

Mental Health Situation and Resilience among Orphans and Vulnerable Children in Sub-Saharan Africa: A Review

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ABSTRACT: *Africa is the continent most prone to strife like wars, political violence, communicable and non-communicable diseases, and violations of human rights. Vices like these result in mental health problems among children and adolescents. Children and adolescents who have experienced war, political violence, diseases or severe violations of human rights in Sub-Saharan Africa, tend to exhibit mental health problems such as depression, anxiety, withdrawal, and conduct disorders and many other psychological problems. Despite exposure to these stressful and traumatic experiences, survivors of these events tend to show resilience due to individual, family and community factors particularly family, peer, school and community support. Large scale interventions such as social cash transfer programs and small scale interventions such as Trauma Focused-Cognitive Behavioral Therapy have proven to improve social capital of children and adolescents, and build their resilience amidst and after adversities.*

Key words: *Mental Health, resilience, protective factors, children and adolescents, sub-Saharan Africa*

INTRODUCTION

There is no doubt that Africa is among the continent most prone to strife such as wars, political violence, communicable and non-communicable diseases and violations of fundamental human rights. In particular, Sub-Saharan African (SSA) has been affected by most of these vices. The situation in this region is compounded by poverty. Most of the countries in this region are low income nations. These vices result in the increase of orphans and vulnerable children. The official definition of an orphan is a child aged zero to 17 years whose mother, father, or both have died. There are, however, other children who are referred to as social orphans even though one or both their parents may still be alive but who have been unable to perform parental duties because of illness or acute poverty among other reasons. On the other hand, vulnerability is viewed as "a high probability of a negative outcome", or an expected welfare loss above a socially accepted norm, which results from risky or uncertain events, and the lack of appropriate means to deal with them (World Bank OVC toolkit). Throughout this review, the terms orphans and vulnerable children are used in this context.

As a result of HIV and AIDS, war, diseases, poverty and high mortality rates, mental health problems particularly among children and adolescents are likely to be more common in this region (Benjet, 2010). Moreover, a systematic review of mental health problems in children in SSA found that overall, 14.3% of children were identified as having psychopathological problems (Cortina, Sodha, Fazel & Ramachandani, 2012). Unfortunately, mental health issues often come last on the list of priorities for policy makers (Gureje & Alem, 2000). This paper will discuss mental health problems in SSA children and resilience among children. Clinical and research implications will also be discussed. To contextualize this paper, childhood mental health problems resulting from armed conflicts, HIV and AIDS, child abuse and poverty, and resilience among such children will be the focus of the discussion.

Review Criteria

This was not a systematic review because the aim of this review

was to provide a summary of literature on mental health and resilience in orphans and vulnerable children in Sub-Saharan Africa. Articles were selected using the author's information research database from earlier literature searches. Additionally, PsycINFO was searched using the following terms: "mental health," "child soldiers," "juvenile chronic diseases," "HIV and AIDS," "Child abuse," "child poverty", "resilience", and "protective factors". Selected papers were full text articles and reports reporting data from studies in Africa among vulnerable groups in English language. The reference lists of identified papers were used for further leads.

Armed Conflicts and Mental Health

According to Themner & Wallenstein (2012), the majority (15 [41%]) of armed conflicts that took place between 1946 and 2011 took place in Africa. Armed conflicts have been associated with a number of negative mental health problems and poor psychological wellbeing of not only children but also adults. Mental health problems that affect children who have experienced armed conflicts include psychological distress, behavioral problems, and mental disorders such as mood, anxiety and conduct disorders (Tol, Song & Jordans, 2013). In addition, armed conflicts have been reported to affect social determinants of mental health and well-being including family, community care networks, access to basic needs and education, morality and spirituality (Tol et al., 2010; Batniji, van Ommeren & Saraceno, 2006). In Uganda for instance, high emotional distress was observed among children aged 9-16 years who were exposed to high rates of extreme events, such as deaths, child abductions, disease epidemics, gender-based violence and poverty within the context of war (Akello, Reis & Richters, 2010). In Sierra Leone, youths who had wounded or killed someone showed increased hostility while girls who had been raped within the context of war showed high levels of anxiety and hostility (Betancourt et al., 2010).

AIDS and Other Chronic Illness

HIV and AIDS is a worldwide problem. However, SSA is the most affected by HIV and AIDS. AVERT International (2011) estimated that 90% of all AIDS infected and directly affected children live in SSA. It is believed that this estimation is far below what is currently prevailing in SSA. Worldwide, it is estimated that

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17.8 million children under 18 have been orphaned by AIDS and that this will rise to 25 million by 2015. Around 15.1 million or 85 percent of these children live in SSA. In some countries which are badly affected by the epidemic, a large percentage of all orphaned children, for example 74 percent in Zimbabwe, and 63 percent in South Africa are orphaned due to AIDS (AVERT International, 2014). Table 1 shows the number of orphans in selected countries in SSA as of 2012. There is also an increase of reported child-headed households within the region (van Dijk & van Driel, 2012; AVERT International, 2014).

In a review of literature evaluating mental health and resilience in families and children living with HIV and AIDS across the globe including majority African countries, Betancourt, Meyers-Ohki, Charrow & Hansen (2013) reported that there are numerous risk factors threatening children whose caregivers are dying or have died of AIDS including, withdrawal from school, witnessing caregiver suffering and decline, experiencing discrimination and stigma. These risks were also recently reported in Ethiopia (Tefera & Mulatie, 2014). Children whose parents are living with HIV often experience many negative changes in their lives. They can start to suffer neglect, including emotional neglect, long before they are orphaned. Eventually, they may suffer from the death of their parent(s) and the emotional trauma that results from such death. In such case, children may then have to adjust to a new situation, with little or no support, and may suffer exploitation and abuse (AVERT International, 2014). Atwine, Cantor-Graae, & Banjunirwe (2005) in a study carried out in rural Uganda, reported high levels of psychological distress in children who had been orphaned by AIDS. Anxiety, depression and anger were found to be more common among children orphaned by AIDS than other healthy children. The authors reported that 12% of children orphaned by AIDS affirmed that they wished they were dead, compared to 3% of other children interviewed. These psychological problems seem to be exacerbated when a child is forced to separate from his/her siblings upon becoming orphaned perhaps due to separation anxiety which may lead to social withdrawal especially after losing a parent or guardian. For instance, in a 2002 survey in Zambia, more than half of orphaned children were separated their siblings (USAID/SCOPE-OVC/FHI, 2002).

Mental health problems and other psychological problems have been reported in other chronic illness such as epilepsy and diabetes mellitus. The prevalence of epilepsy in Sub-Saharan Africa seems to be higher than other parts of the world and estimates within Sub-Saharan Africa vary from country to country. For example, 7.8 per 1000 (95% CI: 7.5-8.2) in Kilifi, Kenya, 7.0 (95% CI: 6.2-7.4) in Agincourt, South Africa, 10.3 (95% CI: 9.5-11.1) in Iganga-Mayuge, Uganda, 14.8 (95% CI: 13.8-15.4) in Ifakara, Tanzania and 10.1 (95% CI: 9.5-10.7) in Kintampo, Ghana, after adjustment for attrition and sensitivity. In Europe, the estimated number of children and adolescents with active epilepsy is 0.9 million [4.5-5.0 per 1000] (Forsgren, Beghi Oun & Sillanpää, 2005) while in the USA for children aged birth to 17 years the estimated lifetime prevalence of epilepsy/seizure disorder was 10.2/1000 (95% CI:

8.7-11.8) or 1%, and of current reported epilepsy/seizure disorder was 6.3/1000 [95% CI: 4.9-7.8] (Russ, Larson & Halfon, 2012). For diabetes, compared to Europe [120,000] and North America and the Caribbean [110,000], the prevalence of type 1 diabetes for children age 0-14 years in Sub-Saharan Africa was 39,000 as of 2013 (International Diabetes Federation, 2013). The common mental and psychological problems in epilepsy and diabetes include fear, stigma and depression.

Constantly seeking treatment and engaging in everyday self-care activities such as frequent glucose monitoring, following a meal plan and correctly preparing or remembering to take insulin or oral medications at the right times can be a source of diabetes-specific emotional stress e.g. depression. For instance, Hapunda and colleagues (2015), found that compared to controls (15.10±9.19), depressive symptoms were more reported in individuals with diabetes (19.12±8.95) aged between 12-70 years old and that there were no differences between young and old patients on depression and diabetes-specific distress. Moreover depression has been complicated in the development of diabetes type 2 (Pouwer, Kupper & Adriaanse, 2010). In a qualitative study stigma and stress mainly from physical, psychological and social stressors were reported among adolescents with type 1 diabetes and their families (Hapunda, Abubakar, van de Vijver & Pouwer, 2015). Birbek et al., 2007 observed that people with epilepsy had high perceived stigma scores compared to control 1.8 vs. 0.4, $p < 0.001$.

Child Abuse, Poverty and Mental Health

Orphans and vulnerable children (OVC) are subjected to multiple ongoing stressful and traumatic life events such as abuse, neglect, parental loss, sexual abuse among others (Murray et al., 2013; Andrew, Skinner & Zuma, 2006). In addition, OVCs and their families continue to live in extreme poverty (Marais et al., 2014; Hailu & Soares, 2008). A Study covering five countries (Cambodia, Cameroon, India, Kenya and Tanzania) found that over 90% of OVCs experienced more than one traumatic event and that the majority had been sexually abused (Whetten et al., 2012). In Zambia, there is high incidence of child post-traumatic stress disorder including those relating to sexual abuse, physical abuse, domestic violence and related symptomatology (Murray et al., 2014). Survivors of child abuse including sexual abuse are at great risk of anxiety, inappropriate sexual behavior, preoccupations, anger, guilt, shame, depression, post-traumatic stress disorder, and other emotional and behavioral disorders (Murray et al., 2013).

Resilience and Protective Factors amidst Adversity

Resilience refers to good mental health and developmental outcomes, despite exposure to significant adversity (Luther, Cicchetti & Becker, 2006). Resilience denotes adaptive processes that support adjustment, with such adjustment being bolstered by social-cultural ecology in which children develop (Masten & Wright, 2010). Resilience can be looked at the individual, family

Table 1.
Percentages by country of Orphans orphaned by HIV and AIDS in Africa

Country	Number of children who have lost one or both parents due to aids, 2012	Children orphaned by aids as a percentage of all orphans, 2012
South Africa	2,500,000	63%
Nigeria	2,200,000	19%
Tanzania	1,200,000	39%
Uganda	1,000,000	37%
Kenya	1,000,000	38%
Ethiopia	900,000	20%
Zimbabwe	890,000	74%
Malawi	770,000	59%
Mozambique	740,000	37%
Zambia	670,000	48%

and community level. Individual resilience refers to the ability of a person to successfully adapt to or recover from stressful and traumatic experience (Crawford, Wright & Masten, 2005) while family and community resilience is seen as the collective ability to adapt and recover from adversity as a family, population or a community respectively (Panter-Brick & Eggerman, 2012). Another important concept that is related to resilience and acts as a protective factor is social capital. Social capital is defined as the resources that inhere in peoples' relationships (Carpiano & Hystad, 2011). Social capital can be at school, family, peer and neighborhood level. Whatever the level, the presence and amount of social capital is important for positive development and health (Carpiano & Hystad, 2011).

Individual, family, and community resilience as well as other protective factors have been found to be common in children with mental health problems arising from armed conflicts, chronic illness or child abuse. For instance, in a longitudinal study in Sierra Leone, youth who had wounded or killed others during the war demonstrated increase in hostility supporting the risk accumulation hypothesis in the absence of protective factors (Betancourt et al., 2010). Youth who survived rape had higher levels of anxiety and hostility, but also demonstrated greater confidence and prosocial attitudes at follow up. Of the potential protective resources that were examined, improved community acceptance was associated with reduced depression at follow up and improved confidence and prosocial attitudes regardless of the levels of violence they were exposed to. Retention in school was also associated with greater prosocial attitudes (Betancourt et al., 2010). Another study by Stark (2006) reported that cleansing ceremonies contributed to well-being and reintegration of former female child soldiers who survived sexual abuse. In Rwanda, a qualitative study of 134 children affected by both the genocide and by HIV and AIDS, found that perseverance, self-esteem/confidence, family unit and collective communal support were identified as critical aspects of resilience functioning in the children (Betancourt et al., 2011). In fact parental separation or rejection at the time of conflict or forced migration had been shown to affect levels of resilience and psychosocial well-being later in life (Siriwardhana, Ali, Roberts & Stewart, 2014).

In children and adolescents with chronic illnesses such as HIV and AIDS, diabetes, and epilepsy, passive coping (e.g., blaming, wishful thinking, withdrawal, self-criticism) are associated with greater psychological problems. For example, Hapunda and colleagues (2015) found some adolescents (14%) with type 1 diabetes used avoidance coping (avoiding injecting themselves insulin) to cope with diabetes related-stress. This is not useful given that young people with chronic illness such as diabetes and HIV and AIDS suffer from depression, stigma and stress. If used for a short period, coping strategies like avoidance can be effective but can also have pervasive effects if used for the long term on both physical and mental well-being of children. Therefore, more adaptive strategies are useful to build resilience in adolescents. For instance, adolescents in South Africa with HIV reported goal-setting as an individual factor of resilience that helped them to cope with their diagnosis of HIV (Petersen et al., 2010). Further, Betancourt et al., (2011); Harms, Kizza, Sebunya & Jack, (2009) found that perseverance and high self-esteem was associated with resilience in adolescents with HIV and AIDS in Rwanda and Uganda.

Family factors associated with resilience include parental monitoring and attachment, overall family functioning and the degree of family impairment. Betancourt et al., (2011) in a qualitative study of HIV affected children in Rwanda found that the family unit was an important resilience factor especially when it included indicators such as living together in harmony, corporation, mutual respect and strong communication. On the other hand, parental impairment was associated with decreased resilience (Woods, Chase & Aggleton, 2006). At the community level, Daniel and colleagues (2007) found that disclosure and openness was related to resilience and self-efficacy while silence, secrecy and stigma contributed to feelings of self-hate, anxiety, hopelessness and confusion among Ugandan HIV and AIDS affected children. Social support including financial, physical and

emotional help from families, friends and communities have been documented as important protective factors in children with HIV and other chronic diseases (Betancourt, Meyers-Ohki, Charrow & Hansen, 2013). In South Africa, contact with extended family, school and peer support, as well as less community violence were associated with less distress and low post traumatic stress disorder in orphans of HIV and AIDS (Cluver & Gardner, 2006; Cluver & Gardner, 2007; Cluver, Fincham & Seedat, 2009). In Zambia programs such as the Social Cash Transfer targeting families affected by HIV and AIDS were shown to improve nutrition and health, increased access to education, improved livelihood opportunities, more confidence and less pressure on the community (Schuering, 2008).

There were no major differences of reported protective factors found in other OVCs such as those abused sexually and those found in children affected by war or HIV and AIDS (Tefera & Mulatie, 2014). For one thing, therapy has been demonstrated to build resilience in children who have been exposed to trauma due to sexual abuse, witnessing death of a loved one and other traumatic experiences. For instance Murray et al. (2013) found evidence of the effectiveness of Trauma Focused Cognitive Behavioral Therapy (TF-CBT) in OVCs in Zambia where a significant reduction of trauma symptoms and shame symptoms associated with the traumatic experience was observed. Social cash transfers have also been shown to significantly increase basic material resources, schools resources, confidence and food security among OVCs in South Africa, Zambia, Malawi, Kenya and other low income countries (Thurman, Kidman & Taylor, 2015; Hailu & Soares, 2008).

IMPLICATIONS AND CONCLUSIONS

Resilience and protective factors experienced by children affected by war, HIV and AIDS or other vulnerable children seem to be similar. Therefore, proven interventions can be replicated with minor cultural adaptations across the areas that most affect the mental health state of Sub-Saharan African children. Specifically, conditional cash transfers (CCTs) programs seem to be effective at the individual, family and community level in building resilience of children including their families. CCTs are designed to increase human capital of beneficiaries by making transfers conditional on certain requirements such as school attendance, visits to health clinics and renewals of immunizations for children in developing nations. The efficacy of CCTs was demonstrated in Zambia by showing that households living on one meal a day decreased from 19.3% to 13.3%, enrollment in school rose by 3% points to 79.2%, the scheme boosted households self-confidence over time; a more positive outlook into the future was enhanced and 73% up from 50% at baseline had a plan for the future (Schuering, 2008).

Coping skills that have been demonstrated to be effective in building resilience should be imparted to OVCs. Families and community workers must be aware about protective factors that increase resilience in OVCs. It is also important to understand the cultural milieu in which OVCs are found in order to understand whether behaviors exhibited by such children indicate resilience or maladaptive behaviors. For instance, an ethnographic study in Northern Uganda initially observed that many children did not suffer from psychological problems related to war and conflict. However, it was later observed that the perceived resilience was related to cultural values regarding respect for others who suffer in silence. The children did not want to rekindle memories of hurt in others who suffered the same experience by talking about their ordeal (Akello, Reis & Richters, 2010). Research on individual differences and differential susceptibility in building resilience is warranted and also important to consider in clinical practice especially in group and individual mental health services such as TF-CBT. From the evolution-biological perspective, individuals are differentially susceptible to environmental influence, with some people being not just vulnerable than others to the negative effects of adversity such as conflicts, poverty, diagnosis of a chronic illness contrary

to the dominant diathesis-stress view (Ellis et al., 2011; Belsky & Pluess, 2009). As such differential susceptibility paradigm has far reaching implications for understanding whether and how much children and adolescents exposed to stressful events respond to such traumatic events. The person x environment interaction is crucial to this view (Ellis et al., 2011). Moreover evidence shows that female report more and elevated mental health problems compared to males on depression and anxiety (Hapunda, Abubakar, van de Vijver & Pouwer, 2015; Piccinelli & Wilkinson, 2000).

Further, clinical measures are seen as gold standards for assessing mental health problems such as depression. Evidence suggests that self-report measures and clinical diagnostic interviews produce different results. For example, 70% of diabetes patients with elevated self-reported depressive symptom scores do not meet diagnostic criteria for major depression disorder on the basis of a structured clinical interview (Fisher et al., 2007). In most of the studies reviewed, self-report measures were used which can only measure relative levels of mental health problems; in future, diagnostic interviews would be ideal because they measure absolute levels of mental problems.

In conclusion, mental health problems remain a big challenge in SSA. There is need for stakeholders to work together in order to ameliorate the problem and to prioritize mental health together with physical health problems. Individual, family and community factors are important in building the resilience of OVCs in SSA. However, given the scale of the problem affecting children in SSA, large scale interventions, such as CCTs that have proven effective in improving social capital and resilience of beneficiaries, should be encouraged and replicated in other communities and regions in Africa. Other interventions such as TF-CBT which mainly focus on the mental well-being of individual children and their families should be implemented alongside.

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