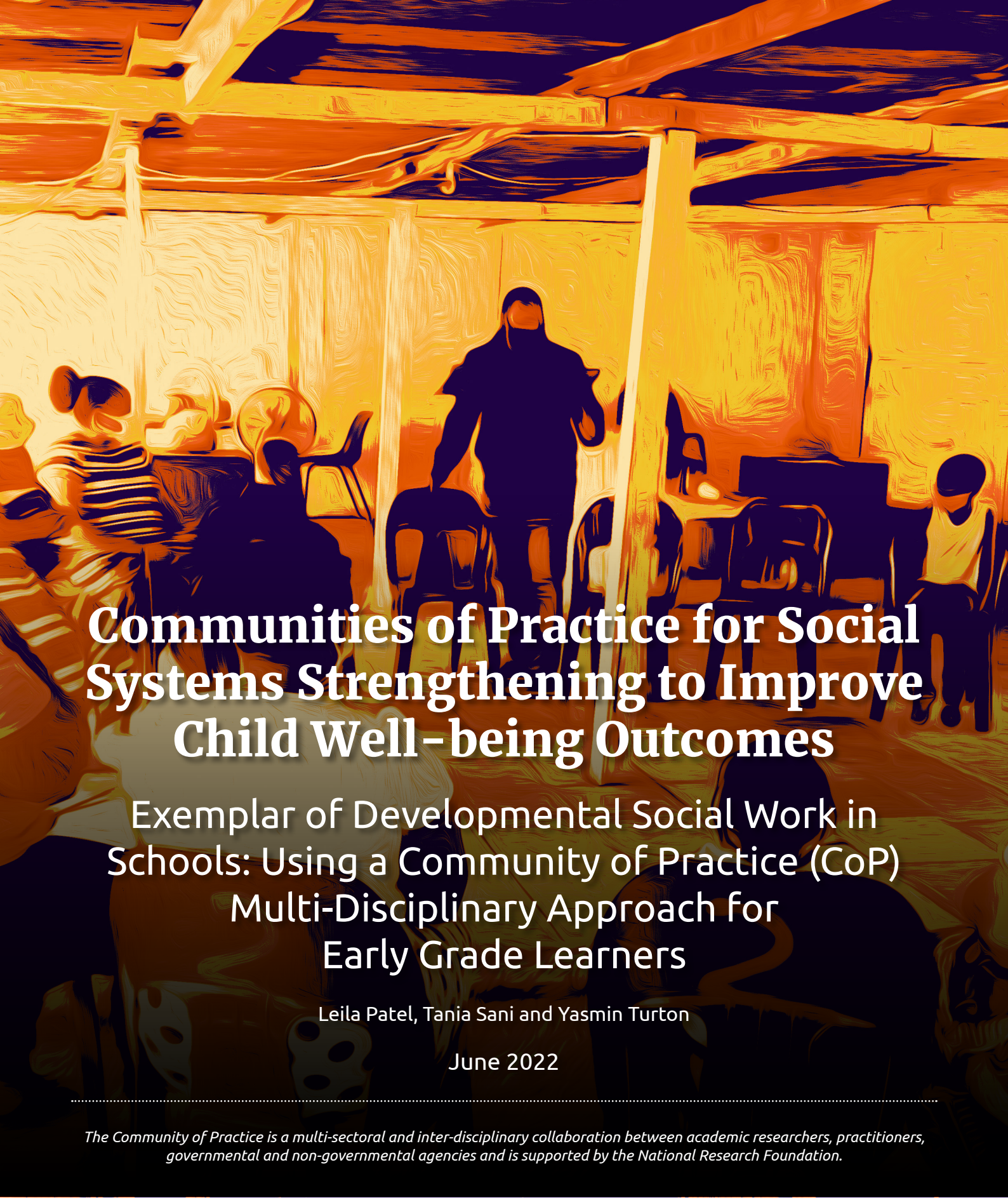

Communities of Practice for Social Systems Strengthening to Improve Child Well-being Outcomes

Exemplar of Developmental Social Work in Schools: Using a Community of Practice (CoP) Multi-Disciplinary Approach for Early Grade Learners

Leila Patel, Tania Sani and Yasmin Turton

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CoP Research Chairs, Collaborating Partners and Investigators

- DST/NRF (SARChi) Chairs: Prof Leila Patel (Principal Investigator) Prof Elizabeth Henning (Co-Principal Investigator) Chair Integrated Studies – Education (Mathematics and Language development in the early years of schooling), University of Johannesburg (UJ)
- Dr Ida Faurie-du Plessis and Dr Nompumelelo Ntshingila (Collaborators) – Dept. of Nursing, UJ
- Dr Rubina Setlhare-Kajee, Dept. of Education Psychology, University of the Western Cape (UWC)
- Dr Hanrie Bezuidenbout and Rhulane Ramsodi (Researchers), Centre for Education Practice Research (Integrated Studies of Learning Language, Science and Mathematics in the primary schools), UJ
- Dr Yasmin Jessie Turton (CSDA)

Centre for Social Development in Africa Collaborators

- Tania Sani (CoP Project Coordinator)
- Dr. Sadiyya Haffejee (Research Manager)
- Sonia Mbowa (Jnr. Researcher)
- Constance Ghunindzirai (Post-Doctoral Fellow)
- Thembeka Somsteu (Administrative Support), UJ

Governmental and non-governmental partners

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- Mr Monyamane (Region F Clinic Manager)
- Alexandra 8th Ave clinic
- Bophelong (region 6) clinic
- Malvern clinic
- Mpumelelo clinic

Gauteng Department of Education

- Johannesburg East district
- Johannesburg West district
- Psychological, Therapeutic and Medical Services (Inclusion & Specials Needs) Directorate
- Malvern Primary School (Malvern)
- Lejoeleputsoa Primary School (Meadowlands)
- Mayibuye Primary School (Doornkop)
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CoP Social Workers

- Nonhle Mavuso
- Nomasonto Madondo
- Yibanathi Mabunda
- Victorian Sithole
- Hope Mokadi
- Kgomotso Mangolela
- Sizwe Savale

Education Psychologists

- Dr Daphne Mawila
- Bernita Soares
- Nomsa Radebe
- Ntombizodwa Shawula
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Acronyms

ALCoP – Advisory Level Community of Practice
CoJ – City of Johannesburg
CoP – Community of Practice
CSG – Child Support Grant
CWTT – Child Well-being Tracking Tool
DBE – Department of Education
DSD – Department of Social Development
GDE – Gauteng Department of Education
DoH – Department of Health
FAMSA – Family Life Centre
HoD – Head of Department
ISHP – Integrated School Health Programme
LLCoP – Local Level Community of Practice
NSNP – National School Nutritional Programme
PS – Primary School
SADAG – South African Depression and Anxiety Group

Executive Summary

The Community of Practice (CoP) addresses the fragmentation of service provision to meet the needs of children and their families in a holistic way. This is a long-standing challenge due to the lack of cooperation and coordination between health, welfare and education sectors serving children and families at a community level. Meeting children's needs holistically requires an inter-sectoral and transdisciplinary response.

The study aimed to understand what the most appropriate cross-sectoral interventions are to step up child well-being outcomes, and to see how these could be delivered across the health, education, and social welfare sectors. This intervention study was implemented and concluded over a two-year period (2020- 2021), and much has been documented about the various stages of the study[1].

This report documents the social work component of the CoP. It provides some guidelines to social work agencies and government departments involved in service delivery to children and their families. It is also a practical example of the implementation of the developmental social work approach within a school and community context. It demonstrates how innovative multi-sectoral interventions that intersect with individuals, families, public and community services can be delivered by a diversity of professions across the health, education, and welfare sectors. It further shows the role social workers can play in a multi-disciplinary setting, and by so doing, it makes a valuable contribution to social work within a school setting. Lastly, the intervention is illustrative of how South Africa's largest cash transfers programme, the Child Support Grant (CSG) may be combined with complementary care services for children and their families.

The report is written as a practical guide which can be used by social work agencies and practitioners and government departments. It can also be used by academics as an example of a practical application of developmental social work in a school and community setting for students. It can also be used as a learning document to assess the viability of the CoP approach within specific community contexts and to identify lessons learnt and adapted in different environments. Although the focus of the document is on social work, there is scope to adapt the practice guidelines for implementation by social auxiliary workers and child and youth care workers.

The CoPs digital assessment tool, the CWTT is an innovation that could be widely deployed in schools to inform care and developmental assessments and intervention. The digital CWTT may be used by other groups/ organisations/ schools/clinics who wish to replicate the programme.

The experiences of social workers in implementing the CoP approach are also documented such as the skills acquired by social workers in implementing the CoP, as well as their increased understanding of working in a multi-disciplinary team and consolidating their own roles as social workers within the team. In the process they learnt about other professions and developed an understanding of how to work better together to promote child and family well-being. Some challenges that social workers faced in implementing the interventions are mentioned and could serve to both bring awareness about these challenges, and to anticipate how these could be addressed in future interventions. Challenges such as the relationship with schools, high caseloads arising out of the referrals by teachers, facilitating access to community resources and services, caregiver/parental involvement, working with other social service professionals and their own safety when working in the communities.

The report recommends that the DBE, in partnership with DSD and DoH consider the institutionalisation and replication of the CoP model to step-up child and family well-being outcomes. Similarly, social welfare agencies working in the field of child and family strengthening could use the CoP model to implement an integrated and multidisciplinary approach to their work. It notes that with further practice, the roles of the different stakeholders could be clarified and that accountability to the team could be enhanced. The focus of intervention also needs to include the caregivers and family members to strengthen their participation and agency so that children may grow and thrive. Ultimately, this can best be achieved when children are part of safe, secure, nurturing and enabling family, school and community environments.

[1] https://communitiesforchildwellbeing.org/useful-resources/

1. Introduction

This report is part of a larger CoP study that explored a Community of Practice (CoP) for social systems strengthening to improve child well-being outcomes. It came about because of the fragmentation in service provision and focuses specifically on using an integrated and multi-disciplinary approach in providing comprehensive services to children and their families within the school and community context. The CoP study targets children and their caregivers who receive a Child Support Grant (CSG) in the foundation years of schooling, namely, Grade R and Grade 1. The rationale is that by investing in children's nutrition and health, improving their emotional and social wellbeing and schooling outcomes at an early age, are important social investments that will benefit the child later in life.

The focus of this report is on the social work component of the CoP. It is an example of the application of developmental social work in practice in five low-income schools in Johannesburg. There is an increasing interest in school social work and this report provides an example of how social development can be applied within the school, child, family and community context. In so doing, it serves as a contribution to social development within a school setting and the role of social work using a multi-disciplinary approach.

The report specifically documents the methods/processes followed by social workers including the development of assessment tools, data collection, setting up communities of practice and specific interventions such as family strengthening interventions. It concludes with the experiences of social workers who implemented the CoP.

It is written as a practical guide which can be used by social work agencies and practitioners and government departments involved in work with children and their families. It can be used by academics as an example of a practical application of developmental social work in a school and community setting for students. It can also be used as a learning document to assess the viability of the CoP approach within specific community contexts. The report identifies lessons learnt to aid the adaption of the CoP approach in different school and community environments. Although the focus of the document is on social work, there is scope to adapt the practice guidelines for implementation by social auxiliary workers and child and youth care workers.

2. The Community of Practice (CoP) study

2.1 What is a CoP?

The CoP was the model used in this study which was aimed at providing a holistic approach to meeting the multi-dimensional needs of children. CoP is a group of people who come together to focus on a specific topic or issue. CoP is defined as "groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis" (Wenger, McDermott, & Snyder 2002, p. 4).

The key concept behind CoP is the sharing of knowledge. Cambridge, Kaplan, and Suter (2005) provided seven reasons why this aspect is important. 1. They connect people who may otherwise never come into contact 2. They provide a shared context for people to communicate and share information. 3. They enable dialogue between people who have an interest in solving the same or similar problems. 4. They stimulate learning by serving as a vehicle for communication, mentoring, coaching, or self-reflection. 5. They capture and diffuse existing knowledge. 6. They introduce collaborative processes and encourage the free flow of ideas and information. They help people organise around purposeful actions. 7. They generate new knowledge, new ideas and new strategies.

This CoP intervention research project is a multi- and trans-disciplinary collaboration between researchers and practitioners across different sub-fields, including social work, sociology, psychology, education psychology, education, mathematics and language curriculum specialists, mental health, nutrition, primary health care, community nursing, public health and school health care services[2]. The study identifies the existing structural and systemic risk factors which impact on child wellbeing outcomes. These include poor coordination, fragmentation of services between different stakeholders, lack of organisation around child wellbeing outcomes instead of around activities and functions that operate in silos; different policy and organisational mandates; inadequate funding and human resource systems; different reporting lines, operating procedures, work styles and cultures

[2] Community of Practice (CoP) for Social Systems Strengthening to Improve Child Well-being Outcomes. Research Brief. 09 July 2021

and knowledge systems; resistance to new ways of working as well as competition between different spheres of government and implementing agencies[3].

Hence, the purpose of this collaboration is to address the disparate and fragmented service provision, which is a long-standing challenge across the health, welfare and education sectors serving children and families; and to accelerate child well-being outcomes in South Africa. The CoP attempts to address this knowledge and service gap and employs a multi-systemic approach to child well-being that locates the child in a wider family, school and community context. Improved cooperation between these sectors could aid the search for innovative solutions that are suited to the local context. The CoP, consisting of key actors across these social sectors and the academy, was established in 2020[4].

The CoP study targets children and their caregivers who receive a Child Support Grant (CSG) in the foundation years of schooling, namely, Grade R and Grade 1. Investing in children's nutrition and health, improving their emotional and social well-being and schooling outcomes are important social investments in the human resources of a country (Patel et al., 2017). These early interventions tailored to meet children's needs in poor families could lead to children securing better jobs with higher incomes in adulthood and the creation of more stable families and communities (Patel et al., 2017; Richter et al., 2018). In addition to social protection measures such as the CSG, collaboration between key sectors is assumed to be instrumental in accelerating child well-being outcomes, beyond only offering the CSG; and provide innovative solutions that are suited to the local context in South Africa[5]. These interventions are well-suited to the local South African context as it reflects deep insights into the unique situation of the community such as local cultures, languages, literacy levels of caregivers, and socio-economic realities.

In initiating the CoP, the team was interested in understanding, firstly, what constituted the most appropriate cross-sectoral interventions to step up child well-being outcomes, and secondly, how these interventions could be delivered across the health, education and social welfare sectors. It would also serve as a way to evaluate the viability of the CoP approach for strengthening social sector systems to improve child wellbeing in urban communities.

2.2 Developmental social work framework underpinning the CoP

The social development approach provides a useful framework for social systems strengthening for children and families. It is pro-poor, draws on inter-sectoral and interdisciplinary social science knowledge, partnerships in development, espouses a participatory ethos and includes a combination of micro, mezzo and macro level interventions that are well suited to address the needs of the target group of the study (Crea et al, 2018; Patel, 2015). This approach further resonates with the multi-systemic, ecological model of child development that draws together the proximal (closest to) and distal (furthest from) intersecting structures (child, family, school and community and wider societal context) in shaping child development outcomes (Bronfenbrenner, 1977; Ungar, 2020). This multi-level, multi-systemic framework situates the child and his/her family at the centre of multiple and intersecting systems, all of which impact on the child's well-being.

The study also identifies that child well-being outcomes may be influenced by the child, the immediate contexts of the child, such as caregiver well-being and family contextual factors and the material well-being of the family as well as the community, the wider society and the world at large (UNICEF, 2020). A rights-based approach to child well-being was conceptualised and deemed appropriate for the South African context. Indicators included the quality of life of the child and his/her family's socio-economic and development context, the care situation, service access as well as the child's status, in terms of health, education and safety.

This study adapted these existing understandings of child well-being and considered child well-being to refer to the whole child and includes the child's physical health, development and safety, psychological and emotional development, social development and behaviour, cognitive development and educational achievement. It also assessed the child and families' lived contexts recognising the significant impact that the wider system and policies have for children and families in South Africa (Bray & Dawes, 2007). Child well-being thus refers to the material, physical, educational, social and emotional well-being of children (Ben-Arieh, 2008; Bradshaw & Keung, 2011; Statham & Chase, 2010; UNICEF, 2007; 2013; 2020).

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[3] Community of Practice (CoP) for Social Systems Strengthening to Improve Child Well-being Outcomes. Findings from Wave 1: Tracking Child Wellbeing of Early Grade Learners and their Families. October 2021

[4] Community of Practice (CoP) for Social Systems Strengthening to Improve Child Well-being Outcomes. Self-assessment Report 2021-2022: 06 December 2021

[5] Ibid, page 4

The social work interventions span the start-up phase, reports on the developmental risk assessments of the children and their families based on data collected in October to December 2020 and the social work interventions that were implemented thereafter.

3. Start-up phase

3.1 Advisory level Community of Practice (ALCoP)

The study began with the establishment of an Advisory Level Community of Practice (ALCoP) made up of academic and research partners who are responsible for the overall leadership and management of the project. The ALCoP developed the digital child well-being tracking tool (CWTT) which was pre-tested and then administered to the children, caregivers and teachers.

The ALCoP served as an advisory board and engaged in collaborative discussions with the LLCoP to develop suitable interventions for the children and their families.

3.2 Local level Community of Practice (LLCoP)

Local level CoPs were established at each of the participating schools which were situated in Meadowlands, Ivory Park, Doornkop, Malvern and Alexandra. These were all quintile levels 1-3 schools in low-income communities and represents the poorest schools. This quintile ranking indicates the poverty score of a school[6]. The LLCoPs included key community stakeholders and comprised of the foundation phase teachers, CoP social workers and outside stakeholders e.g., nursing/health workers from the nearby clinics; local NGO community workers/ social workers; educational psychologists who assessed the children for learning difficulties, as well as representatives from School Governing Bodies (SGB).

The functions of the LLCoPs were to:

- Support children and families in need
- Learn about how to make appropriate referrals to service providers, and for specialised care
- Manage risk, and
- Meet to discuss progress and follow up.

The LLCoP met regularly which was important to provide a space for the team to discuss progress, identify challenges experienced in the school and find solutions.

3.3 Child Well-being Tracking Tool (CWTT)

The CWTT is a digital application that was specifically developed to assess child and family well-being in key domains. The purpose of the CWTT was to (a) conduct a risk assessment of participating children; and (b) inform the development and implementation of intervention and care plans for children at medium and high risk. The assumption was that early interventions tailored to children's needs in poor families in the foundation years of schooling could improve their well-being in the short to medium term with positive benefits in later life (Patel et al., 2017). The level of risk was colour-coded with red reflecting a major concern and indicating the need for an immediate referral; amber reflected some concerns that indicated a need for support/intervention and green indicated no concerns. The social workers focused their interventions on children who indicated high risk in most of the domains.

The Child Well-being Tracking Tool (CWTT) questionnaire was co-designed by partners in the Advisory Level CoP. Both a literature review of child well-being and findings from various studies conducted by the respective chairs and researchers of the different disciplines, informed the domains included in the questionnaire. For each child sampled, data was collected from important role players in terms of the child's overall well-being. These role players included: the caregivers, teachers, and the children themselves. The children and caregivers were interviewed by a social worker who completed the questionnaire. The teachers completed the questionnaires themselves. The nursing preceptors (qualified nurses) conducted a physical examination and completed questionnaires. The CWTT contained six sections to generate data on various aspects of the children and their family contexts. The questions in the CWTT aligned with these domains, focused on economic and material

[6] Van Dyk, H, & White, CJ. (2019). Theory and practice of the quintile ranking of schools in South Africa: A financial management perspective. South African Journal of Education, 39(Suppl. 1), s1-s9. Retrieved from https://dx.doi.org/10.15700/saje.v39ns1a1820

wellbeing, food and nutrition, education, health, and protection and care. The aim was to assess child wellbeing by including both subjective as well as objective indicators of child wellbeing. The focus was therefore on the child and his/her family, the well-being of the primary caregiver as well as the systems surrounding the child. The CWTT further drew on some aspects of a similar child well-being tool[7] developed by UNICEF to assess children of all age groups.

3.4 Data collection

Due to the nature of the questions being asked in the CWTT, it was decided that social workers would be best placed to collect this data from caregivers, teachers and children. The fieldwork team consisted of a Project Manager/Fieldwork Manager, two fieldwork supervisors, seven social workers and seven professional nursing preceptors. The Project Manager (a social worker) was appointed to manage the CoP project/study and was responsible for supporting the field work team in schools.

The social workers were seconded from three non-governmental organisations (NGOs), working in the research areas. One social worker was recruited per area, and two were recruited privately to assist in schools when NGO social workers were unavailable to assist with interviews. The nursing preceptors (qualified nurses) work in the University of Johannesburg's Nursing Department as part-time supervisors of nursing students. The fieldwork supervisors work part-time for the Centre for Social Development in Africa (CSDA) and are familiar with the communities in which the schools are situated.

The fieldwork team was trained in a 1-day workshop hosted by the CSDA CoP team as well as the University of Johannesburg's Nursing Department CoP partners. The training orientated the field workers to the aims and objectives of the study and gave an overview of the schools, communities and caregivers where the study took place. The importance of multi-disciplinary work and collaboration was emphasised. Techniques on interviewing children and caregivers were covered, as well as the importance of translating questions into mother tongue languages.

The CWTT digital app was discussed and demonstrated during the training session. The issue of COVID-19 protocols and safety in the field and schools was discussed in detail. Based on the research information forms returned, appointments to conduct interviews were made with caregivers via phone. In some instances, caregivers included an older sibling or a grandparent; whichever caregiver was available on the day of the interviews. This was not by design but more as a matter of convenience. Interviews were scheduled between 2 October 2002 and 18 December 2020 and were carried out on the premises of four schools. The research team was not permitted access to the physical premises at one school (Ekukhanyisweni Primary School in Alexandra) due to COVID-19 safety protocols. Interviews for this school were carried out at an Early Childhood Development Centre located across the road from the school. Caregivers and children were interviewed at school on days when the child was attending school. Occasionally, when the caregiver was unable to be interviewed at the school or ECD centre, interviews were carried out at the child's home. Interviews were carried out primarily in the local languages spoken at the specific school, and by the children and caregivers.

In addition, participating children at the five schools were also assessed for their number concept development, their early reading competence, and their vocabulary. These tests were administered by CoP partners in Education. Two standardised tests and one custom designed vocabulary test were used. The interview-based tests were administered individually to each child over a period of one month. The differences between the groups of children were their specific school and its first-grade teachers, the languages in which they are taught, as well as the everyday life in their communities. All the schools except one, taught in the mother tongue of the children. The numeracy test, known by its German acronym, MARKO-D SA, has been translated into six South African languages, with four of them standardised and normed for South African use. In the schools where this study was conducted, four languages were used, namely Sesotho, Xitsonga, English and isiZulu.

Following the fieldwork, a half-day debriefing and reflection session was held with the fieldwork team. The session focussed on debriefing the fieldworkers and recording and evaluating their experiences and observations during the fieldwork.

[7] https://www.unicef.org/southafrica/stories/tracking-wellbeing-children-south-africa

3.5 Findings of phase one

During phase one, the CWTT assessed the levels of risk experienced by the child and his/ her family (as discussed under 3.3 on the CWTT). The findings from phase one data highlighted the ways in which child well-being outcomes are influenced by multiple, intersecting factors, drawing attention to the need for innovative, multi-level solutions. Some conclusions from this survey are[8]:

i. The material well-being of children was compromised by the high unemployment rate of caregivers.
ii. Four out of 10 caregivers did not have enough money to buy the things that they needed such as food and basic necessities.
iii. 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 income was insufficient to meet basic expenses and consequently almost a third struggled with indebtedness and over half could not save.
iv. 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, and the quality and nutritional value of the food was inadequate.
v. A fair proportion of children experienced health conditions that needed intervention and a third had incomplete vaccinations.
vi. While caregivers were of the view that the children were well groomed and attending school regularly and were progressing satisfactorily, the teachers had a less positive view about children doing their homework during the COVID-19 pandemic while the majority of parents reported that this aspect was not a challenge. Almost half of the children were older than they should have been for their grade and 22% were identified as having learning difficulties.
vii. The children scored poorly in the mathematics and language literacy tests and were found to not be ready to engage with the grade one curriculum. Their test scores were below the provincial scores assessed prior to the pandemic.
viii. Caregiver and child mental health were most concerning. Over half of caregivers (54%) had depressive symptoms based on the CES-D-10 (The 10-item Centre for Epidemiological Studies Depression Scale) assessment tool.
ix. Teachers reported that 13% of children presented with anxiety and expressed feelings of unhappiness.
x. Two-thirds of caregivers were also concerned about child safety with similar numbers having been exposed to violence at home and in the community.
xi. 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 reported to be doing well on other indicators. For instance, 82% were attending school even though this attendance was on the basis of a rotational timetable (i.e., different groups of learners attend class on different days or at different times), 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 have been of poor quality.

The research also showed that some children and their families have very particular needs and that customised interventions are needed to respond appropriately and timeously. By placing the needs of the child and their family at the centre of intervention strategies, systemic solutions could help to break down the barriers that perpetuate exclusion of groups of children who are left behind.[9]

[8] Community of Practice (CoP) for Social Systems Strengthening to Improve Child Well-being Outcomes. Research Brief. 09 July 2021

[9] For more detailed reading, see the report on Findings of Wave 1: Tracking Child Wellbeing of Early Grade Learners and their Families, October 2021

4. Interventions

The findings showed that there should be avenues for intervention at each level of the system: the child, the family, the school, the broader community and society.

Child	Family
▪ Health – vaccinations ▪ Education – Education psychology assessments (learning) ▪ Food security – referrals to CBOs/NGOS' and govt. agencies ▪ Protection/care - referral for social work service intervention	▪ Family visits by social worker ▪ Participant in a family strengthening programme ▪ Link to food distribution sites ▪ Caregivers with high levels of depression were contacted for follow up support
Targeted community level education	**School level support**
▪ Community education and information exchange: community radio campaign on parental engagement in schooling; nutrition and health; tips for caregivers/parents; financial capabilities ▪ Advocacy for at risk CoP children and families to access services and resources through governmental/NGO services	▪ School level support ▪ Establishment of LLCoP at schools ▪ Creation of referral networks (health, welfare, mental health). The teachers were provided with information on referral organisations in the community ▪ Mathematics and Literacy capacity building of teachers at all intervention schools

From the above, immediate points of intervention were:

i. Identification of children at high and moderate risk (according to the digital CWTT); and making appropriate referrals.
ii. Addressing food insecurity and nutritional needs.
iii. Ensuring health follow ups including vaccinations.
iv. Identification of learning challenges and accessing necessary support.
v. Immediate follow up with regards to child safety and protection, including home visits.
vi. Provision of support to caregivers (mental health and economic wellbeing).

To this end, the intervention plan included:

- Establishment of LLCoPs to address the challenges children and caregivers face.
- Assigning one social worker per school to follow up on families and children in need who will deliver services for a three-month period (follow up home visits, referrals).
- Identifying community resources that distribute food parcels and making appropriate referrals to address hunger and food insecurity.
- Ensuring children are accessing the National School Nutrition Programme (NSNP) on days when they are not at school.
- Working with local clinics to ensure that only children in the sample, not within the school are up to date on vaccinations.
- Conducting full educational psychological assessments of a sample of children at risk.
- Inclusion of families in need for participation in the Sihleng'imizi family strengthening programme.
- Family strengthening community radio and WhatsApp messaging in two of the five areas focusing on:
  - Promoting parental involvement in children's schooling
  - Nutrition and healthy food practices
  - Tips for caregivers to manage stress and difficult behaviours in children; and
  - Money matters.

4.1 Recruitment and appointment of social workers

A job description was developed for the CoP social workers which identified the key areas of work required, such as, case management: coordinating LLCoPs, implementing the child and family intervention plans; facilitating Sihleng'imizi groups: identifying and recruiting red-flagged families from the CoP study to join a Sihleng'imizi group, planning, and preparing and implementing the full 14-week Sihleng'imizi group programme.[10]

[10] Job description of the CoP social worker

The main criteria for the appointment of the social workers were that they had to be open to learning, be proactive with high energy levels, live near or in the communities that the school was situated in and able to speak the same language/s as the CoP families. They had to be familiar with community-based resources and have an openness and willingness to work within and promote the CoP model. Recruitment was done through various contacts in the field, and 5 social workers were appointed, one for each of the schools in order to enhance the school-based support and referrals for children in the study.

4.1.1 Induction and training of social workers

Induction is a critical part of introducing social workers into the organisation, its culture and values. It also helps to set the tone of the relationships between the immediate team and the supervisor and clarifies roles and responsibilities. To facilitate the induction of the newly appointed social workers, the following steps were taken by the Project Manager:

- An introduction meeting: The purpose of this meeting with the social workers and Project Manager was to introduce the CoP research study to them and to explain their roles. The social workers were also allocated to their specific schools.
- School visits: Each school was visited to introduce the social worker assigned to the school and to introduce her to the School Principal and the Head of Department (HoD).
- Further orientation: The Project Manager met with social workers to discuss individual schools CoP results, the identification of children who were "red flagged" and how to proceed with assisting these children.
- In addition, the social workers attended the Sihleng'imizi Training Programme. They were also central to the launch of the LLCoPs and following up on the children identified by the CWTT as being "at risk".

4.2 Establishment of Local Level Community of Practice groups in schools

As indicated earlier, LLCoPs were established at each of the participating schools and included key community stakeholders. Each school CoP group met a few times. A strong focus in establishing these groups was the importance of social workers getting the buy-in and commitment to collaborate from HoDs, teachers, local clinic nurses /health workers and local NGOs. The Gauteng Department of Education (GDE) had granted CoP consent to work in schools and coupled with the CSDA's previous history of running Sihleng'imizi groups in these schools, and collecting wave one data for CoP, they had an established relationship with them. However, the social workers had to work at establishing trust and rapport with teachers by spending time at the schools, talking to teachers about both CoP and non-CoP children, providing psycho-social advice and support (counselling children, parents and teachers who required assistance) and referring children and families to local community services for assistance e.g., local clinics, Child Line, a family life organisation, FAMSA and SADAG, an NGO providing community health support.

The LLCoP groups proved to be very effective platforms for teachers, social workers, health workers, educational psychologists, NGOs and SGB members to connect with each other and to share information on children and families who had been identified as being "at risk" in the study. Children who were identified as being "at risk" in most of the five domains in the study, were visited at home by the social workers in order to get a better sense of the factors impacting on their well-being and that of their families and households. Feedback from these visits were shared with teachers at the LLCoP group meetings. Teachers also contributed information they had on these children, while at the same time respecting confidentiality (all teachers and social workers in the LLCoP groups signed a non-disclosure agreement).

4.2.1 Benefits of LLCoP groups

Some of the benefits of the LLCoP groups was that the collaboration between social workers, teachers, health workers and NGOs facilitated a multi-sectoral approach and better coordination to achieve child well-being outcomes. More specifically;

- The LLCoP groups enabled social workers to share information gathered during home visits with teachers to assist them to see children through a more holistic lens. Many teachers commented that being able to see children as individuals was a result of them attending LLCoP groups. They were better able to understand how situations at home impact on children at school.
- Several CoP caregivers started to engage with schools and teachers after supportive home visits by CoP social workers. Their children showed visible signs of improved well-being e.g.: improved school attendance and academic performance, cleaner and neater appearance, and more outgoing behaviour in class.

- NGOs invited to the LLCoP meetings were given access to and a platform at schools to talk about their services.
- Food insecure families during COVID-19 were assisted by social workers who linked up with local NGOs in the community to provide them with food parcels. In one case a local NGO offered to supplement the school nutrition programme for the whole school.
- The LLCoP groups assisted teachers and professionals who work with children to come together to improve child well-being
- The LLCoP groups assisted social workers and researchers to better understand the lived reality of the challenges faced by schools and teachers on a daily basis and to offer suitable support.
- Social workers were able to balance the views of teachers and caregivers in addressing child well-being e.g., a social worker who did a home visit discovered that the caregiver was not literate and mentioned this to the teacher, who said she understood now why the caregiver was not able to assist her child with homework or even read school notices.
- By raising the need for social workers to be placed in schools during LLCoP meetings, a CoP social worker arranged for the UJ Social Work Department to place four students at these schools to assist with some SBST support work with children at school.
- Teachers learnt skills on how to assist non-CoP children in their classes who have similar challenges to CoP children particularly after the educational assessments were done.

4.3 Social Work Interventions

The CoP social workers engaged with families who were receiving child social grants and who had been identified as being potentially at risk on several of the domains in the CWTT. These families were also the most vulnerable to poverty which is a known risk factor for child well-being.

Multiple interventions are necessary pathways for child well-being; and these include health, nutrition, mental health and education, including the structural enablers to support families in their care responsibilities and family strengthening interventions. The CoP social workers offered the following social work interventions and services to CoP families. These included interventions: 1) at a child and family level; 2) at a school level; and 3) at a community level.

4.3.1 Identifying local resources

Social workers conducted a community mapping exercise when they first started working for CoP, and this process enabled them to identify key community stakeholders. By including community-based NGOs in the local-level CoP groups, teachers broadened their resource base for other children and families that require support. NGOs in turn, were given access to these schools and a platform to showcase their services to schools. During the COVID-19 pandemic, the City of Johannesburg (CoJ) and the Department of Social Development (DSD) social work services shut down critical community services serving vulnerable individuals and groups who needed it most. These services included child protection, gender-based violence and mental health services. The social work teams in schools however, through their outreach work to local NGOs, were able to create a circle of care for some of the CoP participants by linking up with local community-based NGOs who offer free after care programmes, feeding schemes, counselling services, ECD programmes and family outreach services. These NGOs in turn, had all previously struggled to gain access to these schools to formally introduce their services, and during the COVID pandemic the physical accessing of schools became even more difficult.

4.3.2 Psychosocial support

Social workers provided psycho-social support to between seven and 26 families each. They did home visits to do assessments on the needs of the caregivers, children and households. Based on the findings of the assessments, and the presenting problems, they mostly referred families to service providers who could assist the caregivers, for example, for GBV counselling or to the NSNP for food insecure families, or to other NGOs or government departments such as DSD, local clinics and hospitals. Caregivers developed a rapport with, and trust in the CoP social workers and hence, they were reluctant to go to an external service provider and preferred to liaise with the CoP social workers. CoP social workers noted the dilemma they had in providing counselling in all instances, as this was not possible with the CoP workload and for ethical reasons.

Hence, they had to be more discerning about how much counselling they offered the families, and did assist in some instances, for example, where the relationship between a couple was impacting negatively on their child. A non-CoP child was referred by a school to a CoP social worker for counselling at school as a result of a rape. This was done in conjunction with the referral to a child abuse counselling service outside of school.

Social workers did regular follow-ups and monitoring of referrals which they made to check in on the families. They were also involved quite extensively in mediating between families and schools, as well as within families who were experiencing difficulties.

In addition to the above, the social workers each had five families who were part of the Sihleng'imizi Programme. They provided more intensive support to these families. More detail is provided in 6.7 where the Sihleng'imizi Programme is discussed.

4.3.3 Psychometric assessments

Six children from each school who met most of the criteria below and were identified as struggling with schoolwork by the CWTT, were selected to have a psychometric assessment by an educational psychologist:

- Child is above the age range for their grade
- Child identified by teacher as having learning difficulties
- Child identified by caregiver as having learning difficulties
- Child is repeating their grade, or was progressed to a higher grade but did not meet the required academic outcomes for grade R or Grade 1
- Poor academic performance of child in the first term of school (school reports)

Five Educational Psychologists in private practice were contracted and assigned to a school. An important criterion in engaging the services of these psychologists was their ability to speak the home languages of the children in the school they were assigned to, and their openness to working with children and their caregivers at the school premises.

Social workers played a central role in co-ordinating the assessments, as well as obtaining the buy-in from caregivers. All caregivers were contacted through a home visit or by phone and the reason, process and benefits of participating in the assessments explained to them. There were a couple of parents who did not want their children to be assessed, and this was only confirmed once home visits had been conducted.

Social workers set up the assessment dates with the caregivers and psychologists and sat in on most of the initial interviews. They did this to assist and support caregivers to feel comfortable and to better understand the process. They also accompanied the children who were being assessed and followed up with caregivers once the assessment reports were completed. This required social workers to co-ordinate face to face meetings at the schools between psychologists and caregivers, and where caregivers did not arrive, conduct home visits.

CoP had planned for psychologists to attend at least one LLCoP group meeting in order to share their findings on the children they had assessed (within the boundaries of confidentiality). However, only three psychologists completed this process. The remaining three did not have time to do this, although two did forward notes on their findings via the social workers to share during the meetings. The meetings that were attended by the psychologists were successful and very meaningful for teachers, as they provided a true community of practice where ideas were shared, and questions answered.

4.3.4 Health interventions

In addressing the health needs of the CoP children, the social workers attempted to engage the local municipal clinics to come into the schools to assist these children. Unfortunately, local clinics do not have the capacity to vaccinate children at schools or do school-based screening, unless there is a specific campaign such as measles or the HPV inoculations and require caregivers to take the children to clinics for treatment. All children who were missing vaccinations were visited by social workers to encourage and facilitate these children in catching up on these vaccinations. As these home visits were conducted during the height of the COVID pandemic, several caregivers did not feel comfortable going into clinics due to the high risk of infection.

Social workers worked through the LLCoP groups at each school to identify the local clinics and set up appointments to meet a nurse attached to the clinic who would attend to the children and their caregivers when they arrived at the clinics to have their missing vaccination. Social workers liaised extensively via telephone with these caregivers to follow up on them going into clinics and requested them to WhatsApp a photograph of the Road to Health vaccination card once the vaccination had been administered. These home visits and phone calls developed a rapport between social workers and caregivers which was particularly useful if further intervention was required.

The UJ Optometry Clinic and the Wits University Speech & Hearing Clinic were contracted by the Project Manager to do school-based eye, hearing, and speech screenings with children whose parents indicated in the first wave of data collection, that their children had a hearing, speech or visual problem. It is important to note that when the schools were informed about these organisations coming to the school, several LLCoP teachers included non-CoP children in the screenings as the Integrated Health School Programme (ISHP) does not do these screenings anymore due to capacity challenges. These clinics also used students under supervision by professionals to do the screenings, which assisted these students to meet the practical component of their degrees (this was limited during COVID-19 pandemic).

4.3.5 Hunger and food insecurity

Caregivers who had indicated that their children sometimes went to bed hungry and were food insecure, were visited by social workers to find out what the needs of the family were and the reasons for the food insecurity. In cases where children living in food insecure households were not on the list to receive food parcels from their school, social workers, through the LLCoP groups, advocated for these families to be included on these lists. In addition, social workers liaised with local NGOs and DSD to advocate for ad hoc food parcels to be provided to these families. Private Philanthropic initiatives and Faith Based Organisations contributed significantly during COVID towards humanitarian assistance such as food relief. By leveraging these services, the social workers were able to refer at-risk families to these organisations for additional food support particularly during the school holidays when many children do not receive food from the government's national school feeding programme, the National School Nutrition Programme (NSNP).

4.3.6 School uniform support

Social workers also followed up with children who did not have the full uniform. This entailed working closely with teachers and caregivers and advocating with the SGB and parent bodies who assisted individual children to access uniforms.

4.3.7 Sihleng'imizi family strengthening programme

By doing follow up visits to families who had been identified as being "at risk", social workers were able to determine the likelihood of these households benefitting from being part of the Sihleng'imizi Programme[11]. Through developing trusting relationships with caregivers, the households were encouraged to become part of the family strengthening programme. Thirty families were invited to join the Sihleng'imizi groups, which was also run by the CoP social workers. This 14-week programme is an evidence-based family strengthening and intervention programme that included the entire household of the child identified as being at risk and vulnerable.

This was an intensive process and was not the "usual" social work group. Social workers facilitated the sessions and were assisted by a childcare worker/auxiliary social worker who worked with the children during break away sessions. Social workers visited families during the week after sessions to establish trusting and supportive relationships with the families, and to monitor how they were implementing the programme at home. Home visits were particularly important to conduct when families were absent from the group sessions.

Social workers initiated a family buddy system – they were paired up with buddies at the beginning of the group and were given cell phone data and encouraged to support each other during the course of the programme. WhatsApp groups were set up with Sihleng'imizi families and their social workers and childcare workers for the duration of the programme to check in with each other and share information.

Children who were part of Sihleng'imizi, had weekly breakaway sessions during the groups where they worked with childcare workers on the same issues that their adult caregivers did. At times, there had to be follow up work with the children depending on what arose during these sessions, for example, when a child did a collage on alcohol, which reflected what was happening in the home.

Social workers were required to attend weekly supervision sessions especially related to Sihleng'imizi, which took place online. In addition, the submission of group process and progress reports were submitted every week to the Sihleng'imizi supervisor (external supervisor) as well as evaluation forms from caregivers. An additional requirement of the programme was the adherence to strict fidelity protocols for research purposes, a practice many social workers in practice are not required to do. For example, the social workers had to submit weekly

[11] https://communitiesforchildwellbeing.org/useful-resources/

reports and complete weekly fidelity checklists which ensured that they were delivering on the programme as intended. This served as checks and balances to monitor and enhance delivery of the interventions.

4.3.8 Referral of caregivers with depression to telephone counselling services

Caregivers who indicated high levels of depression in the first wave of data collection, were followed up with telephonically 12 months later by a CoP social worker. If they still felt depressed, arrangements were made for telephonic counselling services with South African Depression and Anxiety Group (SADAG) if they wanted to speak to a counsellor.

4.3.9 Linking up families and caregivers to community resources & networks to strengthen families

CoP social workers did a limited number of home visits to families who were not in the CoP study. These children were referred to social workers by teachers who were in the LLCoP groups and were concerned about the welfare of individual children. Information on these visits was shared with teachers and in some cases these families were supported by social workers by offering counselling, referring caregivers for counselling and continued support visits.

4.3.10 Community radio campaign

The Sihleng'imizi radio campaign was designed to broaden the reach of the important content of the Sihleng'imizi programme. It sought to give parents and caregivers practical tips on how to help their children both in and out of school and focused on good nutrition, mental health and finances.

The radio programmes were aired on two Gauteng community radio stations, namely, Alex FM and Voice of Tembisa (Ivory Park), two of the CoP areas. The radio concept included the production of a mini drama of approximately two minutes which used narrative and storytelling as a hook for the talk-show of thirty-minutes where an in-studio guest engaged with the presenter to unpack the issue raised in the drama. The dramas were played prior to the talk-show and together with repeated live-reads were designed to drive listeners to the thirty-minute talk-show[12].

Grounded Media engaged with the radio station presenter and producer to familiarise them with the campaign and provided detailed radio briefs, so they were able to interact with the studio guest in an informed way. The studio guest (a social worker or nurse), was invited to do a telephonic interview in each radio station, based on the topic of the week. Topics covered were: Parental and caregiver involvement in children's schooling, Nutrition, Mental and social capacity, Finances, and Budgeting.

The two social workers who were based in Alex and Ivory Park were guests of these shows every week and would share the tips of parenting with listeners. They were also involved in giving input into the content of the shows as they were seen as the "community experts" and had been trained to run the Sihleng'imizi programme.

5. Supervision, mentoring & coaching

Supervision is an integral part of social work practice and provides an opportunity for social workers to reflect on their practice, discuss challenges and develop solutions. This was particularly important in implementing a CoP using a holistic and multi-disciplinary approach which was different from the norm in social work; and required that social workers work with LLCoP groups to ensure meaningful inputs into the intervention process. In addition, the intensity of the work that social workers were involved in, required some regular debriefing.

Central to the successful and creative implementation of the CoP intervention plans were the team of community-based school social workers, most of whom are newly qualified social workers. The professional roles they played were numerous and diverse and included that of Broker, Advocate, Case Manager, Educator, Facilitator, Organiser, Enabler and Encourager.

The CoP social workers approached the task of improving child well-being outcomes in their respective schools by looking at the child and family holistically, using the school, family and community as a well of resources. The school was identified as being at the centre of the CoP intervention. The role of the caregivers was emphasised, and the social workers focused on strengthening their agency and growing their capabilities. The caregivers

[12] https://communitiesforchildwellbeing.org/useful-resources/

were participants in the process and their engagement in their children's schooling was encouraged. Their own functioning as a caregiver was addressed, such as their mental health, well-being, and having material support from the state.

The intervention process started with the social workers and the Project Manager meeting to discuss the aims and objective of the CoP project. During this process, the importance of using a CoP model in the intervention of children and families was emphasised. This included observing and understanding the school setting holistically, and identifying existing assets and resources in the community, school and family to work in an inter-sectoral and multi-disciplinary way when enhancing child well-being. Communities, families and children were perceived as having strengths, and the social worker's role was assisting to enhance those strengths.

The social workers were encouraged to develop good working relationships with the HoDs and teachers in the foundation phase. The value of effective working relationships with teachers in particular was raised as crucial in order to access children and families, and to address the well-being needs of these children and families.

Using an Action Learning Approach[13], the Project Manager provided both group supervision as well as one-on-one supervision. These sessions initially focused on social workers talking about their experiences at schools with the teaching staff and how to best develop effective working relationships with this crucial group of stakeholders. The importance of being physically present at schools was emphasised as was working around the teaching timetable when approaching teachers and children. Social workers were encouraged to assist teachers and principals to a limited degree with regards to advice and home visits to families who were not in the CoP study who required social work support. This "give and take" approach enhanced the reciprocity between social workers and teachers, and enabled social workers to access children, families and schools during the COVID pandemic when schools were often off limits to outsiders. It also assisted in social workers becoming part of the school team and being perceived to offer value to teachers. By being mindful of how teachers, HoDs, principals and caregivers were approached, social workers were able to claim as much value as they could in the process.

Supervision sessions were often used as information gathering opportunities for both the Project Manager who was also the supervisor and the social workers. The supervisor was able to assess the knowledge, skills and values of the social workers in their various settings and CoP activities and assist them in developing them in areas they needed support in e.g., advice on how to approach community NGOs for assistance with food parcels when the families they worked with were food insecure. The three newly graduated social workers were able to learn from the two older social workers about the importance of doing regular home visits to properly understand what challenges and strengths their families had.

These group discussions assisted the supervisor and social workers to better understand what the different strengths, assets and challenges were in each CoP school, and how best to leverage them to improve child well-being. Social workers were given the opportunity to talk about their work in schools and how they were able to reach the children and families on their list e.g., working with security guards at the school gates who helped them identify caregivers who were difficult to reach. This approach helped to create a culture of openness and confidence that we were all learning in the process. The importance of learning from one another was highlighted as was understanding that what works best in one school, may not necessarily work in another school e.g. one school allowed the social worker free reign in inviting caregivers into the school for meetings whilst the principal at another school did not allow caregivers onto the school premises during COVID-19. Solutions to work around these challenges were often discussed in supervision with all social workers contributing their knowledge and insights.

The ability of social workers to be agile was critical within a school setting particularly during the COVID pandemic. This attribute was encouraged by the supervisor as well of the importance of learning from one's mistakes – this was evident during the Sihleng'imizi groups with CoP families when younger social workers learnt the importance of doing home visits to families after sessions to encourage them to keep on attending group sessions.

The role of social workers in a school setting highlighted the important role they can play in multi-disciplinary teams in schools, and the unique contribution of the school social worker in bringing home, school, and community perspectives to the interdisciplinary process. This demonstrated the importance of a) interdependence, b) the ability to perform newly created professional activities and take on new tasks as necessary, c) flexibility, d) collective ownership of goals, and e) reflection on processes. Social workers were responsible for implementing and coordinating the LLCoP groups and had to be mindful of these aspects.

[13] Tamowski. (2022). Action Learning. *Plays-in-Business.com*. Retrieved from https://www.plays-in-business.com/action-learning/

While group supervision was the dominant form of supervision for the CoP social workers, individual supervision sessions did take place. This was for the supervisor and social worker to check in with each other and to discuss specific families and issues that individual social workers were working with. These sessions took place at the office of the Programme Manager, and more often than not, at the schools the social workers were placed at. The school-based sessions also included planning sessions for individual LLCoP group sessions.

The supervisor maintained regular telephonic and WhatsApp contact with all the social workers throughout their employment on the CoP, both via a team WhatsApp group and individually. These calls related to administrative functions of CoP which needed to be followed up on e.g., number of "red flagged" families visited, children vaccinated. The supervisor recognised that while the administrative aspects of the social work functions were important, they needed to be balanced with the support and educational aspects of supervision which took place in group supervision.

CoP social workers found these supervision and debriefing sessions extremely valuable. It helped them to share, reflect and learn from each other. The group sessions helped to normalise their own feelings of being overwhelmed or anxious at times. While there might not have been much need for individual supervision, sometimes this took place depending on the needs of individual social workers.

6. Social workers' experiences of working in the CoP project

i. Knowledge and skills

While the CoP social workers could rely on their social work training during the CoP interventions, it is the CoP approach that honed and enhanced their skills in practice. They:

- Developed skills in data collection and the use of data in assessment, intervention and in monitoring and evaluation.
- Used evidence-based assessments and interventions in a collaborative and multidisciplinary team.
- Used integrated generalist practice skills e.g., micro (individual child and family level), mezzo (groups methods), and macro (schools and community level) interventions.
- Experienced the intersection with macro level policies e.g., CSG; no fee schools' policy; national school feeding programme; primary health care policies and school level health, support and care policies.
- Developed strong mediation skills.
- Learnt to communicate effectively about the social worker role in a multi-disciplinary team.
- Developed their advocacy skills – advocating for children (food insecure children) and being an advocate for parents with the school.
- Enhanced their facilitation skills – working with groups of caregivers who were older than the social workers, and their children.
- Learnt new skills in short-term, solution focused interventions and case management involving different professionals and service providers. Specifically, they learnt how to manage the number of families they had to work with and ensured that families were counselled, referring families when necessary to appropriate resources in the community, and doing the monitoring, thereafter, writing reports and doing follow-ups.
- Training and capacity building to deliver a family and community strengthening (Sihleng'imizi) intervention targeted at CSG children and their families.

ii. Working in a multi-disciplinary setting

- Social workers learnt to work in a multi-disciplinary team and how to own and develop their own roles as social workers within a multi-disciplinary team.
- In the process they learnt about other professions and developed a better understanding of how to work together to better promote child and family well-being. For example, they understood health needs of children better and the risks to children, for e.g., of wasting and stunting and caregiver mental health.
- Social workers helped to strengthen the relationships between teachers, and health care practitioners, education psychologists in a school setting. They also learnt about the importance of accountability within the multi-disciplinary team and how this collaboration is critical to achieve child-wellbeing outcomes.

iii. Systemic / structural issues.

- The CoP model exposed the systemic and structural challenges that impact on service delivery such as fragmentation of services, lack of collaboration among service professions and across social sectors

including resource constraints e.g., there is one educational psychologist and social worker per education district which spans many schools.

7. Challenges faced by CoP social workers

CoP social workers faced some challenges in implementing the interventions. Noting these could bring awareness about these challenges, and to anticipate how these could be addressed in future interventions. These are briefly summarised:

i. Relationship with the schools

At times it was difficult to work through gatekeepers in the school and for CoP social workers to establish their role and own voice and presence in the schools. When CoP social workers entered the school, the teachers felt that social workers had to solve all the problems in the school. This required constantly working on relationships with teachers and within the LLCoP group itself. Another challenge was navigating the dynamics and conflicts between teachers, and then between teachers and school management; and to not become consumed by this. The social workers had to also be quite persuasive in encouraging teachers to attend and participate in LLCoP group meetings which took place after school.

It was also challenging when teachers wanted feedback about the children from CoP social workers when they did home-visits. On the one hand they needed some information to help them understand the child better, but at the same time, how much to disclose and protect the dignity of the child, was sometimes difficult to navigate.

ii. Being overwhelmed by referrals from teachers and principals of non-CoP children who required support

In addition to organising the eyesight and hearing screenings for the CoP children, the added challenge was when schools wanted these tests to be extended to some non-CoP children due to the demand by schools for these screenings. The coordination and logistics of arranging the screenings of the children was a time-consuming task.

The dilemma was that teachers often felt that they knew of other children who were more in need of assistance than some of the CoP children. Social workers then had to explain the importance of working with the CoP children who were part of the research sample and piloting of the CoP, but at the same time having to compromise and extend some of the services to non-CoP children.

iii. Lack of action from community resources/NGOs

At times, referring children and their families to social workers in other agencies was challenging because agencies did not respond timeously to these referrals. CoP social workers found it more challenging to work with social workers at NGOs, than with other professionals. This might have been due to their high workloads, limited resources and agency policies.

iv. Caregivers/parental involvement

Caregivers initially were not trusting of social workers because of the negative reputations and perceptions of social workers. However, after the CoP social workers conducted home visits, and were able to explain the purpose of the study, trust improved. The caregivers also did not feel that their children were being singled out but were randomly selected to be included in the study.

At times a few caregivers did not use their own initiative and agency to follow through on matters affecting their children and expected social workers to do this for them. It involved extra work and providing hands-on support to encourage these caregivers to engage with teachers and with the school.

v. Working with other social service professionals

The CoP social workers acknowledged and affirmed the role of social auxiliary workers and child and youth care workers. Some of them provided valuable support to the CoP social worker by knowing the community and helping with community engagements and were very resourceful. However, CoP social workers had to sometimes provide professional oversight to how childcare workers addressed their own personal issues and what they then shared with the parents, and what not to share with them.

vi. Safety of social workers

The CoP social workers often did not feel safe doing home visits. At times caregivers were only available after hours because they worked; but some of the social workers felt that they did not even feel safe during day-time visits, as some areas were high-risk areas. They felt that some kind of check-in should be done by someone so that they felt more secure, especially when doing visits after hours.

vii. Wave 2 data collection

During home visits, CoP social workers picked up some data collection errors from the 1st wave data collection. Caregivers sometimes gave different information in the 2nd wave of data collection. This could be that different people were interviewed during the 1st wave and now caregivers themselves were providing the information. It was also noted that caregivers were probably more trusting during the 2nd wave of data collection because they understood the study better and had developed relationships with some caregivers, so there was more trust.

8. Key lessons learnt/Conclusions

Some important lessons and conclusions can be drawn from the social work intervention aimed at improving child well-being outcomes. While an evaluation of the programme will provide more concrete evidence of impact, the preliminary evidence of the CoP social work intervention demonstrates that the multi-sectoral and transdisciplinary approach of responding to the needs of the children and their families, was well received by caregivers and the teachers.

The CoP provides an example of the application of a social development practice model/ developmental social work in South African schools in low-income or deprived communities. Furthermore, it is an exemplar of how to put into practice and assess the feasibility of using a cross-sectoral and multi-disciplinary approach.

All the children involved in the programme were in receipt of a CSG which did provide some level of support to them. However, given the multiplicity of problems faced by these vulnerable families, it was not sufficient on its own. When combined with well-co-ordinated, integrated and complementary support services and interventions, it provided a more holistic approach to addressing the challenges of the participants.

Given the disparate and fragmented service provision which is a long-standing challenge across the health, welfare and education sectors serving children and families, the CoP model provided a useful child and family-centred approach to understand how to break down silos, co-operate around a common purpose and find local level solutions with schools as the focal point of engagement.

The importance of having a coordinating structure in the LLCoPs during this process, was invaluable because it brought together multi-disciplinary teams to address the needs of children and their families holistically. It is evident that improved cooperation across these sectors could lead to finding more innovative solutions to strengthening families. The LLCoPs also facilitated a better understanding, and respect for the work of the different professions in as far as it addressed the different aspects of the child and their families on the one hand. Social workers for example, could better understand the lived reality of the challenges faced by schools and teachers on a daily basis and to offer suitable support. On the other hand, collaboration across multi-disciplinary systems is not easy and requires intense effort and commitment from everyone involved in order to make it successful. Policy guidelines and protocols to promote cooperation between all the parties could help to improve service provision.

There have been numerous challenges, some of these noted in the report. Implementing the CoP has required intense energy and a lot of resources. How one identifies the children who are most in need of the services will remain a tension as the overwhelming need for services overshadows limited resources. Developing the agency of caregivers is critical as their expectations fall on the social workers and others to address their problems. Addressing this over-reliance on the social worker through encouragement and support, strengthening their motivation and active engagement in children's learning and how to use resources optimally, are challenges that will need to be addressed in future. A further challenge is the timeframe of a CoP intervention per school. What happens to the families after one-year when the programme ended? Special consideration needs to be given to how to ensure that the gains made by the families are sustained.

The role of the social workers has been pivotal in holding the space in the LLCoPs and to keep the coordination, cooperation and collaboration going. It has highlighted the importance of having social workers in schools, as the

strategic point of contact with children, their families and in their community context. In an ideal world and given the multi-faceted challenges that children and families face, and the need to have customised interventions and solutions, one would imagine that every school needs a social worker. Further research is needed to refine the CoP model and to inform integrated social assistance, education and health policies in South African schools especially in the early grades. This is an example of a social investment in child well-being and how to disrupt structural disadvantage in the early years of schooling to promote better long-term outcomes.

What the CoP research and intervention study demonstrates is that it is an evolving process and that a few questions remain unanswered as yet. However, the benefits are enormous in terms of providing a locally designed and tested model that could find systemic solutions to ensure that the well-being of children and their families are addressed. This could have a ripple effect on children as they grow up and become the future adults.

9. Recommendations

This document focused on the interventions of the CoP social workers; hence the recommendations are aligned to that:

- The CoP Social Systems Strengthening to improve child well-being outcomes is a model that could be considered for adoption by the Department of Basic Education (DBE) in partnership with the DSD and the DoH. It can also be implemented by social welfare agencies working in the field of child and family strengthening.
- Further practice could address the following within the CoP teams such as roles, professional turf, identify issues and accountability to the team. Clarifying the role of different stakeholders especially that of social workers within a multi-disciplinary team should be further elucidated by all parties within the LLCoP teams.
- From a policy perspective, how to institutionalise the CoP at school and district levels will require further deliberation. This could include among others multidisciplinary professional education and training; the use of paraprofessionals to scale up the interventions in schools including clarification of organisational mandates, resource sharing and accountability are some aspects that require further attention.
- Issues of caregiver agency needs to be addressed to strengthen caregiver well-being, agency and active engagement in children's growth and learning. Sihleng'imizi is an evidence-based programme to make available to more parents.
- The values and ethics of social workers vis-à-vis other social service professionals should be addressed. Many of these values and ethics must be applicable to all professions working with children and families, especially those closely aligned to the social work profession (child & youth care workers and auxiliary social workers).
- The digital CWTT is a valuable resource that was developed by the current ALCoP; it needs to be made available and accessible to other groups/ organisations/ schools who wish to use it to replicate the programme.
- The safety of social workers when doing home visits is a constant concern; home visits remain a critical part of the work of social workers, so some mechanisms are necessary to address safety issues.
- A point was made about CSDA being clear and consistent about what it has to offer families so that it doesn't create expectations that cannot be fulfilled.

10. Helpful Sources

1. Community of Practice (CoP) for Social Systems Strengthening to Improve Child Well-being Outcomes. Research Brief. 09 July 2021
2. Community of Practice (CoP) for Social Systems Strengthening to Improve Child Well-being Outcomes. Findings from Wave 1: Tracking Child Wellbeing of Early Grade Learners and their Families. October 2021
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All publications and resources on the CoP study can be found on the CoP portal at http://communitiesforchildwellbeing.org

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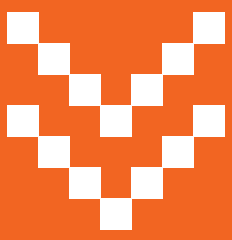

Communities of Practice web link:
https://www.uj.ac.za/faculties/humanities/research-centres/sarchi-welsocdev/projects/communities-of-practice-cop/