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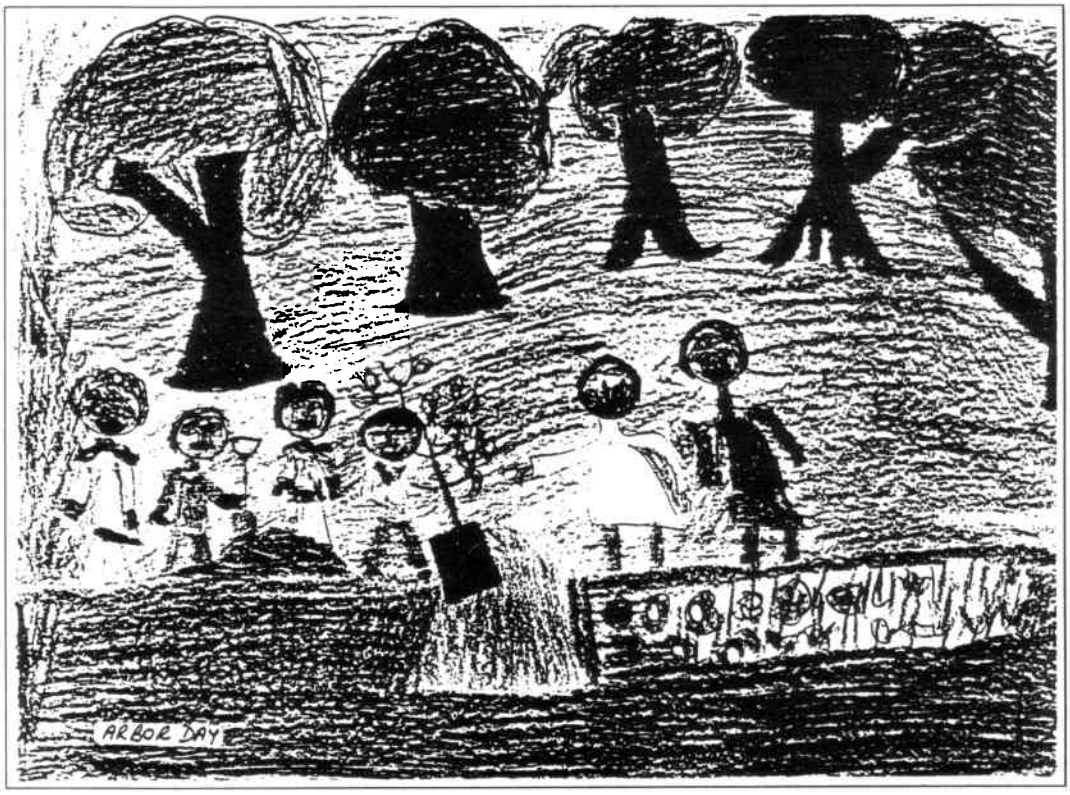
The child care worker



Cover Picture: Arbor Day — View of an autistic child in Pretoria

Tydskrif van die
Nasional Vereniging van Kinderversorgers

Internasionale Geaffilieerde
CWLA
Child Welfare League of America

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National Association of Child Care Workers Nasionale Vereniging van Kinderversorgers

The National Association of Child Care Workers is an independent, non-racial organisation which provides the professional training and infrastructure to improve standards of care and treatment for children in residential settings.
Die Nasionale Vereniging van Kinderversorgers is 'n onafhanklike, nie-rassige organisasie wat professionele opleiding en infrastruktuur verskaf om versorging en behandeling standaarde vir kinders in residensiële omgewings te verbeter.

GUEST EDITORIAL

Reading for their lives

All of us have at one time or another (and preferably not too often) experienced the utter helplessness and vulnerability of sitting in the dentist's chair with our mouths open ...
Taking into account your dependency on the dentist's judgement and skill, how would you feel if, once you were suitably numb, he should indicate that he qualified 25 years ago, hadn't read a single book or journal article on the latest techniques since, and didn't particularly believe in progress?
The youth with whom we work are vulnerable and depend on our judgement and skill.
The child and youth care workers whom we supervise and teach are equally vulnerable and dependent upon our knowledge and skill. The supervisor and middle management team whom we lead depend on new insights, a vision for the future and careful, informed leadership.
There's a vast reservoir of hints, strategies, warnings and delightful tales out there in the world of books. Unless we consciously encourage one another to tap these resources, we're going to lose so much enriching sustenance. Can we afford to? We're also likely to re-invent the wheel and make mistakes we could have avoided. Do we want to?

Questions to Administration
When was the last time you read a child care text?
When was the last time you ordered a book for your library?
Do you have a staff development programme which includes reading as part of work? i.e. Do your staff get paid to read?

Questions to supervisors and in-service trainers.
Which was the last child care book you read? Do you read to grow? Do you read to teach?
Do you have reading time built into your working hours?
Do you actively encourage child care workers to read and teach one another from what they have read?

Questions to child care workers
When last did you read a child care book? Why did you read it? Because you were expected to? Because you wanted to? Do you have access to books? Do you plan to read?

Some ideas
- We have negotiated with Westdene Rondebosch Books in Cape Town to stock child care literature – you may like to be in touch with them. Their telephone number is 021-689-4112.
- Contact your Regional Director or National Director or Publications Deptartment for a reading list.
- Find every innovative way you can to encourage reading in your organisation.
- "Share" ideas or a book review with your colleagues, through the Journal.
- Budget for books, subscribe to Journals.
- Perhaps two or three organisations could share a resource library?

There's a world of books available that can stretch our thinking, challenge our practice, keep us enthusiastic and affirm what we do. Knowledge is one way of empowering ourselves. Empowerment is what our profession needs. Empowered, competent, on-line workers, supervisors, administrators and boards of management are what our children and youth deserve. So read for your life, but more importantly, read for theirs!

– Lesley du Toit

Child Sexual Abuse in Children's Homes: Some Issues

Sister Irene and Eric Harper

Proactive programmes in the Western Cape

In attempting to prevent sexual abuse, proactive programmes have been developed with the following objectives:

- Courses for trainers to continue to run prevention workshops, initiated by Ms R Shapiro (NICRO), and Ms M van Zyl (Rape Crisis).
- Establish a prevention centre. The SASPCAN child sexual abuse centre at Red Cross Hospital has recently been established and is co-ordinated by Ms S Jacobson.
- The creation of a manual for prevention undertaken by Ms R Shapiro, Ms M van Zyl and Ms S Jacobson.
- Collection of research on child sexual abuse in Southern Africa co-ordinated by Ms A Levett who will draw up a report which will be available for study.

In trying to address the needs of childrens' homes in the Western Cape, and as part of the prevention programme, a workshop at NICRO with care workers from Nazareth House, Heatherdale Children's Home, Habibia, Bonnytoun Place of Safety, Oranjia Children's Home, James House and SHAWCO, Mr E Harper and Ms C Narunsky co-ordinated and facilitated the workshop, whilst Mr M Tomlinson helped facilitate. A resolution from the workshop was that the findings should be presented.

Definition and Values

Child sexual abuse is an act in which a more powerful other (97% of the time male) attempts to involve a child in his sexual needs. Child sexual abuse can include pornography, rape, invasion of body space, incest, boundary confusion, exhibitionism, fondling of genitals, penetration, verbal abuse and child prostitution.

Under-developed ego resources, developmental and dependency needs place the child in an unequal power relationship as regards making an informed decision as to how to deal with the confrontation. The coercion can be mildly manipulative, appear as love, bribes, threats, tricks or violence. The act, whether voluntary or involuntary, is an imposition and undermines the child's capacity to experience sexuality (as well as other areas of growth) in terms of his or her own frame of reference.

Child sexual abuse is potentially obscured in that only certain acts are recognised as sexual abuse. This can be traced to myths and ideologies which surround child sexual abuse. Children are said to lie about sexual abuse or to imagine it is happening. Stranger danger is said to be the major problem. The reality is that over 95% of statements reported are found to be true. In most cases the offender is a known and often trusted adult. Furthermore, contrary to popular belief, child sexual abuse is often ongoing (sometimes over a period of years) and takes place at all levels of society. Myths do not exist in a vacuum but must be related to broader ideological issues, which inform us as to the status, position and 'nature' of children in society. Jenny Kritzinger (1988) in looking at the ideology of childhood innocence, argues that a fetish, has been made of so-called 'childhood innocence' such that "a precocious child who appears flirtatious and sexually aware may forfeit her claim to protection because, if the violation of innocence is the criterion by which the act of sexual abuse is judged, violating a 'knowing' child is a lesser offence than violating an 'innocent' child".

Asking questions

Mrs A Levett (1989) in her article entitled 'Child sexual abuse: the damaging effect of popular ideas', argues that we need to think systematically about the consequences of our beliefs and their damaging effects. "This is not to say that we should condone adult/child sexual relating, but the development of effective intervention and prevention is likely to lie in different issues from the ones which dominate the work and research in this work at present."

She poses the following questions:

- Does talking to children about sexual matters damage them?
- If we see a child who behaves in a way which seems to suggest sexual knowledge we should not expect at that age, do we assume that this child has been traumatised by sexual abuse?
- Does this only happen when the child is female?
- If so, what form does the 'damage' take and what further evidence would be required to evaluate this?
- In whose mind is there damage, in the child's or our own?
- If it is our own minds which are offended, how do we transmit this 'damage' to the child?

Some other questions which the care worker needs to ask are:

- Do you feel comfortable talking about sex or sex related issues?
- Are you capable of giving sexual education or in need of sexual education?
- What are your morals about sexual behaviour?
- What do you understand about child sexual feelings?
- If children are sexual beings when do we say they have been sexually abused?
- Is sexual attraction and sexual feelings towards children abnormal and abusive?
- How do you deal with feelings and thoughts which you have which you think you should not have, for example, sexual attraction to children, people of the same sex, a married person?

Child sexual abuse can be said to be part of concentric circles of abusive ideology which propogate *rights over others*, for example, sexism, authoritarianism, patriarchy, lack of respect for childrens' rights, beliefs of ownership, media, myths. The ownership of child sexual abuse is an adult problem which adults need to address so that the 'adult problem' does not become the 'child's problem'. This does not negate the need for appropriate child sexual education but also raises the questions of what is 'appropriate sexual education', namely, how do we impart 'enough' information (neither too much nor too little) without being abusive? Whose need is being met through the education? How do we empower the child to protect his/her right to discover sexuality in terms of his/her own frame of reference.

With media, ideology and language acting as an internalising force of identification, the question needs to be asked: Will the child's frame of reference ever be his/her own? In terms of this dilemma we need to ask who decides what child sexual abuse is, and why are certain acts considered abusive and others not?

Needs and problems in counselling

Through interaction with the child, the child care worker hopes to provide the child with a safe environment, and by so doing to ensure a feeling of safety and containment. The aim of this process is

to facilitate growth and restore a sense of 'I'.

A list of skills needed for the task could read as follows:

Patience, listening, empathy, reach into the meanings of silence, acceptance, discerning, clear, containment, tuned-in, indirect communications, meta-communications, elaboration, clarifying, caring, consistency, teamwork, play, relationship-building, affection, honesty, flexibility, openness, insight, reliability, confidentiality, non-judgemental, balanced, unbiased, realness ...

However, more often than not, the child care worker, upon hearing that he/she has to deal with a child who has been sexually abused, feels anger, confusion, the need to protect, hurt, inadequacy, judgemental, revulsion, voyeuristic, 'if only I ... ', why her/him, denial, panic, hysteria, anxiety, self-punishment for not being able to make better, rushed for time ...

Why do care workers respond differently when hearing they have to deal with child sexual abuse as opposed to other child care areas? They need to ask themselves why when they hear the words 'sexual abuse' they go blank, forget what skills they have, and what they can do for the child. All too often the situation becomes 'objectified', the focus is placed on *the abuse* and *the child* with his/her needs is lost.

One answer to this is that care workers are caught up in *their own* responses, whether denial, titilation, anger or over-identification with the hurt, and they don't have the desire or ability to see *the child's* needs. This is due primarily to two factors:

1. The ideology of sex and the care worker's personal response to sex;
2. The difficulties of child care

Child care work has a low-priority status in the social hierarchy of values. Because of this, childrens' homes are still the unofficial dumping grounds, and whilst the Home may have high ideals and wish to apply the principles of the therapeutic milieu, the realities of poor staff/child ratios, long hours of work, low salaries, difficult (and hopeless) cases and staff burn-out render many Homes unable to move beyond the role of custodial institutions. As such, childrens' homes become abusive environments for *all* their inhabitants. What the child care workers need here is recognition, recognition of their needs, the difficulties they work under, and acknowledgement of their efforts.

Child care workers are a disempowered group who often lack organisational skills to voice their needs. Child care workers can find themselves trapped in the self-fulfilling prophecies which come from labels like 'apathetic', 'burnt out', 'inadequate', 'dependent' and a profession with a high staff turnover rate. Unless child care workers are empowered, and social policy changed, treatment will remain merely palliative.

Being there, to listen

Under this pressure child care workers find themselves working to be perfect, fearing that they will appear imperfect and wanting the right answers to be able to fix things. Only by letting go and accepting what skills he/she has and what needs to be developed, can the care worker be open to "letting God, Care, Love" enfold the dialogue with the child; to releasing the burden of trying to accomplish everything oneself.

This is to be open to the child's experience of the situation, the child's capacity to survive, to the gaps in the child's words (or play) which make the child's expression of feelings incomplete. It is to listen and be attentive to that which the child feels compelled to report and act out over and over again in problems like withdrawal, aggressive to touch, sexual acting out, crying fits, not trusting adults, attention seeking, shame, guilt, bed-wetting, nightmares etc.

Children have a limited range of responses to stress situations. The response may or may not indicate sexual abuse or may or may not be related to the sexual abuse but it does tell us about the childs needs, which can be our starting point. In order to be able to develop a state of 'pure receptivity', of being open to different impressions as they come towards us in a purely human way, the child care worker needs to find an inner stillness and silence. In other words to know oneself and what one needs to be able to give.

Child care work with child sexual abuse, as with other areas of child care, is to listen with the not-knowing ear (Serge Leclaire), to listen to the unsaid, the unheard of, without knowing what you are going to hear.

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Foster Care

Report on the foster care research programme at the Child Welfare Society, Cape Town

Brenda Jacobs

Brenda Jacobs has for the past three years been supervising a team of social workers specialising in the rendering of statutory foster care supervision and reconstruction services.

It has previously been reported that the Child Welfare Society, Cape Town has committed itself to undertake participatory research within each of its major service areas. (*The Child Care Worker*, Volume 8 No 4 April 1990). The single biggest major component of the Society's service involves the rendering of foster care supervision services to those children placed in foster care within our area of operation. (At the end of March 1990 we were supervising 544 foster children). Reconstruction services, which are statutorily required, are rendered to the parents of these children in cases where the parent also resides in our area of operation.
This article outlines the foster care research programme which was initiated in 1987. The principles of the programme, the details of the research study, the outcome data, and the follow-up study will be described.

Principles of the Research Programme
1. *Participatory Research*
From the outset, an attempt has been made to focus on the fact that the programme should involve the participation of workers on all levels, i.e. that they should contribute to decisions as to what is researched, how the problem is defined, and what counts as a successful outcome.
2. *Purpose of the Research.*
It has been stressed that the Foster Care Research Programme should be useful, and related to practice; that it should provide a better, improved, more effective service to clients; and that it must meet the social workers' needs.
3. *Aim of the Research*
The short-term aim was to identify and prioritise areas for 'formative research', the term used to describe and evaluate what is being done in specific areas of practice. The long-term aim is to measure and improve the quality, adequacy, and appropriateness of the foster care supervision and reconstruction services offered by the Society.

Questionnaire on Foster Care areas of practice
In November 1987, a questionnaire was distributed to all staff at the Society so as to identify and priorities areas for formative research. The items contained in the questionnaire were based on aspects of foster care practice, identified by the South African National Council for Child & Family Welfare in their Guide to Foster Care Practice in South Africa (1987) as warranting more attention.
It was envisaged that the responses to the questionnaire would indicate which aspects of foster care practice, staff at the Society considered as requiring research in order to improve their foster care services. In other words, an analysis of the returns would help to determine priorities. The next step would be to embark on formative research in that area i.e. describing and evaluating what is being done in that area of practice.
Analysis of the responses to the questionnaire showed that the highest priority was given to the aspect of 'Restoring Family Life'.
The Guide to Foster Care Practice in S.A. gives the following description of the term 'Restoring Family Life':
"In order to ensure that all children who are separated from their families are in all possible instances again united with them, a goal-directed result-orientated service programme is needed. Research has already revealed that the period immediately after the removal of a child, is the period when parents are most open and accessible for intervention which would restore their children to their care. At the same time, our National Statistics indicate that only a small number of children annually return to their parents. The reasons responsible for this trend could either be that children are mostly only removed from parental care where the chances of restoring parental capacities are very low. The other reason could be that too little attention is given during the post-placement period. In order to rule out this latter-mentioned possibility, a service needs to be developed in which the targets to be achieved within certain limits, as well as the obligations of all parties involved are clearly spelled out, preferably in terms of individual service agreements ... "

Clarification of the Research Question
Meetings were arranged with staff members who were interested in participating further in the foster care research programme. During these meetings, it was decided that the research should also include cases of children placed in foster care for whom the permanent plan was *not* to return home.
It was therefore decided that in our research, we would look at the relationship between the following:
- Reasons for removal of the child
- Type and duration of placement
- The access agreement and
- The permanent plan

The research will thus measure whether the outcome, after 2 years, is the one foreseen by the permanency plan made at the time of removal. If it is, we will describe that as a succesful outcome.

Use of the request for foster care placement form
A form has been devised which is completed whenever a social worker requires a foster placement with prospective foster parents who have been screened by the foster care co-ordinators at the Society. (The foster care co-ordinator posts are specialised posts which focus on the recruitment, screening and preparation of prospective foster parents).
In addition to the identifying details contained in the Form, social workers give the following information when requesting a foster placement:

Reasons for the child's removal
In this section, the social worker must decide whether the child's removal is due to one or more of the following reasons;

– Parental:	Absence Condition Conduct
– Child's:	Absence Condition Conduct Status

On the form, each of these conditions is itemised by up to seven factors from which the social worker selects those that apply in each individual case.

Type of Placement Needed as Related to the Reasons for Removal and Permanent Plan.
In this section, the social worker must decide on one of the following placement options.
- emergency placement to be followed by the child's return to parents
- emergency placement until an alternative placement is secured

- emergency placement until a permanent plan is determined
- short-term placement up to 6 months to be followed by return to parents
- short-term placement up to 6 months to be followed by return to parents
- intermediate placement (6 months to 2 years) to be followed by return to parents
- permanent foster placement
- foster placement with a view to adoption

The Access Contract
Under this section, the social worker must specify the frequency, as well as the duration and location of access in terms of a given list of options. For example, the social worker must specify whether the access will be on a daily, weekly, fortnightly, etc, basis; whether it will be for a period of less than 2 hours, 2 to 6 hours, etc, and whether access will take place in the foster home, the parent's home, a neutral place, etc.

Special characteristics of the child
The information contained in this section is not required for research purposes, but it facilitates the matching of the child in a foster home which will best meet his/her needs.

When the child is to be placed
This information is also not required for research purposes, but it serves as a useful management guide with regard to the urgency of the placement.
It can thus be seen that the Request for a Foster Care Placement form fulfills three functions viz:
- Research Function – It is the source for data for the ongoing research programme to determine whether there is any relationship between Reasons for Removal, Type/Duration of Placement, the Access Contract, and the Permanency Plan.
- Placement Function – It facilitates the task of the foster care co-ordinators in their selection of a foster family, i.e. taking into consideration the special characteristics and needs of the child, the permanent plan for the child, and the strengths and weaknesses of the family.
- Case Management Function – It provides a permanent record of initial decisions and plans made for the child at the time of his/her removal from home. (Once the research data has been captured, the form is filed in the child's case file).

Outcome Data
A detailed analysis was done in January 1990 of the data collected since June 1988. This analysis showed that during this period, requests for foster placement had been made for 132 children. Of this total number, 92% of the children were Coloured and the balance were White. At this stage the Foster Care Research Programme does not include Black children because we do not yet have a foster care co-ordinator post for Black services. The establishment of such a post has, however been identified as an Agency priority.

Reasons for Placement
The most frequent reason for placement was parental conduct – 32%. All the parental factors combined, accounted for 78% of the total.
Where factors in the child were involved, in 77% of the total, it was the child's condition which was given as the reason for removal.
These results reflect a realistic picture of our practice, because when the reasons for removal of a child revolve around the child's conduct or absence, the placement of choice sould be residential care, and not foster care.
The fact that parental conduct is the most frequent reason for removal is significant in terms of rendering reconstruction services. We need to become more aware of prognosis for treatment of parents of the children who we remove. In other words, we need to become more adept at identifying treatable and untreatable families so that we can be sure that those families to whom intensive reconstruction services are rendered, are the families who are more likely to benefit from such services.

Type of Placement Required
The most frequent plan of choice was for an Emergency Placement until a Permanent Plan could be determined – 24%. This was followed by permanent foster placement – 23%. Just over half the requests were for Place of Safety/Emergency Placements – 51%. Of those placements that were not emergencies, the plan for 57% of the children was permanent care, i.e. permanent foster care, and foster care with a view to adoption.
The plan for 35 children (21% of the total) was return to parents within 2 years. However, of these 35, the plan for 3 children was return to parental care within a period of 6 months.
This data indicates that either we need to maintain a resource of foster parents willing to act as Places of Safety, or we need to become more skilled at deciding, at the time of placement, what type of placement is required. The implication of placing a child in a place of safety is that the child will subsequently be moved to another type of placement, and we need to ask ourselves whether this is necessary and in the child's best interests.
This data also indicates that when decisions *are* made on the type of placement more children are placed in permanent care than in temporary care with a view to return to parents.

Access
In 50% of the cases, access was to be at least on a monthly basis, and for 43% of the children, access was to be held in the foster home. for 49% of the children the duration of the access was unspecified, while for 44% the location of the access was unspecified.
In practice, it is frequently found that the social worker has to act as the mediator between the foster parents and parents as far as access arrangements are concerned. The conflicts that occur between the concerned parties must surely have a detrimental effect on the children who already feel a sense of divided loyalty between their two sets of parents. We need to formulate access contracts in accordance with the permanent plan for each child placed in foster care and we need to ensure that the conditions of the contract are realistic and attainable. In other words we need to reduce the number of cases for whom we have been unable to specify the duration and location of the access.
We also need to know how many access plans work out in pracitce. This is an aspect which will be looked at during the follow-up study so that, for example, we can assess whether monthly access is a realistic and viable arrangement.

Follow-up
We have now reached the stage in our foster Care Research Programme where we can begin to conduct a prospective follow-up study. In other words, we have been collecting data for just over 2 years and we can now go back to the cases in order to evaluate descions which were made at the time of removal. The follow-up study will be done in order to answer the following questions:
Has the placement succeeded, i.e. where is the child now (2 years after placement?)
- with original foster parents
- with new foster parents
- returned home
- in an institution
- other

Were reconstruction services rendered as planned?
Are reconstruction services still being rendered to parents, and if so, what is the goal?
- return to parents
- maintenance of contact with child
- supervision of children still in parents' care
- other

Has the Permanent Plan for the child changed?
What is the Permanent Plan for the child now?
- return home
- permanent foster care
- adoption

What access actually took place i.e. were the original plans adhered to?
- frequency
- duration
- location

What are the factors which are preventing the child's return to parental care?
- Absence of parent
- Condition of parent
- Absence of child
- Condition of child
- Conduct of child

It is thus envisaged that the follow-up study will enable us to evaluate the correlations included in our research question. It will indicate, inter alia, whether the conditions of the original access contract where adhered to, and whether these conditions are still applicable. We will also be able to establish whether low levels of planned contact are more or less likely to ensure enduring between the reasons for the child's removal and the factors preventing the child's return to parental care. This, in turn will help us to evaluate the realism of our intervention plans and the prognosis of the parents in terms of treatment.

Conclusion
In the same way that the Society has developed an Abuse Management Manual to assist our social workers with decision-making in the field of child abuse, it is envisaged that the Foster Care Research Programme will result in the development of guidelines/criteria for decision-making in the field of foster care supervision and reconstruction services.
The outcome data has already produced a significant picture of our practice and it is envisaged that this on-going research, together with the intended follow-up study will ultimately enable us to evaluate the quality, adequacy and appropriateness of the statutory services rendered by this Society.

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It's those street kids again

We had been harrassed by one of the Cape Town gangs, who hung about outside the Homestead intimidating children and staff and demanding food – eventually our housefather said "come play soccer with us", and we employed some of them occasionally as casual labour, and handed out spare bread and fruit – reasonable relations were restored. They left one night, saying "if any of the other gangs give you any problems just give us a ring". "Thanks" we said, "Thanks" – and afterwards thought "where on earth do you phone a street gang?" (assuming you wanted to!!)

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A number of strollers who belong to a gang called "The Dock Road Kids" attend Learn to Live regularly. In the beginning they pointed out to the teachers that it was costing them a lot of money to be there. "But we don't charge" said the staff! "Yes" they said, "but imagine what we could be making in begging and stealing if we weren't here!"

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Keith, who is new to us, and extraordinarily bright, tells me one day "you know its quite difficult to be a street kid, you have to think a lot, most children don't have to think much!"

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Reggie drives me crazy; he is one of the most demanding and manipulative children I have ever known. I often end up after an hour or so, saying "Please just go away, get out of my office!" Then Annie tells him, "Choose your person; the one who looks happy and relaxed, start with (persecuting) him/her". So we play "pass the parcel." Katie takes him out of my office into the laundry, and when she can't bear it any more, sends him to Julie who sets him to scraping carrots, after a while she says "Elaine wants to see you" – We're getting better at protecting ourselves – and him!

Sibusiso is one of our children who is "all over the place", sometimes settled, sometimes at school, sometimes truanting, sometimes sniffing. He has this disarming and alarming habit of "recruiting" children for the Homestead. He has on several occasions arrived back from Guguletu shepherding confused, well dressed, and obviously reluctant children to our door. "Look, I've brought you some more children!" The social worker spends the next while returning the "candidates" to their anxious families.

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Adam was the first boy admitted to the Homestead, he is 19 years old now, very limited, charming and unsettled. Recently in Pollsmoor, he described his arrest! A gang intending to break into a laundry in Long Street gave him the job of "uitkyk" (their first mistake) – "I looked up and I looked down then a policeman grabbed my shoulder". "Wat gaan hier aan?" When our social worker saw him in prison he was (understandably) separated from the gang. "What do you need" she asked?" "'n inkleurboek" but when she brought it, they refused: "He might stab someone with the pencil crayons!" they said.

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Five boys leave ostensibly for their school in Langa. I stop at a robot at 11 a.m., there they are, foolishly and spontaneously they run over to my car, "Hello prinsipaal". "Hello." I look silently and pointedly at my watch, they realise their error, faces fall, kicking themselves they slink off.

Cotlands Baby Sanctuary in the southern suburbs of Johannesburg has opened its doors to children of all races. Di Levine interviews the Director of the home, Esmé van Zuydam, for *The Child Care Worker*

Changing to Non-Racial Child Care Services

CCW: The child care community in South Africa is at a crossroads, and we have heard of your home's decision to open its doors to all races. We need to ask some direct questions about how this affected the organisation, your staff, the children, the community. How did it start?
EvZ: Like many white organisations we were low in numbers, we had the facilities to be of use to the community, and it was frustrating that we were not fully functional. As part of a public campaign we invited various agencies to visit the home and we did a needs survey, and from this it was clear that if we were able to consider our region as a whole, there was considerable need for our services, particularly amongst the black community.

CCW: Was this an informal survey among agencies and social workers dealing with children?
EvZ: Initially the informal survey has been our method, yes. Our forward planning committee has contacted the Human Sciences Research Council who will be doing a more formal survey for us.

CCW: How did you go about implementing the changes?
EvZ: Once it was accepted in principle, I contacted the Department of Health Services and Welfare (House of Assembly) and was informed that we didn't need any permit to do this. The legal aspects revolve around the work 'occupant'. The relevant Act refers to 'the occupant' needing a permit as being the person who has certain responsibilities for the maintenance and upkeep of the property, and the children could not be defined as 'the occupant' in this sense. In effect we discovered that there is no law which prevents a creche or children's home serving all population groups.

CCW: This is helpful information for organisations contemplating similar steps. What has been the response of the various state departments, and specifically with regard to the payment of subsidies and grants?
EvZ: The Transvaal Provincial Administration (TPA) were themselves experiencing the need for services and their response was consequently most positive. Grants proved to be a little more complicated. Many people were under the impression that the grants for children placed in places of safety were paid by the Department of Justice, but this is apparently not so. In the event, we now

simply have to send our monthly register of black children to the TPA who pay the grant. At this stage all of our black children are on place of safety orders, but we don't anticipate any further problems when a stage is reached where children must be committed. Originally the plan was discussed with the Commissioner for Child Welfare and he was quite happy to place children here. All of us are caught up in the process of change: we are making adjustments from our side; the TPA is going to have to make its own adjustments as these changes progress. We have found government departments very flexible, and I feel it is recognised that with the challenges we are all facing at this time, everyone has to have an open mind when it comes to making changes.

CCW: Another factor which children's organisations fear is the response of local neighbourhoods, with possible negative consequences for the children concerned. Has this been easier for you because you deal with such small children who are not of school-going age?
EZ: We have had no resistance or complaint from any of our neighbours, and we are in a residential area. Our children do go out quite a lot; visitors and volunteers often take children out. The neighbourhood is consequently very much aware of the changes, but there has been no problem.

CCW: How have staff handled the changes?
EvZ: Very positively. We are all pleased to have the organisation operating properly. And of course many of our child care workers are black people who feel good about the organisation serving all races.

CCW: Any anxiety from white parents?
EvZ: No, as a matter of fact, we have had no resistance from this quarter. There was one enquiry, but once it was explained that this is the pattern for the future in our country, this was accepted.

CCW: What other adjustments have your staff, and your organisation as a whole, had to make? How, for example, do the problems of the children differ?
EvZ: An interesting difference has emerged: the black child is more often neglected or abandoned, while the white child is more often abused and battered. So the black children, although deprived, present less troubled behaviour because they did not go through the same levels of emotional abuse. Once attention is paid to their physical needs, their nutrition, stimulation and human interaction, these children thrive. It is a joy to see their positive response to even simple things, they have been so deprived, even a ball to play with means great excitement. So there are good rewards for staff as well.

CCW: Tell us about the success with reconstruction work which can be achieved towards placing children permanently with a primary caretaker.
EvZ: Here there is an important difference from white children, since so many of our black children are abandoned and thus there are no parents known to us or to the agency to work with. Whole new strategies are used, and a lot is done to try to find the parents or

family. For example, photographs of our children are published in *The Sowetan* in the hope that we may trace some family members. But once this proves unsuccessful, the agency is then altogether free to explore other alternatives like foster care or adoptive parents.

CCW: Which raises the issue of a likely change to Section 40 of the Child Care Act with the possibility of multiracial adoptions in the future. Does your organisation consider this at all?
EvZ: I think quite simply that we have to consider all options, and certainly our organisation has thought about this. We have the situation where there are long lists of prospective adoptive parents in South Africa, and once the Act is changed we will be able to see to what extent multiracial adoptions "happen".

* * *

Disentangling ourselves from apartheid thinking at this level is going to be difficult. In Britain, for example, multiracial adoptions are frowned upon since, along with the United Nations Convention, there is the strong belief that a child has the right to be brought up within his own cultural, language and religious context. Yet here in South Africa we have another set of needs amongst our children. At the institutional level we are also having to learn a new lesson: child care's origins lie in precisely this need for home, food and shelter, and it seems that the wheel of our service is turning full circle. As we try to provide for homeless and abandoned children, we need to rediscover those roots, hoping that what we all learned in the meantime can be usefully applied to our basic care. This insight from Cotlands Baby Sanctuary shines a little more light (and perhaps removes some more of the shadows) on the road we are now waking.

Five Years Ago

For readers who weren't around then, this regular feature remembers features from the pages of this journal this month five years ago

September 1985

The National Conference in Durban took pride of place in this issue. Key- note Speaker Vish Supersad had challenged child care workers on preparing their children for the future, as well as on helping them deal with the current violence and political realities. (The text of his address was to be published in a later issue). Ernie Nightingale's Chairman's Report reviewed the progress of the previous two years, but in warning that a great deal of work lay ahead, he asked for more input from the grassroots and practice levels: "What form this work will ultimately take, depends very much on the direction we receive from you, our members." In a letter to the Editor John Webster summed up his impresisons of Conference: "Applicable, relevant, gainful, productive, exciting, terrific, magic"

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Three clinical psychologists contributed to the issue: Peter Harper wrote on *The Child in Therapy*. An extract: "Characteristic of the problem children I see in therapy is their perseverance and courage to continue – to the extent that I have often though we adults could do well to take a leaf out of their books." L.R. Naidoo from Natal University wrote in *Essential Principles of Discipline*: "Remember that growth to adulthood requires that a child develop his own inner controls." Thirdly, Peter Long of Tafelberg School in Cape Town gave a helpful view of *The Specific Learning Disabled Child*. "Teachers who lack insight into the needs of the specific learning disabled child may cause unnecessary damage. It has been said that some teachers do not accept that under-achieving children who appear normal in all other respects (including having an average IQ) can possibly be anything other than 'lazy' – and therefore believe that added pressure and discipline is required ..."

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Dr Jeannie Roberts of the School of Social Work at the University of Durban-Westville threw out an interesting question when she asked *Child Care a Method of Social Work?* She quotes a 1973 British report which held that " ... residential care is an intrinsic part of social work" as well as Henry Maier in 1963 who felt that residential care should be seen as 'the fourth method' of social work. More contentiously Roberts says: "In practice, child care in residential settings is nearly always regulated by the social work agency." And there were no furious letters to the Editor from territorial child care workers!

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Sharon Bacher (who contributed the fiction piece 'Paully' in our April 1990 issue) in writing on *Sex Education* made the point that sex education is far more than learning 'what goes where'. It involves "the acquisition of gender identity, healthy attitudes to one's body, physiological needs and functions, a sense of ease with one's own sexuality – and the teaching of sexual morality." Bacher drew together some particularly helpful threads relating to sex education and children in care, recognising the significant factor that "these children have a deep need and yearning for physical affection and closeness. To the immature teenager it may seem that a solution exists in a sexual relationship"

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Dr Bala Mudaly had reported on his doctoral thesis in April 1985 and had discussed the phenomenological approach to child care research in July 1985. In this issue he contributed *A Study of Youth in Children's Homes: Some Reflections on their Personal Lives*. He challenged three generalisations: that children's homes are places of *temporary* care; that children's homes are only fit to be used as a last resort; and that social workers and child care workers (as adults) know what is best for destitute children. Mudaly sees the child care worker as "the closest professional person to the child, from the time of rising in the morning to the time of going to bed at night ... a little of many professions, teacher, social worker, parent, nurse, sports coach, trouble shooter".
There is a plea for less emphasis on yesterday and tomorrow, and more on what is today. The worker's task is "constantly to challenge and engage young people to be actively involved in decisions about themselves." If we help youngsters to feel some fulfilment, strength and peace today, there will flow a sense of betterment in the future when they will have better yesterdays to look back on. He quotes the Indian poet Kalidas:
Yesterday is only a memory / And tomorrow only a vision / But today well lived / Makes every yesterday a memory of happiness.

On being the parent of a handicapped child

Many of the basic problems with which parents of handicapped children have to deal come directly from society. Such problems originate in society's perpetuation of certain myths or frauds, to put it bluntly. We are especially susceptible to these myths as we are growing up. One myth encouraged by the romance magazines that teenagers read is that marriage is "eternal bliss". Another more pertinent myth is that of this eternal blissful union will come children who are both physically and mentally beautiful and perfect. Therefore, the parents of a handicapped child have not lived up to the "ideal" and have produced an imperfect replica of themselves. This may cause much unconscious, if not conscious guilt, as well as feelings of inferiority. At the same time, if parents are unfortunate enough to have a handicapped child (which society says subtly they are not supposed to do), society then hypocritically says they must be superparents. They must supply enormous additional amounts of care, love and attention to their child. They must do this, additionally, on a 24-hour a day, 365-day a year basis; otherwise, they are superbad.

As a professional evaluating a child's progress, I can be the most patient, empathetic person on earth for half an hour. I can look critically at the impatient, harried parent. Unfortunately, many professionals encountered by parents of handicapped children do not take the 24-hour a day, 365-day a year responsibilities into account in their evaluation of the parent.
In the back of parents' minds then, is a vague awareness that society is looking over their shoulders and judging whether they are carrying out their prescribed duties, giving much love, attention and devotion, not missing any treatment appointments, providing the best available care etc. This is a "goldfish bowl" type of existence which eventually takes its toll in energy, strength and courage.

Parents of handicapped children must realise that fleeting moments of resentment and rejection of the burdens presented by a handicapped child are natural and do not indicate that they are bad parents. They need to seek help in solving their practical day-to-day problems. The best help can be found in interaction with parents who have experienced and solved such problems. Even though every family's situation is unique and what works for one family may not work for another, having someone with common problems with whom to interact is in itself therapeutic.
Parents must realise also that only by banding together can they bring about the changes in society that are needed. Legislators and other government leaders listen to groups when they might not listen to individuals. Therefore, in order to have their voices heard, parents of the handicapped must unite and seek common goals for their children's welfare.

– Bobby Greer

The above was part of an address in 1974 (and today, 15 years later, it is just as relevant as it was then) by the author, who is handicapped himself, and is also the father of a handicapped daughter. It is reprinted from the "Advocate" (Spring 1987 issue), the magazine of the Autism Society of America.

October Diary

Western Cape

09 08:30 Regional Executive Meeting *Regional Offices*
16 09:30 Forum (Venue to be advised)
25 08:30 PPA course meets *Siyakhathala Place of Safety*
25 08:30 Child Care Workers Skills Conference *Marsh Memorial*

Natal

16 09:00 BQCC 2 *St Philomenas*
19 09:00 Child Care Workers Forum Meeting *St Philomenas*
19 09:00 Social Workers Meeting (Venue to be advised)
23 09:00 BQCC 2 *St Philomenas*
26 09:00 Annual General Meeting of the Natal Region *Ethelbert*
30 09:00 BQCC 2 *St Philomenas*

Transvaal

15 09:00 BQCC *Bramley Childrens Home*
17 09:00 BQCC *TMI Johannesburg*
17 09:00 BQCC *Norman House East Rand*
19 09:00 Social Workers Group *NACCW Offices*
22 09:00 BQCC *Bramley Childrens Home*
24 09:00 BQCC *TMI Johannesburg*
24 09:00 BQCC *Norman House East Rand*
25 10:00 Child Care Workers'
30 09:00 PPA NACCW Group *NACCW Offices*

"Where have you been?"
"Out."
"Who did you see?"
"Nobody."
"What did you do?"
"Nothing"
"Did you enjoy it?"
It was OK."

Health of Street Children in Cape Town

Paul Eric Gebers

Extracts from a dissertation submitted by Dr Paul Gebers to the Department of Paediatrics and Child Health at UCT for the degree of M. Med (Paed.) in 1990.

Throughout the world the care of children in especially difficult circumstances has emerged as a problem in the 1980s. Many children in underdeveloped countries as well as developed countries are neglected, abused or exploited – these include street children, refugees and victims of war and natural disasters. The phenomenon of street children is world-wide. This is also an old problem, perhaps seen in a new light. We read of street children in novels such as *Oliver Twist* of Dickensian times, and *Huckleberry Finn*. However these novels have romanticised the situation of vagrant children. Morris West wrote a book called *Children of the Sun* to start a fund for street victims of Naples in the early 1950s.

In South Africa the concerned public, as well as people involved in the care of children, are taking an increasing interest in the plight of street children. In the *Weekend Argus* of 25 March and 1 April 1989 extensive coverage is given to the extent and implications of the problem. Further articles have continued to appear in the lay press throughout the year. In the Cape, street children were first mentioned as early as 1917 in the Annual Report of The Society for the Protection of Child Life. But it was only in 1978, when the Vagrant Shelter opened in Green Point, that people involved noted that there were an extraordinary number of children among the vagrants seeking food and shelter. Recognising the need, the Child Welfare Society opened the first shelter for street children in Cape Town in 1982.

Definition of Street Children

In the widest sense "a street child is one who has made the street his real home" (UNICEF). Richter quotes Cockburn's definition of street children as "those who have abandoned (or have been abandoned by) their families, schools and immediate communities before they are sixteen years of age and drifted into a nomadic 'street life'".

Ennew further distinguishes between "children on the street" and "children of the street". The former are those children who are on the street to contribute to the family's income by begging or working and then returning home at night; the latter group are those who have made the street their home.

In South Africa street children are known by various names. In Cape Town they are known as "Strollers". In Johannesburg they are referred to as "Amalalapayipe" (those who sleep in pipes) or "Amalunde" (those of the streets). Other names are "Twilight Children" and "Skadukinders".

Demography

The demography of street children has been widely studied. Shane reviewed numerous articles in which a recurring thread is the abuse, neglect and rejection of the young person by one or both of the parents. Newsweek noted that street

Summary

This cross sectional study looks at the health profiles of street children both in institutions and on the street between May and November 1989. The former group had a clinical examination, with blood and urine investigations done where possible; the latter group were only interviewed.

159 street children were interviewed of whom 47 were interviewed on the street. 73 children had clinical examinations; 64 of these had blood and urine investigations.

The age range was 8 years to 19.8 years. 18.2% were females and 28.3% were black.

59,6% of those interviewed on the street had not been in an institution or shelter for street children. 27,2% of the total group had been on the street for more than 3 years.

Health issues

37,1% perceived colds and chest complaints as their main physical health problem. This was confirmed by the fact that 69,2% had a history of respiratory problems.

44,7% said that they would go to a hospital if they injured themselves or were ill; however 36,5% said they would not use or get any medication for problems such as a headache or a bad cold.

37,7% of children used a hospital while they were on the street but 59,7% had not used any facility while on the street.

Most street children (72,8%) washed themselves at least occasionally and 61% washed their clothes.

47,2% had suffered trauma significant enough to seek hospital attention.

56% had skin problems (including lice and scabies) while on the street.

15,7% complained of visual problems and 10,7% complained of reduced hearing.

Dental problems appeared to be of major concern with 37,7% complaining of either toothache or dental caries (23,3% had obvious caries on examination).

73,4% admitted to solvent abuse, 49,9% had never taken alcohol and 12,7% had never smoked.

43% had tried dagga, 10,8% white pipe (mixture of dagga and "Mandrax" which is smoked) and only 7,6% "Mandrax" alone.

10,9% of boys and 10,0% of girls indicated that they had been sexually exploited.

Of the 67 examined 32,8% were below 90% of expected height for age, 44,8% of expected weight for age and 8,6% had a circumference of head below 95% of standard.

There is a 9,4% hepatitis Bs ag carrier rate. No HIV (human immunodeficiency virus) antibodies were detected in 64 sera tested.

Recommendations

On the basis of these results, the following are recommended:

1) Improving accessibility of health care resources.
2) Improving the availability of health care resources.
3) Initiating contact with street children by employing field health workers.
4) Drawing up a health care policy for street children institutions and field care workers.
5) Limit venereal disease management to single dose treatment where possible.
6) Further studies need to be undertaken in the following areas:- solvent abuse, utilisation of health care resources, utilisation of street children shelters and institutions

Further breakdown of habits, physical problems and results of examinations are presented.

children are a symptom of larger problems – "Fever blisters that signal economic and social ailments" – in the countries that they occur.
When seeking figures and statistics concerning street children it is not surprising to note the discrepancy between figures quoted by child care organisations and governmental agencies. The world total is estimated to be between 8 million and 80 million. This figure is a "guesstimate" as one can understand that it is difficult at times to distinguish between children on the street and those of the street. The greatest number of street children occur in South America. In Southern Africa the estimated number of strollers is 9000 with approximately 800 in the Western Cape. The estimates for Cape Town are between 300 and 600.
Most of the daily activities of street children, be it for survival or for leisure, put their health at risk. Survival activities include begging for money or food at traffic intersections, "flagging" or parking cars for money and selling sexual favours, while leisure activities include such activities as solvent abuse, smoking cigarettes and dagga and mandrax tablets as well as alcohol abuse. Other daily activities which can put their health at risk are the children's ignorance about the elements, particularly in relation to their sleeping arrangements, which range from sleeping under the bushes to proper shelter. A large number of street children appear to be knocked down by cars and are subject to assault by older street children, gangs and members of the public, including the police. Personal hygiene of these children would be compromised by the inadequacy of washing facilities and by attitudes of other street children. Although medical and dental services (preventative and curative) may be available, the lifestyle of street children suggests that any authority situation would be avoided as far as possible.
For all these reasons, street children appear to be at a greater risk for ill health.

Discussion
In an international literature review no report was found in which the physical health of street children is documented comprehensively. Locally, apart from the Khayamnandi studies (Henneberg, Shelton and Geard) and Richter's anthropometric study in Johannesburg, no other physical health record has been reported. International studies that are of value for comparison are the Toronto studies and the Boston study because they specifically examine the physical health of street children. In most other international studies the health of street children is either discussed superficially, or is discussed as part of the problem of homeless families or vagrants. Other international studies look at aspects of street children problems such as physical and sexual abuse.
It is therefore appropriate to compare the findings with trends, apparent problems and objective observations. Furthermore data from the study group (157 children) will be compared with data from those interviewed on the street only, (46 children) to indicate either representativeness or differences.

Age
The median age of boys in the total sample was 14,5 years and of girls 15,2 years. The median age in the institutions was 14,2 years with a range of 8 - 19,6 years and on the street the median age was 15,4 years with a range of 8,7 – 19,8 years. Coloured females had a median age of 15,5 years in the institutions while on the street the median age was 17,1 years, whereas coloured males in institutions had a median age of 13,9 years and on the street of 15,4 years.
Statistics for ages of street children in Cape Town are available. The age range for girls in 9 - 21 years with the majority being between 13 years and 17 years (Keen) and for black and coloured males 7 years and 16 years respectively (Richter). The Khayamnandi study noted the age range of black boys as 9 to 17 years with a mean age of 13 years 3,5 months. Garman noted a *mean* age of 16 years 2 months (N = 15). However, one was aged 23 years. Richter's study noted that boys in Johannesburg had a median age of 13,5 years with a range of 7 to 18 years. In Swaziland the majority of boys were aged between 11 and 14 years. In the Philippines 40% of the street children were less than 7 years old. In Toronto 75% of the sample were 15 years of age or younger. In Columbia the average age was 11,6 years (although the non-random sample selected were age 7 to 16 years) and 42,5% were up to 11 years of age. In the Philippines most were in the 10 to 14 year age group.
The limitation of age on admission and the self-reliance of older children would explain the older age of boys on the streets. The older age of girls on the streets (Keen) has previously been documented. One may however, also interpret the younger median age of children in institutions as indicating the importance of shelters in providing the basic necessities.

Race and sex
This study noted that 81,1% (129 children) were male and 18,9% (30 children) were female. Swart noted that in Johannesburg the street population was predominantly male and black. Scharf noted that 10% of the street

children in Cape Town were girls (May 1985). In Cape Town 71,7% of the street children were coloured. In the Philippines 85% of the street children were boys. It makes no sense to compare racial make-up with international literature because of the different populations.
Girls are an integral part of the population of street children in Cape Town. Black children were all Xhosa speaking, although 3 were from the Sotho region. With the rapid influx of black people into the Western Cape the black children will constitute more and more of the population of street children and so their specific needs will have to be addressed. (e.g. Khayamnandi Home for Boys)

Education
The education level indicated implied the highest level of education achieved. 3 children had received no education at all. The median level of education for boys was Standard 2 and for girls Standard 4. Girls were generally better educated than boys and 29,7% of coloured males had more than a Standard 3 education as opposed to 18,4% of black males. McNamara (N = 22) noted that 19% of black boys had attained more than a Standard 3 education. In the Khayamnandi study (N = 13) 46,1% had achieved more than a Standard 3 education (black boys) whereas in the Richter study (N = 97) 34% had achieved more than a Standard 3 education. Bothma's study (N = 9) 44,4% had achieved more than a Standard 3 education. Garman (N = 15) noted an *average* education level attained of Standard 3. Pinnock noted that most children on the Cape Flats had only passed Standard 3. This was a similar finding by Scharf. In Toronto most street children had dropped out of school before turning 14 years of age (approximately Standard 6 education).
Black boys are worse off than their female and coloured counterparts. Rich-

ter notes that a "pass in Standard 2 is considered the minimum education level" for literacy. The majority of street children are functionally illiterate. The findings are compatible with other studies (Pinnock, Scharf) and are an indictement on the state of education in South Africa. It is difficult to compare with international literature because of different educational systems; however internationally there is also an early school leaving age and the majority of street children are barely literate.

Origin

96,8% of street children in Cape Town are from the Western Cape, with a large number (45,9%) of those from Cape Town coming from Bonteheuwel, Elsies River, Guguletu, Mitchells Plain and Khayelitsha.

No local study is large enough to give some meaning to the origins of street children. Richter noted that 87% of the sample came from the Johannesburg/Witwatersrand area. In Columbia Aptekar found that 51% of street children in Cali (the capital of Cauca State) originated from Cali. He noted that in Ganados's Bogota study 41% originated from Bogota. Kerfeldt's study in Calgary, Alberta, Canada noted that 74% came from Calgary itself. However in San Francisco only 28% came from the city itself, with the majority coming from the surrounding regions.

This study also noted that 31,5% had previously been in either a reformatory or a place of safety and that 23,9% had not been living at home before going onto the streets. Richter further noted that "second order runaways" (children who have run away from institutions such as orphanages) accounted for 10 - 20% of the street children population. She also noted that 19% had been previously admitted either to a reform school or a place of safety.

Other studies have also noted that only a small number of street children are as a result of being orphaned (8% Richter) (6% Scharf).

Most street children originate from the immediate metropolitan area. However street children are present in areas other than the large metropolitan centres. The geographical situation of the city or town in relation to other centres, the ease of access by transport as well as the political situation account for major differences (e.g. San Francisco versus Calgary). The migrant labour system in South Africa brings its own unique situation.

Admission to street children institutions

59,6% of those interviewed on the street had not previously been in a street children institution. 49,1% of those interviewed in the institutions indicated that it was their first admission. Of note is that 23,3% of the total sample (21,3% of those interviewed on the street) had been admitted on three or more occasions (for more than two consecutive nights) to these institutions. Most of the children in Patrick's House had been referred from The Homestead.

Time on the street

35,3% of street children interviewed had been on the street less than 6 months whilst 27% had been on the street for more than 3 years. As Richter has indicated, time on the street is not necessarily a single period but may be interspersed with time spent at a home or in a street children shelter. She further described three groupings of "time on the street". Those who rapidly make their way to institutions, i.e. less than 6 months (36%), those who were on the street for 12 to 18 months (44%) and a more "chronic" group of children who were on the street for two years or more (20%). Aptekar found that 66,7% of the street children of Cali, Columbia had been on the street for less than two years.

It would appear that the longer the child is on the street (Richter, Saltonstall) the more he/she is distanced from rehabilitation resources and becomes absorbed into the street life culture.

Sicknesses

37,1% of street children perceived colds and chest ailments as problems. Only 5% perceived motor vehicle accidents as a problem and 17% assaults or burns. Comments were made such as "lots of problems because we live like bergies (vagrants)", "get dirty" and "get cold". Another noted that his problems were from solvent abuse. These comments were the exception rather than the rule. No other data exists on what street children perceive as being physical health problems on the street.

When considering the number of street children who have been pedestrian victims in motor vehicle accidents (MVA) (11,3% while on the street) as opposed to assault (15,7%), it is evident that MVAs are not considered a problem, despite the severity of the outcome in most instances (89% required admission).

The fact that 10,7% did not know what physical problems were encountered and 7,5% indicated no problems, implies either a poor self esteem or a lack of understanding of the physical health of fellow strollers. Saltonstall notes that street children accept the environment and physical health problems as part of the street culture, i.e. abnormality has become "part of a standard".

Medical resources

59,8% indicated that they would use a hospital (day or general) for a serious physical ailment, 3,8% would use The Homestead and 20,8% nobody at all. As far as obtaining medical supplies for minor problems, 36,5% did not worry about the problems, 18,9% used a hospital and 2,5% used The Homestead. The corner cafe was an important source of supply (22%).

Answers to actual facilities used noted that 37,7% used a hospital (although on questioning about admissions while on the street the figure obtained was 47,2%), 16,4% the dentist, 3,8% the TB clinic and 1,9% the veneral disease clinic. (Some indicated that their veneral disease was treated at the hospital.)

An incident recorded by Bothma relates that a girl was reluctant to go to a nearby hospital following trauma as she had not paid a bill for her confinement.

Only 15,1% indicated that they would use a day hospital despite the fact that the day hospital in Cape Town is in the central Cape Town centre. A number indicated that they found the service better at the general hospital as opposed to the day hospital. At the day hospital they were considered a nuisance and problems arose because they were not escorted. A small number would use a street children shelter. If medical facilites were improved this would become an important factor in drawing children from the street.

Of concern is the lack of use of available resources. In London and Toronto mobile vans have been introduced with effect to improve the access to basic health services. The Toronto mobile medical van offers assistance from counselling to management of sore throats and testing for venereal disease and hepatitis. In London the homeless tend to be "mutually supportive" rather than using day centres or clinics. In San Francisco a "comprehensive array of services" are offered in a clinic directed towards street youth. Miller *et al.* investigated homeless families in King County, Washington and concluded that there was an under-utilisation of medical services. The American Academy of Paediatrics also documents a problem of access to health care by the homeless. McCormick found that the reasons why the youth were not uitlising large hospitals and clinics were that the young people "lacked trust" and found the health care resources intimidating as many of the health care providers showed a "lack of tolerance of the kids and their life styles". Other problems included unrealistic expectations of youth on the street, a fear of involvement with the medical establishment/authorities)

and a lack of understanding or education about basic physiological and health care issues (Manov). Brickner in New York also noted the problem of access to health care. Goldman quoted from a study by Goldberg on Toronto's street children where they found that there was a reluctance of street children to seek medical advice, that non-compliance in these adolescents was a problem and that few were "candid" about their circumstances. This last statement implied that the physicians or health care givers were not able to recognise or meet their real needs (Drake).
Manov showed that street youths are an "extremeley high risk, hard to reach population whose multidimensional health care needs are largely unmet". She further stated that these youths tended to delay preventative and interventive medical care until there were genuine dysfunctional problems.
This study has revealed the inadequacy of medical facilities and resources for street children in Cape Town, which is exacerbated by the lack of tolerance and understanding for these children at these facilities.

Bathing
73% of the street children interviewed, bathed. However of the total sample, only 48,4% bathed regularly. The facilities most often used were the municipal showers or baths (63,8%). Other facilities used included water from taps used by the flower sellers and showers on the beach front at Sea Point. Clothing was washed by 61,6%. Bothma noted that in a group of strollers a canal was used regularly for bathing and the washing of clothes was assigned to two girls in the group. (Children in Bogota were using the fountains for bathing.)
41,6% of children either never bathed or bathed irregularly. The strollers of central Cape Town have access to a very good, clean and well maintained public washing facility. I am not aware of other such facilities existing in other areas where street children congregate.

Sleeping facilities
Most street children sleep against a building (61%); this may be a verandah, in a doorway or in an alley. Generally however, most children sleep in situations which do not afford much protection from the elements, be it wind, cold or rain.
In Nairobi children slept in doorways or rubbish skips. In Botswana they slept in culverts, empty buildings and vacant lots. Other references are to makeshift shelters and under bridges, in the veld or mountains, in bus terminals, subways or parks. Some would use just a blanket or sleep under a coat or newspaper.
Sleeping facilities constituted a major problem for street children as they felt unsafe at night, were often robbed of their belongings and also had difficulties with sleeping. They often complained that they got cold at night or had aches and pains from the hard sleeping surfaces.

Past medical history
47,2% of strollers had been admitted to a hospital while they were on the street. A large proportion of these admissions were due to trauma (MVA 36%, assault 60% and other 14%). Overall, of the total sample, 31,4% suffered some trauma whilst strolling. Of those assaulted on the street (N = 18) needed admission: 1 laparotomy, 3 for chest drains, 1 fracture of the femur and 13 for observation and wound care.
77,8% of those involved in a MVA (N = 18) were admitted and 8 of these had fractures. Of the total sample therefore (N = 159) 5% required admission to a hospital for MVA related trauma. In all these instances the trauma was incurred while victims were pedestrian.
The majority of admissions to a hospital while strolling, other than for trauma, were due to respiratory tract infections. Two individuals had been admitted for rheumatic fever; 1 of these whilst strolling.
Richter noted that 34% of her sample had received a head injury at some time, of which 52% were as a result of assault and 48% were as a result of an accident (some related to car accidents and some to solvent abuse).
Trauma plays a significant part in the morbidity of street children. By virtue of their daily activities they are constantly exposed to the dangers of vehicular traffic.
However it appears that their abuse of solvents (Sokol) as well as drugs alter their perceptions and reflexes (SANCA, Watson) and results in this high trauma rate.
Physical abuse by the public and police are also commonplace (Scharf, Swart). The hospitals most frequently used are dependent on the street children's proximity to the various hospitals. The New Somerset Hospital was used for 42,9% of admissions. A number of young children said that they had been turned away from Groote Schuur Hospital for being "under age".

The bibliography for this feature can be obtained from *The Child Care Worker*, P.O. Box 23199, C laremont 7735. Telephone/Fax: 021-88-3610

COURSEWORK

The Diploma in Child Care Administration

Many enthusiastic applicants for this course breathed an audible sigh of relief when they heard that the commencement has been scheduled for January 1991. The course planners initially intended the course to begin in July 1990, but due to various practical difficulties and by popular request of interested candidates the course will start at the beginning of next year.
The NACCW is for the first time offering a distance teaching training programme. This means that students receive child care management training without leaving their job. Their work environment is in fact used as the classroom and the framework in which the theoretical material is integrated.
Nationally recognised experts have been involved in compiling the course content. Scheduled telephone conferences with the lecturers will support and assist students with assignments which are directly related to their ongoing practice.
At a seminar in the middle of the first year and again in the second year students will have an opportunity to meet other candidates, to share their progress and problem-solve in a course conference with lecturers and other experts in the field.
Each of the two years of study is divided into two semesters. The last semester of the second year is a supervised practicum during which students will develop a project of their own choice which will integrate course material with their work situation.
Admission to the course is open to matriculated occupants of senior and middle management positions in residential care settings.
Fees are R750.00 per semester. Enquiries regarding financial support can be addressed to The Children's Foundation. The fees include all study material and tuition fees. Only twenty students are accepted for each class, and applications (available from the NACCW's National offices) must be received by no later than *20 November 1990*. You now have another chance to apply if you have not already done so.

– Marcelle Biderman-Pam
Course Co-ordinator

How the man-in-the-street sees the children's home

"Dear/Hello Mrs Social Worker
I hear that my grandchild/niece-nephew/stepchild/half-sibling/neighbour/child's school-friend, etc., etc., is in your Home ...

Is he/she allowed:
to go out *or*
to have visitors *or*
receive letters *or*
receive or make phone calls *or*
receive gifts *or* sweets *or* extra pocket money?

Can I take him/her out for a burger?

I thought that once the welfare got hold of a child nobody else had a say ...

I've wanted to contact the Home for ages ... (but I was too scared).

I didn't want to interfere ...

I thought he/she would be looked after by you people until he/she is 18 ...

I knew they'd gone to the place of safety, but then I didn't know what had happened to them ... "

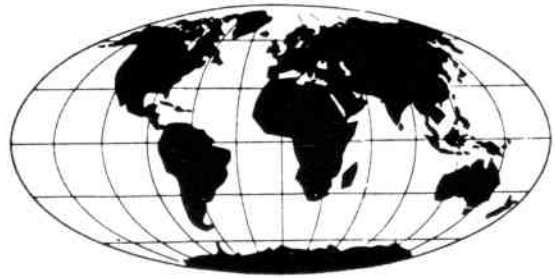
These are but a few true examples of what we have seen, read and experienced over the last few years. It is quite shattering to realise the impression that the man-in-the-street has of the 'welfare', 'homes', etc.
Do some people really believe that children are removed and banished, to suddenly reappear in the community at age 18?
We have developed a policy, whereby soon after admission and with judiciousness and discretion, we encourage children to contact extended family members and friends and inform them of their new address, phone number and relevant details (e.g. visiting and telephone times, contact persons, etc.) and to encourage them to keep contact.
All it usually requires is a telephone directory, a few phone calls, and/or writing paper and stamps. It makes the child feel that they haven't been 'deported' from their communities and rejected by previous contacts who meant a lot to them. We have found this to be so, especially where the child has a deceased parent.
By being involved, the child care worker or social worker ensures that the correct information is imparted and the person contacted is assured that this has the Home's blessing. This friendly attitude usually makes the task of pursuing contact with the child less daunting for the person(s) involved and after chatting informally to staff, some sort of relationship is initiated.
The time spent by the worker with the child, is concrete proof to the child of care and concern and helps cement bonds. It also reassures the child that he/she is not being 'taken away', but that he/she and his/her whole world is being accepted and welcomed.
The positive role which some grandparents may be able to play at a time like this, cannot be over-emphasised. Grandparents also hurt when families split up, their own children suffer trauma and they lose contact with grandchildren. Their relationship can be very special, involving quality time, positive input and providing an anchor and a sense of belonging. By giving love and security during this rough period and by telling the children about their roots, maternal and paternal, gives them a sense of identity and belonging.
Children need to feel loved and accepted by everyone even though the family has been separated. The mutual hurt often draws them together and in our experience, we have definitely found this to be true.
Let us as staff do something to dispel the myths of the man-in-the-street regarding children's homes.

— *Margaret Davison*

A Prize for Child Care

A South African child care worker could win R15 000 for her favourite charity in a competition which will be held nationally for the first time this year.
A national search has been launched in South Africa to find and reward those people who have rendered exceptional service to the infant community.
The winner of the Glodina/Procare Award for Service to the Infant Community will be able to nominate a charity or service organisation to receive a Fifteen Thousand Rand award, according to a press release by the organisers.
A spokesman for the two sponsor companies said that they had long realised that while many businessmen and women were rewarded for high profile endeavours, those who work behind the scenes in less visible yet vital areas were seldom rewarded.

The inaugural award, which was offered on a regional basis in Natal last year, was won by Sister Lorraine Ibsch for her dedicated work as housemother at a school for the handicapped in the early 60's and her present work at the Edith Benson Babies Home. This year the competition has been extended country-wide.
Judges in this year's competition include popular television personality Adrian Steed, whose concern for South Africa's youngsters is legendary, as well as Adele Thomas, Director of the Johannesburg Child Welfare Society.
Candidates for nomination must be actively engaged in caring for underprivileged infants younger than three years of age. It is not necessary for this to be a formal job situation, as the degree of self-sacrifice and conditions under which the nominee performs his or her tasks will all be taken into account.
Nominations, together with a few paragraphs as to why it is believed the candidate deserves the award, should be sent to Glodina/Procare Award for Service to the Infant Community, Box 47566, Greyville, 4023. Closing date for entries is November 29, 1990.



Newsbriefs

NATAL

Regional Meeting

This took place at St. Thomas' Childrens Home in the fairly recently completed Nursery School premises. What a happy feeling came through to us from both the staff and children. Our thanks to St. Thomas' for their hospitality.
A presentation was done by the Child Care Workers forum and took the form of role plays to illustrate the need for support and communication systems for child care workers within their organisations. Let there be no doubt that we have acting talent in Natal!
Feedback from small group discussion brought forth concern about the rights of the child care worker in the event of abusive action by a child and the recognition that child care workers must acquire management skills to cope with their jobs. These issues, along with others identified by child care workers attached to Forum, will be channelled through the Regional office for programme development.
It was good to see child care workers, new to NACCW's activities, making contact with colleagues from other organisations – the spirit of the NACCW in action.

The Annual General Meeting of the Natal Region

The Annual General meeting of the Region takes place on the 26th October at Ethelbert Children's Home, Malvern at 9.00 am. The National Director will be the speaker. Please make a note of the date and make every effort to attend.

School Holidays

These are upon us again and extend through until the middle of October. Consult the diary for dates of the BQCC etc.

Zulu BQCC

The course offered in Pietermaritzburg is now completed and by the look of the results we can be very proud of colleagues who undertook the lecturing. Evaluation by students of notes and the structure of the course was very positive though, as always, there was the plea of "too much work".

Social Workers Group

This group continues to meet. Most recently Boys Town, Desainagar hosted us and explained the peer group system and their programme.
The next meeting is scheduled for the 19th October.

TRANSVAAL

Graduation Party

Our Graduation Brunch will be held at the Johannesburger Hotel on Wednesday 28th November 1990 from 09h30 to 12 noon. The hotel requires a substantial deposit before that date so it is necessary to book your places by remitting the amount of R20-00 to the NACCW offices before November 5th.
We hope to provide the same music you so much enjoyed last year once again.

BQCC

A Social Workers Group will take place on October 19th at 9 a.m. at the NACCW offices.

Problem Profile Approach

The NACCW group doing the PPA course will meet on October 30th at the NACCW offices.

A Trip to Israel

Coleridge Daniels of Leliebloem House

In July this year a group of twenty community and youth leaders from South Africa completed a four week intensive workshop at the Histraduts International Institute for Development, Co-operative and Labour studies (Afro-Asia Institution) in Tel-Aviv. This was the 11th workshop on the role of people's organisations in community and nation building. The concept of the workshop was developed in response to requests made by leaders of the Labour movement in our country who wanted a tailor made programme designed to answer the needs both in terms of the content and in terms of time frame. Thus the workshop has taken on the character of an intense and comprehensive program of relatively short duration limited to a small number of participants.
The aim of the 11th workshop was to examine in depth the problems and the potentialities of our people's organisations in our communities for greater participation in the developmental process.
A proposition that these organisations must expand their areas of active concern by embarking on economic and social welfare projects was a central focus. The workshop was modular in form and was built around five main themes in addition to the Introductory and Concluding sessions. These themes were:

1. Development and Underdevelopment

- The comprehensive nature of the development process.
- Aspects of development such as population policy, the urban and rural economies.

2. The Labour movement in developing countries

- Industrial relations and collective bargaining.
- Workers participation in management
- Economic activities of trade unions and co-operatives.

3. Expanding the horizons of the Labour movements

- Basic need satisfactions; health, education, old age care, child care, pension and provident funds.
- The labour movement and community development.

4. Danger of Adolescents at Risk

This module was a fine tuning programme which is designed for the personal, social and economic development of young people who leave or drop out of schools each year with very little hope of finding a job or their true place in society.
A background:
a. Any program aimed at socio-economic development of adolescents must be built on solid participation by the community.
b. All research has shown that the informal sector of any country is far more efficient and productive in providing employment for people.
c. The most important fact which prevents people from either employing themselves or seeking employment is not the lack of skill training but negative attitudes towards work and life.

5. From Theory to Practice

The experience and character of the Histradrut (they are the General Federation of Labour of Israel) provided a background case study for the workshop. Each participant was asked to play an active role in each part of the program by presenting relevant material from the experiences of his or her own organisation. Thus a real dialogue developed amongst the participants. At the conclusion of each theme, reports were presented by each participant. These reports were discussed by the participants and staff and conclusions were drawn constituting a fascinating insiders view of each organisation present. In the case of a workshop like this one, demanding the active participation of all and a free flow of knowledge and experience heterogenity has many advantages over homogenity.

To sum up such an intensive workshop as this one is very difficult. Perhaps it would be more appropriate to quote the words of one of the participants at the final evaluation session. "The lectures, the study visits, discussions and the knowledge and experience thus gained has been enormous. The workshop has been organised in such a manner as to bring about interaction among participants and in my opinion the lasting positive results are the strengthening of national solidarity. It also enabled the participants to physically experience the concepts of co-operation in the kibbutz and moshavs as well as the role of the Histradrut. The participants will have the opportunity to utilise their knowledge and experience gained at the workshop and to make qualitative and meaningful contributions to the development of the organisations and the welfare of their members."
I, too, am very confident that I will be able to do so in my organisation. In conclusion I would like to thank the staff and Committee of Leliebloem for affording me the opportunity of attending this workshop in Israel.