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Child and Youth Care

A Journal for Those Who Work with Children and Youth at Risk and Their Families

On the Development of Family Work in Residential Programs
Thom Garfat

Helping Children to See and Appreciate Their World
Kathy Mitchell

Celebrating the Life and Service of a Child and Youth Care Hero
Merle Allsopp

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A Lesson from Noupoort

During the months of June and July, the Noupoort Christian Care Centre has occupied a controversial place in the country's media. Over its decade-long life, initially as an unregistered and later on as a temporarily registered service provider, it has frequently been the focus of media attention. The centre operates in the area of residential treatment for people with substance abuse difficulties. A previous incident that earned it notoriety, involved the death of a sixteen-year-old in 2001, whose body was found chained by the neck to the door of a cell in the punishment wing of the facility. The recent return to the spotlight for the centre was precipitated by a Court Order requiring the Department of Social Development to make a decision on the matter of granting permanent registration to the centre.

Reactions to the report, made public by the Department after an assessment of some aspects of the facility's functioning, have been varied and often extreme. Desperate parents and relatives of children and adult residents, have come out fighting the findings of the assessment and its recommendations against registration. Strong supporters of fundamentalist Christian approaches taken to the treatment of social problems have likewise been vocal in the media, in support of the reported successes of the centre's approach. Others have given testimony to humiliating and allegedly brutal treatment. Both "sides" appear to have one thing in common – they feel strongly about the issue of the possible closure of the Noupoort Christian Care Centre.

There are many lessons to be learned for the child and youth care field from this apparently ongoing saga.

In these past months we have seen the Department of Social Development being prepared to take a stand in respect of the policy framework within which facilities operate. The seventy-four page report on the assessment of NCCC, is testimony to this. It also demonstrates the Department's capacity and willingness to take action when necessary. The contents of the report reflect the expectations of the Department in respect of the requirements of professional conduct and accountability in the organizations it registers. We see demonstrated in this situation the state playing its role as it ought to – being a transparent monitor, accountable to the public for ensuring that services reflect the country's policy framework. Hopefully this sets a positive example in respect of unregistered children's homes.

The second lesson perhaps nudges the Department further along its road of development. Clearly there is an urgent and desperate need for facilities that offer what NCCC sets out to offer – that are offered within the parameters of the legislative requirements of the country. There can be no doubt that there is a need for secure residential treatment facilities for young people addicted to substances. If (as the report on NCCC seems to indicate) many of the young people in the program found the 'holding' or 'containment' of the program to be helpful, the Department has a responsibility to ensure that such programs are developed and supported.

Where there is a need for a social or treatment service, this need will elicit a response from some quarter. Tardiness on the Department's side in timeously monitoring such responses, will only lead to unnecessary spending of resources, and much suffering on the part of desperate individuals in search of effective social services. The lessons from Noupoort are clear. Service providers must be respectful of South Africa's policy injunctions; the Department is beginning to take seriously its monitoring role; and where there are service gaps, these must be filled responsibly.

Merle Allsopp

NACCW

The National Association of Child Care Workers is an independent, non-profit organisation in South Africa which provides the professional training and infrastructure to promote healthy child and youth development and to improve standards of care and treatment for troubled children and youth at risk in family, community and residential group care settings.

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Contents

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© Benny Gool

EDITORIAL 2
Merle Allsopp

On the Development of Family Work in Residential Programs 4
Thom Garfat

Management – Communication 7
Escom

Ethical Dilemmas in South African Research – Part 2 8
Nosisana Nama and Leslie Swart

Helping Children to See and Appreciate Their World 12
Kathy Mitchell

Personality Profile 15
Vincent Hlabangana

Celebrating the Life and Service of a Child and Youth Care Hero 16
Merle Allsopp

FACTS ABOUT DRUGS 18
Cape Town Drug Counselling Centre

Where Can I Find the Policy? 22
Merle Allsopp

The Complexities Associated with Antiretroviral Therapy and Nutrition 24
Prof. FJ Veldman

My life after my mother's death 25
Sifiso Luthuli

SAQA 26
Sandra

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Apology: In the June issue of Child and Youth Care the article on Delegation (page 9) was published with the incorrect reference. It was not written by Annette Cockburn, but taken from "You're not on your own". A Management Guide for Development Organisations in South Africa – sponsored by ESKOM. Child and Youth Care apologises for this error

Tell us what you think ...

Whether you are a regular or a first time reader of the journal, PLEASE drop us a line or a note and tell us:

- ***what was of use to you***
- ***what you would like to see covered in future***

Child and Youth Care values your opinion.

On the Development of Family Work in Residential Programs

By Thom Garfat

Dr Thom Garfat, child and youth care worker, consultant, teacher and keynote speaker for the coming 15th NACCW Biennial Conference writes on his pioneering work with families.

The first article I ever wrote for publication appeared in 1982. It was about how child care workers (that was the right name then) could ensure that they failed at working with families. I was working in a residential treatment centre in Quebec at the time, and had just come from teaching child care and family work. Much of my previous experience had, in fact, been in working with families. Just before I left my previous place of employment I had the opportunity to spend a few days with Carl Whittaker, the great family therapist. We talked about how I was going to be the director of the residential centre and how I was looking forward to integrating family work and residential care. He basically wished me well, but suggested I shouldn't get my hopes too high because in his experience the two did not work well together – not that they shouldn't, just that they hadn't in his experience so far. Well, he was right (as he was about so many things), and the satirical article I referred to above was written in recognition of all the things we seemed to be doing to ensure that we didn't succeed in this relatively new venture of integrating residential care and family work.

But how the times have changed.

As I write this, I am aware of numerous places where these previously competitive approaches have been integrated into a fuller approach to helping young people and their families. I know of residential programs where the family is defined as the client, others where families and residential facilities work cooperatively for the benefit of the young person and family, and still others where the residential program is defined clearly as a support to family work, done by child and youth care staff. I know of residential programs where training in family work is an essential part of basic staff development, where youth care workers spend part of their time in the facility and part of their time in the family homes, and where case conferences about young people focus on the family as a whole. As a result of these changes, residential care is no longer the same as it used to be. In many cases residential staff no longer work in isolation from the family, no longer blame the parents for the situation of the young person, and no longer compete with the family work being done.

There are, of course, programs that still work in isolation, where the child and youth care staff seem to know, or care, little about families. And there are still places where there is destructive competition between residential staff and those who do the work with families – and the fact that these are conceptualized as separate roles may be part of the problem. In general, however, at least in the part of the world that I work in, this situation has been, and is, changing rapidly. The result is a developing expectation that residential

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programs work with the whole family, not just the identified youth. And programs are doing just that.

In fact, much as it might surprise many, the residential program is possibly the place to be if you want to learn about a child and youth care approach to working with families. With the dramatic shift that has occurred to family inclusion and family work, residential programs may well be where child and youth care work with families actually develops to its fullest.

Over the course of the years we have learned many things, and I wanted to highlight just a few of the things that are helping with this transition.

These are not our children. Over time we have come to recognize that these are not our children, these are the children of their parents. Although this seems like a simple statement, it has profound implications. When we think like this we start to realize that we need to know the parents better. We need to know their life, their culture, their values, and their dreams. We need to get to know them because in knowing them, we come to know more about this young person. Also, when we accept that these are the parents' children, we come to see that in helping the parents, we help the young person.

The residential facility is not home. A recent discussion on CYC-NET focused on the idea of home visits, and the consensus seemed to be that children do not go on "home visits" for the weekend. They go home. Home is where they belong – if they are "visiting" anywhere, they are visiting the residential facility. In the past we often thought of the residential facility as the children's home, and as a result we engaged in activities and interactions with the youth that encouraged them to shift their allegiance to the program, away from their real homes. In essence, we stole children from their families.

Families are not the enemy. We used to blame parents for the behaviour of their children. We thought that they were the cause of the problems. As a result we were in a constant battle against the family, trying to protect the children from the parents. Now we have shifted to a point where we frequently think that we are in a battle with the family against the problem, trying to overcome this problem together. We are allies together in this battle.

The more we divide the work, the more we divide the family. Historically, when a child was placed in a residential facility, any work with the family was only with the parents. That family worker was separate from the facility staff. Often they worked on different issues, competed with and blamed each other, and at times didn't even talk to each other. The end result of such an approach was to encourage and support the isolation of parents and youth. Our approach to helping was in fact doing just the opposite of what was needed. Now it is more common to see residential staff directly involved in working with families, ensuring that our issues don't get in the way of family development and also ensuring that we are all on the same track. When we are all genuinely a part of the same team, competition is reduced dramatically.

The message we give to parents through such an approach is that this is all connected.

The residential centre is a support to family. We have come to think of residential care as a system of care that should be used, whenever possible, to support the development and enhancement of family functioning. As a result, we are constantly asking the question "What can this program do to support the work being done with the family?" We look for ways in which we can support the family, and we look at ways in which we might be interfering with the development of the family. We see ourselves as being in the service of the family. We no longer ask how the family work can support the child's development but rather, how these two services can work together to support the family.

There are, of course, many other things we have learned – the above are just a few that seem to have been helpful to some people in programs making the transition to working effectively with families. Another time we might discuss some others, like the impact of systems thinking, self-awareness, and intervention planning, and how having families in the residential program is, in fact, changing the culture of care. A child and youth care approach to working with families has developed – a model based on the principles and values of the child and youth care approach – and that is part of the reason why family work is developing so quickly in the residential arena.

Here are some other lessons:

Building on what you know is easier than starting over. Because there has developed a model of working with families that is based on the values and principles of child and youth care practice, it is not necessary for the staff to learn a whole new set of practice principles. For example, the essence of child and youth care practice involves the utilization of daily life events as they occur. The child and youth care approach to working with families is based on the same principle, and as a result, the workers already know much about how to work this way. Or one might look at how child and youth care work is based on developmental principles and how the child and youth care approach to working to families is also based on developmental principles. Or how child and youth care practice is based on "doing together," as is the child and youth care approach to working with families. Thus the workers who make this transition retain the foundation of effective practice that has been historically successful in working with the individual youth.

It is easier to modify a program than to get funding for a new one. Everyone knows the difficulty involved in financing a new program. But modifying an existing program can often be done without the same pain. Oh, there is pain involved in encouraging programs to change, that is true, but at least one can change slowly and move to a new approach at a pace that fits for the staff and program. As people learn a new way, they also continue to experience satisfaction in their current work. Most programs that are changing are doing so slowly, so that the developments that do occur are well integrated. Staff are able to develop themselves at a pace with which they are comfortable. Thus we see many programs changing to work with families as a modification of a current approach, and we see far fewer new programs developing that work just with families.

The more support that is available the easier it is for everyone. There are two main areas in which family work based in residential programs offers greater support than other programs. The first, of course, lies in the fact that the residential staff are constantly in contact with one another due to the realities of running a program 24 hours a day. The other, and perhaps more important, area is that because the residential program is open 24 hours a day, it is possible to offer support to the family at all times. While it may not always be possible for a worker to go to the family, there is always someone for the family to call. More support translates into more opportunity. The child might reside in the centre as well, only as much as is necessary, and respite is easily available during periods of transition, for example.

There is a cultural demand for residential programs to change in this way. For whatever reason (financial, philosophical), there is pressure on residential programs to involve, and become involved with, families. While some might experience this pressure as negative, it can in fact be a very positive force for development. In simple terms it often translates into easier access to funding for the necessary training or staffing. It also supports changes to a program when the staff know that their changes are supported by the professional community. Residential staff find it wonderful to feel they are developing in a way that is being supported, rather than being seen as part of an archaic service.

Yet more could be said. However, the point I am trying to make is that residential centres may well be the area in which family work develops to its fullest for a variety of reasons. So, maybe it is time we stopped fighting among ourselves, because the more we remain divided, the more we encourage the division of families. The less we work together, the less we help.

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Garfat, T. (1982). Avoiding success and ensuring failure in working with unmotivated families, Journal of Child Care, 1(2), 77.

This article: Garfat, T. (2001) On the Development of Family Work in Residential Programs, Editorial. Journal of Child and Youth Care, Volume 14,2, iii

Continuing the series on Management …

Communication

Adapted from: You're not on your own, A Management Guide for Development Organisations in South Africa

What is communication?

Good communication skills are amongst the most important things that a manager and a team need to develop in an organization. Most organizations can improve on their internal communication. It is the job of the manager to help them do so. In order to do this, the manager needs to understand more about communication.

Why good communication is important in organisations

The better the communication in an organization, the better the chances of building a positive and successful organization.
Communication helps to build an organization in two ways:

1. It helps the organization achieve its vision and goals
2. It makes the people in the organization feel positive about the organization and committed to it

When communication is used to ask for or give information, provide opinions for discussion, explain something, summarise, or instruct, it is usually concerned with helping the organization achieve its visions and goals.

When communication is used to encourage, express feelings, praise or sympathise, it is usually concerned with making people in the organization feel positive about the organization and committed to it.

By making people feel good about the organization, we are encouraging them to take action, which in turn helps the organization achieve its vision and goals.

Informal communication is also very important in organizations. It gives people a chance to get to know each other better. People find out about what is going on when they, for instance, talk over a cup of coffee or catch a taxi together. Social events or workshops also give people a chance to communicate and get to know each other better.

Things to Think About When Communicating

When you want to communicate something in your organization, you should answer the following questions:

- What do I want to communicate?
- Who do I want to communicate our message to?
- Why do I want to communicate it?
- What is the best way of communicating it?

Forms of communicating

There are many different forms of communicating, for example, reports, letters, meetings, workshops, telephone, newsletters, social gatherings, debate, discussion groups, etc.
Before you decide what form to communicate in, you must already know the answers to the following questions:

- What do I want to communicate?
- Why do I want to communicate the message?
- Who do I want to communicate the message to?

Often your decision about the best form of communication to use will depend on an answer to the questions: Who will the receiver be? What response do you want? If you answer these questions before you send any messages, your message will be the right message in the right form.

Self Development Exercise

1. Make a list of four things you have done to communicate with the people in your organization this week.
2. How have they helped your organization to achieve its vision and goals?
3. How have they helped to make people feel positive and committed to the organization?

Reference

Reasearched and compiled by Vanessa Rockey of BMI (Pty) Ltd for Eskom Community Development

Ethical Dilemmas

In South African Research Part 2

Ethical and Social Dilemmas in Community-based Controlled Trials in Situations of Poverty: A View from a South African Project.

Nosisana Nama and Leslie Swartz from Human Sciences Research Council and Department of Psychology, University of Stellenbosch

Collecting Data in a Developing Country

(i) Community expectations

As the assessor on the project, Nosisana Nama (NN) must not provide any service to the community. There are of course the obvious exceptions of crises where ethical considerations call for immediate action regardless of the research implications

As mentioned earlier, we attached our project to an existing community-based health programme which provides services in the area within which we work. In practice, we have erected prefabricated buildings on the grounds of that project. This means that we are, in the eyes of community members, associated with a project which is a service project and which assists all people who come to it. The basis on which we gained access to the community, furthermore, was that we would be assessing a way of helping mothers and infants. It is therefore understandable that members of the community may regard all our staff - including the assessment team - as there to provide immediate services. It is difficult to dispel this perception for at least three reasons. First, the change in role of one of the assessors (NN) from project advocate to data collector may have caused confusion. Second, the levels of functional literacy in the community are low, so printed material reminding residents of our particular role would be of limited value. Third, and most crucially, there are so few resources that people find it hard to accept that a project which clearly has resources and expertise would not want always to provide immediate assistance.

(ii) Physical health problems

An example of how the assessor role is understood by the public can be seen in the common occurrence of mothers bringing their physically ill children to NN for help. There are clearly two understandable misperceptions at work here. The first is that assessors will see it as part of their work to provide assistance - a reasonable assumption given previous experience of services and interpretations of our entry to the community. Secondly, because our assessments focus on mental health issues and also include collection of various indices of physical growth and health, such as anthropometric data[1], community members may assume that our assessors have training in intervening with physical illness in children.

When our assessment team is confronted with a child who is ill, the decision about what to do is relatively easy - the child is referred to the community health workers who have access to skills and medication in the physical health area. From a research point of view, this referral is probably not a serious breach of the assessor role as the chances are that were our project not operating, the mothers would have approached the community health project anyway for help. It is possible that control group mothers are more likely to use the assessors on our project as a means of accessing the physical health project. By contrast, the intervention group mothers may be approaching the intervention team to access the physical health project. For reasons of maintaining blindness to the intervention, we cannot

currently know whether this is the case, but this is something which can be assessed at the end of the project. Other issues, though, are more complex and difficult to gauge.

On occasion, mothers have come for their assessments with infants who are clearly ill. Some of these mothers have not identified their children as ill, however. For example on one occasion a mother brought a child in for the assessment and the child was running a fever and lying limply in the mother's arms. Under these circumstances, it was not possible to assess mother-infant interaction (an important variable in our study), and the mother was referred to health services for treatment, and asked to return when the child was well. This intervention in the infant's life - referral to health services - may clearly impact on the outcomes we are assessing, but it is ethically necessary.

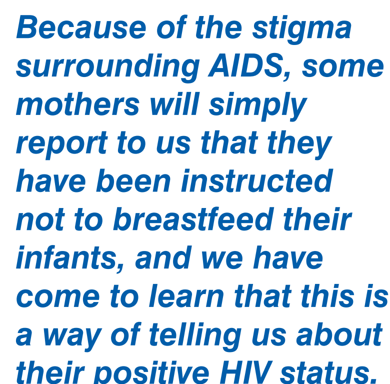
(iii) HIV/AIDS

The rate of HIV in South Africa is very high. The Western Cape province, where Khayelitsha is situated, has the lowest rate in the country, with an estimated prevalence[2] of 7.1% amongst women using antenatal services (Tshabalala-Msimang, 2000), but this is still a very high figure, and is rising. Disclosure[4] of HIV status is a complicated matter in South Africa.

There are also currently fierce debates in South Africa about the advisability of giving antiretroviral therapy to pregnant women. Antiretrovirals have been shown to reduce the risk of transmission of HIV infection to infants of HIV positive women. For the duration of much of our study, the Ministry of Health was arguing that the efficacy[3] of antiretrovirals in this context has not yet been proved, and that the provision of these drugs was too expensive (le Page, 2000). In Khayelitsha, though, there has been a pilot study of antiretrovirals for pregnant women, and this study is being closely watched by the rest of the country.

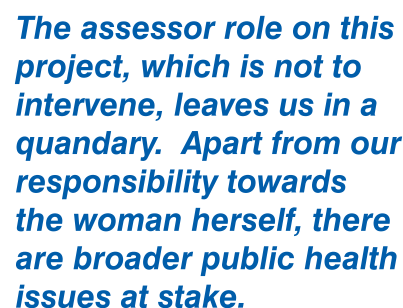
Against this complex background, HIV-positive women are giving birth in the situation of poverty of Khayelitsha, and some of them are seen by our project. On one occasion, NN undertook an assessment of a mother and a two-month-old infant who appeared very ill. The child's HIV status was not revealed to NN, but she learned about a month later that the child had died of AIDS not long after the assessment. Apart from the emotional toll that this takes on an assessor (an issue to which we shall be returning below), an opportunity was lost to offer appropriate support to a mother and her dying child.

Because of the stigma surrounding AIDS, some mothers will simply report to us that they have been instructed not to breastfeed their infants, and we have come to learn that this is a way of telling us about their positive HIV status. Sometimes mothers do disclose that they are HIV positive - this has been happening in our more recent assessments. Increased rates of disclosure may be related to increasing confidence about our project in the community. Most of these



women, understandably, are very distressed and they score high on measures of depression. One pregnant woman, however, who reported that she was HIV-positive seemed unperturbed and did not rate as depressed. This led us to wonder about whether she was fully aware of what the implications of positive HIV status was for her in her context. Many questions were raised for us. Was the mother fully aware about HIV? Had she been adequately[5] counselled? Was she in denial? The woman, furthermore, was married, and was probably having unprotected sex with her husband. We were unsure whether she had been infected by him or whether he was at risk of infection from her. The assessor role on this project, which is not to intervene, leaves us in a quandary[6]. Apart from our responsibility towards the woman herself, there are broader public health issues at stake.

All of this takes place against the background of a very personal relationship between the assessor and the mother and child. The assessor has ongoing contact with these children at least (within our current



research grant) to the age of 18 months. This contact is not purely instrumental - an emotional relationship develops which is fostered partly by the physical contact an assessor has with a child - helping pick the

child up and seat him or her comfortably in an infant seat, for example. A relationship of trust develops between the mother and the assessor, and there may be an implicit[7] (and reasonable) expectation from the mother that the assessor will assist with promoting the health and safety of the child.

(iv) Cultural Beliefs in Witchcraft

Beliefs in supernatural forces are found throughout the world and across all social classes (Swartz, 1998). These beliefs may however interact with local conditions of poverty and deprivation, as the following two examples show.

On one occasion, a pregnant woman came for her assessment claiming that she was not pregnant. She explained her pregnant shape by saying that her aunt had put evil spirits in her stomach. NN decided on this occasion not to proceed with an assessment but suggested instead to the mother that she consult with a doctor to enquire about pregnancy. The mother was encouraged to return after this visit, but she did not return until later the following week, when she arrived with her newborn baby, and asked for food for the baby.

In a different context, there might have been serious concerns about this mother's mental state – there could even be questions about whether she was psychotic[9] when she first came to see us. In Khayelitsha, however, belief in witchcraft is not always culturally strange, and certainly does not always imply psychosis[8] (Swartz, 1998). Nevertheless, it is important methodologically[10] for us to consider the possible impact on our data of a case such as this. For the safety of herself and the child, the mother was referred to another mental health project for full assessment and possible intervention. Her needs however related not just to mental health issues. Cultural factors may have played a part in suggesting to this woman that she was not pregnant. This belief in turn led to lack of preparation for the birth, a factor which can have devastating implications where money is scarce and it takes time to amass[11] what is necessary for the care of an infant.

(v) Child Protection Issues

Another case involves an infant, the youngest of four children. All the children in the family were living with the father and the paternal grandmother. This occurred after the paternal grandmother had moved to Khayelitsha from a rural area to live with the parents and the children. Following conflict between the mother and her mother-in-law, the father of the children took his own mother's side and ordered the mother of the children to leave the home. He said further that if she took the children with her, he would not provide for them financially. Being unemployed herself, and with little chance of finding employment and no social security, the mother chose to leave the children with their father and paternal grandmother. The mother continued to see the children when she could, but was not living in the home. On an assessment visit when the infant was eighteen months old, the mother was very depressed and agitated because she alleged that her four-year-old daughter was being used by the paternal grandmother for witchcraft purposes. She reported that the four-year-old had told her that the maternal grandmother required her to fly naked with the grandmother through the air at night. On one occasion, the child had been lost for three days. When she was eventually found, the child said that she had been under the maternal grandmother's bed, where a snake had been licking her body.

On further exploration by NN, the mother said that she had witnesses to these events. The mother had reported the alleged witchcraft to the local street committee (the informal local political organisation). They had called the family to a meeting at which the four-year-old had repeated her claims about the maternal grandmother. The maternal grandmother herself had agreed that she was indeed a witch who kept a snake under her bed. The mother lived under such impoverished conditions that she could not without assistance take custody of her children. NN was concerned for the wellbeing of the children and felt compelled to refer the matter for further action to

the local social worker. Because of case loads, it is unlikely that the case will be seen soon by the social worker. Similarly, the mother was advised to apply to the Maintenance Office for assistance. The most desirable outcome would be that the husband would be ordered to support the children financially while they are in the mother's care. Again, waiting time for an intervention could take months or even years.

More recently the mother claimed that she had had a period in which she had been dead. She said that she had come to life again only after her family had consulted an indigenous healer. This alleged death was, she said, as a result of witchcraft on the part of her mother-in-law.

This case, highlights some of the dilemmas of our work. It was not possible to assess the child when the mother was in an agitated state so the appointment for the assessment was postponed. There are also questions however about the assessment as a whole: the children are not in the care of the mother, and the grandmother is effectively the primary caregiver. Our protocol allows for assessment of whomever the primary caregiver is at the time, but the grandmother because of her alleged status as a witch was not amenable to cooperate in the study.

From a western perspective, the entire context of assessment in this case may appear foreign or bizarre, but there is no question in the community that the grandmother is a witch. Community members believe strongly that the children should be with the mother. There are however no resources to return the children to the mother's care.

If there were adequate social service facilities in the community, it would have been possible to refer the entire family for an urgent and comprehensive assessment. In terms of our role in our project, we have clearly for ethical reasons done more than simply assess according to the variables we are studying. We have also done less than these children almost certainly need. This once again places us in the unclear area of being assessors who also are forced by circumstances to intervene. We do not know, however, whether what we have done has made an appreciable difference to the children involved.

(vi) Ubuntu and the Cultural Imperative to Help

In all research projects taking up people's time and possibly imposing on them to a degree, there is a question of compensation for the respondents. In our own study design, we give mothers a set of infant requirements such as soap and shampoo, before the babies are born. At two months we provide each mother with a romper for her child, at six months a baby food hamper, and at twelve and eighteen months an item of clothing for the children. Mothers are also compensated financially if they lose wages as a result of an assessment visit. While mothers wait with their babies they are given tea and biscuits and juice and biscuits for the older children. When the project was planned, the project team decided against giving financial incentives[12] to mothers for their attendance and rather to give items for the children as we were concerned about the effects in the community of these mothers' being paid. Women in particular (and, by extension, their infants), in a country with exceptionally high rates of gender violence (Gibson et al, 2002), may be vulnerable to having money they have been given taken away by men.

Some mothers arrive for the assessment in desperate circumstances. In some cases, it is possible to refer the mothers to local nutrition and child health services, but on occasion, the need is immediate and extreme. Sometimes, NN gives money to the mothers from her own pocket. This is done out of a sense of humanity which, within Xhosa culture is expressed in the term '*ubuntu'.* This term literally means 'humanness', and relates to the Xhosa proverb '*Umntu ngumntu ngabantu*', which means that a person is a complete person only through humane dealings with other people (Burger, 1996). This ethical principle, which has deep cultural roots and resonance, overrides concerns about study design and the analytic division between assessment and intervention in a controlled trial.

Acknowledgements

This study was supported by a grant from the Wellcome Trust. We acknowledge the helpful input from our colleagues on the Thula Sana project and especially Mark Tomlinson and Peter J. Cooper. Without the participation of the women in Khayelitsha, this article would not have been possible. We are also grateful for the comments made by the anonymous reviewers and by Janet Bostock. We are solely responsible for the content of this article.

Glossary

[1]**anthropometric data** – information about the measurements (size and shape) of the human body.
[2]**prevalence** – how widespread a disease is: the total number of people in the population with the disease.(incidence being the percentage of population)
[3]**efficacy** – ability to bring about the result that is needed: to deliver the goods.
[4]**disclosure** – letting other people know about
[5]**adequately** – in a good enough way.
[6]**quandary** – not knowing what to do/which way to turn
[7]**implicit** – can be either 'complete' or suggested/hinted at
[8]**psychosis** – a severe mental disorder that causes people to lose touch with the real world
[9]**psychotic** – someone suffering from a psychosis.
[10]**methodologically** – relating to the study of method but it is now used rather loosely to mean little more than 'the way in which a problem is dealt with or approached.
[11]**amass** – store up/collect together.
[12]**incentive** – something that encourages a person to act in a certain way.

Helping Children to See and Appreciate Their World

Kathy Mitchell

"Will your work with children be a time of beginnings or of endings?
A time of making connections or of severing relationships. Will their time with you be a time of addition and multiplication, or a time of subtraction and division?
A time of growing or shrinking?
A time of rainbows or of quicksand?
Will your journey together be one of "No Frills" "No Stops" "No Detours" "Do it My Way" – or will you take the scenic route?
What will you and your children make happen together; how will you shape your time together?
Whatever you choose to enrich with imagination, wonder, attention or other ways of looking, becomes part of the reality of a child – and can for a little while be filled with Magic.

Enriching

What can you share with your kids?
How will you provide a safe place for them where they feel free to explore and pursue the "sweet smell of success"?
The children will be waiting for something special to happen to them, for that precious time that you might have with them to become someone that they will remember for the rest of their lives.
Believe that you can do something beautiful in their lives, and that they can grow beyond the hurt and pain and rejection of their past – and they will surprise you; they will amaze you.

Safety first

Your children will only grow with you if they feel safe. They will only learn to see the beauty of their world when they are safe from humiliation, put downs, harsh criticism and being ignored. They will trust you with their feelings only if they feel that you value their ideas, that you will not betray them, that you protect their dignity.
Virginia Tanner reports "the child of four seems to possess tremendous creative energy, but by the age of nine seems to have it so diminished that it is no longer a source of rich fulfillment. Could it be that through …. Lack of vision, hours of unguided television, stereotyped toys; we are stifling the very thing that will bring them their richest moment of happiness?"

Starting with you

Reach for the things that have become important in your life. Get in touch with your deepest feelings and concerns, your strengths and weaknesses.
Cut through the layers of inhibition, programmed responses, and stereotyped answers. Be willing yourself, to experiment with new ideas – even at the risk of them failing – and ask yourself questions.
Never stop asking, never stop looking, and giving, and communicating. You can share the wonder of your world, and in so doing, help your children to find the wonder of theirs. The challenge we will face in our work with children will not be to "make everything better," but to help them to look beyond the obvious, and to face their world with renewed hope and courage. It will be our task to challenge them to think, wonder, imagine and express their own questions, answers and ideas – without tension or fear.
Remember, beauty is not seen when one is afraid.

Some guidelines

Children gain an appreciation of beauty and a feeling of wonder – by doing things. This means sensing, feeling and responding. We cannot force children to see beauty as we might do; we can only give them the opportunities and guidance.
We can sensitise them to the splendour of a sunset, to

© Benny Gool

the rhythm in rainfall, to the expressions in someone's eyes. But how they perceive these things is personal to each individual.

Opportunities for aesthetic experiences enrich life for any child. It does not matter whether an activity is useful for anything else; at times, doing something for the sake of doing it is enough. Children find things exciting for many different reasons: it might be because things are colorful, different, changing, moving or weird.

When planning a stimulating activity for children in order to increase their aesthetic appreciation, ask yourself the following questions:

- Can they experience it with more than one sense?
- Can they interact with it?
- Is it interesting for them?
- Is it colorful?
- Is it rewarding – fun, adventurous, exciting, intriguing?
- Is there an element of surprise about it? Often the most meaningful learning takes place in those unanticipated surprise moments which occur in the midst of the humdrum of the day.

If you are open and flexible, and responsive to the children and their needs and interests, you will find many opportunities for meaningful discovery.

First step

Teach your children to SEE life.

"It is only with the heart that one can see rightly; what is essential is invisible to the eye". Teach children to OBSERVE. "We can't appreciate or sympathise until we learn to SEE."

The first step toward sensitivity is observing. There are things to be learned from everything we see; and metaphors for life everywhere we look. You don't necessarily have to go to a national park or a vast forest, or climb a high mountain to experience nature. We don't have to look very hard to find nature. We just have to look hard to find nature. We just have to look hard to really see it.

Awareness of others

Start with things. Take a walk with your children and see what you can observe together. Try to notice things you have never seen before. Think and talk about why they are the way they are. Look for comparisons to make between what you see and some aspect of your life.

Our children have missed so much. When other children were learning about things, ours were often preoccupied with uncertainties, fears and loss. Now, with less experience and less time, they have to catch up. They have to make increasingly difficult decisions in life without knowing enough and without understanding enough. We start with inanimate things, but soon enough they must be able to see and understand the more complex phenomena of people. Unlike nature, the important and meaningful things in people lie beneath the surface and it takes more than sharp eyes to find them.

When you look at rocks or trees or mountains they stay put and invite you to spend as long as you like at looking and understanding. People don't stand still at all. They move, their emotions change, their needs evolve, and they may intentionally not show you on the outside what they are feeling on the inside. But we can teach our children to see people – to become aware of others.

Again, begin with yourself. You are vital in encouraging free, natural and easy communication. You are a role model, a prompter, a helper, an audience. Your response to the child's utterances will encourage or inhibit the free flow of communication. Share yourself with your children.

Share your favourite book, food, word, song, something, and anything – because sharing means that you care enough to want to give of yourself and your life to others.

Emphasize the good

Encourage Happy Talk time by helping youngsters to get in touch with the things that are right and good in their world.
Make time for them to give themselves completely to a listening experience: play music to them, read to them, and help them to hear the colour and brightness of music, the melody of words.
Help them compile a list of their "most beautiful words" and their "most hated words". Give them a 'feeling" vocabulary with which to express their inner thoughts.
If your own mind ifs filled with wonder and the joy of life, then your work with children will reflect that enriching attitude.
You will be able, then, to encourage, to teach, to guide. You will be able to learn again to see the world with the eyes of a child.

Benefits of sensitivity

- Children (and adults) gain more insight into their world and therefore become more sensitive to others.
- Children are more likely to become self-learners, because they experience the joy of discovery.
- Life is more exciting when one has the capacity to be puzzled and surprised.
- Children are more tolerant when they have learned that there are many possible ways of seeing and doing things.
- Children become more independent because they have learnt to think and ask questions.
- People who are open to, and appreciative of beauty become exciting to be with, and to learn from and share with.

Give children opportunities to experience with all of their senses, to get in touch with their inner world – butterflies in the tummy, the lump in the throat, the glow of pleasure in achievement – and finally to see beyond the obvious with their eyes and their hearts.

Conclusion

We have come a long way from the oppressive juvenile justice system of the old era. However, a leap to a free-for-all approach will probably not benefit the children we claim to serve.
Assessment Centres, among other initiatives, have paved the way to a more child-friendly reformation of the juvenile system in South Africa.

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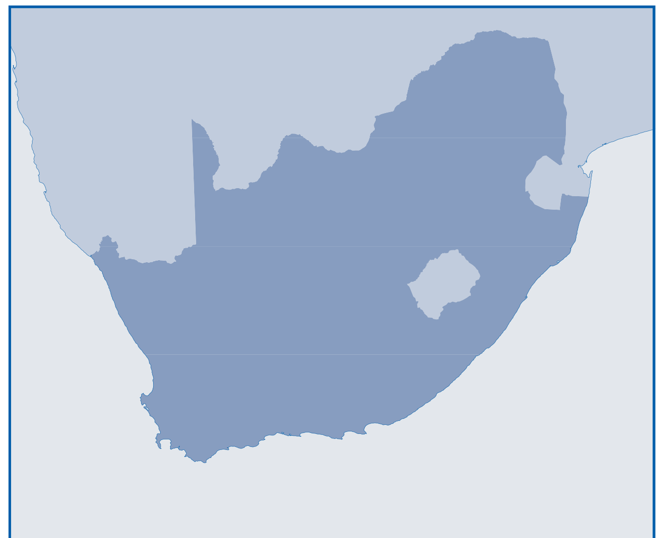

Facts About South Africa to Help Children 'See' their World

Johannesburg is one of **the most treed** cities in the world, making up one of the **largest non-commercial** forests globally.

The Cape Peninsula has **more species of plants per hectare** than any other area in the world.

South Africa has one of the richest, most **biologically diverse** and most **oceanographically complex** marine environments on earth. National Geographic calls it **"the Serengeti of the Seas"** – with **3 000 kilometres of coastline.**

At Blombos Cave in the Southern Cape**, two pieces of ochre** engraved with geometric patterns were found to be over 70 000 years old**, and were accepted as** the earliest evidence of abstract thinking **by our human ancestors.**

South Africa has **"The Big five"** – elephant, leopard, rhinoceros, buffalo, and lion – but also boasts the **"Big Sea Five"** of whale, shark, dolphin, marlin and tuna.

South Africa's **tap water is rated the third** cleanest in the world.

South Africa has 900 species of birds; that is 10% of the world's variety. Of these, you will also find the **largest bird, the ostrich**, and **the heaviest flying** bird, **the Kori Bustard.**

At Klasie's River on the Southern Cape coast, the remains of some of the **earliest modern humans** found anywhere in the world have been discovered.

From: The South African Story "South African Alive with Possibility"

Vincent Hlabangana

NACCW Western Cape Region

Vice Chairperson

I finished Matric in Zimbabwe in 1991. I was not clear about what I would do in life after matric. As a shy young man and son of a rural peasant farmer, my self-esteem was still very low, and I doubted any possibility of being anybody special. My uncle introduced me to the local Catholic Church where, after a year of involvement in youth work and parish tasks, I was elected as the youth chairperson of my parish. I started going to national church conferences and diocese meetings!

I could not, at this stage handle the respect which people bestowed on me. It was overwhelming, and yet raised my self-confidence. My life took a turn when in 1993, I was elected as a youth chairperson of my diocese. But despite these positive developments in my life, I still felt hollow. I felt something was missing, almost disconnected within me. A need was unmet. In 1994 I moved from Zimbabwe to Johannesburg and joined the Salesian, Catholic religious order where my experience of working with young people at risk started. In 1997 I moved to Cape Town where I did my practical training at Don Bosco Youth Hostel and Learn to Live Projects For Street Children as an assistant teacher.

In 1998, I left the Salesian Religious Order but decided to continue with Don Bosco's dream and mission of working with poor young people. Thanks to the Homestead Organisation, I was able to grab the opportunity to explore my dreams by being employed as a child and youth care worker.

My early years in the field were not easy! I could bear the challenges of shift work, but the workload was incredibly overwhelming. Don Bosco's famous phrase: "The fact that you are young is enough for me to love you" kept me ticking. I benefited from the support of experienced child and youth care workers and my personal resiliency. In 1998 I did my first child and youth care training in developmental assessment. It was when I was introduced to the Circle of Courage that I became aware of my own 'broken circle' and why I felt hollow. Growing up in a huge family of step-parents and step brothers and sisters, I never got the attention I required. Despite its challenges, the child and youth care field had given meaning to my life! Working in a diverse team of child and youth care workers and young people has contributed to my own sense of attachment, and I am able to give to other children services I did not get myself.

As a novice in Child and Youth Care, I could feel that I was lacking something but could not figure out what it was, until Annette Cockburn encouraged me to enroll for tertiary studies in 1999. In 2002 I achieved the National Higher Certificate in Child and Youth Development.

The period 2003 – 2004 has been marked by a train of events that have contributed profoundly to my development. I felt honored to attend my first conference - the 2003 14th Biennial Conference in Kimberley. I completed the training of trainer's course in 2003, and joined the team of NACCW trainers in the Western Cape Region. My special thanks go to Sandra Oosthuizen for encouragement in this regard. In the same year I was invited to serve on the Editorial Board of "Child and Youth Care" and then completed the National Diploma in Child and Youth Development and graduated in 2004.

I am currently registered for the degree course, and was recently elected as the Vice Chairperson of the Western Cape Region of the NACCW. To feel and be part of an enormous group of professionals committed to the upliftment and betterment of young people's lives is phenomenal!

My sincere thanks and gratitude go to all members of the NACCW, my colleagues, young people, and my family for believing in me and my professional growth and development.

"GHOTSO, PULA, NALA" (PEACE, RAIN AND PROSPERITY)

Celebrating the Life and Service of a Child and Youth Care Hero

Alfred Rens 18-08-1963 – 24-07-2004

Alfred Rens - Alfred to some, Rens to others, and affectionately nicknamed ‘Master’ by school friends, made a contribution to child and youth care on a national level in South Africa. No matter by what name they called him, child and youth care professionals across the country expressed the same views on Rens in the week after his passing away. They spoke of him as a man who was respectful to others, of his wisdom, his gentleness and his intelligence. He was known to all as a child and youth care worker fully committed to children’s rights, and to ethical professional practice. He was well-liked from Limpopo Province to KwaZulu Natal to the Western Cape.

One was consistently struck by the sense of Rens’ presence. That hard-to-describe term refers perhaps to the ‘soul texture’ of a person. Being in his company left one with an awareness of the beautiful texture of Rens’ soul. It was felt in the way he looked at one, and in the way he spoke. Rens radiated a calm, peaceful integrity.

In child and youth care we speak of the ‘being and doing’ functions of the worker. We must not only be able to ‘be’ with young people, but we must be able to ‘do’ things with them. Rens combined both of these functions skillfully and was (as young people have testified) an excellent practitioner. He demonstrated an openness to innovation, and was eagerly involved

in new approaches to child and youth care. He was a member of the Professional Foster Care team, was involved in the Adolescent Development Program, took on Restorative Conferencing, and later on was highly supportive of the implementation of the Isibindi model in the Northern Cape. Such was his dedication to his work that only a few weeks before his death, and in a physically weak state, he was engaged in Wilderness Therapy training – in the mountains.

And he was active in the child and youth care field beyond the practice level. Committed to the professionalisation of the field, he obtained his Diploma in Child and Youth Development from TSA and was busy studying towards his degree. As a trainer Rens was versatile, being able to train a range of courses from Foundations in Child and Youth Care to Restorative Conferencing. He took on the role of trainer in a characteristically serious way, always being well-prepared and deeply familiar with his material. As the Northern Cape Training Coordinator for the NACCW he was considered a pleasure to work with, being organised and efficient.

Rens served as the Vice Chairperson of the Northern Cape NACCW Regional Executive

Rens was a member of the Standards Generating Body for Child and Youth Care, and represented South African child and youth care workers at a number of international gatherings. He was a part of the 1999 NACCW Danish Study Tour undertaken with the support of the Peter Sabroe Semanariate.

Our Danish colleagues taught a wonderful concept that applies to Rens' approach to leadership. They taught that at times we need to be 'in front' of someone, at times 'alongside' and at other times 'behind' in order to facilitate development. Rens demonstrated being comfortable with all three of these positions as a child and youth care leader. A fierce warrior, Rens possessed the courage and integrity to risk unpopularity by challenging unethical practice. He made his voice heard in meetings, strongly advocating for the professionalisation of child and youth care, and supporting those who made efforts to transform. But oftentimes he was quietly but strongly in the background, and his presence could make all the difference to the tone of a gathering.

Involved in many community activities, one never gained the impression that he sought leadership, but that leadership sought him. Given the quality of his

Committee for a period of seven years. His attitude to developing others brings to mind the admonition of Don Mattera when he said "Ready, steady…and look behind you to see who you can take with you". There can be no doubt that Rens, in the role of regional leader has contributed significantly to the exponential growth in the child and youth care field experienced in that region. This growth and development was demonstrated in what must for Alfred have been one of his finest achievements – his coordination of the outstandingly successful 14th Biennial NACCW Conference, a task for which he gave up his studies temporarily.

commitment to the service of others, and the quality of what he as a person brought to his work, it seems that Rens would have been successful in any field. As child and youth care workers we are grateful that he chose our field. Even in his closing days, Rens continued to focus on the work of serving children and youth at risk. The child and youth care field is proud to have been associated with him. We will always be proud of his memory. We mourn the loss of a child and youth care hero.

Merle Allsopp

FACTS ABO

We are facing a growing challenge of substance abuse amongst the youth in South Africa. Research reveals three primary areas of concern. The first is that the percentage of youth who try drugs is increasing. The lifetime use of cannabis among grade 11 students appears to have almost doubled in both males and females over a 7 year period from 1990 (Fisher, A et al. 1998). The second trend is that people are starting to take drugs at a younger age. This is of concern as the younger you are when you first start taking drugs the more likely you are to become addicted, and the prognosis

Adapted from information provided by the Cape Town Drug Counselling Centre

Tik-tik

Cocaine

Heroin

TIK – TIK

Chrystal meth, or methamphetamine is also called speed, crank, ice or "tik-tik", which is locally sold in drinking straws. It can be snorted (reaches brain in 3 – 5 minutes) or swallowed (effects felt in 15 – 20minutes). Both these methods cause a long lasting high. It can also be injected by dissolving it in water (effects felt in about 15 seconds) or smoked – which is most popular – by heating it in an ordinary light bulb (called a lollipop) , glass pipe or on foil (produce effects in 6 seconds). The latter 2 methods produce an intense, short lived rush.

Short-term effects of the drug

The effects experienced include extra energy, increased activity, decreased fatigue, loss of appetite and a ravenous sexual appetite. It also leads to increased temperature, dilated pupils, dry mouth, rapid speech, tremors, false sense of confidence and power, irritability and aggression. People on the drug may also show compulsive behaviour, like picking at skin, pulling out hairs, and compulsively cleaning.

Long –term effects of the drug

These include dehydration, heart attacks, damage to blood vessels, lung infections, vitamin and mineral deficiencies, lowered resistance to disease, weight loss, stroke, and organ damage (particularly to the lungs, liver and kidneys). Changes in brain chemistry heighten the intense psychological dependence and compulsive drug seeking over time. Schizophrenia like psychosis often also sets in, characterized by paranoia and visual and auditory hallucinations.

Dangers

Rapid resistance, as each time the drug is used the rush is smaller, compelling the user to take increased dosages more often. Long lasting, if not permanent damage to dopamine producing cells in the brain (these effect the body's ability to experience pleasure)

Withdrawal

Intense mood swings, violent behaviour, severe depression and suicidal feelings, confusion, anxiety, psychosis, delusions and hallucinations, stomach cramps and nausea.

Cocaine

This is a powerful 'upper', or stimulant and in large doses, a hallucinogen. This is considered as one of the most addictive substances on the planet. It is also known as coke, blow or snow. In powder form the drug is snorted. The drug can also be smoked ("basing") after the powder is converted into crystals ("freebase" or "rocks"). This has become the method of choice, as the high is much more intense – it is also much more addictive.

Effects of drug

20 – 30 minutes euphoria, feeling of wellbeing and overconfidence, increased energy, hyperactivity, rapid pulse and dehydration. In larger doses it can lead to hallucinations, hyper-excitability, convulsions or heart failure. Symptoms also include loss of appetite and weight, insomnia, anxiety, runny nose, frequent sniffing and nose bleeds, loss of concentration.

Dangers

The first high is the most intense and addicts have described their experience as "falling in love" – this leads to an irresistible compulsion to repeat the sensation, which soon starts to rule the user's life. Negative effects include suicide from lows, dependence, criminal behaviour, impurities and other drugs 'cut' into cocaine, psychosis, voices and obnoxious smells, damage to nasal tissue, heart attack and cardiac failure, convulsions and fits, respiratory failure.

Withdrawal

The initial phase is intense & lasts about 4 days, usually followed by 2 less intense phases of between 4 and 10 days. These are characterized by lethargy, periods of cravings, depression and irritability, nausea and vomiting, shakes, insomnia, muscle pain and weakness.

Heroin

It is also known as H, horse, smack or slag. Thai white is now most popular and is purer than brown street heroin. It can be injected under the skin ("spiked") or directly into a vein ("mainlining") It is also sniffed, inhaled ("chasing the dragon") or smoked (the latter is most popular in South Africa).

UT DRUGS

for successful treatment is reduced. The last area of concern is that youth are using more addictive drugs. We have seen a steady increase of heroin use over the last five years, and a recent dramatic increase in the use of crystal methamphetamine (tuk) in the Western Cape.

A primary component to rising to this challenge is public education regarding not only the nature of substance use, abuse and addiction; but also the most effective methods for treatment and prevention. This article provides a starting point towards this end.

Effects – short term
Warmth and contentment – not unlike an orgasm. However, the high wears is of short duration tolerance develops quickly. Symptoms experienced are impaired breathing, clouded mental functioning, nausea and vomiting, suppression of pain, spontaneous abortion, mood swings, personality changes. Physical effects also include constricted pupils, constipation, loss of appetite and weight, sleepiness, decreased sex drive, slurred speech, impaired reflexes and co-ordination.

Effects – long term
Long term use can result in severe addiction, infection of heart lining and valves, arthritis and other rheumatologic problems. Sharing unsterilised needles can lead to exposure to infectious diseases such as HIV/AIDS and hepatitis B and C and collapsed veins. Impurities in the drugs can lead to bacterial infections and abscesses, amongst others.

Withdrawal
Withdrawal begins within 4 to 6 hours and peak after 48 to 72 hours. Symptoms, though very unpleasant, is rarely life threatening. These include sweating, nausea, vomiting, trembling, hyperventilation, convulsions, stomach cramps, diarrhea, hallucinations and feelings of terror. There is a risk of heart collapse. The skin is often cold, sweaty and covered in goose flesh – from there the saying “going cold turkey”.

Dagga

Also known as marijuana, cannabis, pot, hashish, weed, gangster, Mary Jane, chronic, dagga pot, ganja, grass. Usually sold in a stop, one gram rolled in a piece of newspaper (“zol” “joints” or “bricks”) or a plastic bank packet (bankies). It is often smoked with tobacco (“slow boat”) or Mandrax (“white pipe”). It can be eaten (“dagga koekies”) or drunk as tea. Though its use does not always lead to the abuse of other drugs, it does put users in contact with the drug world and may make experimentation easier and more inviting; hence it is referred to as the “gateway drug”.

Effects of drug
These include intoxication and light-headedness, euphoria and relaxation, talkativeness, heightened awareness, feelings of detachment or unreality, impaired concentration, short-term memory loss and depression. Resistance develops over time. The person may show bloodshot eyes, be sleepy, have mood change, lack motivation, show increased appetite, have a dry mouth, nausea and a persistent cough.

Dangers
It can be harmful to the lungs, increasing the risks of emphysema and cancer. It affects brain function – especially memory and behaviour and causes impaired brain development with prolonged in use by kids. The psychological dependence has been linked to anxiety and panic attacks, as well as decreased motivation and interest. Decreased sex drive, as well as decrease in fertility of both men and women have been reported, as well as foetal abnormality. There may also be a decreased resistance to infection.

Withdrawal
Restlessness, anxiety, insomnia, irritability, craving, aggression.

Ecstasy

A potent stimulant and mild hallucinogen and is favourite on the “Rave Scene”. It is also called E, the love drug, Superman, Domes and New Yorkers. It is usually swallowed in tablet form, but can also be crushed, sniffed or dissolved in liquid and then drunk.

Effects of drug
The effects begin within about 30 minutes, with the peak of the “high” lasting about 2 – 4 hours. The user experiences increased stamina, joy, exhilaration, loving, sensual and mystic feelings. Increased physical and emotional energy, decreased inhibitions. Lights, music and dancing seems more meaningful to users. Physical symptoms include an increase in blood pressure and heart rate, a decrease in co-ordination and appetite, dilated pupils, sweating, dry mouth, thirst, dehydration, increased body temperature, blurred vision. Even 2 or 3 tablets permanently damages brain cells. It also compromises the immune system.

Dangers
Because it reduces the user’s awareness of the

Dagga

need for rest, eat and sleep, they risk severe and even deadly consequences due to dehydration, heat stroke, respiratory failure, liver damage, brain damage, paralysis and psychological disorders, delirium, coma. Because it is unregulated, there is no control over what the tablets may contain. In South Africa heroin, cocaine, rat poison, chalk, caffeine, asprin etc. have been found in the mixtures.

Withdrawal

It is psychologically addictive and can cause depression, paranoia and anxiety.

Mandrax

Mandrax

It is known as Titanic, Buttons, Mandrakes, Mandies, MZ, Whites, MX and Cremora. It is sold as a white tablet and is usually crushed, mixed with dagga and smoked in a pipe or bottle neck ("white pipe"). It can also be swallowed and injected.

Physical symptoms

Effects of drug

The immediate high can last up to 10 hours leading to feelings of calm and happiness – worries disappear. Eyes may be red, the person may stumble and stagger (feels weak and numb) and speech may become slurred or mumbled. Afterwards some become aggressive, irritable and confused as the high wears off. Nausea, vomiting, exhaustion, falling over and passing out. Loss of weight may be experienced. The person may have constant headaches, stomach pains, decreased alertness and concentration, become painfully thin, gaunt with a sallow face and show emotional instability.

Dangers

This drug depresses the central nervous system. Physical and psychological dependence develops rapidly. It is often "cut" (mixed) with harmful substances. It can lead to convulsions, personality changes, respiratory and circulatory failure leading to coma and death and an impaired immune system.

Withdrawal

It is difficult to stop without support, because of the psychological as well as physical dependence. Withdrawal starts a few days after the person stopped and lasts a few days. Symptoms include sleeping problems, nervousness, anxiety, irritability, headaches and eating problems. Users may experience scary flashbacks several years after quitting.

White pipe

Tranquillisers

These are known as Mother's little helpers, Yellow Roaches, Downers, and Tranks. They are most often prescribed by doctors and most often taken orally, although they can also be smoked.

Effect of drug

They combat anxiety, tension and induce sleep. In excess they lead to drowsiness, mental 'fussiness' and a hangover effect. Tranquility may be followed by muscular tension, convulsions, insomnia, breathlessness, panic attacks and sweating.

Dangers

Their effects are increased with alcohol and can be lethal when combined with large doses of alcohol, barbiturates and Mandrax. They are highly addictive and tolerance soon develops. It can be dangerous to stop at once, so withdrawal should take place over time, under the supervision of medical personnel.

Withdrawal

Sleeplessness, headaches, depression, dizziness, memory loss, anxiety, panic attacks, trembling, convulsions, heart palpitations, hallucinations.

Inhalants

These include solvents as well as gasses, like glue, petrol, cleaning fluid, nail polish remover and paint thinners. Amyl Nitrite ("Poppers") which are often used at clubs also fall into this category.

Effects of drug

Immediate high lasts 15 – 45 minutes and slows down the body's functions. It is characterized by euphoria, dizziness, light-headedness, freedom from inhibition. This is followed by amnesia and severe depression. Drowsiness, numbness, coughing, irritation to nose and eyes, vomiting, diarrhoea, double vision, slurred speech, red face after use, followed by paleness is also experienced.

Dangers

Physical and psychological dependence develops rapidly. Death can set in due to asphyxiation, spasms of the larynx, cardiac failure, damage to heart, kidneys, liver and lungs and damage to nervous system, decreased oxygen to brain. The brain and bone marrow can also be damaged irrevocably.

Withdrawal

Symptoms can include insomnia, anxiety, irritability and nervousness.

Help is available at:

SAFE SCHOOLS CALL CENTRE: Provides immediate free online communication to learners, parents, educators and support staff needing help with safety, crime abuse and a variety of school related issues

CHILDLINE/LIFELINE: Toll free: 08000 55 555

CAPE TOWN DRUG COUNSELLING CENTRE: 021447 8026

SOUTH AFRICAN NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE: 021 945 4080

NAR-ANON: Support groups for families and friends affected by someone's drug addiction: **HELPLINE: 088 129 6791**

NARCOTICS ANONYMOUS: Support groups for recovering addicts **HELPLINE: 088 130 032710**

Signs suggesting alcohol and other drug abuse

- Weight loss, pale face, circles under eyes
- Red eyes (or frequent use of eye drops)
- Unexplained skin rashes
- Persistent cough, frequent colds
- Changes in sleep and/or eating patterns
- Deterioration in personal hygiene
- Odour of alcohol or other drugs
- Obvious intoxication

Behaviour changes

- Increased need for and use of money
- Quitting or getting fired from jobs
- New friends, lying, secretiveness, mysterious phone calls
- Attendance problems at work or school
- Drop in performance at work or school
- Accidents at work or school
- Mood swings (e.g. angry outbursts, sadness/ depression or elated mood)
- Verbal and/or physical abuse of family members
- Spending more time alone
- Quitting hobbies or extracurricular activities
- Theft and missing valuables, alcohol or medication

Items to look out for

- Alcohol or other drugs in their possession
- Mouthwash, breath sprays or eye drops
- Thinners, tippex or other solvents (indicates inhalant abuse)
- Bank bags, rolling papers (Rizla, etc), broken glass bottle tops. “roach” clips, pipes of various shapes and sizes, pieces of tinfoil, mirrors, razor blades, small screens or burnt spoons
- Seeds (from dagga plants)
- Incense burning
- Burns or stains on hands and clothing

If you are concerned about someone you know, contact a counselor at the
CAPE TOWN DRUG COUNSELING CENTRE
Tel: (021) 447 8026 during office hours
E-mail: ctdcc@iafrica.com

Things you can do if you are concerned about someone else’s use of mood-altering substances

1. **Educate** yourself and others about the positive and negative effects of substances, the risks of using them and what resources are available.
2. **Make informed choices** about your own use of mood-altering substances (e.g. relax and have a good time without necessarily using alcohol, cigarettes or other mood-altering substances) and address any problems you may experience.
3. **Discuss** alcohol and other drug use openly with different people. (No moralizing or shaming. Let people explain their views, share your values and why you feel the way you do).
4. **Take notice** of the signs that suggest problematic use of mood altering substances in the people around you.
5. **Set clear limits** for yourself on the way someone else’s substance use affects you and decide on consequences that you are willing and able to carry through should their behaviour not change. (Avoid empty threats and consequences that are delayed or don’t make sense).
6. **Be honest, clear and caring** with the user, saying how you are being affected by their actions and what limits you have set.
7. **Offer support** to the user by giving information about treatment options should they choose to seek help.
8. **Be consistent** in the way you apply your limits and consequences. (Be prepared to lose a person’s affection for a while and avoid feeling guilty for their poor decisions. This does not make you a bad person).
9. **Monitor yourself,** by trying to be aware of ways in which you may be making it easier for problems to continue (i.e. problematic helping roles).
10. **Get support** –you’ll probably find may others in similar situations.

For confidential information and advice, contact a counselor at the
CAPE TOWN DRUG COUNSELING CENTRE
Tel: (021) 447 8026 during office hours
E-mail: ctdcc@iafrica.com

Where Can I Find the Policy?

This is the first in a series of articles on the policy requirements in relation to services to children. It deals with Orphans and Vulnerable Children in the context of HIV/AIDS: South Africa's International and Constitutional Obligations to Children.

Introduction

Prospective service providers are frequently confused by the complexity of the policy framework in respect of the provision of social services to children and youth in the context of the HIV/AIDS pandemic. Those wishing to provide care and support services to orphans and vulnerable children are often confused as to whether their planned services fall within the policy framework. A community group asked very sensibly "Where is the policy?".

Over the past decade South Africa has developed comprehensive policy in respect of children and youth who may be at risk for one reason or another. Some may argue that South Africa's policy framework is not comprehensive enough. The developments in respect of the original Children's Bill and the Child Justice Bill are testimony to efforts made to rectify this. These bills if enacted will make adjustments to the framework. But at this time "the policy" is not one policy, but a matrix or set of policies and laws that *together* provide the parameters for the way in which services ought to be delivered. Those seeking either donor or state support are encouraged to both become familiar with the policy framework, as well as plan to contextualise their services well within the framework.

The information in this article is adapted from the publication "Health and Social Services to Address the needs of Orphans and Other Vulnerable Children in the Context of HIV/AIDS: Research Report and Recommendations" by Sonia Giese, Helen Meintjies, Rhian Croke and Ross Chamberlain (2003).

Obligations in terms of International Law

A number of global and regional human rights instruments prescribe the State's responsibilities towards children.

The most relevant in relation to orphans and vulnerable children are:

- *The United Nations Convention on the Rights of the Child* (CRC, 1990), governs both civil and political, and social, economic and cultural rights for children. The CRC has four core categories of rights; survival, development, protection and participation. The CRC also identifies a number of vulnerable categories of children in need of special care, including children in poverty and those with disabilities, and expressly prohibits discrimination against such children (Article 2).

  Two important articles to consider are articles 18 and 20. In article 18, the CRC recognises that although "parents and legal guardians" have primary responsibility for the upbringing of their children, State parties must render appropriate assistance to "parents and legal guardians" in the meeting of these responsibilities. Article 20 calls for "special protection and assistance by the State … (when a child is deprived of) … his or her family environment". The State therefore has a responsibility to support caregivers to care for their children and, in the absence of "family" care, to provide for the child's growth and development needs in a more direct manner. South Africa ratified the CRC in 1995.

- The *African Charter on the Rights and Welfare of the Child* promulgated under the auspices of the former Organisation for African Unity (OAU), mirrors the rights in the CRC using concepts and a dialogue that is relevant to children living in African contexts. South Africa endorsed the African Charter in 2000.
- The *International Covenant on Economic, Social and Cultural Rights* (ICESCR) (1966), provides for everyone the right "to social security, including social insurance". Article 10(3) of the ICESCR makes explicit provision for state parties to take "special measures of protection and assistance on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions". With regard to allocations to socio-economic rights, this has been interpreted as giving precedence to children, above the population in general (Cassiem & Streak, 2001; Van Bueren, 1999). South Africa acceded to ICESCR in 1994.

Constitutional obligations

The Bill of Rights of the Constitution of South Africa sets out the civil, political and socio-economic rights of all persons. In addition to providing everyone with the right to have access to water, sanitation, housing, social security, food and health care, the Constitution provides these same rights for children in a separate clause using stronger wording.

Section 28 (1)(c) of the Constitution gives children "the right to basic nutrition, shelter, basic health care services, and social services". This wording has been interpreted by child rights advocates to mean that the state has an obligation to prioritise the delivery of a basic package of services and benefits to children.

Section 28(1)(b) provides that every child has the right to family care or parental care, or to appropriate alternative care when removed from the family environment.

The National Program of Action

South Africa's Reconstruction and Development Program (RDP) aimed at redressing the legacy of apartheid and giving attention to the nation's priority needs. It provided a framework for social and economic policies, laws, and programs. Within these, children were given special consideration through a series of goals which entrenched the tenets of the Convention on the Rights of the Child. Priorities identified by the RDP were adopted in the National Plan of Action for Children.

The framework for a National Program of Action for Children (NPA) is one of the major instruments aimed at ensuring a comprehensive approach to co-ordination of efforts for children by all sectors of South African society, from national to local levels, and for government as well as civil society.

The NPA is a mechanism for identifying all plans for children developed by government, non-governmental organisations and other child-related structures, and for ensuring that these plans converge in the framework provided by the Convention on the Rights of the Child, the Constitution and the country's development program.

The NPA has an important role to play in monitoring both the efficiency and the impact of efforts. It also provides a means for reporting on progress with action for children to both the South African Parliament and the international committee monitoring implementation of the CRC.

South Africa's approach to operationalising a rights-based approach to children through the NPA framework is innovative. Linking child rights and the CRC to the Constitution, and directing this approach at laws, policies and programs is appropriate in a society committed to addressing the human rights violations and inequities of the past.

The NPA provides a useful template on which to develop actions with a direct impact on children, and efforts towards the realisation of this goal are under way. In reviewing progress, remaining challenges of special concern are:

- the need to accelerate the appropriate allocation of resources for children, and
- the extension of interventions to ensure coverage of the whole population, especially those rendered most vulnerable through poverty.

Conclusion

South Africa has acknowledged the international and constitutional imperative to accord children high priority in policy and law reform, and service delivery. Government has made progress by ratifying and endorsing international human rights instruments to protect and promote children's rights and by incorporating these principles into its policy and law reform agenda. However, much work still remains to be done, particularly with regards to socio-economic legal reform and program implementation. Furthermore, the policy reform arena has not yet fully taken cognisance of the extent of the impact of poverty and HIV/AIDS on children.

In the next edition *Child and Youth Care* outlines the social development policy and legislative framework.

Reference

Giese, S. Meintjies, H. Croke, R. & Chamberlain, R. 2003 *Health and Social Services to Address the needs of Orphans and Other Vulnerable Children in the Context of HIV/AIDS.* Cape Town: Children's Institute University of Cape Town.

The Complexities associated with

Antiretroviral Therapy and Nutrition

Part II: Chronic Side-Effects

Prof. FJ Veldman, School of Health Technology, Central University of Technology, Bloemfontein Free State

Nutritional management is important in the care of people infected with the HI virus. HIV infection results in complicated nutritional issues for patients, and there is growing evidence that nutritional interventions influence health outcomes(1).

Chronic side effects of antiretroviral treatment (ART) are those that develop over a period of time. In most cases these side effects do not hold immediate life-threatening conditions to the patient. However, they need intensive and chronic medical and lifestyle treatment. These side effects include insulin resistance (commonly known as diabetes mellitus type II), raised blood cholesterol and triglyceride levels, hypertension, lipodystrophy (redistribution of body fat) and in males, osteoporosis (2). Some of these conditions are known risk factors for heart disease and stroke.

Up to 63% of HIV-infected patients receiving Protease Inhibitors[c] develop abnormal fat redistribution (3). This takes the form of fat layering around the organs of the body. Lipodystrophy is problematic in that it is one of the very few physical characteristics by which people on ART could be identified. This could lead to stigmatization and even motivate individuals on ART to quit their medication.

Up to now, a metabolic profile[b] with raised blood cholesterol and triglyceride levels, with concomitant hypertension and insulin resistance, were commonly known as metabolic syndrome. The syndrome is generally associated with a westernized unhealthy lifestyle (i.e. overweight individuals, consuming large amounts of fat and very little fiber in their diet). Overweight or obesity is generally caused when the caloric[a] intake (i.e. amount of food) of an individual exceeds the caloric use (i.e. food required to maintain normal bodily function). The excess calories are stored in the form of fat. Some combinations of ART (especially those that include the protease inhibitor class of drugs) cause metabolic disturbances similar to that of metabolic syndrome - even in the absence of a high caloric intake.

Treatment of metabolic syndrome consists of a combination of lifestyle changes and medication. Lifestyle changes are the most preferred due to the high cost and additional burden of medication treatment, especially in people on ART with already difficult medication intake schedules.

In most cases recommended lifestyle changes for treatment of metabolic syndrome would include the following: weight loss, a reduction of total dietary fat intake, an increase in dietary fiber intake, an increase in plant protein intake, exercise, stopping of smoking, etc. These recommendations are problematic in resource-poor settings, taking into consideration that most patients will be caloric deprived (i.e. undernourished and often underweight). In a way, this could be classified as a novel metabolic disorder. It is questioned whether normal lifestyle recommendations used to treat metabolic syndrome in over-nourished individuals can be used to treat metabolic syndrome in undernourished individuals.

Increased exercise can decrease central fat accumulation, but at the expense of increased peripheral[d] fat wasting (2). Special considerations need to be given to the role of nutrition. The major issue is how to implement these interventions in the absence of available, and nutritionally adequate food. Nutrition intervention for caloric deprived or wasted individuals would mainly focus on the increased intake of energy dense foodstuffs, with little regard to the specific type of available fats (saturated or polyunsaturated) or protein (animal versus plant protein). However, placing the treatment of metabolic syndrome next to that of caloric deprivation would imply that nutrition intervention should now include careful dietary guidelines (low fat, high carbohydrate and high fiber intake), without compromising the caloric content of the diet. Guidelines would therefore highlight the value of healthy eating without lowering (or even increasing) the total amount of food consumed by the individual.

A second nutrition treatment option would be to focus on the treatment of caloric deprivation, followed by treatment of metabolic syndrome. However, this method would be less advisable as it is unknown what the effect of a sudden change in dietary intake would be in patients on ART.

Currently there are a number of potential targets for dietary modification among patients with HIV infection and lipodystrophy. Hadigan et al. (4) showed that the ratio of polyunsaturated to saturated fat in the diet, dietary fiber intake and alcohol consumption are the only dietary factors that contribute towards the chronic complications associated with ART. Dietary intervention studies are necessary to determine whether alterations in polyunsaturated fat intake and increased dietary fiber will be to the benefit of patients. It also seems highly likely that a reduction of alcohol and cholesterol intake will be beneficial. However, further investigation is needed to assess the impact of dietary intake and its modification on metabolic risk factors in individuals receiving ART. Also, no diet should interfere with antiretroviral drug absorption or the overall wellbeing of the person.

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2. Carr, A. and Cooper, D.A. 2000. Adverse effects of antiretroviral therapy. **The Lancet**, 356:1423-1430.
3. Carr, A., Samaras, K., Thorisdottir, A., Kaufman, G.R., Chisolm, D.J., Cooper, D.A. 1999. Diagnosis, prediction, and natural course of HIV-1 protease inhibitor associated with lipodystrophy, hyperlipideamie, and diabetes mellitus: a cohort study. **The Lancet**, 353:2093-9.
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Glossary

[a]**Caloric:** the unit of energy released by a specific food when the body breaks it down
[b]**Metabolic profile:** both physical and chemical features of the body associated with a specific disease or abnormality
[c]**Protease inhibitors:** these substances inhibit the ability of the virus to duplicate itself within the human cell [d]**Peripheral:** near the surface of the body

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My life after my mother's death

Sifiso Luthuli, nineteen-year-old head of his household talks of his experience of caring for his siblings, with the help of a community-based child and youth care worker.

My mother passed away in 1998 and my life changed. My father said that we, my sisters and brothers and I had to go and stay in Vryheid with his stepmother. This was very painful, but we went with my sister Smangele to Vryheid. She and I stayed with them for only two weeks and then came back. After some time Smangele got sick and I took care of her. I took her to hospital – the doctor said she had TB and she was admitted. When she came back from hospital she went to stay with our relatives in another township.

My father was a taxi driver. He got sick as well – he was suffering and the disease affected his knees and he was not able to drive. I went to Adams Mission to tell his younger brother, and we suggested also taking him to Vryheid to his stepmother. I was left alone at home when the message came from Umlazi that my sister didn't make it. I thought that I would never survive all that pain. I went to the public phones to phone my father in Vryheid, but because he was sick he didn't come. He said that I should go to Adams and tell his younger brother that we had to take Smangele's body to Vryheid. After the funeral my father told me that I will grow as a very strong man. We came back to Durban with the children as their life was not good in Vryheid. My father's brother took them with him to Adams.

I was alone at home, and my life was very hard. My income was R210 from people who were renting rooms in the house. After one year the children came back from Adams and then the situation became tougher because we were supposed to share that small income. They told me everything that was happening when they were there – they were fixing cars in the evening. If they did not do this they never got food. When they came to stay with me I was choosing to find food for them, and forgetting about myself sometimes.

One day when I was coming from school I found two people sitting in the yard. They were Sis Sbongile and Hlengiwe. They introduced themselves. When they said they are taking care of orphaned children, I had hope.

Sis Sbongile started to visit us every day. She found out that we have birth documents and our mother's death certificate. She referred me to the social worker and we met with her in the social worker's office. The social worker was surprised to hear my story. She registered my name and gave me another date to come with the children so that we could go to the court. The magistrate didn't believe that I could take care of my siblings so she delayed the court process, but because the social worker told the magistrate that Sis Sbongile was spending a lot of time with us, she agreed to process a foster care application.

It was very hard during this time, but Sis Sbongile was there to support us. She used to come home while we were at school to prepare something for us to eat after school, and help us with homework. She came with food from the project. She even made sure that the neighbors helped us. She was doing everything with us until she left food well cooked for supper.

One of my brightest day's came. I received the grant. I didn't know how to say thank you to her! I did say "thank you Sis Sbongile", but I thought it was not enough. She didn't go even when we received the grant. She did everything with us, helping me to open a bank account, a funeral plan, an investment account, doing groceries altogether and shopping. The children were choosing clothes of their own choice. We paid school fees. She taught me how to sign, and she helped me to learn to use one and the same signature before we went to the bank.

I have people to talk to if I have any problems. People I believe in. I would like to say to those who have the same problem I had before: "Don't lose the hope, somehow things will change for you as they did for me".

SAQA for Students

More Questions and Answers

Sandra Oosthuizen

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The best way to get to grips with the overwhelming amount of information contained in the SAQA (South African Qualifications Authority) process is to continue asking questions and hoping that the answers slowly provide one with the next piece of the puzzle! Many child and youth care workers in training have responded with questions to the articles published in this journal in the past six months. This month's SAQA page is combined with the Student page, focusing on common enquiries from child and youth care students.

Q: How do I find qualifications on the NQF (National Qualifications Framework)?

A: The qualifications and unit standards on the NQF are all listed on the National Learner Record Database (NLRD). This database is available from SAQA. You could access it via internet on the SAQA website at www.saqa.org.za or you could contact the SAQA offices, and request it to be sent to you. SAQA contact details are listed at the end of this article.

Q: How do I find a training provider to train me once I know which qualification I want to learn?

A: Training Providers who train qualifications which are registered on the NLRD will be listed as accredited training providers with the Education Training and Quality Assurors (ETQA). The quality assurance is regulated by the Sector Education and Training Authorities (SETAs). You could access the list of training providers by contacting the appropriate SETA within which the qualification falls, eg social work, will fall within the Health and Welfare SETA. You request from the SETA the list of training providers that offer that specific qualification.

Q: What if there is no training provider in the area in which I live and work?

A: Contact the training provider with whom you would like to do your learning. If they cannot assist you in any way, then contact the SAQA head office (contact details at the end of the article) and report it to the Quality Assurance and Development Directorate. They will initiate a process with the appropriate ETQA to extend the accreditation of an appropriate provider to offer the qualification in the requested area.

Q: When and where do we access the child and youth care work qualifications?

A: These qualifications are not completed as yet. The first qualification should be available at the beginning of 2005. It will be registered on the NLRD. *Child and Youth Care* will continue to publish information regarding the progress of this process.

Q: Will there be learnerships in child and youth care work and at what level on the NQF (National Qualification Framework)?

A: Yes, there will be learneships in child and youth care work pitched at various levels on the NQF. The level at which the qualification is registered on the NQF will determine the level at which the learnership is designed. The learnerships will be designed after the registration of the qualifications.

Q: Can universities, technikons and schools offer learnerships?

A: Yes, universities and technikons and schools will be offering learnerships. *Child and Youth Care* will keep you posted as to the progress regarding learnerships.

Q: I need my South African qualifications evaluated for study and work purposes abroad. What must I do?

A: Recognition of South African qualifications in foreign countries is up to the host countries. You could enquire from SAQA as to the evaluation done by The Centre for Evaluation of Education Qualifications (CEEQ). They will evaluate your qualifications, but only within the context of South African qualification regulations. The contact details of overseas evaluating agencies can be obtained from SAQA (contact details at the end of the article).

Q: As a learner who is employed in an organisation, how do I access state-subsidised training if the organization is exempt from paying the Skills Development Levy?

A: All organisations, whether exempt from paying the levy or not, have to register with the South African Revenue Services (SARS). SARS will issue the organisation with a levy-exempt number. The organisation has to then send the letter to the appropriate SETA within which they were registered with SARS. The SETA's require the organisation to complete a Workplace Skills Plan which needs to reflect the training needs of the employees within that organisation. The employees need to give input into the development of the plan and need to be informed as to progress on the implementation of the plan. The SETAs hold funds in a "Discretionary Grant Fund". This fund can also be accessed by employers exempt from paying skills levy. These funds can only be accessed if the employer submits a Workplace Skills Plan, which then enables the employee to access subsidised training.

As learners in the child and youth care field, it is critical that you stay informed as to the progress regarding the new developments in the field. It is important for the field that individuals make every effort to understand that the SAQA process impacts on them - and how it impacts. Responsibility for learning and professional development is in the hands of each individual!

The Standards Generating Body progress on registration of unit standards and qualifications will be discussed in next month's issue of *Child and Youth Care*. Please feel free to continue forwarding questions for our mutual benefit to: The Director, NACCW, P O Box 36407, Glosderry, 7702 or fax to 021-762 5352.

SAQA Contact details: Tel: 012-431 5000
Postal Address: Postnet Suite 248, Private Bag X06,Waterkloof, 0145

Ref: www.saqa.org.za

Days to Remember

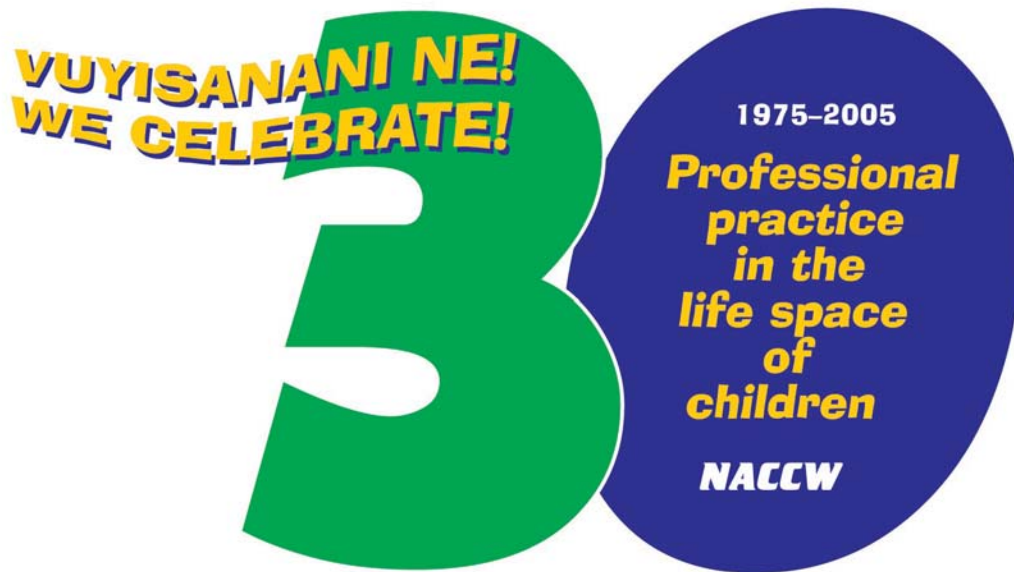
August

4 – 10	National Child Injury Prevention Week
4 – 10	National Cancer Week
9	National Women's Day
9	International Day of the Worlds Indigenous People
12	International Youth Day
24 – 30	National Deaf Awareness Week Cerebral Palsy Week

September

3 – 7	School Aids Week
21	World Gratitude Day
21	International day of Peace
24	Heritage Day

NACCW 15th BIENNIAL CONFERENCE



Tuesday 5 July – Thursday 7 July 2005
University of Western Cape, Cape Town

Keynote Speaker: Dr Thom Garfat

First Call For Papers

The Association invites those working in the area of young people at risk and their families to submit proposed papers and workshop outlines for possible inclusion in the Conference Program. Presentations may focus on practice, programs or policy as they impact on the transformation of child and youth care services and relate to the Conference theme.

Your proposal must include the following:

Name/s of Presenter/s; Address; Telephone Number;
Fax Number; E-mail address

Provisional Title of Presentation; Proposed format

Summary of presentation and intended outcomes
(200 - 300 words)

Send your proposal to Sandra Oosthuizen:
Fax: 021-762-5352 or e-mail: sandra@naccw.org.za