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Child and Youth Care

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

Talking about Child Care WorkFritz Redl

High Court rules on the rights of unaccompanied foreign childrenAnn Skelton

32 Page Bumper Issue

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Editorial

The Year in Brief

Merle Allsopp

So many things happen in one year. These are some of the happenings (or non-happenings if you like) relevant to the child and youth care field from 2004.

A non-starter …the Professional Board for Child and Youth Care, which has not yet been inaugurated - as the ministerial appointments to the Board have not yet been finalized. The SACCSP has in fact been an unconstituted body for the latter part of the year for the same reason. Hope lies in the fact that the Council is now operational. Surely we can hope that the Professional Board for Child and Youth Care will begin its five-year term of office early in the new year?

Quick off the mark … has been the Standards Generating Body for Child and Youth Care Work. Starting its work in January, this representative body has designed a Qualification in Child and Youth Care Work on NQF Level 4 which awaits SAQA approval. This officially gives non-matriculants access to the field, and a career ladder that culminates at doctorate level. It will standardize the outcomes of training offered by all training service providers at this level, and form the foundational building blocks for all child and youth care work learning. Constituting a breakthrough in the regulation of training, and an official recognition of auxiliary work in the field, this Qualification is the first to be developed by the SGB which aims to generate standards for the professional level by mid-2005.

Not yet passed …is the Children's Bill. Considered a blessing by the non-governmental sector, this means that there is still room for negotiation on, and possible inclusion of key exclusions from the Bill. Concerted effort from the Working Group on the Bill, (and especially from the Children's Institute of the University of Cape Town who also facilitated children's participation in the law-making process) is to be commended for having had considerable impact on the process. Next year will hopefully see the return of the Bill to parliament, and the return of some of its most protective clauses, eliminated in the current draft by a department moving ahead rather too swiftly.

Also not yet passed …are the Sexual Offenses Bill and the Child Justice Bill. The latter is the responsibility of the new Minister of Justice, who has not yet re-introduced the Bill to parliament. Early next year?

Encouraging … has been a process initiated by the Department of Social Development to define policy for orphans and vulnerable children. Aiming to close the policy gaps for children affected by the HIV/AIDS pandemic, there is a high level of accord between government and the non-governmental sector on the content areas. Look out for it early in 2005.

Pleasing … has been the interest shown by the Department of Education in gearing up to implement the requirements of the new legislation for children. This department in the Free State has initiated a process to train 6000 educators in managing children in line with the policy requirements. The National Department is too engaging in national consultation about the implications of the legislation in respect of inclusion of learners with emotional and behavioural barriers to learning. A court order continues to nudge the Eastern Cape Department of Education to work hard to develop secure residential facilities for children sentenced to reform school. There has been progress on this task during the year, and it is expected that the province will cease to send children to facilities out of the province next year.

Disappointing …has been the long-awaited policy on the financing of social services, finally emerging with the title 'National Policy on Financial Awards'. Offending the non-governmental sector in its very name, the policy has attracted a great deal of criticism. More action is to be expected in this regard in the new year.

In the media …has been the poor relationship between some of the children's facilities in Cape Town and the local Department of Social Services and Poverty Alleviation. Frustration has reached uncomfortable levels where the latter Department fails to answer letters, and engage with the sector in the true, respectful spirit of partnership. Perhaps a connection is to be made in the new year in the best interests of children and youth?

Embargoed … is a research report commissioned by the latter Department early in the year on the places of safety and detention that

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it runs. Undertaken by two eminent legal professionals, the report is rumored to be highly critical of many facilities, and to be serving to reinforce this department's commitment to privatizing services to the business sector.

Transforming … are the residential facilities run by the state in the Durban region of KwaZulu Natal. The Department of Social Welfare and Population Development in the region has committed itself to transforming its places of safety and detention into residential treatment centers, operating on a continuum of care, serving all children at risk. We look forward to diminishing numbers of children in prison, and efficient delivery of child and youth care services for children both in need of care and protection and in conflict with the law. If Durban can do it, what about others?

In court …has been the issue of unaccompanied foreign children. A court judgment (described in this issue of *Child and Youth Care*) has clearly defined such children as being provided for in terms of the Child Care Act, taking a step closer to the realization of children's rights for this vulnerable category of children.

A first …was the conference held in Durban to engage community-based child and youth care workers into the broader profession. Attended by 350 delegates, most of them working at community level, and run in partnership by the NACCW and the Durban region of the Department of Social Welfare and Population Development, the conference provided a platform for recognizing the role of community-based child and youth care workers in the context of the HIV/AIDS crisis, and initiated the full inclusion of this group in the field.

Another first … has been the inauguration of the Zambian Association of Child Care Workers, marking both the usefulness of child and youth care work in the African context, and the importance of professional associations in advocating for effective practice with children and youth at risk. For the NACCW, and South African child and youth care workers, it means that we are not alone on the continent. African child and youth care is becoming a reality, and we can look forward to connecting with more of our regional colleagues as ZACCW swings into action.

Represented …were South African child and youth care workers at the biennial FICE conference by NACCW Chairperson Francisco Cornelius. FICE is of course the world body that is concerned with children in residential facilities, and children and youth at risk. Given our track record in respect of transforming the child and youth care system (believe it or not, we seem to be moving much faster than other countries!), much interest was shown in our country…to the extent that there were murmurs of the conference being held in South Africa in 2010. Should we bid? Watch this space!

Celebrated … was the International Year of the Family in many forums across the country, in the context of increasing hardship for many families, but more creative working solutions being found by many social service professionals.

As we close 2004… we are mindful of the extraordinary suffering caused in our country, and in many other countries, for children by the HIV/ AIDS pandemic. May our field be energized to continue to transform compassion into action for children and youth at risk in 2005.

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.

Disclaimer: The views and opinions expressed in this journal are not necessarily that of the NACCW and Editorial Board.

In preparation for the commemoration of the NACCW's 30th "birthday" and the coming of age of Child and Youth Care Work in South Africa, this is the first in a series of lesser-known articles by the founding fathers of the profession

Talking about Child Care Work

– Fritz Redl at a conference on residential treatment in Toronto in 1976.

Let me begin by showing you a few slides. We shall not need a screen, projector or any other such equipment. Mental slides will be quite sufficient for us today. All of us child care workers have seen this type of slide often enough. But these slides make up the 'stuff' of which child care is made. I simply wish to look with you at a few of these slides to see a few familiar situations and also to explore the sorts of new problems we are having to face in our work with children.

Case 1. The Case of the Indignant Sucker.

We see in this slide a dining area with a small group of kids. At one end of the group is David, at the other is John. All of these children have been thoroughly diagnosed so you need have no fear. There is a good thick file on each child. David has got bored. Eating politely is not what he has been used to. He wants some action. One thing he has learned is that it is best to get someone else to start the action. He decides on John. After blinking at him very slowly he takes his own glass of milk and tips it just a very small amount. Only a few drops of milk spill onto the table. John's attention has been engaged by David and without hesitation he rises and throws his own glass of milk over the chief child care worker. John yells at the worker: "That guy is bugging me, why can't you get him off my back?" The worker, while drying himself off, begins the investigation. Quizzing John he is told finally: "David made me do it". Quizzing David he is told, "It's nothing to do with me". David is indignant and yells: "You sons of bitches, why do you always have to get me mixed up in it?"

Now both children in our slide need treatment but treatment for what? I would hazard a guess that David's misbehaviour is not pathological, and go on to assert that his behaviour is over-skilled for the market value of his age. If he were a little older and if he were in a different social context he would likely by doing very well indeed. Somewhere along the line David has got to learn to use this talent for instigation to positive effect. Somehow John has got to learn not to be drawn into this type of difficulty. Both children need the services of an acute child care worker who can deal with the situation as it arises.

Those of us who work daily with children have to be continually sorting out such situations, and know that this is not an easy task. The child care worker is the one who is there. Behaviours such as these described in Slide 1 do not occur during the clinical hour. It means that people who are *with* these children have to be careful. David and John have to be watched. If they get too bored some distraction may be necessary.

Case 2. Will you take him back?

The matter of *distraction* can be illustrated through the use of a second slide. Imagine a classroom situation in which one child is very, very active. He has been diagnosed as hyperkinetic. Someone has sold me,

the teacher, on this kid and on the significance of his diagnostic classification. After he comes to the classroom I find him to be constantly on the move. This is alright up to a point, but the other kids have to know that I'm no fool. So I arrange for a distraction. I arrange for him to be able to go to the pencil sharpener more-or-less when he feels like it. This is a good arrangement since sharpening pencils is a reasonably legitimate activity for the student. This works out very well for a time. But after a few days he begins to play the xylophone using the other kids' heads as an instrument. I can't tolerate this, nor can the other children. So now I go back to the diagnostic centre and say that he has now got some new symptoms and suggest that maybe he should be placed elsewhere. This is a slide that we have all seen, and one which we should be trying to eliminate from the series. One intervention worked well (use of the pencil sharpener as a distraction), now is the time to create a new intervention, not arrange another clinical interview. Thinking up ways of intervening is, of course, not easy. This is particularly true when there is a lot of action taking place. Let me illustrate this in a third slide.

Thinking up ways of intervening is, of course, not easy. This is particularly true when there is a lot of action taking place.

Case 3: Paranoia Under the Chestnut Tree.

In this slide we see a child care worker at the waterfront. He likes kids and has been taken on for this reason. It is a difficult job, since with swimming there has to be order. He has made the arrangements very clear at the beginning of camp; the children can have a lot of freedom but the one thing which is not permitted is dunking one another. But still the fact is that spirits do run high and children do dunk others. That is what has happened in the slide. That our worker has seen it happen is something of a fluke, given that he labours under a tremendous physical handicap, having no eyes in the back of his head. Swivel his head though he may, he cannot see it all.

And so we have our slide of Bobby in the action of dunking John. The worker he gets Bobby to sit under the chestnut tree. There's no point in faulting the worker. Now we have Bobby under the tree. What you have to realize is that the tree is like a throne. From his throne, Bobby sees a very great deal. Certainly his eyes see what our guard does not see due to his lack of having eyes in back of his head. Now Bobby is able to start digging up his paranoid fantasies. Now he has the evidence that no one likes him anymore.

Any limit may be okay. But how long does the limit last? The snag is that longer does not mean that effects are achieved faster.

The problem which I have been discussing in this slide is a familiar one to us, and it is largely a problem of *timing.* Any limit may be okay. But how long does the limit last? The snag is that *longer* does not mean that

effects are achieved *faster.* Returning to Bobby's crime, how long can we leave him under the tree? The worker has got to let him back but when? Unless the child is considered very closely we shall leave him in a situation where his own crazy fantasies will become stronger and stronger. ("Ray, didn't you see Bill shoving Peter under? Why don't you pick on him like you pick on me ..."). So timing must be considered rather carefully.

Child care workers do not get enough training in the art of timing. When is it best to talk to the child, now or tomorrow? As a general rule we need to be flexible in terms of what the individual child needs. Trying to ensure

that one particular child benefits when you are working with a group is sometimes very hard to arrange as the next slide clearly shows.

Case 4: Ghouls for Breakfast.

Imagine now that you are with a group of youngsters aged about 8 to 13. In this scene we find a staff that has finally decided on the use of a behavior modification programme. This staff is a little more sophisticated than some because they have at least given some thought to the whole matter of finding appropriate reinforcers for the

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particular children in their care. The members do at least realize that the whole of North American society cannot be revolutionized by the use of candy. In our slide the staff persons have been very thoughtful about finding reinforcers that are appropriate for each child. Charlie, though, has presented a bit of a problem. So far as can be determined, there is nothing much that Charlie wants except for the opportunity to stay up until 10:00 p.m. on Friday night so that he can watch the Ghoul Show. The staff are dead-set against the proposal, thinking that ghouls are the last thing that Charlie needs. But they finally give in thinking that he will fail to collect the right

While it is certainly true that we have learned a good deal during the last fifteen years it seems to me that our problems have become not easier, but more difficult.

number of points during the week for doing the various assigned tasks.

Charlie does make it. In view of the contract, the staff have to go through with their side of the bargain. He watches the T.V. show. At breakfast Charlie has his moment. Half of the children become so agitated they wet themselves. But after a few days all the children want to watch the Ghoul Show. This, they have decided, is what they need not candies. You can, I think, imagine the child care worker's predicament at this point. In pointing to a behavior modification programme as being instrumental in creating this difficulty, it should be realized that I am by no means being critical of this approach. What I am critical of is *over-simplification.* All I am trying to do is warn against taking too superficial a view of these children's difficulties, and also to point out that great care is needed in the design of any group-treatment programme.

Perhaps now we can put slides behind us and try to address ourselves to some problems in the treating of adolescents. While it is certainly true that we have learned a good deal during the last fifteen years it seems to me that our problems have become not easier, but more difficult. It seems to me that changes in our society during the past fifteen or twenty years create new challenges for the child care worker. Let me give you a few examples:

1. The Adolescent has "Depersonalization and Role Freeze" Against the Adult.

Bobby likes you, the child care worker. But he can't like you too much because you set the rules. He must freeze his role, because you are the one in uniform (not literally, of course, but in effect). Even if he likes the worker a lot he may have to give him or her up. These children may abandon you, sometimes when you least expect it. This is one way of dealing with authority, and it seems to me that more youngsters are using it than previously. It is not the worker, but the role they are battling. As I said, we have always seen this but it seems that adolescents are now more of a society unto themselves than was the case 40 years ago.

2. The Adolescent has an "Inability to Deserve".

In my view, many adolescents suffer from the fact that they cannot come to deserve their earnings. Penalty and

reward systems do not always work well in a society where Cadillac's are simply won by parents. Our whole culture feeds into this illogical dispensation of goods. There is a difference between finding $10 on the street and earning $10. Many adolescents (and adults) do not care whether or not they earn the money. But they become indignant at the end of the week if the reward is not forthcoming. The problem, from the perspective of the child care worker is: "How do I help this youngster enjoy fulfilling the contract?" Workers need to learn how to be able to help the child experience how to deserve.

3. There has been an increase in the "Suction Power of Rituals".

We adults have all sorts of rituals. We also enact rituals with the children in our care. The threat is a good example. Take, for example, the kid who gets sent out of dining room. To be sure this was a friendly sending out. The child knows he deserved it. Five minutes go by and all is fair. But after five minutes he begins to wonder if he deserved twenty minutes. What will he do for the next fifteen minutes? The child care worker is patrolling up and down in the corridor.

Of course we have to make children aware of the consequences of their behaviour. But sometimes we as workers lose sight of these consequences. We resort to threats we could not possibly want to carry out (if we were in our right mind at the time). But to return to our John who is now getting bored after five minutes have passed. He puts his foot into the corridor. The worker ignores it. He does it again, putting it out a little further this time. Again the worker ignores it. Now he puts it out even further still. The counsellor is now worried about his own prestige. He says to John: "If you do that again you'll have to go to the quiet room". (Where you can make as much noise as you like and even try to wreck the place). Now if only the worker had not said this! He has thrown down the gauntlet. We might as well be looking at two four years olds. Or we might well be working ourselves up to fight a duel in 19th century Germany. One man makes the slightest suggestion that the other has erred in his manner. The other replies suggesting that the other, not he, was in the wrong. Finally, it escalates into one saying to the other: "You are lying". Now they have to choose weapons and shoot. Now they are puppets on a string, nothing can be done to prevent the duel for honour that is at stake. Too bad it happened that way but...

nothing can be done to prevent the duel for honour that is at stake.

Our therapist has succumbed to the suction power of the ritual. It was not necessary. Under what conditions is a threat reasonable? Under some circumstances it has to be a help, but not under those outlined above. We should remember that the adolescent's need for ritual is great. Which kids have high vulnerability to suction? Most of the data we get on the is of limited value compared to a knowledge about a particular child's suction power of rituals.

4. There Exists a "Group Code Cassette".

In trying to make my point I am in this instance going to turn to modern technology. I wish to make an analogy between the adolescent's behaviour and the operation of a modern-day tape cassette recorder.

Not uncommonly a youngster will make a violent attack on me. He is in a rage and he lashes out. It is as though the "group-code system" has suddenly been switched on. Many youngsters do not actually want to hit anyone but they have to face the question. "What will happen to me if I don't?" The code does not permit a youngster to "take it" from an adult. The child care worker has to know what the duelling code is. Kids are dependent on the group code and the worker has to know about the group's values. It is important to remember that it is not so much that the adolescent rejects you, or your rules, but that the child has now come under a new code. Has the child "blown" or is it that the "Group Code Cassette" has come into play. This phenomenon of group code cassette would appear to be different from the breakdown of controls.

Let me close by commenting briefly on something we need, and on where we are as child care workers today. One thing we need and often don't have is data on a given child. Is this particular child allergic to the usual calming techniques or not? If I put my hand on his shoulder will it work, or will it make matters worse? Everyone who had the child before me had to figure this out, and many people know the answer. But now when I need the information there is no one who will give it to me. We have got to learn how to generate our data and how to transmit it to colleagues.

Where are we today? The role of the child-care worker is emerging out of a sort of poorly-paid baby sitting job into a new profession. It is not just a composite of nursing, social work, psychology and so on. It has started to emerge. We are beginning to be able to offer thoughtful suggestions to the people who count, but who often think the issues surrounding disturbed children are simple. Can we help people get over the idea that it is *not* a matter of either/or, for example, either all these children should be locked up, or they should be on the street. What this means is that we should have a *variety* of programmes. We have more children in need than ever before. And all too often only one or two of their needs are met in a programme. Often there are a dozen or so needs left over. We as child care workers must become experts in creating life spaces for children.

Christopher Webster took notes of this talk.
This feature: Redl, F. (1982). Child Care Work. *Journal of Child Care*. Vol.1 No.2. pp 3-9

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What we can Expect from Governing Boards

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

What is a governing board?

Other names used for governing boards include:

- Executive Committee
- Management Committee
- Management Board
- Board of Trustees
- Board of Directors
- Governing Body

The board is a group of people who make up the decision-making body of the organisation. In organisations without staff, especially the small or new ones, board members can also be in charge of the day-to-day running of the organisation.

Serving on the board of a non-profit organisation should be a valuable, growing experience. A board member serves as a voluntary member of an organisation and is not a paid member of staff. If the organisation so wishes, they may choose to give board members a payment to cover the direct costs of their involvement in some form. For example, they *may* provide a travelling allowance for travelling done for the organisation.

Who makes up a board?

There are a number of different methods used to make up the people who sit on the board. These include:

- Representatives can be elected from the members of the organisation
- People from the community who are interested in the organisation can be nominated
- People from the community who are powerful or are important can be nominated
- People with experience in the types of activities the organisation does, can be nominated, such as an accountant
- External agencies like government, funders and other organisation can recommend certain people with specific skills or expertise.

Who can be on a board?

When people are appointed to sit on the board of an organisation, it is important to look at the type of person that one is considering. Here are some of the characteristics or qualities that such a person should have:

- Enough information and understanding of the organisation
- Interest, commitment and willingness to serve on the board
- Time to go to all the necessary meetings
- Some qualifications or experience relevant to the organisation
- Can listen and accept other people's ideas
- Have knowledge, experience or the ability to organise and manager people and money
- Have the awareness and insight to know when to step down from his/her position on the board.

The role and functions of a board

Often the most important decision that a board makes is to select the top manager, the executive director or chairperson who will manage the organisation. The overall role of the board is to govern the organisation. But what does this mean? The boards' job of governing the organisation has two functions.

- To protect the public interest

Non-profit organisations get special tax treatment and they are working with money that has come from the public (companies, foreign donors, members, fees, etc). Therefore it is the board's job to look after the public's money by making sure that the organisation spends the money properly, and in the way it said it would.

- To be sure the organisation successfully and effectively does what it sets out to do

Here a board member has responsibilities that he/she has to do ("formal responsibilities") and things that would b e a help

to the organisation ("helping responsibilities").
Formal responsibilities include:

- Hiring and (if necessary) firing the top manager, the executive director or leader of the organisation
- Delegating the organisation's management functions to the executive director. These jobs include planning, staff development and training, directing and controlling
- Looking over and agreeing to the plans the organisation has made
- Making sure the organisation can continue to do its work – making emergency decisions when management cannot carry out what it needs to and stepping in when there is a crisis
- Looking after the board so it remains a healthy, well organised governing body that can help the organisation to successfully do what it set out to do
- Making sure the organisation is financially accountable – that it can show the public where and how the money it received has been spent.

Helping responsibilities:
Board members, by law have to do their formal responsibilities that we discussed above. But in most non-profit organisations the board members should also give extra help if the organisation is to succeed. Every non-profit organisation needs the help of its board member in areas like planning, fund-raising and community relations. The actual work of the help offered by board members will, however, be delegated to staff. These will vary depending on the organisation.

The healthy non-profit board will set up a committee structure to look after a lot of its work. This means that the board can give out many of its functions and responsibilities to the committee members and therefore have more time to assist the organisation in other areas. Committees are the work-horses of the board.

Reference

Rockey, Vanessa, 1995, You're not on your own, Researched and compiled by of BMI (Pty) Ltd for Eskom Community Development

Appointments @ Durbanville Children's Home

Durbanville Children's Home

is a programme of BADISA, a joint ministry action of the DR Church and UR Church (Western and Southern Cape). The Children's Home provides residential care and development programmes to 144 children in need and 25 disabled children.

Child and Youth Care Workers
(non residential)
5 posts

Your duties as Child and Youth care Workers will entail the following: supervising, caring, disciplining, stimulating and educating traumatised children; basic administration; working as member of a team, with volunteers, teachers, therapists and families. Thorough understanding and sensitivity for traumatised children, as well as the ability to relate to children of all ages and both sexes, are essential. Applicants must be able to communicate fluently in English and Afrikaans. We are awaiting applications from persons with the above and are in position of a valid Code 08 driver's license. A Qualification in Child Care, complemented by relevant experience, will serve as a recommendation.
Remuneration comprises a negotiable salary, a medical and retirement scheme, as well as attractive leave benefits.

Forward a comprehensive CV to:
The Manager
Durbanville Children's Home
1 Church Street
DURBANVILLE
7550

Durbanville Kinderhuis

is 'n program van BADISA, 'n gesamentlike bedieningsaksie van die NGKerk en VGKerk (Wes- en Suid-Kaap). Die kinderhuis bied residensiële versorging en ontwikkelingsgerigte programme aan 169 sorgbehoewende kinders, insluitend 'n eenheid vir 25 erg gestremde kinders.

Kinder- en Jeugsorg Werkers
(nie-inwonend)
5 Poste

U pligte as Kinder en Jeugsorg Werker behels die volgende: Versorging, dissiplinering, stimulering en opvoeding van 12 getraumatiseerde kinders; administrasie; werk in spanverband met vrywilligers, onderwysers terapeute en familie. Vereistes vir die pos behels begrip en sensitiwiteit vir getraumatiseerde kinders, vermoë om met kinders van alle ouderdomme, geslag en kulture te werk; Afrikaans en Engels kan kommunikeer.
'n Geldige kode 8 rybewys en 'n kwalifikasie en ondervinding in Kindersorg is 'n sterk aanbeveling. Salarisse is onderhandelbaar en word aangevul deur 'n mediese- en aftreeskema asook ruim verlofvoordele.

Rig 'n volledige CV aan:
Die Bestuurder
Durbanville Kinderhuis
Kerkstraat 1
DURBANVILLE
7550

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High Court rules on the rights of unaccompanied foreign children

Ann Skelton

The protection and care of unaccompanied foreign children came under the spotlight in September in the Pretoria High Court. In a precedent-setting judgment, Judge Annemarie de Vos castigated the "apathy" of government officials who had failed to act in accordance with South Africa's Constitution, statutory law and their own stated policy and were also in breach of international law.

The judgment was delivered in response to an urgent application brought on Wednesday 8 September 2004, by the Centre for Child Law and Isabelle Ellis, the curator ad litem for 13 unaccompanied foreign children. Lawyers for Human Rights-Pretoria Law Clinic acted as the attorneys and counsel for the applicants.

The importance of the judgement is that: · It removes any doubt that may have existed about the fact that unaccompanied foreign children should be dealt with under the provisions of the Child Care Act.

Judge de Vos indicated that in her view unaccompanied foreign children should have legal representatives assigned to them by the state in terms of section 28 (1)(h) of the Constitution. She ordered that the Krugersdorp Commissioner for Child Welfare must assign legal representatives for the children if it appears that substantial injustice would otherwise result.

The judge found that there is a positive duty on government departments to liase with one another to formulate and implement practical arrangements regarding unaccompanied foreign children found in South Africa.

In her judgment, Judge Annemarie de Vos noted that South Africa has recently celebrated the 10th anniversary of the first democratic elections and that we as South Africans are justifiably proud of our democracy and the principles enshrined in our Constitution. She also noted that we have an icon in Nelson Mandela whose love for children is internationally known. However, the lofty ideals set out in our constitution and government policy become "hypocritical nonsense" if they are not translated into action by the people who have been appointed and paid by the government to make them a reality. She noted with deep concern that the children had remained in detention since February, and she said that government's failure to act in the best interests of the children was shameful.

The order that was handed down on Wednesday 8 September 2004 directed the Department of Social Development to bring the children, presently detained in Dyambu Youth Centre, before the Krugersdorp Children's Court in order for inquiries to be opened for them in terms of the provisions of section 12(2)(c) of the Child Care Act 74 of 1983 within15 days. In addition, the order interdicted the departments concerned from bringing or admitting any further unaccompanied foreign children to Lindela, and directed that in future such children should be dealt with in terms of the Child Care Act. Regarding the children who have recently been brought to Lindela the judge said their detention is unlawful and invalid and must cease immediately.

History of the case

This application was the fourth in a series of applications that have been brought in relation to these children. On 3 March 2004 the Centre for Child Law brought an urgent application on behalf of a number of unaccompanied foreign children who were detained at Lindela Repatriation Centre

At the time of that application the detained children were being held together with adults also detained at Lindela. They were facing imminent and unlawful deportation. The Court granted an interdict preventing the Minister of Home Affairs from proceeding with the deportation of the children and also appointed Advocate Isabelle Ellis as curator ad litem for the children. The curator's powers and duties included, amongst others, to investigate the circumstances of the children in detention,

to make recommendations to the Court regarding their future treatment and to institute legal proceedings in enforcement of their rights.

The curator recommended that the children be moved immediately to a place of safety known as Dyambu, and that children's court inquiries would be held in respect of each of them. The children were moved from Lindela to Dyambu Youth Centre on 2 April 2004.

The reason it is important to hold children's court inquiries is firstly, to establish the status of the chidren. Some of the children may have legal rights to remain in South Africa - affidavits before the court actually demonstrated that South African children have been found at Lindela on suspicion of being foreign children. Secondly, if unaccompanied foreign children are to be repatriated, international law requires that there must be a proper investigation into whether there is a suitable home for them to return to, and adequate arrangements must be made for their safe reintegration into their communities. The Department of Home Affairs' standard practice has been to transport the children by train or truck and dump them without money, food or assistance at the nearest police station on the other side of the border, or at the border itself.

During May 2004, the Krugersdorp Commissioner of Child Welfare refused to conduct Children's Court inquiries in respect of these children, because in his view foreign children fell outside of the ambit of the Child Care Act.

On 21 May 2004 the High Court set aside the Commissioner's refusal to conduct children's court proceedings, and ordered him to conduct such inquiries.

This having been ordered, the next step fell to the Department of Social Development, as it is the task of social workers to open the inquiries. This did not happen, despite repeated attempts by the applicants to get action through telephone calls, meetings and correspondence. A letter was sent to the Department of Social Development in early August, warning that the matter would have to go back to court if the children's court inquiries were not opened by a specified date. No reply to the letter was received. The inaction on the part of the Department of Social Development necessitated this urgent application.

The children had been in detention since February, and by August were becoming very frustrated with the process. Staff from the Centre for Child Law saw the children on Monday, 23 August 2004 and found that their anxiety about their continued detention had reached crisis proportions. The children believed that they were being "punished" for no reason and they objected to the fact that they are currently being held at a facility which houses children awaiting trial.

New children being admitted at Lindela

A second aspect of this application deals with a further problem, namely that whilst the Departments have been unable to effectively deal with the first group of children dealt with by this application which was initially brought in March this year, more unaccompanied foreign children are being arrested and detained at Lindela Repatriation Centre, in contravention of the Constitution. The affidavits before the court indicate that on 4 August this year employees of Lawyers for Human Rights, the Centre for Child Law and the Human Rights Commission saw and interviewed 13 children at Lindela.

The final solution

The matter is not yet complete, and the aim of the Centre for Child Law in this litigation is to get the various departments to come up with a clear set of guidelines according to which unaccompanied foreign children will be dealt with, and for this to be made an order of court.

Children's Litigation Project
Centre for Child Law (University of Pretoria)
Phone 012 420 4502
Fax 012 420 4499
Email: childlaw@postino.up.ac.za

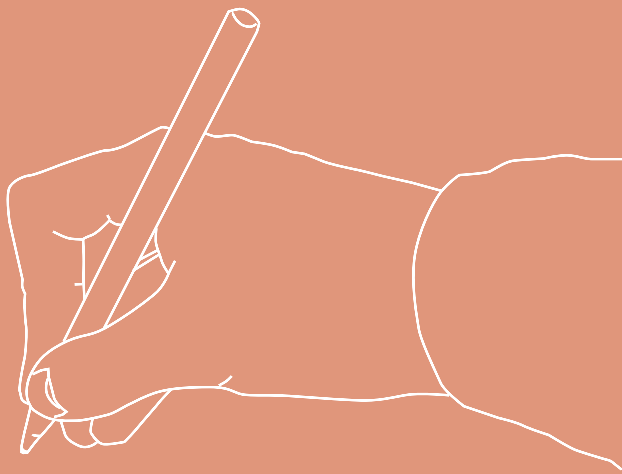
Obituary

Nondumiso Angelina Nqoza

She was born at Lady Frere at Qhoboshana Location on the 04 April 1977. She started her primary education at Cala Village Junior Secondary School and matriculated in 1996 at Cala Senior Secondary School. She completed a Computer Literacy Course with University of Transkei in 2000. She then joined the Child and Youth Care field where she obtained certificates on Basic Qualification in Child care, Street Work Course, Professional Foster Care and Family Preservation.

Nondumiso was still working as a volunteer of Cala Holy Cross Children's Home/Isibindi Project when she passed away on the 25th April 2004 after a critical illness. She left behind her only one beloved daughter Ohwetu Hope Nqoza doing grade 5 this year. As the organisation and co-workers we regretfully announce this great loss of membership and pitifully say "May God Bless her soul to rest in Peace and be our Ambassador in Heaven."

Morgan Enoch



WRITING A GOOD PROPOSAL

As the process of writing a proposal is undertaken, these are some of the general points to remember:

Select a concise, relevant title for your proposal that contains key words under which it can be filed. Try to be sure that the title describes the project in a nutshell. Do not however try to be catchy in writing the title if the project is serious.

Give yourself enough time to get the necessary signatures required for final submission of the proposal. Be sure also to allow enough time for writing the proposal. Generally these activities are time-consuming, especially if one is approaching proposal-writing for the first time, or if the proposal is complex. Remember the saying “the devil is in the detail”. There are many details to be thought of in writing a proposal. The final copy should be neat, legible and carefully proofread. Mistakes must be picked up before the proposal is submitted, as they detract from the appearance of efficiency. If one has written the proposal, one is often not the best person to do the proofreading. After working on a document for a while one often misses errors. Try to get someone else (who has a critical eye) to scrutinize the document before submission.

Keep the language simple and direct. Avoid trying to sound clever, or trying to make what you are doing seem more complex than it really is. Make use of tables and diagrams if they help to explain your points, but do not be excessive with them. Use appendices rather than overcrowding the main text, and do not repeat yourself. Be concise, and keep the proposal ‘tight’ if you wish to ensure that it is inviting for the reader. Even complex concepts can be communicated well in few words.

Do be sure to follow the exact format specified by the funding agency. Deviating from the requirements set by the agency from whom you are requesting support gives an impression of you as a partner who will “do your own thing”. Find a way to work with the agency’s requirements, and adapt your own style of conceiving of the project to meet these. Avoid terms or acronyms that someone unfamiliar with your agency might not understand.

The proposal should flow from one section to the next, and ideas should flow in sequence. The proposal should unfold like a story in the sense that each new section should link to the previous one and the picture of your project should unfold logically. By the time the section on the budget is reached, the funds that you are requesting, and the things that you are requesting them for should be apparent to the reader.

The following are usual categories included in a funding proposal and each will be discussed in detail:

- Project Summary
- Overall Problem or Issue Statement
- Project Goals and Objectives
- Project Strategies
- Project Work Plan
- Project Resources and Budget
- Project Evaluation
- Appendix

1. Project Summary

This one or two page summary appears at the beginning of the proposal, but should not be completed until you have completed the proposal. The summary should briefly:

- Identify your organization
- Describe the issue
- Describe the target group
- State the project goals and objectives
- Describe the strategies
- State the total costs of the project, listing the funds already committed and the amount requested

2. Overall Problem Or Issue Statement

You may know the project is needed – but you will have to define and describe that need well enough to convince others that it is needed.

The problem or issue statement is a critical part of your plan – it represents the reason behind your proposal.

A. Describe your overall view of the problem or issue to be dealt with.

- This should include a definition of the problem or issue as your understand it, including:
  - Knowledge of the present situation
  - How the problem or issue is experienced by the target group
  - Demonstrated needs of the target group
  - How these needs relate to the purpose of the proposed project
  - What obstacles and supports exist for the target group in relation to the problem or issue.
- The problem or issue statement should:
  - Be clearly related to the goals of your organization
  - Be supported with statistics, experience and/or testimony from people who are recognized as knowledgeable about the subject matter
  - Be reasonable – can you reasonably do something over the course of the funding
  - Be stated in terms of your target group rather than needs or problems of your organization
  - Avoid jargon – if you need to use it, define it
  - Be interesting and written in an up-beat, appealing manner.

B. You may want to explain why your group is best suited to do the project and include an outline of your previous interests and accomplishments in this area.

3. Project Goals And Objectives

The project goals and objectives are general and specific statements of what you intend to accomplish with the project.

A. List the goals of the work to be done.

- Goals are broad, general statements of what you are trying to accomplish with the project
- Most projects have 2 – 3 goals
- To write your goals:
  - Refer back to the definition statement about the overall problem or issue that the project will deal with
  - Ask yourself "given the way we have described this problem, and given what we know about the obstacles etc, what are we trying to accomplish with the project?"
  - Write general goal statements to reflect those thoughts
  - The goals statements should be general, each goal statement should be written separately, and they should not contain strategies or solutions.

B. List the objectives developed for each goal.

- Objectives are specific, measurable statements of what you want to accomplish by a given point in time to reach the project goals.
- Most goal statements have 2 – 6 objectives.
- To write your objectives:
  - Look at the goal statement
  - List what you want to do in order to meet each goal
  - Write the objectives to reflect what you want to achieve, but do not include how you are going to do it (the how will be described when you develop your strategies).
- Useful objectives are:
  - Specific rather than general (keep the goals general, make your objectives specific)
  - Realistic rather than unrealistic (it's wise to think "small and possible" so the work can get done rather than trying to do too much)
  - Focused on one thing at a time, rather than including several points in one objective. When several objectives are written into one, it is difficult to plan strategies around that objective, and hard to know if you have achieved it.
- A well stated objective should:
  - Tell WHO
  - Is going to do WHAT
  - when
  - how much
  - and how it will be measured.

4. Project Strategies

Strategies are a series of activities carried out to meet the objectives. You will need to describe the strategies that you plan to implement for your project.

A. Some steps to take in developing and choosing strategies are:

- List all the possible strategies that could be used to reach the objectives
- Review those strategies from several perspectives
- Make decisions about which strategies to use

B. Exercises for checking strategies:

- Checking out the positives and negatives.
  - Write your strategy on a page, draw a line down the centre of the page, on one side list everything you think could hinder you, or get in the way of the work, check to see if any positives eliminate any negatives.
- Checking the strategy with useful evaluative words.
  - Is the strategy adequate (will it be enough).
  - Is the strategy appropriate (are we the right people to be doing it).
  - will the strategy be effective (will it work).
  - is the strategy be efficient (is it a wise choice for the resources that we have available).
  - what will be the side effects of using this strategy?
- Checking to see what resources are needed to do the strategy.
  - Do a resource review to see if you have the skills and resources available to carry out the strategy.
  - List the strategies against the following headings: people, time, money, space, skill, equipment, knowledge.
  - Ask which of these you need to complete the strategy, which you have, don't have and where you think you can get them.

5. Project Work Plan

In this section, you will need to provide a plan of what work has to be done, by when, how the work will be organized and who will do it. This will require a calendar or chart that provides a schedule of work outlining the project goals, objectives, strategies and evaluation plan. The following steps will provide you with information to use in developing the work plan, time lines and budget:

- List the project objectives and chosen strategies
- List the tasks you need to do for those objectives and strategies to be met
- Put the tasks in the order that they should occur
- Estimate times and dates to create a schedule
- Estimate the resources needed for your activities (including time, money, skill, people, equipment, facilities, information, etc)
- Assign responsibility to people for various activities

6. Project Resources And Budget

In this section, you will need to describe all the resources that you require to complete the project. The budget must be complete and every potential expense should be documented. This is important as the funder may support certain elements of the budget and not others (e.g. printing costs).

- If forms are provided with the application, use those
- List how many resources you will need and how much the project will cost
- Resources include money, people, and organizational needs
- List other funders you are applying to
- If you have received funding from other sources, note the amount received and from whom
- Indicate "in kind" support from other groups (donations of goods and services such as office equipment or secretarial help)
- If the project is to continue beyond the period of the funding request, indicate your plans for obtaining further or future financial support.

7. Project Evaluation

In this section, you will need to describe the evaluation process that you intend to use throughout your project. A clearly outlined evaluation process can help to clarify goals, define objectives and refine procedures during the initial development of the proposal. Evaluation serves the following purposes:

- It makes the work of the project visible
- It helps to develop and maintain an understanding of the project's work
- It provides people with information to help make decisions about the project
- It identifies if and how the goals and objectives were met.

Overall, evaluation assists everyone in understanding what made the project successful, and why and what hindered the success. Some specific questions to consider when developing the evaluation process:

- What do you want to know from the evaluation of this project and why (go back to your stated goals and objectives to clarify what is supposed to be evaluated)
- What does "success" mean in terms of the objectives developed for this project (think about success in the broad sense, not just numbers). Consider different types of success – projects don't always achieve what they thought they could or would, but useful things happen that are worth knowing.
- What are the evaluation goals and objectives (what is the evaluation trying to accomplish and what are you going to do in your evaluation by specific times?)
- What evaluation tools should be used to collect information? The work of the project can be recorded with journals, files, meeting logs. The achievements of the objectives can be reviewed or measured by talking to participants/workers, using questionnaires, interviews, and evaluation forms.
- Who is going to gather and look at the evaluation information – are you going to hire someone from within or outside, or use an internal committee?
- How are you going to change the project activities if needed? Allow for regular evaluation meetings throughout the work and build flexibility into the project.
- Who is the evaluation for and who will use it?

8. Appendix

In this section, you may want to include:

- Letters of support, which should:
  - Reflect a knowledge of the organisation's work and an appreciation of the project that is being endorsed
  - Be written because the sender genuinely supports your group and its work. It should not be just an obvious response to a request for such a letter.
  - If possible, be addressed to the funding agency rather than to "Sir or Madam" or "To Whom It May Concern"
- Resumes of present and, if available, potential staff.
- Charts, diagrams, statistics and other material not incorporated into the body of the proposal.
- Description of your organization, letters of incorporation, most recent financial statements.

Reference
Most of the information in this document is sourced directly from: (1) Applicants' Guide to Proposal Development (1988). Health Promotion directorate. Health and Welfare Canada. (2) Resources for Community Groups (1985). Ministry of Citizenship and Culture, Province of Ontario. Available in the Community Action Pack, Health Canada.

Stress Prevention and Management

By Edna Rooth

Introduction

Stress is any demand, pressure, tension or force we may experience. Stress is not necessarily bad – positive stress can be very useful. We all need stress, but not in an unbalanced way that causes distress. Stress is an essential part of being alive – either positively or negatively. We all react differently to stress and have different responses to its various forms.

Stress becomes distress when the negative stresses in our lives far outweigh the positive ones; in other works, when our stresses weakens rather than challenge us.

How we experience stress also depends on how we react to it. Different people are able to tolerate different levels of stress.

Understanding Stress

Ask the group to give their own definitions and understanding of stress. Make notes of their comments and display. These notes are essential for reference and further discussion during the workshop. In addition, the experiences and knowledge of the group are used as starting points, which makes for good lifeskills facilitation.

Sharing The Stretch

Ask the participants to name the parts of their bodies which hurt when they are in a stressful situation. Let the participants stand in a circle, then ask each one to demonstrate a stretch or body movement capable of alleviating pain in a part of the body they mentioned previously. The whole group must then copy the movement. For example, Zaida feels neck and shoulder pains when tense. She tells the group: *Roll your head from side to side, slowly. Then, when you are starting to feel a little bit looser round the neck, imagine that you have a pen tied to your upper back. Now try to write a compliment to yourself on the wall!* Zaida then demonstrates this action and the rest of the group copy her. Note that some participants will not give verbal instructions but will simply demonstrate the movement.

Each person has a turn demonstrating a stress-relieving movement. The participants thus experience a range of movements, some of which may be very relaxing. Lead a short discussion after this ice-breaker and make a note of useful movements for future workshops.

Make sure you tell the participants that they do not have to carry out any movement that causes them physical strain or discomfort. They should not force their bodies or do anything they are not comfortable with. Participants with back and neck problems must take care.

Brainstorming Coping Strategies

All the participants sit in a circle. Go around the circle asking each person to share a coping strategy they use when in a stressful space or situation. Write these down.

Ask the group to choose a few of the suggested strategies to try out.

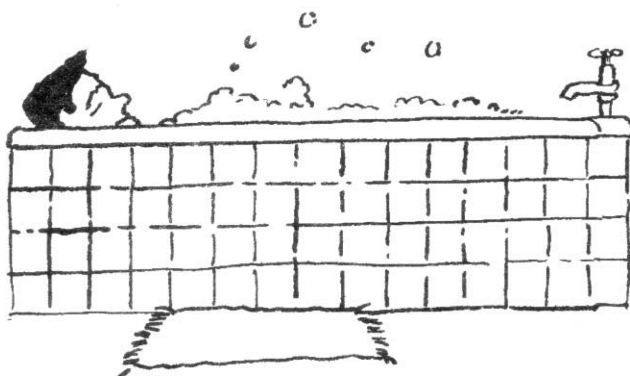
The fact that each person may have a different favourite coping strategy is very useful: it gives the participants a whole range of things to try out. There should be something there for everyone,

especially among those strategies which the group gets to test.

Once again, note that experiential learning avoids relying solely on books or 'experts'. What it does is rely on the skills the participants themselves have developed to deal with stress. Often, all participants need to do relieve stress is the space in which to connect with and explore their stress; or the opportunity to rediscover a stress-relieving technique used successfully before.

Coping strategies typically offered by workshop participants are listed below.

- long, luxurious baths
- going to a good film
- shopping or window-shopping
- getting something just for oneself
- going out to dinner
- changing one's routine
- hugging a tree
- playing with children
- pampering oneself
- dancing
- doing something just for oneself
- playing with pets
- giving a silent scream
- eating healthy food like fruit or fresh vegetables
- having a strong cup of tea
- reading a book
- taking an iron supplement
- getting regular exercise
- laughing
- painting
- working with clay
- baking or cooking
- gardening
- being nice to somebody
- phoning a friend
- talking about it
- having safe sex
- meditating
- doing deep breathing



- listening to music
- going for a long walk
- playing non-competitive sports
- scribbling with crayons
- doing nothing and not feeling guilty about it
- visiting friends

If applicable, the facilitator can ask participants to demonstrate how to use the strategy. For instance, breathing exercises can be shown to and experienced by the group.

Remind the participants that some strategies only work for some people: they should not worry if they cannot relate to all the strategies.

Below are detailed examples of coping strategy demonstrations:
The Silent Scream
(See picture below)
Give the group the following instructions. You may need to demonstrate this first.

Close your eyes. Clench your hands into fists and kick your feet. Without making a sound, ***scream, scream,*** *let it all out, yell, without making a sound ... Put your tongue out, open your mouth as wide as possible, let all the tension, anger and frustration* ***go, go, go*** *... Slowly breathe out and gradually open your eyes. How do you feel now?*

My Space Bubble

Slowly guide the following visualisation. Pause often to give participants enough time to visualise.

Imagine that you are going on a journey to a faraway planet. You are in a space bubble that you have created. You can move freely inside this bubble. Everything is very peaceful and quiet. Nobody else can get into the bubble. Try to imagine what the bubble looks like, what colour and shape it is. Start moving around in your space bubble, remembering that you are safe from any interference. Lie down on the floor ... imagine that you are on your way ...

Start your journey through space and time and look down on the earth far, far below you. The earth seems very small and far away. You feel as if you are looking back at the earth from a great distance ... Ask yourself what really matters now.

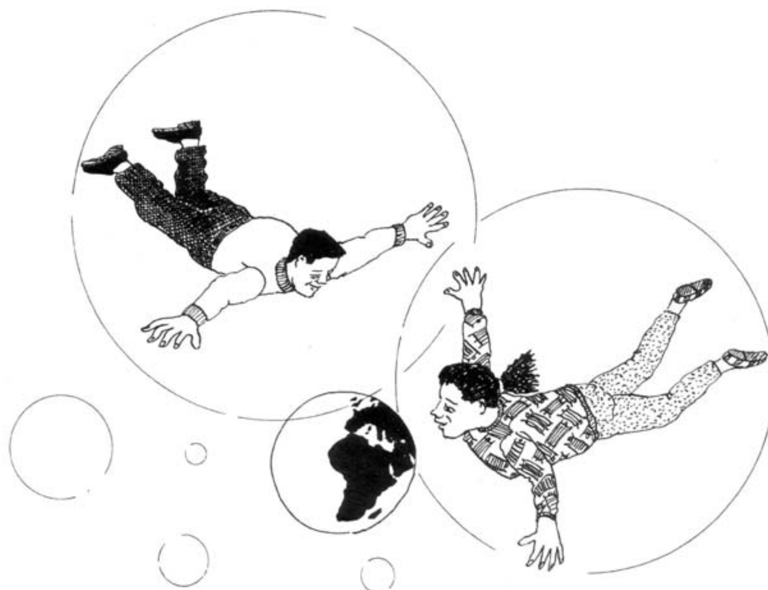
Continue your private journey in silence. You do not have to reach the faraway planet ... the important thing is that you are on a journey.

Return to earth only when you are ready.

Watch the earth get closer and become larger. Look to see where you are going to land.

Feel the ground under your space bubble, move about and have a look around the inside of the bubble.

Very slowly, climb out of your space bubble and stretch.



Try to create a space bubble for yourself whenever you feel you need to gain perspective on what stresses you.

Have a brief discussion after this exercise.

Breathing

The way we breathe can play an important role in stress management. Many people hold their breath when in a tense situation. This can become a habit. Without being aware of it, we can end up holding in our breath a great deal of the time.

Some people are in the habit of breathing very shallowly. When we do not get enough oxygen into our bloodstream, our organs deteriorate and waste products poison our system.

This contributes to anxiety, tiredness, depression and nervousness.

Ask the participants to become aware of their individual breathing styles and to comment on them.

Remind the participants not to strain themselves and to avoid discomfort during the activities below. Instruct them as follows:

Breathe out as slowly and as long as you are able. Breathe as if you were just about to blow out a candle, but don't blow it out.

Breathe in, counting to five. Hold this breath for five counts. Slowly breathe out, again counting to five. Repeat.

Once the participants are used to this activity, you can extend the count to ten.

Finally, give the participants a feather each. They must keep the feather in the air by blowing on it. This activity only works outdoors or in a well ventilated room.

Listening In And Out

Get the participants to sit on their chairs in an upright position. Their feet must be placed firmly on the ground and their hands lie loosely in their laps, with the palms turned upwards.

Ask them to close their eyes and to identify and listen to the furthest sound they can hear. It might be traffic, birds calling, people making a noise, the wind blowing through the trees. After about 30 seconds, ask the group to bring their listening in and to identify and listen to the closest sounds they can hear. This may include their own bodily sounds like breathing and heartbeat. When you notice that the group has become very still, ask them to send their listening out again to listen to the furthest sound they can hear. Wait for the group to become still once more before requesting that they bring their listening back to the closest sound they can hear.

Lead the group to listen in and out a few times before ending the exercise. First get the participants to stretch while keeping their eyes closed. Then ask them to breathe in deeply, and as they breathe out, slowly open their eyes.

Ask the participants for their comments. Point out the value of this exercise as

- a stress reliever
- an aid to becoming less panicky and more focused
- a means to become more centred and
- a device for leaving behind a current activity and moving on to a new one.

This exercise can be used without other people noticing. It can even be used during stressful meetings.

Balance Cycles

Ask the participants to divide up a typical week into sections. An example would be:

- Having a headache
- Complaining
- Laughing
- Crying
- Doing some things I enjoy
- Doing some things I hate
- Driving
- Eating
- Having fun
- Going to work/school
- Having a break from work/school
- Reading
- Relaxing
- Sleeping
- Spending time with my family
- Spending time with friends
- Watching TV
- Just resting at the weekend

The purpose of this catalogue is to allow participants to become aware of how they are spending their time. They should then be able to identify possible imbalances in their lifestyles. For example, somebody who works seven days a week, never has a vacation and spends most of their free time sleeping may have an unbalanced lifestyle.

Give the participants time to fill in their **balance charts.** They decide where the imbalances are, then discuss what they are going to do about it in small groups.

Stress And The Self-Concept

Negative self-concept formation causes stress. **Negative self-talk** in particular causes a great deal of stress. We all have to continue work on an enhanced self-concept. Without constant **attention to** and **effort** to change negative self-talk, stress management cannot occur.

It is important that the facilitator allows space for participants to talk about stress and the self-concept.

Stress And Work

Participants often indicate that most of their stress is work-related. It may be necessary to give participants the opportunity to identify the causes of stress at work and then to let them have small group discussions on creative strategies to counter stress at work.

Reflection

Ask the participants to reflect on the nature of stress, on their own stress level and on strategies to counter stress. Sharing personal experiences and strategies is very important as group members can learn so much from one another. Participants also gain comfort from knowing that they are not isolated in their experiences of stress.

As the facilitator, you should do your best to ensure that when participants leave the workshop, they have set up one or several networks aimed at supporting each other in their efforts to develop, adapt and use stress prevention strategies.

Discuss what form the networks should take. They can vary from telephone contact to regular meetings and participants can choose what suits them best.

Reference

Rooth, E. 1995. Lifeskills A Resource Book for Facilitators. Macmillan Boleswa: Swaziland

SAQA

Qualification in Child and Youth Care Work on the NQF!!

Sandra Oosthuizen

Hard work on the part of the Standards Generating Body during this year has resulted in the body produceing its first qualification. This, the first ever qualification in Child and Youth Care Work prepared for the NQF has been submitted to the South African Qualifications Authority for approval. The qualification was published in the government gazette for a period for public comment (13 October – 14 November 2004). At the end of this period three comments were received from individuals in the field of child and youth care work. These comments were discussed at the following SGB meeting, and a full day was used integrating the suggested changes which the SGB considered valid and critical to the sector.

The qualification submitted to SAQA looks like this:

- It is pitched at level 4 (equivalent to grade 12) on the National Qualifications Framework
- The qualification will take approximately 1 year to complete.
- It has a credit value of 146 credits
- The credits imply that 1460 notional hours of learning will need to take place. (Notional hours include classroom time, reading time, doing assignments as well as practical work, etc)

Unit standards are the bite-size chunks in which the qualification is divided to be more accessible for child and youth care workers. The following child and youth care work unit standards make up the core part of the qualification which equals 89 credits:

Unit Standard Title	Level	Credits
Demonstrate a basic understanding of the fundamentals of C&YCW	3	10
Demonstrate knowledge of the developmental approach to therapeutic work with children and youth at risk	4	5
Apply personal developmental strategies and skills to enhance effective service delivery in child and youth development	4	5
Promote and uphold the rights of children and youth at risk	3	4
Demonstrate basic caring skills for children and youth at risk in routine contexts	3	6
Use basic communication skills in interactions with children and youth at risk	3	5
Demonstrate basic interpersonal skills with children and youth at risk and their families	4	12
Observe, record and report in child and youth care work context	4	5
Participate in a developmental assessment	4	8
Work as part of a team, under supervision, with children and youth at risk	4	5
Demonstrate knowledge of programming and activities in C&YCW	4	6
Apply basic behaviour management and support techniques in routine child and youth care work contexts	4	10

You will also need to select electives, totaling 21 credits, from the following list:

Unit Standard	Level	Credits
Identify expertise and resources	4	3
Apply knowledge of HIV/AIDS to a specific business sector and a workplace	3	4
Perform basic first aid	2	4
Describe how to manage substance abuse and addiction in the workplace	3	2
Apply knowledge of community issues in relation to development projects	3	4
Establish a community resource project	5	20
Participate in the estimation and preparation of cost budgets for an element of work and monitor and control actual cost against budget	4	6

Monitor budgets related to community projects	5	8
Demonstrate knowledge of lifespan development theories for application in child and youth care work	5	5

The rest of the qualification is made up of language and mathematic unit standards (56 credits). These unit standards are compulsory in order to qualify at this level. This is a SAQA requirement with which the SGB was required to comply.

This is a new way of looking at how one becomes qualified in child and youth care work. The person with this qualification at level four will most likely be required to work under supervision at all times. This is the first step towards becoming a professional child and youth care worker. The following qualifications will be pitched at levels 6 (degree) and level 7 (honors degree) on the NQF. The Masters degree will be at level 8.

Please forward any questions to: The Director, NACCW – fax: 021-762 5352 or e-mail headoffice@naccw.org.za

Positions Offered
James House is a Family Preservation Programme operating in Hout Bay, Western Cape. The following positions are available for 2005.

Social Worker: Full-time position
The ideal candidate will be:
- A registered social worker
- Have knowledge of the transformation of the child and youth care field
- Have worked in the child and youth care field for a minimum of two years
- Have a valid driver's licence
- Be Fluent in a least two of either Xhosa, Afrikaans or English

Child and Youth Care Worker: Full-time position
The ideal candidate will be:
- Qualified in at least the BQCC
- Current membership of the NACCW
- Able to demonstrate the transformation of the child and youth care field
- Have a valid driver's licence
- 1st language must be Afrikaans

Interested persons are invited to submitted for attention Mark Gamble. Fax: (021) 7900928

Goodbye S'bongile and Good Luck!

NACCW professional services sadly says goodbye to S'bongile Manyathi at the end of this year. S'bongile has contributed significantly to the field of child and youth care over the past 17 years, at first running a successful center for girls sentenced to a reform school, and over the part 10 years as a Professional Consultant for the NACCW. In this position, S'bongile has traveled to all parts of the country offering training and consultancy to residential and community-based organizations. She has represented the NACCW in other countries including Denmark and latterly Zambia. A person of stature, she was recently a popular candidate for election to the Professional Board for Child and Youth Care Work.

S'bongile has over her decade-long tenure at the NACCW been an important roleplayer in many of the important transformational initiatives. She considers that this opportunity to be on the cutting edge has been exciting. She was one of the first lecturers for the first Certificate course in child and youth care run by Unisa, and was the first trainer to adapt child and youth care material to a community setting. "It is amazing", says a smiling S'bo, "to see how far we have come. I undertook that training, not knowing that only five years down the track, people would be receiving recognition for the role that they would be playing in our communities." It is apt that she named the NACCW model for community-based child and youth care – Isibindi!. Courage!

She is also proud of the development of Black child and youth care workers that has occurred over the decade of democracy – to which she has made so profound a contribution. Another highlight has been the connection with the other African countries. "I have always wanted to see us draw on each other".

S'bongile leaves the NACCW to continue to fly the child and youth care flag. She will be joining the Department of Social Welfare and Population Development in the Durban region as Assistant Director: Child and Youth Care. In this post she will drive the transformation process of the child and youth care system in the region. The NACCW is proud to have been served by a child and youth care worker, and a social worker of note over these years. The Association wishes her well in this new position. Thank you for your contribution to building our profession. Thank you for your contribution to the NACCW. Hamba Kahle our colleague.

The Zamb and Youth

Barrie Lodge

"The Zambian Association of Child Care Workers ZACCW is now officially launched"

The loud speaker system gave the words and echo so they rang out over the quadrangle.

There was restrained applause – this was probably the right thing to do in the company of an elder.

"Do we sing in Zambia?"

A loud and drawn out "*Ye – es*"

"Then now's the time to sing" - it was surprising that we needed permission to be African in Africa! But that's all that was needed. Suddenly the place erupted into celebration. Not only singing, but dancing, drums and a procession. A colourful Zambian celebration. And so it should have been because history had been made!

Only a few days before, Zambia had celebrated its fortieth year of independence, and the South African President, Mr. Thabo Mbeki had spoken to the world of the need for partnerships in Africa. In his speech he implied that the principal Zambian partner was likely to be South Africa. The governments of both South Africa and Zambia should know that within days of announcing a development strategy for Africa in Zambia, the field of child and youth care came out publically, and signed a written memorandum of agreement to work in partnership towards improving the quality of care for troubled children and youth – the Zambian Association of Child Care Workers (ZACCW) and the National Association of Child Care Workers (NACCW) South Africa. Within days a national initiative had been launched to promote the optimum care and development of children and youth in Zambia, especially for those children who by force of circumstance grow up in environments which place their physical, social, emotional, intellectual and spiritual development at risk. It had its epicenter at this launch in Lusaka, but has allowed for regional representation in Livingstone, the Copperbelt and the other provinces.

On the same occasion, another forty Zambian child and youth care workers graduated with the Basic Qualification in Child Care, and over fifty stood and publically declared their allegiance to a code of ethics to ensure ethical practice in their work with Zambian children and youth. There was good reason to sing and dance!

Four significant events occurred that weekend in Lusaka. The day before, on the basis of a now State registered and acknowledged constitution, the first members of the Zambian Association of Child Care Workers elected an Executive Committee, leaving vacancies for provincial representatives. The Executive Committee members are as follows:

Felix Mwale: Chairperson
Margaret Chirwa: Vice Chairperson
Patricia M M Ndjlovu: Secretary
Louis Mwewa: Treasurer
Robert Sihubwa: Committee Member

ian Association of Child Care Workers is Born.

The next day followed the official launch of the ZACCW and the signing of the memorandum of agreement by Revd. Barrie Lodge, of the NACCW South Africa, and Felix Mwale, the newly elected chairperson of ZACCW. The graduation of the BQCC candidates, the first trained by trained Zambian trainers, was followed by a memorable speech on child and youth care by Ms. Zeni Thumbadoo, Deputy Director, NACCW South Africa.

It is remarkable that Child and Youth Care Workers had driven the process of establishment and recognition so quickly. The first meeting between South African and Zambian colleagues was at the 14th NACCW Biennial Conference in Kimberley, South Africa in July 2003. Then quickly followed the training in Lusaka of about 30 child and youth care workers in the BQCC by Sbongile Manyathi, and the first consultative process towards the formation of an Association in December 2003. A group of trainers were trained in KwaZulu Natal earlier this year. The new Zambian Association is very clear that by the end of this year it will have regional representation in other provinces. It all shows that children's needs are truly high on their priorities.

The future looks very promising. The ZACCW now plan on brining a sizable delegation, including youth to the NACCW 15th Biennial Conference in Cape Town in July 2005. It is here that the idea of Africa partnerships and African links in the field of child and youth care can in some way be extended and formalized into a strategic plan. Perhaps the NACCW Conference can launch an initiative to hold the first truly All African Conference somewhere in Africa in the years between National Conferences? Certainly the ZACCW and NACCW partnership is a model for what can be achieved in Africa to the benefit of children of Africa.

© Photographs taken by Barrie Lodge

Where Can I Find the Policy?

This is the fifth 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 HIVAIDS and health.

Health sector policy and legislative context

Introduction

This series was begun to answer the seemingly straightforward question "Where can I find the policy?" in relation to services for children made vulnerable by the HIV/AIDS crisis. As indicated in previous articles, the policy and legislative framework in this regard is complex and extensive, and must be thoroughly understood by prospective service providers. In order to be able to render services it is also necessary to be familiar with policy guiding the activities of related sectors. Hence the focus of this month is on policy governing the health sector. This article is adapted with permission from the publication by Sonia Giese, Helen Meintjies, Rhian Croke and Ross Chamberlain (2003) entitled "Health and Social Services to Address the Needs of Orphans and Vulnerable Children in the Context of HIV/AIDS: Research Report and Recommendations".

The transformation of South Africa's health sector is founded on the principles of the primary health care (PHC) approach (Declaration of Alma-Ata at the International Conference on Primary Health Care, 1978). The PHC approach dictates that health services should be equitable, focus on promotive and preventive health activities, and provide good continuity of care from the primary to the tertiary levels. It furthermore requires that health is viewed holistically and that there is good co-ordination between all sectors that impact on health.

The 1997 White Paper on the transformation of the health system recognised children as a priority group for attention, with special consideration for those living in poverty. It proposed the delivery of a universally accessible essential package of PHC services as a means of ensuring children's rights to basic health care.

In the context of the overall commitment to children, the health sector is obliged to pay special attention to this vulnerable group – applying its laws, policies, plans and programmes to the attainment of equity in health service delivery. Despite significant legislative reform in health over the past decade however, the challenge of formulating specific legislation to guide child health care remains. Progress in this regard is described below.

Child health related legislative framework

The revision of the National Health Bill provides a new framework for the governance, organisation, management and delivery of the health care system as proposed in the White Paper. However, despite the White Paper recommendations for children, the most recent draft of the National Health Bill (Republic of South Africa, 2002b) overlooks children as a special group in all but the recognition of their Constitutional entitlement.

Child health related policies, programmes and campaigns

Over the past few years a number of plans and programmes have been developed to address national health priorities for children. Some of these are described briefly below.

The National Maternal, Child and Women's Health policy (1995)

In 1995 the first ever comprehensive policy for the care of children, mothers and women was written to guide the activities of the Maternal Child and Woman's Health (MCWH) directorates at national and provincial levels (Department of Health, 1995). The goal of the policy

for children was to "enable each child to reach his/her maximum potential within the resources available and to enable as many children as possible to reach adulthood with their potential uncompromised by illness, disability, environmental hazard or unhealthy lifestyle".

Health Sector Strategic Framework: 2000-2005

The Department of Health's 5-year Strategic Framework (Department of Health, no date-a) for the current period elaborates on the MCWH policy and makes provision for specific child-related interventions in a number of areas which include: Reducing infant mortality rate and under-5 mortality rate; Implementing the National Programme of Action for Children in all provinces; Implementing the Integrated Management of Childhood Illnesses (IMCI) in all provinces; and Reducing prevalence of wasting and stunting among children, as well as underweight for age among children under 6.

For children with HIV/AIDS, additional relevant objectives in the framework are: "social mobilisation of communities"; improving "community- and home-based care", and strengthening support and referral mechanisms for patients and their caregivers; expanding the Lifeskills Programme to both primary and secondary schools; and searching for affordable and practical strategies to reduce mother-to-child transmission.

This strategic framework provides an opportunity to revise norms and standards for child health services and to review targets towards achieving more effective health care delivery to children.

The primary health care service package

In response to the proposal for such a package in the MCWH policy and the White Paper, a package of PHC services was launched by the Department of Health in 2000 (Department of Health, 2000b). A similar package for hospital care is being developed.

For children, the PHC package includes the following basic services: health promotion; preventative health care services; immunisation; developmental and genetic screening; growth monitoring; and School Health Services. It also makes provision for acute curative care using approved protocols such as IMCI, and emergency care.

The package makes little specific mention of children with chronic conditions (which includes children with HIV infection and AIDS) and of victims of sexual abuse and violence. The opportunity nevertheless remains to define those specific interventions needed by children thus affected, before full district-level implementation of the package by 2004.

Free health care for children

Currently health care at the primary level in South Africa is free for everyone.

The State President's 1994 'State of the Nation' address declared free health care at all State health facilities for children under 6 and pregnant women who are not covered by a medical scheme. Notice 657 of 1994 identifies the relevant service facilities as hospitals, community health centres, clinics, mobile and satellite clinics, State-aided hospitals that are subsidised more than 50% by the State, and district surgeons.

However, in the implementation of the free health care policy, hospital facilities have varying practices on user fees for children, and many hospitals do charge user fees based on a sliding scale. No child should be denied access to health care on the basis of inability to pay, but the incorrect application of the user fees policy could have serious consequences for children living in poverty, especially those requiring frequent hospital care.

Several other specific preventive and curative programmes have been developed to respond to the priority health needs of children. These include nutritional programmes, preventing common childhood illnesses through vaccination, treating common potentially life-threatening conditions, health promotion, prevention of HIV transmission from mothers to young babies, and several specific clinical protocols.

Programmes addressing hunger and malnutrition

Among the range of strategies for promoting good nutrition for all South Africans, the Integrated Nutrition Plan (INP) (Department of Health, 2002b) contains some specific interventions for children, viz. addressing micronutrient deficiencies in children; promoting breast-feeding; and contributing to household food security, especially to alleviate short-term hunger of primary school learners. However, the INP is not yet fully functional in all areas of the country and still requires significant planning and co-ordination before its intentions are realised.

There are several strategies currently being delivered within the framework of the INP:

- The 2002 **Food security, nutrition and health campaign** component of the INP aims to promote healthy eating practices (in those who have access to food), promote the production of micronutrient-rich foods, stimulate household food security and stimulate income generation using food gardens as entry-points. In addition, draft regulations for the fortification of maize meal and flour are due to be finalised in 2003.
- The **Protein-Energy Malnutrition Scheme** (PEM Scheme) is a legacy of the former Health Department's nutrition plan and is delivered through clinics to children who are undernourished. A 1997 provincial evaluation (Hendricks, Fernandes, Roux, & Hussey, 1997) highlighted sub-optimal coverage, as well as significant under-utilisation of allocated budgets.
- The **Primary School Nutrition Programme** (PSNP) is intended to address short-term hunger in primary school learners not eligible for the PEM scheme, and has the goal of improving both school attendance and performance.

  Evaluations conducted in 1996 (Child Health Unit, 1997) and in 2000 (Department of Health, 2002b)

describe several administrative and logistical problems that impacted on the quality of the food, the coverage of the programme and the ability of the programme to reach its objectives. Where learners had access to the programme, the evaluation showed the positive contribution of the PSNP to learner cognitive attentiveness.

In 2002 Cabinet announced transfer of the PSNP from the Department of Health to the Department of Education as from 2004, to expedite delivery. This offers an opportunity to review the role of the school in addressing problems of hunger and nutrition faced by vulnerable learners.

- The **Vitamin A supplementation programme** addresses the critical problem of vitamin A deficiency in young children. Vitamin A has a proven role in reducing the impact of infections on child health.

  The national supplementation programme provides for routine administration of vitamin A capsules to children between the ages of 6 and 60 months, as well as additional supplementation to children that are particularly vulnerable to infections, malnourished children and children with chronic conditions such as HIV/AIDS.

  The implementation of this programme is beset by logistical difficulties relating to the procurement and availability of the correct dosage of vitamin A capsules. Of special note is the result of a rapid appraisal of primary level services for HIV-positive children (Giese & Hussey, 2002) which showed that only 35% of clinics reported administering vitamin A supplementation to HIV-positive children.

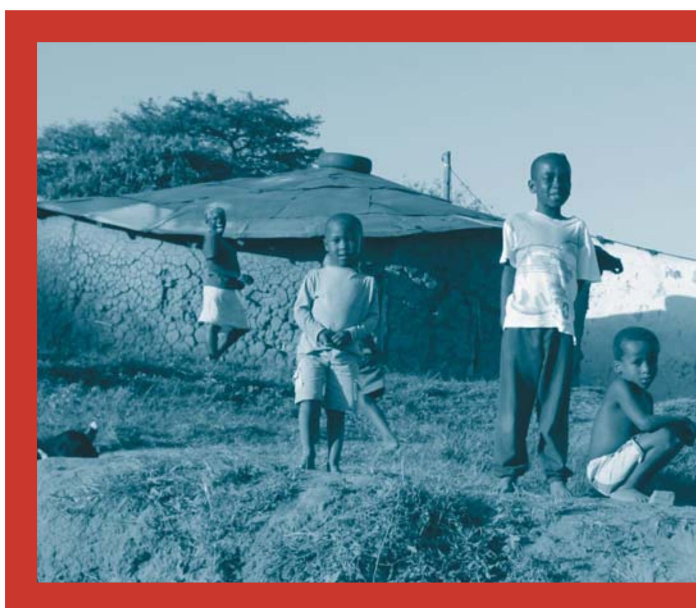
Programmes aimed at reducing childhood infections

Common preventable childhood infections remain a significant cause of death and disease in South African children under the age of 5, and several programmes to reduce morbidity and mortality in young children focus on this area. HIV poses special challenges as a major underlying cause of disease and death from other infectious diseases in children. Some of the key strategies to reduce infectious disease in general are mentioned below.

- **The Expanded Programme of Immunisation** (EPI) aims to reduce childhood morbidity and mortality from common childhood infections that are potentially fatal through routine administration of vaccines against the following conditions: measles, TB, diptheria, tetanus, pertussis, hepatitis B and Haemophilus influenzae.

  Success of the programme lies in access to preventive health care services and follow-up of children who miss their immunisations. This has implications for young children who do not have adult caregivers or whose caregivers are too sick to take them to health services.
- **Integrated Management of Childhood Illnesses** (IMCI) has three main components: application of standard case management guidelines for the management of a few priority health conditions; development, supervision and support of health workers; and a series of strategies which target household and community interventions.

  The priorities addressed are diarrhoea, acute respiratory infections, measles, childhood emergency medical conditions and, most recently, guidelines for the management of children infected with HIV are being incorporated. The programme is currently being rolled out across the country.
- **The Policy framework for non-communicable chronic conditions in children** provides the framework for service provision for children with non-communicable chronic conditions, viz. conditions that last longer than a year and are not infectious. The final draft of the policy was released for comment in October 2002. The key objectives of the policy are: To define basic health services required at each level of



the health service; To define the responsibilities at each level; To define the relationships between these levels to ensure co-ordination and continuity of services; And to delineate the support services required to sustain the programme.

  A key challenge for the implementation of the policy is the need for co-ordination with other departments and programmes responsible for specific areas, such as HIV, to ensure that all chronic conditions are addressed comprehensively by health services.

Policies and programmes aimed at children of school-going age

Several health related policies target children of school going age. These include the Health Promoting schools policy, the School Health Services Policy and the Youth and Adolescent Health Policy.

- The **Health Promoting Schools (HPS) policy** aims to develop school-based responses to various health needs of children through collaboration between learners in schools, parents and caregivers, educators and the community at large. For example, the approach includes targeting hunger through establishing food gardens at schools - as an income-generating means, as a source of food for hungry children at school, and as a source of learning.
- The **School Health Policy** is the health service component of the HPS and contains guidelines for addressing the health barriers to learning, specifically for children that have just entered school, as well as doing health promotion and education within the school setting.

  Both the Health Promoting Schools and the School Health Policy have the potential to impact on the health knowledge and health behaviour of children and youth, and offer opportunities for the identification and support of vulnerable children through schools. Finalisation towards full implementation of these policies is in progress.

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- **Youth and adolescent health policy guidelines** (Department of Health, 2002) present a holistic and integrated approach to health for children and youth aged 10-24 years. Some of the health priorities identified for this group include sexual and reproductive health; mental health; substance abuse; violence; unintentional injuries; and nutrition. The policy guidelines propose the use of general strategies for addressing these health priorities, including: promoting a safe and supportive environment; providing information; building skills; providing counselling; and improving health services. Schools are identified as one of 7 intervention settings where these strategies could be applied.

The Mother to Child Transmission Prevention (MTCTP) programme

The administration of antiretroviral therapy to an HIV-infected mother before, during and after labour, as well as to the newborn baby, is an effective intervention for reducing transmission of the virus from mother to child. In South Africa, given the number of births annually and the current HIV prevalence rates, an effective MTCT programme can save the lives of thousands of babies annually. Effective implementation of this programme requires a good clinical infrastructure, good counselling and testing facilities, as well as good support to the mother and baby pair after delivery. Support is especially needed for infant feeding and follow-up care.

The MTCT programme has already been implemented to nearly universal coverage in some provinces, but a number of provinces still lag behind.

A recent evaluation of the 18 initial pilot sites showed that the programme has numerous potential benefits to mothers and their newborn babies and reiterated the urgent need to fast track the roll out of the programme and to address infrastructural challenges (Health Systems Trust and Department of Health, 2002).

Clinical guidelines for managing HIV/AIDS in children

A number of clinical protocols have been developed by the Department of Health to guide health practice for the management of adults and children infected with HIV/AIDS. Specific child-related protocols developed so far include: Feeding of infants of HIV-positive mothers; Prevention of mother-to-child HIV transmission and management of HIV-positive pregnant women; Clinical management of HIV in children; Diagnosis and treatment of TB in the context of HIV infection.

Conclusion

Over the past decade there has been significant progress in the development of a comprehensive set of policies and programmes to address the health needs of children. Use of available resources to ensure that all children in South Africa have access to the freely available basic package of services is an attainable goal. The greatest challenge lies in scaling-up all the good plans to full implementation through activities which can make a real difference to children’s health.

Apology: The first two articles in this series were incorrectly attributed to Merle Allsopp. *Child and Youth Care* unreservedly aplogises for this error.

Reference

Giese, S., H. Meintjes, R. Croke, and R. Chamberlain (2003). *Health and Social Services to address the needs of orphans and other vulnerable children in the context of HIV/AIDS in South Africa: Research Report and Recommendations. Report submitted to HIV/AIDS directorate, National Department of Health, January* 2003. Children’s Institute, University of Cape Town: Cape Town.

HIV-AIDS and Nutrition
– Some Practical Issues

Prof. FJ Veldman

School of Health Technology, University of Technology, Free State

Previous articles published in this journal underlined the importance of nutrition during HIV-AIDS (1). It was also explained that nutrition is not only an important health issue for those people suffering from the consequences of HIV/AIDS, but also for those receiving antiretroviral therapy. Recent studies do show that HIV infected people with a healthy nutrition status, especially those with a healthy micronutrient[1] status, take a much longer time to progress to AIDS. They therefore need antiretroviral therapy at a later stage as compared to individuals with bad food intake (2).

Weight loss is by far the most important issue when treating or assisting an individual suffering from HIV/AIDS (3). It is very important to be aware that the loss (in terms of health) associated with weight loss cannot be regained simply by gaining back the lost weight. This is problematic. Another important factor seems to be that individuals with HIV/AIDS require more energy compared to healthy individuals. The body consumes energy to fight infections, and therefore requires more food to prevent weight loss. The burden contributed by the additional presence of diarrhea and vomiting in some patients cause a vicious cycle to exist.

Our general understanding of the ingredients of a healthy diet now becomes questioned. We are so used to being told that we have to eat less fat, consume more products with dietary fiber, less cholesterol and more vegetables and fruit. However, when dealing with food deprived individuals (people with very little access or ability to eat food) these guidelines become irrelevant. Even the classical recommendation of "exercise" becomes a threat, since this will cause some individuals to loose even more weight.

Given these factors how does one define "healthy eating" for people living with HIV/AIDS? The following section will explain important aspects of healthy eating and offer practical tips for those who are in the position to give advice and support to individuals or families living with people suffering from HIV/AIDS.

Drink plenty of clean and safe water

- Drink about eight cups of water per day, and even more if you are suffering from diarrhea, vomiting, or fever. You can also drink fruit juice, soups and other beverages.
- Collect your water from a protected source, and store it in a clean container. If water is not from a protected source it should be boiled for ten minutes and cooled down afterwards before drinking.
- Use the bleach method to make water safe when it is not possible to boil the water:

Add 1 teaspoon (5 ml or 1 capful if the bottle has a screw cap) of bleach to 25 litres of water. Mix it well and let it stand for 2 hours (or preferably over night) before using it.

- Avoid drinking tea or coffee with a meal, as they reduce iron absorption from food.
- Limit your alcohol intake.
- Increase the number of meals and snacks in a day.
- Exercise regularly but not strenuously.
- Prevent weight-loss during and after illness.

Hygiene

- Many of the germs responsible for food poisoning are spread through feces. Aim to use a latrine and keep it clean and free from flies. Keep the surroundings clean. Wash clothes, bedding and surfaces that might have been contaminated with feces in hot water with soap.
- Always wash hands with clean water and soap or ashes before, during and after preparing food or eating, and after visiting the toilet. Dry hands on a clean towel or cloth.
- Keep all food preparation surfaces clean. Use clean dishes and utensils to store, prepare, serve and eat food.
- Wash vegetables and fruit with clean water.
- Cover food to prevent from flies and dust contaminating the food.
- Keep rubbish in a covered bin and empty it regularly.
- Cook meat and fish well.
- Keep raw meat and fish separate from other foods.
- Eggs should be hard boiled and never eaten raw.
- It is not safe to buy products after their "sell buy" date or eat it after the "best before" or "use by" date. Do not taste food that you think might be spoiled.

When having diarrhea

- Drink plenty of fluids.
- Avoid caffeine-containing beverages (coffee, coca cola, chocolate, etc.).

- Eat, even when you don't feel like eating.
- Replace lost nutrients.
- Eat fat free or low fat foods.
- Avoid concentrated sweets, foods that are high in fiber such as fruits and or vegetables and uncooked foods).
- Talk with your doctor or pharmacist about medications that may reduce diarrhea.
- Avoid aluminium-containing antacids[2] and switch to magnesium-containing antacids.

Preparing an oral rehydration drink when having diarrhea or vomiting

To one litre of freshly boiled water add half a teaspoon of salt and eight teaspoons of sugar. Stir or shake it well.

or

A rehydration drink can also be prepared from one litre of clean water, half a teaspoon of salt and eight teaspoons of powdered cereals (rice is best, but fine ground wheat flour, maize, sorghum, or cooked mashed potatoes can also be used). Boil for five minutes to make a liquid soap or watery porridge. Cool the drink quickly.

Foods that may benefit people living with HIV/AIDS

- Basil - helps to relieve nausea.
- Cardamom - helps with digestive problems, pain, diarrhea, nausea, vomiting and loss of appetite.
- Cayenne - stimulates appetite, helps fight infection, heals ulcers and intestinal inflammation.
- Chamomile - helps digestion and provides relief from nausea.
- Cinnamon - good for colds and weakness after colds or flu. Stimulates appetite.
- Cloves - stimulates appetite, help weak digestion, diarrhea, nausea and vomiting.
- Coriander - helps to increase appetite and reduce flatulence.
- Fennel - helps to increase appetite, combat flatulence and expel gas.
- Ginger - improves digestion, energizes, relieves diarrhea and stimulates appetite.
- Lemon grass - has a calming effect.
- Mint - has an anti-inflammatory effect and helps digestion.
- Parsley - reduces intestinal colic.
- Peppermint - may help nausea.
- Thyme - has antiseptic and antifungal function. Relaxes nervous coughing and increases mucosal secretions.
- Turmeric – aids digestion, is an antiseptic and an antioxidant.

Patients with HIV/AIDS also develop sores (thrush) in their mouths which makes it difficult to chew and swallow. This can indeed be very painful.

Recommendations for relief of some of the symptoms of thrush

- Eat soft, mashed, smooth or moist foods such as avocados, squash, pumpkins, papaya, bananas, yoghurt, creamed vegetables, soups, pasta dishes, and minced food.
- Add liquids to food or soften dry food by dipping in liquids.
- Drink cold drinks, soups, vegetable and fruit juices.
- Use a straw for drinking fluids.
- Rinse gums with bicarbonate of soda if teeth brushing is painful.
- Chew small pieces of green mango, kiwi or green papaya to help relieve pain and discomfort.
- Drink spice teas, fermented sour cabbage or yoghurt.

What to avoid when having symptoms of thrush.

- Spicy and salty foods such as chillies and curries.
- Acidic or sour food such as oranges, lemons, pineapple, vinegar, and tomatoes.
- Foods or drinks that are too hot or too cold.
- Foods that need a lot of chewing such as raw vegetables, or are sticky and hard to swallow such as peanut butter.
- Sweet foods, sugar, honey, and sweet fruit and drinks
- Patients on medication for candida should use fluoride-containing products and mouth rinses without alcohol.

Malnutrition is a serious danger for people living with HIV/AIDS. Even at the early stages of HIV infection, when no symptoms are apparent, HIV makes demands on the body's nutritional status. Good nutrition cannot cure AIDS or prevent HIV infection, but it can help to maintain and improve the nutritional status of a person with HIV/AIDS and so delay the progression from HIV to AIDS. It can therefore improve the quality of life of people living with HIV/AIDS.

Glossary

[1]Micronutrients: nutrients required in trace (small) amounts
[2]Antacid: substances used for correcting the acidity of the stomach (bicarbonate of soda, Enos, Tumbs, etc.)

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Child and Youth Care Work as Healing ...

by Sue de Nim

Introduction

Children and youth at risk enter programs with enormous amounts of pain and unhappiness, much of which they have been carrying around with them for many months and years. However, their painful feelings of rejection, hurt, worthlessness and despair often remain hidden beneath surface behaviours including bullying, withdrawal, scapegoating and violence. As such, many workers fail to address the pain, and instead, respond to difficult and unpleasant behaviour, sometimes with anger or rejection. When a young person is sad, child and youth care workers might think they are being helpful by saying things like, "Don't worry, you'll be fine" or "It's not so bad" or "Don't cry" or "Of course your mother loves you", as though the child can "get over it" through sheer willpower. It is as though the pain must be done away with as quickly as possible, and the process of healing must be instant. Perhaps the worker's words are well-intentioned, but often, they do nothing more than give the message "I don't want you to be sad", "Your feelings are wrong", "Your pain is unacceptable so please don't show it to us". When emotions are unexpressed, they do not miraculously disappear; they can remain inside until the emotional pressure becomes so great that self-control is temporarily suspended.

Perhaps, it is time to think about how comfortable we are with others' pain, for it is only through healing - itself a painful process - that young people will truly be able to move on with their development. Kind words and opportunities for new experiences without deep inner healing may be as effective as trying to fill a bucket with water without mending the holes in the bucket first. Such healing is a key in the emotional development of young people so that they become able to acknowledge and value their own feelings, whether positive or negative, and to learn how to express them appropriately.

The Invitation ...

I would like to invite you into the pain of an adolescent, thrust into a world where everything is unfamiliar. This is the pain which needs to be healed, the pain which requires great courage from the child and youth care worker. Read on if you are willing to face this challenge ...

I'm Angry

This morning, I woke up in an unfamiliar place, a place where the people are strangers to me. I don't want to be here. I am filled with dread. I think the strangers expect me to be "more settled" now that I have returned to school. I feel as settled as a volcano which is about to erupt! I'm angry and resentful and I know I'm going to hate that school today as much as I did yesterday. I never said that I wanted to go there. They told me it would be my choice, but it wasn't. They lost patience because I took too long to decide so they decided for me. And now my sadness and pain has turned into something else, something which makes me want to hurt others, something which will show them that *I* am in control.

I'm Invisible

Perhaps, it would have been different if they had been willing to touch my pain. I know they must have seen it, because I have cried so many tears that my eyes look like those of the broken man who sits slumped outside the bottle store. I am sure that the emptiness inside me must cause every sob to echo like raging thunder, so why don't they hear it? They go about their business as though nothing has changed, except

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that everything has changed! Am I the only one who knows it, who sees it, who *feels* it? Why won't they help me to scream, to cry, to grieve? Why don't they hold me and tell me "it's OK"? Why won't they wipe away my tears and comfort me. Instead, they walk around me as though I exist as a collection of bones and muscles and skin - but without the ability to feel. I think I must have become something dangerous. I have disappointed them because I'm not as strong or adaptable as they thought. I'm sorry I haven't been able to cope. I don't have the energy to try any harder. I'm using everything I have to prevent myself from dissolving into the nothingness inside of me. The vacuum sucks me inwards, tempting me to succumb to something terrifying - something so raw that I suspect it will result in madness or death or maybe something even worse. But nobody can see it.

Perhaps, the horrible thing inside me terrifies them too. Perhaps, they don't know what it is or how to be with it. Perhaps, they are frightened because they have spent so long avoiding their own pain. Perhaps, a glimpse of mine might cause them to dissolve into their own nothingness or madness or death. So we dance around each other making sure that we never really make contact - just in case we spread the dangerous thing to each other.

I'm Scared

They're calling me again. I have to get ready for school so that I don't make the others late. I have to leave the warm haven which is my bed - the place where I am safe - and enter the unsafe places, the places where the strangers look past me, or ask me questions which I don't want to answer, or don't know how to answer. I have to put on that ugly uniform which makes me look like one of the others, when I know that I am not one of them. I am an alien, a person who doesn't fit, something that can't be understood. I have to eat my breakfast, the food that tastes like nothing. Perhaps, if I eat enough it will fill the gaping hole inside of me.

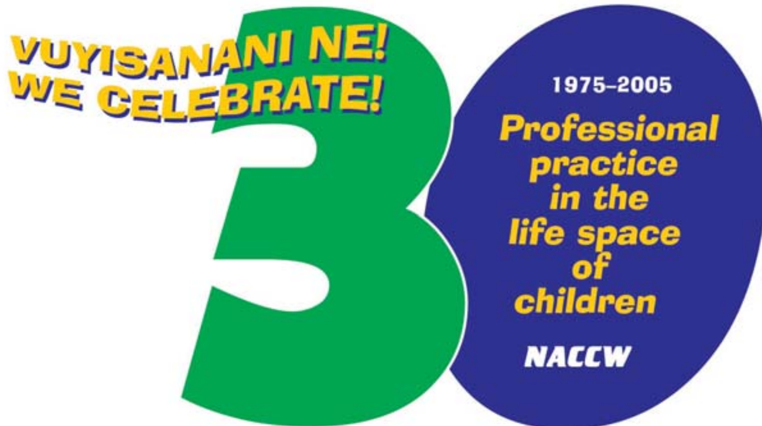
I'm Alone

On the way to school, the strangers try to make conversation with me about today's classes or sights that they find interesting along the journey. I mutter a response in a feeble attempt at politeness, but their words are intrusions into my world. I want to be left alone with my thoughts. There's a familiar song playing on the radio and I'm reminded of happier times, times with people who knew me, when the world made sense, and I knew my place in it. I find the strangers' conversations an insult to my past, a past which is both my comfort and my pain in the present. I wish they'd just keep quiet. I have only a few more minutes in the car. As much as I hate the journey, I don't want it to end. When we get there, I'll have to get out of the car and join the throng of faceless uniforms, talking about what they watched on television last night, or laughing at shared jokes, or planning outings together. They talk of people and places that I've never heard of, and I don't understand all the words they use. Can it really be that we speak the same language? I don't want to speak like them, or have their conversations because that would be a compromise, an indication that the strangers are right, and that everything I know to be true is, in fact, a lie. I cannot betray my past by venturing too far from it. The ground is uneven and I know that if I fall, my carefully-constructed exterior might disintegrate to reveal the shameful thing within. The safest thing is not to get too near, in case they invite me even closer and realise that I am something foreign, something incomprehensible, something that doesn't really belong here. I think I'll go and stand somewhere and try to look as though I'm waiting for someone. If I look impatient and keep glancing at my watch, they wont see that I am totally alone. They'll think that I too have friends, that I fit in, that I have a life, that I am more than a shadow. They'll think that there is someone coming to be with me, to talk and laugh with me. They'll think that I am one of them, and that I am acceptable. So, I'll stand there waiting for my fictitious friend, hating myself for my deception, yet clutching at my differentness, and desperately wanting the bell to ring so that I have somewhere to go, a place where I'm supposed to be, where my absence might be noticed.

My Hope

But perhaps, today will be different. Perhaps, someone will see me, the real me. Perhaps, someone will see my pain and loneliness and they will recognise it and call me a little nearer. Perhaps, there is another misfit who will stand waiting for nobody and see through my pretence. Perhaps, there is someone who is able to look upon the twisted mass inside me without turning away in revulsion, but instead, cup it in their hands and heal my aching wounds with tenderness and understanding. Perhaps, that person is you?

NACCW 15th BIENNIAL CONFERENCE



5 to 7 July 2005
University of Western Cape,
Cape Town

Keynote Speaker:
Dr Thom Garfat

Conference Fees

Full three days
Early Bird registration by 20 May 2005
- NACCW individual members: R360
- Non-members: R480

Late Registration by 20 June 2005
- NACCW individual members: R400 (R450 after 20 June)
- Non-members: R530 (R600 after 20 June)

Daily rate
- Individual members: R150 (R170 after 20 June)
- Non-members: R190 (R210 after 20 June)

Daily Lunches and Teas included and Dinner-Dance on Wednesday evening 6 July

Accommodation available at Conference Venue
Dinner, Bed and Breakfast (including bedding): R110 per person per day

Registration enquiries
Sharleen Daniels or Sandra Oosthuizen - Tel: 021-762-6076

Registration form will be published in the February and April issues.

Second 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

Submissions Must Be Received No Later Than 20 January 2005