ADVANCED PROJECT PAPER

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TRAUMAS OF ORPHANHOOD

F-11: **Can design and produce a significant artifact or document that gives evidence of advanced competence.**

F-12: **Can conduct a review of scholarly literature and write a comprehensive document concerning the effects of an infectious disease upon women, orphaned and vulnerable children.**

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AIDS Orphan

Shockquake has passed.

The dust has settled on life's ruins.

Man, woman, child, home,

From school to a cold hearth

And stove and no lighting

Mama's voice, calling, badgering,

Yes, it is true,

Oh, to hear even the sound

of her nagging.

No light shining and lost

In the dim of grieving.

How do men, women like these, cry?

They become adult

Between the passings,

Another rite of passage,

To where?

Child to child, child to adult

Uniform politely tattered,

No more money for food, fees,

One more year to go

And how to get there?

No more, never any more,

"Love thy neighbor as thyself."

Standing down is out as the

Sun shines on the hazy trail... (Vuyo Ophelia Wagi 371)

INTRODUCTION

"THE WORLD IS OUR HOME". Dr. Raymond Mosha expressed these unequivocal and memorable words to our study abroad group at an initiation ritual on November 28, 2011 in Arusha, Tanzania. By keeping an open mind, and allowing myself to savor the unique human diversities around the globe, I have become more profoundly aware that the world is truly my home. As I continue to reflect upon Dr. Mosha's sentiment, it has become clear that his words form the cornerstone of my passion for the peoples, traditions and social concerns of cultures unlike mine.

Over the past several years, I have had the opportunity and pleasure of visiting countries on the continents of Africa, Asia, Europe, and South America. As I traveled to these far-away places, I experienced a "window to the world" where I observed the peoples and their traditions. For example, I enjoyed dining experiences at an African bee hive, a Turkish farm house, an Argentinean sheep ranch, and the historical Hutong neighborhood in Beijing, China. I even had a Tango dance lesson (in flip-flops) in Buenos Aries. I had the opportunity to visit UNESCO World Heritage sites, museums and monuments. I observed various religious ceremonies and rituals in major cities and rural communities. In Tanzania I attended mass and witnessed the indigenous peoples bringing chickens and bags of rice as offerings to the priest. While these experiences were delightful on their face, I continually pondered social issues, especially the magnitude of HIV/AIDS and its impact on peoples around the world. It was reported in a UNAIDS 2011 World AIDS Day Fact Sheet that, globally, there were 34 million people living with HIV at the end of 2010. The same fact sheet reported that 22.9 million people in sub-Saharan Africa were living with HIV at the end of 2010 (1,2). Another UNAIDS Fact Sheet entitled "Children Orphaned by AIDS in sub-Saharan Africa" stated that "more than 11 million

children under the age of 15 in sub-Saharan Africa have lost at least one parent to HIV/AIDS; 34 million children have been orphaned overall" (1).

My window on Africa in 2005 initiated an intense yearning to study the impact of HIV/AIDS because I sensed it was burdening down women and children in sub-Saharan countries. Weighing most heavily on my heart was the fate of children orphaned and left vulnerable by the loss of a parent due to AIDS.

I began my SNL journey in 2005 with a focus on cultural studies. While I chose courses that emphasized diverse global locations, I was most interested in studying Africa and its peoples. In my Research Seminar paper entitled "Non-Kin Placement of an AIDS Orphan" I focused on the impact that HIV/AIDS has on women and children in South Africa. I designed a qualitative research proposal that sought to assess a non-kin alternative placement option for a child orphaned by AIDS. In a Peoples and Cultures of Africa course I studied the colonization and independence of African countries. I focused on the impact of HIV/AIDS in Africa in my Infectious Diseases course. Dr. Mosha's African Spirituality and Education course taught me how the indigenous Chagga peoples take a holistic approach to educating their children for life and living by emphasizing morals and spirituality from birth on. In all of these courses I wrote final papers addressing HIV/AIDS and its impact on African children who are left orphaned and vulnerable. Additionally, I completed two ILP's for my focus area—one on the Marquesan art of tattooing and the other on the Turkish Whirling Dervishes.

My hope to return to Africa did not waver during my study program at DePaul. That hope turned to reality when I participated in a Study Abroad Program tailored to learning about social and cultural issues in East Africa. While I relished the idea of being with the people, I had a very special reason this time. I was being called to visit orphanages that care for abandoned

children—many of them HIV positive or ill with malaria. I felt the experience would help me to reconcile my emotions of sadness and compassion that I have carried for these children since 2005. I also wanted to learn more about the empowerment of women to take charge of their lives, both in health and social matters. While in Tanzania, I was able to personally interview Esther (Dr. Mosha's friend) who has AIDS and learned how she contracted the virus from her husband who is now deceased, along with her daughter, son-in-law and two grandchildren who also died from AIDS. My final paper, based on excerpts from field notes taken on the trip, focused on orphaned children, HIV/AIDS and inequalities of African women.

Finally, I believe an essential part of my SNL educational growth emanated from my learning experiences in East Africa. It was an adventure, but more importantly, the trip offered me a means to immerse myself completely in the lives of the Tanzanian peoples. What follows is a brief summary of two extraordinary visits to orphanages that strengthened the foundation upon which I built this Advanced Project paper.

The Trip

After a long and arduous travel schedule, our study abroad group arrived in Arusha, Tanzania on November 28, 2011. Tired, happy to be standing, and a bit in awe of our new surroundings (especially the beautiful African sky and its magnificent display of stars), we were warmly greeted by Sister Apaulina at the Franciscan Sisters Hostel. We spent the next two weeks in the care and comfort of the Sisters. What follows are excerpts from field notes of my visits at two orphanages in Arusha. I had the opportunity to see first-hand the little ones who are in the care of those who take the place of moms and dads, grandparents and/or other relatives.

Our first visit took place at St. Joseph Health and Orphans Centre. We were greeted warmly by Sister Chrispina Mnate and the boys and girls who sang and danced for us. Trained

as a nurse/midwife, I also recall, or perhaps it is my image of her, that Sister is tenderly referred to in some circles as the "Mother Therese of Arusha". She told us the story of her vision 10 years ago that she was being called by God to provide a home for orphans. She went to a priest for support and guidance. He told her to pray for 14 days and she would know if it was the right thing to do. Her prayers were soon answered when the first three street children came to her shelter by way of the local police. It is her philosophy to take children from 0-3 years of age. At that age, it is much easier for Sister to instill within them the virtues for living a moral and spiritual life. As of the date of our visit, St. Joseph's is home to 45 non-adoptable boys and girls.

Our second visit took place at the Samaritan Village Orphanage on November 30. We were first greeted by the Social Director who introduced us to Josaphat Mmanyi, the founder (1994) and presiding director of the orphanage. Josaphat, a slight but impressive individual, told us that he felt a need to provide a home for abandoned children. He accepts children from 0-2-1/2 years of age. When asked about the age range, he replied that he believes it is best to take in children of this age because he and his staff can lovingly teach and prepare them for adoption by helping them to feel that they are deeply cared for and they will not be abandoned again, at least not while in his care. On that day, November 30, the orphanage was home to 27 boys and girls, some of them are HIV positive or have malaria. Josaphat also told us that when the children are found, sometimes on the side of a road and often near death, they are brought to the Samaritan Village by the local police. He related horrific facts about the condition of some of the children when they are found: the child is clinging to life after the parent or parents have beaten the child on the head with a sharp object, or worse, they tried to suffocate the child by sticking its head in a squat toilet where it is hot and tight.

When the van arrived at the Samaritan Village set among lush banana trees on a slight hill, I saw children swinging on a swing set and running around. Although they were smiling and curious, they also appeared shy. One little boy was standing at the top of the stone wall, holding a bucket in his hand. He had the most beautiful big brown and sad eyes. He was clearly waiting to be swooped up into someone's arms when we arrived. As soon as I stepped out of the van, he stretched out his arms to me as if to say "Take me". How could I resist, even for a moment, the calling in my heart to hold and cuddle an orphaned child? (I later learned from Josaphat that this little guy's name is Elijah and he is about 2 years old and has been at Samaritan Village for quite awhile). As we settled in for an orientation by Josaphat, Elijah fell asleep in my arms, his little finger curled around my shirt collar. Elijah did not smile, except when I picked him up. I could not wiggle a smile out of him after that. He clung to me until I had to release him to one of the staff members as we prepared to leave. Although I am at home now in my country that is so different from Elijah's homeland, he made an imprint on my heart and I will never forget him.

After visiting St. Joseph's and Samaritan Village orphanages, I had many questions that linger to this day. How did the parents who abandoned their children fall through the cracks of Tanzanian society? Were they victims of HIV/AIDS and had no way of caring for the child after its birth? Perhaps they, too, were victims of abandonment and had nowhere to go for help. I will address, in the following literature review section, (1) the havoc that has been created by HIV/AIDS in Sub-Saharan African countries and cultures, and more specifically, (2) the enormous pain and trauma suffered by the children left orphaned and vulnerable by the disease.

STATEMENT OF TOPIC

Assessment of the HIV/AIDS Virus as it relates to the inequalities that limit African women to take care of themselves, and the resulting trauma to children who are left orphaned and vulnerable by HIV/AIDS.

LITERATURE REVIEW ESSAY

A RELENTLESS VIRUS

A. History of HIV/AIDS in Africa

The effectiveness of any infectious agent (virus, bacteria, fungi) is based on an ecological triangle which encompasses the following three interactive elements: (i) the causal agent; (ii) the human host; and (iii) the social and biological environment (Lashley & Durham 5). One of the most effective infectious diseases to emerge in the Twentieth Century was the human immunodeficiency virus ("HIV"). There are two types of HIV. HIV-1, the most deadly and universally widespread infection, originated from the Simian Immunodeficiency Virus ("SIV") in the *Pan troglodytes troglodytes* subspecies of chimpanzee. HIV-2 originated from the SIV of Sooty Mangabey monkeys, but the virus is rarer and less infectious (Lashley & Durham 53). It is believed that mutations occurred in the organism which caused the viruses to "jump" the species barrier (Lashley & Durham 53). A widely-held hypothesis among those in the scientific community suggests that the causal agent for HIV infection was first transmitted to the human host through animal blood, most likely from hunters butchering and ingesting raw bush meat (Lashley & Durham 153).

Author John Iliffe writes that it was not until the late 1950's that doctors in Kinshasa, Western Equatorial Africa saw a new and life-threatening pathogen among its peoples, but could not identify it as HIV. For 20 more years the strange and deadly virus spread slowly in Kinshasa (43). Because HIV has a long asymptomatic incubation period, it would not be until the 1970's

that HIV, growing as a "silent" epidemic, began to spiral out of control, and to infect the peoples of East Africa and sub-Saharan Africa (Iliffe 3)

In 1982 the first case of HIV in South Africa was diagnosed in a white male homosexual flight attendant who allegedly contracted the disease in New York (Iliffe 43) The news was touted in South Africa that a "Gay" plague had invaded their country. Medical authorities then concentrated on the white male homosexual community (Iliffe 43,44).

In 1986, news came that HIV was beginning to spread in the South African black population when a migrant Malawian mineworker was diagnosed with HIV. Random testing then revealed that two black South African men had been infected by a mineworker (Iliffe 44). When the government ordered screening of all mineworkers, trade unions, among other groups, resisted and screening was abandoned (Iliffe 44). By 1987 blood tests suggested that the incidence of HIV was already eight times higher among blacks than whites in South Africa (Iliffe 44). KwaZulu-Natal was the province with the highest HIV prevalence. It was determined that this mostly rural region with a dense population, was more at risk of HIV infection because of a high rate of migration and sexually transmitted diseases. Further, couples where one partner was a migrant worker were twice as likely to contract HIV. Sub-Saharan Africa was confronted with the disastrous AIDS epidemic because it was the first AIDS epidemic (Iliffe 58). Moreover, Africans refused to admit that the virus emanated from SIV within Africa and considered that fact a "racial slur"(Iliffe 58). Cultural mores came into play impeding the recognition of HIV/AIDS as a deadly infectious disease and its treatment. Treatment was perceived as expensive, ongoing and widely unavailable.

B. The HIV Pathogen

According to the National Institute of Infectious Diseases ("NIAID") the human immunodeficiency virus ("HIV") belongs to the retrovirus family in a subgroup known as lentiviruses ("Biology" 1). Lentiviruses are referred to as "slow" viruses. Symptoms of lentiviruses may not appear (or lie dormant) in one's body for a number of years; hence the categorization "slow" virus ("Biology" 1). Thus, the HIV virus can spread widely among humans before it is detected. Acquired immune deficiency syndrome ("AIDS") is the result of the HIV microbe.

C. How Does the HIV Pathogen Cause Harm in the Human?

When a person is first infected with HIV, a large number of his white blood cells (type CD4+ T) are invaded by the virus at the infection site (NIAID "Causes" 1). At this critical stage of the infection, particles of the virus are infused into the blood and carried from the infection site to organs of the body, most notably the lymphoid organs which are responsible for the production and maturation of white blood cells (NIAID "Causes" 5). HIV is distinctive because even though our body's immune system is hostile toward most viral infections, HIV mutates so rapidly as to confuse the system. The brain is also an organ where HIV cells can hide and regenerate (NIAID"Causes" 8). Although the nerve cells within the brain are not penetrated by HIV, supportive cells (astrocytes and microglia) can be infected thereby weakening or damaging a person's neurological functions (NIAID "Causes" 9). By manifesting itself in the brain, HIV attacks the central nervous system resulting in cognitive impairment, including slowing of concentration and memory. The body also suffers physically in that motor skills are affected, including gait change, tremors or weakness in the legs. Changes in behavior also occur, including depression and withdrawal from society (NIAID "Causes" 9).

The immune system of a healthy person has approximately 800-1200 CD4+ T white blood cells per cubic millimeter of blood (NIAID "Causes" 1). HIV will cause a person's good CD4+ T white blood cells to be reduced to less than 200 cells per cubic millimeter of blood (NIAID "What are HIV and AIDS" 1). This severely compromises the immune system and AIDS, the final stage of HIV emerges in the form of an opportunistic infection, for example, pneumonia or tuberculosis (NIAID "What are HIV and AIDS" 1).

D. Transmission and Current Treatments

The HIV virus is transmitted through sexual contact, blood transfusions, contaminated needles (either in clinics or on the street) and from mother to unborn child (Lashley & Durham 164). However, the child may later test negative for HIV. According to author Emma Guest, "All children born to infected mothers initially test positive for HIV, because their mothers' antibodies are present in their blood. However, the majority of them lose these antibodies, become HIV-negative and go on to live healthy lives. The Elisa HIV antibody test to confirm a child's HIV status can be done after 15-18 months" (42).

According to the World Health Organization ("WHO"), the best antidote we have to date to combat HIV/AIDS is antiretroviral therapy ("ART") (1). When a person receives ART, he is receiving a combination of three or more antiretroviral ("ARV") drugs that work together to suppress the HIV virus which in turn slows the progression of the disease (WHO 1). The AIDS Foundation South Africa wrote that the infected person must understand that ARV treatment is ongoing and that they will stay healthy only as long as their CD4+ T white blood cell count remains high (AIDS Foundation "Treatment...").

Dr. Anthony Fauci, Director of NIAIDS, reports that two new experimental therapy possibilities are on the table in South Africa. First, the Centre for the AIDS Programme of

Research in South Africa "CAPRISA" discovered that the antiretroviral drug tenofovir can be formulated into a vaginal gel that would protect women against HIV infection (1). Second, under consideration is a tenofovir tablet to be taken by women as a preventive measure (Fauci 1). While these two therapies are not treatments, this type of prophylaxis is an important defense in fighting the epidemic.

II. SOCIO-CULTURAL ISSUES THAT IMPACT HIV/AIDS IN SUB-SAHARAN AFRICA

Many studies have shown that there are certain social obstacles that have had great impact upon the proliferation and eventual pandemic of HIV/AIDS in sub-Saharan Africa.

A. Denial/Prejudice

When it was first suggested that the HIV virus originated in Africa, the African intellectual community's response was that it was the "white man's burden" because they thought it had been imported to Africa by white American and European homosexuals (Iliffe 80). That mindset formed the framework for denial of causation that permeated the continent. Some black South Africans thought HIV was a tactic of Apartheid to wipe out the black population. Immigrants and refugees from other countries were also blamed (Iliffe 80). In part, denial/confusion by the population was understandable because from the time of incubation of the virus until its final stage (AIDS) distinctive symptoms are not apparent. Initially, the government was responsible for spreading the fear that once a person contracted HIV, death was imminent (Iliffe 81). After former President Nelson Mandela left office, he acknowledged his irresponsibility in not acting more swiftly in the crisis. Under Mandela's successor, President Mbeki, 5 million people were living with HIV and many were dying, yet he questioned whether there was a link between HIV and AIDS (AIDS Foundation "Response to Epidemic" ___).

B. Gender Inequality

According to researchers, Omoyibo and Ajayi, "Gender equality refers to that stage of human social development at which 'the rights, responsibilities and opportunities of individuals will not be determined by the fact of being born male or female', in other words, a stage when both men and women realize their full potential" (3737). However, when gender equality is not acknowledged within a culture, HIV becomes a more challenging problem. Andrew Gibbs, writes, "Gender inequalities are recognized as a major driver of HIV in sub-Saharan Africa, placing women at increased risk of contracting HIV compared to men" (1620).

Modifying sexual behavioral patterns is a major challenge in sub-Saharan Africa. While prevention-education still remains an important avenue to increase knowledge about dangerous unprotected sex, especially to the younger population, it is not enough because HIV infection rates are increasing. Two cultural dynamics in sub-Saharan society must be addressed. First, women are not empowered to say "no" because of deep-rooted gender inequalities. As a consequence of that dynamic, safe sex is not emphasized especially to girls and women who are more likely to be infected with the virus (AIDS Foundation "Challenge/Behavior Change"___). Second, at the onset of the epidemic, the use of condoms was thought to be unmanly (Iliffe 134). Specifically, in South Africa, condoms were used mostly for casual or commercial sex and were labeled "the prostitute's identity card"(Iliffe 134). In addition to these two cultural dynamics, South Africans often make the choice to go untested for HIV because they fear a positive diagnosis. Factored into this fear is a despair that family and medical support will be in short supply (AIDS Foundation "Challenge/Behavior Change"___).

C. Stigmatization

In Africa, those who suffer most from stigmatization are the poor, women, the young, and sex workers (Iliffe 88). As reported in 2001, high levels of stigmatization were evident in the rural areas of KwaZulu-Natal province. According to author Iliffe, "People known to be AIDS sufferers have had their homes burnt to the ground. Some barely able to walk, have been chased by mobs into the bush....Teachers and pupils act together to chase the children away because they are 'unclean'" (88). While some would say that the stigma is less today, the argument can be made that the most vulnerable still want to keep their "shameful" infection a secret (Iliffe 89).

D. Poverty

When those who live in the poor rural areas of sub-Saharan Africa are diagnosed with HIV, they suffer the gravest consequences of the disease. KwaZulu-Natal, a high poverty area in South Africa, is the most severely effected province. 26% of its work force (especially young women between 20-34 years) is infected with HIV (Thurlow, Gow & George 2). Approximately one-third of the province's population live below the $2 a day poverty line (Thurlow et al. 2). It becomes very difficult for those experiencing the onset of illness to obtain the necessary basics to sustain and prolong life. Two of the most crucial basics are proper nutrition and access to area clinics that administer ARV treatment. However, because the waiting list is long and the criteria for treatment stringent, some people do not receive treatment until they are seriously ill with AIDS (AIDS Foundation "Treatment, care and support"___). Poverty further exacerbates the problem when the breadwinner or caregiver in the family becomes ill (AIDS Foundation "Treatment, care and support"___). Children and older adults are often then placed in a position of caring for the terminally ill adult and then suffering the trauma of losing a loved one. According to author Diane Duggan,

> Many factors influence a young person's reaction to the death of a parent....AIDS generally runs a protracted, erratic course....There are periods of relative health punctuated by awful and sometimes disfiguring symptoms, such as profound weakness,...visible skin lesions, and wasting. Youngsters living at home witness the suffering and deterioration of their parent, and the household must revolve around his or her health care needs. This creates prolonged and inescapable stress within the family, culminating in what was an inevitable and often grueling death (11).

In a book entitled Women Writing Africa: The Eastern Region one of the authors, M. Mulokozi, wrote about a Tanzanian poet, Vuyo Ophelia Wagi, in this way. "...She wrote sad and contemplative poetry, often grappling with life's intangibles—the meaning of life, death, time, the hereafter..." (370). She also wrote of the "harsh realities" of HIV/AIDS and its implications on the children left behind after the death of their parents. Due to economic constraints, assistance is not always forthcoming, even from relatives (Mulokozi 370).

III. ORPHANS AND VULNERABLE CHILDREN ("OVC")

According to researcher, Brigitte Zimmerman, "Orphans are one component of the group termed 'orphans and vulnerable children,' or OVC." This group is defined as follows:

> Children are [considered to be in the group of OVC] when they have one or more of the following: have parents or caregivers who are ill or dying; do not have parents; do not have family; do not have a home; are traumatized; live in an area with high HIV prevalence or proximity to high-risk behaviors; live on the street; are in jail or prison; are exploited or abused; are discriminated against, are at risk of social exclusion. Because of their low socio-economic status, anatomy, and their generally weaker physical health, girls are especially vulnerable (883).

In a UNICEF report, dated August 2006, entitled "Africa's Orphaned and Vulnerable Generations-Children Affected by AIDS", it was estimated that by the year 2010, 53,100,000 children (between the ages of 0-17) would be orphaned in sub-Saharan Africa. Of that number, 30% or 15,700,000 would be AIDS orphans (35). The report further addresses a myriad of problems suffered by orphans, including a propensity for acquiring sexually transmitted diseases

(including HIV/AIDS), becoming pregnant at an early age, dropping out of school, and exhibiting psychological and emotional problems (UNICEF 21, 22). Additionally, AIDS orphans are particularly burdened by stigma and discrimination if they are taking care of a parent or sibling with AIDS while attending school. One teenage girl said it this way:

> Even my friend told me she won't eat with me again. One told me right to my face that I've got AIDS and should stop going to school and stay at home. I would feel terrible. Cry deep down. I would sit alone and cry alone. People would be staring at you saying nothing, even those who used to be happy when they see you were not anymore (qtd. in UNICEF 22).

The tragedy of AIDS does not end with the death of the parents or caregivers. Life continues for those left behind—those who are called "orphans and vulnerable children" (Guest 1). Some will go to extended family, an orphanage, a child-headed household, or become children of the street. There are complications associated with each of these outcomes. The following discussion examines these problems and how they affect the children left behind by HIV/AIDS.

A. Extended Family Care

i. Grandmother versus Auntie

In African cultures, when a child is orphaned due to the death of a parent, the disproportionate share of the child's care traditionally falls on the extended family. More often than not, it is the maternal side of the family, an older single woman, most likely a grandmother or aunt, who takes responsibility to foster the child (Howard, Phillips, Matinhure, Goodman, McCurdy & Johnson 1). However, as the numbers of orphans rise in sub-Saharan Africa, community and governmental assistance for caregivers is beginning to break down. According

to researcher Kristian Heggenhougen, "In many instances, the signs of collapse are already visible, with the destitution of children taken care of by a poor grandmother, and also with the growing phenomenon of second-generation orphans who are left when that grandmother dies....Increasingly, we see child-headed households—households in which children, sometimes as young as 10 years old, take care of their siblings"(3).

When a grandmother takes responsibility for her orphaned grandchildren, she treats them equally and lovingly. Her devotion makes up for the material possessions which are almost non-existent. Sometimes, however, it is an aunt who provides the best care for the orphan (Guest 25). John Munsanje, who operates a non-governmental organization ("NGO") in Zambia, assists distressed widows, grandmothers and orphans. He offers the following contrast between a grandmother and aunt as caregiver:

> Grannies are the fairest guardians. An aunt is more likely to discriminate slightly in favour of her own children. And her husband may resent the extra mouths to feed.
>
> But if I had to choose, I think it's better for an orphan to go to an auntie because she's usually got more money. Also, grannies are bad at disciplining children. You never get fierce grandmothers. They want to be nice (qtd. in Guest 25).

Author Guest further asserts that AIDS is breaking down the traditional African family. As AIDS orphans grow into adulthood, they will no longer have the loving support of a grandmother to provide free child care, socialization and education for their children (27). Those children will never experience the love a grandparent provides.

ii. Complications that Confront Extended Family Caregivers

In a study conducted in sub-Saharan Zimbabwe, researchers Howard et al. found that, "Zimbabwe's AIDS epidemic feeds and is fed by an economic meltdown marked by 70% unemployment, triple-digit inflation, a shattered agriculture sector, drastic cuts in social spending, and political uncertainty and paralysis" (2). This tragedy fuels poverty and exacerbates the inability of the extended family to care for orphaned children. Howard et al. found that,

> Many caregivers, especially the elderly, are impoverished, ill, tired, and emotionally drained from having cared for and buried relatives and taken in their orphans....Government programs are underfunded and difficult to access....Without such support, a caregiver's illness or age-related frailty may thrust the foster child into the role of caregiver or head of household (2).

Moreover, some of the most vulnerable children in the study were single orphans living in a home with a single AIDS parent. In that home situation, impoverishment was imminent (Howard et al. 9).

In order to study some of the barriers and incentives that a caregiver might experience in caring for orphans, Howard and his team conducted a qualitative cross-sectional survey of 212 adult caregivers in rural eastern Zimbabwe (1). They provided the participants with a questionnaire that queried their "well-being, needs, resources, and perceptions and experiences of orphan care" (1). The answers by the participants provided the following information: (1) most were single women, over the age of 60, (2) most were struggling to provide food for themselves and their foster children, (3) most experienced hunger in the household twice or more

a week, and (4) most had no income-producing occupation. Lack of money was the most frequently stated barrier to fostering an orphan, and to that point, more than 59% of the participants indicated that they had "no one" to turn to for help (Howard et al. 4). Perceptions shared by all participants were anxiety about contracting HIV/AIDS from their foster child and the associated stigma. However, in spite of the anxiety/stigma issues, 90% of the participants were very willing to care for a relative's child (Howard et al. 4).

When the participants were asked about the best experience of fostering an orphan they expressed "...satisfaction of doing their duty, ...helping the child and...joy of having the child in the family" (Howard et al. 7). Additionally, the participants felt they gained respect in their communities, and most felt optimistic about the future life of the orphan (Howard et al. 7). However, when extended family cannot foster an orphan, that child may be placed in an orphanage or become a member of a child-headed household.

B. Orphanage Versus Foster Home

An orphanage, also termed "children's home" is another placement option for a destitute child after he/she has lost both parents, grandparents or other close relatives are unwilling to foster the child (Zimmerman 888). In a study conducted in 2004 in Malawi, Southeast Africa, researcher Brigitte Zimmerman sought to compare two different care structures for orphans—a foster home and an orphanage (881). She based her research on the following classifications:

1. The material situation--how the physical and material needs of the orphan were met;
2. Lodging--sleeping space, sanitation facilities, recreational areas, size of living space and security;
3. Food variety and quantity;
4. Clothing;

Education; and

5. Health care.

Overall, it was more advantageous for a child to be placed in an orphanage than in a foster home (Zimmerman 892-902). For example, in an interview with a 15 year-old girl in foster care, she learned the following about the girl's sleeping arrangements,

> We share three blankets with 11 people and we give the blankets to the people who are sick, and then to the littlest ones...I used to live with my grandfather though and there I slept with the chickens, and they were loud [in the morning]. At least now it is quiet (qtd in Zimmerman 893).

Additionally, food and quantity was more generous in an orphanage; 90% of the children responded that they had three meals a day while only 10% of children in foster care had three meals a day. All of the children in orphanages who were interviewed reported that they had one pair of shoes and more than one outfit to wear. 80% of children in foster care who were interviewed had only one change of clothes—none had pajamas. Orphanages were also deemed better equipped financially to provide educational essentials (for example, school fees, uniforms and books) because they have access to outside funding that is unavailable to foster homes. Finally, children in orphanages receive better health care because of NGO's, while foster homes typically depend on the public health care system (Zimmerman 897, 898, 902).

Nonetheless, while an orphanage provides a safe and comfortable "roof over the head of the orphan" it may also create psychological problems for children that are irreversible. According to researchers, Kalsoom and Waheed, "children deprived of a loving family environment experience lasting damage to their intellectual, emotional well being and development. A lack of care and attention may result in stunted growth, lower IQs and a number

of behavioral and psychological problems" (80). Orphans whose parents are dead may exhibit psychological problems such as "sadness, feelings of loneliness...and...poor control over one's circumstances" (Kalsoom & Waheed 80). When a child suffers from social rejection, his/her feelings may result in childhood depression and low self-esteem. Depression in orphaned children is often camouflaged. For example, the child acts out his feelings in different behavioral patterns, for example, "irritability, temper tantrums, violence, risky actions, and/or refusal to go to school" (Kalsoom & Waheed 80).

Life in an orphanage is far from ideal. While an orphanage can help in placing an orphan in a foster home, there are not enough foster homes willing to accept the growing number of HIV orphans (Guest 96). According to author Guest,

> HIV-positive mothers who understand that their babies have a good chance of surviving, because the majority of babies born to infected mothers do not contract the disease, are less likely to abandon them. Relatives or neighbors are more likely to foster an orphan if the state helps with the grocery bills and school fees" (96).

Finally, a family unit of mother and father is the foundation upon which the personality and self-esteem of a child is formed. Children who enjoy the warmth and love of both parents generally inherit the capacity for living by good moral standards and developing good interpersonal and intellectual skills (Kalsoom & Waheed 80). In a healthy family structure, the parents exhibit social contact from birth forward which is essential for childhood development. Orphanages cannot provide the necessary familial bonding that is missing in a child's development process. According to author Guest,

> Children in orphanages are hungry for affection. They rush to staff and visitors for hugs. They cling to adults' legs. They like to sit on adults and play with their watches or their earrings. If someone else seems to be getting a more central position in a hug, they shout, push and scramble in. As long as they are evenly distributed it is just about possible to have a child on each leg. When staff and visitors go home, they must gently peel them off (93).

C. Child-Headed Households

The HIV/AIDS pandemic in sub-Saharan Africa has severely impacted children because of AIDS-related parent mortality. Author Guest describes the trauma experienced by a young girl named Molatela who was thrust into the role of head-of-household after the death of both of her parents. In Molatela's words,

> My father died first and we buried him on Saturday...She trails off and looks panicky, 'I've forgotten the date...The funeral was very big. And after we'd buried him, my mum died at 12 o'clock on the Sunday. She was so ill in hospital that they didn't tell her that my father had died....My mum was always sick. Maybe since '95. But my father was only sick since June this year and he died in July. Very quick. It was a shock. I didn't know he was sick too (qtd. in Guest 131,132).

The Actuarial Society of Africa estimated (in mid-2007) that a total of 4.1 million children in South Africa had lost one or both parents (Meintjes, Hall, Marera & Boulle 40). Of that number, 18% of the children had lost their mothers to AIDS (Meintjes et al. 40). Exacerbating the

suffering of the children is the concern that extended families are stretched to the limit to provide support for them. In a study conducted in north-central Namibia, researchers, Kuhanen, Shemeikka, Notkola, and Nghixulifwa, proposed that the extended family is "...on the brink in the sense that their capacity to absorb orphans and care for them properly has been pushed to its limit or perhaps exceeded it" (127). As a result, orphans, sometimes as young as 10 years, are thrust into a child-headed household ("CHH") (Francis-Chizororo 712). A CHH is defined as a "household headed by a person who is under age 18 (i.e. a legal minor)" (Kuhanen et al. 126).

i. Poverty

Poverty develops in CHHs because of the lack of monetary support, employment skills and other resources, for example, government-provided orphan maintenance grants. Most of the CHHs visited in the Kuhanen et al. study were extremely poor. The children lacked an adequate supply of food and clothing, medicine, school fees and uniforms. According to an AIDS worker in the Namibia study,

> ...Young adult is not ready to head a house. In most cases they are not employed. They're not earning anything. So, they are given the responsibility to take care of the house, and to feed the younger brothers and sisters....This person lacks resources. He is unemployed; he's not mature [enough] to head a house. He didn't head a house himself but he was under his mother or father, or grandmother's house, and was just taken there" (qtd. in Kuhanen et al. 129).

Most of the heads-of-household who were interviewed in the study disclosed that they depended on "support from neighbors, in terms of food handouts" to survive. Food supply, in terms of life necessities, places the most strain on CHHs (Kuhanen et al. 129).

Another serious problem confronting CHHs pertains to property grabbing. In the Nambian study, researchers Kuhanen et al. found that CHHs were denigrated by relatives of the deceased parents. Relatives grabbed tangible property and land that rightly belonged to the orphaned children. For example, they "claimed cattle, beds, linen, cooking utensils and even corrugated zinc sheets from the house roof" (130). Neighbors also stole food from CHHs from time to time. This kind of orphan exploitation could be lessened if a legal guardian were present in the home to provide security against that type of abuse (Kuhanen et al. 130).

ii. Division of Labor in CHHs

Children who control CHHs do not label themselves as "mother and father" although they have taken those duties upon themselves (Francis-Chizororo 720). Tendai, a child head interviewed in Francis-Chizororo's study described the duty arrangement in the following way,

> In the house, we never use these terms; 'father' or 'mother'. The community says them. I might source for food, fees, etc but I never consider myself father because of this role. But the people in the village are the ones who view me as father because of the provider role I have. One who does the cooking most of the time acts like the mother. We do not call each other father or mother. We are orphaned children who happen to live in the same household (qtd. in Francis-Chizororo 720).

Even though the heads-of- household do not necessarily distinguish themselves as mother and father, they do divide their duties along gender lines. The female is responsible for giving advice to the younger members in the house (much as adults do), disciplining and reprimanding her siblings and distributing household chores. The male, typically the designated bread-winner, sources for food, works (if possible), and provides clothing and school fees for his siblings.

Some of his earnings might also go to other siblings living with relatives. Child heads have the most influence on the day-to-day running of the household (Francis-Chizororo 720).

Conflicts are inevitable within CHHs. In particular, arguments ensue when a male child wields control over his female sibling. As researcher Monica Francis-Chizororo wrote, "The issue of boy's control over adolescent girls often created tension and conflict between the two sexes. Particularly intense conflict was noted where girls started having relationships with boys" (721). Orphaned children, particularly girls, must continually renegotiate their place in CHHs. Without parental guidance and support, they struggle to be independent, to understand their sexuality, and to move within and out of the household with freedom (Francis-Chizororo 727).

As the AIDS epidemic continues to spread throughout sub-Saharan Africa, child-headed households will continue to rise because the over-extended family system cannot keep up with the alarming rate at which children are orphaned (Kuhanen et al. 130).

D. When the Safety Net Fails - Orphans Turn to the Street

In a UNICEF report (2010) entitled "A Study on Street Children in Zimbabwe", children of the street were defined as follows: "...homeless children who live and sleep on the streets in urban areas. They are totally on their own, living with other street children or homeless adult street people"(89). 30.7% of the children who participated in the above study were orphans and 18.3% of the children were abused at the hand of their guardians (98). The report also indicated that HIV/AIDS and poverty had taken a toll in rural areas of Zimbabwe. However, most children of the street do not know how their parents died, or if they do know, will not acknowledge that it was AIDS that killed their parents (Guest 146). Moreover, the study reported that children who were in foster care and received inadequate physical and emotional care resorted to the streets.

Coupled with those problems, was the issue of education--over 25% of the street children in the study had never been to school (UNICEF 95).

Author Emma Guest portrays the life of a street child in this way,

> Street children live close to the edge. They find it hard to keep clean, healthy or clothed. Many people despise and distrust them, kick them and shout at them. The drugs and alcohol they use to make life bearable make them more vulnerable....Some are beyond help. Glue-sniffing has irreparably damaged their brain or they've stumbled into the path of a car (144).

In her book, Children of AIDS: Africa's Orphan Crisis, author Guest also talks about how street children often die young. According to Guest, "...Cut off from mainstream society, they rarely get the education that might protect them from AIDS. They are far more at risk of rape than children with homes to sleep in and they tend to start having sex at a vulnerably young age. Even if they know about HIV, safe sex is not high on their list of priorities when, for some, sex buys food" (147).

There are ways in which the "absolute homeless" or "roofless" can fortify themselves with food and clothing (Ward & Seager 92). In the words of one little girl in the Ward and Seager study, "I am an orphan, all my siblings are married and no one looks after me" (89). Soup kitchens, church organizations, the Salvation Army and "ordinary people" are available if the child seeks them out (Ward & Seager 92). This outreach service arrangement "...enables children to develop trust in services that do not require a large personal commitment (such as a soup kitchen)" (Ward & Seager 93). The programs also endeavor to help the children "develop the trust and courage required to make more serious commitments to shelters and long-stay

programmes" (Ward & Seager 97). The above options may provide a sense of protection to a child of the street if they commit to seek help.

IV. TRAUMAS EXPERIENCED BY OVC

A. Coerced Sex– A Means to Earn Money for Food and Shelter

In an interview with a 13 year-old Kenyan AIDS orphan, author Emma Guest asked the girl why she had given up her virginity for an apple. The girl replied "No one's ever given me anything before" (qtd. in Guest 1). According to author Guest, children, especially young girls, respond to a sexual favor when:

> ...they lack shelter and protection or because selling sex is their only means of survival. Abused children are more likely to take greater sexual risks or find themselves in abusive relationships in adulthood. The trauma of rape can destroy people's self-esteem. Orphaned girls are particularly vulnerable to sexual abuse because they've assumed adult responsibilities, such as caring for dying parents or raising siblings, without the maturity to understand quite what has happened to them (158).

Researcher Maria-Carmen Pantea also addresses some reasons adolescent female orphans become victims of forced prostitution. She writes, "Extreme poverty, malnutrition, and human immunodeficiency virus (HIV) orphanhood may push adolescent girls into prostitution in the context of increasing tourism and demand" (2). According to Dr. Kevin Lalor, the term "forced" "...lay on a continuum of coercion which started with male 'pleading' and 'persuading' and escalated to assault by hitting, in some cases with belts, shoes and sticks" (96). Further he writes that forced prostitution may convert to "economically coerced sex" when older men and/or boys become the young girl's "sugar daddy" (Lalor 98). South African pediatrician Neil McKerrow

observed that "these children lose the joy of their childhood and the skills that childhood develops in children...The girls are so susceptible to sugar daddies. They just need a little attention" (qtd. in Guest 158).

As previously written in Section A, when a child is left without parents, the social custom in African culture is that the extended family is the best placement option for that child. However, sometimes involuntary forced prostitution prompted by family members becomes an issue. According to author Thozama Mandisa Lutya,

> Historically, families could move children of relatives from rural areas to urban areas in order to access employment or educational advancements. Currently, such relatives might be doing so for the purpose of forced prostitution. In this context, it becomes difficult to define the trauma experienced at the hands of family members of human trafficking for involuntary prostitution especially in families where sexual abuse could be shrouded in secrecy" (72).

Young females are particularly vulnerable to forced prostitution. The AIDS epidemic is compelling older boys and men to seek out younger girls on the assumption that they are not infected with HIV (Lalor 100). Further, a young girl's susceptibility to forced prostitution occurs because, "... the cultural expectations of obedience and subservience makes 'it extremely difficult to negotiate safe sex and to control their sexual lives'" (Lalor 100).

B. OVC At Risk for HIV/AIDS

When an HIV-positive father remains alive after his wife dies, girl children left behind are more at risk for HIV. These maternal orphans tend to engage in unsafe sexual practices and marriage earlier because they often turn to much older men who are HIV-positive (Gregson,

Nyamukapa, Garnett, Wambe, Lewis, Mason, Chandiwana and Anderson 786). Researchers Mmari, Michaelis and Kiro conducted a study in the Kisesa Ward of Northwest Tanzania, an area devastated by the HIV epidemic. By conducting in-depth personal interviews and focus group discussions they collected data from maternal/paternal and double-orphans regarding their sexual activity. These researchers sought to identify certain risk factors that caused orphans to engage in unsafe sexual practices. (Unsafe sex is defined as "vaginal sexual intercourse without any protection") (Mmari et al. 801). They also wanted to investigate whether or not gender played a role in an orphan yielding to dangerous sexual behavior (Mmari et al. 800). According to Mmari et al. , "Recent studies conducted in South Africa, Tanzania and Zimbabwe have all demonstrated that losing a parent (to AIDS or other causes) significantly increases the likelihood that a young person will have earlier sexual debut, become pregnant and even acquire HIV" (799). Furthermore, female orphans are at a higher risk to contract HIV because they are driven into bad sexual behaviors in order to stay alive (Mmari et al. 800).

The main reason female orphans engaged in unprotected sex was to make money for themselves and their family. In the words of one female participant in the Mmari et al. study,

> I was fifteen years old the first time I tried sex. I did it because I didn't have any money. I just found myself doing sex so that I could get some money. The man came to me and he said he would give me money. He gave me 5000 shillings (about $5). I didn't know him well. I needed money for clothes (qtd. in Mmari et al. 804).

All of the participants interviewed felt that "…female orphans were at highest risk for HIV because they were most likely to have the 'lust for money'" (Mmari et al. 804).

Orphans are often forced to move from home to home to safeguard themselves. Reasons for this pattern of migration include "...sickness, remarriage, unemployment, death of a guardian, circumstances in other households that require their help, and the chance to attend school" (Zimmerman 886). In other instances, children migrate because of abuse and/or discrimination. Caregivers expect the orphan to be beholden to them because they have taken on additional financial responsibilities (Zimmerman 886). When familial and community support are absent, the orphan is destined to end up on the street.

Researcher Erick Nyambedha conducted a two-year long project entitled "Children on the move: everyday life practices and perceptions of kinship and relatedness among migrating Luo children in western Kenya". He was interested in learning if the migratory life pattern of a female orphan was a factor in contracting the HIV infection (287). He followed one 15 year-old girl named Adongo to learn if her lack of protection within an extended family made her more vulnerable to HIV-risk behaviours (287). According to Nyambedha, "...lack of protection for orphans by the extended family can expose female adolescent orphans to situations where they are more likely to become HIV-infected, especially when men 'take advantage' of the situation and begin providing them material rewards in exchange for sex" (292). In Adongo's case, she lacked protection from her extended family because she was born out of wedlock. Because the Luo are a patrilineal society, she was deemed not to belong to any extended family (Nyambedha 292). As Erick Nyambedha noted, orphans who are forced to migrate from one place to another may develop a hopelessness that leads to risky sexual behavior (293). Author Maddy Coy similarly writes in a paper titled "Moved Around Like Bags of Rubbish Nobody Wants..." that young girls, when forced with migration from place to place, are targets for coerced sexual encounters, including prostitution (254).

Finally, researchers Halifors, Cho, Rusakaniko, Phil, Lritani, Mapfumo and Halpern, conducted a study in Zimbabwe in order to determine if adolescent female orphans who remained in school were less likely to engage in unsafe sexual behavior. According to Halifors et al.,

> "Children of parents who die of AIDS suffer from the trauma of sickness, death, and associated hardships. The burden of caring for a sick parent, younger siblings, and of household subsistence often falls to adolescents, and many are forced to drop out of school and prematurely take on adult roles. Sexual behavior increases with school dropout, leaving adolescent orphans more vulnerable to HIV" (1082).

The above researchers concluded that female orphan girls who stay in school are at a much lower risk of contracting HIV because "...staying connected to prosocial adults, peers, and institutions results in better adolescent health and behavioral outcomes" (Halifors et al. 1083).

C. Educational Challenges for OVC

1. The Holistic Method of Teaching

Education is the fundamental building block upon which a child's moral and intellectual mind is fostered from birth forward. From this positive point of view, author Raymond Mosha discusses the *ipvunda* concept of holistic education in his book, The Heartbeat of Indigenous Africa. According to Mosha, "...ipvunda means to mold, to form, to raise up a person in *all* aspects: physical, intellectual, and moral, with special emphasis on the moral aspect" (16). The *ipvunda* process begins at the moment of birth. Further, according to author Mosha, "For the first three months, the mother is the main caregiver and nurse for the infant. In fact, the mother remains the central formative person for the baby.....In summary, the baby is prepared for the

practice of two fundamental human virtues: bonding with others or a strong sense of belonging, and playfulness or joyfulness" (Mosha 21,22). Holistic education begins with the parents and extends to grandparents, aunts/uncles and village elders. It is an ongoing method of teaching for life and living. Further, according to Dr. Mosha, "The active presence of a parent figure in a child's life is so crucial that an orphan is inherited by the deceased man's brother and his wife, who treat the young child as their own" (23).

While the above holistic approach is the ideal basis for a sound education of children and young adults, Mmari et al. addressed the issue of the intergenerational communication gap which contributes, in their opinion, to the spread of HIV. To bolster that point, they offered the following words of a female caregiver,

> The reason we have HIV is that the children and parents are negligent. In the past, we used to have a night fire where the parents taught the children good ethics, but now, we have forgotten that culture. We don't even follow up what our children are doing. We have neglected our culture. We have forgotten to teach and advise our children like what our elders used to do in the past (qtd. in Mmari et al. 805).

Conversely, some of the participants in the Mmari et al. study did not feel that the parents or caregivers were negligent in giving advice. The children simply did not want to listen because, according to a female orphan participant, "Many youth find that their parent's advice is just nonsense" (qtd. in Mmari et al. 805).

ii. The Traditional Method of Teaching

The traditional educational system presents some negatives for girls. They are often denied the opportunity to attend school because parents or caregivers do not place as much value

on their education as their male counterparts. Education for girls is thought to be a "waste of money" (Mmari et al. 805). Moreover, "In terms of education, orphans have often been reported to be less likely enrolled in school" (Kurzinger, Pagnier, Kahn, Hampshire, Wakabi and Dye 726). Double-orphans (both parents deceased) are more deprived of the opportunity to attend school (Kurzinger et al. 730). Researchers Kurzinger et al. also point out that children who live in female-headed households are greatly at risk for not attending school for the following reasons:

> Children living in female headed households and children not living in their family of origin are less likely to attend school and to be at proper level....In female-headed households, which could experience economic difficulties, school fees, uniforms, domestic responsibilities or paid work could be a barrier to education.... there may also be discimination [sic] in terms of not providing education for children not living in their family of origin (730).

iii. Deceptive Cultural Practices - *mila potofu*

The idea of *mila potofu* (Swahili word for deceptive cultural practices) presents a problem for teaching HIV prevention education in schools. Researchers, Oluga, Kiragu, Mohamed and Walli, stated: "...the notion of *mila potofu*...emerged as a key reason for educators' difficulties in teaching HIV/AIDS prevention education in schools and for high HIV infection rates. Since these cultural practices cause harm, and in many cases lead to death, they are of moral concern" (365). One of the taboos that falls within the notion of *mila potofu*, and predisposes people to HIV, is discussion between adults (parents and educators) and children about sex. In a study conducted in primary and secondary schools in Kenya and Tanzania, Oluga

et al. interviewed teachers, teacher trainees and college tutors regarding their experiences in approaching the subject of sex and HIV in the classroom. They concluded that young women and children of both sexes were uncomfortable discussing sexual matters (Oluga et al. 369). According to Oluga et al., "In Kenya and Tanzania, not unlike other African countries, the discussion of sex with young people, especially girls, is seen as indecent, unhealthy and unacceptable" (369). Oluga et al. also found that teacher trainees were not taught by their mentors how to present HIV prevention information to their students. The trainees also expressed fear that they would be admonished by parents for speaking about sex to their children in the classroom. Finally, these researchers found that:

> This conspiracy of silence present in Tanzania and Kenyan cultures (and beyond) conspires to keep young people ignorant about the basic biology of HIV/AIDS and how various cultural beliefs, traditions and practices might be challenged in order to protect them from HIV/AIDS infection" (370).

In conclusion, Oluga et al. found that it is important that educators find a way to teach children about HIV prevention while simultaneously allowing them to maintain their deeply valued cultural traditions (376).

iv. Factors that Encourage Orphan Girls to Stay in School

Adolescent orphan girls who stay in school are more likely to be "protected from early sexual debut and other HIV-related sexual behaviors" (Halifors et al. 1082). In their research, Halifors et al. found that:

> School attendance may play an important role in reducing HIV risk through a number of factors, including greater exposure to HIV messages,

> better cognition to make use of prevention knowledge, and greater self-efficacy. Educational support and continued schooling may also improve attitudes about gender equity, by decreasing women's exposure to coerced unprotected sex and early marriage (1082).

If female orphans stay in school they have a better opportunity for a brighter independent future free from coerced sex, unwanted pregnancy or early marriage (Halifors et al. 1087). Halifors et al. wrote, "If schooling results in better future expectations, more equitable gender attitudes, and more concern about the consequences of sexual intercourse, it is reasonable to expect that students who have an assurance of school support may be less inclined to marry or have sex" (1087). Finally, in addition to education, a school setting also provides orphans the opportunity to develop routine and order in their lives while bonding with caring adults (Halifors et al. 1083).

Conversely, when female orphans do not stay in school, their future becomes dismal for the following reasons: (1) low status within the community; (2) limited personal independence; (3) shorter life span due to health issues; and (4) earlier marriage and child-bearing (Gregson et al. 793).

V. MENTAL HEALTH CONCERNS OF OVC

A. Bereavement and Silence

i. Grieving

Researchers, Van der Heijden and Swartz write, "The term 'grief' derives from the French word *grever* which means 'to encounter' or 'to burden"' (41). After the death of a parent, orphans and vulnerable children are often susceptible to socioeconomic burdens that place psychological and developmental trauma on them. Cultural mores also marginalize their ability to grieve (Van der Heijden & Swartz 41). According to Van der Heijden and Swartz,

"...children living in the wake of HIV and AIDS...are limited in their agency to deal with loss. The 'ideal' image of childhood, 'one where children have love, time and a safe place to play, nurturing, schooling' and connections to their cultural traditions is not the case for many children..." (41). When a parent or caregiver dies, the child not only suffers that loss, but also encounters the loss of material provisions, familial bonding and role models. He or she may not have an adult with whom to share their grief and the event becomes life-altering (Van der Heijden & Swartz 42). Heijden and Swartz, write,

> In almost all death contexts, children will seek answers and comfort from caregivers and other adults in their lives. When perceived stigma around AIDS-related deaths is combined with extant [sic] cultural taboos about talking to young children about death, this lack of support from adults is further exacerbated (42).

If a child's parent or loved one dies of AIDS, his/her expression of grief becomes more unlikely because of the stigma associated with HIV/AIDS. The child suffers with feelings of avoidance, shame, fear and guilt by the community (Heijden & Swartz 44).

In African cultures, children do not participate in family illness matters. The tradition of remaining silent about the death of a parent or loved one plays a significant role in whether the child will grieve naturally. For example, Malawian children (under 10 years of age) are not told that a parent has died. In Zulu culture, "...death...is associated with 'pollution' and children are kept away from an ill or dying person and excluded from rituals-even if the deceased is a parent" (Heijden & Swartz 46). When a parent dies and children are excluded from the conversation and rituals surrounding the death, they are more likely to experience confusion and emotional turmoil which impacts their grieving process. Children become more vulnerable if they not allowed to

memorialize the pain of death. Ultimately, they may suffer traumatic consequences that shape their emotional wellness (Heijden & Swartz 47).

ii. The Vhutshilo Programme

Vhutshilo, means "life" in Venda, an indigenous South African language. The *Vhutshilo* Programme was initiated as a peer-led intervention strategy by the Harvard School of Public Health, and later established by the South African Centre for the Support of Peer Education. *Vhutshilo* offers grieving children psychological support and also acts as a conduit to educate children and young adults about HIV prevention (Van der Heijden & Swartz 42). The program is especially helpful "...in communities afflicted by poverty and HIV and AIDS, where community and family care networks become volatile or decimated, and where 'without caring adults to protect them, children can be manipulated into doing almost anything'" (Van der Heijden & Swartz 42).

Vhutshilo utilizes a slightly older teenage peer group to interact with grieving children to address anxieties associated with the "culture of silence". According to Van der Heijden and Swartz, "In some African contexts, children may be considered too vulnerable to deal with the experience of a death (or multiple loses [sic]), and so 'death-talk' is avoided while silence is embraced" (46). In most cases, older peers have experienced the same kind of trauma and are able to provide comfort and psychological support to young children. Peers meet with children in "Grief and Loss" sessions. The sessions "...help members talk about and learn to cope with the illness and loss of family members and friends, especially in the context of the AIDS pandemic" (Van der Heijden & Swartz 42). In the words of one 10 year-old girl,

> My favourite session was the one that covered bereavement; that if you're bereaved, you cry if you want to, or if you want to laugh, you laugh...it

> was quite appropriate, because I had sadness in my heart, because I lost my mother when I was young (qtd. in Van der Heijden & Swartz 43).

In a session setting, peer educators also address the challenges of cultural practices, for example, the taboos of silence and removal of the belongings of the deceased. In order to help the children cope with the loss of a loved one, they are asked to bring a meaningful object that reminds them of their deceased parent or caregiver. This teaching method allows the child to memorialize and stimulate their emotions. Van der Heijden and Swartz write,

> Memories can be pleasant and make us smile, but can also elicit emotions of anger, regret and grief. Memories may be stimulated by a song, a place, an object, a gesture, a smell or a sight....Loss reminders...may result in more extreme emotional numbing or avoidance in children...whereas such reminders may [also] be beneficial or healing for children (47).

Children in the Grief and Loss sessions are also encouraged by their peer-led educators to create memory boxes and books. This exercise helps the children to portray their life stories. It is particularly important tool because it is a "...way of addressing social and cultural influences like age-discrimination and a 'lack of discussion within the family concerning HIV/AIDS...and taboos around sexuality and death and a lack of skills in communication within the family setting"' (Van der Heijden & Swartz 47).

The *Vhutshilo* Programme led by teenage peer (rather an adult) educators is an avenue by which vulnerable children can engage in "death talk" in a culturally sensitive manner. In this social setting, children are allowed to talk and cry and, consequently, may become more resilient in articulating grief at the death of a loved one from AIDS (Van der Heijden & Swartz 48).

At the end of their research project, Van der Heijden and Swartz concluded that the *Vhutshilo* Programme was of value notwithstanding the fact that boys were less inclined to express their emotions in the sessions. Conversely, girls were more open to talking about their feelings and experiences. But more importantly, all of the children appreciated the sessions and boys and girls alike disclosed painful memories because they had not previously been given the opportunity to fully engage in remembering the details of the death of their loved one.

B. Mental Health of Children Living in the Era of AIDS

i. Feeling the Agony and Stress of Orphanhood

In an article entitled "Children of the AIDS pandemic" Lucie Cluver (researcher and study director of the Orphan Resilience Study), referred to a 15 year-old girl participant named Lindiwe who struggles with her HIV-positive status and the secrecy surrounding her parents' deaths. According to Cluver, Lindiwe's "...parents were said to have died of 'TB and bewitchment', but their symptoms confirmed that their deaths were among the 850 caused each day by AIDS in South Africa" (1). AIDS is now in its 31st year and Lindiwe is one of 12 million children in sub-Saharan Africa who have been orphaned by the disease (Cluver 1).

Cluver and her team measured the psychological stress of the participant children in an Orphan Resilience Study. One way to query the children about stress was to ask them whether or not they experienced nightmares and flashbacks about a deceased loved one (Cluver 3). According to Cluver, "Their responses revealed that children orphaned by AIDS were 117% more likely to be suffering from post-traumatic stress disorder than children whose parents were alive, and also...67% more likely than children orphaned by other causes, including homicide, suicide and cancer" (3). Cluver and her team also found that a child feels the pain of orphanhood long before a parent dies on the following social rationale: "People gossip about the

family; the children may be bullied or excluded from the community; and infected caregivers are often severely impoverished and depressed" (Cluver 4). To bolster that rationale, Ms. Cluver offered the words of one little girl participant, "They say that my mother is a prostitute and I will die just like her" (qtd. in Cluver 4). Children who live with a parent who is ill or dying with AIDS are more predisposed to endure a lasting psychological syndrome. Characteristics of the syndrome include depression, post-traumatic stress disorder and anxiety (Cluver 3).

While conducting the Orphan Resilience Study, Ms. Cluver also found other significant indicators that affect the mental health of a child who is living with a caregiver afflicted with AIDS. According to Cluver,

> ...5% of children in healthy families are physically abused (slapped, punched or hit with a sharp object at least once a week) and 8% are emotionally abused (told at least once a week that they are lazy, stupid, or threatened to be sent out of the house or cursed by an evil spirit. For children living with a caregiver who is sick with AIDS, the numbers rise to 12% and 23% respectively (5).

Ms. Cluver concluded from the data collected in the Orphan Resilience Study that the psychological disorders of children orphaned by AIDS, continue to worsen as they grow older. By contrast, the psychological health remains sound among children whose parents are living. Additionally, children who have been orphaned because a caregiver has died of another disease, for example cancer, do not suffer the same psychological stress as an AIDS orphan.

ii. Agony and Stress of Double-orphans

Double-orphans are more likely to suffer depressive trauma because they have lost both of their parents. The trauma may likely intensify if the child is placed in an orphanage. In such

an institutional atmosphere a child may fall into depression, especially if he/she has a low self-image. (Kalsoom & Waheed 81). According to Kalsoom and Waheed,

> Depression and self-esteem may be viewed as a vicious cycle. The inability to relate one self to others may lead to low self-esteem which leads to depression. The depression then leads to further inability to relate one self positively in social situations, which adds to the feelings of low self-esteem (81).

Kalsoom and Waheed also found that another type of depression referred to as *anaclitic* may occur when a child suffers prolonged separation from its parent. While Anaclitic depression is seen more in adults, it may also manifest itself in children. The child may exhibit certain behavioral patterns including crying, immobility and apathy (81).

In a study conducted in a high HIV prevalence area in northeastern Namibia, researchers Ruiz-Casares, Thombs and Rousseau sought to measure the mental health of AIDS orphans. Using the children's depression inventory ("CDI") Ruiz-Casares et al. circulated a questionnaire to 163 participant children that requested that they answer, among other questions, (1) the status of their parents (whether they were living or deceased) and (2) how they had been feeling in the past two weeks. At the conclusion of the CDI study, Ruiz-Casares et al. found that,

> ...orphans, and particularly double orphans, are vulnerable to elevated symptoms of depression...consistent with other studies in sub-Saharan Africa that have found elevated rates among orphans due to AIDS or other causes. Disruption in family functioning, socio-economic deprivation, and lack of supportive services may partly explain the burden of child and adolescent mental health (373).

Ruiz-Casares also noted that it is important to ask orphans how their parent(s) died. If their loved one died from AIDS, they are more likely to report that they are suffering from depression. Orphans who have lost a parent to a disease other than AIDS are not as prone to mental stress (374).

C. Psychosocial Support System for OVC

Among the many layers of psychosocial trauma suffered by orphans and vulnerable children, lies the pain of stigma and discrimination due to HIV/AIDS. The trauma becomes even more severe when the child is faced with isolation from individuals and community. If the child is directly affected, he/she may be excluded from school for fear of infecting others. In addition, this painful segregation may result in the denial of health care and other support services that are otherwise provided to healthy children and adults. Health care providers who ignore the rule of confidentiality and reveal one's HIV status also add to psychosocial trauma (UNICEF 29). The child may then turn to a traditional healer for physical and emotional support.

i. Traditional Healers

In a Traditional Medicine HIV/AIDS project conducted in Dar-es-Salaam City, Tanzania, researchers Kayombo, Mbwambo and Massila sought to study the role of a traditional healer and his/her ability to assist orphans and vulnerable children in coping with the loss of a parent to AIDS. Traditional healers, who often go unnoticed, work at the grassroots level within a community, to offer psychosocial support services at a local *vilinge* (clinic) (1). According to Kayombo, Mbwambo and Massila, psychosocial support is defined as:

> ...an ongoing process of meeting physical, emotional, social, mental and spiritual needs of orphans and vulnerable children, all of which are

considered to be essential elements for meaningful and positive human development (2).

In African cultures a child is never considered an "orphan" because it is the custom that the extended family will care for the child. However, because of the AIDS pandemic, the extended family is often stretched to the limit to provide physical and emotional support to their orphaned relative. In some cases the caregiver may discriminate against the orphan by holding back on food, education and overworking them. The child may then seek out the traditional healer who treated their deceased parent (Kayombo, Mbwambo & Massila 2).

Using a psychosocial support model represented by a wheel, Kayombo et al. wrote that traditional healers should be cognizant that all of the spokes of the wheel work in tandem to sufficiently support an orphaned child. The representative spokes are as follows:

(1) physical needs – food, shelter, basic health care;

(2) emotional needs – love, encouragement, self-esteem, guidance;

(3) mental needs – formal education, general skills, motivation;

(4) social – integration into a community without fear of stigmatization, forming friendships, peer acknowledgement, sense of belonging; and

(5) spiritual –creating a belief system that accentuates hope for the future.

The traditional healers who participated in the study were chosen because they provided health care to HIV/AIDS patients and were members of traditional healers associations. An in-depth questionnaire was submitted to them requesting their input regarding the AIDS orphans they were treating (Kayombo, Mbwambo & Massila 4). Subsequent interviews with the healers revealed a number of common problems associated with caring for the orphans. The children exhibited,

> ...repeated illness especially those who were HIV positive, anger, guilt conscience, fear, sometimes isolation from playing mates and feeling that they were being oppressed....some of the children were crying now and then especially young ones '*baba yangu yuko wapi*' (where is my father) or *mama yangu yuko wapi* (where is my mother), sleepless nights and nightmares were common (Kayombo, Mbwambo & Massila 5).

ii. Traditional Healers Help to Instill Coping Strategies

Traditional healers reported that orphans who display anxiety in the form of crying or talking in their sleep were undoubtedly seeing "shadows" of their deceased parents or grandparents. According to the Kayombo team, the healers "...had to give them remedies that can remove the parents' and grand parents' 'shadows'" (5). Remedies included giving the child something to wear around their neck or wrist. The healers also soothed anxious children by reciting a litany of prayers asking the parents and grandparents to "...leave the child so that s/he can stay comfortable" (5). Other remedies included storytelling, theatre, choir, traditional dances and providing examples of other orphans who have become successful in life (Kayombo et al. 5).

The Kayombo team concluded that in order to treat orphaned children, it is essential to recognize and appreciate the cultural belief in "shadows." According to Kayombo et al.,

> "The 'shadows' from parents and grand parents who have died reflects the belief of traditional African culture that people who have died are alive in an 'other world' and have an influence on people who are living in our world; and that is why they believed that they come in the form of 'shadows' to their beloved ones. To remove the 'shadows' is done through rituals which are accompanied with litany of names of people who have died asking them to stop coming to orphans because they create fear and make them fail to cope with orphanhood (6).

All of the above coping mechanisms utilized by traditional healers are meant to help the orphaned child integrate into society with a positive feeling of acceptance and hope for the future.

iii. UNICEF Fosters Psychosocial Support for OVC

UNICEF hosted the Fifth Global Partners Forum in June 2011 which buttressed the initial framework laid out in the 2004 forum that focused on strategies to help HIV/AIDS affected children. Among the key policies addressed in 2011 was an initiative to provide psychosocial support to children living with HIV. According to the report entitled "Taking Evidence to Impact: Making a Difference for Vulnerable Children Living in a World with HIV and AIDS," a survey conducted among Zimbabwean adolescents who sought HIV services revealed "…the most common challenges for adolescents were psychosocial in nature and included stigma, difficulty identifying with HIV-negative peers, anxiety about sexual relationships and future planning, and low self-esteem and feelings of hopelessness" (27). When and if implemented, the following interventions would be beneficial in supporting OVC.

1 Integrate psychosocial services into far-reaching HIV/AIDS programs;

2 Educate families so that they can provide support to OVC who are traumatized and grieving;

3. Prepare OVC living with HIV/AIDS to tell their families and friends so that they can better deal with their feelings of isolation;

4. Encourage HIV-positive adolescents to become advocates to spawn support from governmental bodies to ensure that they receive adequate funds to live the best life possible; and

5. Link clinics and social services so that they provide proper nutrition to maternal orphans, particularly within their first year of life.

The above local and world support systems are available to orphans and vulnerable children, but the struggle to alleviate the trauma that a child suffers from the effects of HIV/AIDS remains daunting.

CONCLUSION

HIV/AIDS continues to come down like a sledgehammer on the peoples of the world. For example, in sub-Saharan Africa 22.9 million people are living with HIV. More disturbing is the fact that 11 million children in sub-Saharan Africa under the age of 15 have lost at least one parent to HIV/AIDS. The future for children forsaken in the era of AIDS is bleak. Without certain interventions, orphanhood will continue to spiral out of control. I base my opinion on the following information that I gleaned from my literature review.

(1) Until women are lifted up from under the veil of gender inequalities, they will be the source of unwanted HIV infection and pregnancy. Condom use by males is practically unheard of in certain cultures. HIV often goes undetected because the person is unwilling to be tested. More disturbing is the fact that if a person is HIV-positive, it is held in secret from family and community.

(2) Proper nutrition and access to medical help is especially important to an AIDS patient. However, the lack of money and/or transportation means the person will probably not receive proper care. Children are then placed in the position of taking care of the dying parent or loved one. Most likely a girl child will not be able to attend school which may lead to further trauma.

(3) In most African cultural belief systems, an orphan is supposed to be taken into the loving arms of the extended family. This is not always possible because the family may be afflicted with poverty, aging, illness or a combination of these difficulties requiring alternative

care. None of the alternative care options (an orphanage, a foster home, or a child-headed household) can compare to the warmth and love of a family unit. Worst of all, when these three options fail, the orphan resorts to living on the street where he begs for food to survive.

(4) Girl orphans are particularly vulnerable to sexual and mental abuse. Incidents of exploitation will not change until a girl's right to "say no" is fostered in an educational setting. I believe that it is crucial for girls to be educated beyond the primary level. However, studies suggest that a girl's education is not as valuable as that of a male.

(5) Until economic assistance is forthcoming from governmental agencies and private funding, orphanhood will grow at epidemic levels. Unfortunately, until the hand of corruption is taken out of power, funds will never reach the service facilities that need it most—clinics and hospitals. If AIDS patients do not receive proper care to prolong their lives, at least until their children are in a position to take care of themselves, orphanhood will continue to escalate.

Finally, I want to believe that the discouraging conditions of orphans and vulnerable children that I have alluded to in this paper will constitute a "call to action" on the part of local, state, and worldwide agencies. Only those holding the purse strings can help to alleviate the trauma that is suffered by the "innocent ones."

My Hands-on Learning Perspective

I was fortunate to have observed the children at two orphanages that I visited in East Africa. It was evident to me that these two institutions were doing a lot to help the children grow into responsible citizens. However, even a well-meaning institution cannot possibly administer to every child the daily doses of emotional care and love that they need. The experience spoke to my sense that it truly is the "innocent ones" who yearn to belong and be loved. I am reminded time and again of author Emma Guest's quote,

> *Children in orphanages are hungry for affection. They rush to staff and visitors for hugs. They cling to adults' legs. They like to sit on adults and play with their watches or their earrings. If someone else seems to be getting a more central position in a hug, they shout, push and scramble in....When staff and visitors go home, they must gently peel them off* (93).

As our group prepared to leave the Samaritan Village Orphanage that day in December, a staff member had to "peel" little Elijah from my arms. His eyes appeared sad and empty as we parted. He reached out to me once again, but our time was up. I left that day with the hope that the right family would come along and adopt him. I later learned, however, that there are miles of "red tape" to untangle if someone other than a Tanzanian wishes to adopt a child.

Finally, as I conclude this Advanced Project paper, I reflect upon the fact that I have had an opportunity, through travel, to weave a colorful tapestry of many different cultures and their traditions. While most of the threads are bright and exciting, some are dark and fearful because the AIDS pandemic has wreaked havoc and hopelessness on orphaned children. I cannot believe that any culture anywhere in the world deems it acceptable for a child to be left without the love, protection, emotional/physical and spiritual guidance that a loving parent can provide. Moreover, every child deserves a respectable chance at life and living. But most of all, orphaned and vulnerable children must have the same chance as their counterparts who are living in homes not afflicted by HIV/AIDS.

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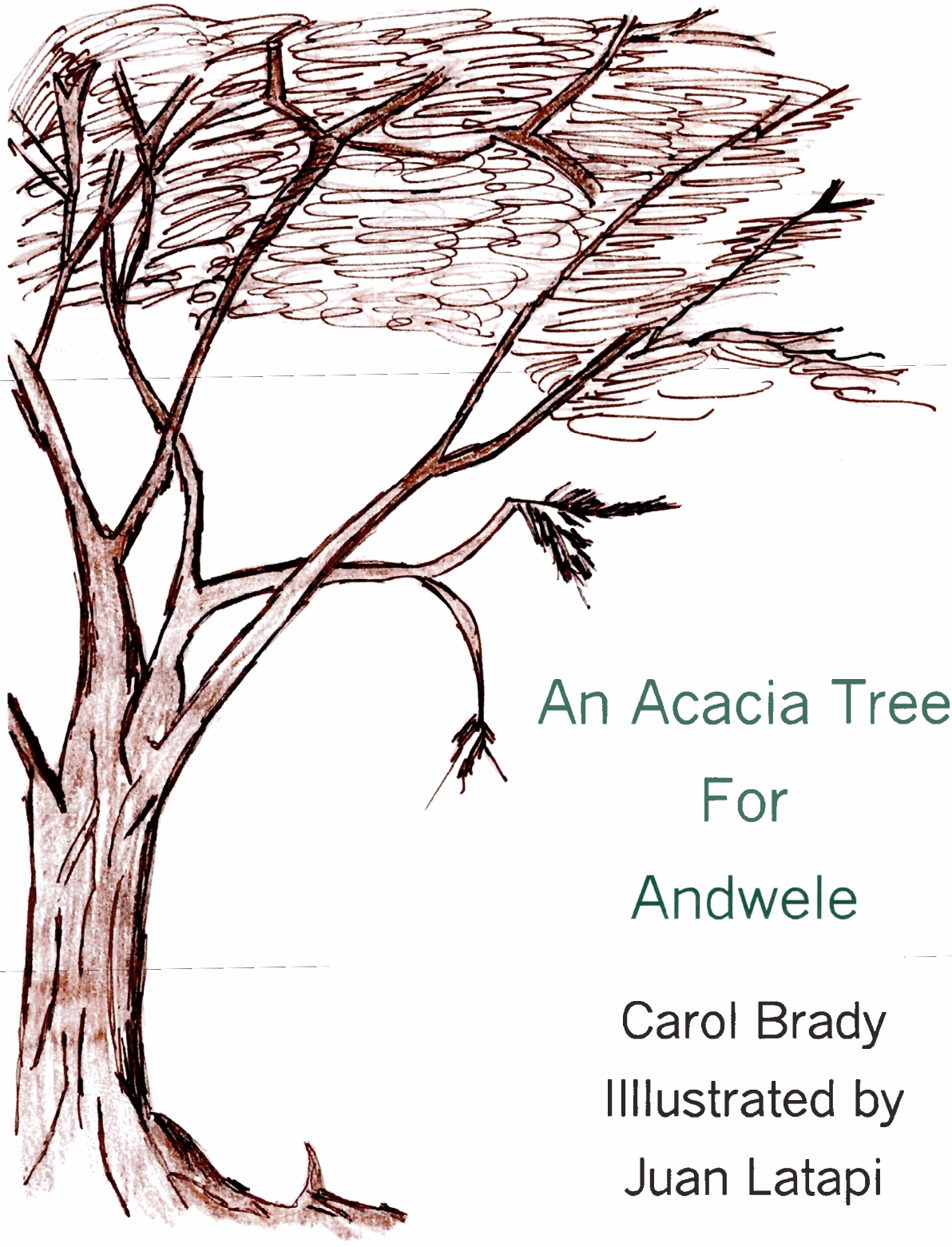


An Acacia Tree For Andwele

Carol Brady
IIIlustrated by
Juan Latapi

I dedicate this book to the millions of children around the world who have been orphaned by HIV/AIDS.

My love especially goes to one little boy named Andwele at the Children of Dreams Orphanage in Moshona, Tanzania.

He will live forever in my heart.

C.B.

Your arms reached out to me.

Take me.

I held you tight.

We let go,

Never to forget

C.B.

Chapter 1

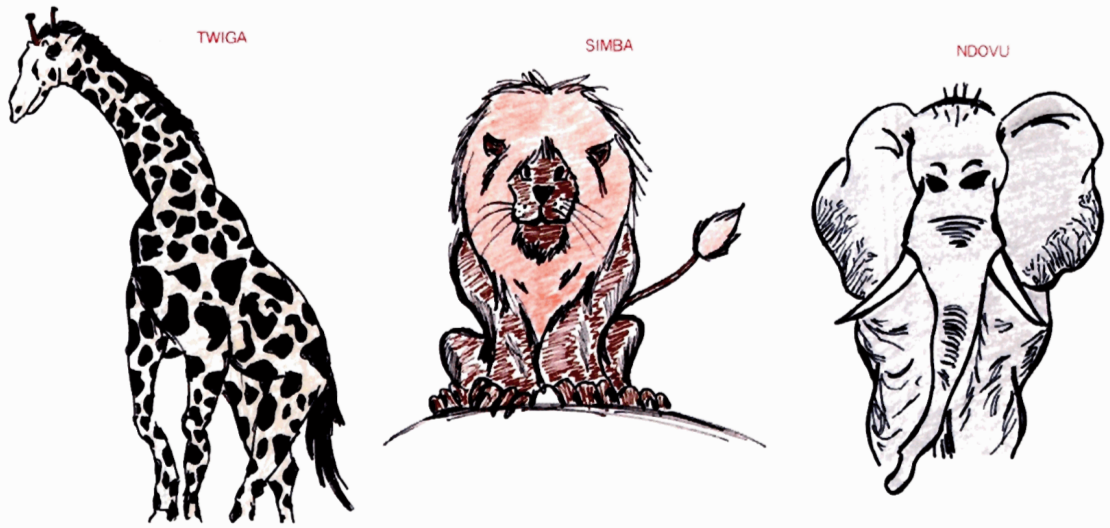
Andwele's Tears

Jumamosi **(*Saturday*) afternoon had come. The sun was shining brightly on the Children of Dreams Orphanage in Moshona, Tanzania.**

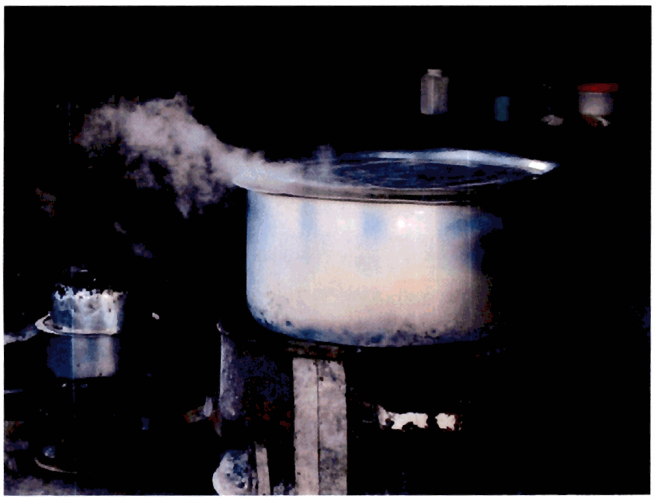
Banana trees close to the orphanage wore lush green leaves and fruit. Birds were singing a sweet song. White cottony clouds bounced playfully in the deep blue sky.

There were many children at the orphanage—some little, some older. But there was one very sad and special little boy named Andwele. Andwele was eight years old. He had been at the orphanage since he was one-day old.

As Andwele grew from a toddler to eight years, he did not want to play very much with the other children. He spent most of his time alone. He loved learning to read and write English. Books became his companions. He day-dreamed about the *twiga, simba and ndovu* (giraffe, lion and elephant) that live on the savannahs in East Africa. Maybe someday he would get to see them for real.



Jaboli, the *baba* (father) of the orphanage, Teacher, Nurse and Cook, all noticed tearful streaks down Andwele's handsome face on some days. They wondered why Andwele was feeling so sad. Nothing seemed to make him happy, not even when Cook made a tasty lunch of hot rice and goat stew for the



children.

Jaboli decided that he must do something about Andwele's gloomy mood. So, after much careful thought and prayer, he took Andwele aside and asked, "Do you want to tell me why you are sad and crying sometimes?"

Unsmiling, Andwele replied, "Now that I am eight years old, I have been wondering why I do not have a mama or a *nyanya* (grandmother) to take care of me. Why did I come here? Why do I have to stay in an orphanage—doesn't anyone want me?"

Jaboli thought for a moment. "Andwele, I only know what the old woman told me about you when she brought you here as a newborn baby. I have prayed about telling you. I think you are old enough now to hear the story. Would you like to go for a walk in the banana grove and I will tell you how you came to Children of Dreams Orphanage?"

"Yes, baba, I want to hear the story."

Hand-in-hand, Jaboli and Andwele set off for a walk in the bright sunshine of the banana grove.

In a short while, Jaboli paused in the shade of a banana tree. "Let's sit for awhile Andwele, and enjoy our snack of fresh pineapple slices that Cook made for us. The pineapple was so sweet and juicy. It dripped down their chins. They giggled.

Finally, Jaboli asked, "If you are ready to hear the story, I will tell you what the old woman told me. "

"Yes," replied Andwele, "I am ready."

Sitting face-to-face with Andwele in the cool shade of the banana tree, Jaboli began the story.

Chapter 2

The Old Woman's Story

One night, after darkness fell, a young woman, alone and sick with fever, left her newborn baby boy under an acacia tree in a grove nearby her village.

There was sadness in her heart. Tears fell when she laid him down because she knew she could not take care of him. Not even her mother's milk would keep him alive because a doctor told her she had an infection that would have made him sick too.

Andwele interrupted Jaboli, "What was the sickness?"

Jaboli thought for a moment and answered, "Andwele, it is an infection that hurts your body and you need medicine right away. In the little villages far away from hospitals, the medicine is not always available. Let's talk about it when you are a little older. You and the other children will learn how to protect yourselves from getting the infection." "Okay," said Andwele; he seemed satisfied with Jaboli's answer.

"Shall I continue with the old woman's story?" "Yes, answered Andwele."

After the young woman kissed her baby for the last time, she prayed to her ancestors that someone would come along soon and find him.

A day of hunting for food, left a family of twiga, ndovu, and a pride of simbas very tired. They came to the acacia grove to rest for the night.

"But," exclaimed Jaboli to Andwele, "the old woman said that a very surprising thing happened with the ndovu. "

"What happened?" asked Andwele—his eyes searching Jaboli's face for a clue.

The ndovus heard a crying sound, just like the sound a baby ndovus makes when it is unhappy. They investigated where the sound was coming from. And, there beneath a tall acacia tree, lay a baby bundled in colorful red cloth.

The mama ndovus sensed trouble for the bundled baby. She made a loud trumpeting sound and gathered her family together. They made a protective ring around the tree to shield the bundle. They stood guard through the night.

Andwele's eyes widened. "Really? <u>Please</u> baba, tell me more."

In the morning the old woman came from her hut in the nearby village of Sekei to the acacia grove to gather firewood. She was not frightened to enter the grove because the animals had gone for a morning food hunt. Suddenly, as she came nearer a tall acacia tree, she heard a crying sound.

Bending down, she saw a cold and shivering baby. She picked the baby up and cuddled him close to her. She was feeling sad. She knew in her heart that she could not possibly feed another mouth at her house, especially a tiny newborn. Besides, she had no living relatives left because they died of the sickness too.

Jaboli continued.

She brought the baby home with her and talked to the elders of her village. The elders decided that she should take the baby to an orphanage where he would be safe and loved.

The next morning, with the baby swaddled on her back, the old woman set out from her village to walk the many miles to the Children of Dreams Orphanage.

"So, she did the next best thing, Andwele. She met with me and I promised her that you would be welcome in my family and I would make sure you were loved and protected from

harm. I told her too that I would tell you the story when you were old enough to hear the truth."

With that, Andwele broke into a smile.

He seemed pleased that he knew something about his mama and why he had been left. Jaboli was happy that he could finally tell Andwele the story. The sun was going down and it was time to walk back to the orphanage.

The sun rose brightly again on the next morning—*Jumapili* (Sunday). Jaboli could hardly wait because he knew that Andwele and the other children were going to get a big surprise. Andwele and his friends would be going on an unforgettable adventure with new friends from across the ocean.

Chapter 3

The Little Yellow Bus

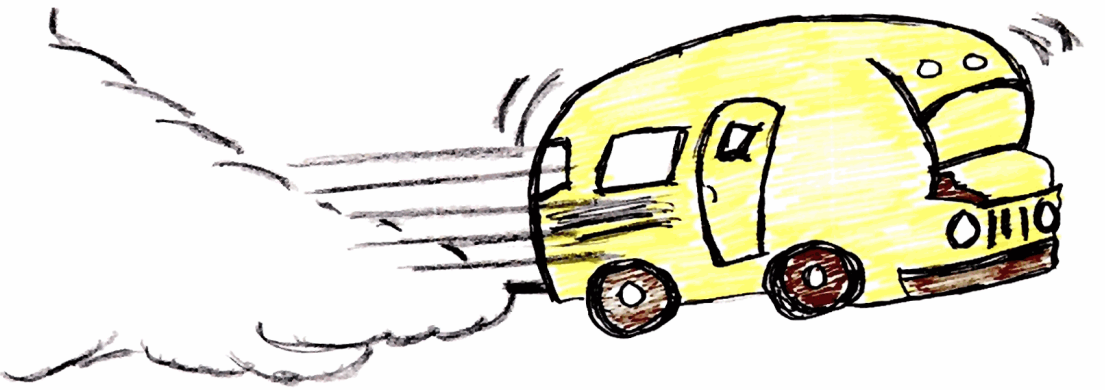
Mrs. Dilly and her fellow travelers from America arrived in Arusha, Tanzania early on *Jumapili* morning. After a long flight, they were weary, but excited too. Mrs. Dilly had been dreaming for a very long time about visiting the Children of Dreams Orphanage to meet the children.

The sun was high in the sky when Jaboli received a telephone call that Mrs. Dilly and her friends had arrived and that they were planning to visit the orphanage later that afternoon. Jaboli made the announcement to the children, Teacher, Nurse and Cook as they sat in a circle in the parlor of the main house.

When Jaboli said "visitors" a smile broke out on Andwele's face. He always loved it when visitors came. Maybe he would have a chance again to practice English with one of the visitors.

But, Jaboli had a BIG secret. He did not tell Andwele and his friends that when Mrs. Dilly called, she asked permission to take the children on a special adventure the next day. Jaboli was excited for the children and he promised Mrs. Dilly that he would keep the secret.

The little yellow bus with its passengers moved along the main highway out of the bustling city of Arusha until it reached a red-clay dirt side road.



The driver turned onto the bumpy, dusty road. The driver swerved to miss the holes in the road. The passengers laughed and swayed to the rhythm. Along the road were village mamas, *nyanyas* (grandmothers) and children cooking and washing clothes. They smiled and waved to the smiling faces in the bus as it made its way to the orphanage.

Finally the bus came to a clearing and in the middle of a banana grove stood the orphanage that Mrs. Dilly had dreamed about. There, waiting patiently on a stone wall, was Andwele.

As Mrs. Dilly stepped out of the little yellow bus, Andwele held out his arms to her. She reached for him and swooped him into her arms. There was delight in Andwele's big smile.

I was waiting for you.

You were waiting for me.

As the group settled in with the children, Andwele asked Jaboli, "May I have permission to take Mrs. Dilly on a tour around the grounds of the orphanage?" Jaboli answered, "Yes, Andwele you may—but only if Mrs. Dilly is not too tired from her long trip." Mrs. Dilly was more than excited to spend time with Andwele.

Mrs. Dilly and Andwele walked to the vegetable garden, the chapel and the well. They did not exchange many words, but with Andwele's hand in hers, Mrs. Dilly already felt a heart-to-heart connection with him.

Visiting time was growing short. Mrs. Dilly and Andwele spent the last few minutes together sitting on the stone wall. It seemed the perfect time to ask Andwele the question that Mrs. Dilly was so excited about.

"Andwele, would you like for me to come back tomorrow?" "Oh yes, Mrs. Dilly." Andwele broke into a wide smile--his eyes misty with tears. "Please promise you will come back tomorrow." Smiling, Mrs. Dilly said, "I promise Andwele, I will be here bright and early in the morning. But tonight, I want you to dream about going to a very special place tomorrow where you will see tall trees with an umbrella on top. And, if we are lucky, we will see animals too."

Andwele thought for a moment, "What do you mean--a tree with an umbrella on top?" Mrs. Dilly replied, "The tree is very tall, with a thick trunk. The branches and leaves, all at the very top, fan out like a giant umbrella. You will see what I

mean tomorrow ."

Sliding down from the stone wall, Mrs. Dilly said, "For now, Andwele, I wish you sweet dreams. It will be a long and exciting day tomorrow. *Tutaonana kesho* (see you tomorrow) Andwele." Mrs. Dilly and her friends got on the little yellow bus and waved goodbye to Andwele and the other children.

Chapter Four

The Promise

Mrs. Dilly and her friends were up bright and early on *Jumatatu* (Monday) morning. The sun was already shining bright as they boarded the little yellow bus for their trip to the orphanage.

As they rolled along, they saw mamas and babas walking beside the road carrying fruits and vegetables to the local markets to sell.

Mrs. Dilly turned to her friends and said, "Let's stop at one of the markets and buy some fruits and vegetables to bring to the orphanage." It was a good plan.

Mrs. Dilly asked the driver to stop at a roadside market.

When Mrs. Dilly and her friends stepped off the bus, they were amazed at the colorful display of goodies before them.

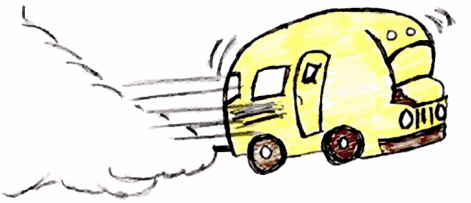
Carrying two big baskets, they loaded them full to the brim with pineapples, mangos, green beans, bananas, and oranges. They had some extra shillings so they also bought two big bags of rice.

Now the bus was loaded with fruits and vegetables. They set off for the orphanage.

At the orphanage, it was already 9:00 o'clock in the morning with no sign of Mrs. Dilly and her friends. Andwele was beginning to wonder if she was coming back. He was starting to feel sad again, but, soon Andwele and his friends heard a rumbling sound coming down the road to the orphanage.

Andwele shouted to his friends, "Maybe it is the yellow bus coming back!!"

And, sure enough, it was the bus.



Jumping up and down, Andwele and his friends screamed, "We are going on an adventure; we are going on an adventure."

As soon as the little yellow bus arrived, Mrs. Dilly was greeted by Andwele. With a sunny look on his face, he said, "*Jambo* (hello) Mrs. Dilly." "Jambo to you Andwele," said Mrs. Dilly holding out her arms to him. Andwele came running to her. "Mrs. Dilly, you did keep your promise." "Of course," said Mrs. Dilly, "I would never tell you something that I did not mean."

"But, before we get started for the day," said Mrs. Dilly, "our group has brought a surprise to Jaboli that he will share with you and the other children. Would you like to help me and my friends with the surprise?" "Yes," replied Andwele.

The driver opened the back doors of the little yellow bus. Andwele and his friends looked in. They clapped and chanted "*Asante sana*" (thank you very much) Mrs. Dilly and friends."

They saw the baskets that were so big and full of goodies, but they could not carry them alone.

They ran to get Jaboli.

He came out to the bus and together they carried the baskets of fruits, vegetables and bags of rice to the main parlor of the house. Jaboli was so surprised and happy with the gift that he could not stop saying *asante (thank you)*!!"

It was already 10:00 and Mrs. Dilly was so excited to tell Andwele and the other children about the adventure. Jaboli, who was in on the surprise, signaled "thumbs up" to Mrs. Dilly to tell the kids where they were going. Cook was in on the surprise too. She had already fixed box lunches for everyone. The driver of the little yellow bus was ready to roll.

Holding her hand to her heart, Mrs. Dilly said with a big smile, "Children, we are going to Tarangire National Park for the day. It is a long ride, but if we leave now, we will arrive by lunch time. Then we will have the whole afternoon to look for *twiga*, *simba* and *ndovu* and the tall trees with umbrellas at the top." Andwele and the other children clapped and cheered.

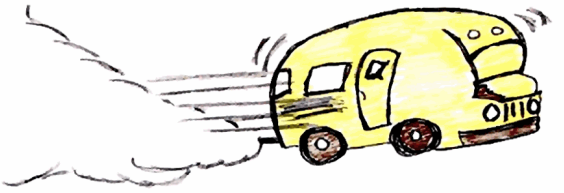
One by one, they picked up their box lunches and got on the bus. Mrs. Dilly and her friends were so happy that they could provide this special adventure for the children. Mrs. Dilly

hoped it would be a day that the children from the orphanage would never forget. Especially, a day that would hold promise and happiness for a very special little boy named Andwele.

Chapter Five

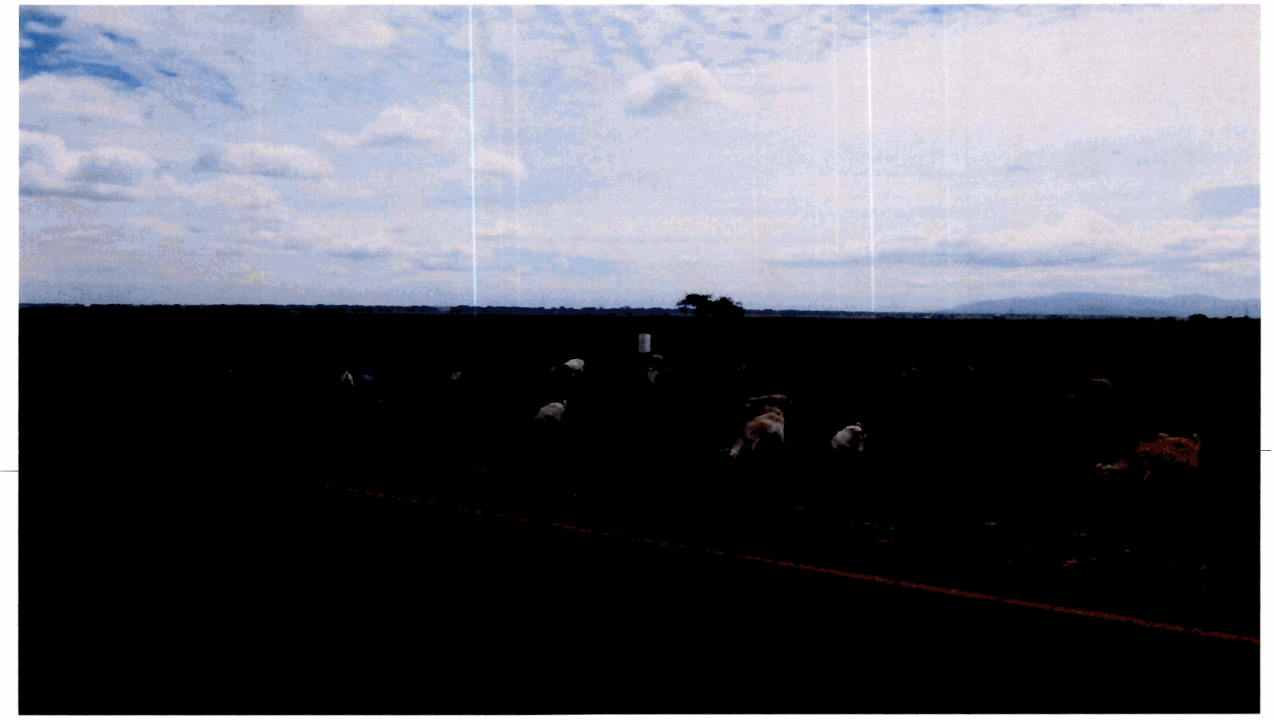
The Trip to the Park

It was a warm and beautiful day—perfect for an adventure. Rolling, rolling, the wheels of the little yellow bus sped down the highway.



Mrs. Dilly, her friends and the children were singing and laughing!

Oh look, Andwele" said Mrs. Dilly pointing out the window, "See the man dressed in a colorful red poncho—he is herding his goats and cows toward a pasture where there is good grass for eating.



This is the job of a herder, Andwele. He does the same thing every day—all day. What do you think of that?" Andwele thought for a moment, "I think he must get very tired and hot." "Yes, but if the goats and cattle eat well, they will give good milk and meat," said Mrs. Dilly.

They were already just one hour into the trip and Mrs. Dilly could tell that Andwele was really loving the adventure. Her heart felt good that he was so excited. Settling back on her seat, Mrs. Dilly said to him, "There is a lot to see on our way to the park, so keep your eyes open. Why don't we play a game. If you see something you have never seen before, like an animal, shout it out. Then everyone on the bus can see what you spied too." "That sounds like fun Mrs. Dilly."

There was so much more to see. Settling back into his seat, Andwele felt more and more excited. "Mrs. Dilly," whispered Andwele, "this is one of the best days of my life. *Asante, asante.* I can't wait until we get to the park."

Rolling, rolling, the wheels of the little yellow bus sped down

the highway toward the Tarangire National Park.

Chapter Six

The Animals

It was almost noon when the little yellow bus arrived in the park. After the entrance fee was paid by the driver, the bus set out on a road into the park--it was narrow and zigzagging. Signs along the way warned visitors to stay in their busses and cars. "Why can't we get out of the bus Mrs. Dilly?" asked Andwele. "For a very good reason." answered Mrs. Dilly. "There are *ndovu (elephant)* and *twiga (*giraffe*)* roaming around. This land is their home and we do not want to frighten them. Even though people come every day to see them, they are wild animals. Be patient; keep your eyes open, I promise we will see them soon."

As they drove further into the park, the children began to see smaller animals on the sides of the road—love birds, ostrich, impala, gazelle and a family of baboons.

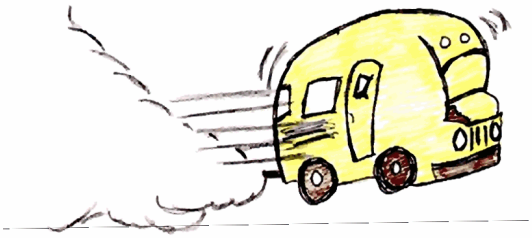
There was even a bug pushing a ball of dirt along the roadside. The bigger the ball of dirt became, the harder it was for the bug to push it. But the bug never gave up. He kept pushing and pushing. The driver of the bus was very kind--he stopped so everyone could see the animals. He told the children little stories about some of the animals. Mrs. Dilly had her camera ready to take pictures!! There was much excitement on the bus. "But," thought Andwele, "where were the *ndovu* and *twiga."* He hoped he might even see a *simba (*lion*).*

It was after 1:00. Mrs. Dilly asked the driver to look for a nice cool spot to have their box lunches. Going deeper into the park, the driver turned off on a side road. He was headed for the river because he knew there would be shade and picnic tables there. Feeling a little drowsy, Andwele was about to put his head on Mrs. Dilly's shoulder when he looked out the window. "Am I dreaming?" he shouted to Mrs. Dilly and everyone on the bus, "Look, look over there, an ndovu family."

Sure enough, crossing the field were several ndovu. The mama ndovu was heading the herd, babies were tagging along, and the baba was bringing up the rear. The driver stopped short. Everyone on the bus hung out of the windows!

The ndovu came pretty close to the bus as they crossed the road to the other side. "Their ears and feet are so big and their skin so wrinkly" cried Andwele. "Yes," said Mrs. Dilly, "they are really fascinating animals. Let's watch and see what they do." Pretty soon the ndovu were taking a mud bath in a big puddle near some big trees.

They rolled and rolled, got up and dried off in the hot sun. Then they stood for a rest under some acacia trees. "See Andwele, the ndovu are standing under the trees with the umbrella at the top. The big branches provide them protection from the sun. I hope we can find an acacia tree to sit under after we have our lunch." The little yellow bus moved on down



the road toward the river.

Chapter Seven

The Acacia Tree

It wasn't long before the driver pulled up next to a picnic table on the bank of the river. He got out of the bus and with binoculars up to his eyes, he said quietly, "Look children."

pointing across the water. "See that strip of tall grasses on the bank of the river? See the lioness and her cubs?

She is sunning herself, and her little ones are playing tag with each other." The driver passed his binoculars around to Andwele and his friends. The lioness and her cubs seemed so close to them--they could not believe their eyes!! "Stay very quiet so she does not hear you and run away." They watched for a few minutes, but Mrs. Dilly called, "Come for lunch children."

Lunch was very tasty. Cook had sent little pieces of chicken, fried banana, an orange, cookies and a fruit drink. Andwele and his friends finished quickly. They were ready to move on to see more animals, but Mrs. Dilly had another plan. She thought it would be a good idea to have a little rest before setting out again. She explained to the children that the little yellow bus didn't have air conditioning. It was mid-day and the hot sun was beating down. She didn't want Andwele and his friends to get sick.

So, Mrs. Dilly said to Andwele, "I know you are anxious to get going, but before we do, I spotted a big acacia tree not too far from here. We could walk there, rest for a little bit, and then get back on the bus for the rest of our adventure. Would that be okay with you?" Andwele, said excitedly, "Yes, I would love to see the acacia tree. My *baba* told me a story about an old woman and an acacia tree."

Tugging on her hand, he said, "Let's go, let's go."

It didn't take long to get to the BIGGEST tree that Andwele had ever seen. It was certainly bigger than the banana trees he was used to seeing back at the orphanage. The trunk of the acacia was so huge that Andwele couldn't get his arms around it and neither could Mrs. Dilly. Giggling, they tried holding hands, but still they could not stretch around the trunk. Looking up at the umbrella at the top of the tree Andwele could see that it was high in the sky. It stretched far and wide. Once again, Andwele could not believe his eyes.

Since there was plenty of room to sit and rest under the acacia tree, Mrs. Dilly spread out a little blanket. "I am interested to

know what you think about the acacia tree." said Mrs. Dilly to Andwele. "Why do you think it is so important to animal life on the African savannah." Andwele thought for a moment. "I think it is a good resting place for animals to come. The umbrella is like a roof over their heads. They can get out of the hot sun and when it is stormy, they can stay dry. I have read in my books that giraffes really like to eat the leaves of the acacia tree. So, the tree gives food too."

"So, Mrs. Dilly, I think it is a safe place for the animals. It is like their house. Is that the right answer, Mrs. Dilly?" "That is a perfect answer, Andwele."

Andwele and Mrs. Dilly sat for a little while. There was a cool and gentle breeze blowing. Sitting under the acacia tree, Mrs. Dilly felt peace in her heart. Andwele's face looked peaceful too, but their time under the acacia tree was growing short. The little yellow bus would be ready to leave soon. Mrs. Dilly wanted to help Andwele see and understand how the acacia tree and his home were alike.

"Andwele," asked Mrs. Dilly, " Why were you so interested in seeing an acacia tree? Is there something special about that kind of tree?" With tears in his eyes, Andwele nodded his head. "Yes, Mrs. Dilly. It is hard to think about, but my baba told me that an old woman found me under an acacia tree when I was just one-day old. He said that my mama left me because she was sick. She prayed that the ancestors would send someone to find me. That's how I came to my baba's orphanage."

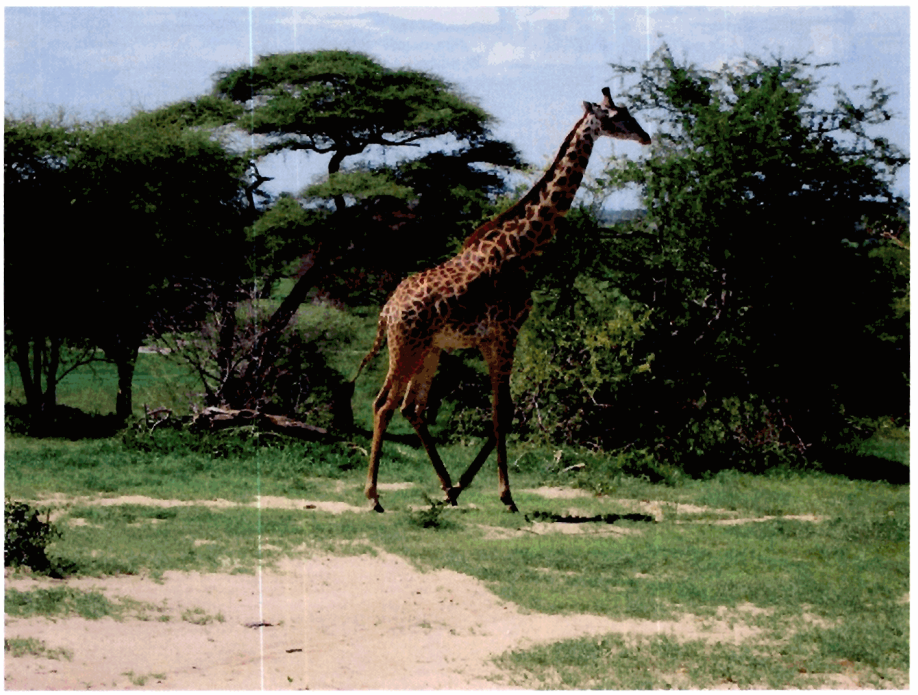
Mrs. Dilly put her arms around Andwele. "It is okay to cry Andwele. Sometimes tears wash away the sadness you feel in your heart. "But," said Mrs. Dilly, "Let's talk about your home and how it is like the acacia tree. The tree provides protection for the animals and Jaboli's home provides shelter for you and

the other children. God provided the acacia trees so that the animals roaming on the savannahs would have food and a place to get out of the hot sun. God provided a way for you to live in Jaboli's home where you have love, friends, good food, a cozy bed and books to learn new things."

Mrs. Dilly continued. "There are thorns and flowers on the acacia tree, Andwele. The thorns hurt, but the flowers are sweet. The same is true at your baba's home. Sometimes words and thoughts hurt, but love is sweet" I have loved every moment we have spent together Andwele and you will ALWAYS be in my heart. Remember the sweet and I will do the same. Now we have just one more thing to do before we run for the little yellow bus."

"Let's look for acacia tree seeds, Andwele. Take one and put it in your pocket. I will do the same." "What are we going to do with the seeds?" asked Andwele. "You will see tomorrow when I come back to your baba's house for our last visit together. Take my hand, Andwele, let's run for the bus!!"

With plenty of light still in the sky, the adventure wasn't quite over. Maybe they would see more animals on their way out of the park. As the bus chugged along, one of the children shouted, "Look a *twiga* (giraffe)."



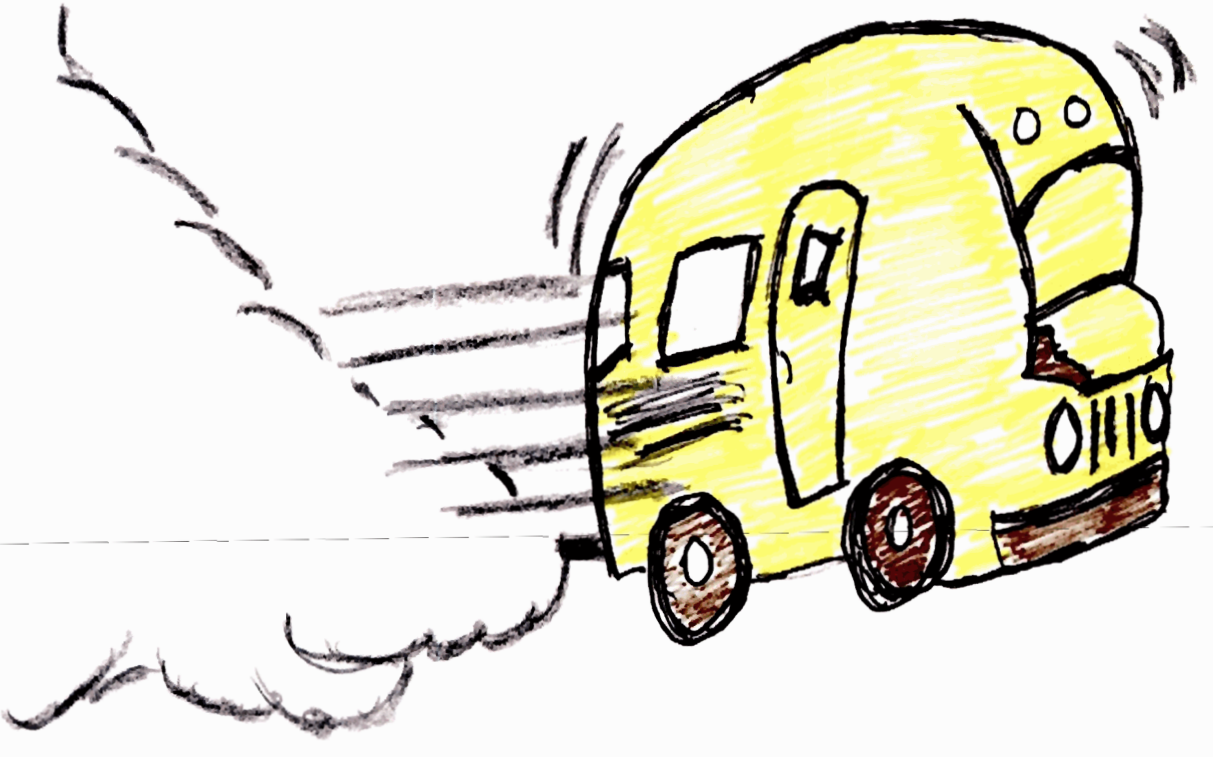
Sure enough, the *twiga* crossed right in front of the bus. Scooting close to the window, Mrs. Dilly said, "Andwele, the *twiga* is going toward the acacia tree. See, he has such a long neck that he can reach the highest branches of the umbrella." She was right. The *twiga* slowly strolled over to the tree and began munching the leaves.

As they came closer to the park exit, the children saw more *ndovus* (elephants) and even a pride of *simba* (lions) *laying still*

in the grass.

But the driver warned that nighttime was coming. As they left the park, Mrs. Dilly and the children had a chance to see the brilliant sky in shades of yellow, orange and red as the sun went down in the African sky.

Happy and tired, the children fell fast asleep. Rolling, rolling, the little yellow bus sped down the highway toward the Children of Dreams Orphanage, Andwele's home.



Chapter Eight

Planting Love and Hope

It was *Jumanne* (Tuesday) and the last day that Mrs. Dilly and her friends would spend with the children at the orphanage. Already she felt sad at leaving Andwele. She knew in her heart that she would never forget him. Would he remember her??

The little yellow bus rolled down the highway and arrived at the orphanage in mid-morning. As usual, Andwele and his friends were waiting on the stone wall.

Mrs. Dilly stepped off the bus and hugged Andwele. "Jambo, Mrs. Dilly!!" said Andwele, bouncing up and down. "Please tell me what we are going to do with the acacia tree seeds that we brought home in our pockets."

"Okay, Andwele, but first," said Mrs. Dilly, pointing to the stone wall, "let's sit down and talk. I have to tell you something." They sat hand-in-hand for a little bit. Mrs. Dilly smiled and said, "Right now I am feeling very sad because today is our last visit together. I am going back across the ocean tomorrow, and I will miss you very much when I get home."

Tears came to Andwele's eyes. "Mrs. Dilly, since I met you I have been so happy. I have learned that I can cry sad and happy tears. I will never forget you. I will keep learning my English because I know you would be proud of me. You are very special and loving. I will always remember you." Andwele reached out to Mrs. Dilly and gave her a big hug. Mrs. Dilly hugged back!

Cook was ringing the lunch bell. It was almost time for Mrs. Dilly and her friends to leave. "Andwele," said Mrs. Dilly, "after

our lunch together we are going to plant your acacia tree seed in a very special place in the garden. When I get home, I will do the same with my acacia seed. Let's promise each other that we will keep the seeds watered. We will heap love on them and watch them grow into beautiful strong trees. Just like the handsome and strong man you will be one day."

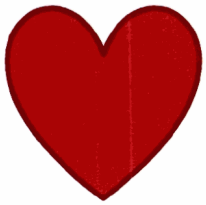
Your arms reached out to me.

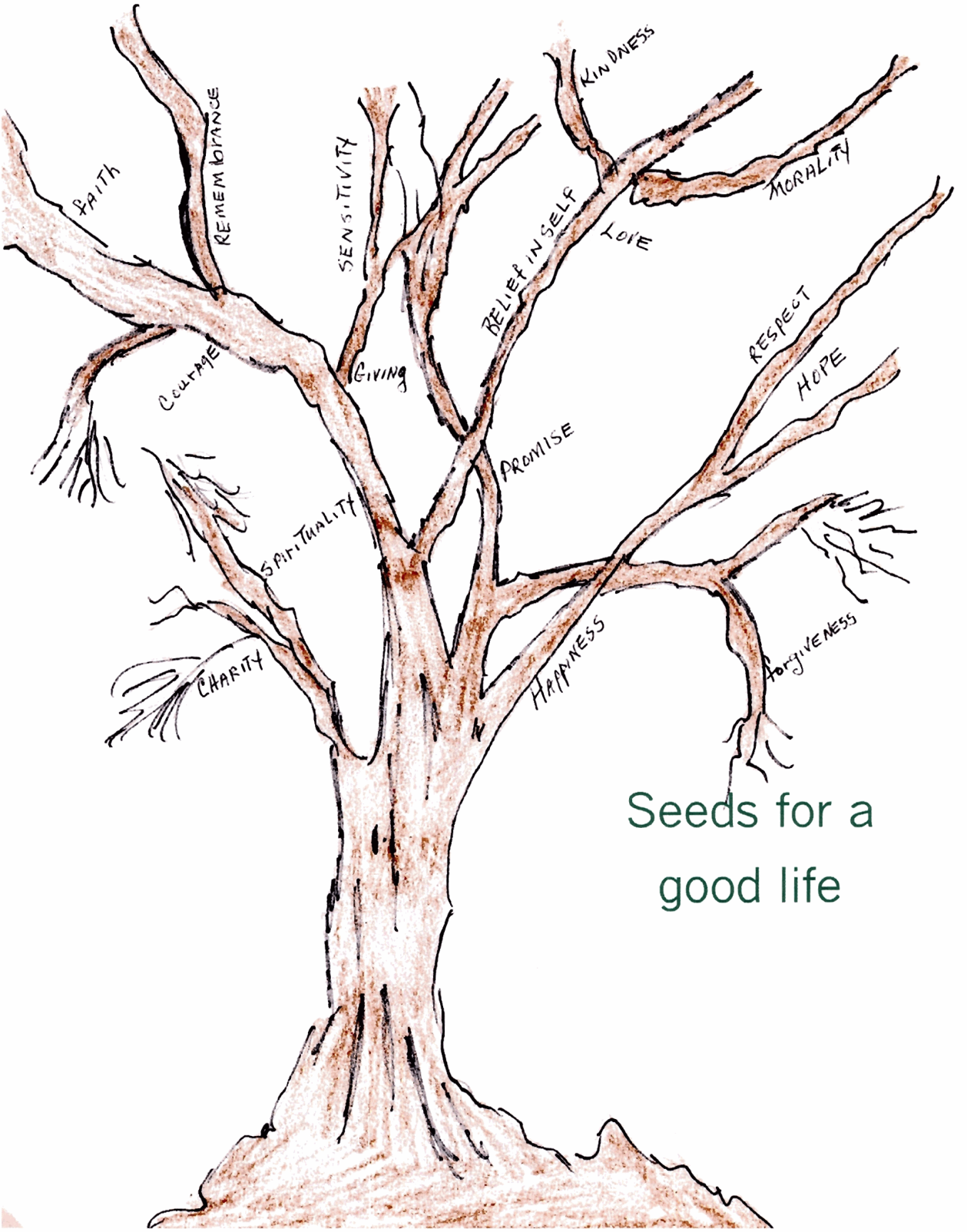
Take me.

I held you tight.

We let go,

Never to forget.




FAITH
REMEMBRANCE
SENSITIVITY
KINDNESS
MORALITY
BELIEF IN SELF
LOVE
RESPECT
HOPE
COURAGE
GIVING
PROMISE
SPIRITUALITY
CHARITY
HAPPINESS
FORGIVENESS
Seeds for a
good life