Community of Practice for Social Systems Strengthening to Improve Child Wellbeing Outcomes

Towards the institutionalisation and scaling up of the CoP approach in the Foundation Phase

Findings from the qualitative research on participant feedback about the CoP study (2020-2023)

Aislinn Delany and Helene Perold | June 2024

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Preface

It is a privilege to contribute a short preface to this report compiled by Aislinn Delany and Helene Perold titled *Towards the institutionalisation and scaling up of the CoP approach in the Foundation Phase. Findings from the qualitative research on participant feedback about the CoP study (2020-2023).* On behalf of the Community of Practice (CoP) team, I wish to congratulate the authors for producing an accessible and excellent report.

Not only were the authors able to distill the essential features of a complex, integrated intervention study, they also gave voice to teachers, social workers, nurses, educational psychologists and child care workers about how to scale up and institutionalise innovation in school based support services for early grade learners.

Based on feedback sessions in six focus groups, concrete and feasible recommendations were generated on strengthening social systems across education, health and social development, based on a bottom-up thematic analysis of the findings. Real world challenges and achievements are identified, leading to pointers for action in six domains. These include the need to strengthen governance across the social sectors, and promote school-based leadership, commitment and a culture of integrated service delivery. A key feature of the CoP is its collaborative partnership approach to service provision. Useful lessons learnt and pointers for action are provided, drawn from child and family wellbeing assessments using a digital application and multidisciplinary interventions. Other recommendations focus on the need for financial, human, administrative and infrastructure resources. Ways to strengthen staff capacity to deliver services in new and different ways are also 'offered. This is a critical success factor in increasing the reach of school based support services and in making integrated practice an integral part of everyday practice across the three sectors. Standard setting and documenting routinised processes of service provision at the nexus of school, family and community are advocated, as well as the use of evidence to inform decision making and action.

The multidisciplinary CoP approach is supported by existing policies in education, health and social development. However, a gap exists between policy and implementation. The CoP is an exemplar of how integrated school-based support services may be delivered. It has been tested over a three-year period and much has been learnt about how to deliver the intervention. This report takes us a step further. It provides valuable learning from implementation on how best to extend its reach at Gauteng schools and beyond, as well as how to make integrated practice an integral part of the delivery of school based services.

Finally, given the vast challenges facing children in poor and disadvantaged families and communities, there is an urgent need for early investments in the Foundation Phase to improve psychosocial, health and learning outcomes. Investments of this kind could break the cycle of cumulative disadvantage that they face, overcome inequality gaps between rich and poor children, and position them for wellbeing improvements in the short to medium term that are necessary for leading more fulfilling and productive lives in later life.

Leila Patel
Principal Investigator of the CoP and Distinguished Professor of Social Development, CSDA, University of Johannesburg, South Africa

Acknowledgements

The qualitative study on scaling up and institutionalising the CoP model flowed from the CoP study conducted between 2020 and 2023. Acknowledgements for the overall CoP study are contained in Appendix 1. This report documents the findings from six focus groups run during the qualitative study in the second half of 2023.

We thank Professor Leila Patel for her overall guidance, and CoP team members Prof. Sadiyya Haffejee, Tania Sani, Nosoyiso Fikani, Asiphile Maqaga and Thembekile Somtseu for planning, implementing and facilitating the focus group discussions at the five schools. For their participation and feedback at the schools we thank the principals and deputy principals, heads of department, teachers, local CoJ clinic or ISHP nurses, GDE Johannesburg East & West district officials, GDE ISS (Inclusion & Special Schools unit) educational psychologists, Gauteng Province DoH dieticians & nutritionists, community-based NGOs and community-based mental health practitioners.

A sixth focus group was run with the CoP and UJ Engineering teams, along with other participants involved in the data collection process, to review the development, process and outcomes of the Child Wellbeing Tracking Tool. Our thanks go to Professors Leila Patel, Jace Pillay, Arnesh Telukdarie, Lauren Graham and Sadiyya Haffejee, and to Dr Lukhanyo Nyati. Thanks also go to CoP team participants Tania Sani, Sonja Mbowa, Nosoyiso Fikani, social workers, Nomasonto Madondo, Bongiwe Somdaka, Ntsako Sambo and Nomsa Mhlanga, as well as Ruth Chauke, Kgaogelo Kubyane and Renney Tshwana from the CoP Limpopo team. We also thank Reginald Mongwe, Christian Tshukudu, and Xolani Maphisa from the UJ Engineering team for their contributions to the discussion. This report draws on the outcomes of that focus group discussion, which are captured in full in a separate report.

Acronyms

ALCoP	Advisory level Community of Practice
CoJ	City of Johannesburg
CoP	Community of Practice
CSDA	Centre for Social Development in Africa
CSG	Child Support Grant
CSTL	Care and Support in Teaching and Learning
CWTT	Child Wellbeing Tracking Tool
DBST	District Based Support Team
DSD	Department of Social Development
DBE	Department of Basic Education
DoH	Department of Health
GDE	Gauteng Department of Education
HoD	Head of Department
ISHP	Integrated School Health Policy
LLCoP	Local level Community of Practice
LSAs	Learner Support Agents
SBST	School Based Support Team
SIAS	Screening, Identification, Assessment and Support policy
UJ	University of Johannesburg
WHO	World Health Organization

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Executive summary

The Community of Practice (CoP) study was launched in 2020 to implement an approach that enhances children's wellbeing by bolstering the social support systems around them. Focused on Foundation Phase children in five urban Gauteng primary schools,[1] the multi-year study involved an intervention designed to ensure better wellbeing outcomes for children at high or moderate risk, and to improve their academic performance.

This report examines how the CoP process and collaborative ways of working could be institutionalised and scaled up in primary schools, in line with South Africa's care and support policy framework. It is based on data from a qualitative study conducted in 2023 that gathered the perspectives of teachers, social workers, nurses and others who had participated in the local level CoPs at each of the five schools between 2020 and 2023.

The analytic framework

Institutionalising an approach or a process means to "make it integral to an organisation, society or culture, so that it is seen as 'normal'" practice (WHO, 2023). **Scaling up** refers to increasing the reach of the approach (e.g. including all children in a phase or a school) or introducing the approach into new settings (e.g. new schools or areas) with the aim of achieving the same outcomes on a larger scale.

Drawing on a WHO Checklist, the data from the qualitative study were analysed according to six domains of institutionalisation.

High-level findings and summarised recommendations

Governance

At a national level there is considerable policy support for an approach such as the CoP that promotes intersectoral collaboration to address barriers to learning and supports the health and wellbeing of children at a local level. An element that is less well developed at both policy level and in practice is the alignment between social services and the education system. The CoP approach offers a practical means of strengthening the implementation of the DBE's care and support mandate by promoting intersectoral collaboration at a school level and centring the role of social service workers in supporting vulnerable children and their families. Study participants agreed that the SBST would be a logical home for the CoP approach, but raised concerns that the SBSTs are under-capacitated and focus largely on academic performance.

Recommendations: Embed the collaboration and coordination features of the CoP in the SBSTs. This requires working with the GDE and school leadership to review SBST roles, responsibilities, operations and their alignment with local level CoPs, and identify gaps and additions required, particularly in relation to capacity. The role of the district and DBSTs in supporting this integration should be formally captured in care and support protocols. Protocols are also needed to manage confidentiality and issues of compliance with the POPI Act (2013).

Leadership, commitment and culture

Integrating the CoP model at primary schools depends on the principal's commitment to championing holistic psychosocial support for young children at risk and supporting the staff to adopt new ways of working. School leaders need to recognise the importance of integrating social services support into school operations and embrace the task of creating a culture of collaboration. Awareness of the impact of psychosocial wellbeing on school performance needs to be strengthened at a district level as well.

Recommendations: Opportunities should be provided for school leaders to become more informed about how to build a culture of holistic care and support within the school. When phasing in the CoP approach, primary school principals who have experience of the CoP intervention are encouraged to establish support networks with other principals in nearby primary schools who are new to the initiative. This will also help them link their schools and establish relationships with stakeholders and organisations in the broader community.

Collaborative action

The CoP study demonstrated that collaboration and coordination are central to achieving collaborative action in schools, bringing together – at a local level – personnel from education, health, and social development as well as NGOs, primary health care services and community-based players. Study participants were particularly appreciative of the partnership with and access to the CoP social workers. Knowledge sharing and feedback loops proved critical in building these

[1] In 2023 a baseline study was also conducted of the CoP approach in Moutse, a rural area in Limpopo Province.

relationships and fostering collaboration. In light of these benefits, the extremely limited provision of social services workers by the GDE and DSD needs to be addressed because those workers are so thinly spread that they are largely ineffectual in supporting the psychosocial needs of Foundation Phase children.

Challenges were experienced in securing the collaboration of nurses because they are also spread thinly across many schools. In some areas of Johannesburg, primary health care services are delivered by clinics under the auspices of the City of Johannesburg while in others, services are delivered by the provincial Department of Health. Despite the Integrated School Health Policy there is a lack of alignment between these healthcare services in relation to the breadth and depth of support they provide to primary schools.

Recommendations: It is necessary to resolve the lack of interdepartmental collaboration between education, health and social development in the provision of support services to children. This means forging cross-departmental operational agreements for financial resource allocation and human resource provision to impact effectively on a growing need in schools. Furthermore, close monitoring and support from the district and provincial level support teams will be required.

Resources and capacity strengthening

Having been conducted primarily in no-fee primary schools, the CoP study highlighted the challenge of promoting child wellbeing in the resource-scarce environments in which the schools operate. While being aware of the financial constraints within government, participants perceived the absence of resources for social services as being a lack of political will, particularly as the situation has not improved notably over time. Three factors were identified as constraining the provision of psychosocial support in disadvantaged primary schools. First is the disconnect between the scale of need among at-risk Foundation Phase learners and the support that could be accessed, given the GDE and DSD's limited social services capacity for schools. Second, overcrowding in the schools makes it difficult for teachers to identify learners in need of additional support, particularly if they appear to be coping in class. Third, the department has employed Learner Support Agents (LSAs) to help schools offer psychosocial support to learners, but these young people have no professional training or supervision for the tasks they are meant to carry out.

The evidence shows that capacity strengthening is required both for SBSTs and for teachers in the Foundation Phase. Participants were concerned that SBST members lack sufficient knowledge of psychosocial support and what it entails in practice. It was also suggested that SBSTs require management training to function more effectively. Teachers requested support in understanding the psychosocial issues facing their learners, how these manifest and how to manage them in class.

Recommendations: Attention needs to be given to the ratio of community-based social workers to schools or classes of learners, as the current ratios are unsustainable. DBE and DSD need to draw on auxiliary social workers and other paraprofessionals to amplify the social services human resource complement available to schools, noting, however, that they too need to be supervised by fully qualified social workers, as do the LSAs. Staff training, supervision, mentoring, coaching and performance management of all 'front line' staff is critical to building a culture of care and support in schools, and will require working in integrated and multisectoral teams at a school level. The DBE, in partnership with DSD and DoH, among others, would need to mobilise the financial and human resources required to operationalise the CoP approach. Data from the CoP study can be used to develop costing and human resourcing scenarios.

Standards and routinised processes

A key aspect of embedding collaborative ways of working at a local level is developing norms and standards, protocols and routine processes that make this kind of engagement part of the 'normal' routine. These include having routinely scheduled CoP/SBST meetings that include stakeholders from across relevant sectors, establishing clear roles and responsibilities for CoP members and developing clear and simple protocols for referrals. It would be necessary to develop a plan of how the CoP approach would be implemented over the year, accompanied by management and administrative arrangements to facilitate the implementation.

Recommendations: Representatives of GDE, the DSD, DoH districts, primary health care clinics and other local external stakeholders will need to jointly develop an implementation plan with clear objectives of how the CoP approach will be implemented over the year in the primary schools. This would need to be accompanied by memoranda of understanding or service level agreements across departments to clarify the roles, responsibilities, and mandates of each.

Using evidence to inform decision-making

Study participants appreciated the CoP assessment of selected children using the Child Wellbeing Tracking Tool because it provided a comprehensive and evidence-based means of identifying the vulnerabilities faced by individual children and assisted with prioritising the interventions needed by them in a context of limited resources. They also appreciated the proactive nature of this approach, and that the findings then triggered further investigation and intervention by the CoP social worker, thus going beyond what can be identified and addressed in the classroom alone.

Recommendations: Strategic choices need to be made about the purpose of using an evidence-based assessment tool: it could be used for monitoring child wellbeing to inform more effective policy and planning, and/or it could also be used to conduct child wellbeing assessments to inform individual interventions. The digital CWTT has been tested and the risk profiles it produces have been shown to be useful, but the tool would need to be trimmed for more effective scaling up. Issues such as who would collect the data and how, data cleaning, and quality assurance and management of the data at scale, all need to be considered. Attention must also be paid to how data will be analysed, interpreted, and acted upon.

Conclusion

An enabling environment exists for integrating the CoP model into primary schools. It flows from the alignment between South Africa's care and support policy framework and the goals of the CoP model, taken together with the regulatory requirements of SBSTs and DBSTs. The high-level recommendations made here for scaling up and institutionalising the CoP model are offered to give more tangible expression to the policy frameworks through school-level practice, using an organic, "bottom up" approach to expansion.

1. Introduction

Children's wellbeing, social welfare and health impact directly on their ability to learn. Strengthening the support systems around children – in their families, schools and communities – can start to reduce barriers to learning.

This report examines how a collaborative Community of Practice (CoP) approach that aims to strengthen the social systems around children could be institutionalised in primary schools and scaled up in line with South Africa's care and support policy framework (see Box 1 on policy context). It is based on data from a qualitative study conducted in 2023 with the local level CoPs at five Gauteng primary schools in which the CoP was piloted between 2020 and 2023 (also known in this report as the 'CoP study schools'). The purpose of this report is to contribute to research, advocacy, integrated practice, and community education on social systems strengthening for better child wellbeing outcomes.

1.1 The context for holistic integrated services for children

Children's rights are guaranteed under the South Africa Constitution. But the effects of apartheid and underdevelopment continue to impact negatively on their wellbeing. Historical inequalities persist and combine with ongoing challenges of poverty, food insecurity, and exposure to violence.

Children living in poor households are often exposed to clusters of risks, such as overcrowding, unsafe environments, and stressed caregivers. Financial strains are a significant risk factor for child and caregiver wellbeing, with knock-on effects such as poor mental health of caregivers that impacts on their ability to parent, behavioural difficulties with children, and child malnutrition.[2] In addition, the range and quality of services that children and their families can access varies substantially depending on where they live.

These overlapping challenges create environments in which children may encounter barriers to their full development. Such challenges are made more difficult by fragmented service provision for young children, which is a longstanding feature of the health, welfare, and education sectors. But interventions that promote and support protective factors in children's environments can mitigate these risks and promote children's health and wellbeing. International guidelines for promoting the health and wellbeing of children and adolescents (WHO & UNICEF, 2020) emphasise the importance of multi-sectoral responses and holistic, integrated services to promote better care for children.

The CoP approach discussed here was implemented in response to the fragmented nature of support services for early grade learners who attend public schools in disadvantaged areas in South Africa, and the need for a coordinated response across sectors to address these gaps and strengthen social services for children.

Box 1: The South African policy context in for child wellbeing

Various policy documents make provision for more holistic and integrated services for children in South Africa. For example, the *White Paper for Social Welfare* (1997) promoted intersectoral collaboration in the delivery of community-based developmental welfare services. The Department of Social Development's *National Child Care and Protection Policy* (2019) provides a blueprint for coordinated and integrated childcare and protection programmes.

Similarly, the *Integrated School Health Policy* (ISHP, 2012) calls for a partnership approach to integrated service provision across the health, education, and social development sectors. The implementation is focused on a district level, with school health teams being responsible for delivering and co-ordinating the integrated school health package to learners. Community participation is also encouraged. But while the ISHP refers to the need for assessments during the Foundation Phase to identify health barriers to learning and to identify children who have or are at risk for long-term health, psychosocial or other problems (DoH & DBE, 2012, p. 13), it is not clear to what extent the latter is carried out in practice. Studies have noted other challenges in the implementation of the ISHP, including insufficient collaboration and coordination between departments, and a limited awareness among teachers of psychosocial support services (Dibakwane & Peu, 2018; Lenkokile et al., 2019; Pillay et al., 2023) .

The CoP's local level approach to providing support for learners is in line with three national policy directives. First, *Education White Paper 6: Special Needs Education* (2001) advocated for strengthening education support services by establishing district based support teams (DBSTs). The subsequent policy on *Screening, Identification, Assessment and Support* (SIAS, 2014) also envisions teachers identifying learners in need of support and assisting them to access the support with the help of school based support teams (SBSTs) and DBSTs where needed. While the SIAS policy refers to a broad range of 'barriers to learning', the alignment of the policy with social services is not well developed. Third, the broad understanding of barriers to learning is also reflected in the *Care and*

[2] For this reason, a policy recommendation emerging from the CoP study is the need for the value of the Child Support Grant to be raised to the food poverty line in the short term.

Support for Teaching and Learning (CSTL) programme adopted by the Department of Basic Education (2008), which identifies priority focus areas based on the Department's mandate of care and support, and which includes social welfare services. There is therefore a clear policy framework for an intersectoral approach to learner care and support that operates at a local level.

Despite this supportive policy framework, some gaps remain. For example, the integration of education and social work services is not clearly elaborated within the ISHP or SIAS. Nor is the policy framework, described above, harmonised in practice. From the perspective of the CoP study schools, despite a memorandum of understanding being in place between the Department of Education and the Department of Social Development, the provision of social service support to schools is extremely limited. Support from the Department of Health occurs more regularly, but is not consistent, and much depends on the schools' relationships with their neighbouring clinics. These gaps work to the detriment of vulnerable children in Foundation Phase. There is also no standard, multi-dimensional assessment to identify children at risk. It is these gaps in coordination and collaboration as well as in the assessment of children's wellbeing that the CoP intervention aims to address.

2. What is the Community of Practice intervention?

The Community of Practice (CoP) was established in 2020 to enhance children's wellbeing by bolstering the social support systems around them, to ensure better wellbeing outcomes[3] and improved academic performance. Housed in the Centre for Social Development in Africa (CSDA) at the University of Johannesburg (UJ) and funded by the National Research Foundation (NRF), the study was guided from inception by the South African Research Chairs Initiative (SARCHI) represented by Professors Leila Patel, Jace Pillay, and Elizabeth Henning,[4] as well as Professor Shane Norris of the NRF Wits Centre of Excellence in Human Development. In 2023, Prof. Tanusha Raniga, professor of social work and Interim SARCHI Chair in Welfare and Social Development joined the team, with Prof. Patel continuing in her capacity as Principal Investigator of the CoP study (see Appendix 1 for the full listing of the CoP research team).

Building on research that suggests that strong multi-sectoral and multi-disciplinary collaboration can ensure better outcomes for children, the CoP team partnered with stakeholders in the health, education, mental health, protection, and welfare sectors. The initiative brought together 22 researchers, 84 practitioners (teachers, nurses, social workers, education psychologists), and 19 governmental and non-governmental partners and development organisations who are instrumental in the care of children.

An Advisory level CoP (ALCoP) was established to guide the project and, in each of the five pilot schools, local level CoPs (LLCoPs) were established to run the initiative at school level. These comprised teachers of children in the foundation years (Grades R to 3), social workers, nurses and education psychologists.[5]

This intervention study was conducted in five urban public primary schools in some of the poorest wards in Johannesburg, Gauteng, between 2020 and 2023. The target group of the CoP study were children in their foundation years of schooling. The same target group is the focus of the baseline study initiated in Moutse, Limpopo, in 2023 as part of a pilot which is ongoing.[6]

The children were assessed using a digital tool known as the Child Wellbeing Tracking Tool (CWTT) specifically designed for this purpose, which provided an integrated assessment of their material circumstances, health, nutrition, education, and the psychosocial wellbeing of the child and caregiver.

Once children were identified as being at high or medium risk of compromised wellbeing, tailored interventions were developed for them and their families and coordinated by a social worker allocated to the school. The CoPs also liaised directly with service providers in the community, and referred children and families to food relief agencies, welfare, and mental health services, and to primary health care clinics. Children in need of screening for sight and hearing were referred to UJ's Optometry Department and audiology services at the University of the Witwatersrand; those with learning difficulties were referred for assessment to an education psychologist. Assessments were also conducted of all the CoP children to gauge proficiency in mathematics and language. Figure 1 provides an overview of the CoP model.

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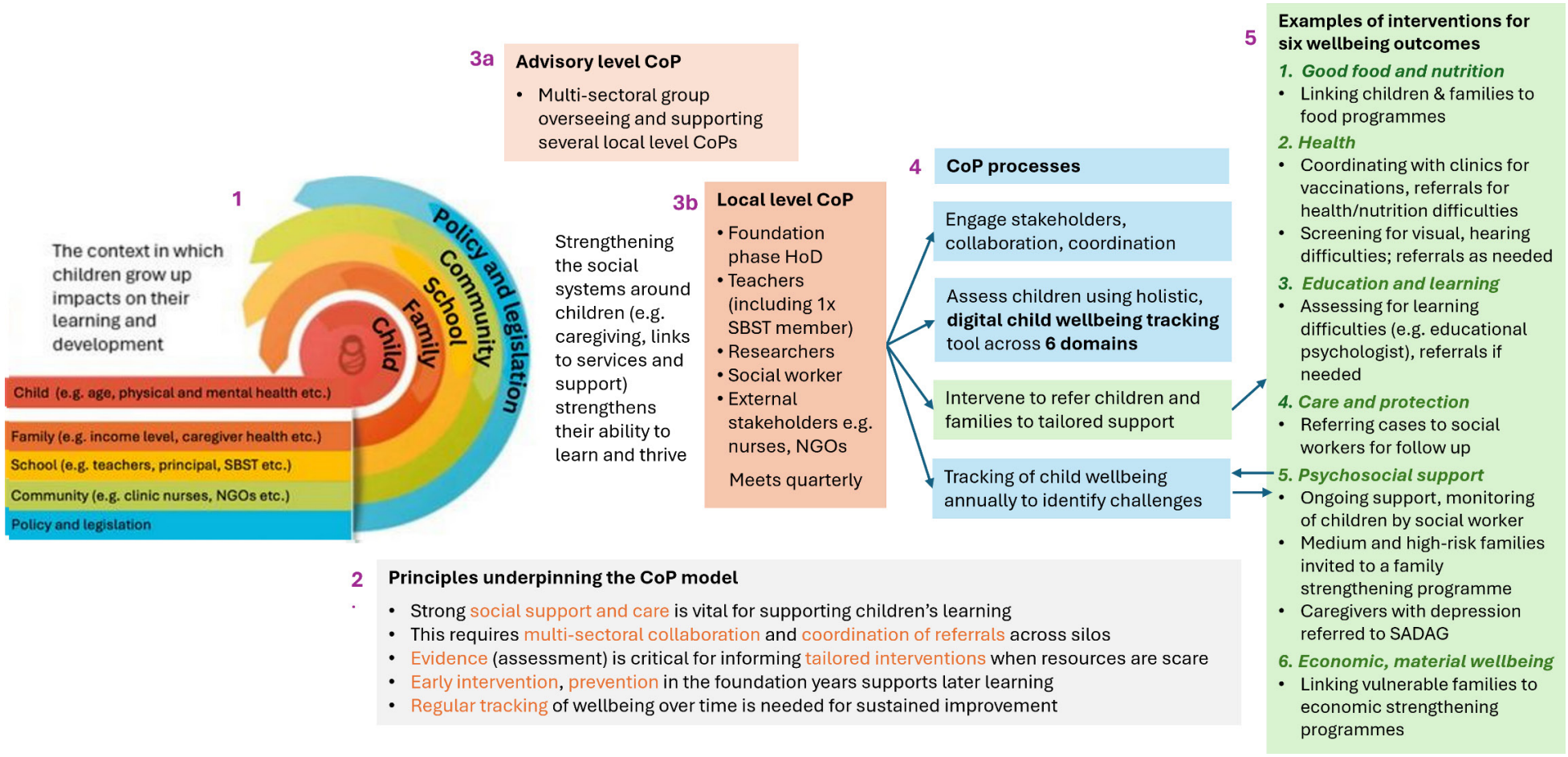
[3] See Appendix 3 for an overview of the indicators of children's wellbeing.

[4] Prof Leila Patel, Distinguished Professor and former DSI/NRF Chair in Welfare and Social Development (Principal Investigator), UJ; Prof Jace Pillay, Chair in Education Psychology (Co-Principal Investigator), UJ; Prof Elizabeth Henning Chair in Integrated Studies of Learning Language, Mathematics and Science in the Primary School (Co-Principal Investigator), UJ.

[5] See Appendix 4 for an overview of the evolution of the multi-year CoP intervention.

[6] In the five urban schools, the sample size was initially designed to be 200, but the launch of the CoP study coincided with the start of the COVID-19 pandemic, which made it difficult to proceed as planned. Nonetheless, 162 children were identified for the sample, of whom 123 ultimately participated in the study across the three years. In the rural Moutse site, 87 children participated in the baseline.

Figure 1: Overview of the CoP model



Source: Authors' own illustration

Teacher support workshops were offered in mathematics and language teaching, which were well received. Selected families received a family strengthening (group-based) intervention, which was run by the social workers. The intervention included parenting skills, nutrition education, financial literacy training, knowledge, and skills in accessing community resources, and strengthening parental/caregiver involvement in the child's schooling.

The study demonstrates the importance of monitoring the multi-dimensional wellbeing of children and their families in their school and community contexts (see Box 2 for outcomes of the study).[7] Some interventions may target children while others may target caregivers, the whole family group and/or teachers, health care practitioners, and health and social service agencies operating in communities. The evidence-based approach not only helps to identify children's priority needs and difficulties to be addressed in schools. It strengthens the quality of the school's engagement with NGOs and other agencies operating in surrounding communities and presents an opportunity for government departments to use school-generated evidence for purposes of planning and resource allocation.

Box 2: Impact of the CoP

A comprehensive longitudinal analysis of the children's wellbeing was produced over the three-year study and the results bring into sharp focus the multiple factors that affect children's wellbeing, and how the CoP intervention impacted on these (Patel et al., 2023).

The changes that occurred between Wave 1 (2020) and Wave 3 (2022) of the CoP intervention include the following: A decrease in the number of children experiencing difficulties (measures using the Strengths and Difficulties questionnaire which covers five domains), from 35% in Wave 1 to 11% in Wave 3. Levels of caregiver depression more than halved from 52.6% in Wave 1 to 23.5% in Wave 3. There was a reduction of 38% between Wave 1 and Wave 3 of children who were afraid to go to school, and children's access to food and nutrition improved, with an additional 18% of children eating three meals a day. By Wave 3, 10% fewer children experienced health challenges that prevented them from attending school (see Appendix 5).

2.1 About this report

This report focuses on a key priority of the CoP – institutionalising the model in the Foundation Phase at primary schools and taking it to scale. Following its first phase, the CoP now seeks to embed its collaborative approach to strengthening child wellbeing among key role players, and to facilitate its adoption within the social development, educational and health systems.

To this end, Phase 2 of the project has seen active engagement by the CoP team with a range of government departments and development agencies, all of which play a prominent role in policy research, locally and internationally, and which are instrumental in advocating for the scaling up of the CoP model. A memorandum of understanding (MoU) was signed with the Department of Social Development (DSD) at the national level. Discussions with the Department of Health (DoH) as well as the Department of Basic Education (DBE) are ongoing. These developments signal how multi-stakeholder collaboration is central to the CoP approach in practice.

2.2 Methodology

The qualitative research component was introduced to inform the prospect of institutionalising and scaling up the CoP intervention. Focus groups were conducted at the five urban Johannesburg primary schools to tap into the experience of LLCoP participants and gather their insights. Participants comprised principals, Heads of Departments (HoDs), teachers, DSD social workers and a social worker from the GDE, as well as DoH practitioners who had been active in the LLCoPs. A sixth focus group was conducted with the CoP research team and the UJ engineering team who worked to design and develop the CWTT. Participants reflected on the process of developing the digital tool, the quality of the data, the purpose of the tool, and lessons learnt about its potential for evidence-informed decision-making. The research methodology used in this Phase 2 study is described in more detail in Appendix 2.

Limitations of the data gathered from the focus groups include an over-representation of teachers in relation to other service providers (social workers and health workers), and gaps in information about the health aspect of the CoP, such as the involvement of clinics and school health practitioners. In addition, while this report focuses on the insights from participants at a local level, it does not include inputs from officials at district, provincial or national level.

[7] See Appendix 5 for the topline findings from the CoP study.

2.3 Report structure

This report is the product of this research process and is divided into four sections.

1. The introductory section provided an overview of the CoP framework for a multi-stakeholder, school-based care and support intervention.
2. The second section provides a short overview of the conceptual framework for institutionalisation and scaling.
3. The third section documents the lessons learnt from education, social development, and health practitioners about the possibilities for institutionalising and scaling up the CoP model.
4. The last section examines implications for scaling up and institutionalising the CoP model and provides a set of high-level recommendations for consideration.

3. What do we mean by institutionalising and scaling up?

After implementing the CoP approach over three years in urban Johannesburg and initiating a further pilot in rural Moutse, the focus shifted to considering how the CoP process and collaborative ways of working could be institutionalised and scaled up.

The CoP research team conducted a short literature review of existing and emerging literature to inform their thinking on this question. The review found that there is limited literature on multi-sectoral collaboration between service providers in the social sector, as well as on systematic barriers to cooperation. But the review did identify several factors associated with successful scale up of evidence-based interventions, as listed in Box 3.

Box 3: Success factors associated with scaling up evidence-based interventions

- → Key providers (purveyors) are effectively capacitated.
- → Variations of implementing agencies are considered; no one size fits all.
- → Enabling organisational level factors are in place with feedback loops for continuous improvement.
- → Stakeholders are engaged and committed to collaboration.
- → Support from leaders is essential.
- → Space for bottom-up learning creates opportunities for innovation to flourish.
- → Enabling institutional frameworks are in place (e.g. policies and procedures, adequate funding, staffing levels, infrastructure).

3.1 Definitions and framework

Institutionalising an approach or a process means to "make it integral to an organisation, society or culture, so that it is seen as 'normal'" practice (WHO, 2023). This involves identifying the core elements, competencies and processes that make up the CoP approach; considering ways to embed them systematically into the local school context; and finding ways of working so that they become routine and are sustained over time.

Scaling up can refer to increasing the reach of the current approach (e.g. including all children in a phase or a school) or introducing the approach into new settings (e.g. new schools or new areas) with the aim of achieving the same outcomes on a larger scale.

When considering how this approach could be embedded into the ways schools work on a larger scale, we drew largely on a WHO checklist (2023) for institutionalising the use of evidence during the policy-making process. The checklist identifies six domains of institutionalisation (see Box 4). We adapted these domains slightly in line with the themes that have emerged from the data, by combining issues of leadership and commitment with changing culture; we also added a further domain on the use of data to inform decision-making and tailoring of interventions.

Box 4 : WHO Checklist – six domains of institutionalisation

1. Governance
2. Standards and routinised processes
3. Leadership and commitment
4. Resources and capacity strengthening
5. Partnership, collective action & support
6. Culture

(WHO, 2023)

4. Study findings

This section presents the findings of the qualitative study. It comprises reflections on the implementation of the CoP model provided by participants in the LLCoPs. The guiding questions for this study were: What lessons were learnt from the experience of implementing the CoP approach that can inform (a) how this school-based support approach could be institutionalised, and (b) how it could potentially be scaled-up to reach more children?[8]

The section is structured across six domains, namely:

a. Governance
b. Leadership, commitment, and culture
c. Collective action
d. Resources and capacity strengthening
e. Standards and routinised processes
f. Use of evidence to inform decision-making

4.1 Governance

When considering how to entrench a CoP approach into educational systems and practice, it is important to consider issues of mandates and policy, structures, oversight, and accountability.

At a national level, there is considerable policy support for an approach such as the CoP initiative that promotes intersectoral collaboration to address barriers to learning and supports the health and wellbeing of children at a local level (see Box 1 on the policy context). In addition, both the Integrated School Health Policy (ISHP, 2012) and the Policy on Screening, Identification, Assessment and Support (SIAS, 2014) advocate for school-based support to be complemented by community participation and networks, while the SIAS policy emphasises the importance of engaging with children's parents and caregivers in care and support processes. Further, the SIAS policy notes that "the norms and standards of ordinary schools are to be expanded to accommodate a standard allocation for all schools to address care and support needs for learning" (DBE, 2014, p. 20).

An element that is less well developed at both policy level and in practice is the alignment between social services and the education system. The CoP approach offers a practical means of strengthening the implementation of the DBE's care and support mandate by actively promoting intersectoral collaboration at a school level (in line with policy mandates) and centring the role of social service workers in delivering social service support to vulnerable children and families.

The ISHP and the SIAS policy both refer to the school based support teams (SBSTs) as the primary delivery structure of the support services for learners at school level. Additional support is provided by district based support teams (DBSTs) as needed. Although the local level CoPs were externally initiated, they were firmly embedded in the school structures. Study participants agreed that the SBST would be a logical home for embedding the CoP approach.

However, there was a strong sense from participants that the SBSTs at the five schools were under-capacitated and focused largely on the curriculum and academic performance (see Box 5). As a result, there were numerous contributions suggesting that more needs to be done to engage with the psychosocial needs of the learners, both in schools and the environments in which children live.

Box 5: Perceptions of the functioning of SBSTs

"The emphasis, when it comes to SBST... is more on curriculum than other things….and then they neglect other things like behaviour, emotional intelligence, emotions, and all those things... And yet, here at school as teachers, we experience behavioural problems, bullying" (School 5).

"I think their [SBST] role is limited to the institution itself. You know, they can't expand to an extent of going, you know, house visits or whatever. So, we are saying, the [CoP] programme, it was helpful around that because [it helps us] go deeper. And also, another thing, the colleagues that are serving in the SBST, I don't think most of them are capacitated" (School 4).

Given that a core component of the CoP approach is collaboration across sectors, the model provides a practical way to strengthen the role of existing SBSTs in providing support to learners across health, education, and social development sectors. Many school-based participants strongly associated the CoP approach with the placement of a social worker

[8] For more detail on the methodology used, please see Appendix 2.

at the school for a period, and clearly articulated how having ready access to social services enabled the school to get *"to the bottom of the situation"* (School 4) in the case of learners at risk. Therefore, in addition to considering potential mechanisms for coordinating the collaborative CoP approach, embedding a CoP approach within the SBSTs would require consideration of how crucial professional social services and skills could be brought closer to schools.

The collaborative approach could also assist the SBSTs to develop relationships with external stakeholders who could bring in additional skills and resources and assist the SBST members to adopt a more proactive prevention approach to addressing psychosocial challenges. Participants noted that *"it needs to be a long-term project"* (School 3), highlighting the need to systematically build ongoing psychosocial support into school structures rather than relying on once-off engagements, which are likely to be less effective (see Box 6).

Box 6: The need for sustained social service support

"You know, we have stated that to our superiors many times, that we cannot form rapport with our clients because there's five of us running around a hundred and something schools, so it's quite difficult for us to really have a stable relationship with our clients" (Gauteng DSD Social worker, School 2).

Institutionalising a CoP approach could take the form of a senior SBST member (such as the Foundation Phase Head of Department) taking on the role of coordinating the CoP processes, with support from the rest of the SBST. At regular intervals, the SBST meetings could include a focus on CoP activities and the monitoring of referrals, with external stakeholders in attendance. The standard SBST meetings could continue to be held in-between. A clear outline of CoP roles, responsibilities, tasks and processes would be required to provide the CoP focal person and the expanded SBST with an understanding of what is required to implement a CoP approach and what the role of the different stakeholders would be, given their varying mandates. It would also shape delegated responsibilities and benefit the SBST by providing guidance on bringing in additional capacity for care and support.

Departmental accountability for the implementation of the CoP approach would then follow the same procedures as for the implementation of school based support. Another possible layer of accountability would be to allocate a designated CoP oversight role to at least one member of the DBST who would then be responsible for providing guidance to the schools in the district.

While the CoP approach aims to draw on resources and skills that exist in the community, it is not possible to rely only on external resources to deliver the social support required. Resourcing issues are discussed in a later section, but it is evident that strengthening the social support role of SBSTs requires closer collaboration with social services workers, including social workers and other paraprofessionals. This highlights the need to consider issues of supervision and mentoring structures to assure the quality of support provided, and to avoid potentially causing harm.

Another governance-related issue raised by participants concerned the sharing of information from the assessment of children using the CWTT. Any processes to institutionalise and scale up the approach would need to ensure compliance with the Protection of Personal Information (POPI) Act (2013) regarding data capture, data management and storage. Confidentiality issues are of primary concern in sharing assessment information with the teachers and social workers who are mandated to work with the children.

4.2 Leadership, commitment and culture

The school environment is one in which a range of stakeholders play their roles to create the conditions for children's learning to flourish. Each school is thus an ecosystem in which the role players work together to achieve the conditions for effective teaching and learning. The stakeholders include principals, HoDs, teachers, learners, administrative and general assistants, the senior management teams, SBSTs and school governing bodies. Within the school ecosystem, stakeholder roles are interdependent and function through a network of relationships that enable the school to thrive. All these need to be aligned to the purpose of fully developing the learners by providing holistic support for their academic performance.

Schools also function within a wider ecosystem comprising the DBE policy frameworks, the school district, the child and their family, the community in which the school is located, service providers from the health, social development, and safety/protection sectors who engage with the school, as well as NGOs and community-based organisations. Proactive leadership is equally critical in this wider ecosystem. For example, national and provincial leaders have the task of forging greater integration with government departments that have the mandate to provide psychosocial resources to schools, and championing their closer collaboration. The CoP study showed that collaborative relationships between the internal and external components of the school community are fundamental to implementing new ways of working in both contexts.

Box 7: Principles underpinning the CoP model

- → Strong social support and care is vital for supporting children's learning
- → This requires multi-sectoral collaboration and coordination of referrals across silos
- → Evidence (assessment) is critical for informing tailored interventions
- → Early intervention, prevention in the foundation years supports later learning
- → Regular tracking of wellbeing over time is needed for sustained improvement

At the local level, integrating the CoP model into a primary school depends largely on the principal's commitment to helping staff embrace new ways of working. It starts with a vision of holistic psychosocial support for at-risk children in the Foundation Phase within the context of the DBE care and support policy framework and the ISHP. School leaders who embrace the principles underpinning the CoP model (see Box 7) understand the need to create a school environment that recognises that children's effective learning depends on their basic needs being met. According to one principal, this means going *"to the bottom of the situation that these children find themselves in"* (School 4). Developing a shared commitment to these principles among staff will go a long way to building a more holistic and collaborative culture in the school. The research shows that numerous teachers were aware of the need to adopt a holistic approach that responds to children's needs. A teacher captured this well when she said: *"By [the term] 'holistically' we are talking about everything that involves the life of a child"* (School 3).

The school's senior leadership is key in managing its relationships with external stakeholders such as the DBE, DSD and DoH. Good communication and coordination by the CoP team assisted teachers to navigate complex referral processes and facilitated their access to the limited number of social workers and educational psychologists available from the GDE and DSD. Furthermore, it became apparent that the localised CoP approach encourages innovative relationships between a school's internal and external ecosystems. For example, with the help of the social worker some schools were able to develop relationships with NGOs and community-based organisations in their area, as well as with the SAPS, *"who came in to talk about drugs"* (School 3). In another case external support helped resolve a difficult situation in the school: *"We worked together with the NGOs, SAPS, when we had the problems, and especially that one … [about a specific incident of a girl] … We could manage to place her, neh?"* (School 4).

The school's senior leadership has the task of creating a culture of collaboration in which teachers and HoDs are encouraged to share their concerns, insights, and knowledge about at-risk children with each other and with the social worker or other professionals active in the CoP. This became clear in one of the focus groups in which the principal's appreciation was summed up as *"the collaboration between you, the social worker and the parents … kind of like making the loop around the child"* (School 4). The principal pointed out that since the conclusion of the CoP at the school, things had deteriorated for the children who had worked with the social worker: *"Since [the social worker] left, they, they are regressing. …Those anger issues are now surfacing again. It's like they are not being taken care of"* (School 4).

Within the context of collaboration, all the focus groups mentioned the importance of improving the relationship between the school and the parent community: *"We need to find a way to get the larger community involved"* (Principal, School 3). A teacher referred to the intrinsic relationship between society, community, and school when she suggested that the school hold regular community-based discussions: *"Teach the community... and invite all the stakeholders. … This society is very sick; there are a lot of things that… happen outside the school and then they come..."* (School 5). In this regard the CoP demonstrated how reaching out to families can strengthen parenting skills and how caregivers struggling with depression can be referred to support (see Box 8).

Box 8: CoP impact on school-parent relationships

One principal reflected that: *"I've seen it contributing positively to our kids … and to our school community in a sense that it has also that element of parental involvement. You [the CoP] were able to reach out to those parents"* (School 4).

A second principal summed up the impact of the CoP outreach to families this way: *"Once parents reach out to parents and communicate with parents, some of them come through and it impacts positively on the child's life. The home visits as well, tremendous impact"* (School 2).

At district level, awareness of how psychosocial support is central to school performance, also needs to be strengthened. This will align the district with the school's efforts to integrate the CoP approach and CoP human resources (such as social worker support) with the SBST's mandate and will help to address associated issues of resourcing and accountability.

School leaders are likely to encounter several challenges in embedding this systemic approach to school system strengthening. First, and key among these, is the reality of schools in poor communities that function in a context of scarce resources.[9] This confronts school leaders with tough choices about priority areas of expenditure, juggling available resources, and seeking new financial and human resources wherever they can be found, but these are rarely sustainable. Second, schools are not helped by the fragmentation between government departments which impacts on service provision and weakens cross-sectoral collaboration. And third, despite the supportive policy environment already described, this study found that in the drive for improved academic performance, teachers have virtually no time to attend to the needs of poorly performing learners.

Another institutionalisation challenge will be where to locate the driver of the CoP initiative. During the CoP study, the initiative was driven by the CoP team based at the University of Johannesburg, supported by external funding. This begs the question: Is there a need for other levels of leadership and new champions to support the process of phasing in the initiative and linking schools who wish to be part of the innovation?

4.3 Collaborative action

In a context of high levels of poverty, unequal access to services, budgetary constraints, and poor communication between state departments that tend to work in silos, the CoP model is designed to work quite differently.

The CoP design is guided by well-established findings that collaboration between multiple stakeholders, and the use of knowledge and expertise from various disciplines, is central to creating an environment that promotes and supports child wellbeing. In the CoP study schools this occurred through relationships that were forged, and structures and processes established, for purposes of what might be termed intentional collaboration. This refers to the actions taken to establish close connections between multiple stakeholders and to harness these in service of addressing the needs of at-risk children in the school's foundation phase.

In this section we examine what the data tell us about how collaborative action manifested in the CoP, and what it suggests about institutionalising the model.

4.3.1 Collaborative partnerships

Partner collaboration occurs in the school when the CoP social worker coordinates the cases of children identified as being at risk, and helps the teachers gain insight into how this vulnerability manifests and how they can respond to it in class. A teacher described the relationship with the social worker as *"making her also to become part of us"* (School 4), suggesting that the teachers embraced the presence of the social worker and felt that she was supporting their work. Through the collaboration, teachers came to see the value of psychosocial support (see Box 9) and came to appreciate the professional expertise of the CoP social workers who see children holistically: *"like not only them at school, but also at home"* (School 4).

Box 9: Teacher perspective on value of CoP social worker

"I think it was good to have a social worker in the premises, because some of the learners have social problems at home. We only look at them maybe academically. But you can see that these children have issues that a professional can deal with them and see and assess them. And then they get a lot of help" (School 2).

The partnership also benefited the social workers. One described how working with teachers enabled her to *"understand who is the child, how does she perform in class, where you can improve or what are the challenges at home…. So, it was insightful and fruitful."* (DSD social worker, School 5) Another gained new awareness of the teaching context and the constraints that teachers face in supporting children in need: *"I think it did give me the other picture of the child's life, because for them [teachers] it's academics… And also… [they] have too many children in [a] class. Until you come into school you don't know this. You have no idea that teachers work like this"* (School 5).

In one school, teachers spoke of how the presence of the social worker helped to bridge the gap between the school and caregivers, as described by this participant: *"If a teacher is calling you, haai, it's teacher, they just dismiss it. But hey, a social worker is coming and knocking at the door, then they start seeing the seriousness of the situation"* (School 4).

The relationships between the CoP study schools and the health sector were generally positive. All five schools shared their appreciation of the involvement of clinic nurses who carried out various routines at the schools: *"We are happy with the healthcare workers"* (School 1); *"the health professionals, they do come to school … we have a good relationship with*

[9] Four of the five urban schools in the study were no-fee schools: Three in quintile 2 and one in quintile 3. The fifth school was in quintile 4.

them" (School 5); *"we have the clinic nearby and [it] is actively involved" (School 3); and "they tell us when they come to us. Yeah they're functioning very very well, with the Department of Health"* (School 2) .

Some of the schools described how the nurses often focused on vaccination drives. For example: *"We did have nurses come in. Yes, they did innoculations. And they met with the learners to help them prepare for the innoculations. And they followed up with them. … It helped us because the parents didn't do it for all those years that they were supposed to …And we wouldn't even have known if they didn't pick it up; we would never have known. And then they filled in the gaps … I think everyone is now vaccinated. Of the group"* (School 2).

The feedback from participants indicated that the involvement of health professionals from the Integrated School Health Programme provided a more diverse range of services. One school mentioned that health professionals from the ISHP had come to deworm the learners (School 5). Another described how *"the sister came and identified those learners who were malnourished"* (School 4). In this instance there was evidence of how the ISHP health professional collaborated with the CoP team at the school: "*And then the intervention from her side was very good because those children were assessed, and then working together with the information from them, plus this, and then we referred them to [the CoP coordinator]"* who was able to provide a social worker to engage with the children's families (School 4). In both schools these health professionals were from the ISHP and appeared to approach their school visits with a wider set of concerns than did the nurses from the clinics.

The interface between the school-level CoPs and the health practitioners was particularly evident in respect of children who were identified as having vision and auditory difficulties at school. Participants made it clear that one of the benefits of screening the children through the CoP's Child Wellbeing Tracking Tool was that children who needed specialised care could be referred to agencies that would provide the necessary support: *"In terms of screening eyesight [identified through the CWTT] … our kids … were referred to St. John's [Eye Hospital] … yes, some of our learners went to [a commercial optician] … And then we never had a problem, dealing with them. And whatever the information that was given after the observation or diagnosis, and then we sent them to Maponya Mall and some of them were given the specs. So, we would like that to continue because we are having some problems, especially from my classes"* (School 4).

In addition to voicing their appreciation for the involvement of health professionals in learner healthcare, some participants suggested that it would be advantageous if the range of health services to schools could be expanded: *"If nurses come to school, they come for those vaccines. They don't have that thing that … they'll check their ears, their eyes. Yeah, they don't do that. Maybe they'll come for the vaccine or an outbreak, where they vaccinate children. They don't come and do check ups like that. But with the, the CoP, at least those nurses, when they came in, they were checking those things. Checking their eyes, their ears, if the child can see on the board, whether the child needs glasses…"* (School 2). In another school the request was for *"health talks, which is sexual education, HIV and AIDS awareness, substance abuse, vaccinations, vision and hearing screening"* (School 1).

The insights provided by the participants on school health care suggest that the conventional relationships between schools and clinics are somewhat ad hoc and cannot be described as collaborative partnerships that evolved over time. It needs to be noted that the first year of the CoP study (2020) coincided with the first year of the COVID-19 pandemic. Collaboration with the DoH at that point was hampered owing to the department being under pressure to deliver pandemic-related health services.

However, where the school-level CoPs were able to interface with the teachers and the health care practitioners, the outcomes were more substantial with longer-term impact. Two examples were noted above: first, health practitioners' support for learners found to have difficulties with their vision and their subsequent access to glasses; and second, the availability of a social worker who could follow up with families of children assessed by the health practitioner as being malnourished. This suggests that the CoP approach helped facilitate intersectoral collaboration at the school site, which in turn produced locally targeted solutions for the children in need.

4.3.2 Coordination

Over the course of the CoP study, it became clear that the key to collaborative action was effective coordination that established regular opportunities for routine multisectoral collaboration. The CSDA CoP team coordinated the initiative, worked with the stakeholders inside the school, and harnessed the services of external stakeholders in the wider community.

Effective coordination depended on three critical elements:

- *resources* to employ a dedicated coordinator;
- sufficient *time* to build relationships with stakeholders in and outside the school, and to gain their buy-in to the project; and
- doing the *hard work* - team building, planning, logistics - to set up the school-level CoP with the school leadership.

This included training the CoP members (teachers, HoDs and others) in its purpose, and showing how they could benefit the child's academic performance by having his/her psychosocial challenges addressed. The CoP coordinator noted that visible results were key to building stakeholder participation: *"If teachers can see the value of bringing in a child who has been assessed to have an eye problem, and they are referred to [an optician] and the child improves academically, the teachers buy in".*

In addition, the value of using a community-based approach to draw families into the school life of their children was mentioned by school principals and other focus group participants. *"When [the social worker] visited the households out there, I've seen it making a huge difference, in the sense that you reach out there and make it a point that you go to the bottom of the situation. Because you know, as an institution we deal with things at a face value"* (School 4).

4.3.3 Knowledge-sharing

The CoP process helped teachers develop shared knowledge of underlying factors impacting on children at risk, and how to support these learners. This happened in two ways. First, the CoP screening process provided evidence of the factors affecting the child's behaviour in class: *"the assessments allowed them to find cases of problems and neglect that impacts on learning"* (School 3) and *"with screening, it helped us a lot. In grade one, from grade R. So, whatever we learnt from you, coming back when it was implementation, it was much easier"* (School 4). Second, the social workers were able to provide relevant feedback to teachers (without compromising client confidentiality) *"so that you have got a common knowledge with what … she was going through."* (Teacher, School 2). Feedback loops are critical for collaborative action and ongoing learning.

Gaining new knowledge about holistic support and the cross-sectoral resources needed to support this approach, emerged as a key gain for one principal who participated in the CoP process and commented: *"I just want to thank you, especially for being here, to come and empower us, share the knowledge that we have…"* (School 4).

4.3.4 Systemic alignment

As outlined earlier, the discussions suggested that there is strong alignment between the roles of the SBST and the CoP in providing support to at-risk Foundation Phase children. School-level CoPs could help the SBSTs fulfil their holistic learner support function more effectively. For example, CoP members at the school used to meet every six weeks to monitor at-risk learners, thus following up more frequently than SBSTs, which in the CoP study schools mostly meet once a term. In addition to securing the involvement of professional psychosocial support, the CoP also helped the schools reach into the community to identify causes of learner vulnerability and offered family strengthening support.

Conditions for achieving such integration between the SBST and the CoP are part of a culture change in the school, driven by the principal and senior leadership towards collaboration around psychosocial support. Integration requires designated role players, clear lines of responsibility and accountability, training in management skills and psychosocial awareness, and effective communication and administrative routines.

Collaboration across government departments is another aspect of collaborative action. During the three-year implementation period, the CoP found that effective collaboration between departments was a challenge. As outlined above, some policy synergy exists between the departments of education, social development, and health, but operations vary greatly and the capacity of DSD and the DBE to provide psychosocial support to large numbers of schools is very limited.

In the focus groups, social workers from DSD explained how they are too few in number to offer consistent support to the many schools in their district: *"We are only seven social workers for 300 … schools …So we can't do preventative work… We only respond. …I call us fire fighters and ambulances. Because we only go to schools when the situation is out of control"* (School 1). Further consideration needs to be given to the appropriate ratio of social workers to schools in this context.[10]

These are constraints that would need to be resolved for the CoP model to be institutionalised in schools. While the CoP social workers were instrumental in connecting some schools and families with external resources such as NGOs and community-based organisations, many of these agencies are themselves under-resourced and do not have the means to provide sustained social service support where government departments cannot.

The CoP study demonstrated that collaboration and coordination are central to achieving collaborative action in schools seeking to adopt a holistic approach to wellbeing as part of their drive for academic excellence. Achieving this culture change depends on committed leadership – both in schools and in the wider ecosystem of the education,

[10] Most of the CoP study schools have close to 1,000 learners enrolled. At a recommended ratio for an individual caseload of one social service practitioner to no more than 60 cases (DSD, 2011, p. 33), and assuming that one quarter of the learners require psychosocial support, these schools would require four social workers per school.

social development, and health sectors. It also requires addressing the inadequate resource flows for professional social service human resources that constitute a core component of implementing the CoP model. The evidence shows that at present there is a mismatch between the resources allocated for psychosocial support in schools, and the immense need for meeting the basic needs of vulnerable learners.

4.4 Resources and capacity strengthening

The education environment in which the CoP was implemented is characterised by a scarcity of resources. Four out of the five schools in the CoP study are no-fee schools and depend wholly on departmental funding, receiving no income from external sources: *"[There are] not enough resources inside the school and also from outside sources [contributions from parents and private sector sponsors], as we are a non-fee-paying school"* (School 1). In one case the expectations of provision outstripped the resources provided by the department: *"Our challenge is that our school is a full-service school, but yet we don't have enough resources for that"* (Principal, school 5).

The provision of social services to support primary schools is limited: *"I just want you to bear in mind that there's five social workers responsible for all the schools in Johannesburg East at the Department of Social Development"* (DSD participant, School 2). Another participant put this into perspective by describing the recommended ratio of a social worker's caseload (for individual cases) as *"it's one social worker to 60 clients"* (School 1). The under-supply in both DSD and the GDE largely restricts their social workers to running once-off workshops with learners and teachers (e.g. about bullying), and training teachers on how to fill in referral documentation. They do not have the time to engage consistently with the children who need support, nor with their families, which makes it impossible to build trust or coordinate cases – both of which are essential elements "in building and maintaining these multi-stakeholder relationships to protect students" (UNICEF, 2022, p20).

Participants were very aware of financial constraints and budgetary challenges confronting the government, but some expressed frustration and concern that for years the psychosocial component of schooling has been under-resourced, as in this comment from a teacher: *"My thinking is, you knew about this 20 years [ago]; can't you in the next financial year [allocate funds]… ? Come on … I mean really, for how many years? … If we really want to do something, we discuss it, okay, we'll check in the next financial year, where, what, yeah, gradually, until we meet what we want"* (School 2). This was reinforced by the principal who remarked: *"I'm glad that the department official is here as well. But we all know that there's financial constraints. Especially at schools like ours. We really need social workers. We have 969 learners. You [CoP] have touched only a few. And you can see the impact that it has had"* (School 2).

She went on to describe the scale of need: *"Teachers are just too busy... and we don't have the skills to find out really the real issues. And there's just too many learners with those kinds of issues. … We had a suicide last week, at our school. In grade 6. A learner in Grade 6. And you know that this is throughout other schools as well. So, there is a huge need"* (School 2). This was supported by teachers who described that they cannot give individual attention to learners in classes of 45-52 children: *"Overcrowding, it's a problem. You can't give individual attention .. So, you just teach for the sake of doing your job. You just go with the flow because you can't go reach all of them. It's difficult"* (School 5).

Recognising the challenges posed by the resource-scarce environment in which their schools are functioning, some focus groups proposed that their schools should fundraise to generate the financial resources needed to secure assistance from specialised professionals. It was also suggested that universities be asked to make available their senior education psychology and other specialised students for practicals in schools to support the psychosocial efforts of SBSTs and teachers. However, it was also noted that there are limited numbers of such students and that they would require supervision.

In implementing its care and support policy framework, the DBE has employed Learner Support Agents (LSAs) on two-year contracts to assist schools in carrying out their care and support mandate. According to the DBE, the role of an LSA (DBE, 2020, p. 22) includes: "screen and identify vulnerable learners and develop a plan to support them; develop an implementation plan on the care and support activities that the school will undertake in a particular year; provide basic counselling to learners who are experiencing or have been exposed to trauma; and in collaboration with the SBST, conduct visits to the homes of learners who are not performing well."[11] The framing of these tasks is consistent with some of the functions carried out by the CoP social workers in the community of practice.

However, the LSAs are young people who are newly out of school, and many have received little or no training for the role they are expected to play in providing psychosocial support to young children. While the directive mentions that the school management team should seek in-service training in psychosocial support through the District Office and other stakeholders, there is no indication of professional training for the LSAs. Instead, they are advised to consult professionals in cases beyond their sphere of competence.

[11] The directive notes that counselling children and conducting home visits can only be undertaken if the LSA has "received prior training".

Consequently, the focus group participants recommended that LSAs be supervised by professional social workers to strengthen the support they provide. This was based on their experience with the CoP, which demonstrated the value of consistently integrating professional social services in their schools. This perspective is supported by a UNICEF resource that cautions how, in low-income countries where resources for social service work are scarce, there may be "a tendency to rely on less qualified para-professionals and even volunteers who have not received sufficient training, and who do not possess the necessary competencies and skills to effectively manage and operate highly complex and demanding situations, including acute child protection needs and situations such as trauma. These workers may be exploited in the name of 'community service' and yet may not be held accountable under any regulatory frameworks" (UNICEF, 2019, p8).

The participants discussed how LSAs with little training may be assisted to be helpful to the SBST in carrying out tasks related to its psychosocial mandate and reiterated that supervision is key to ensuring that their outputs are productive: *"If we had someone like [the CoP social workers] training them in the things that they could do. I mean, obviously there are things that they can't. But …like writing a report … and maybe some of the other things are not that complicated to do"* (School 4).

Across the focus groups the following resources were cited as being critical for learner care and support in their schools:

- Specialised human resources such as social workers, remedial teachers, psychologists, occupational and speech therapists.
- Auxiliary social workers, and possibly community health workers, LSAs and volunteers with appropriate experience.
- Infrastructural resources such counselling spaces conducive to encouraging young children to speak freely to counsellors.
- Family strengthening programmes to produce positive outcomes for the learners involved, and to improve the engagement between their parents and the school.

4.4.1 Capacity strengthening

The need for capacity building and strengthening manifested in two different parts of the schools: the SBST and the Foundation Phase teachers.

School Based Support Teams

A key function of the SBST is to support "learners who have not benefited enough from the teacher's intervention and need additional support from the school's experienced and/or highly qualified teachers" (DBE, 2014, p. 30). This role aligns with key goals of the CoP model in improving child wellbeing outcomes. Although SBSTs were present and functioning in all five schools in the CoP study, in most cases this was not optimal. According to the participants, most of their SBSTs meet once a term and comprise 3-4 teachers and a coordinator who may be an HoD or deputy principal.

It became clear that the SBSTs face several challenges in providing holistic learner support. SBST members have little time to monitor or follow-through on learners who need psychosocial support, and typically the SBST coordinator has many other duties: *"It becomes too much for them, because they are only... three. So, they don't have enough help… they tend to neglect some of the issues … they just brush it off like, oh, this one comes to school dirty… [but] let's solve these bigger ones"* (School 5).

Participants were also concerned that SBST members lack the professional knowledge and experience to offer psychosocial support: *"We are dealing with not necessarily only referrals…. there are other issues that need to be addressed that are deeper … background check of the kids and how best can they assist. …doing this part, I don't think they've got that capacity"* (School 4). The focus groups reported that the SBSTs do not have the capacity to reach out to learners' homes as the CoP social worker was able to do, and most seem to have neither the time nor the information to draw on the services of NGOs and other agencies in the school community, which are likely to be stretched as well.

What emerges is that integrating the CoP model into the SBST needs to be supported by committed leadership that builds a culture of holistic care and support within the school. The principal would delegate responsibility for running and strengthening the SBST to a member of the senior management team who in turn would: facilitate support for SBST management training as needed; facilitate training to build the SBST's understanding of why psychosocial support is critical to school and child wellbeing; ensure clear role definition for SBST members; schedule SBST meetings and develop communication protocols that feedback SBST deliberations and actions to the staff; and manage these processes. Conditions for achieving such synergy between the SBST and the CoP are discussed briefly in Section 4 below.

Foundation Phase teachers

The teachers repeatedly mentioned how they do not feel equipped to deal with psychosocial issues, having had a very basic introduction to educational psychology during their professional training. As mentioned previously, they also described several constraints that make it difficult for them to give special attention to vulnerable learners. These

include a lack of time to focus on children who are struggling to cope in class and a lack of knowledge about the issues facing their learners.

In addition, many teachers themselves feel vulnerable e.g. *"Sometimes as teachers we also have stress, anger, anxiety, mental health problems…"* (School 3), while some worried that they may lose their jobs if they *"get involved"* in a learner's family matters because they might *"get burned"* (School 1), referring to parents or children making comments about them on social media. A CoP social worker mentioned that teachers rarely have access to wellness support: *"… some teachers are facing real mental issues, and I feel like they are not getting enough support from GDE or the district…"* (School 5).

Capacity building is thus required for the Foundation Phase teachers in psychosocial knowledge and skill, gaining more understanding of the drivers of children's vulnerability, and learning practical ways of responding to such children in their large classes. Significantly, teachers mentioned that they need *"relevant and constant training"*, indicating that their professional development should be ongoing and incremental.

4.5 Standards and routinised processes

This section considers the tools, protocols and documentation processes that are required to ensure that social support and collaborative ways of working become "normal" and routine, and that they are of high quality and delivered in an ethical manner. Developing and implementing norms and standards, protocols and routine processes could help to add structure to care and support practices and embed these ways of working across sectors at the local level.

In relation to routine processes, there were a number of contributions from participants noting challenges with care and support processes, such as irregular nature of SBSTs meetings in some schools. As one participant noted, *"That's the weakness, this thing where you don't...maybe once in three weeks you come together, all of you guys and sit down and talk about issues... that doesn't normally happen. Maybe everyone is busy too. Maybe if they can have a planning for their meeting"* (School 5).

Other concerns centred on the referral processes as well as protocols for accessing support. A key component of the collaborative CoP approach is building a network of support around the children and the school, and being able to make referrals where additional support is required. Some spoke of difficulties firstly in accessing formal assessments of children with learning difficulties and special needs, and secondly in referring children in need of further support. This was partly due to a lack of special needs schools in the vicinity.

Teachers also spoke of the challenge of having to write in-depth case reports for referrals, but not having the time to do so. As a result, participants recommended simplifying the referral process or making more skilled human resources available to speed up the process.

Participants also reported a lack of familiarity with the formal protocols for reporting suspected cases of child abuse and neglect, using the reporting Form 22. As one teacher noted, *"[We need assistance with] how to fill out the form [22] here. Like when I went for the GDE workshop, I think they did mention it, but they didn't go in-depth… they're not guiding us on how do we go about actually completing that form and stuff"* (School 2). Social workers spoke of teachers not having the time to write the required reports (see Box 10). Participants also reported being unsure of how to contact GDE or DSD social workers, as well as a *"hesitancy to report matters"* (School 2) for fear of being *"wrong"*. Not all were familiar with the requirements for mandatory reporting under the Children's Act (38 0f 2005, Section 110). Beyond the formal child protection processes, some teachers were also unaware of NGOs and other resources in their area and asked for contact lists of possible sources of support.

Box 10: Child protection referrals

"When cases are referred to us, some teachers, they don't even have time to write it down. And our supervisor, once it's written, he will refer it to us. So, some teachers, to assist the child, they just call and say, there's a child in need, please attend. Because we acknowledge that teachers, you know, psychological, social support is not their core. We understand that that's our baby. So sometimes we just attend the kids..." (Social worker, School 5).

Developing standards and routinised processes

Aspects of the CoP model can be developed into routine processes that could assist with some of these challenges. For example, conducting a community mapping process at the start of each year would familiarise SBSTs with resources available in the community. Planning SBST meetings with a CoP focus at regular intervals would provide ongoing opportunities for collaboration and accessing external support, and for entrenching routine monitoring of the progress of referrals as well as other activities such as the assessments and screening activities outlined in the ISHP.

One possibility for putting this into action is to develop an implementation plan or joint plan of action that outlines the specifics of how the CoP approach will be put into practice over the course of a year. This could be done relatively simply at a local level but would need to be accompanied by management and administrative arrangements to facilitate service delivery. This may include:

- MOUs or service level agreements between departments;
- developing practice guidelines for how different institutions will collaborate in the coordination and monitoring of the CoP programme's key deliverables;
- and developing protocols and norms and standards around referral processes, information sharing, issues of confidentiality, and the ethics of working with children, among others.

If the CoP approach were to be scaled up, the implementation plan would need to consider the roles of different spheres of government and detail the governance or accountability of each institution or level of government, as well as other stakeholders, in the delivery of CoP services.

Furthermore, building in protocols and mechanisms for supervision, training and mentoring would be critical, especially where paraprofessionals (such as social auxiliary workers, learner support agents and community-based workers) play a role in identifying vulnerable children and families and in providing care and support. Such protocols would need to be aligned with the regulations and existing frameworks on supervision for the social work profession in South Africa.

In addition, the SIAS policy calls for all children to be screened at admission as well as at the beginning of each phase and directs that these findings be recorded in the Learner Profile. The ISHP also requires learners to be individually assessed by a nurse once during each of the four educational phases. Integrating an annual holistic assessment such as adopted in the CoP study would provide a foundation for informing these assessments in a comprehensive manner, and a means of tracking progress made (either at an individual or grade level) over time.

4.6 Using evidence to inform decision-making

A fundamental premise of the CoP approach is that evidence should inform decision-making about what forms of support or intervention to prioritise, and which children should be targeted for additional support.

The SIAS policy identifies the class teacher as being responsible for initial screening and identifying of learners "as being vulnerable or at risk (as pointed out in the Learner Profile)" (DBE, 2014, p. 28). Teachers are also responsible for assuming "the role of a case manager, driving and coordinating the support process" (DBE, 2014, p. 28). In this study, teachers largely felt that they knew their learners well enough by the second term to identify those who needed additional support, but they also recognised that, due to the number of children in their classes, heavy workloads, and their focus on the curriculum, they may not always see *"beyond the uniform"*. As one participant explained, *"You can see that the child is wearing a good uniform. And then you think that's okay, everything is fine...whereas maybe beyond that, you don't know... screening the uniform only doesn't tell you exactly what is happening behind"* (School 3). There was broad appreciation for the objective and holistic assessments of selected learners in the CoP study, both in that they assisted in identifying children who may currently be coping in class but were at risk, and because they informed interventions that included further investigation by the CoP social worker, which went beyond the role that teachers can play.

The annual assessments conducted as part of the CoP study with selected learners in the Foundation Phase were comprehensive and involved interviews with children's parents or caregivers and their teacher, and an assessment by a health practitioner. The digital CWTT was used to assess children's wellbeing across the six domains (see Appendix 3) and, as one principal put it, extended the focus of providing support *"beyond teaching and learning"* only, to include *"other social problems that learners are experiencing"* (School 3).

The CWTT provided a data-driven means of identifying the vulnerabilities faced by children and, in turn, assisted with prioritising the interventions needed and which children should receive additional support. This ability to prioritise support is important in a context where access to professional skills and resources is limited.

Participants reported appreciating how an objective, multidimensional assessment of children's circumstances helped them to better understand the impacts of the child's environment on their learning and behaviour in class, and to identify children in need. These discussions highlighted the importance of feedback loops in enabling teachers and others in the school setting to support learners. As one teacher explained, *"I think [being part of the CoP] was a great experience. Especially after the interviews that ma'm [social worker] had with our team. Because she was going into detail, even interviewing the parents, going to the home, to the houses. So, you get to know the learner. You get the feedback...you have got a common knowledge with what she [the learner] was going through"* (School 2).

Such assessments provide a data-driven basis for determining how to support learners and how to target the support in a context of limited resources. They make it possible to increase the efficient use of scarce resources and increase the effectiveness of interventions by ensuring they are targeted to meet children's specific needs. The CoP assessment made

use of a digital tool, which opens opportunities for efficient data collection and (almost) real time findings. However, as noted below, these efficiencies require well trained and capacitated teams to ensure the systems run smoothly and accurately, and require an investment in training, the use of digital technologies and devices, and data management and storage.

If an annual assessment were to be institutionalised and scaled up, the data from these assessments could be used in two ways to improve care and support in schools: 1) at a district or school level, for monitoring the progress of a (randomly selected, representative) cohort of children on specific wellbeing markers (e.g. nutrition, vaccination etc.) and tracking progress for the group as a whole each year; and/or 2) at a school level (which could be aggregated at higher levels), as a case coordination tool to identify individual children in need, to develop and implement individual support plans, and to track their progress over time.

Scaling up these assessments for monitoring purposes at a district or provincial level could provide education planners with useful evidence for planning and budgeting for interventions, and for identifying where interventions are not meeting the need, or where gaps exist. Regular (annual) assessments would support a proactive preventive approach, identifying challenges – and addressing them – early on.

Participants appreciated using the assessment findings for case coordination, as was the case in the CoP study. They could see how the data collection and assessment, and the time invested in the CoP meetings to promote collaboration, translated into greater support for the learners. In the case of teachers, these processes provided visible benefits within the classroom setting. In this scenario, the data would provide guidance to health and social service practitioners on where the needs lie and act as a 'trigger' for further assessments, including home visits as needed, and engagement with parents and other relevant stakeholders.

Both options require careful thought and planning around how to institutionalise and scale up such assessments. The digital CWTT has been tested and the risk profiles produced have been shown to be useful, but the tool would need to be trimmed down for monitoring purposes (as it is currently expanded to include research questions). Given the budget and human resources required for data collection, consideration would need to be given to the testing and piloting of a revised tool as well as to how to select the children to be assessed. Issues such as who would collect the data, how it would be gathered, the training of data collectors at scale (including on ethical issues such as informed consent, privacy and confidentiality, and working with vulnerable families), the cleaning, quality assurance and management of the data at scale, and the pros and cons of possibly developing a largely automated process to inform case coordination, would need to be addressed.

5. Implications for scaling up and institutionalising the CoP model

This study set out to identify ways in which the collaborative CoP approach to strengthening the social systems around children could be institutionalised at a school level, and how it could be scaled up in line with existing policy frameworks. Several potential strategies for scaling up and integrating the CoP approach have been identified in the preceding sections and are discussed here.

5.1 Scaling up

We have defined scaling up as extending the reach of the CoP approach to more children in the Foundation Phase, to achieve the same outcomes on a larger scale. In this study, we identified the existing SBSTs as a logical home for the CoP approach. The SBSTs could also form the basis of an organic approach to scaling up the CoP model, since both the ISHP and the SIAS policy make provision for SBSTs to be established in all schools.

Scaling up across primary schools

One way to phase in the CoP model would be to expand it initially to other primary schools in the same geographic areas as the five Gauteng schools that participated in the study. The intention would be to use the SBSTs as the base for expansion, building on the experience and external stakeholder relationships already developed by the CoP study in these areas.

We are mindful that the feedback from the five schools in this study showed two key features of how SBSTs function: first, the SBSTs are not always in place or functioning optimally; and second, we did not find clear operating procedures or regulations being used by these SBSTs. These two features correspond closely to the findings from a 2021 study which found that in the implementation of the regulatory framework for inclusive education in South Africa, "significant implementation challenges have been reported. The 2018/19 Auditor-General's report found that '78% of School Based Support Teams at full-service schools audited were not established and/or did not adequately function to ensure that inclusive education is planned, implemented, recorded and reported'. Challenges to the effective functioning of SBSTs include infrequent meetings and limited understanding of the extent of their role. The lack of funding to allow at

least the SBST Coordinator time to fulfil his or her duties is a significant impediment" (EELC, 2021, pp. 53-58). These observations correspond closely to the reports received from school participants in our study.

Scaling up the CoP approach would provide an opportunity for the DBE to strengthen the SBSTs by ensuring they are properly established, training them in appropriate operating procedures using an understanding of care and support, building their skills and knowledge for implementing a holistic approach to psychosocial support, and supporting them with professional social services expertise.

Scaling up assessment of children

Four issues require consideration to guide the scaling up of the digital tool (the CWTT) for multi-dimensional assessments. First is to consider the purpose of assessments: Are they for monitoring progress broadly, and/or are they intended to inform interventions with individual children? This will determine the selection of learners to participate in the assessments: if the focus is on monitoring the progress of a cohort of children, a sample could be randomly selected; if the focus is on intervention, case coordination and management, the selection should involve children who are likely to be at higher risk (e.g. those whose caregivers receive the CSG).

Second, while a digital tool such as the CWTT promises several advantages such as efficient data collection, (almost) real time findings and collective data for planning purposes, the assessments will still need to be supported by a well-trained and capacitated team who can collect the data, trouble shoot and assure the quality of the data, and clean, analyse and interpret the data. This would require investments in training, the use of digital technologies and devices, and the human resources needed to act on the findings.

Third, due consideration would need to be given to logistical issues such as data management and storage, and governance issues such as compliance with the POPI Act (2013) and enabling feedback loops while also ensuring confidentiality. Fourth, the CWTT has been tested and was appreciated by participants for the holistic assessment provided, but if it were to be scaled up it would need to be trimmed down, and a revised tool and data collection system would need to be piloted.

5.2 Institutionalisation

Institutionalising the CoP approach involves embedding both the values and the mechanisms and protocols into the everyday practices of the school so that they become routine and are sustained over time. The following sections outline how this could be achieved, drawing on the six domains considered in this study.

5.2.1 Governance

An enabling policy framework is already in place for an approach that promotes intersectoral collaboration to address care and support at a school level, although the alignment at a policy level and in practice between social services and the education system is less clear. Our study suggests that there is an opportunity to fill an operational gap by providing a practical means to implement collaboration for quicker, effective service delivery, and by attending to the provision of social work services in schools, particularly in the Foundation Phase. Steps taken in this direction to address the latter would be in line with good practice outlined by UNICEF and would strengthen the implementation of both policies and the Care and Support of Teaching and Learning programme: "The key role of the social service workforce needs to be recognised by ministries of education. Ministries of social welfare and ministries of education need to work together to ensure the integration of the workforce within education structures" (UNICEF, 2019, p. 8).

As noted above, integrating the CoP model into the SBSTs provides a practical means to implement the integrated and inclusive services envisaged by these policies, by bringing in additional capacity and skills through the collaborative approach and foregrounding the importance of social services support that we found to be largely absent at a school level. A clear understanding of the roles, responsibilities, and processes of both the SBSTs and the CoP would be required to better understand how the collaboration and coordination features of the CoP could most effectively be embedded. We have suggested that a single, senior Foundation Phase staff member could coordinate the CoP processes from within the SBST, but further consideration should be given to the staff capacity that would be required, given the number of classes in Foundation Phase in each school. The role of the district and DBSTs in supporting this integration should also be considered, bearing in mind the constraints and challenges identified in the EELC study (EELC, 2021).

5.2.2 Leadership, commitment, and culture

Proactive leadership at a school level is required to bring about a culture change within the school, as well as to manage collaborative relationships with those outside the school. Integrating the CoP model at a primary school depends in part on the principal's commitment to championing a vision of providing holistic psychosocial support for young children at risk and supporting the staff to adopt new ways of working. The school leadership also needs to recognise and support the importance of integrating social services support into school operations and embrace the task of creating a culture

of collaboration. This study found that the localised CoP approach encourages innovative relationships to be developed between a school's internal and external ecosystems, but noted that awareness of the impact of psychosocial wellbeing on school performance needs to be strengthened at a district level. One challenge in scaling up such an approach is that in the CoP study the intervention was driven by an external team; institutionalising the approach means that the leadership at each school will be key in taking on this role.

5.2.3 Collaborative action

The CoP study demonstrated that collaboration and coordination are central to achieving collaborative action in schools that seek to adopt a holistic approach to learner wellbeing. This occurred in three ways: partner collaboration; programme coordination; and systemic alignment between the CoP and its stakeholders.

Partner collaboration lies at the core of the CoP approach which brings together – at a local level – personnel from education, health, and social development as well as NGOs, primary health care services and community-based players. Participants in our study were particularly appreciative of the partnership with and access to the CoP social workers. This was evident in the trust-based relationships that were built in each school between the CoP social worker and the Foundation Phase teachers. Knowledge sharing and feedback loops proved critical in building these relationships and fostering collaboration, particularly in respect of the social worker's role in reaching out to learners' homes and offering support to vulnerable families. In light of these benefits the very limited provision of social services workers by the GDE and DSD needs to be addressed because those social workers are currently unable to fulfil their support function in relation to the needs of young at-risk children and their families.

Challenges were experienced in securing the collaboration of nurses from the ISHP because they are spread thinly across many schools. In some areas of Johannesburg, primary health care services are delivered by clinics that are under the auspices of the City of Johannesburg while in others, services are delivered by the provincial Department of Health. This created confusion in the CoP team about mandates, roles and responsibilities of the different health care service providers and in securing the requisite permission from the appropriate senior management structures. Collaboration with the Department of Health was also hampered by the pressure of delivering health services during the COVID-19 pandemic. These issues were addressed in the second and third year of the CoP study. For effective institutionalisation of the CoP approach at school level, greater clarity of mandates, roles and responsibilities of the child health care component including management systems are needed.

Coordination emerged as the key to collaborative action and ensuring a successful outcome. It rested on three critical elements: *resources* for a dedicated coordinator of service provision for at risk children, preferably a social worker; *sufficient time* to build working relationships with stakeholders in and outside the school; and *investing in team building, planning and logistics* with the school leadership to set up the school-level CoP. Central to achieving these conditions was the buy-in of the school leadership and the dedicated focus of the local level CoP team as well as the social workers allocated to the respective schools.

The systemic policy and structural alignments discussed earlier provide the conditions for integrating the CoP approach with the SBSTs. What became evident in our study is that there is little operational engagement between the DBE and DSD, and to some degree between the DBE and DoH. Of particular concern is the very limited resource allocation to social work services in schools, which impedes efforts of the available social services personnel to support vulnerable learners effectively.

5.2.4 Resources and capacity strengthening

Having been conducted primarily in no-fee primary schools[12], the CoP study demonstrated the impact of the resource scarce environment in which the schools operate. Participants commented repeatedly on the lack of resources available, even in the case of a full-service school that is unable to deliver all the expected services. As mentioned previously, the provision of social work and related social services by DSD and the GDE to the primary schools is extremely limited and consequently ineffectual in respect of the psychosocial support needs in Foundation Phase. Participants were very aware of the financial constraints within government, but perceive the absence of resources for social services as being a lack of political will, particularly as the situation has not improved notably over time. Some suggested doing school fundraising to employ a social worker, but this is clearly not sustainable, particularly in a resource-scarce community, and would only exacerbate inequalities.

A key finding of this study is that policymakers need to consider ways to bring professional social work and related social services closer to schools. UNICEF advises that, "depending on context and resources, social service workers can be school-based or community-based and linked to either one school or a small cluster of schools, with regular

[12] Of the five schools, three were quintile 2 schools and one was a quintile 3 school. These were 'no-fee' schools. Only one school was a quintile 4 school.

visits to each" (UNICEF, 2019, p. 8). They also caution that whichever approach or model is taken, "it is important not to overstretch the social service workforce to the point where interventions become less effective."

Two other factors were mentioned as constraining the provision of psychosocial support in Foundation Phase classrooms. First, overcrowding in the schools produces class sizes of up to 50+, making it impossible for the teachers to provide individual attention to learners who are struggling in class, or to identify children who are vulnerable, but who may appear to be coping. Second, curriculum coverage is a key priority, with the result that teachers can ill-afford to spend time coaching or counselling children who cannot keep up, or to coordinate assistance for children beyond the classroom.

In the context of the DBE's care and support policy framework, the department has employed Learner Support Agents (LSAs) to help schools offer psychosocial support to learners. Their role is aligned with the tasks carried out by the CoP social workers (DBE, 2020), but these young people have no professional training for the job. Drawing on the UNICEF perspective, we see the risk here as being that LSAs "may be exploited in the name of 'community service' and yet may not be held accountable under any regulatory frameworks" (UNICEF, 2019, p. 8).

Furthermore, the evidence shows that capacity strengthening is required both for SBSTs and for teachers in the Foundation Phase. In the case of the five schools, most SBSTs meet quarterly, which provides little opportunity to monitor or track learners who need psychosocial support. Participants were concerned that SBST members lack sufficient knowledge of psychosocial support and what it entails in practice. It was also suggested that SBSTs require management training to function more effectively.

Integrating the CoP model into the SBST provides an opportunity to strengthen the structure so that it is better able to fulfil its mandate, supported by psychosocial expertise from social workers, educational psychologists, and related paraprofessionals. Steps required to achieve this have been discussed above. Teachers need training to equip them to identify and deal with psychosocial issues facing children,[13] including familiarising them with the services that are available and the protocols for referrals. Many teachers feel vulnerable themselves and rarely have access to wellness support.

5.2.5 Standards and routinised processes

A key aspect of embedding collaborative ways of working at a local level is developing norms and standards, protocols and routine processes that make this kind of engagement part of the 'normal' routine. Examples of ways to do this include having routinely scheduled CoP/SBST meetings that include stakeholders from across relevant sectors and provide regular opportunities for collaboration and building relationships; having clearly established roles and responsibilities for CoP members; developing clear and simple protocols for referrals; and establishing a work plan for the year that includes community mapping of available skills and services as well as screening and tracking of interventions; and developing protocols and mechanisms for supervision, training and mentoring, among others. One way to do this is to develop an implementation plan or joint plan of action that outlines the specifics of how the CoP approach will be put into practice over the course of a year and is accompanied by management and administrative arrangements to facilitate the implementation.

5.2.6 Using evidence to inform decision-making

While the SIAS policy (2014) calls for teachers to develop a learner profile, there is currently no multidimensional assessment of children to inform decision-making about which children should be targeted for additional support and what forms of support or intervention to prioritise. This study found that participants appreciated the CoP assessment of selected children using the CWTT because it provided a comprehensive and evidence-based means of identifying the vulnerabilities faced by individual children and assisted with prioritising the interventions needed by them in a context of limited resources. They also appreciated the proactive nature of this approach, and that the findings then triggered further investigation and intervention by the CoP social worker, thus going beyond what can be identified and addressed in the classroom alone. While the CWTT can be scaled up, there are several issues that would need to be considered to inform its implementation, as discussed in section 4.6.

[13] In its recommendations for skills development for inclusive teaching and learning, the EELC study (2021, p.94) emphasises four ways in which teachers need to be skilled and supported "to ensure all children can learn in ordinary schools".

6. Conclusion and recommendations

As has been outlined earlier in the report, the alignment between the policy framework and the goals of the CoP model, and the regulatory requirements of SBSTs and DBSTs, provide an enabling environment for integrating the CoP model into primary schools. We offer the following high-level recommendations for consideration in scaling up and institutionalising the CoP model using an organic, "bottom up" approach.

1. Governance

a. Work with GDE and school leadership to review the existing roles, responsibilities, and operations of SBSTs and the local level CoPs. Identify alignment and gaps, and any additions that would be required to embed the collaboration and coordination features of the CoP into the SBSTs.
b. Identify a senior staff member (e.g. Foundation Phase HoD) to coordinate the CoP approach within the SBST. Consideration should be given to whether more than one staff member will be required, given the number of Foundation Phase classes in the larger schools.
c. The role of the district and DBSTs in supporting this integration should also be considered and formally captured in care and support protocols.
d. Develop protocols that outline how confidentiality relating to children and families' personal information will be maintained, and how issues of compliance with the POPI Act (2014) will be addressed.

2. Leadership

a. Strong leadership will be required to establish a culture of collaboration and care in the school, as well as a focus on early intervention and response. Opportunities should be provided for school leadership to become more informed about how to build a culture of holistic care and support within the school.
b. When phasing in the CoP approach, encourage primary school principals who have experience of the CoP intervention to establish support networks with other principals in nearby primary schools who are new to the initiative. This will help strengthen principals' efforts to introduce a culture of holistic support and collaborative ways of working in their schools. It will also help them link their schools with stakeholders and organisations operating in the broader community.

3. Coordination and collaboration

a. Resolve the lack of interdepartmental collaboration around the provision of social services support to children identified as being at risk. This means forging the cross-departmental operational agreements for financial resource allocation and human resource provision to impact effectively on a growing need in schools.
b. This needs to be accompanied by close monitoring and support from the district and provincial level support teams.
c. Strengthen coordination with the ISHP and local and provincial primary health care services. Clarify mandates, roles and responsibilities between local authority primary health care clinics and provincial primary health care services, and strengthen the supervision and management of staff.
d. Inter-departmental coordination between provincial departments of education, health and social development is needed.

4. Resources and capacity strengthening

a. While consideration has been given to norms and standards for social worker caseloads or individual clients (DSD, 2011), further attention needs to be given to the ratio of community-based social workers in learner support units to schools or classes of learners. The current ratio of a handful of social workers to hundreds of schools is not viable.
b. DBE and DSD need to draw on auxiliary social workers and other paraprofessionals to amplify the social services human resource complement available to schools, noting, however, that they too need to be supervised by fully qualified social workers.
c. LSAs provide a potential school-based resource, but require ongoing training to effectively carry out their role of assisting with psychosocial support. They cannot substitute for qualified professional social service personnel and need to be supervised by professional social workers to strengthen the support they provide. A CoP social worker, working with the SBST, could play this role.
d. Participants also made recommendations for critical resources required for learner care and support in their schools. This included specialised human resources such as social workers, remedial teachers, psychologists, occupational and speech therapists; infrastructural resources such as counselling space conducive to encouraging young children to speak freely to counsellors; and family strengthening programmes to produce positive outcomes for the learners involved, and to improve the engagement between their parents and the school.

e. Capacity building is required for the Foundation Phase teachers (and other staff members) in psychosocial knowledge and skill to gain more understanding of the drivers of children's vulnerability, and to learn practical ways of responding to such children in class.
f. Staff training, supervision, mentoring, coaching and performance management of all 'front line' staff is critical, and will require working in integrated and multisectoral teams at a school level.
g. The DBE, in partnership with DSD and DoH, among others, would need to mobilise the financial and human resources required to operationalise the CoP approach, under the banner of the CSTL programme in schools. Data from the CoP study could be used to inform a human resource plan and provide scenarios of cost implications.
h. In addition, a closer working relationship needs to be established between the DBE and the DoH for streamlined collaboration in schools. While there was some cooperation between the five schools and their respective primary health care clinics, these relationships need to be strengthened and extended beyond the intermittent monitoring of vaccinations and other routine health checks. Consideration should also be given to the potential for community health workers to augment the health services available to schools.

5. Standards and routine practices

a. Representatives of GDE, the DSD, DoH districts, primary health care clinics and other local external stakeholders will need to jointly develop an implementation plan with clear objectives that outlines the specifics of how the CoP approach will be implemented over the year. This would need to be accompanied by memoranda of understanding or service level agreements across departments to clarify the roles, responsibilities, and mandates of each. Accountability mechanisms (performance management and monitoring and evaluation) for each institution or level of government and other stakeholders also need to be specified.
b. Other routine processes that would need to be formalised include clear and simple protocols for referrals and guidelines for information sharing and issues of confidentiality, as well as for supervision, training, and mentoring, among others.

6. Using evidence to inform decision-making

a. Consideration would need to be given to the purpose of adopting an approach that involved multi-dimensional assessments to make strategic choices about the use of an evidence-based assessment. First, the assessment (drawing on the digital tool) could be used for monitoring child wellbeing at schools in Gauteng to inform more effective policy, planning and implementation of SBSTs. Second, the tool can be used to conduct child wellbeing assessments to inform individual interventions to improve child wellbeing outcomes. Understanding the purpose of the assessment (or combination thereof) will guide how the assessments are implemented.
b. The digital CWTT has been tested and the risk profiles produced have been shown to be useful, but the tool would need to be trimmed down for more effective scaling up. The revised tool would need to be tested and piloted.
c. Issues such as who would collect the data, how it would be gathered, the training of data collectors at scale (including on ethical issues such as informed consent, privacy and confidentiality and working with vulnerable families), and the cleaning, quality assurance and management of the data at scale, all need to be considered. Attention must also be paid to how data will be analysed and interpreted, who will then act on the findings, and the pros and cons of possibly developing a largely automated process to inform case coordination.
d. All of this has financial implications in terms of the costs of investing in the technology, training, and human resources involved. Data from the CoP study can be used to assess the cost implications of this investment.

7. References

DBE. (2014). *Policy on screeing, identification, assessment and support.* Pretoria: Department of Basic Education.

DBE. (2020). *A guide for Learner Support Agents and schools on providing psychosocial support to learners.* Pretoria: Psychsocial Support Directorate: Department of Basic Education (DBE).

Dibakwane, S. T., & Peu, M. D. (2018). Experiences of school health nurses regarding the provision of the school health service delivery in the Tshwane district. *African Journal of Primary Health Care & Family Medicine, 10*(1), 1-8.

DoH, & DBE. (2012). *Integrated school health policy.* Pretoria: Department of Health and Department of Basic Education.

DSD. (2011). *Generic norms and standards for social welfare services.* Pretoria: Department of Social Development (DSD)

EELC. (2021). *Let In or Left Out? A 20 year review of the regulatory framework for inclusive education and its implementation in South Africa.* Cape Town: Equal Education Law Centre (EELC).

Lenkokile, R., Hlongwane, P., & Clapper, V. (2019). Implementation of the integrated school health policy in public primary schools in Region C, Gauteng Province. *African Journal of Public Affairs, 11*(1), 196-211.

Patel, L., Sello, M., Haffejee, S., Mbowa, S., Sani, T., Graham, L., . . . Bezuidenhout, H. (2023). *How well are children faring? A longitudinal assessment of child wellbeing in the COVID-19 pandemic in selected Johannesburg schools over three waves from 2020-2022.* Johannesburg: Centre for Social Development in Africa, University of Johannesburg.

Pillay, J., Patel, L., & Setlhare-Kajee, R. (2023). Teacher awareness of psychosocial support available as per the Integrated School Health Policy in South Africa. *South African Journal of Childhood Education, 13*(1). doi:10.4102/sajce.v13i1.1172

UNICEF. (2019). *Guidelines to strengthen social service workforce for child protection.* New York: United Nations Children's Fund.

WHO. (2023). *Supporting the routine use of evidence during the policy-making process: a WHO Checklist.* Geneva: World Health Organization (WHO).

WHO, & UNICEF. (2020). *Working document: Investing in our future - A comprehensive agenda for the health and well-being of children and adolescents.* Geneva: World Health Organization.

Appendix 1: The Community of Practice Research Team

Research Chairs, Collaborating Research Partners, and Investigators

- DSI/NRF (SARCHI) Chairs:
  - Prof Leila Patel, Distinguished Professor and former DSI/NRF Chair in Welfare and Social Development (Principal Investigator), UJ
  - Prof Jace Pillay, Chair in Education Psychology (Co-Principal Investigator), UJ
  - Prof Elizabeth Henning Chair in Integrated Studies of Learning Language, Mathematics and Science in the Primary School (Co-Principal Investigator), UJ
  - Prof Tanusha Raniga, Interim South African Research Chair in Welfare and Social Development, UJ
- Prof. Shane Norris (Collaborator), Director of the DSI-NRF Centre of Excellence in Human Development, University of the Witwatersrand
- Prof. Lauren Graham (Collaborator), Director of the Centre for Social Development in Africa, UJ
- Prof. Nompumelelo Ntshingila (Collaborator), Department of Nursing, UJ
- Dr Tintswalo Victoria Nesengani (Collaborator), Department of Nursing, University of Pretoria
- Dr Lukhanyo Nyati, Data Scientist and Researcher, University of the Western Cape
- Dr Wanga Zembe-Mkabile (Collaborator), Medical Research Council
- Prof. Arnesh Telukdarie (Collaborator), Professor of Digital Business at the Johannesburg Business School, UJ
- Dr Megashnee Munsamy (Collaborator), Institute for Engineering & Enterprise, UJ
- Tania Sani (Project Coordinator), Prof. Sadiyya Haffejee (CoP Research Manager), Matshidiso Sello (Researcher) and Sonia Mbowa (Researcher), Thembeka Somtseu (Administrative Support), Benter Mangana (Financial Management), Dr Constance Gunhidzirai (Post-Doctoral Fellow) CSDA, UJ
- Dr Rubina Setlhare-Kajee (Researcher), Department of Education Psychology, University of the Western Cape (UWC)
- Dr Trishana Soni and Dr Lucia Munongi, Department of Education Psychology, UJ
- Dr Hanrie Bezuidenhout and Rhulane Ramasodi (Researchers), Centre for Education Practice Research (Integrated Studies of Learning Language, Science and Mathematics in Primary Schools), UJ

Government Partners

City of Ekurhuleni, Department of Health
Department of Science & Technology
Gauteng Department of Education
Gauteng Department of Education; Psychological, Therapeutic and Medical Services (Inclusion & Special Needs Directorate)
Gauteng Department of Health
National Research Foundation
The City of Johannesburg
The National Department of Basic Education
The National School Nutrition Programme

Non-government Partners

Childline Gauteng
Families South Africa (FAMSA)
MES (Mould Empower Serve), Johannesburg
Save the Children
UNICEF SA
Soul Food

Community Health Services

University of Johannesburg Optometry Clinic
University of the Witwatersrand Speech & Hearing Clinic
Local City of Johannesburg and Gauteng Provincial clinics

Participating Schools in Johannesburg

Ekukhanyisweni Primary School (Alexandra) (Quintile 2)
Mikateka Primary School (Ivory Park) (Quintile 2)
Mayibuye Primary School (Doornkop, Soweto) (Quintile 2)
Lejoeleputsoa Primary School (Meadowlands, Soweto) (Quintile 3)
Malvern Primary School (Malvern) (Quintile 4)

Fieldworkers

Social workers: Nonhle Mavuso, Nomasonto Madondo, Yibanathi Mabunda, Victorian Sithole, Bongiwe Somdaka, Hope Mokadi, Nomsa Jase, Nokuthula Tivane, Ntsako Sambo and Kgomotso Mangolela

Field Supervisors: Marium Mayet, Sydney Radebe, Thembelani Adonis, Abongile Njoli, Tsakane Sithole, Keletso Mohlala

Nursing preceptors:[14] Glen Malape, Kwanele Mbazo, Busisiwe Sithole, Busisiwe Gambu, Kevin Ndlovu, Lindani Dlamini, Linkie Thathetji, Khalirendwe Mukondeleli, Andrea Britton, Nompumelelo Mabena, Rethabile Budlela, Roselene Mugwidi, Triphinah Maboela, Zizipho Nomqonde.

[14] A preceptor is an experienced practitioner who provides supervision during clinical practice and facilitates the application of theory to practice for students and staff learners. https://www.google.com/search?q=preceptors+meaning&sca_esv=562684738&ei=0eD2ZN_EGNibkdUP5ayrmAw&oq=preceptors&gs_lp=Egxnd3Mtd2l6LXNlcnAiCnByZWNlcHRvcnMqAggEMgUQABiABDIFEAAYgAQyBRAAGIAEMgUQABiABDIFEAAYgAQyBRAAGIAEMgUQABiABDIFEAAYgAQyBRAAGIAEMgUQABiABEjvNF

Appendix 2: Methodology

This qualitative study used focus group discussions as our data collection method. The method was chosen because it facilitated dialogue and reflection between participants from different sectors who were involved in the local level CoPs (LLCoP) in the CoP study.

School focus groups

At each of the five urban CoP schools, a focus group discussion (FGD) was organised with the LLCoP group established there in 2020. The purpose of the FGD was to canvas the views of LLCoP participants who had participated in the three waves of the project from 2020-2023. The research team used a discussion guide to prompt conversation in two areas: (a) participants' understanding of the CoP approach; and (b) their views on scaling up the CoP model to other schools in the community and institutionalising it in practice.

A purposive sampling method was used. Participants were selected if they were involved in the CoP study schools programme, including administrators at district level. The different social sectors in health, nutrition, education, social work and educational psychology services had to be represented. Each focus group had to consist of approximately 20 participants, comprising the following categories of personnel: CoP social workers, DSD social workers, Foundation Phase and Intersen teachers, 1 HoD, the school principal or deputy principal, local CoJ clinic or ISHP nurses, GDE Johannesburg East & West district officials, GDE ISS (Inclusion & Special Schools unit) educational psychologists, Gauteng Province DoH dieticians & nutritionists, community-based NGOs and community-based mental health practitioners.

Each session lasted between 1.5 and 2 hours. During the discussions, participants were divided into small groups comprising a mix of representatives from each sector. Each group was facilitated by a CoP team member or by the external researchers. Participants were given the opportunity to discuss three key questions:

- How can we expand and improve on the school-based support/CoP function in schools?
- What resources are needed to expand and improve on the school-based support/CoP function in schools?
- What are the challenges or barriers to expanding and improving the school-based support/CoP function in schools?

The focus groups were transcribed, and data analysis proceeded to answer the research questions. Thematic analysis was used to analyse the data according to the framework for scaling and institutionalisation discussed in section 3.1.

Challenges and limitations

In the first three urban schools, at least 90% of the intended representatives participated. Participants were divided into small groups as per the proposed method. Three CoP study members and two external researchers facilitated the small groups. More teachers were represented than any of the other sectors, but this is not surprising given that the intervention took place in the schools.

The main challenge was that in some schools, staff changes meant that the original LLCoP participants were no longer available, and newer education, health and social development personnel participated in the FGDs. Consequently, some of the questions for discussion had to be tweaked, but there were sufficient participants from the original LLCoPs to ensure that their experience of the process could be drawn on.

In the last two urban schools there were fewer participants than in the first three. Accordingly, the discussions were held in plenary with the entire group instead of in small groups. Furthermore, in these two schools, some of the targeted stakeholders were not represented such as the dietician, one principal, the GDE, the local CoJ clinic, and a DSD social worker, causing a further dominance of teacher perspectives.

In addition, while this report focuses on the insights from participants at a local level, it does not include inputs from officials at district, provincial or national level.

The CoP and UJ Engineering teams focus group

A key element of the CoP study was the development of an application for monitoring the wellbeing of children – the Child Wellbeing Tracking Tool (CWTT). The CWTT was conceptually developed with inputs from experts across health, welfare, psychology, social work, and education. It comprises of a set of questions that give an indication of child wellbeing in six domains, namely good health, nutrition and food, economic and material wellbeing, education and learning, protection and care and psychosocial health. A team of engineers developed the two components of the CWTT:

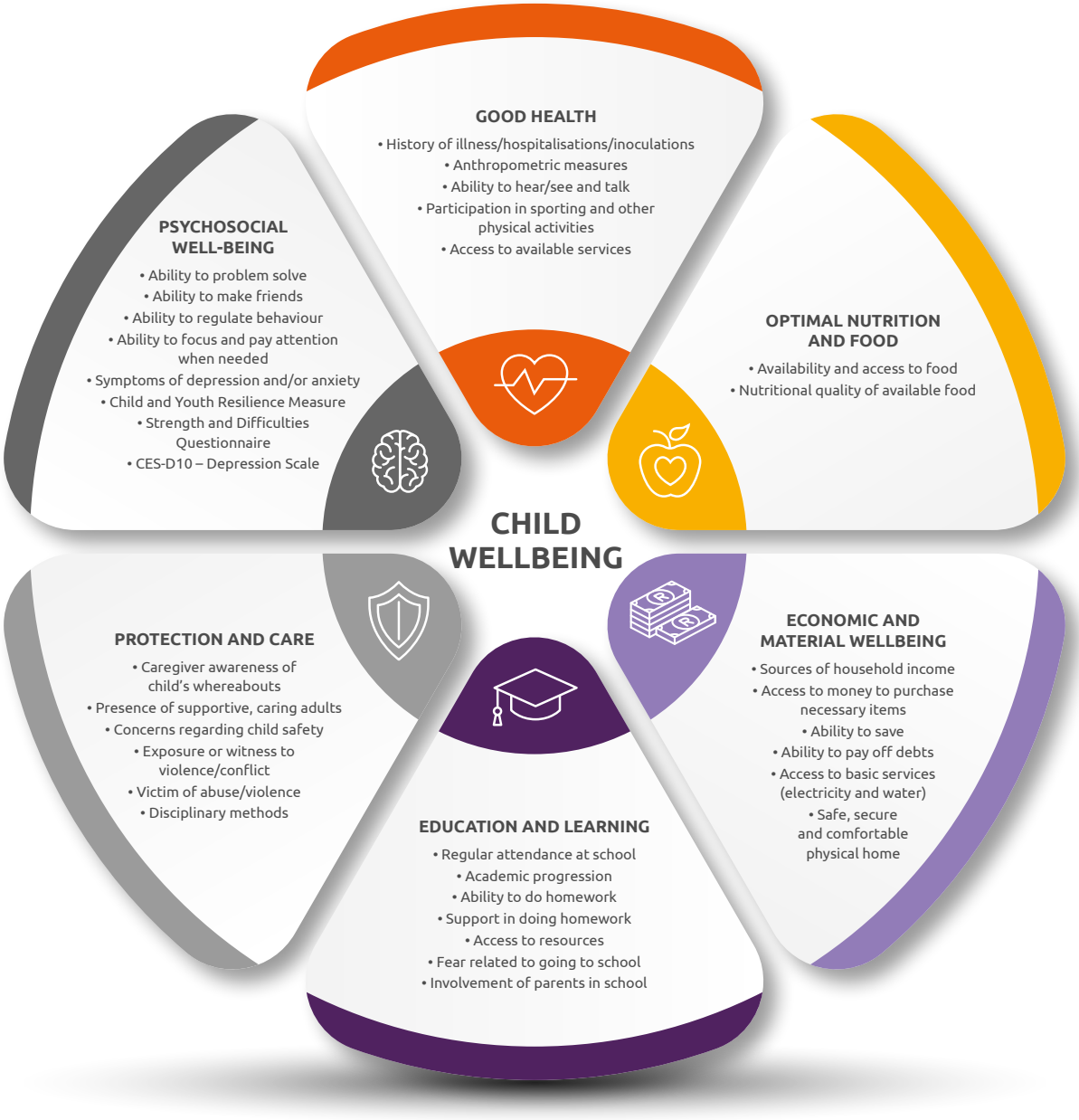
a. A data collection component, which allows individuals to collect data in the field that is then merged for each child and analysed.

b. A data presentation component, which presents the data in an easy-to-use interface that shows which children are at risk and in what domain of wellbeing. This interface is intended to support intervention planning and enable teachers and other practitioners to track whether improvements are occurring over time.

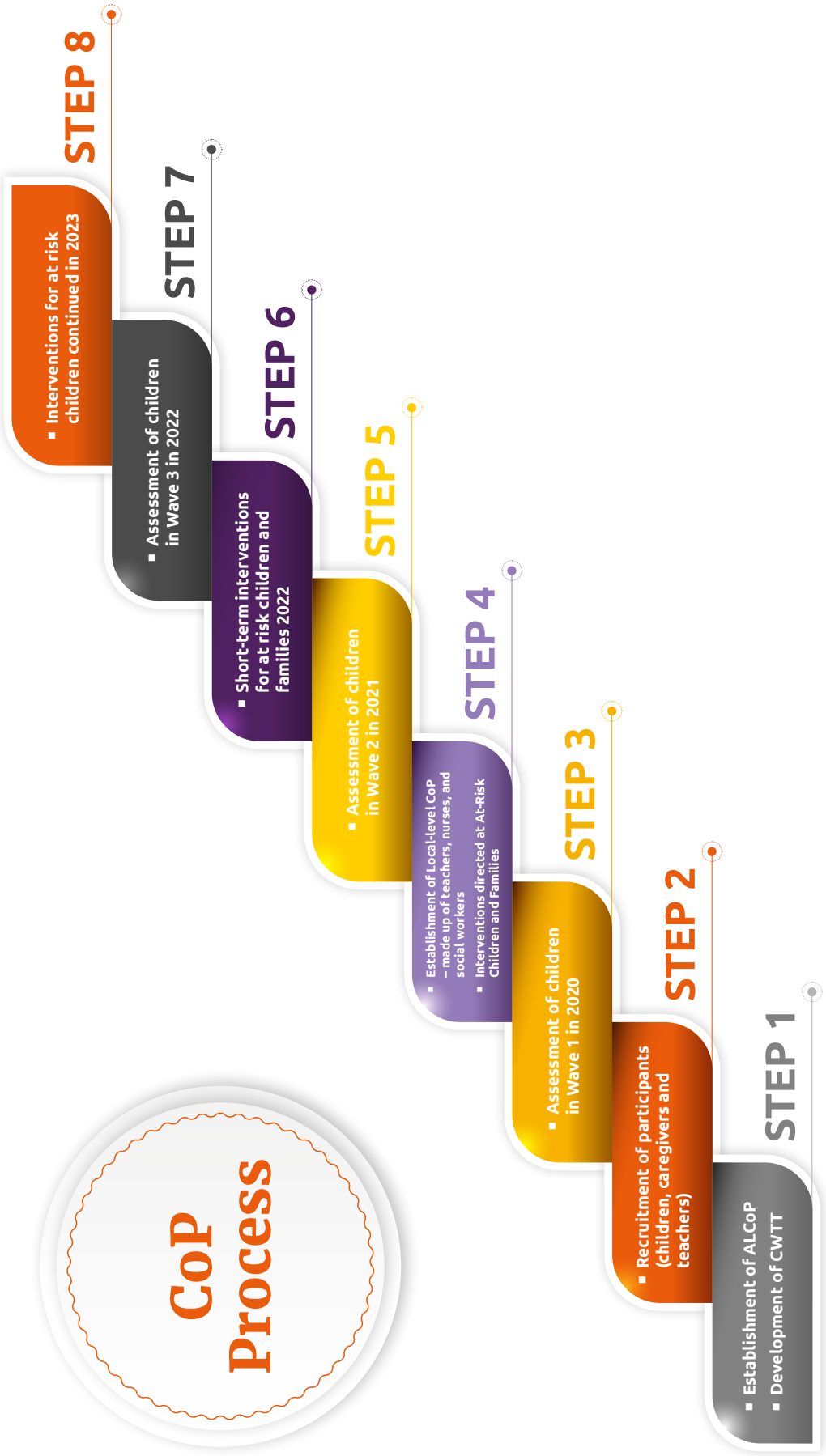
During the development of the application, there were several successes and challenges. In November 2023, a sixth focus group was held with members from the CoP and the UJ Engineering teams to reflect on these challenges and to consider what would be needed to potentially scale up the use of the tool and to institutionalise it's use.

The focus group comprised 19 participants (both in person and online) and was facilitated by the two independent researchers conducting the qualitative study for scaling up and institutionalising the CoP model. The findings that emerged from this sixth focus group discussion are documented in a separate report.

Appendix 3: Overview of child wellbeing domains in the CWTT



Appendix 4: Evolution of the multi-year CoP intervention in Gauteng



Appendix 5: Topline findings from three waves of the CoP study

Psychosocial wellbeing of caregivers and children

- Results from the Strengths and Difficulties assessment showed a gradual decrease in the number of children experiencing difficulties, from 35% in Wave 1, to 24% in Wave 2 and 11% in Wave 3.
- Fewer children experienced emotional, peer and social difficulties by Wave 3 compared to Wave 1. Conduct difficulties improved by 16%, but remained high with a quarter of the children still struggling in this area.
- Levels of caregiver depression more than halved between Wave 1 and Wave 3, from 52.6% in Wave 1 to 23.5% in Wave 3. This was possibly influenced by the simultaneous increase in the support Levels of caregiver depression more than halved between Wave 1 and Wave 3, from 52.6% in Wave 1 to 23.5% in Wave 3. caregivers received which increased from 31.7% in Wave 1 to 69.9% in Wave 3.
- High levels of caregiver depression (23.5%) in Wave 3 is a significant risk factor for children's psychosocial development.

Care and protection

- Six out of ten children continued to be exposed to hostile and violent behavior at home and in the community.
- Concerns regarding children's safety due to the pandemic decreased over time from 63.8% in Wave 1, to 50.4% in Waves 2 and 3 respectively.
- This occurred alongside an increase in the time that family members spent with children, from 79.8% in Wave 1 to 91.3% in Wave 3 which is a positive mitigating factor.

Education

- The majority (62.6%) of the children were in Grade 2 and Grade 3 (34.15%) at Wave 3. In 2021, 18.5% (n=10) of children who were in Grade 1 in 2020 did not move on to Grade 2 and 5.1% of children in Grade 1 in 2021 did not move on to the next grade in 2022.
- Caregivers perceived a gradual improvement in their children's educational progress, with 82.9% of caregivers reporting such in Wave 1 to 88.6% in Wave 2 and 91% in Wave 3. By contrast teachers noted a gradual decrease in children's school performance from 86.2% in Wave 1, to 82.5% in Wave 2 and 73.3% in Wave 3.
- Teachers reported that child participation in class improved.
- Teachers flagged concerns about children not doing homework, which declined between Waves 1 (71%) and 3 (64%). This contrasted with caregivers who reported consistently high scores of over 90% on children doing homework across the three waves.
- Teachers noted little fluctuation in school attendance over the three waves.
- There was a reduction of 38% between Wave 1 and Wave 3 of children who were afraid to go to school.

Child hunger and malnutrition

- At Wave 2, no children were going to bed hungry in the last seven days, as compared to the 16 (13.7%) children in Wave 1. At Wave 3, we saw a slight increase again, with 6 children reportedly going to bed hungry.
- Children's access to food and nutrition improved, with an increase of 18 % for those eating three meals a day.
- Most children ate protein (95%) and vegetables (93%) twice a week.
- Negligible decreases in stunting occurred over the three waves. This is a persistent and challenging issue that has not improved significantly over the past three decades.
- Changes in the proportion of overweight children decreased marginally.
- There was a 14% increase in wasting between Waves 1 to 3. Likewise, 11% more children were underweight over the same period.
- An increase in households with 3-4 children was observed. Other studies found that it is children in larger households that are more vulnerable to hunger (Van der Berg, Patel & Bridgman 2022). When these indicators are taken together, half of the children in the study experienced at least one indicator of malnutrition.

Child health

- Greater responsiveness to children's health needs was achieved.
- Fewer children experienced health challenges (10%) that prevented them from attending school by Wave 3. More children were able to access health services (4%) between Waves 2 and 3.
- Greater awareness by caregivers of health challenges requiring specialised screening and intervention was achieved. Examples are difficulties with eyesight, speech and hearing.
- Higher vaccination rates were recorded by Wave 3 compared to Wave 1, but almost a third of the children continued to have incomplete vaccinations.
- More children were engaged in physical activities after school. This increased by 18 % between Waves 1 and 3.

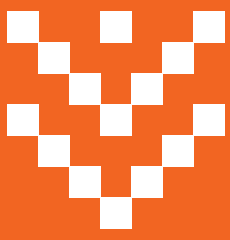
Economic and material wellbeing

8.1.1 Household level changes

- Household composition shifted over the three waves. There was an increase in the size of households with three to four children. This was possibly due to financial stressors.
- Most of the children (41.5%) lived with their mothers and other relatives.
- Access to essential resources improved over time. For example, a decrease was found in the number of children without a mattress/bed and improvements in household protection against wind and rain.

8.1.2 Changes due to the pandemic

- The material wellbeing of children and their families was significantly compromised during the pandemic.
- Full-time employment recovered marginally reaching 16% in Wave 3 compared to 20% in Wave 1.
- Improvements are evident in caregivers' earnings in the form of part-time (7%), casual work (5%) and self-employment (10%), but unemployment remained stubbornly high at 63% among child support grant (CSG) beneficiary families.
- At Wave 3, 85% of the sample received the CSG and 40% of households had access to the SRD.
- Social grants cushioned the economic shock of the pandemic, but grant values were low with 29% of households not having sufficient money to buy the things that they need.



Communities of Practice web link:
https://communitiesforchildwellbeing.org/