

## **TATU TANO – A PORTRAIT**

***“My grandmother covers me with a blanket”*** (very young child in Itongo living with the grandmother). ***“I take my grandmother to the hospital when she is sick”*** (boy, about 11 years old, Kihumulo)

***“The child give me hope”*** (HIV+ mother about her son). ***“When I was sick, she brought the food in the hospital and cared the siblings”*** (HIV+ mother about her daughter)

The Tatu Tano (which means three/five i.e. small groups) are support groups formed by (orphaned) children living with grandparents or living with HIV+ parents – mostly with the mother because the father died - that run as part of the broader Kwa Wazee Project. The groups were started initially as a response to the needs of the children who live in the households of older people. Over the last few years as we have run these groups we have learned a lot about the needs of children living with grandparents or with ailing parents and how best to support the children.

We have outlined some of our learning below in the background section as it informs the project we wish to fund. We then follow with a short history of the growth of the Tatu Tano groups and then an outline of our project proposal for 2011 for the Tatu Tano groups follows.

Over the last few years as we have run these groups we have learned a lot about the needs of children living with infected parents and how best to support the children.

### **1. THE BACKGROUNDS**

#### **1.1 Orphaned children living with grandparents/children living with HIV infected parents**

##### **Why are we targeting grandchildren? “Voluntary” and “crisis” fostering**

In Tanzania, 40% of all orphans and 72% of the most vulnerable children are being cared for by grandparents, particularly by grandmothers (Ministry of Labor/HelpAge: “Achieving income security in old ages for all Tanzanians”, 2010, p. 19).

We learnt from the critique around the use and misuse of the concept “AIDS-orphans” that it is always questionable to identify a special group among the children based on one characteristic. Identifying is always also a process of labeling, creating a process of exclusion and inclusion. Additionally no group is homogenous. Labeling all the “orphans”

as one group and treating them as one group doesn't respond adequately to the multifaceted reality.

We know that there are many orphan children living with grandparents<sup>1</sup>. But even this group of children living with grandparents belongs to quite different categories. We have learned that the reasons children live with grandparents are various and include:

- It is common for the first grandchild of a family, especially if it is a girl, to return to the maternal parents at an early age to help them with daily tasks.
- Children of a daughter who is either not married or has been abandoned by her husband or has decided to leave the house of her husband often live with grandparents.
- Grandchildren living with grandparents are often children whose parents (one or both) have died.
- Grandchildren who have fathers or mothers but are not supported by them sometimes move to live with their grandparents. It seems that the number of parents who abandon their children (children often describe this as “my parents got lost”), is increasing.

Esther Goody's description of the difference between “voluntary” and “crisis” fostering of grandchildren is, we think a good one. “There is a gradation in reasons for keeping a child: from sociability to convenience to alleviating a difficult situation to a dramatic event like death of a parent or being thrown out of the house” (quoted in Susan R. Whyte/Michael A. White: “Children's Children: Time and Relatedness in Eastern Uganda” *Africa* 74 (1) 2004, p. 80).

“Crisis fostering” is caused by external factors which force grandparents to accept the burden to be “locked in a never-ending carousel of caring for grandchildren and even great-grandchildren without the necessary material security and a chance someday to sit down and to be cared for by others”. Ingstad adds: “While grandchildren previously were a source of support for the grandparents, they are becoming a burden in the time of AIDS”. (Benedict Ingstad: “The value of grandchildren: Changing relations between generations in Botswana”, *Africa* 74 (1), 2004, p. 73).

### **“Skipped generation households”**

It is well known that HIV and AIDS has led to an increase of households made up of the old and the young – more recently called “skipped generation households”. The ODI defines those “skipped generation households”(SGHs) as follows:

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<sup>1</sup> There is little research done on the actual numbers of children living with grandparents but a national survey of Botswana indicated that 64% of the sample of elderly had grandchildren living with them. This may be similar in other countries.

“SGHs occur when an older person, often a grandparent, becomes the primary caretaker for a child who has lost one or both parents, or whose parents are absent for a prolonged period of time. This is distinct from an older person headed household where the middle generation may still be present; it is also distinct from a child-headed household in which there are usually no older people present, or if they are present they may be too sick to act as a household head.” (ODI Project Briefing, no. 33, November 2009).

It is useful to look at the characteristics of these skipped generation households. HelpAge International, the Overseas Development Institute (ODI), UNICEF and UNAIDS recently carried out a study in Uganda and Zimbabwe to improve the understanding of how these households cope especially during emergencies, but also to increase the understanding of those households in general. The study concluded that:

- Old age often led to a decrease in the quality of health and in physical capacity, resulting in less access to income generating opportunities and resources and more burden placed on children for productive and reproductive-related tasks.
- The age of grandchildren cared for also impacts on the household’s capacity, with older people in Zimbabwe noting that it was more difficult caring for children aged 0-5 than over 5 years.
- Findings show that long-term crises have eroded family and community support: whilst older people are taking in grandchildren, they reported being unable to turn to family and others for support, that their contributions were no longer recognized, and they were seen as an additional burden to already overstretched households.
- Despite the fact that many older persons are ill equipped and under-prepared for parenting, findings show that children living with grandparents are more likely to be looked after lovingly, and treated fairly, compared to those living with other extended family members and that children would rather live with their grandparents than with other relatives. According to NGO-respondents, grandparents were also seen as being more reliable as caregivers.

Quotation from grandchildren living in the Nshamba area about their grandparents

- She accommodates me since I have been born, and she is not disturbing me.
- - She doesn’t disturb me as the mother-in-law did, where I lived before.  
- How did the mother-in-law disturb you?  
- She didn’t give me food.
- - She doesn’t disturb me.  
- What do you mean by that?  
- She doesn’t beat me and she doesn’t abuse me (i.e. using bad words)
- - She makes me joyful.  
- How?  
- She gives me time to rest and is also doing work for me like fetching water, so I can rest.
- The grandmother always is our hope.
- The granny does more than the uncle can do.

40 grandchildren were asked to say how comfortable they were with their granny on a scale of 1 to 10, 10 being the most comfortable and 1 being least comfortable. The average stood at 7.9 which means that most grandchildren were quite comfortable living with their grandmother” (Glynis Clacherty: “Living with our Bibi” 2008).

## **Children living with HIV-infected parents**

Kagera was the area earliest and most severely stricken by HIV / AIDS beginning in the early 1980s. In no other area of Tanzania has HIV spread faster and nor were the consequences of the pandemic more severe than in Kagera. In the Muleba District where the project operates, every third child is an orphan and nearly half of all women are widows. (*Kagera Region Socio-Economic Profile 2003, Tanzania National Bureau of Statistics*).

Although the infection rate in Kagera has considerably dropped in recent years the number of orphaned children is still high. Many of them have lost the father and live with an infected mother. In a study which started in 1991-1994 children who were not orphaned at that time were followed up again in 2004. By then 23% of them had lost one or both parents before they reached the age of 15 years (Beegle et al. “Orphanhood and the long-run impact on children”, 2005).

Since 2006, three hospitals have started to provide Anti-Retroviral Treatment (ART) (Rubya, Ndonge and Bukoba Government Hospital). Children will probably have their parents for a longer time: the main intervention will not anymore be to prepare them for the death of their parents but to strengthen and develop their resources and capacities and to increase their resilience.

## **1.2 Looking at the children’s side**

Kwa Wazee works since many years with children of both groups. Research done in 2008 with grandchildren in Nshamba (Clacherty, 2008, Living with our Bibi) and experience over the last few years working with skipped generation households in the KwaWazee Project<sup>2</sup> and operational research since 2009 done with about 120 children living with unwell parents shows that many children share the following characteristics:

### Multiple losses:

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Children living with grandparents have experienced multiple losses, and they are mostly aware that another loss, that of the grandmother, might be close. In the research project in 2008 we asked the children to draw all the houses where they had lived during their lives until they came to live with their grandmother. This exercise showed high levels of migrancy among the children. Most had moved many times in their lives, migrating with the mother from the father's house after his death, then migrating again when the mother died often to other relatives and then to the grandmother. Most of children living with unwell parents have experienced the loss of the father, and they are mostly aware that another loss, that of the mother, might be a realistic possibility.

#### Troubled perspective for the future:

In an impact assessment carried out as part of the Kwa Wazee Project, a good number of children living with grandparents or with unwell parents expressed the fear that they would not reach the age of twenty years or they would end as streetchildren (This is consistent with research in Uganda where orphans had a significantly lower expectation to have own children and to expect a long life).

#### Heavy workload:

Most of the children of both groups described a heavy workload and little time to rest or to play. For grandchildren this is largely due to the fact that skipped generation households are normally composed of the grandmother and a few children – often only one grandchild who is responsible for all the chores. One grandchild in Nshamba declared: “We are working more than other children. In a ‘normal’ family the father is clearing the bananas and the mother is cultivating and the child goes to the river. When the child comes back, the mother started already to cook. Work is shared between them. But a grandchild has to do everything.”

For children living with unwell parents the workload is composed by house chores, care for the unwell parent, getting medicine for them, and often to do day labor in order to support the household with basic goods.

#### Discrimination/stigma from the community:

Community members expressed the view that grandparents, due to their age, are not able to educate the grandchildren properly and that the grandchildren would become unruly.

Children report heavy stigmatization in the environment and the school due to the disease of their parents. They are “accused” to be infected themselves, or told that their surviving parents will also die soon.

#### Missing leisure and friends:

The workload diminishes the time for leisure and the time to spend with friends. For many children the school tea and lunch break offer the only opportunity to play. “I work a lot, but often I’m not allowed to go to play” (Grandchild from Kihumulo).

Discrimination limits additionally the chance to get friends and being integrated.

### Poverty:

Poverty is certainly not exclusive to grandchildren living with grandparents or living with infected parents. Nevertheless, it constitutes mostly a structural element of the skipped generation household and households affected by HIV and AIDS.

The impact of poverty has different layers. Just to indicate some: The children suffer from rejection at schools, where they are frequently chased because of missing uniform, shoes, exercise books and pens and become objects of discrimination and stigma.

Support from neighbors or friends are less frequent due to the missing reciprocity. The relationship between grandchildren/grandmothers and children/infected mothers suffer from unfulfilled expectations on the part of the children and guilt on the part of the grandmothers/infected parents that they can't provide the basic needs.

Poverty has a big impact on the psychosocial well-being of the grandchildren. They reported in Itongo:

- - If we have no money, there are a lot of feelings.
  - What feelings?
  - Where do we get the money for the food?
- We (where our grandmother gets the pension) know that tomorrow we get food. For the others they might be that there is no food. They ask themselves if they will find somebody who will support them or if they have to go to work. They are hungry.
- It is also difficult for the bibi to sleep well. She thinks about the food for tomorrow. She has to wake up the children and send them to go to work for food.

### Psychosocial well-being and intergenerational relationship:

There is another important argument to consider the systemic approach in the intervention i.e. working with the generation of the carers and working with the children, coming from the aspect of psychosocial well-being. Laurie Bauman tells us that the quality of relationship between the child and the cared adult is a central predictor for the child's mental health (Laurie Bauman et.al. "Children caring for their ill parents with HIV/AIDS", *Vulnerable Children and Youth Studies*, April 2006; 1(1): 56–70). We can assume that this is also true for skipped generation households.

## **2. CHILDREN AS CARERS**

### **2.1 Grandchildren as "care givers"**

In 2003 when Kwa Wazee started to work the topic of "child carers" was like a white spot on the map of HIV/AIDS and its impacts. Fortunately there is a process of change (at least on the level of awareness - not yet so much on the level of practical interventions and programming):

The following research programs have brought some evidences and facts about the situation of this group of child carers that might go into the millions:

- Glynis Clacherty: "Child carers. Child-led research with children who are carers". (Save the Children UK, 2010), this has been followed by a number of pilot projects.
- Lucy Cluver, research in progress in South Africa on child carers in AIDS-affected families.
- Ruth Evans "Children's Caring Roles and Responsibilities within the Family in Africa" (Geography Compass 4/10 (2010), 1477-1496) and "The experiences and priorities of young people who care for their siblings in Tanzania and Uganda." Research Report, Univ. of Reading 2010.

Talking about the caring role of the grandchildren means that we acknowledge and highlight the fact that caring is a two-way relationship where often the amount and aspects of the caring role have been reversed. Grandchildren perform a considerable amount of care for their grandparents, apart from the "ordinary" chores for children such as fetching water and collecting firewood.

- I help her to write a letter when she needs it because she doesn't know to write
- I take her to the hospital (boy of about 11 years)
- I support her washing clothes and cooking (boy)
- I help to fetch water and cook food (boy)
- When the bibi is sick, I can go to call the neighbors for support (boy)
- I can support her when she is sick – I can cook and fetch firewood (boy)
- I shave her hair (girl)
- I can chop firewood for the bibi (girl)
- I cut her nails (boy)
- I take out the jiggers (sand fleas) from the feet (girl)
- I lift the heavy pot from the fire (girl)

Often the performed work transcends the culturally defined gender barriers (e.g. boys cooking, girls chopping firewood) which can increase the children's isolation as this kind of work is stigmatized in the community. Additionally grandchildren play an important role in the emotional well-being of the grandmother:

- "If my grandchild is not here, I feel like being in a grave".
- "I would feel lonely. We eat together and we talk while eating, and then I feel much better."
- "When the grandchild shifts to somewhere for a week, then I can't stay at home, because you can't talk to anybody. So I have in the evenings to go to visit people as compensation."
- "We chat together which is so joyful." (Kwa Wazee: "Explorations" 2007).

## 2. 2 Children living with unwell parents as "care givers"

Also children living with infected parents perform a considerable amount of care for their unwell parents, apart from the "ordinary" chores for children such as fetching water and collecting firewood etc.:

- Always he asks how I feel – if he should stay today away from school (about a boy)
- She helps me in times of problems – she helps me much in thoughts (girl)
- He cares me when I'm sick (boy)
- He cares the siblings (boy)
- When I'm sick, she helps a lot (girl)
- We share concerns (girl)
- We help each other in times of thoughts (boy)
- She prepares my bed when I'm sick (girl)
- He takes the ARV in the hospital (boy)
- She remembers me every day to take the ARV (girl, 9 years old)
- The child give me hope (boy)
- When I was sick, she brought the food in the hospital and cared the siblings (girl)
- When there is conflict in the family she says: "Relax, God will help us", and this gives me the courage to support and tolerate it (girl)
- The whole family depends strongly on him, also for planning and discussing problems. Even when I can't give him money he tries to get some (boy)
- When I have problems I look at her and I'm happy to see her (girl, 6 years)
- I depend really on her in any matter and I pray to God to help her to go on with the good heart to help me (girl)

Often the performed work transcends the culturally defined gender barriers (e.g. boys cooking, girls chopping firewood) which can increase the children's isolation as this kind of work is stigmatized in the community.

Families are systemic units with mutual dependences. In a household with unwell parents the balance between the members of this unit is "reconstructed" according to the health status of the adults. Both sides – adults and children – are forced to find this new balance which transcends normally the cultural definition of "normal" balance. Kwa Wazee addresses this topic in supportive training with both sides: with the parents and with the children.

### **3. GUIDELINES FOR INTERVENTIONS and ACTIVITIES**

Based on the above "diagnosis" we have been able to summarize the needs of children living in skipped generation households or . This information can be used to direct and guide interventions:

- Interventions should contribute to a more structured and predictable future. This might include secure education, increased security about the assets through will writing, promoting discussions and planning with grandparents and grandchildren about possible emergency situations.
- Interventions should increase the income security of skipped generation households.

- Interventions should contribute to decrease the work load through labor-saving investments (e.g. improved stoves, water tanks) and through promoting mutual support groups. Further interventions should promote income generation which is profitable and less time-consuming.
- Interventions should promote networking among the grandchildren in order to decrease isolation and stigma. Among five proposed possible motivation for forming groups most children selected the motivation “similar experiences with illness and death the parents” as their leading motivation.

#### Kwa Wazee implements or promotes the following activities

- Educational support (school fees, school material) is the biggest support in financial terms.
- Income generation: Kwa Wazee support the children in their income generating activities through training and loans.
- Leadership training: Due to the (natural) changes and circulation in child-led organizations leadership training is a continuing activity.
- Training of Youth Facilitators: The same as for leadership applies for the Youth Facilitators.
- Savings: Kwa Wazee trains the groups in order to maintain/increase the transparency and accountability.
- Self-defense: Kwa Wazee trains assistants in order to strengthens the local groups.
- “Peace is a decision”: to include the boys into a process of gender sensitivity regarding their own gender role which will lessen the burden of the girls to “rewrite the gender rules” and hand over a pro-active role to the boys in the process of molding and defining their own gender role.

Dreams.....

.....to build up a children’s forums in order to bring the idea of an active young citizen closer to the children.

.....to develop a course of protection for younger children (5-10 years old)

.....to give children courses in health care to support older people and unwell people and to support sick peers.\_

## 4. TATUTANO AND ITS MILESTONES

### 2008: Consultation and start of the TatuTano

Tatu Tano was started in April 2008 when we invited 133 grandchildren for a consultation. We selected them according to the school they frequented in order to increase the possibility that they know each other.

The consultation included the following topics

- Can it happen that in the morning the grandmother is very sick and can't get up? What would you do? Who would support you? They selected among five possibilities – one would be “other children”.
- Looking at possible support of other children and experiences of cooperation among children.
- Measuring the feelings after doing work together (with the Dino pictures: joy, stress, doubts and hope) which showed an overwhelming good experience.
- Discussion: should we try to form groups? Children voted in favor or against. The big majority – in some groups even all of them – voted in favor.
- We supported them to find the children living in the neighborhood and gave them a form where they could write the names and what they would like to do together. We requested those who would form a group, to bring the form back to our office.

The TatuTano experienced a rapid growth – in December already 32 groups existed.

### 2010: Assuring the quality: Youth Facilitators

In 2009 the growth of TatuTano continued – new areas like Buganguzi, Kishanda and Mubunda were added. But the numeric growth was not fully translated into growth of quality as Lydia Lugazia explains after having participated in all cluster meeting:

“In the cluster meetings all groups of the area are supposed to attend the cluster meeting. My main impression was that of the existing 56 groups only few have been really strong groups, others I considered as rather weak. ....It concerns mainly the economic performance, i.e. the income generation projects. Many groups decided to sell either sugar cane or Bugege (a small dried fish) with the result that the market was not big enough to accommodate many sellers – especially for sugar cane.....  
... It is necessary to review the project. I heard many times that “We are planning this and this” but there was no sign of the implementation although they planned the new activities since two, three months.  
....In some groups the chairperson of the group knew how much funds the groups had, but even the cashier didn't know about it, much less the ordinary group members. So the question comes up: Who controls the funds of the group? Also I observed that in some groups the members of the same group reported different things which mean that not all the members are aware about what is happening in the group.

It was evident that something must happen in order to consolidate and strengthen the movement. One selected strategy was to train experienced TatuTano-members as Youth Facilitators. Apart from a general introduction in coaching and monitoring we requested them to facilitate each step of the sessions for the TatuTano-groups (e.g. “Why am I in a group?” or “Goals of the group”) with their fellows – in order to learn “to swim” as facilitators. Additionally we prepared step-by-step handouts for them. We felt that this time-consuming training was beneficial – for the Youth Facilitator who gained self-confidence, and for the groups who encountered well prepared and motivated facilitators. The training program for the Youth Facilitators is on-going.

The coordinator noted after a new round of visits: “First I noted a good attendance. Then I was impressed how they organized their time and their agenda. Finally we assisted when they elected new leaders or reelected old ones: it was a real election campaign in front of all the children. I had also the impression that the link between the Youth Facilitators and the group was operational – the children knew who their facilitator was and have been informed about the visits.”

#### 2010: Integration of the children living with infected parents in the TatuTano

The integration of the around 30 groups, composed by children living with PLWHA, started in the beginning of the year.

The assessment with these children at the end of 2010 sounded quite positive: most of the children indicated that their common experience of illness or death of parents and the necessity to care for adults (unwell parents and older people) was a good foundation for cooperation. The PLWHA-children also saw a chance to learn from TatuTano concerning small income generation projects and savings.

#### 2010: Self-defense for girls

Kwa Wazee realized the high incidence of sexual violence and sexual exploitation of sometimes very young female TatuTano-members. As a response Kwa Wazee organized in April 2010 the first self-defense course for girls from TatuTano. The program has been developed in cooperation with Natalie Uhlmann from PALLAS (Switzerland).

The training, which lasts between 12 and 14 days, is composed of physical/technical training of defense techniques and – based on an interactive workbook - reflection on the role and conditions of young females in Tanzanian society. The age of the children is between 11 years and 18 years – the average age is 14 years.

Many of the participants meet every week or twice a month on Saturday for refreshment training. Some have also started economic activities. Self-defense groups are functioning in all 13 clusters.

In 2010 Kwa Wazee has trained 187 girls, in 2011 150 girls, in 2012 362 girls and in 2013 463 girls, among them girls in three Secondary School and one Primary School – totally 1'152 girl-children and –youth.

#### 2012: “Peace is a decision” – gender training for boys

Kwa Wazee considers that the girls – as the most frequent victims of sexual violence – have the priority in any intervention which is also reflected in the budgets. But we are aware that a better balanced gender relationship needs also changes from the male side – i.e. from the boys who are part of the groups.

In February 2012 Kwa Wazee piloted a two-week training course for 14 male trainers with the support of Natalie Uhlmann (PALLAS). Afterwards the trainers have applied the course during one week to 15 boys under supervision.

Kwa Wazee developed an interactive workbook for the ten-day training and piloted the first courses in August 2012. Until end 2013 around 250 boys have been – among them also male students in the mentioned Secondary School.

Kwa Wazee noted with satisfaction that the boys have been very interested in the course. We assume that it is a reaction on the changes in the Tanzanian society: the traditional male role becomes more and more obsolete on the background of the economic changes.

2013: Focus on agriculture and animal keeping

One of the objectives of Kwa Wazee is to promote the transition of the young people to a safe and productive livelihood, to build economic assets and financial literacy.

In 2013 the focus was on agriculture and animal keeping. In 41 training days nearly 1'000 children have been trained in the areas of cultivation of groundnuts, vegetables, sorghum, soya beans, beans, sunflower and to establish a tree nursery; of keeping bees, chicken, rabbits and goats; and in storage, food processing, natural pest control and soil management. They have been provided with seeds, and on a loan base, with animals.