

## Health Connections: A Culturally Sensitive Approach to HIV/AIDS Prevention Programming in Zambia

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### Abstract

Nearly half of Zambia's population is under 15 years old, with an estimated 630,000 "AIDS orphans," children whose parents have died from HIV/AIDS, and are now left to survive without complete families. Zambian caregivers of these AIDS orphans have been overwhelmed with the task of providing grief counseling services to these children. Nursing professionals at the University of the Incarnate Word responded to the professional development needs of grief counselors in Zambia, and launched *Health Connections* in 2004-2006. Health Connections is a cross-cultural grief education program designed to educate caregivers in a rural Zambian village on how to help grieving children. The purpose of this paper is to discuss the process of assessment, planning, implementation, and evaluation of the Health Connections "train-the-trainers" program.

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### Introduction

Since 1981, a growing number of Zambian adults are being diagnosed with HIV/AIDS and their children, faced with the physical death of one or both parents, are being left behind to cope. The institutional reaction to these orphans' loss is variable: the operative is sometimes as though grieving children forget about their loss because they may not talk about it; or they are simply told to move on with their lives. Either of these insensitive treatments may cause children to experience increased spiritual, emotional, physical, psychological, and behavioral turmoil. Better knowledge of the psychosocial impact of HIV/AIDS on Zambian children, and greater understanding of developmental responses of children to grief and loss are needed to guide program planning. Only when health care providers are able to design culturally sensitive grief support programs will a measurably positive outcome be predictable.

The purpose of this paper is to discuss the magnitude of HIV/AIDS epidemic in Zambia, the psychosocial impact of HIV/AIDS on Zambian children, and the developmental responses to grief and loss. This paper also

describes a program for caregivers of orphaned African children. The program, Health Connections, was designed to provide continuing education on grief counseling for health care providers.

### HIV in Zambia

The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates more than 25 million people have died from Autoimmune Deficiency Syndrome (AIDS) since 1981 (Joint United Nations Programme on HIV/AIDS, 2006). Globally, 64% of all people infected with HIV live in sub-Saharan Africa (UNAIDS, 2006). In the region, Zambia has been the hardest hit with HIV/AIDS. By the end of 2005, an estimated 930,000 Zambian adults and children died of AIDS related deaths (UNAIDS, 2006).

The Republic of Zambia is a relatively large country located at the head of the sub-equatorial Africa (World Health Organization [WHO]) (2006). In 2005 alone, 1,000,000 adults and children were living with HIV – fully 17% percent of the total population has been affected, with 98,000 deaths (UNAIDS, 2006).

Approximately 710,000 children have been orphaned due to AIDS (UNAIDS, 2006). Those living with HIV/AIDS include all adults (one million), women (570,000), and children (130,000) (UNAIDS, 2006). Individuals 15-49 years of age are considered adults. The data underscore the disproportionate burden of HIV/AIDS on Zambians and the need to train caregivers how to help orphaned children to cope with the death of their loved ones.

### **Program Assessment**

The first part of this program entailed a needs assessment. While the population is clearly in need of support, it had to be determined where the best point of entry and what the best plans for improvement might be.

Because it was assumed that training caregivers of children orphaned by AIDS would be the logical point of entry, as they were the most likely to have direct impact on the process, local caregivers were interviewed to collect information establishing a baseline of current operations and perceived need. The evidence collected from caregivers during direct questioning was completely consistent concerning the symptoms of grief in children and the demonstrated psychological impact of losing a parent. Home-based-care volunteers in Mongu and Limulunga, Zambia reported an overwhelming sadness and stress shown by children in the homes they visit. They realized that supporting physical needs — nutrition, health, education — was not sufficient for these developing children, and that addressing their emotional needs was critical.

Recent research demonstrates that a child's feeling of loss does not dissipate over time but continues to impede the child's ability to lead a healthy, productive life (Kirwin & Harmin, 2005; Lyles, 2005; O'Toole, 1988). Intervention programs are needed to help children and adolescents work through the grieving process. To be effective, these efforts need to be targeted at specific age-groups and the interventions must remain rooted in the community. For this reason, present caregivers, including teachers and family members, urgently need active direction and support in promoting successful outcomes.

The program piloted here was a set of workshops delivered by American nurses in Mongu, Zambia in collaboration with local health care providers, nurses, community volunteers, and volunteers of Women's Global Connection in San Antonio, Texas. It was estimated that this population was average for AIDS infection and children in need. These initiatives developed relationships for furthering American nurses' understanding of the Zambian culture and the continuing epidemic of AIDS.

Phase 1 was a five-day workshop administered to 30 local caregivers training to become grief educators in their surrounding community. The curriculum presented was specially designed for this program, called "The ABCs of Healthy Grieving" and focused on fundamental principals and problems of psychological health during grieving with the goal of helping caregiving adults and children develop healthy grieving behaviors. Led by Dr. Sarah Williams, this workshop was launched in May, 2004 following the needs assessment.

Phase 2 was a sequel five-day workshop focused on training caregivers and teachers how to plan and to facilitate grief and loss workshops and was implemented in May, 2005. Led by Dr. Eula Pines, 24 participants attended.

Dr. Pines also developed the curriculum and led the final assessment and discussions with collaborators resulting in "Healing Connections" and the creation of a plan of operation for an ongoing "train-the trainer" program, described below, with pedagogical information about how to help grieving preschool children process their feelings of grief. A native Lozian teacher assisted with the translation of the program curriculum and co-facilitated fall and summer 2006 programs.

### **Program Planning**

#### **Psychosocial Impact of HIV/AIDS**

The American nurses spent the planning phase of this project considering the psychosocial impact of HIV/AIDS on children, developmental responses to death, and healthy tasks for mourning children. Bowlby (1973) describes attachment behaviors as strong kinship bonds

between parents and children that provide a secure base for them to thrive and grow. This relationship with the parent or consistent caregiver is the “glue” that bonds children during their personal growth (Bowlby, 1979). When this bond is threatened or broken through the loss of a loved one, children experience feelings of insecurity, thus setting the stage for multitudinous outcomes (Worden, 1996; 2002).

Children grieve within the context of the family and cultural norms. When a family member dies of HIV/AIDS, children may continue to undergo a particular wounding experience that includes stigma, shame, secrecy, fear of disclosure, loss of other family members, and survivor’s guilt (Dane, 1996; Goldman, 2000; 2003). In addition, the instability and insecurity that follow the death of a parent may be superimposed on the child’s incapacity to understand the diagnosis.

Kelley (2006) postulated that two categories of children have emerged from the HIV/AIDS epidemic: orphans and vulnerable children (OVC). Orphans are defined as children under age 18 who have lost one or both parents (United Nations Children's Fund [UNICEF], 2004a). Vulnerable children refer to those children who reside in households affected by HIV/AIDS. They are children who have an ill parent; children whose families are stretched beyond coping by the addition of other orphaned family members, children whose families previously looked to wealthier relatives for security in times of need, and children who can only turn to persons as impoverished as themselves or become street children (UNICEF, 2004b).

In 2003/2004, Zambia conducted its second situation analysis of orphans and vulnerable children revealing that by the year 2002, over 15% (710,000) of all children under the age of 15 had lost one or both parents to AIDS (UNICEF, 2004a). As the HIV/AIDS epidemic unfolds, society is becoming more aware of the psychosocial impact on children, overlapping and operating interdependently among many psychosocial domains. These domains include: economic, migration, changes in caregiver and

family composition, new responsibilities, forego of educational goals, loss of home/assets, and alterations in health (Ritcher, 2004). Other domains include vulnerability to HIV infection, long-term psychological effects of emotional deprivation, and psychosocial trauma from the loss of parental attachment bonds.

Psychosocial trauma may continue as children move to live with foster parents or extended family members (Webb, 2004). They may be treated as second-rate family members and discriminated against in the allocation of food, work and other resources (UNICEF, 2004a). Children are also at increased risk for deprivation syndromes manifested as failure to thrive, decreased motivation, increased passivity, and lower cognitive performance. The United Nations World Food Programme (UNWFP) (2006) reported that Zambia is one of the world’s poorest countries, with 87% of its 11.7 million people living on less than two dollars/day. Vulnerable children must cope with the resulting escalation of poverty as they attempt to access basic necessities such as food, shelter, clothing, and education, thus, translating into potential dire consequences for them.

Other psychosocial needs included psychological and emotional support. Kelley (2006) reported that in schools, orphaned children who are grieving the loss of parents and other family members are frequently identified through their apathetic listlessness, excessive reserve, and strained relationship with their peers. Thus, the future health of Zambia depends upon our ability to protect the health of its children. Growing recognition of the insidious relationship among HIV/AIDS, grief, loss, and the importance of initiating grief counseling is challenging health professionals to design grief support programs (McKissock & McKissock, 2003) in order to prevent maladaptive coping behaviors and to address health issues prevalent among Zambian children.

Moreover, controlled studies have found that the death or anticipated deaths of parents, siblings, and other family members retain a profound effect on the remainder of the child’s life (Oltjerbruns, 2001). Typically, children are not

in a position parallel to adults and do not grieve the same way as their elders (Jellinek, Patel, & Froehle, 2002; Lyles, 2005; National Cancer Institute, 2006; O'Toole & McWhirter, 1988; Rando, 1984; Worden, 1996). For them, the cumulative effects of unresolved grief can be enduring and compromising (Kristjanson, Cousins, Macpherson, Dadd, & Watkins, 2005).

It is well known that the interplay of culture and family systems affect grieving children. The rich Zambian cultural traditions value the roles of the family. Traditionally, extended family members and grandparents have provided children with nurturing and support after the deaths of their parents. Recently, the HIV/AIDS epidemic and resultant poverty have taken a toll on the structure of the family systems (Dane, 1996; Goldman, 2003), having a severe impact on the ability of these systems to provide support for the individual family members and leaving communities behind to cope with the psychological and emotional distress (UNAIDS, 2006).

Psychosocial well-being is essential for children's survival and development particularly in enduring situations (Kristjanson et al., 2005). Psychosocial interventions and methods that enhance children's, families', and communities' capacities to cope with the devastation of HIV/AIDS are needed in Zambia (Kelley, 2006; UNICEF, 2004a/2004b). Children need love, security, encouragement, and a sense of belonging to cope with grief and loss meaning that in the context of a diminishing support system, the developmental reactions of children to death warrant special attention (Bowlby, 1979; Jellinek et al., 2002).

#### **Developmental Responses to Death**

In infancy, children often miss contact, sounds, smells, and sight of the deceased parent. Possible consequences include crying, alterations in health status, and sleep pattern disturbances (Goldman; 2000; 2003; O'Toole, 1989). Thus, meeting the infant's physiological needs and safety are the priority, ordinarily requiring nurturance, cuddling, and patience (Lyles, 2005).

Between ages three and six, children have no understanding of the permanence of death (National Cancer Institute, 2006), and believe that to be dead is to be sleeping. They may think that the person is alive in some limited way. They may ask lot of questions such as how does the deceased eat, go to the toilet, breathe, or play? Their concept of death may involve magical thinking (Goldman, 2000). Sometimes with self-blame attached, the child may believe that his or her thought caused the deceased to get sick or die. The child can understand that biological processes have stopped, but will likely see this as reversible (Lyles, 2005). Difficult emotions may include fear, sadness, confusion, anger, agitation, guilt, and worry. Regressive behaviors are commonly manifested with repetitive questions and clinging. Orphans may experience alterations in bladder and bowel functions. Some children play out scenes of death, change, and feelings (Corr, Nabe, & Corr, 2003; Lyles, 2005).

From the ages of six to nine, children may view grief as final and frightening, but as something that happens to older persons (not themselves). They may become afraid of school, experience behavioral and learning problems. Children may become overly concerned with their own health and fear of abandonment. Clinging and spiritual concerns are also common (NCI).

By the age of nine, death is seen as unavoidable and not a punishment. At age 12 and above, death is seen as final and something that happens to everyone. Heightened emotions, guilt, anger, shame, and increased anxiety are common. This age group fears rejection and does not want to be perceived as different from their peers (Goldman, 2003). High-risk behaviors may be observed (Lyles, 2005). Thus, the above understanding of age-related grief and mourning, and approaches to grief counseling for children are important as implications for health care providers (Worden, 2002; Jellinek et al., 2002). Furthermore, having caring adults can provide support and help children to meet the tasks of mourning.

### **Tasks for Mourning Children**

Worden's (1996) tasks for mourning children include: 1) accepting the reality of the loss; 2) experiencing the pain of grief; 3) adjusting to a new environment; and 4) investing in new relationships. To negotiate the first task, children need to be told the truth about the death of the family member and be given age-appropriate information. Worden points out that this task takes time, but children will develop cognitively, eventually understanding that death is irreversible. It is important for caregivers, families, and communities to include children in the cultural rituals following the death. But, family decisions must be respected.

The second task of mourning is to allow the expression of pain through healthy grieving. Common responses to loss may include physical, emotional, behavioral, cognitive, social, and spiritual reactions. Caregivers are cautioned to approach this task gradually because children are not able to sustain the intensity of painful experiences.

The third task of mourning is to adjust to an environment in which the deceased is missing. A child's adjustment will be determined by the roles and the relationships with the deceased. For example, older children may have to take on more responsibilities and forego childhood pursuits. Moreover, the loss of a parent or both parents to AIDS may mean the children must relocate or separate from other siblings and relatives.

The fourth and final task of mourning is to relocate the dead person within one's life. Worden (1996) notes, the task of facing the loss of the deceased is not to give up the relationship, but to find a new and appropriate place for the deceased loved one within one's emotional life.

### **Program Implementation**

The "train-the-trainer" program was piloted from the planning process, above, in 2005 with a second segment taking place in 2006. Two sessions, both one week-long workshops (5 days) one year apart, were designed to deliver important elements for grief counselors,

including information awareness about how children grieve and a discussion of the above psychosocial impact of HIV/AIDS on children. Pre-and post testing measured awareness of developmental responses to death, tasks for mourning, and myths about how children grieve. Training was then delivered regarding age appropriate intervention designed to help children to cope with loss and grief. Subsequently, programs have been initiated locally, implementing the design. Adult learning concepts informed the development of all workshop materials, including the training manual and materials utilized in subsequent program applications.

### **Participants**

Prior to the implementation of the program, the investigators received approval from the university's Institutional Review Board to conduct this pilot program. All participants gave written consent to participate in this pilot program. A bilingual Lozian educator translated the consent forms and pre/post tests to Silozi, a common native language. The director of the Limulunga Preschool invited 24 caregivers in the local community and 19 attended both workshops taking both the pre- and posttest. All expressed interest in learning how to help grieving children. The workshop participants were primarily women (n=17; 90%), widowed (n=8; 44%) (see Table 1). The participant ages ranged from 25-64, with a mean and standard deviation of  $44.05 \pm 13.34$ .

Eighty percent of the participants have been providers of care to a loved one with HIV/AIDS, and indicated a willingness to help in the fight against the regional AIDS epidemic. Their educational level ranged from grade (standard) two to college. The majority of participants (n=13; 68%) reported a sixth grade education level or higher (see Table 1). The cross-cultural training team included Dr. Pines, an African-American nurse who is an experienced grief counselor and two Lozian bilingual teachers with extensive knowledge and experience in early childhood education and contact with the local community.

Table 1  
Demographic Characteristics of Program Participants (N=19)

Variable	Frequency (Percent)
Gender	
Female	17 (89.5)
Male	2 (10.5)
Marital Status	
Married	3 (16.7)
Separated	1 (5.6)
Single	5 (27.8)
Widow	8 (44.4)
Other	1 (5.6)
Education	
Standard 2	1 (5.6)
Standard 3	2 (10.5)
Standard 5	1 (5.6)
Standard 6	2 (10.5)
Grade 7	4 (21.1)
Grade 9	1 (5.6)
Grade 12	1 (5.6)
Form II	2 (10.5)
Form III	2 (10.5)
College	1 (5.6)
HIV Caregiver	
No	4 (21.1)
Yes	15 (78.9)

### Workshops

The two pilot program workshops shared the overall goal of training adults about the needs of grieving children and helping caregivers in the process of counseling children experiencing grief. Table 2 summarizes the goals, methods, and content of workshop. Over the five days of training, group discussions and small group activities provided opportunities for participants to explore their personal beliefs about death and dying.

### Program Evaluation

A modified Navigating Children’s Grief Exam, developed by Lyles (2004) was utilized as pre- and posttest to determine participants’ knowledge of children’s grief. The instrument contains 22 true/false and multiple-choice questions such as: “Over time, children tend to

forget about loss” and “Children may express grief in which of the following ways.” with a choice among four responses, all applicable. Immediately following each question, the respondents must indicate “My confidence level in my answer to this question is:” choosing one of three levels of comfort, “Very confident,” “Somewhat confident” and “Unsure.” Participants required approximately 40 minutes to complete the pre/post test. Certain words were not recognized, such as “fretting,” and “task,” which required translation at the time of test administration. Additionally, many participants were unfamiliar with the multiple-choice format indicating degrees of confidence. They indicated familiarity with the true/false format. No explicit reliability or validity data for the instrument is available.

Table 2  
Summary of Five-Day Workshop Goals, Methods, and Content

Workshop Goals	Methods	Content
<b>Day 1</b> 1. Establish rapport and review workshop objectives. 2. Relate understanding of grief and loss in children. 3. Discuss coping tasks for grieving children. 4. Identify age appropriate activities to meet coping tasks.	<ul style="list-style-type: none"> <li>• Group Activity: Getting To Know You</li> <li>• Pre-test</li> <li>• Lecture, discussion</li> <li>• Case study</li> <li>• Role play</li> </ul>	<ul style="list-style-type: none"> <li>• Normal grief and children developmental responses</li> <li>• Understanding the needs and coping tasks of grieving children</li> </ul>
<b>Day 2</b> 1. Facilitate the expression of children’s grief. 2. Discuss importance of peer groups for grieving children.	<ul style="list-style-type: none"> <li>• Lecture, discussion</li> <li>• Group activities: Feeling faces</li> <li>• Reviewing and discussing - Video: Aarvy Aardvark Finds Hope (O’Toole; 1994)</li> </ul>	<ul style="list-style-type: none"> <li>• Let’s talk about death</li> <li>• Let’s talk about loss</li> <li>• Let’s talk about grief</li> <li>• Let’s talk about feelings</li> </ul>
<b>Day 3</b> 1. Explore changes associated with parental deaths. 2. Design activities to help children meet their coping tasks.	<ul style="list-style-type: none"> <li>• Lecture, discussion</li> <li>• Storytelling: Brave Bart (Sheppard, 1998)</li> <li>• Learning activities: Healing connection chain, memory book, puppets</li> </ul>	<ul style="list-style-type: none"> <li>• Let’s talk about changes</li> <li>• Validating losses</li> <li>• Let’s say goodbye</li> <li>• Talking through puppets</li> </ul>
<b>Day 4</b> 1. Design and present 10-15 minute teaching presentation to colleagues. 2. Post-test 3. With supervision with children.	<ul style="list-style-type: none"> <li>• Group presentations</li> <li>• Post test</li> <li>• Learning activities with preschool children (guardians bring own children)</li> </ul>	<ul style="list-style-type: none"> <li>• What is dead?</li> <li>• Feeling Faces: happy, sad, scared, angry</li> <li>• How to make a memory book</li> <li>• How to make puppets</li> </ul>
<b>Day 5</b> 1. Help children how to say goodbye. 2. Evaluate training.	<ul style="list-style-type: none"> <li>• Group activity: Puppet show</li> <li>• Complete evaluations</li> </ul>	<ul style="list-style-type: none"> <li>• Commemorating and memorializing</li> <li>• Reflections</li> </ul>

The tabulation of the 44-item pretest/posttest scores revealed increased accuracy in responses as well as increased confidence levels on every item. On the pretest, 63% of the respondents (N=19) scored under 60% correct on the content questions, meaning they answered no more than 13 of a possible 22 correctly. Only two participants scored this low on the posttest (10.5%), where, however, their scores had nonetheless effectively doubled, from an average 30% on the pretest to an average 57% on the posttest. This gain on the posttest was fairly consistent with the group’s overall average

gain of 28.7%, where the average score on the posttest was 82.5%, over 18 of 22 answers correct.

Gains in confidence rose in tandem. The middle indicator, which read “somewhat unsure” or “somewhat confident”, was removed from the calculations and only ratings of “very confident” and “unsure” were counted. Thus where pretest content scores show an average correctness of 53.8%, the confidence measurement of the same questions was “very confident” 68% of the time, offset by “unsure,” 7%. On the posttest, where

the average correct score was 82.5%, the confidence measurement of the same questions was 88% “very confident,” with only .4% “unsure.” Thus a rise in overall confidence accompanies the rise in correct scores, and the two scores become closer to each other on the posttest (82.5% correct and 88% - .4% = 87.6% confidence). The outcome was judged excellent by the participants, also.

In addition to the above evaluation process, following the lecture and experiential activities, each participant shared his or her learning experiences. Each participant developed and presented 15-minute presentations to colleagues and preschool children demonstrating their proficiency in their new grief counseling positions.

Daily debriefing and planning among the site collaborators guided the educational process. Interestingly, at the beginning of the training, only one participant related feeling comfortable using the word “dead.” Instead, they preferred using “passed away.” By the end of the training, the majority of the participants reported increased comfort using the word “dead.”

Increases in confidence and knowledge were related in comments by the participants. For example, a co-facilitator, noting the value of the training stated:

Now [everyone is] talking about helping others family members and people in the community. I told my granddaughter that her mother was dead. I never told her before. She’s nine years old and she needs to know the truth. I gave her a picture of her mother to put in her memory book. Her mother was my daughter.

This comment confirms how the child had been subjected to great doubts and uncertainty regarding the absence of her mother. The family member, after the training, felt confident and convinced in the value of it enough to help her granddaughter grieve by performing some of the tasks the training taught. Other participants likewise report performing some of these tasks stating, for example, “I learned that children do understand the meaning of dead,” and “I learned

that we should tell children the truth about their parents when they die.”

Other statements regarding grieving emerged as well, suggesting the future expansion of this program to encompass grieving adults. For example, “I learned that I am still grieving the loss of my daddy,” and “I talked to my two boys about the death of their daddy yesterday. One of them said, is that why you look like this? Both of them gave me a [a drawing of a] lady with a sad face. They said it was a picture of me. They told me I make them feel sad, too. I talked to them about their father’s — my husbands’ — death.”

The task of talking about death often revealed other underlying issues. For example, the parent’s shielding the truth was transformed into a new level for doubt for the children who had to live with an untruthful parent: “I learned that my two children knew that their mother was dead. I never told them. When I asked them to draw a picture of a dead person, they drew a picture of my wife. She was lying in a coffin. The picture looks just like my wife.” The children’s picture opened their father’s eyes – and the path to constructive grieving.

Drawing was a good therapy overall, with many participants recognizing their family members in the act of grieving, without having previously “seen” this. For example, one participant stated, “I can understand changes, because my daughter died and left me with her children.” This participant’s drawing reflected an older woman with a sad face and two small children. Many of them recognized their ability to facilitate grieving by helping others draw or act out the experience of grief: “I learned that drawing, storytelling, and playing help children to get their feelings out”; “I will teach other children how to make memory books”; “The children really like the puppet plays”; “Aarvy was a good way to explain grief and feelings”.

The director of the preschool felt very positively about the program, also. She commented, “This program has validated the value of the preschool grief and loss program. We need to take the program into the surrounding communities.”

While reliability and validity data are not available on the Lyle's (2004) Navigating Grief Inventory, the above qualitative data strengthened the evaluation process. Moreover, the authors will evaluate future programs using 10 items true and false culturally appropriate questionnaires in combination with focus groups.

### **Discussion**

The outcome of these pilot programs accords with findings of other scholarship. Wood, Chase, and Aggleton (2006) examined self-narratives of teens at six sites in Zimbabwe. A key finding was that the teens desired direct communication with adults concerning parental illness and AIDS-related deaths, but adults were not able to identify and manage the emotional distress of grieving children positively. Wood et al. (2006) emphasized that in order to create an enabling environment for orphans, program planners must build the capacity of key adults in the orphans' lives, particularly surviving relatives, caregivers, and teachers, to address emotional issues relating to parental death (Wood et al., 2006).

Lyles (2005) encourages caregivers to accept mood swings, allow hidden feelings unless there is a risk of self-harm, and encourage the expression of feelings through writing, art, music, art, journaling, storytelling, singing, and sports. Caregivers should allow regressive behaviors, listen, and provide simple age

appropriate responses to questions using elements from the rich cultural traditions of Zambians to help with the expression of feelings (dancing, singing, storytelling, and other physical activities).

Supportive relationships with caring adults and peers are important, including their role in watchfulness for early warning signs of high-risk behaviors (Rando, 1984; Wakenshaw, 2002). Listening, answering questions truthfully, sharing, encouraging caregivers to share grieving experiences, offering physical support, and allowing choices about involvement in death and mourning rituals are empowering and assist children with meeting the tasks associated with mourning (Barnard, Moreland, & Nagy, 1999).

### **Conclusion**

The HIV/AIDS pandemic has taken its toll on orphaned and vulnerable children in Zambia. The extended family structure is fragile and needs additional community support to strengthen the capacity of children to cope with the loss of parents, sibling, family members, and changes. In the wake of the AIDS pandemic, health care providers are challenged to meet the needs of this population. Programs such as the pilots described here should be expanded to meet the needs of the greater population of school children, and new programs, developed along the same lines, should be piloted for grieving adults and caretakers.

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