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Community of Practice for Social Systems Strengthening to Improve Child Well-being Outcomes

Research Brief
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with the Centre of Social Development in Africa, University of Johannesburg

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Introduction and background

Children's rights are enshrined in South Africa's Constitution. The country's apex law, in Sections 27, 28 and 29, guarantees children's rights to basic education, health, food, care and social assistance (National child care and protection Policy, 2019). Sadly, the daily reality for millions of South Africans differs greatly from the protections promised by the Constitution. Close to two thirds of children – a total of 12.8 million, most of them African and Coloured – live in poor households that struggle to meet their basic needs for nutrition, clothing, and shelter (Hall & Sambu, 2017). This has consequences far beyond childhood, both for individuals and society. It may manifest in poor mental and physical health outcomes as well as poor school performance and high drop-out rates, among others.

South Africa has several social policies that are intended to improve child wellbeing outcomes, including free basic education and primary health care, the Child Support Grant (CSG), and the National School Nutrition Programme. A range of other child protection and welfare services are also available through both state and civil society organisations. However, children may still fall through the cracks of service provision due to fragmentation and a lack of functional co-operation between the health, welfare, and education sectors (Richter, et al., 2018).A way to ensure that no children are left behind requires a coordinated response between these social sectors collaborating and cohering around shared goals and actions.

Investing in children's nutrition, health, improving their emotional well-being and schooling outcomes are important social investments in the human resources of a country (Patel, et al., 2017).Not only could this lead to them securing better jobs with higher income in adulthood, but it could also create more stable families and communities and ultimately, a more stable and peaceful society (Patel et al., 2017; Richter et al., 2018).

This Community of Practice (CoP) intervention research project is a multi- and trans-disciplinary initiative involving collaboration between researchers and practitioners across different sub-fields like social work, sociology, psychology, educational psychology, education, mathematics and language curriculum specialists, mental health, nutrition, primary health care, community nursing, and public health and school health care services. The CoP study targets children in the foundation years of schooling, Grades R and Grade 1. Early interventions tailored to meet children's needs in poor families during this development stage could have positive long-term benefits for children, their families, and communities. This collaboration between key sectors is assumed to be instrumental in accelerating child wellbeing outcomes beyond only offering the CSG and could aid the search for innovative solutions that are suited to our local context in South Africa.

The research is led by a team of researchers, all of whom have a specific expertise in areas such as social welfare, education, health and mental health. The project is led by, principal investigator Prof. Leila Patel, Chair in Welfare and Social Development together with co-investigators and research chairs, Prof. Jace Pillay, Chair in Education Psychology and Prof. Elizabeth Henning, Chair Integrated Studies – Education (Mathematics and Language

development in the early years of schooling). Collaborating academic partners include Dr Ntshingila and Dr Du-Plessis-Faurie (Nursing), Prof Arnesh Telukdarie (Engineering) Prof Lauren Graham, (Centre for Social Development in Africa) SDA, Dr. Wanga Zembe Mkabile (Medical Research Council) and Prof Shane Norris (Centre of Excellence in Human Development). External collaborating partners include UNICEF, the City of Johannesburg, the Gauteng Department of Education, Department of Basic Education, and the Department of Health. The research is funded by the National Research Foundation. Read more about the study https://www.uj.ac.za/faculties/humanities/csda/Pages/Theme-3-Welfare-and-social-development-innovations-.aspx.

Aims and objectives

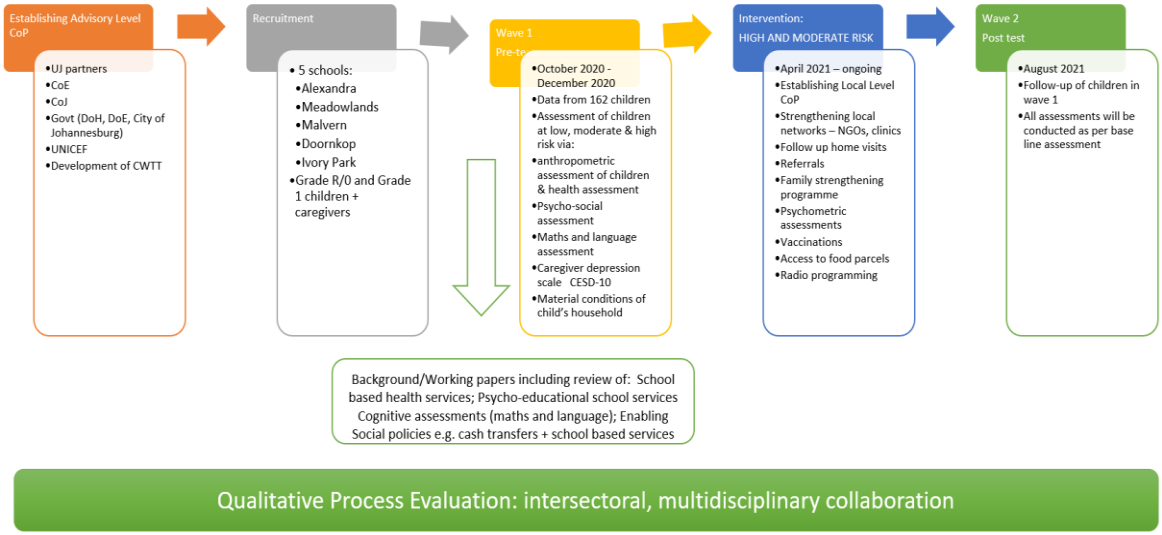
In initiating the CoP we were interested in understanding, firstly, what the most appropriate cross-sectoral interventions to step up child well-being outcomes are; secondly, how these interventions could be delivered across the health, education and social welfare sectors and thirdly, is the CoP approach a viable way of achieving social sector systems strengthening to improve child well-being in urban communities.

In line with this, we identified a number of objectives. These included:

- Development, testing and implementation of a digital Child Well-being Tracking Tool (CWTT) to assess how children are faring.
- Development of a risk assessment profile(s) for the children.
- Development and implementation of co-ordinated intervention plans for at risk children.
- Delivery of integrated services co-ordinated by a social worker.
- Assessment of the outcomes of the intervention.
- Development of generic solutions and action plans and guidelines to step up child well-being outcomes across the social sectors.
- Documenting the lessons learnt from this collaboration to improve co-operation across the social service sectors.

Study Design

Figure 1.1 Depicts the study design and methods used for the study



The study began with the establishment of an Advisory Level Community of Practice (ALCoP) made up of the research partners who are responsible for the overall leadership and management of the project. Five Local Level CoPs were established at each of the schools where the project was implemented involving all the role players in the assessment and intervention plans for the children who were at risk in different domains. The ALCoP developed the digital tracking tool which was pre-tested and administered between October to December 2020.

A mixed methods design was used, with the quantitative component informing the qualitative component at each stage. A pre-test post-test research design is being implemented. Wave one of data or a pre-test assessment has been conducted. Wave 2 will follow post the intervention and will be implemented from August – September 2021. Sampling for the CCWTT data collection involved randomly selecting one Grade R and one Grade 1 class from the participating school in each community. Parents and caregivers in each of these classes were invited to participate in the study. Across all 5 schools, a total of 162 children and their families participated. Schools were situated in Meadowlands, Ivory Park, Doornkop, Malvern and Alexandra.

The Digital Child Well-being Tracking Tool (CWTT)

The Child Wellbeing Tracking Tool (CWTT) contained six sections labelled A-F. These domains are all central to the concept of child well-being and relates the physical, educational, or cognitive development of the child as well as their social and emotional well-being.

- Section A contained demographic information for both the child and their caregiver and was completed by the caregiver.
- Section B was made up of five child wellbeing domains namely; education, food and nutrition, health, economic and material wellbeing, and, protection and care. Section B was completed by the caregiver.
- Section C, also completed by the caregiver asked questions about the caregiver's mental wellbeing and ability to cope during the COVID-19 lockdown.
- Section D, completed by the child's teacher, assessed the child's behaviour in class.
- Section E, completed by the nursing preceptor, assessed the child's physical wellbeing including their Body Mass Index.
- Section F assessed the child's psychological wellbeing using standardised psychometric tools.

Based on the above assessments, children were classified into high, medium and low risk groups.

Key findings from the CoP baseline assessment

Material well-being of children and families

- Most caregivers had some secondary education (55%), 30% had completed school and 8% had post-secondary education.
- The majority of caregivers in the sample were unemployed (65%). Approximately 17% were employed full-time, 9% of caregivers were employed part-time and 5% of caregivers were self-employed (5%) and/or did some piece work (4%).
- The majority of households (89%) received one or more Child Support Grants followed by the old age pension grant (16%).
- In addition to the Child Support Grant, about 57% of households received other sources of income and only 35% had enough money to buy the things that they needed.
- Approximately 27% of respondents struggled to pay off their debts and 54% of caregivers were struggling to save money monthly.
- Most children lived in households that have access to basic resources and services, like water, sanitation, and electricity.
- Just over 90% of children lived in households that had protection from rain and wind, access to drinking water at home, electricity, and a toilet at home.
- About 55% of caregivers in the overall sample had depressive symptoms. In some schools, there appeared to be higher depression scores, for example, caregivers from

Meadowlands appeared to have the highest depressive symptoms (78%), followed by those in Doornkop (60%). Just over 40% of caregivers in Alexandra, Malvern and Ivory Park presented with depressive symptoms.

- A majority of the caregivers reported not having family or community support in times of need (63%).

Children's health, nutrition, education and wellbeing

- **Approximately 13% of caregivers stated that children in their household did not have enough food to eat while 24% said that there were times when children did not have enough to eat.**

Health:

- Approximately 21% of child had some health concerns that indicated a need for support or health interventions.
- Approximately 13% of children were stunted, 6% appeared to be wasted, 7% were underweight, 4% were overweight.
- Approximately 15% of the caregiver's reported that their child's health was stopping them from going to school.
- Almost 39% of their children did not participate in any sporting activities outside of school hours.
- Health care workers reported that 33% of the children's vaccinations were not up to date and approximately 20% of the children had dermatological conditions.

Education:

- Primary school learners lost 70% to a full year of learning between March 2020 and June 2021 (Shepherd & Mohohlwane, 2021)
- From our sample, 46% of the children were in grade 1 while 54% were in grade R. Of these children 21% of them where older for grade 1 (8 years old) and 6 % were older to be in grade R (7 years old).
- Caregivers appeared to have a positive view about the children's progress at school as well as their own involvement in their children's schooling.
    - Approximately 84% said their children were progressing with their schoolwork, 88% said their children did their homework as required and 94% said that there was always someone to help the child with their homework.
    - 36% of the children were afraid or refused to go to school, the majority being in Grade R.
- Teachers' responses regarding child school attendance, progress and well-being appeared to be lower than that reported by caregivers.
    - Approximately 68% of children do their homework as required
    - Teachers identified 22% of children with a learning difficulty

- Teachers reported that 80% of caregivers were involved in their child's education and 90% of children attended school and were well groomed.
- Teachers identified symptoms of anxiety in 13% of children and unhappiness in 7%.
- Teachers also reported that about 18% of the children had difficulty in controlling their behaviour and 14% of the children struggled to calm themselves down when they are upset.

Protection and care domain

- 64% of caregivers reported being concerned about the safety of their children while 8% of the caregiver's reported that their children have been victims of abuse or violence and 67% had been exposed to some form of violence at home or in the community.

Implications of Baseline Findings- Where to next?

From the above, immediate points of intervention will focus on:

1. Identification of children at high and moderate risk; make appropriate referrals.
2. Addressing food insecurity and nutritional needs.
3. Ensuring health follow up's including vaccinations.
4. Identification of learning challenges and accessing necessary support.
5. Immediate follow up with regards to child safety and protection, including home visits.
6. Provision of support to caregivers (mental health and economic wellbeing)

To this end our intervention plan includes:

- ❖ Establishment of Local level CoPs to address the challenges children and caregivers face.
- ❖ Assignment of one social worker per school to follow up on families and children in need who will deliver services for a three-month period.
- ❖ Identify community resources that distribute food parcels and making appropriate referrals to address hunger and food insecurity.
- ❖ Ensuring children are accessing the School Nutritional Programme on days when they are not at school.
- ❖ Working with local clinics to ensure that all children in the sample (and within the school) are caught up on vaccinations.
- ❖ Conduct full educational psychological assessments of children at risk.
- ❖ Inclusion of families in need for participation in the Sihlengimizi family strengthening programme.
- ❖ Family strengthening community radio and WhatsApp messaging in two of the five areas focusing on: (a) promoting parental involvement in children's schooling; (b)

nutrition and healthy food practices; (c) Tips for caregivers to manage stress and difficult behaviours in children; and (d) money matters.

Conclusion

We may draw the following conclusions from the study findings. First, the material well-being of children was compromised by high unemployment rates of caregivers which was significantly higher than the national unemployment rate in the third quarter of 2020 when the survey was conducted. Four out of ten caregivers did not have enough money to buy the things that they needed such as food and basic necessities. Although different questions are used, the findings are similar to the NIDS-CRAM findings for the same period in 2020 (Van der Berg et al., 2020).

Social grant monies were an important source of survival for these families with 89% of households receiving one or more social grants. Although just over half of the households received other sources of income, taken together, this was insufficient to meet basic expenses and consequently almost a third struggled with indebtedness and over half couldn't save.

Second, despite the dire material deprivation of the children and their families, over half had access to food but this was insufficient for 13% of the children who did not have enough food to eat. This varied across the study areas with two areas (Doornkop and Meadowlands in Soweto) reporting higher rates of child hunger. These figures are slightly below the NIDS-CRAM findings of 16% at the same time in 2020 (van der Berg, Patel and Bridgman 2020).

Of concern is that a fair proportion of children experienced health conditions that needed intervention and a third had incomplete vaccinations.

Third, the majority of children attended school, were well groomed and were progressing satisfactorily according to their caregivers and teachers. However, teachers had a less positive view about children doing their homework during the Covid-19 pandemic while the majority of parents reported that this was not a challenge. What was worrying is that almost half of the children were older than they should be for their grade and 22% were identified with learning difficulties.

Forth, caregiver and child mental health were most concerning. Over half of caregivers (55%) had depressive symptoms and this varied across the areas with some areas such as Meadowlands and Doornkop having unusually higher rates of depression. Teachers reported that 13% of children presented with anxiety and expressed feelings of unhappiness. Two thirds of caregivers were also concerned about child safety with similar numbers having exposure to violence at home and in the community.

Despite these disconcerting findings about the material and psychosocial well-being of the children as well as experiences of violence in their households and communities, children were doing well on other indicators. For instance, 82% were attending school even though this was on a rotational timetable, 69% were assessed to be in good health and almost all children were living in households where they had access to basic services, even though these may be of poor quality.

Addressing children's needs holistically requires an inter-sectoral and transdisciplinary response. Although the social grants policy mitigates household poverty and food insecurity, the unusually high rates of unemployment means that the grants are clearly not sufficient to address these challenges. Complimentary services across different social sectors need to be better co-ordinated to respond to the diverse challenges that children and their families are faced with. In view of the fragmentation of service provision, a lack of cooperation between the sectors and the silos in which services are delivered, collaboration is problematic. Each function is also governed by separate laws, organisational mandates, reporting lines, operating procedures, different work styles and cultures as well as different knowledge systems, budgets and human resources. Collaboration is easier said than done in such complex systems. Policy guidelines and protocols to promote cooperation between all the parties could improve service provision. Practitioner training and 'learning by doing' could promote more seamless collaboration and the crossing of closely guarded boundaries between service agencies. The research thus far also shows that some children and their families have very particular needs and that customised interventions are needed to respond appropriately and timeously.

Finally, it is our contention that the CoP model provides a useful learning vehicle to understand how to break down silos, co-operate around a common purpose and find real life solutions with the school as the focal point of engagement. By placing the needs of the child and their family at the centre of our intervention strategies, we hope to find systemic solutions that could cut through the barriers that perpetuate exclusion of groups of children who are left behind.

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