Children First Vol 7, No 47 Social grants in rural areas

Beating a path through a maze of bureaucracy :

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Drawing on ethnographic data collected by a longitudinal study on the impact of HIV/AIDS on rural households in rural KZN, this report highlights some of the difficulties experienced by rural residents in applying for child grants. Ethnographic research uses participatory observation methods in which researcher and subject can perform activities together. Assisting families who wish to apply for welfare grants can provide valuable insights into the people's experience of the application process and related agencies.

The first case study describes the difficulties faced by a foster mother, raising a chronically ill child, when she attempted to apply for welfare support. The child's mother had died two years previously from AIDS and his aunt immediately fostered the child informally. The child was chronically ill with repeated episodes of TB and other opportunistic infections. The foster mother has struggled for a year to submit an application for welfare assistance through a child support grant, a care dependency grant or a disability grant. She has had to contend with the stringent requirements for eligibility for state assistance, the confusion caused when doctors were required to sign application forms and a lack of synergy between the health and welfare departments.

The second case study describes a complex domestic situation in which a pensioner supports a large number of grandchildren whose parents have died, are ill, or do not provide maintenance for their children. The carer has experienced numerous difficulties in trying to apply for foster care grants, including extortion by local leaders, inability to track the children's fathers, and lack of documentation.

Case study 1: Sana's story

Sana, a sickly eight-year-old boy, is a member of a household participating in our research study. Following his mother's death two years ago, Sana was fostered by his mother's older sister, Khethiwe. The two have lived as a small unit within a larger homestead headed by Khethiwe's mother, Mrs Zulu. Khethiwe stopped working some three years ago after sustaining injuries from a vehicle accident. Early in 2002 she applied for a disability grant for herself. It was not until the end of the same year that Welfare informed her that her application was unsuccessful. The Welfare office attributed her unsuccessful application to her doctor's unfavourable medical report. Khethiwe currently depends on her boyfriend and her mother for financial help. Khethiwe's mother's situation is also difficult, since she supports three of her other grandchildren using her pension and a child care dependency grant received for one of her grandchildren who is physically disabled.

Sana is a frequent outpatient at a referral hospital 60km away. He is prone to gastrointestinal illnesses and has had two episodes of TB. The last TB episode was diagnosed after he experienced a progressive eye infection that had started to obstruct

his vision. Sana's illness has been a drain on the financial resources of the Zulu household over the last five years. Khethiwe thought that Sana's mother probably died from AIDS though TB was the official cause of death. At the time when we began visiting the Zulu homestead, Sana's foster mother had already made several unsuccessful attempts to apply for a foster care grant. Since the child was by this time older than seven he was not eligible for the child support grant and the Welfare Department suggested that she should try to involve the child's biological father in order to obtain a foster care grant. The boy's father lives locally and is also very ill. Sana's foster mother had been informed that the foster care grant could only be accessed if it was established that the biological parents of the child were both dead or in poor health and unable to work. Since Sana's father was known to be ill, Khethiwe was advised to ask him to seek a certificate of ill-health from a physician in order to expedite her efforts at applying for the foster care grant. However, fearing stigmatisation, he refused to cooperate.

Following the foster mother's unsuccessful attempts to get the father's cooperation, a social worker suggested that the foster mother should instead apply for a disability grant on the grounds of the child's poor health. The social worker also indicated that once Khethiwe's application was submitted, the Welfare office would submit an additional application to the Provincial office for her to receive the foster care grant as well. The quest for the disability grant entailed numerous visits to the hospital where Sana was receiving treatment and to the local district surgeon. Attempts by the foster mother to obtain the support of the ophthalmologist treating Sana's eye infection at the hospital were futile. The doctor argued that he did not have strong grounds on which to motivate for a DG since the boy was responding well to treatment. It was at this point that we began to assist Sana's mother in her efforts to apply for the grant. We sought help from one of the local district surgeons but were refused assistance on the grounds that he needed to see the child's hospital medical records. The hospital, however, refused to release the medical notes to the foster mother. We then asked the district surgeon to write to the ophthalmologist requesting the child's medical history. We returned to the ophthalmologist, who provided a hand written prognosis of the boy's condition, but again indicated that he would not support a disability grant application since the child was receiving and responding positively to TB treatment. He suggested that we instead try to apply for the child support grant. We explained that as an eight-year old the boy was not eligible. We then tried to emphasise the child's medical history and the financial strain this was having on the mother and her family but the ophthalmologist continued to refuse to sign the disability grant application form. The specialist's advice was that the foster mother should seek assistance from the paediatric clinic that was also monitoring the child's condition.

- In the paediatric clinic none of the doctors spoke Zulu; the nurses needed to act as translators. Sana's foster mother does not speak English and, since the paediatrician appeared extremely harried, we described the boy's medical history on behalf of the foster mother. The doctor seemed willing to help the child obtain a disability grant but warned that in order to test for eligibility the boy would need to have blood tests taken to establish the underlying cause of ill-health. His view was that the boy would be eligible for the grant if he tested positive for HIV. He asked that the child return for a series of blood tests the following day and completed a requisition form for a disability grant application. Two weeks later we went back to the hospital to collect the test results.

However, the child's medical file had been misplaced by the TB clinic and the administration staff refused to search the record room. Since we knew that the doctor would refuse to complete the disability grant application unless he had the medical notes we persuaded the staff to let us search through the hundreds of medical files that were lying on the floor. After an hour, the file was found and the child could receive his test results.

- Khethiwe was told that Sana was HIV sero-positive and received some posttest counselling. Returning to the paediatric doctor, we found that he now reversed his earlier position regarding the child's eligibility for the grant. He said now that the child's HIV sero-status was known to be positive there was very little he could do, since there are 'multitudes' of children who are HIV positive but have not been able to access the child dependency grant. He referred us to the resident occupational therapist to see if the child could be assisted, although he did not indicate what help they might offer. On going home, the foster mother did not return Sana's medical file to the TB outpatient reception. Fearing that the records would again be lost causing more difficulties, Khethiwe decided to keep them.

The following week we tried another tack. On the advice of the Welfare office we went to a different local district surgeon whom we were told would be better disposed to help. The district surgeon examined Sana and looked through her medical file. Without further questions or delay, he filled out the application form and advised Sana's mother to follow up on the application with the Welfare office in a month's time. Amonth later, she went to the Welfare office and filled out additional forms and was then told to return for the outcome of her application in three months time. Sana and his foster mother now await a decision from the welfare office about their case.

This case study highlights several issues:

1. *Length of time and cost of applying for grants*. It took Sana's foster mother more than a year to be able to submit an application for assistance in caring for the child. Without the assistance of the research team, is it doubtful that she would have succeeded in overcoming the enormous hurdles placed in her way. Each visit to the hospital cost her over R30.
2. *Lack of information about social grants by GPs and hospital doctors*. The family received conflicting information from medical staff and the Department of Welfare about the eligibility criteria for disability grants, particularly with respect to HIV/AIDS and TB. Some local GPs also appeared to be acting as gatekeepers for grants, either wanting to limit the numbers applying for grants or making decisions about those in 'need'. Other doctors in contrast appear comfortable in assisting families in obtaining welfare support.
3. *There was a lack of information exchange between the local departments of health and welfare*. Although doctors are authorised to sign application forms, they do not appear to be trained or supported by the Department of Welfare.
4. *The particular characteristics of the child – his age, medical condition, and surviving father – combine to preclude this child from receiving the existing grants*. He is too old for a child support grant; he is HIV positive and very sickly but not ill enough to warrant state support in the form of the care dependency grant.

Case study 2: Rosta and her foster children

Rosta is an unmarried pensioner of 63 years of age. She lives at her brother's homestead in an informal settlement and resides with one of her daughters, Busangani, and seven of her grandchildren. Rosta has been in very poor health and was recently diagnosed with a second bout of TB that landed her in hospital for three weeks. Rosta and her children occupy two mud huts on her brother's property that are in a very poor condition. One of her daughters, Nomusa, died of AIDS in 1997 leaving behind three daughters -Silindile (13), Thobile (9) and Dolly (6) – for whom Rosta has sole responsibility. All three, like Rosta's other grandchildren, are not supported by their father and depend primarily on Rosta's pension for survival. Busangani, Rosta's daughter, is able to bring in only an extra R100 a month for looking after a neighbour's disabled child.

- Thobile is an extremely sickly child, who has been in and out of hospital over the past three years. She has had two episodes of TB and continues to cough, despite her last TB treatment. Dolly is also not a healthy child although she is stronger than Thobile. Dolly and Thobile have a different father from Silindile's. None of Rosta's grandchildren receive state assistance. Busangani has not been able to get the child support grant for her two daughters, both under 7 years, because she does not have an identity document. She recently applied for an ID and currently awaits a response from Home Affairs.

- Rosta faces numerous hurdles in trying to access foster care grants to support Nomusa's children. To start with, a death certificate was never prepared for her deceased daughter Nomusa, who died on the way to her biological father's village in northern KwaZulu- Natal. Rosta's initial attempt to get the local induna (headman) to sign a death report form for the processing of a death certificate failed. The induna demanded an upfront payment of R50, which Rosta did not have. Unable to raise enough funds, Rosta asked us to assist her. The first step we took was to verify the legality of the induna's demand for payment for processing a death certificate. A visit to the local Home Affairs and TLC offices revealed that, although it was not procedural or legal for the induna to demand payment for his services, it is generally known and accepted that he extorts money from the community in this manner. The apparent complacency demonstrated by the government officials in respect of this matter was quite disheartening. We collected a copy of the death report form from Home Affairs, hoping to accompany Rosta to the induna's residence and to ask him to sign it. On a separate occasion, however, a woman who is both a caregiver and a neighbour to Rosta cautioned against us intervening in this manner. She told us that a close confidante of the induna's wife had explained that it would not be easy for Rosta to get the induna's support for a number of reasons. To start with, Rosta did not report her daughter's death to him at the time that it had happened. Furthermore, Nomusa was not buried in the area that falls under his jurisdiction but was buried at her paternal village. Ordinarily it would have to be the induna of the settlement at which she was buried that signs the death report form. A further problem expressed by the caregiver was that Rosta was not introduced to the induna when she came to settle at her brother's homestead and that she never attends community meetings convened at the

induna's residence. Given these reasons, the view is the induna is not likely to assist Rosta.

We stressed to Rosta the importance of tracing the whereabouts of the fathers of Nomusa's children, since Welfare requires foster carers to prove that the other parents of her grandchildren cannot be found, are dead, or are simply unable to support their children owing to ill-health. Rosta's biggest problem is that she has never met the fathers of Nomusa's children. She heard on the grapevine that Silindile's father died some years back but does not know where and how to contact his family in order to get hold of his death certificate. She was also told recently that the father of Thobile and Dolly was last seen in town two years ago looking very sickly. No one in her family and in her community knows his natal village. However, even if Rosta had more information with which to trace these men, it is doubtful that she would be able to proceed because of lack of funds and lack of cooperation from people she does not know.

The other constraint that Rosta faced for a while was the absence of birth certificates for all her grandchildren, including Nomusa. She was advised that the only way by which she could get birth certificates for her grandchildren was if she changed their surnames to her own maiden surname. For Home Affairs to consider her application for birth certificates, her grandchildren would have to bear her name. This process did not take long. However, the two return trips she made on foot to the local Home Affairs office and the long queues she had to endure took their toll on her health.

To date, Rosta has not been able to obtain the necessary documents required by Welfare to access state assistance for her grandchildren. She recently went to the police station to seek assistance but was referred back to the induna. During our last visit to her home, Busangani informed us that her mother will not be able to take the children to school because of lack of money to pay school fees.

This case study highlights several issues:

1. *Enormous financial, emotional, physical and time efforts are required of foster carers to obtain foster care grants*. The foster carer in this case study is a 63-year-old who looks after seven grandchildren. In addition to all her other responsibilities, it is up to her alone to track down and secure the assistance of absentee fathers or establish that they have died or cannot be traced.
2. *Cases can be extremely complex*. This case involves children of different ages, different mothers and fathers, a range of jurisdictions, different documents and processes. Each child is considered as a separate case, instead of as part of a household or family unit.
3. *The grant process is not only determined by the Departments of Welfare and Home Affairs*. There are other people, notably doctors and izinduna, whose cooperation is essential but, as we can see in these case studies, may be reluctant to assist.