intervention
Kumakech et al ⁷⁰ Mbarara University of Science and Technology, Uganda; Lund University, Sweden	Uganda	Cluster randomized controlled trial	326 people, 10–15 years of age	Beck Youth Inventory assessment and questionnaire	STATA	Approved	Good	Peer group support, management	Significant improvement in depression, anxiety, and anger with intervention
McDermott ²⁵ Rhodes University, South Africa	South Africa	Case study	1 person, 11-years old	Clinical interviews	Narrative analysis	Not stated	Good	Integrative long-term psychotherapy	Reduction in hyper-vigilance, improvement in healthy play, development and maintenance of relationships with peers

(Continued)

Table 2 (Continued)

Study	Setting	Study design	Sample	Data collection	Data analysis	Ethics approval	Quality of data/reporting	Intervention(s)	Summary of findings
Nelson et al ³⁹ Horizon/Population Council	South Africa	Case report	1 person, 11 years old	Beck Youth Inventory assessment and questionnaire	Assessment translated into English	Approved	Average	Psychotherapy, management	Intervention was helpful in meeting the needs of the child
Schaal et al ⁶⁷ University of Konstanz, Germany; University of Bielefeld, Germany; Vivo Foundation, Germany	Rwanda	Pre-post test experimental design	26 people, 0–18 years of age	Interviews	Three doctoral-level psychologists and two graduate students	Approved	Good	Interpersonal psychotherapy, individual narrative exposure therapy	After 6 months, narrative Exposure Therapy intervention was more effective than Interpersonal Psychotherapy at reducing post-traumatic stress disorder and depression symptoms
Van der Heijden and Swartz ²⁸ Child, youth, family and social development program, South Africa	South Africa	Experimental study	89 people, 10–13 years of age	Sentence completion activity, interviews, focus groups, observations	Compared with three other similar qualitative studies	Not stated	Poor	Grief and loss session	Children unable to talk about death or grief due to cultural practice

are affiliated with global charity organizations: none were published by authors from SSA. Kieling et al³¹ argue that health professionals in SSA ought to become more involved in service and policy development in order to take ownership of interventions within their communities; we would also urge them to lead and publish their research. This is important because the assessment of the success of an intervention from an outsider (etic) perspective may be different from a community (emic) perspective. Best practices do not appear to be shared between countries in SSA; few studies appeared to situate their work alongside that of others. This might be a consequence of the inaccessibility of health care information generally throughout SSA, but it highlights a need for professionals to communicate the effectiveness of interventions and transferable elements to other countries and cultures through publication and other sources. It is hoped that recent moves in open access information might facilitate this (eg, Health Information for All⁵⁶).

With regard to the participants recruited to intervention studies, numbers ranged from 1 to 1,500 people and the age group most frequently cited was between 11 years and 14 years of age, perhaps suggesting that this age group are the most accessible and willing to participate. The majority of studies included both orphans and vulnerable young people and reported parental death as being a consequence of AIDS, indicating that this is the leading cause of orphanhood in SSA. Surprisingly, only six of the studies reported receiving ethical approval. The most common intervention implemented was psychosocial support, and the majority of interventions aimed to manage traumatic grief. Most interventions were delivered by members of the community as opposed to health or social care professionals, implying that mental health services are unable to meet the needs of communities or that community members are better placed to deliver these services. The reason for the lack of health-care-based interventions could be the scarcity of skilled healthcare professionals. Within the mental health sector in SSA, there are only 0.05 psychiatrists, 0.61 nurses, and 0.04 psychologists for every 100,000 people.⁵⁵ Resource limitations and the financial means to train staff can be significant barriers to service delivery.⁶² Maj⁶⁴ suggests that there is a need for psychiatrists to be trained to a higher standard, to cover a wider area of the population and to adhere to psychosocial interventions.

Conclusion

This scoping review has shown that CTG is an important topic within SSA and is highly relevant to the global mental

health agenda. Although the rate of new HIV infections is said to be decreasing, the number of orphans has increased to unprecedented levels: SSA was said to account for 90% of the world's AIDS orphans in 2009.² As the number of orphans rises, CTG in SSA is also set to rise. Despite this, the psychological health needs of adolescents are seldom recognized or adequately addressed in policy and programs. It is with this in mind that we present a number of recommendations developed from the reviewed literature that will help inform service development and future research priorities.

Recommendations for service development

- Educate service providers in identifying mental health problems through open-access training manuals/toolkits.
- Develop interventions/programs that prevent and/or manage traumatic grief in young people across countries throughout SSA, in order to increase service provisions and close the current gap.
- Design interventions/programs to meet the holistic (eg, material, physical, psychological, social, emotional, and educational) needs of young people.
- Create interventions/programs to prevent and/or manage the effects of a variety of psychological traumas (eg, violence, sexual abuse).
- Design interventions/programs to remain culturally sensitive (eg, single-sex groups, anonymity).
- Direct service providers and health professionals to tackle stigma and discrimination of HIV/AIDS, orphanhood, and mental illness.
- Direct service providers to increase awareness and promote interventions to members of the public and organizations.
- Encourage community providers to facilitate partnerships with health and social-care services for information sharing.

Recommendations for research

- Conduct a systematic review comparing specialist and nonspecialist interventions in SSA.
- Conduct observational research to ascertain why particular interventions are effective in certain contexts. This will identify cultural, environmental, political, and social factors and provide insight into transferability of interventions.
- Conduct longitudinal studies that aim to show associations between investment in child and adolescent mental

health and improved child development, and reduced mental health problems in adulthood and improved economic productivity.

- Conduct qualitative studies to develop a greater understanding of the childhood experience of traumatic grief leading to interventions/programs tailored to the holistic needs of young people in SSA.

Author contributions

Both authors contributed toward data analysis, drafting and revising the paper and agree to be accountable for all aspects of the work.

Disclosure

The authors report no conflicts of interest in this work.

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