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

Report on an interdepartmental governmental meeting held to discuss mechanisms for scaling up and institutionalising the Community of Practice approach[1]

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[1] The Community of Practice research team comprised five Research Chairs, 20 Collaborating Research Partners and Investigators; 10 Government Partners; six Non-government Partners; three Community Health Services; five participating schools in Gauteng; and 30 fieldworkers.

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Acronyms

CoP	Community of Practice
CSDA	Centre for Social Development in Africa
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
LSAs	Learner Support Agents
MoU	Memorandum of Understanding
SBST	School Based Support Team
SIAS	Screening, Identification, Assessment and Support policy
UJ	University of Johannesburg
WHO	World Health Organisation

Introduction

An interdepartmental governmental meeting was convened by the Centre for Social Development in Africa (CSDA) at the University of Johannesburg on 10 July 2024, attended by 25 Gauteng officials from the departments of Education, Health and Social Development as well as the Community of Practice (CoP) staff.[2] This followed the publication of the results of the CoP study conducted from 2020-2023, and the follow-up study on how this approach could be scaled up and institutionalised.

The purpose of the meeting was to share the findings and recommendations of the study on scaling up and institutionalising the CoP, and to get everyone thinking together about how to progress and strengthen (a) school-based support teams (SBSTs) at Gauteng schools, and (b) the implementation of the Integrated School Health Policy (ISHP), to improve learning outcomes.

Prof. Leila Patel, Distinguished Professor and Principal Investigator, welcomed participants to the meeting and introduced its purpose. She outlined how the multidisciplinary CoP approach is supported by existing policies in education, health and social development, but that a gap exists between policy and implementation. The CoP is an exemplar of how integrated school-based support services could be delivered. It was tested over a four-year period, and much was learnt about how to deliver the intervention.[3] On this basis, the CSDA convened this meeting to explore how best to extend the reach of the CoP approach at Gauteng schools and beyond, as well as how to make integrated practice an integral part of the delivery of school-based services.

1. Key findings and recommendations[4] about scaling up and institutionalising the CoP approach

The 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,[5] 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.

In 2023, a qualitative study was conducted to gather information about how the CoP approach[6] could be scaled up and institutionalised in primary schools. Focus groups were held with the teachers, social workers, nurses and others who had participated in the local level CoPs at each of the five schools between 2020 and 2023, and a sixth focus group discussion was held with the team that developed the digital tool – known as the child wellbeing tracking tool – that was used to conduct assessments with selected children.

The study analysed the data across six domains of institutionalisation, as outlined by a World Health Organisation (2023) checklist: Governance; leadership, commitment and culture; collaborative action; resources and capacity strengthening; standards and routine practices; and using evidence to inform decision-making. At this meeting Aislinn Delany, one of the researchers, presented the key findings and recommendations in each domain of institutionalisation.

a. Governance

The research found that an enabling policy framework is in place through the following mechanisms: the Screening, Identification, Assessment & Support (SIAS, 2014); the Integrated School Health Policy (ISHP, 2012) (community participation); and the Care and Support for Teaching and Learning (CSTL) Programme (2008), which intends to prevent and mitigate factors that have a negative impact on the enrolment, retention, performance and progression of vulnerable learners in schools by addressing barriers to learning and teaching. The challenge is that there is insufficient alignment between social work services and the education system in the policy framework and in practice.

Integrating the CoP model into the SBSTs[7] provides a practical means to implement the integrated and inclusive services envisaged by these policies because it brings in additional capacity and skills through the collaborative approach. This foregrounds the importance of social services support that is largely absent at school level.

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[2] See Appendix A for list of attendees.

[3] The full report on the outcomes from the longitudinal CoP study can be found at https://communitiesforchildwellbeing.org/wp-content/uploads/2023/09/CoP-Research-Report-Wave-3.pdf.

[4] The key findings and recommendations listed here are high level summaries of those contained in the main report which can be found at https://communitiesforchildwellbeing.org/wp-content/uploads/2024/06/CSDA-_-CoP-_-Research-Report-_-CoPStudy-_-A4-_-May-2024-_-4.pdf

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

[6] See Appendix B for infographic.

[7] The research report on scaling up and institutionalising the CoP approach recommended that SBSTs would be an appropriate vehicle for institutionalising communities of practice in schools.

Recommendations

- Work with the Gauteng Department of Education (GDE) and school leadership to review the responsibilities and operations of the SBSTs and local level CoPs to identify alignment and gaps.
- Identify senior staff to coordinate the CoP approach within the SBST and consider the ratio of staff (CoP coordinators) to classes in the Foundation Phase.
- Consider and formalise the oversight role of the district and District Based Support Teams (DBSTs) in relation to the integration of the CoP approach.
- Develop protocols on how confidentiality of personal information and compliance with the POPI Act (2014) will be maintained.

b. Leadership, commitment, culture

The study indicates that school leadership needs to recognise and support the importance of integrating social work services into school operations, and that principals need to embrace the task of creating a culture of collaboration. At the same time the awareness of the impact of psychosocial wellbeing on school performance needs to be strengthened at district level.

In the CoP study, an external team drove the intervention, including placing a CoP social worker at each of the five schools for a period of time. Integrating the approach means that the school leadership will be key in taking on this role at school level.

Recommendations

- Strong leadership is required to establish a culture of collaboration and care in the school.
- Provide opportunities for school leadership to network with other principals in nearby primary schools who are new to the initiative.

c. Collaborative action

The CoP approach creates local partnerships between teachers, health workers, social workers, and other professionals. It also integrates NGOs and community-based players into providing holistic school support.

> *"I think it was good to have a social worker [on] the premises because some of the learners have social problems at home. We only look at them maybe academically."* (School 2)

> *"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".* (Project coordinator)

Coordination emerged as key to collaborative action, and visible results helped build participation.

While systemic policy and structural alignment provides the conditions for integrating the CoP approach into the SBSTs, poor operational engagement between the DBE and the DSD results in limited resource allocation for social services provision to schools.

Recommendations

- Forge cross-departmental operational agreements for financial resource allocation and human resource provision. This needs to be accompanied by close monitoring and support from the district and provincial level support teams.

d. Resources and capacity strengthening

The study showed the impact of the resource scarce environment in which the schools operate. While focus group participants were aware of the financial constraints and budgetary challenges confronting government, there was expressed frustration and concern that for years the psychosocial component of schooling has been under-resourced.

> *"Our challenge is that our school is a full-service school, but yet we don't have enough resources for that."* (School 5)

In particular, the undersupply of social services personnel restricts their role to crisis intervention and occasional workshops, and does not allow for consistent engagement with schools, children or families. In the focus groups DSD social workers commented as follows: "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 at School 2) "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)

The substantial need for psychosocial support and resources was stressed by one of the school principals:

> *"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."* (Principal, School 2)

This includes support from social workers, educational psychologists and related paraprofessionals.

Recommendations

- Identify how social work services can be brought closer to schools.
- Consider the ratio of community-based social workers to schools or classes of learners.
- Draw on auxiliary social workers and other paraprofessionals to amplify the social work services available to schools. Build in critical supervision by fully qualified social workers.
- Learner Support Agents (LSAs) require ongoing training and regular supervision to effectively carry out their role.
- Training is needed for Foundation Phase teachers on psychosocial issues and practical ways to support children in class.
- Staff training, supervision, mentoring, and performance management of all 'front line' staff is critical. This requires working in integrated and multisectoral teams at a school level.
- Relationships between schools and primary health care practitioners, including community health workers, need to be strengthened.
- The DBE, in partnership with the DSD and the DoH, among others, will need to mobilise the financial and human resources required to operationalise this multi-sectoral approach. Data from the CoP study could be used to develop a human resource plan and develop scenarios of cost implications.

e. Standards and routine processes

A key aspect of embedding the CoP approach is to develop protocols, norms and standards, and to formalise processes to make them routine:

- Hold routinely scheduled CoP/SBST meetings including stakeholders from across sectors.
- Provide regular opportunities for collaboration and building relationships.
- Define clearly established roles and responsibilities for School Based Support Team members.
- Develop clear and simple protocols for referrals.
- Establish a work plan for the year that includes community mapping of available services as well as screening and tracking of interventions.
- Develop protocols and mechanisms for supervision, training and mentoring, among others.

Recommendations

- GDE, DSD & DoH districts, primary health care clinics and other local external stakeholders need to jointly develop an implementation plan for the year with clear objectives.
- This needs to be accompanied by MOUs or service level agreements to clarify roles, responsibilities, and mandates.
- Accountability mechanisms (performance management, monitoring and evaluation) for each stakeholder need to be specified.
- Formalise clear and simple protocols for referrals and guidelines for information sharing and issues of confidentiality, supervision, training, and mentoring.

f. Use evidence to inform decision-making

> *"…the assessments allowed them [the CoP] to find cases of problems and neglect that impacts on learning."* (School 3)

The SIAS policy (2014) calls for learner profiles, but there is no multidimensional assessment of children to inform decision-making about the support required.

CoP participants appreciated the CoP assessments using the CWTT because they provided a comprehensive and evidence-based means of identifying children at risk; they assisted with prioritising the interventions in a context of limited resources; and they triggered further investigation and intervention by the CoP social worker, thus going beyond what can be identified and addressed in the classroom alone.

Recommendations

- Decide whether to use multi-dimensional assessments to monitor children's wellbeing and/or to inform supportive interventions.
- Trim down the digital CWTT for more effective scaling up; test and pilot the revised tool.
- Identify who would collect the data, how it would be collected, the training of data collectors at scale, and the cleaning, quality assurance and management of the data at scale.
- Consider how data will be analysed and interpreted, who will act on the findings, and the possibility of developing a largely automated process to inform case coordination.
- Assess the costs of investing in the technology, training, and human resources involved, drawing on data from the CoP study.

2. From research to practice: "Implementation is easier said than done" *(Fixsen et al 2005)*

Owing to a lack of time, Prof Leila Patel was unable to present the meeting with suggestions that may be helpful in thinking about the next steps, drawing on evidence from implementation science by notable authors in this field.[8] The main points from that presentation are provided here.

There is a huge time lag in translating what we know works for children and families into practice, and it is a messy, non-linear and interconnected process. Implementation scientists tell us that there are set stages to the process despite its 'messiness' and that three drivers must be in place to support practice, organisation and systems change:

a. Competencies critical to successful outcomes:

- **Selection of staff:** are they fit for purpose?
- **Training:** what training do they need to implement the programme with fidelity (accurately)?
- **Staff support:** mentoring, coaching, professional supervision, performance management.

b. Organisational drivers

- **Systemic interventions** – e.g. CoP is a systemic intervention across three departments.
- **Facilitative administration** – administration across all three departments that facilitates the implementation. This includes resourcing and infrastructure.
- **Decision support data** – using administrative data and research evidence to inform decision making e.g. how well are children faring in our schools?

c. Leadership

- Leadership must be adaptive
- Leaders must have technical know-how

Fixsen and Blase state that: If all three drivers are in place AND they feed into a performance management system that assesses fidelity (e.g. are we doing what we set out to do?) THEN it gives rise to effective strategies AND LEADS TO improved outcomes for children and families.

Achieving these outcomes typically occurs through four stages of implementation, usually over a period of 2-4 years, as shown in Figure 1.

[8] Fixsen & Blase (2005); Metz & Bartley (2012)

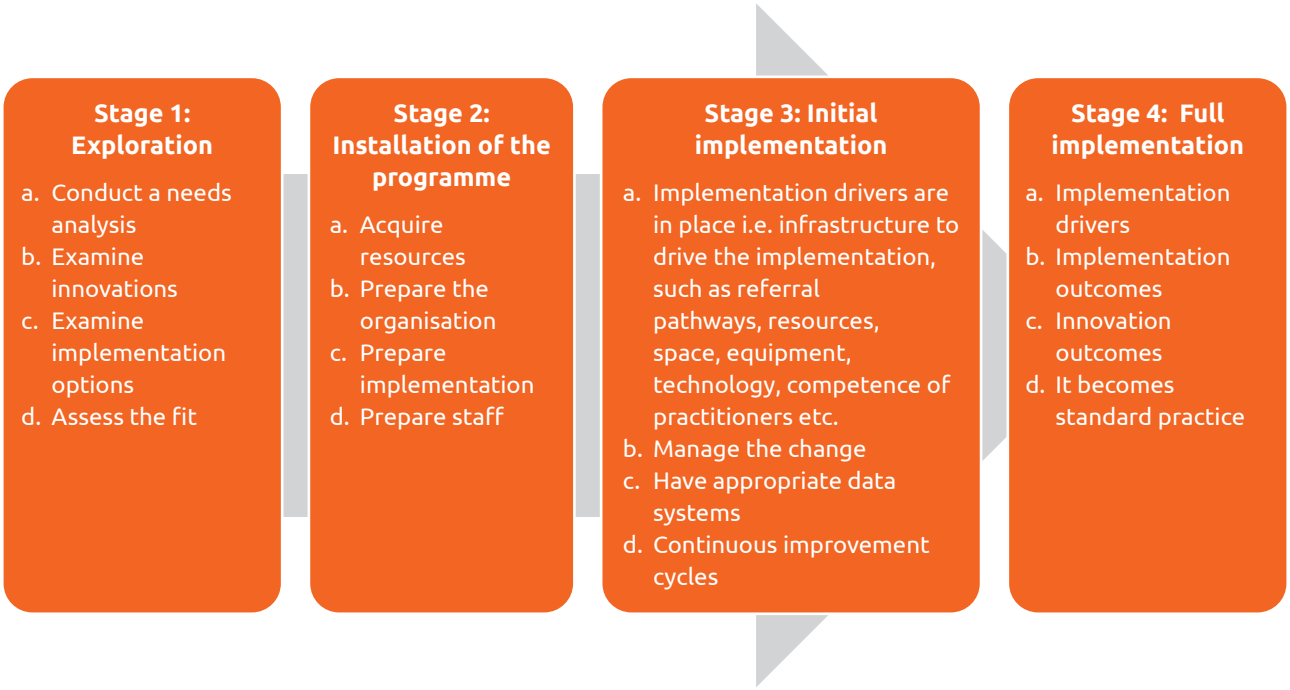

Figure 1: Four stages of implementation over 2-4 years (adapted from Metz & Bartley 2012)

This meeting was convened at **Stage 1: Exploration**. At this point the CoP study has completed step (a) by conducting a needs analysis among at-risk Foundation Phase children in five schools. It has also contributed to step (b) by implementing an innovation that brings to the schools support from social workers and NGOs working in the communities in which the schools are located. The innovation produced substantial results which make it possible to design interventions for at-risk children and their families, and which provide important information for planners in the departments of education, health and social development.

This meeting was held to initiate step (c) which is to examine options for implementing the CoP approach, as well as step (d), which is to assess the fit between the CoP approach and the context in which it could be scaled up and institutionalised. This requires the development of an action implementation plan and can use implementation science (such as that quoted above) to guide us on questions we need to ask collectively - across the departments of education, health and social development - to inform the development of such an action plan.

Decisions to inform the development of an action plan

The WHO Checklist used in the study on scaling up and institutionalising the CoP provides a framework for examining six domains of action:

- Governance – enabling organisational environment
- Leadership at all levels (school, district, national), commitment & organisational culture
- Collaborative action – partnering
- Resources & capacity strengthening
- Standards and routinised processes
- Using evidence to inform decision making

This framework helps us to identify questions that need to be considered to inform the development of an action implementation plan. These include making decisions about:

- The short-term options to strengthen SBSTs
- The timeline of the plan
- Whose buy-in and support is needed?
- Are there existing inter-departmental agreements/MOUs? If not, is this a good starting point?
- What should be in such agreements? For example: Sharing resources (human and financial); staff training & development; partnering; roles of district support teams & school based support teams; other implementation drivers?

3. Participant discussion of the CoP recommendations

Following the presentation of the findings and recommendations from the study on scaling up and institutionalising the CoP, participants discussed three questions in small groups, which they then reported back to the plenary session:

- How appropriate and feasible are the recommendations to scale up (i.e. increase the reach of) school based support (health, education, and social development) in the Foundation Phase in Gauteng schools?
- What additional recommendations do you wish to make?
- What should be the next steps?

3.1 How appropriate and feasible are the recommendations to increase the reach of health, education and social development support in the Foundation Phase in Gauteng schools?

There was support for the CoP approach among the participants, with three aspects being mentioned in particular. The first is the importance of building a **multi-disciplinary team to support the SBST** so that *"you don't simply have teachers who are not necessarily equipped for those roles; they are supported by others who need to come to those meetings"*. The team would comprise professionals such as the clinic sister, a social worker, and NGOs based in the community who can offer psychosocial support. This would require allocating time and resources to increase the functionality of the SBST and would help teachers who have difficulty providing support to individual learners in overcrowded Foundation Phase classrooms.

The second is the value of the **digital tracking tool** to monitor how social services are being delivered and to whom. It was felt that this would be valuable to support evidence-based decision-making in the GDE, particularly in light of a lack of specific data mentioned by one participant: *"most of our conversations are very subjective because of the lack of that evidence base"*. It was also noted that the CoP child wellbeing digital tracking tool provides data about what individual children need and helps to reach out to their families as well. This information is not currently available to Foundation Phase teachers nor the GDE.

The third observation made was that the CoP approach is well aligned with the **campaign for quality in learning and teaching** (QLTC): *"we need to have that seen within the context of the Quality Learning and Teaching Campaign so that that forms a framework within which the integration of psychosocial support into the school for Foundation Phase can be contextualised"*. Through the campaign the CoP approach *"could be mirrored at district and provincial level so that one makes sure that there are relationships across all the levels"*.

Opportunities

Participants mentioned a number of opportunities to integrate discussion about psychosocial support in primary schools into their current work: *"These are optimal moments at which some of this discussion can be integrated into the work that's ongoing"*.

One of these is about strengthening mechanisms for closer cooperation between the departments of Education, Social Development and Health at provincial level. One group identified the need for the DoH to be more closely involved in this process and it was agreed that there is now an opportunity for the discussion to become more inclusive of the health representatives.

Secondly, the GDE has a newly signed MoU with DSD and is currently developing an implementation plan. One of the key issues here is the ratio of social workers to schools. *"Social development in that MOU has got only 147 social workers versus 2,200 schools; and it's even more now because our independent schools are also reaching out more and more for support."*[9] It was mentioned that in the following week the GDE would discuss with its districts and social development coordinators how and where the MoU touches on the CoP approach and its recommendations.

Thirdly, the Department of Health is reviewing the Integrated School Health Policy (ISHP, 2012) which will include reviewing the MoU and service level agreement between the departments: *"An MOU incorporating **all three departments** is critical and required. And I think it's an ideal time; I'm talking to colleagues in Education and DSD to do it now because we've got the new guys that are in now, so we can capitalise on that matter."*

Another opportunity concerns government partnering with a wider range of NGOs and organisations that are active in schools. When DSD outlines priorities for the NGOs they work with, they could include working with SBSTs in the template they use for this purpose. A DSD representative described how in an effort to deal more effectively with issues like child protection, child justice and bullying, the department called for presentations by NGOs and had an encouraging

[9] It was pointed out that not all independent schools are well-resourced: *"Our independent schools are not all affluent schools … schools in townships, in the inner city need support"*.

response: *"Some of them [NGOs] that came up, they were getting donor funding from very big corporates and so on. But we didn't know they were in the schools."*[10] The department is also seeking to introduce a parenting programme.

3.2 What additional recommendations do you wish to make?

3.2.1 How to select schools for scaling up

There was general agreement that an incremental approach would be necessary to scale up a CoP approach for increasing psychosocial support for primary schools. This is in line with the recommendations made in the report on scaling up and institutionalising the CoP approach. In addition, it was suggested that schools most in need should be strategically targeted.

One suggestion was that high-risk or 'chronic' schools could be candidates for rolling out the CoP approach. Another was that schools with specific needs should be targeted in order to track students who are at risk, using and/or adapting the digital tracking tool that the CoP had developed during the study.

It was ultimately suggested that the GDE should consult the curriculum division to assist in identifying schools that could participate in the programme.

3.2.2 Resources

The CoP research noted that schools operate in a resource-scarce environment and participants at this meeting reiterated that there was little likelihood of finding additional resources for a CoP-style programme: *"There's no new money"*. To innovate within these constraints, some participants argued that doing more with existing resources required a change of mindset and new ways of working: *"It's about working smarter, working differently, managing the resources to best advantage. Time is one resource, but there are other management strategies that could be used."*

While it is important to guard against 'double-dipping', it was suggested that it may be possible to allocate resources budgeted for training and infrastructure to be used for the same purpose in scaling up efforts to strengthen SBSTs, as suggested. This would be in keeping with both policy and budget intentions. For this to happen, however, it will be necessary to examine the cost drivers involved in the CoP approach and understand them better.

A strategy that was mentioned in all the groups concerned mapping where resources and services are currently located and drawing on these more effectively: *"So our idea is to get to know who's in schools, what they are doing, their capacity, their funding, so that with that information we can start to map [a resource base]."* This would lay the ground for new proposals from organisations who would like to provide social and other services to schools. During discussion there were numerous mentions of the value of DSD drop-in centres and child protection organisations that could help swell the social services available to primary schools that have identified at-risk children in Foundation Phase.

Based on the results of the CoP study, it was felt that the Department of Health needs to feature more strongly in the discussion about developing a holistic approach to psychosocial support in primary schools: *"I think there is a number of programmes that the Department of Health are doing, and they equally have a number of staff that complement the work in schools, but it's not coming up as strongly. And that includes your community workers, health promoters, your ward-based teams, your outreach teams, as well as your issue teams"*.

Finally, it was suggested that third and fourth year social work students could conduct their practical work in schools in which the CoP approach is being implemented, provided their supervisors were trained appropriately: *"Because we find some of them are placed under supervisors who don't know the education sector"*.

3.2.3 School Based Support Teams

As noted in section 1 above, the research report on scaling up and institutionalising the CoP approach recommended that SBSTs would be an appropriate vehicle for institutionalising communities of practice in schools. This is because the alignment between the SIAS (2014) policy framework and the goals of the CoP model, as well as the regulatory requirements of SBSTs and DBSTs, provide an enabling environment for integrating the CoP model into primary schools.

Participants noted the research finding that many SBSTs are not fully functional but felt that with support they could be strengthened. It was suggested that for an SBST to be functional, it needs to be institutionalised through the following actions:

[10] However, there was the recognition that donor-funded NGOs need to comply with their donors' requirements, "*so they can't just fall in and do everything that this programme wants*".

- The principal must be involved, in line with the protocol outlined in the SIAS policy which states that "The principal is ultimately responsible for the establishment, functioning and support of the SBST".[11] This was echoed by one participant who said: *"If school leadership, the SMT in general, is going to take seriously the adoption of a holistic psychosocial support approach, it needs to rest with the principal."*
- It was also recommended that the principal should chair the SBST meetings or play an active role in its deliberations.[12]
- SBST members need to understand their roles so as to play their part in channelling psychosocial support to learners in need.
- The importance of involving a multi-disciplinary team was mentioned in section 3.1 above. Participants reiterated the value of combining the expertise of the clinic sister, a social worker, and NGO representatives familiar with the community, to support the SBST in providing psychosocial support for Foundation Phase children at-risk. It would also help take the pressure off teachers who are SBST members but may not have psychosocial knowledge or experience.
- The School Governing Body needs to allocate resources to facilitate the functioning of the SBST.
- The District has an important oversight role in relation to SBSTs.[13] The establishment, functioning and support of the DBST at any district is the ultimate responsibility of the District Director, who also needs to be a member of this structure to give it direction and support for it to be effective.

Participants stressed the importance of involving members of the community to assist the SBST in developing a holistic approach to its work. Some also mentioned that facilities for integrated health and psychosocial counselling should be considered in primary schools. This accords with the suggestions made by teachers and principals who were involved in the CoP study.

3.2.4 Coordination and collaboration

Throughout the meeting, participants raised concerns about the issue of coordination between the departments, within departments, and with other stakeholders, and made recommendations to achieve a seamless collaboration across the three sectors. For example:

> *We need to **bring the stakeholders together**.*
>
> *We also need that collaboration between the service delivery partners - DSD, Health and Education – to **resolve the issue of working in silos**.*
>
> *We need to identify the skills, who can do what, and who can commit to doing what, so that we **don't duplicate efforts**. And **improve communication** and workload.*
>
> *It's about **mapping and coordinating our services more effectively** to strengthen the school-based support in a more coordinated way. So we must capitalise on those partnerships for services and for resources.*

Participants felt it important to understand how the school nutrition programme complements the Social Development food security programme. Some suggested that the CoP digital tracking tool or its app could help avoid double dipping.

Other suggestions were to foster collaboration between SBSTs in clusters within a local community; and to explore whether the health, social and psychological resources in special schools might be able to assist SBSTs in surrounding schools. One participant commented on the resourcefulness of community-based NGOs that are able to mobilise community participation to extend the services they provide.

GDE participants suggested that they should work more closely with colleagues in the Curriculum and Management branches to explore how to strengthen psychosocial support in primary schools. Their argument was that while contact time is primary, academic progress is being compromised by issues that teachers face with children who are not coping: *"All of us know how difficult it is to get time and get things done in the school. Why? Because the teaching and learning process is heavily structured and guarded, with good reason: because contact time is paramount. But the issue is that contact time is being eroded by these social issues."*

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[11] https://www.included.org.za/wp-content/uploads/2018/01/PRINT_IESA_EU-Factsheet-04_Role-Function-of-the-SBST.pdf.

[12] Examples of how this could take place are recorded in this research: https://www.researchgate.net/publication/318361362_School_based_collaborative_support_networks_in_fostering_inclusive_education_in_selected_South_African_schools?enrichId=rgreq-12b54b229aaad3ed301fa74d348dd8e2-XXX&enrichSource=Y292ZXJQYWdlOzMxODM2MTM2MjtBUzo1MjQ0NDk2ODY0ODcwNDBAMTUwMjA0OTk1NzM5OA%3D%3D&el=1_x_3&_esc=publicationCoverPdf.

[13] https://nect.org.za/materials/messages-to-schools-and-parents/2021/pss-messages/20-august-2021-care-and-support-weekly-message.pdf.

Sharing information across the three departments also needs attention. A DoH participant mentioned that their department was holding a DHS delivery model and configuration study summit the following week, during which there would be discussion about how they share and integrate data: *"How do the data from the three different departments talk to each other?"* was her question. She also mentioned that for the DoH data on learners to be shared with other departments, certain processes need to be followed e.g. NGOs or departments need to apply for permission to access the data by completing a form for the HoD's signature.

Two key recommendations flow from this area of discussion:

- Conduct due diligence processes to understand what is getting in the way of better coordination between the three departments.
- Map out partnerships – be they interdepartmental and/or with NGOs – to increase the skills base and resources for introducing interventions (such as a CoP approach) that complement processes (such as SBSTs) already in place.

4. Next steps

Prof. Leila Patel encouraged participants to take a long-term view on how many social, psychological and health service providers would be required to provide support to schools as discussed at this convening. She also stressed the necessity of working strategically across the three departments against the background of scarce resources:

> *This is a small study, but we can extrapolate from this. If you were to look at your resource allocations, this will help you to think about the school ratio for education psychologists, for example. So that would give you a target that you need to work towards for the number of school psychologists over time; in the next 10 years or 20 years that's where you want to be with the numbers that you should be having. The same with the health side.*
>
> *You've got the infrastructure, you've got the policy for School Based Support Teams. If they can be empowered and capacitated, you can actually have a viable system of support.*
>
> *You're working with adolescents in high school, but there is a huge gap here in the Foundation Phase. And if we can correct or support people earlier on - families, children, and communities - we will have better outcomes in schooling, but also in the community. And the model that we've developed is different to what you have. So, it is challenging, I think, but you can take parts of it that speak to you.*

In response, participants made the following suggestions:

- Senior management in the three departments should go back to their respective authorities to present the CoP concept and develop a shared understanding of how to go forward together.
- Once there is a common understanding, the MoUs currently in place could be reviewed to incorporate more prominently the element of strengthening SBSTs, using all or some aspects of the CoP approach. *"It's a paper-based MoU … that's as far as it goes. So, if we want to get this going, we need to bring the movers and shakers in our department. Because we need this."*
- In this way parties to the MoU would be able to establish mechanisms for cooperation and hold each other accountable for their respective roles.
- To get social workers closer to schools, DSD suggested that they should examine the potential of their current NGO partnerships. Looking ahead to the next financial year they would be able to call for proposals from the NGO sector in relation to using the CoP programme to support SBSTs in various communities: *"So that can be nicely packaged and put out there for out next financial year project."*

Participants also pointed to the importance of getting political will and buy-in, *"because otherwise we'll never be able to get this programme institutionalised in our school environments"*, said one. Another pointed out that: *"In fact, it's part of the Premier's pro-poverty basket where he's exactly talking about what is here. … We can pitch this at Premier level. If he buys into this concept, we roll out such a programme in all our high-risk primary schools."*

Ultimately it was suggested that the three departments each need to share the CoP study findings with their Chief Director and beyond to DDG level, to build an understanding and awareness of how children's wellbeing changed for the better through the CoP approach, and what still needs urgent attention if at-risk children are to thrive in Foundation Phase. They would be able to share how the systems in place could ensure that some of these things happen. It would also be important to share the findings and the scaling up proposals at District Director level.

> *After all is said and done, this [the CoP study results] is where the children are at the moment. And they will only progress academically if those systems are in place. And I think that is the driving force. Because remember, directors are pushing for results. But we're looking at the foundation here of these kids. We need to get that system in place. So that is a discussion we all have to have.*

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Appendix A: Attendees at the interdepartmental meeting on 10 July 2024

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Dr Shaheda Omar	Director Teddy Bear Clinic	
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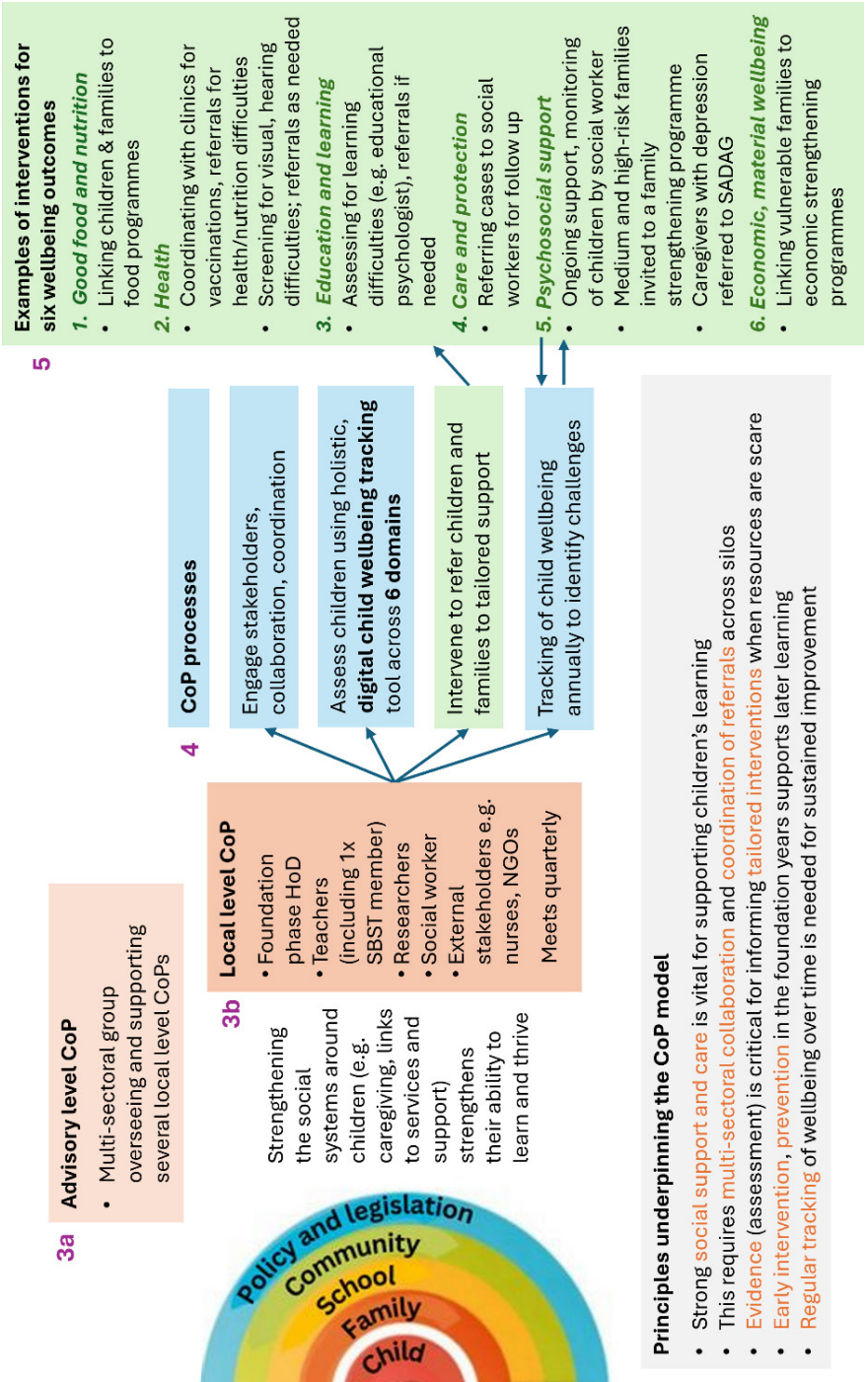
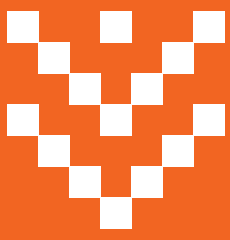
Appendix B: The CoP approach to improving child wellbeing in the Foundation Phase





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