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Child and Youth Care

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

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Our True Name

Child and youth care as an occupational group has made great strides in South Africa over the last few decades. But we all know that there is still much to be done to bring about a profession that is recognized and respected. In different parts of the country, child and youth care workers are called by a range of different names – none of which convey the true meaning attached to their work. For many years those in the employ of the state have been called 'social auxiliary workers'. Who knows what such a person does? In some provinces, state-employed child and youth care workers are known as 'care officers'. Does anybody know of this profession? In some areas we have the old-fashioned term 'house parent' in use. Frighteningly, some programs refer to us as 'mothers'!

The HIV/AIDS pandemic has ushered in a level of confusion on this issue too. The term 'home-based care worker' is often shortened to 'care worker' causing confusion of roles at community level. 'Caregiver' is also a term used to describe us at times, when in fact it is meant to indicate a person who is caring for a child or adult who is not doing so contractually – as part of a job for which they are either being paid a salary or a stipend, or are officially engaged without being remunerated.

We know that what we call a person goes a long way to defining what that person does, and how the person views him or herself. In some instances perhaps there is a resistance to calling us by our true name – precisely to keep us in particular carefully designed (and limited) positions. As long as we are called by a name that is linked to a role that anyone, by virtue of biology can play in life, our professional ambitions are kept in check. As long as the state calls us by a name that does not denote a profession, we remain a cheap labour force - and an untapped resource.

Disappointingly too the term 'child and youth care worker' has only obliquely found its way into the Children's Bill. The Bill refers to 'staff' of residential facilities without any special designation of those who work in the life space – a situation that we hope will be put right as the parliamentary process proceeds.

Even in the professional realm we see confusion about exactly what we are. Our friend Sue De Nim articulates what we do that is distinct from other professions in the Spotlight on Students pages this month.

One of our difficulties is that we sometimes ourselves struggle to say what we do and therefore who we are. Child and youth care work when well done looks easy! And many of us work from a place of informed intuition. But it is essential for our growth as a profession that each and every one of us learns to say, and to say loudly and clearly what it is that we do and who we are. Is the desire to be seen for who we really are, not a part of human nature? Are we not all wishing to be called by our true name? If so we must speak up and call ourselves by our true name. We must call ourselves 'Child and Youth Care Workers'.

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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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.

Coming from your center, being there, teaming up, meeting them where they're at, interacting together, counseling on-the-go, creating circles of care, discovering and using self, and caring for one another:

Central Themes in Child and Youth Care

Mark A. Krueger

ABSTRACT: During the past 40 years, significant advances have been made in understanding and developing professional child and youth care with troubled children. In this article, which first appeared in the *Journal of Child and Youth Care*, 5.1 (1991), the literature is reviewed and concepts, principles and themes for teaching and learning are presented.

Child and youth care is about caring and acting – about being there, thinking on your feet, interacting, and growing with children. It is rich, intense, difficult work that requires passion and commitment. When it goes well, troubled children can make tremendous strides. When it goes poorly, their obstacles may seem almost impossible to overcome.

As important as it has always been, however, child and youth care was not well understood or developed in North America until the middle of the century when a few pioneers began studying and writing about it. Since then there have been numerous contributions to the knowledge base from practitioners, teachers, and administrators. In this paper their work, and the themes that appear to from it will be reviewed.

A Brief Chronology of the professional Child and Youth Care Literature

According to a study conducted by the National Organization of Child Care Worker Associations (Krueger et al., 1987), professional child and youth care in North America is practiced across a continuum of services including treatment centers, group homes, correctional institutions, special schools, temporary shelter care facilities, independent living programs, foster and natural homes, communities, and street corners. Its roots, however, are in residential treatment. In the 1950's child and youth care advocates began to write about residential treatment as a holistic method that with the proper skill and adequate knowledge of human development could be used to teach, treat, and nurture troubled children.

In *Children Who Hate and Controls from Within: Techniques for the Treatment of the Aggressive Child*, Redl and Wineman (1951, 957) introduced psychodynamic management techniques and ego support programs for residential care. Redl, a leading pioneer in the professionalization movement, also

developed a popular counselling technique called "The Life Space Interview" (1959). Meanwhile, other pioneers like Myer (1958), Burmeister (1961), Trieschman et al. (1969), Foster et al. (1972), and Beker et al. (1972) wrote books about creating the therapeutic milieu. These books, of which *The Other Twenty Three Hours* (Treischman et al., 1969) is best known, provided a foundation for the systematic care of children and youth throughout the course of a day.

Others found new ways of applying psychodynamic, human development, sociological, cultural, and social learning theories. For example, Nicholas Long (Long, 1966; Long, et al., 1976; Powell, 1990), a student of Redl's, developed a child care method (The Conflict Cycle) for dealing with stress and anger. Maier (1975, 1979, 1987) identified the components of care and described the important role care and caregiving play in human development for children at home and away from home. Bronfenbrenner (1977, 1979), the recognized leader of a major paradigm shift in the science of human development, introduced ecological caregiving and caring human connections. Vorath and Brendtro (1974) developed a group method of caregiving that is based on sociological concepts. Weaver (1990) urged greater sensitivity to cultural differences and described methods of cross-cultural care. Several authors advocated for social learning and competency approaches (Durkin, 1990; Ferguson and Anglin, 1985; Fox 1990).

In a comprehensive textbook, *Re-Educating Troubled Youth*, Brendtro and Ness, (1983) reviewed major child and youth care developments and practices from historical as well as modern perspectives. Proposals for improving the group care system, child and youth care environments, and curricula for teaching child and youth care work were also developed (Ainsworth and Fulcher, 1981; Beker and Feuerstein, in press; Krueger, 1986, 1990; Linton, 1969, 1971; Maier, 1987; McElroy, 1988; Reiger and DeVries, 1974; VanderVen, et al., 1982; Whittaker, 1980), as were additional books about techniques (Krueger, 1988; Savicki and Brown, 1981).

Recently, Brendtro et al. (1990) presented their research on the Native American Circle of Courage and encouraged members of the field to study and advocate for similar values of belonging, mastery, independence, and generosity in working with troubled children. Authors have also turned to creative writing as a way to describe the rich and intensive nature of the work and to portray the roles of self discovery and personal growth in child and youth care (Condit, 1989; Fewster, 1990; Krueger 1987a, 1990). Finally, four recent anthologies, *Choices in Caring* (Krueger and Powell, 1990), *Perspectives in Professional Child and Youth Care* (Anglin ct al. 1990), *Knowledge Utilization in Child and Youth Care Practice* (Bekerand Eisikovits, in press), and *Challenging the Limits of Care* (Small and Alwon, 1988) include chapters that cover the scope of the field.
A review of these anthologies, the references cited earlier, and articles in *Child and Youth Care Quarterly*, *The Journal of Child and Youth C*are, *The Journal of Child and Youth Care Work*, and *The Child Care Administrator,* led to the conclusions discussed in the next sections.

Developmental Care

Developmental care has become the central theme in child and youth care practice and in this context Maier's work (1979, 1987) is significant. A collection of his papers, titled *Developmental Group Care of Children: Concepts and Practice* (Maier, 1987), is the most comprehensive analysis of care and its applications. In one pivotal paper, The Core of Care: Essential Ingredients for the Development of Children at Home and Away from Home (Maier, 1987, pp. 109-120), he identifies the components in care as bodily comfort, differentiations, rhythmic interactions, the element of predictability, dependability, and personalized behavioral training. He concludes that child and youth care or caregiving requires sensitivity to and interventions that address:

(a) children's basic physical needs and privacy requirements;
(b) their differences in temperament;
(c) their underlying developmental rhythms;
(d) their need for predictable responses and dependable adults; and
(e) the importance of the personal element in behavioral training.

From his work and the work of many of the authors noted above, and others, at least eight basic principles appear to have emerged:

1. Care is a central element in building helping relationships;
2. When caregiving and care-receiving are mutual, a nurturing human connection is formed (Maier, 1987; Trieschman, 1982);
3. The components in the core of care as defined by Maier are essential for the development of children at home and away from home (Maier, 1987, pp. 109-120);
4. Child and youth care is a sophisticated practice that requires considerable skill and formal knowledge;
5. Effective child and youth care workers are caring people (Austin and Halpin, 1989);
6. Every child needs a connection with "at least one person who is crazy about him or her" (Bronfenbrenner, 1977, p. 5);

7. Children are more apt to respond to psychodynamic, sociological, social learning, ecological, and human development approaches when they feel cared about;
8. Care work takes time, patience, and persistence.

Child and Youth Care Work Themes

In comparing personal experiences (practicing and teaching care over twenty years) with the literature, nine additional themes evolved. In the author's opinion, these themes outline key knowledge areas for teaching and learning in child and youth care.

Coming from Your Center

"I tell them to follow their bliss," Joseph Campbell, the famous mythologist, responded during a television interview in which he was asked what advice he gave students about choosing their work. After devoting his life to studying myths and religions throughout history, he knew that people could only be happy if they made choices that came from their own spiritual center. Al Treischman, a renowned leader in this field, once talked about having a "twinkle in your eye" for working with children (Treischman, 1982) and workers often talk about a feeling they have in their guts for the work. The message here is clear: the primary motive for being a caregiver has to be that something in your center or gut or heart or all of these is telling you this is what you want to do. Without this feeling, there is not much that can be learned that will be helpful.

Being There

Troubled children have been psychologically and or physically abandoned throughout their lives and their greatest fear is that they will be abandoned again. To trust and grow, they need dependable and predictable connections (Bronfenbrenner, 1979; Maier, 1987; Krueger and Powell, 1990) — caregivers who they can count on, who are on hand to talk when they are ready, to support them when they are motivated to learn, to encourage them to try again when they fail (Krueger, 1988) and to also be there when they are neither ready, motivated, nor interested in a helping hand. Thus, coming into the field requires a commitment to being there with an understanding of the time it takes for troubled children to begin to trust adults.

Teaming Up

Teamwork is the in thing (Garner, 1988). Decisions about how to treat, educate and care for youth require the insight and consensus of all those who are involved in the lives of the children, including child and youth care workers, administrators, consultants, parents, and the children themselves. Further, these decisions need the mutual support of everyone as they are being implemented.

Meeting Them Where They're At

We need to relate to and work with children as developing beings ... It is important to remind ourselves that the developmental approach does not permit preoccupation with deviant, pathological, or defective behavior. ... When an individual's affect, behavior, and cognition are evaluated as distinct processes, care workers can rely on predictable patterns of development progression instead. (Maier, 1987, pp. 2-4).

Maier and the other developmentalists have shown that troubled children can only respond to self and skill-building interventions that are geared to their emotional, cognitive, social, and physical needs, and that are conducted in a process of care (Beker and Feuerstein, in press; Maier, 1987, pp.109-120). The goal is to meet them where they are at, with child and youth care interventions (Durkin, 1990; Fox, 1990; Juul, 3989; Krueger, 1983; Maier, 1987; Munoz, Savicki and Brown, 1981) that focus on building strengths rather than concentrating on weaknesses.

Interacting Together

"When we do things to youth and not with them, it's not going to work so well" (Trieschman, 1982). "Children are not objects, they are subject beings and caring is always an action carried out by one subject being in regard to another subject being" (Austin and Halpin, 1989, p. 2). This requires a non-judgmental, unconditional caring attitude that is based on valuing and understanding all children as unique individuals who are capable of making their own choices (Fewster, 1990). Caregivers can never consciously allow or give permission to children to do anything physically or emotionally harmful to themselves or others, but their greatest hope has to be that through their teaching, counselling, and nurturing interactions with children, the children will learn and be empowered to make the best choices for themselves (Krueger and Powell, 1990).

Counseling on the Go

Crises are opportune times for adults to model and teach social and emotional competence ... For children under stress we must interpret adult intervention as an act of support and protection rather than hostility. ... We must acknowledge and accept the feelings of children without necessarily accepting the way in which they choose to express them (Excerpts from Nicholas Long's principles of the Conflict Cycle as summarized by Powell, 1990, p. 26).

Troubled children need counselling at bedtime, during kickball, in the arts room, and during fights and temper tantrums as much as during scheduled office visits; and no matter how tough or aggressive or passive they are at times, the prevailing underlying feelings they experience are anxiety, fear, sadness, and depression (Long et al., 1976; Redl, 1959; Trieschman, et al., 1969). With the use of psychodynamic (Long et al., 1976; Powell, 1990; Redl, 1959) guided group interaction (Brendtro and Ness, 1983), social learning (Fox, 1990), creative/ expressive (Juul, 1989; Pirozak, 1990) and self discovery (Fewster, 1990) techniques, they need help to learn alternative methods of expression and to cope with these feelings as they surface throughout the course of daily living.

Creating Circles of Care

In traditional Native society, it was the duty of all adults to serve as teachers for younger persons. Child rearing was not just the responsibility of biological parents but children were nurtured within a larger circle of significant others. From the earliest days of life, the child experienced a network of caring adults (Brendtro et al., 1990, p. 37).

In studying the Native American circle of courage, Brendtro, Brokenleg, and Van Bockern (1990) understood the ecology of care. Today in caregiving, as in most other helping professions, it is widely acknowledged that parents, siblings, relatives, helpers and members of the community are all part of a troubled child's circle of care, and long term change is dependent on making this circle functional again (Brendtro et al., 1990). Thus every effort has to be made to conduct care giving interventions in homes and communities, and in harmony with familial (Garfat, 1990) communal, cultural (Weaver, 1990), and interdisciplinary team systems (Fulcher, 1981; Garner, 1977, 1982, 1988; Krueger, 1987b; Van der Ven, 1979) that are interconnected with a child's development (Bronfenbrenner, 1979).

Discovering and Using Self

Charolette was inviting me to consider the idea that self-examination and discovery is a process of observing self in action. At the broader level this is compatible with the preference for cerebral realms of theory and philosophy to follow experience, rather than vice-versa (Fewster, 1990, p. 147). The idea is that when we are experiencing another person, particularly at the feeling or emotional level, we are actually experiencing ourselves (Fewster, 1990, p. 42).

These selected quotes come from conversations between a worker and his supervisor in *Being in Child Care: A Journey into Self* (Fewster, 1990), which beautifully exemplifies and summarizes the belief that a full understanding of and relationship formation with children can only be achieved through self awareness and discovery (Fewster, 1990). In child and youth care, workers with the help of supervisors, teammates and teachers have to constantly strive to understand their own feelings and experiences in relationship to how they influence interactions with children and families.

Caring for One Another

"It is inherent that caregivers be nurtured themselves and experience sustained caring support in order to transmit this quality of care to others" (Maier, 1987, p. 119). Child and youth care is difficult and demanding work. To overcome the stress and fatigue, managers, supervisors and practitioners in professional child and youth care organizations have to do everything possible to create a supportive, caring environment for themselves (Bieman, 1987; Krueger, 1986a, 1986b, 1987b; Mattingly, 1977) with the awareness that the patterns of care they create for one another are interconnected with the patterns of care they create for the children.

In professional child and youth care, coming from your center, being there, teaming up, meeting them where they're at, interacting together, counselling on the go, creating circles of care, discovering and using self, and caring for one another, are actions, thoughts and feelings that when woven together provide a foundation for effective daily interactions. Further, it is the holistic mix of teaching, counselling, and nurturing approaches as summarized above rather than any single approach that makes child and youth care unique from other helping roles.

Conclusion: The Growing Knowledge Base and The Need for Care

The references in this article are representative of the work of many authors who drew upon both practice experiences and work from related fields such as psychology, special education, social work, human development, and the arts to collectively create a rich and exciting knowledge base for a new profession. A knowledge base, however, is a dynamic entity which is constantly changing and growing and open to interpretation. This contribution is the result of one effort to summarize and organize the literature at a given point and time. The goals have been to provide an outline for curriculum development and to encourage further investigation. With the changes in contemporary child rearing patterns and the rising numbers of poor and dysfunctional families (Carman and Small, 1988; FICE, 1988; Mech, 1988), the need to learn and practice child and youth care is greater than ever before.

from: http://www.cyc-net.org/cyc-online/cycol-0100-krueger.html

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Child and Youth Care intends publishing a series of articles on management, skills. These will include Time Management, Communication and Conflict Resolution. The first in the series is on

Delegation

Annette Cockburn

What is delegation?

Delegation is a word which is often misunderstood in organizations. Delegation is not about handing out work to other people. For example, when a project co-ordinator decides which of two typists should do a particular job, he/she hands out work to one of the typists that he/she chooses. This is handing out work and is not delegation.

Delegation is about handing over responsibility and authority with a job. For example; when the executive director of Izintaba, Mpumi Nkosi, asked Lydia Matla to organize an educare workshop Mpumi was delegating, because Mpumi gave Lydia the responsibility to get the job done and the authority to make it happen.

Delegation is, in fact, a time management tool. If a manager learns to delegate properly, it will help him/her to manage his/her time better.

Why is delegation important?

Delegation has its problems but there are definitely advantages for someone who learns to delegate properly. Effective delegation can make the difference between a successful and an unsuccessful manager, between being exhausted from too much work and the smooth running of an organization. Managers have to delegate because they cannot do everything themselves.

Advantages of delegating

There are many advantages for a manager of a developmental organization who delegates. Here are some of the advantages:

- When a manager delegates the routine parts of his/her job, it means that he/she can get on with the parts of the job that only he/she has the expertise to do
- The staff members that receive the delegated work feel motivated, and that they are important and trusted
- The employees that receive the delegated work have the chance to grow and develop and learn new things. This is good for the organization and the staff themselves
- The manager has time for other important jobs like evaluating the organization and strategic planning, rather than just coping with the day-to day demands

Why can delegation be difficult?

Some people or managers find it difficult to delegate for a number of reasons. Here are some of the reasons people find delegating difficult and some solutions to these difficulties:

- Delegation can be risky because the manager gives work to someone else. If the work is not done properly the manager will still be responsible for the work. Managers are responsible for the work of their staff, whether it is good work or bad work. This is why it is so important to help your staff to give of their best.
  -Solution: Coach well, have faith
- Often the tasks which a manager knows should be delegated are tasks he/she enjoys doing himself/herself.
  -Solution: let go of these tasks and learn to enjoy looking at the organization from the bigger picture, and doing things like planning and evaluating.
- Managers often worry that if they delegate tasks, they won't look busy enough.
  -Solution: remember that the thinking, planning and meetings that a manager must do are important work.
- It often takes time to delegate tasks. Coaching someone so that they are ready for the delegated task and helping them learn from their mistakes,

when you could do it yourself in half the time, can be very frustrating.
-Solution: understanding that this kind of coaching is part of a manager's job, and that once the task has been learned, it will save you time. You will also have a more motivated and confident employee.

- Managers worry that if they delegate the hands-on work, they will be out of touch.
-Solution: do spot checks and observations – but not too many or else the members of your organization will feel you don't trust them.
- Some managers are afraid that employees will "do it better" and show them up.
-Solution: understand that it is not a competition, but a way of getting the work of your organization done as well as possible.
- Some managers worry that "he/she can't do the job as well as I could".
-Solution: it doesn't matter, as long as he/she does it well enough. A job which is done differently does not mean it is done badly.

Steps in delegating

The steps in delegating are:

1. Decide what you want to delegate. Identify the specific task that you are going to delegate. It is important to be clear about the results you expect from the task.
2. Decide to whom you will delegate the work to. Choose a person who is ready to take on more responsibility, and who has the skills, interest and confidence for the task you have decided to delegate. You might feel that the person needs more training to help them do the job properly. Make sure you consider how much work the person has to do at the time you want your job done, maybe you need to give some of their normal tasks to someone less busy.
3. Explain carefully what needs to be done (the project or task). Explain why it needs to be done and why you are delegating it. Say how well it must be done. Give a specific time by when it must be done.
4. Ask the employee to give input about how to do the task.
5. Give guidance when necessary
   - listen well to his/her ideas first
   - share your own experiences
   - ask questions, for example, what consequences would you expect
   - give advice on how to get information

   BUT
   - don't shoot his/her ideas down in flames
   - don't jump in with your counter suggestions
6. Check whether the person who has received the task feels confident and has the skills to do the task. Maybe you need to organize training for him/her.
7. Give the employee responsibility and authority for getting the task done. Make sure everyone in the organization knows that the employee has the responsibility and the authority to get the task done. Be very clear about what he/she can do on his/her own and what he/she should check with you first.
8. Set up a communication system (e.g. a fortnightly meeting, or a weekly chat) to give the person support, especially in the beginning. Discuss how much follow-up to expect. Don't interfere if things start going wrong, but rather help the employee to think through the problems and solutions.
9. Accept the completed project and thank the employee for his/her effort. Don't accept unfinished, inaccurate or unprofessional work.
10. Accept responsibility for poor work for which you may be responsible.
11. Go over the lessons learnt from the delegation process.
12. With regular tasks, there should come a time when the task should become part of the employee's job.

STEPS IN DELEGATING

Decide what you want to delegate
↓
Decide to whom you will delegate
↓
Explain the task – how well – by when
↓
Get the person's input about the task
↓
Give responsibility and authority
↓
Communicate – set up meetings – don't interfere
↓
Accept the task when it is complete
↓
Accept responsibility for the completed task

Activities

1. Make a list of tasks that you ask other members of staff to do for you. Next to each task, write down whether you are actually delegating that task or whether you are simply handing it over without giving over responsibility or authority.
2. Make a list of tasks that you do that you feel you could delegate to other people in your organization. Next to each task write who you feel you could delegate the task to and what skills or training they would need in order to do the job properly. Discuss this list with the other staff members of your organization.

Ethical Dilemmas In South African Research

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

Introduction
Abstract

All psychological and social research presents ethical[1] dilemmas, many of which centre around the difficulties which may flow from the power imbalances between those conducting the research and the research respondents or participants. Issues of power are magnified[2] in research undertaken in contexts of poverty, and there is a burgeoning[3] literature on ethical issues in research in developing countries. In this article, we augment[4] the existing literature by focusing on the experiences of an assessor working in a controlled trial of a mother-infant intervention in a poor South African community. We consider issues of community expectations, the presentation to our project of physical health problems, the issue of HIV/AIDS, cultural beliefs which impact on the research, child protection issues, and the tensions between research assessment and ubuntu – a cultural norm[5] which requires helpful engagement with others. We suggest that a consideration of experiences such as those we have had may assist with the development of further research.

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

In order to develop knowledge which will be of use to communities and which will improve people's lives, it is necessary to conduct research. There are many debates internationally, however, about what constitute the best ways in which to conduct research, and there is a growing literature which argues that many research endeavours may have negative outcomes for respondents and for communities (Benatar, 2001). Psychologists, as researchers and practitioners, face ethical dilemmas wherever they work, and considerable effort continues to go into providing useful guidelines by which research and practice can be planned and evaluated (American Psychological Association, 1992; Azar, 2002; British Psychological Society, 2002).

At the heart of much of the concern about ethics is the reality that there is usually a power imbalance between professionals and their clients, and between those conducting research and research respondents

(Schüklenk, 2000). Particular concern has been raised in the literature about the importance for ethics of being sensitive to issues of power imbalances on the bases of gender (Westmarland, 2001), race and ethnicity (Baldwin-Ragaven, et al, 1999; Hall, 2001), sexual minority status (de Gruchy & Lewin, 2001), as well as mental disability and illness (Macklin, 2001; Schüklenk, 2000). Informed consent, to name one key, though at times controversial issue, (Kahn, Mastroianni & Sugarman, 1998) is hard to assess when respondents are vulnerable, needy, or from a different cultural context and assumptive world from that of the researchers.

Poverty and deprivation are risk factors for many poor outcomes, including many diseases and many adverse social conditions, including violence, demoralisation, and difficulties in human development (Desjarlais et al, 1995; Gibson et al, 2002). These risk factors are not however evenly distributed across the globe. Poor countries carry a much greater burden of human misery and ill-health than do richer countries (World Bank, 2001a, World Bank 2001b). It is therefore essential that researchers interested in global well-being conduct research in low-income countries, and especially research which carefully explores the possibilities for interventions which can improve life in these countries (Isaakidis et al, 2002). The paradox of the situation is, though, that all the difficult issues of power imbalances and cultural differences discussed above can all too easily be magnified when research is conducted in developing country contexts. Every difficulty which may be found at the microlevel of research anywhere can take on greater significance and impact in the developing country research context. There is a rapidly increasing literature on the enormous difficulties, both logistically and ethically, even the most resourceful and best-intentioned researchers face in working in poor countries (Arnot et al, 2000; Benatar, 2002; Jesus & Higgs, 2002; Rugemalia & Kilama, 2001). There have been innovative contributions both about how we should be reconceptualising ethical issues in such countries (Lindegger & Richter, 2000), and on how we can begin to assess whether ethical targets have been met in such contexts (Leach et al, 1999). Much of the literature on these issues address important broad questions about ethics and research design and practice, as well as the key question of how best to develop and strengthen research capacity in poor countries (Nchinda, 2002). Far more rare, however, is a consideration of how these macrolevel issues are realised at the microlevel of actual research projects (Haney & Lykes, 2000), and we have been unable to find detailed descriptions of challenges facing fieldworkers in psychological intervention research in Africa. Such descriptions may be useful in contextualising the broader issues, giving them a human face, and providing qualitative data which may be helpful to spur new thinking both within individual projects but also in broader research design contexts.

In this article we present microlevel information of this kind, focussing on the experiences of an assessor within a controlled trial of an intervention in South Africa. First, we introduce our project, before moving on to a consideration of the assessor's role. We then consider issues related to collecting data in a developing country, before discussing the implications of our work for our own research, and that of others.

The Thula Sana Project

The Thula Sana Project is a community-based intervention with mothers and infants in Khayelitsha, Cape Town, South Africa. Khayelitsha is a peri-urban[6] settlement with a population of between 500000 and 1 million, many of whom are migrants[7] to the city from impoverished rural areas (Cooper et al, 1999; Mash, 1998). Fewer than one in five of the dwellings are formal houses; most residents live in shacks. Migration patterns to and from rural areas make for an unstable and shifting population. Unemployment runs at approximately 66%. There is no social security in South Africa, so unemployed people receive no money at all. Of those who are employed, most earn less than the household subsistence[8] level. Education levels are commensurately[9] low, with a functional illiteracy rate approaching 25%. In some areas (including part of the area in which the project is situated) there is no electricity, no running water, and communal taps are shared by up to 50 households.

Services such as rubbish removal are irregular and inefficient at best in some areas (Cooper et al, 1999; Mash, 1998).

A community-based survey was conducted in part of Khayelitsha, and the rate of post-partum[10] depression was found to be 34.7%, around three times that found in Britain and similar countries (Cooper et al, 1999). International research has shown that both maternal depression and social adversity lead to compromised social, cognitive, and emotional outcomes for infants (Murray & Cooper, 1997; Murray et al, 1996; Olds et al., 1998). An important follow-up question is whether it is possible to intervene with mothers to improve maternal mood and to facilitate improved mother-child interaction, and to impact on cognitive, emotional, and social outcomes (Murray & Cooper, 1997).

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Given the situation in Khayelitsha both with respect to social adversity and with respect to maternal mood, an intervention was designed to attempt to improve outcomes. The project is called the Thula Sana project - this name literally means 'Hush little baby' in Xhosa. It is a controlled trial, with one group receiving a home visiting programme by trained community workers, and the other receiving the usual care offered in that community. The randomised controlled trial design is one which has been argued to be well suited to the assessment of treatment effects, and is well regarded as a method for research into interventions in Africa. (Birckmayer & Weiss, 2000; Fetterman et al, 1996; IJsselmuiden, 1997; Isaakidis et al, 2002; Joubert & Katzenellenbogen, 1997; Rothman, 1986).

In designing our project in a context of extreme poverty and very little infrastructure[11], we were faced with both logistical and ethical questions. From a logistic point of view, we were concerned that it would be difficult to keep track of a highly mobile population. Adding to this difficulty is the fact that in some parts of Khayelitsha, addresses are not fixed to specific geographical locations – for example, though many shacks are numbered, if the residents of a shack decide to move and to build a new shack elsewhere, they may take the number of their shack with them to the new location. As far as ethics are concerned, we were worried about providing any intervention to some members of a community desperately short of services, while withholding services from other community members. We were fortunate to begin to address some of the ethical and the logistic concerns by attaching the project to an existing community health project. This is a non-governmental health programme with university links which, amongst other services, offers assistance to new mothers in the physical care of their infants, focussing on such issues as breastfeeding, nutrition and hygiene. The project has an existing staff experienced in keeping in touch with a mobile population. The project does not however explicitly offer emotional support and an intervention designed to impact on mother-infant interaction, which is the extra component our intervention addresses. In attaching ourselves to this project, we were aware that Khayelitsha residents served by the project – including those in the control group - were receiving more services than average in the township. This decision can of course affect the external validity of the project, but was ethically necessary.

The home visiting programme itself is undertaken by trained women from the community. Assessments of mothers and later of infants as well are undertaken antenatally[12], and at two months, six months and eighteen months post-partum. The assessments are conducted by the assessment team, a member of whom is the first author (NN). The assessment team, in keeping with the controlled trial design, does not know who is receiving the intervention home visiting programme. NN is a Xhosa-speaking African resident of Cape Town who has a background in mother-infant work and training as an occupational therapy assistant. She does not live in Khayelitsha, but goes to work there five days per week.

The Development of the Assessor's Role

Nosisama Nama was one of the first employees of the project and had the important role of introducing the project to the community and establishing credibility, which is essential if any endeavour is to

begin successfully in South Africa. Local communities are very much aware of the fact that in the past researchers (who were mainly white) would collect data on impoverished people without making any contribution to improvement of their lives (Dawes, 1985). Since the late 1980's in particular, communities have been vigilant about this form of exploitation, and it is only through consultation with local community and political structures that access can be gained. In this regard, NN's experience of and sensitivity to community issues was central to the project's beginning. She personally had to attend meetings and to promise various organisations that the project would benefit the community. As NN becomes better known in the community, furthermore, the more she becomes seen as a person able to offer assistance in the community.

As further funding was secured and the project itself began, NN's role changed. She is now an assessor, blind to the intervention status of the mothers and infants with whom she is working. This is a very different role from the original one of advocate for the project and its benefits. It can be argued that there are inherent problems with an advocate for a project then becoming an assessor in that same project. In the ideal world, these roles should be separate – the assessor should not be seen by the community to have any investment in the outcome of the project. Given the resource constraints under which we were working, however, coupled with local politics, this dual role was necessary. This may well have had implications for how the assessor's role developed.

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]Ethical	what is right and wrong
[2]Magnified	made bigger
[3]Burgeoning	growing
[4]Augment	add to
[5]Norm	standard
[6]Periurban	close to town
[7]Migrants	people from another area
[8]Subsistence	amount of money and food needed to survive
[9]Commensurately	similarly
[10]Post Partum	after birth
[11]Infrastructure	systems which support a community
[12]Antenatally	before birth

Pat Maqina

– Northern Cape

My journey as a Child and Youth Care Practitioner

It all started in 1991, back in Kimberley when a decision was made not to place back on my shoulders those red epilates on a white dress – nursing. I wanted to work with children and women. My mother was not in favor of my decision, saying that working with children was not a profession like nursing.

Early one morning after having seen my children off to school, I took a walk down to what was previously known as Galeshewe Place of Safety. I had no formal documentation with me. I asked to meet with the manager of the institution. The man said he had no vacancies, but there would be vacancies at the Children's Homes which were to be opened soon. He requested me to submit a C.V. and told me to go to the Department of Welfare for an interview. I went back home very excited, as if I had already obtained employment. My mother said "My child are you really taking a job to work with people's troubles." I said, "If I am offered the opportunity, I am taking it and hope to make the best out of it."

At the office of Department of Welfare, in that well laid out waiting room, we were about 20 persons waiting to be interviewed. I had extra documents with me to convince the panel that I was the right person for the job! As people came out of the interview room they were commenting about how difficult the questioning was but I stayed positive and confident. My turn came. When I went out of that room I was confident that I had got the post as a Care Giver – in a cottage system. Three days went by. I will never forget that particular Tuesday morning, when I received a telephone call, saying that I had been successful.

The day came when I reported for work. I was very inquisitive, and was tasked to write and present how I see my role in working with children who displayed inappropriate behaviour (then it was said Aggressive Children). I had only been employed for a week – had not yet engaged with any child/youth.

The employees of the three institutions – i.e. Lerato Place of Safety, Galashewe Place of Safety and Tlhokomelo Children's Home were exposed to a week long training programme facilitated by the Cape Provincial Administration (CPA). The training was entitled "Caring for Children" and was supposed to give us an insight into working with children. Every morning we wrote a test. Seemingly we all passed with flying colours.

On the 1st December 1991 we moved to Tlhokomelo Children's Home. With all the enthusiasm and excitement, I prepared my cottage – which was to house 10 children both boys and girls. I had eight young persons and was later blessed with a 5 year old boy. Then came the challenges – the 5 year old was a Haemophillia A . My nursing experience came into perfect use.

I had no knowledge of writing what was called an occurrence book – where I had to report every incident and how it was handled. We were not called "Child and Youth Care Workers" but "House Parents". I had to plan a routine and programs and I must say the resource "The Other 23 Hours" and NACCW journals came in very handy. Management met with House mothers every week to plan and listen to challenges experienced in our interaction with children. We discussed each child and drew up a plan for each child.

In 1993 I did the BQCC Course. I came back to implement what I had learned. Now I had some direction for my interactions with youth in the cottage. I was already a member of the NACCW – serving on the executive committee. I used the training a lot in the cottage to harmonize relations, and when running programmes. My learning journey became very interesting, as the interventions we learnt were implementable although we struggled without supervision. In 1994 I was exposed to the Core Concepts and Behaviour Management courses which helped me to intervene appropriately because now I understood what prompted an inappropriate behaviour.

Then came the Transformation of the Child and Youth Care system. The facility I worked in was eventually closed. I was redeployed to Galeshewe Place of Safety. This was youth in conflict with the law. My roots in childcare issues were strong so I managed to cope. I kept myself abreast through reading the journal and involving myself in the activities of the NACCW.

In 1997 I underwent the Professional Foster Care Training. I worked in a facility and volunteered 24 hours a month of my free time to the Professional Foster Care Program, as a Child and Youth Care Worker working directly with biological families, their communities of origin and the foster family and foster child. This gave me an understanding of the importance of a holistic developmental approach when working with children, youth and families. This is now exciting! I found satisfaction, as I could implement what I learned, engaging developmentally, interacting in the life space of children according to a plan (IDP). In 1998 I was seconded by the Department of Social Services to manage the Professional Foster Care Program. Through the correct implementation of this indigenous innovative model I was able to make a difference in the lives of children, youth and communities. The primary goal of reunification of children with families of origin became a reality.

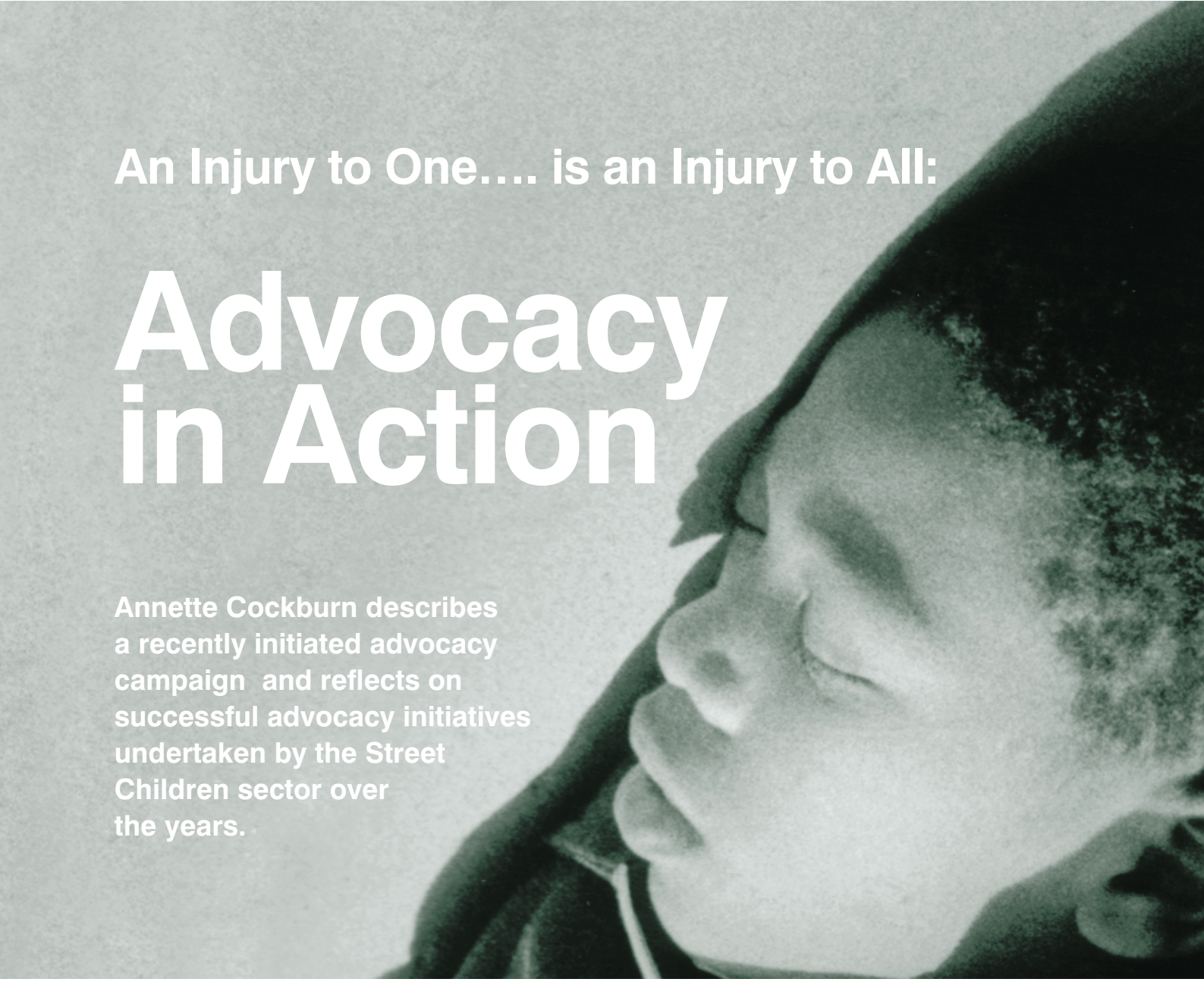
In 2002 I registered with TSA studying Child and Youth Development and in this very year initiated a poverty eradication program, to create jobs for parents of children and youth placed in the program. I can proudly say a soya mince factory has been established employing 10 biological, foster parents and youth from the ADP program. We hope in future this business will offer employment to 50 people.

I am still on a learning journey, in the process of training Restorative Conferencing in the Northern Cape Province, and implementing the *Isibindi – Creating Circles of Care* Project in one of the impoverished communities in Kimberley, with along term aim of establishing a Child and Youth Care Agency.

An Injury to One…. is an Injury to All:

Advocacy in Action

Annette Cockburn describes a recently initiated advocacy campaign and reflects on successful advocacy initiatives undertaken by the Street Children sector over the years.



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The murder of a Street Child in Cape Town led to the initiation of an Advocacy Campaign by the Homestead (Projects for Street Children) in order to bring to the attention of the public, the media, the decision makers and the justice system the outrage in the Childrens Rights Sector which followed the cold blooded shooting of a 17 year old boy, Xolani Jodwani, outside a nightclub in the city.

Last month we described the steps to be taken in planning an advocacy campaign and how lobbying could take place. Interestingly the term to "lobby" comes from the actual physical place outside parliament in which members of the public could buttonhole a politician in order to raise an issue or seek support. You can still mingle with politicians outside parliament during tea breaks or when sessions are over!

The Advocacy Process

1. The Issue: Identify the Problem

In this case the issue was the flagrant violation of Human Rights. That children have a right to care and protection is not only enshrined in our constitution, but also in all the International Instruments to which South Africa is a signatory.

2. Goals and Objectives: Be clear about your purpose

Our goal is to mobilise child rights organisations to stage a protest outside the Magistrates Court when the perpetrator is brought to trial. Attempts to have bail denied were unsuccessful and the person charged

with the murder of Xolani Jodwani was given R20 000 bail. The magistrates and public prosecutors were contacted and informed of the advocacy action.

3. Target Groups or Audience: Who are you aiming at?

When you take part in advocacy and lobbying you need to be clear about who you want to influence and whose support you need to make an impact on decision makers.

In this case the whole Child Rights network is the target as well as the media and the justice system. The media were bombarded with letters and requests for interviews and charged with promoting public awareness of the crime. Both print and radio media gave the murder extensive coverage and lawyers were approached to formulate inputs to the Child Justice System.

4. Building Support: Networks are Essential

Why should organizations network?

Networking means staying in touch with organizations and key individuals who can affect your work or help you to achieve your goals. Networking can serve many purposes and can help you to:

- Build alliances that will strengthen your advocacy campaign
- Get access to information that will help you in your campaign
- Influence other organizations to take up and support your campaign

What should we know about networking?

Networking should be an ongoing part of our work. Networking is not just public relations – it should be meaningful communication and co-operation between organisations with shared interests. There are many different ways to network. Some of the methods are informal or form part of your normal work, while others are part of setting up a networking system. Here are some examples:

- Send your newsletters and information pamphlets to organisations and individuals with whom you want to network
- Get to know key people in organisations that share your interests and talk to them regularly about common issues and problems
- Attend the meetings, AGMs and events of other organisations
- Attend political and community events where key organisations and decision makers will be present
- Attend conferences, seminars, consultation meetings, etc. Make sure your organisation is represented by someone who can speak for and raise the profile of your organisation. Lots of informal networking happens at these events
- Offer support and advice to other organisations when you can and ask for it when you need it
- Use your skills, contacts and expertise to help key decision-makers and organisations – networking happens naturally when you work together
- Always have copies of your fact sheets and contact details so that you can hand them out to any useful contacts you meet

5. Developing a Message: What will you say and do - and how?

The message in this case was one of outrage. This was delivered to a large number of stakeholders through the media, and via networks. Letters were written to key players and parliamentarians were lobbied for support.

6. Channels of Communication: Understanding the Systems

In order to advocate and lobby effectively you need to know how government works. You need to know who is responsible for what.

You and Your Representatives

You can contact your representatives in Parliament in one of several ways.

You can phone or write to them in Parliament. The address is: Parliament, Private Bag X15, Cape Town 8000. The telephone number is 021 403 2911. Ask the switchboard operator to put you through to your MP or leave a message for her or him.

You can also contact your representatives at the Constituency Office in your area. You can get the addresses and telephone numbers of these constituency offices by phoning Parliament or one of the political parties.

When Parliament is not in session, it may be easier to reach your representatives through their constituency offices.

7. Mobilizing Resources

In this case we will ask a number of organisations to produce placards and banners, and get permission from the City Council and traffic department to stage the protest as the court case gets underway.

8. Monitoring and Evaluation

Collecting information (research), and monitoring and evaluation are processes that take place throughout the advocacy campaign as well as at the end.

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Constant evaluation and adaptation of your advocacy and lobbying effects is the best way to ensure success. To build and improve your campaign, you need to monitor your vision, long-term and short-term goals, and the effectiveness of your strategies.

The idea behind monitoring and evaluation is to get useful feedback and change your strategies and/or goals if necessary. Good advocates assess the effectiveness of their past efforts and set new goals based on their experience.

Monitoring is the ongoing measuring of your goal against what you achieve and what you do not achieve.

Evaluation means collecting information about the process, outcome and impact and then looking carefully at this information:

- What has happened with your efforts?
- Have you succeeded in reaching your objective?
- How can you improve your strategies?

Monitoring and evaluation helps you to:

- Look at the work you and your organisation are doing and whether you are meeting your goal
- Examine the networks or partnerships which are involved
- Examine the messages that have been created
- Examine the target groups that have been reached
- Examine the policy efforts that have been undertaken
- Examine the strategies you have adopted
- Examine changes that have occurred as a result of your campaign
- Look at opportunities for a new area of work/campaign, once you have achieved your goal

These steps are used throughout the world, especially in developing countries, to plan and implement advocacy and lobbying initiatives.

In the Past…

Homestead social workers were among the first to bring to the notice of the press the appalling conditions under which children awaiting trial were held in Pollsmoor. The exposé was part of what led to the Free the Children Campaign.

If the police assaulted the children we always laid charges, and eventually a policeman was convicted. The witness was so small he had to stand on a stool in the witness box. The sentence? R50.00 or 50 days!

Horrified by the sexual exploitation of Street Children we brought a dozen debriefed and supported children to testify in a well-publicised trial of a Cape Town paedophile. When children still visited his flat in contravention of his bail conditions, we invited a national TV station to film the circumstances under which children still visited his flat. He was finally tried, convicted and sentenced.

"To the best of my knowledge there has never been a conviction in South African courts of a sex offender where street children have been the complainants. I believe this time that the testimony of street children has not been considered unreliable. I believe that in this judgement, these most marginalized and damaged of children, have been awarded some credibility and a measure of protection. Those who might in the future exploit and abuse them, will think twice as a result of this judgement. I thank all those who have supported us and promoted this cause over the last two years. I salute and celebrate those who were there in judgement and in witness today, and I also affirm the children who were sure enough, and brave enough, to tell it how it was. 'When will there be justice in Athens? There will be justice in Athens when those who are uninjured are as indignant as those who are!' (Greek, anon.) This was a case when those who were uninjured were very indignant indeed."

– Annette Cockburn, The Argus, 30/5/2000

Let your voice stop a bullet

Join us in a demonstration outside the Cape Town Magistrates Court on the **9th of September 2004.**

"Gerald Jacobs was a driver at the Homestead who decided to embark on a social work degree. When the post of Street Worker was advertised, he submitted this application."

The Bus Stop

It was 17h45 and I was waiting for my already late bus, trying not to breathe in too much in an attempt to prevent more carbon monoxide filling my lungs. "I still need to fetch my kids", "I'm going to be late for my meeting", were just some of the complaints heard in the very long queue. I tried to think of something positive amidst all this fretting and fuming. I wondered what my brother had made for supper and how I'd savour every inch of pasta which was always the order of the day when he cooked.

My attention was suddenly drawn to a little boy who was going through the dirt bin, trying to find something for supper. Everybody had soon forgotten about how late they were and the silence in the queue hung like smog on a late summer afternoon in the CBD, as the boy soon had everybody thinking about how fortunate they were.

"Wat is jou naam?" I asked, the question had everybody looking at me as if I'd spoken in some alien language. The boy responded quite casually. Our conversation had the ears of everybody in the queue. Elroy was new on the street and had heard the other boys speak about Yizani, (our drop in centre) but didn't really know where it was. As I went on to tell him what time he should be there next morning, everybody seemed much more at ease about speaking to him and loosened their holds on their handbags. I joked with him trying to get him to lend me his takkies for the weekend! He wasn't prepared to trade anything I had to offer for his takkies, so he quickly responds with a loud *"Jys mal"* which had everybody chuckling.

Elroy's departure got everybody chatting to me about street children as they voiced their concerns and problems around the issue. What was clear from the conversation was that everybody was concerned about street kids and wanted to help in some way. As somebody indicated *"I want to help, but how?´*They realized that their perceptions about this marginalized minority had prevented them from making any meaningful contribution toward the plight of street children.

I believe that as a *Street Worker* it is imperative to build trusting relationships with the street kids, police, businesses, security companies and people working the CBD. By building *trusting relationships,* I can change perceptions people have about children on the street. In so doing, I will make The Homestead and its services more visible in the CBD and people more responsible toward street kids. Getting children off the street would not only be my responsibility but everybody working in the CBD.

Being a *social work student,* my knowledge of *social welfare law and policy* would stand in good stead in piloting the rights and needs of children on the street. My familiarity with all the kids and vagrants on the street would go a long way in voicing these concerns and building bridges between them and authority figures in Town. Being able to apply theoretical knowledge to *curative, preventative* and *rehabilitative* strategies can only strengthen the pivotal function of street work at The Homestead.

I'm an avid footballer with loads of experience, which includes completing a "level one" coaching course at the famous *Manchester United* soccer academy in England. This would certainly help me build the necessary self-esteem and skill needed at Yizani to settle the score with the unbeaten glamour boys of Elukhulselweni.

So the bus finally arrived and I was left pondering on the difference I could make granted the opportunity of working on the street…

Community-based Child

In the context of the HIV/AIDS pandemic a number of professions have provided important services. Home-based care workers provide for health care needs in the community and have developed a positive reputation for delivering services to many people whose health is seriously compromised by the HI virus. As the number of children who are affected by the pandemic increases, the need for services aimed at fostering the development of growing children and youth has become evident. All national policies stress the importance of providing for children affected by the pandemic at community level. There is a call for the provision of 'psychosocial care' to be offered to children *in the context of their homes and communities*. Such 'psychosocial care' also must then by definition take place in the context of enormous personal suffering. Child and youth care work is a profession that is perhaps uniquely positioned to respond to the call of policy requirements in this area.

The profession is by definition one that is carried out in the context of the lifespace of the young person. It addresses issues of personal suffering, and seeks to engage in activities that promote developmental as well as therapeutic experiences. Some may argue that such undertakings are complex in nature and can only be undertaken by those at a professional level. However given the intense nature of the current situation in respect of children and youth, the country's skill shortage, as well as the need for the provision of employment opportunities, child and youth care as practised by trained community members appears to be offering a cost-effective response to children and youth affected by HIV/AIDS. The *Isibindi* Project: *Creating Circles of Care* as developed by the NACCW in conjunction with a number of partners is currently operational in three provinces. In the context of these projects, child and youth care workers operating at auxiliary level are providing for the developmental needs of numbers of children. In a situation where child and youth care is a brand-new 'profession', much confusion exists in relation to the work that they are doing. Frequently child and youth care workers in residential care are not even recognised as such but in many cases are still referred to as 'house parents', or even 'care officers'. So the work being done by community-based child and youth care workers is often not yet well understood.

This excerpt from a summary of a work record demonstrates some of the central elements of child and youth care work in action in a community setting. We see processes of engagement and relationship building, processes of family relationships being healed, of the child and youth care worker 'being with' or 'hanging out' with the young person. We see her being provided with what Nicholas Long refers to as 'experiencing joy'. We see a child and youth care worker doing everyday things that are in fact the minutiae that make up our lives…

Child and Youth Care Work with Nomuza

Nomuza is a girl of 16 yrs of age doing grade 11. Nomuza was born out of wedlock and her mother is married to another man. Nomuza stayed with her grandmother until she passed away and then moved to her mother's house. She is now staying with her mother, stepfather and her siblings. At one stage she stayed with her biological father and his family. She had problems with her stepmother – they did not get along and she presented with behavioural problems.

Nomuza was a virginity test goer until she fell in love with a guy who didn't respect that. He didn't know his status and passed the HI virus on to Nomuza. She was not aware that she was HIV positive, but started to suffer from unhealing sores on her private parts and eventually tried to commit suicide.

Summary of the Intervention

Nomuza didn't tell her mother about her problem, but her mother knew about child and youth care workers. She visited the Isibindi Project and spoke to Zamela

and Youth Care Work

By Smangele Zungu and Merle Allsopp

the Coordinator, together with Nomuza. She asked Zamela to talk with Nomuza as she wanted to know the reason for her attempting suicide. Nomuza opened up and told Zamela that she was tired of the unhealed sores on her private parts. Zamela encouraged her to go for HIV testing, preparing her for the possibility of a result indicating that she may be positive. Then Zamela introduced Nomuza to Nomathemba, a local child care worker who works in the project.

The child and youth care worker started to help Nomuza's mother who had been selling fruit in town and had stopped because of her concern for Nomuza. The child and youth care worker together with her mother took her to the hospital where she was to find out that she was indeed HIV positive.

Nomuza was admitted to hospital for 4 days. When she was in hospital, she asked the child and youth care worker to ask her biological father to visit her in the hospital. It was not easy for the child and youth care worker because Nomuza's father was very angry with Nomuza because she had stopped going for the virginity test, and she was sick. Nomathemba visited Nomuza's father and she told him about Nomuza's concern. He was angry but he said he would visit her out of respect for the child and youth care worker. Nomuza was very happy and she warmly thanked the child and youth care worker.

The doctor prescribed Bactrim tablets only and nothing to help her bad sores. She had to collect her medication at a local clinic. When it was time for her appointment with the doctor, the child and youth care worker went to the clinic to join the queue so that it was easy for Nomuza when she arrived. Our project helped Nomuza with gauzes, bandages, savlon, milk and pronutro.

The hardest thing in helping Nomuza to apply for the disability grant is that she does not have a birth document, but the child and youth care worker referred her to the social worker and the social worker wrote a letter to the District Office to request food vouchers for the family. She has now applied for her ID book.

The child and youth care worker continued to help the family. Nomuza was not bedridden at first. She could walk. When she saw the child care worker coming she would stand up and go outside to welcome her in the yard. The child and youth care worker told Nomuza about a memory box and they designed a memory box together.

The child and youth care worker continues to visit the family to talk with Nomuza so that she will get better. Her mother is also very happy and works together with the child and youth care worker.

Challenges

- She was very frail (she had TB) and could not sit or stand. She was bedridden. Every Monday she had to be at the clinic for a sputum test. Nomathemba had to be at the clinic by 6h00 to join the queue for Nomuza because there are a lot of people who go for sputum tests. Nomathemba asks the person behind her to keep her space when she goes back to get Nomuza.
- Nomuza had problems with her TB medication. It made her more sick – vomiting, body itching, and diarrhoea. She refused to take TB pills from her mother. Nomathemba and Zamela had a discussion with her about her TB medication and avoiding side effects. She agreed to take it but wanted Nomathemba to give it to her. We also arranged E-Pad and Pronutro for her so that she takes her medication with something in her stomach.
- The sores on her private parts were very painful and had to be dressed and cleaned daily to avoid becoming septic. Nomuza asked Nomathemba to see to her sores – Nomathemba tried all sorts of vaginal creams but the sores would disappear and then return within a week.
- Nomuza's mother is very cross with Nomuza's boyfriend Shayo because he infected Nomuza with the HI virus. He once came to visit Nomuza and the mother hit him with a knobkerrie. Because of that incident Nomuza developed asthma and could not

breathe at all. Nomuza told Nomathemba that she is deeply in love with Shayo. She said she would kill herself if her mother carried on meddling in their relationship. Nomathemba and Zamela had a meeting with Nomuza and her mother about Shayo – and her mother accepted the situation.

- Nomuza's father approached Nomathemba about her role in Nomuza's life. He also wanted to know why Nomathemba was not involving him – yet initially he had refused to be involved. He demanded to have a meeting with Nomuza, her mother and Nomathemba. He told them he wanted Nomuza to move back into his house, but Nomuza told her dad she does not want to move back because she does not get along with her stepmother. Nomathemba outlined her role in Nomuza's life and the matter was left there.
- Nomuza enrolled in grade 11 this year but her health is deteriorating. Nomathemba had to accompany Nomuza to school every day because Nomuza is weak and could not walk properly. She had to use a walking stick. She was battling to get up in the morning. Zamela had a meeting with Nomuza and her mother discussing Nomuza's health and school. Zamela felt that Nomuza's health was deteriorating because of school pressure. They agreed on Nomuza staying at home for a while to focus on her health. Nomathemba reported to Nomuza's school teacher that she is going to be at home for a while.

Admitted to hospice

Nomuza got very sick and the clinic told us they can't admit her. Nomathemba spoke to the TAC (Treatment Action Campaign) worker about Nomuza's condition. Nomathemba and Nomuza had previously had a discussion about her speaking to TAC's worker to see if she could help in organising good/best medication. The TAC worker and Nomuza got along very well and as a result of her intervention Nomuza was admitted to a hospice as she was very sick at that time. Nomathemba visited Nomuza at the hospice and found out that Nomuza had a lung infection because of the wrong TB treatment being given to her by the clinic/hospital. Nomuza has recovered as a result of the hospice treatment. She was recently well enough to enjoy a 17th birthday celebration!

The Complexities associated with

Antiretroviral Therapy and Nutrition

Part I: Acute Side-Effects

Prof. FJ Veldman

School of Health Technology, Central University of Technology, Bloemfontein Free State

Over the past decade most people have become accustomed to talking about HIV/AIDS and its impact on industry, family life, society and the individual. Despite the public and political complexities surrounding HIV/AIDS, the management of the disease was up until now straight forward because treatment options were limited. With antiretroviral therapy (ART), HIV treatment is more complex than before and not well understood. ART in South Africa was previously only available to those few fortunate enough to afford the medication, as well as the expensive laboratory tests and lifestyle changes needed to support treatment. ART is now being introduced into the public sector. The major issue at stake is whether ART programs in resource-poor settings need a different approach compared to those programs implemented in rich countries. The challenge is to identify the issues that impact on the outcome of ART - the combination of the characteristics of the patients and the chronic side-effects associated with the drug regimens (meaning course of treatment) taken by these population groups.

The classical view of an AIDS patient is that of someone suffering from malnutrition and wasting. In Africa it was therefore known as the "thinning" disease. Loss of lean body mass (which include muscles) is associated with severe disease (1). In wealthy countries patients are placed on ART before lean body mass stores are depleted. Most patients receiving ART are therefore in a relatively healthy physiological state. This is not the case in resource-poor settings. ART given to wasted patients does cause weight gain. However, recent studies show that this weight gain is mainly in the form of fat and very little muscle(2)

Most complications associated with ART could in some way be related to nutrition or require nutrition management. Expected complications mainly occur due to interactions of the drug regimens with some nutrients (meaning nourishing substances). Complications also occur as chronic metabolic (meaning the process by which food is digested and energy supplied) disturbances that occur over time (which will be discussed in a second paper to be published next month). Other side-effects such as nausea, diarrhea, bloating, taste disturbances, gastrointestinal side-effects, appetite suppression, or fatigue – as well as the presence of opportunistic infections – could either impair food intake and be to the detriment of the patient. The diet of the patient should be adapted in the presence of these side-effects.

Food plays an integral part in ART. Some medications can not be taken with food, others should be taken with food, others with food with specific macronutrient (fat, carbohydrates and proteins) compositions (eg. a low fat meal). It is therefore important to design timetables to assist patients with the timing of food and drug intake. Furthermore, patients should be made aware of special considerations for each drug they take, such as restrictions on the use of alcohol, antiacids containing magnesium and aluminum, and which fluids to take their drugs with (some drugs restrict the use of fruit juice, alcohol, caffeine containing beverages, etc.). These requirements should be adhered to due to the fact that they mostly influence the absorption of the drugs, and therefore the effectiveness of therapy.

Patients are also made aware that some specific ingredients in food interact with the drugs and should be used with caution. These interactions are to the detriment of treatment. The use of traditional medicine with unknown herbs are reasons for concern. Known traditional substances like these include: algae, aloe (used as remedy for constipation), bitter melon, calamus, cat's claw, chamomile, comfrey, echinacea, ephedra (also ephedrine in weight management drugs), garlic, germander, ginkgo biloba, ginseng, kava kava, licorice root, American Mandrake, rue, St. John's wort, sassafras, and seeds, pits, barks or leaves of apple, apricot, bitter almond, cassava beans, cherries and peach (3). These products should be used with caution. Other potential interactive substances that are found in food also include alcohol, benzyl alcohol, caffeine, lactose, mannitol, oxalate, phenylalanine, phytates, propylene glycol, sorbitol, starch, sulfites, tartrazine, tyramine and other pressor agents (dopamine, phenylethylamine, and histamine)(3).

It is important to acknowledge that nutrition for people taking ART is different to nutrition for people living with HIV/AIDS without taking ART. This message needs to be clear. The outcome of ART depends on a mixture of co-factors of which some are known. An understanding of the close link between nutrition, food and ART could determine whether public health programs will prosper or fail. Not only the effects of ART on metabolic level (food-drug interactions, chronic side-effects, etc.) but also the important link between food intake and drug adherence, which are not well understood in general, could be used to the benefit of those individuals receiving ART. This should in the long run support a positive outcome of treatment and be to the benefit of the individual patient.

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More about Learnerships and Child and Youth Care Work

Sandra Oosthuizen

Subsequent to previous articles published on learnerships, several questions on the subject have been submitted to the Association. The questions are helpful in clarifying issues regarding the learnership process and the responses to them forms this month's article.

What learnerships do the NACCW offer?

Neither the NACCW, nor any other training provider in this field, is yet in a position to offer any learnerships. This is because the Child and Youth Care Work Standards Generating Body (C&YC WSGB) is still in the process of generating the unit standards for the field. Once these unit standards have been generated, any accredited service provider will be able to design training programs which offer learnerships.

When will learnerships be available?

The unit standards are being written at present. As the process is complex and lengthy, it is not possible to specify a time for completion. However the C&YC WSGB is committed to producing these unit standards as quickly and thoroughly as possible. Each unit standard must undergo a lengthy process of registration and the final qualification's matrix for the field must also be registered. An SGB has a shelf-life of three years. The C&YC WSGB aims to complete the design of unit standards and qualifications well within that timeframe.

How long will it take a learner to complete a learnership?

The length of the learnership will depend on the learning program offered. Each unit standard and qualification requires the learner to be in training for a certain number of hours. The length will also be guided by the level on the National Qualification's Framework (NQF) at which the learnership is pitched. For example, a qualification pitched at NQF level 4 (grade 12 equivalent) requires 1200 notional (the total estimated time spent in study) hours of learning. The learnership might require more hours as the practical component is added. The Outcomes-Based Education (OBE) system affects this learning time as well. OBE states that when a learner is able to perform a task according to the outcome, and is assessed accordingly, the outcome is achieved and the learner is successful. Learners are therefore able to complete learning programs according to their own timeframes.

What are the benefits of doing a learnership?

A learnership combines theory and workplace practice. The learner is exposed to learning in the workplace. There are role models available and supervision as required by the learning program. All these aim to assist the learner towards a better level of practice as theory is implemented. Organisations benefit from learnerships by being able to help employees acquire qualifications that are of high quality and meet the skills shortage that our country faces. Employees also benefit in that they obtain good qualifications relevant to their workplace that will provide a basis for further personal development. A person who successfully completes a learnership will have a qualification that signals occupational (work-related) competence (capabilities) and which is recognised throughout the country

Who ensures that the learner is exposed to good quality theory and practice during a learnership?

SAQA, through the Quality Assurance and Development Directorate, interacts closely with Education Training and Quality Assurors (ETQA'S) in order to ensure that the provisioning of learnerships is quality assured. Quality Assurance cuts across all activities involved in the learnership from provision of programs to assessment of learner achievement. Every training provider has specific requirements which need to be adhered to and monitored by a Quality Management System (QMS) which the ETQA's inspect.

Can learnerships benefit the youth of today?

Learnerships can especially be considered for youth. There are learnerships available in many sectors. Learnerships belong to the Department of Labour. The list of learnerships could be requested from the Department of Labour or from the various Sector Education and Training Authorities (SETA's). It is important for organizations who work with youth to ensure that they are educated in respect of the possible learnerships. Learnerships could be the most cost-effective way for youth to obtain an education leading to permanent employment.

Reference: SAQA website - www.saqa.org.za

Please forward any questions to The Director, P.O. Box 36407, Glosderry, 7702 or fax it to 021-762 5352.

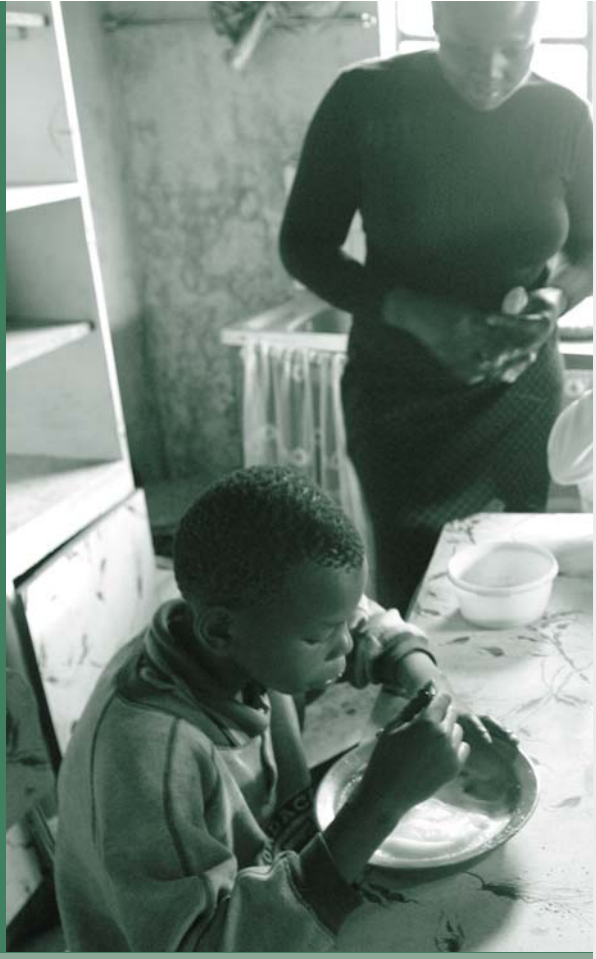
Children and Trauma

1. *A Response to Trauma is Normal:* Children respond to extreme stress in various ways. They express feelings of fear, fear of dark, fear of being alone, sleeping problems, over-sensitivity to ordinary family stress, regressive behaviours, increased irritability and health problems. These feelings and behaviours are normal when a child is dealing with a traumatic situation. With time, for most children these will decrease with intensity and frequency.
2. *Engage with children on their Fears:* Talk with them and be careful to listen. Provide reassurance and comfort to your children. Patience will be required. Let them know their feelings are okay.
3. *Do Not Gloss Over Feelings:* The feelings that children may have in response to trauma may not have a quick cure. Don't try to make the feelings go away by ignoring them or joking about them. Do not embarrass your children about their ongoing feelings about a traumatic incident. Otherwise they may begin expressing their feelings in less acceptable ways.
4. *Listen Again:* Listen to the story of the incident as many times as the child wishes you to hear. Encourage him/her to talk to you about feelings. Work with your child to find ways to help them him/her feel safe. Gradually find less disruptive ways to comfort him/her.
5. *But Don't Force a Reluctant Child to Talk:* Allow your children to talk about their particular experiences with trauma. However, do not force them to talk and don't be surprised if they will not talk about it when others bring it up.
6. *Contain Your Own Feelings:* Do not transfer your fears to your child. While it is important to teach children safety measures, do not make them feel as if they are under constant threat of danger.
7. *Strengthen Other Areas:* Build your child's self-confidence. Look for ways to give them successes and control. Do not do everything for them.
8. *Trauma is in the Eye of the Beholder:* Be alert to your children's needs even if they were not directly involved in the traumatic event.
9. *Remember:* Pay attention to anniversaries of the event. Original feelings about the event will resurface.

Adapted from original by Lou Ann Corley

I am your Child and Youth Care Worker

By Sue De Nim



I am your child and youth care worker and this is what I do ...

I create and implement the routines of daily life. Some of this work – the provision of food, clothing and shelter, for example – might appear quite basic and mundane. In fact, these provisions are your rights and are necessary for your survival. However, I know that your previous experience in these areas might have been damaging, and so the way in which I provide them can be of therapeutic value to you. I know that routines can give predictability and a sense of security, quite different to the chaos and anxiety you are used to.

While you eat, I eat with you, demonstrating appropriate behaviour and engaging in conversation so that mealtimes may be opportunities for relationship-building and belonging. I make sure that the food is culturally-appropriate because I know that your connection to your culture affirms you, your family and your identity. I recognise that at times, you might over-eat or hoard food because when you lived at home, you were used to going to bed hungry because your mother had spent her meagre earnings buying your father new shoes so that he might get a job at his next interview. This is what I do and I do this because I care.

I am your child and youth care worker and this is what I do ...

I make sure that you have appropriate clothes to wear, that your clothes fit and suit you. I make sure that they are washed and ironed so that when you are wearing them, they feel fresh against your skin, and you can feel that you look good. I encourage you to dress neatly and tidily, to take pride in your appearance because I believe that this will help you to recognise your own value. I acknowledge your need to wear the latest fashions even though I don't always like them. I do this because I know that your clothing expresses something about who you are or about who you *want* to be, and that it is important that you fit in with your peers. This is what I do and I do this because I care.

I am your child and youth care worker and this is what I do ...

I make sure that the environment we share is comfortable and stimulating. I encourage you to put your photographs on the walls and to play the games you see on the bookcase in the lounge. Together, we sew and paint some brightly-coloured cushions for the

couches and pick a bunch of spring flowers to place on the dining table. I invite you to display your artwork on the kitchen cupboard. I do these things because you need stimulation and I want this to be a place where you feel welcomed and accepted – despite your challenging behaviour. This is what I do and I do this because I care.

I am your child and youth care worker and this is what I do ...

I spend time with you, sharing the events of your daily life and assisting you to make meaning of your experiences which contributes to your healing and development. I listen to your stories because they help me to know you, and knowing you helps me to make better decisions about how to work effectively with you. I help you with your homework because I know that you struggle to concentrate at school, and you are often distracted when you miss your family. I teach you to make your bed so that you can take care of yourself and experience a sense of mastery. We talk about your dreams as we wash the dishes together because dreams build hope and purpose. I put a plaster on your knee when you fall because I want you to know that I am concerned about you and that you matter. I cheer loudly when you score a goal, knowing that your previous achievements have been few and you often refer to yourself as a "loser". I watch television with you and share opinions about the programmes because I want you to know that it's okay for us to have different perspectives and to think critically. I clap my hands as you sing your favourite song because I believe that this acknowledges your individuality and connects us through the shared rhythm. I enjoy your laughter as I try to learn some new dance steps from you because I know that you need to be the expert sometimes and there is much that I can learn from you. This is what I do and I do this because I care.

I am your child and youth care worker and this is what I do ...

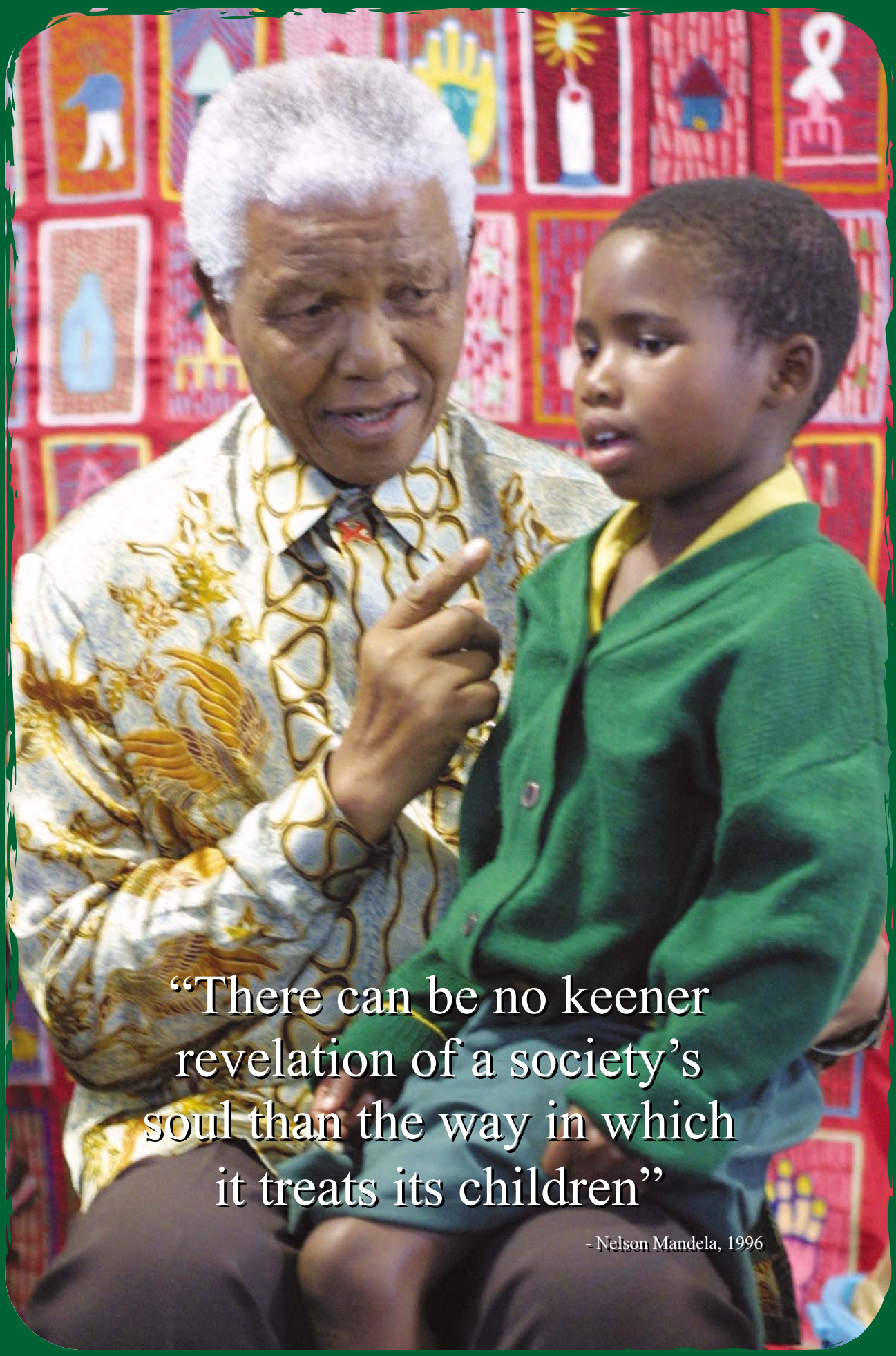
I am not a social worker. I am not a teacher. I am not a nurse. I am not a nanny. I am not a psychologist. I am not a substitute parent. I am not a family therapist. I am not a psychiatrist. I am not a security guard. I am not a day mother. I am not a guidance counsellor. I am not a community development worker.

I am a child and youth care worker.

I am a child and youth care worker and I do all of these things because I care. My caring is conscious in that every aspect of everything I do is planned and purposeful. Every word I utter and every action I take are considered carefully so that your experience of me and the environment might heal your brokenness and build new strengths. I know that much of what I do might seem quite basic to a casual observer, but I know that this work will never be simple because human beings are complex and there is not a single one who fits neatly into any theory. I know that the care I offer is potentially therapeutic and I can explain in detail why I do the things I do. I also know that your experience of my care is probably the key to your future because "development occurs by small steps through the minutiae of ordinary human interactions..." (Maier, 1987:16).

I do these things, these simple, yet complex, things, because I believe that they are important. They are important because you are important.

This is what I do and I do this because I care.


"There can be no keener revelation of a society's soul than the way in which it treats its children"
- Nelson Mandela, 1996