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Intersectoral collaboration before and during the COVID-19 pandemic in the Western Cape:

implications for future whole-of-society approaches to health and wellbeing

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As the 'universal recipient' of failing societies, the health sector has a particular responsibility to advance whole-of-society approaches to health and wellbeing through intersectoral collaboration.

The profound health, social and economic impacts generated by the COVID-19 pandemic have necessitated collaboration among societal actors in an unprecedented fashion, elevating the status of the health sector and positioning it to advance intersectoral action on health.

This chapter reflects on intersectoral collaboration in the Western Cape prior to and during the COVID-19 pandemic. We describe forms of intersectoral collaboration that emerged in response to COVID-19; how these drew from a prior formative initiative in the province, referred to as WoSA (whole-of-society approach); and the lessons and opportunities these experiences offer for future intersectoral collaboration for health and wellbeing.

Three key mechanisms of intersectoral collaboration implemented during the period are considered: technical and logistical support from the health sector to other sectors to mainstream and optimise COVID-19 responses; inter-governmental Joint Operation Centres mandated by the Disaster Management Act; and collaborative district processes drawing on the whole-of-society approach and forming the basis of a COVID-19 Provincial Recovery Plan. The evidence from these experiences is that the trust relationships, governance structures and common data systems established in the COVID-19 period can be leveraged for future intersectoral collaboration. However, this will require a shift from disaster management to developmental mind-sets and from reactive to proactive approaches. Current governmental planning and accountability frameworks characterised by silos remains a challenge.

As the 'universal recipient' of failing societies, the health sector has a particular responsibility to overcome governance challenges to intersectoral collaboration and to advance whole-of-society approaches to health and wellbeing.

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Introduction

Intersectoral collaboration (ISC) is recognised as key to addressing the social determinants of health, laid out in the Sustainable Development Goals (SDGs) as the interlinked challenges of poverty, inequality and climate change, among others.[1] At the core of intersectoral action for health is collaborative governance, a term that describes arrangements where "one or more public agencies directly engage non-state stakeholders in a collective decision-making process that is formal, consensus-oriented, and deliberative and that aims to make or implement public policy or manage public programs or assets".[2] Despite the need for ISC, there is an uncontested understanding that the shift from silos and from vertical to horizontal ways of working is difficult to initiate and sustain.[3] There is a paucity of evidence on successful experiences of ISC and action on health in low- and middle-income countries[4], including South Africa.

The COVID-19 pandemic has dramatically emphasised the need for integrated ways of working, as its ramifications and the measures needed to limit its spread have an impact far beyond the health sector. The effects of the COVID-19 crisis and responses to it have deepened existing social inequalities and exacerbated economic challenges.[5] An analysis of data from the National Income Dynamics Study – Coronavirus Rapid Mobile Survey (NIDS-CRAM) suggested that income-related health inequality in the COVID-19 era increased six-fold compared with findings obtained in 2017.[6] In the Western Cape Province (WC), the pandemic has created a new urgency to address the interlinked problems of inequality, poverty, unemployment, violence and crime, which were already longstanding features of the provincial landscape.[5]

Methodology

The chapter is a reflective case study that describes and explores the experiences, research and insights on ISC processes in the Western Cape, jointly conducted by provincial insiders and their academic partners. The case study was constructed from a combination of structured collective reflective processes, documentary sources and rapid assessments, conducted prior to and during the COVID-19 period, and conceptual frameworks on ISC. In a first step, the forms of ISC were mapped, followed by the selection and development of more detailed embedded case studies of three ISC mechanisms. A cross-case analysis identified the enablers and constraints of intersectoral action and lessons were drawn on the collaborative governance of whole-of-society approaches, including the role of health sectors in these approaches.

Key findings

Forms of intersectoral collaboration

Shortly after the declaration of COVID-19 as a national disaster in March 2020 and the implementation of lockdown Regulations, a number of intersectoral processes were activated in the WC. These processes entailed technical and logistical support from the health sector to other government sectors to facilitate the mainstreaming of the COVID-19 response; mobilisation of the Joint Operation Centres (JOCs) mandated by the Disaster Management Act (57 of 2002); and a 'Hotspot Strategy' tailored to the needs of the province, drawing on prior local experiments with a whole-of-society approach (WoSA).[7]

The Disaster Management Act provides for the establishment of national, provincial and municipal disaster management centres to ensure integrated 'whole-of-government' (WoGA) responses, vertically across governmental spheres and horizontally between sectors. These various mechanisms fed into the launch in March 2021 of the Western Cape Recovery Plan[5], which seeks to address the deep-seated and longstanding 'transversal' challenges of unemployment, wellbeing and safety, revealed and exacerbated by the pandemic.[5] The Recovery Plan is in alignment with the priorities set out in the Western Cape's Provincial Strategic Plan (2019–2024).[8]

WoSA is a place-based approach to ISC, launched in 2017 in four local areas (corresponding to sub-districts) of the WC, which aims to activate integrated approaches to key social challenges across the life course. The WC Department of Health (WC-DoH) played a key role in designing and championing WoSA as part of multi-level governance structures established to support, steer and draw lessons from the local experiments. WoSA adopted a 'principled engagement' strategy of generating common understandings and trust as the basis for co-designed joint action. Thus, while the COVID-19 crisis catalysed intersectoral mechanisms, these were not new phenomena in the WC. Apart from WoSA, a longer experience with other forms of collaboration also provided the foundational relationships, templates and ways of working within and across governmental spheres that were leveraged for the COVID-19 response.

The various forms of ISC applied in the WC during the COVID-19 pandemic represent a continuum of interdependencies and collective action, from conversation to collaboration, over the short, medium and long term.[9] The following sections describe three COVID-19-related ISC mechanisms along this continuum in more detail:

- Engaging non-health government departments and sectors to optimise COVID-19 responses

- Experiences of the Joint Operation Centres established to address COVID-19 in rural districts of the Western Cape
- Advancing a whole-of-society approach to 'safety' as one of the key priorities in the Provincial COVID-19 Recovery Plan.

Engaging non-health government departments and sectors to optimise COVID-19 responses

At the start of the pandemic in South Africa, the WC-DoH leadership identified the need to work with and harness the input of other sectors of government and the private sector. An informal cross-sectoral support team of public health specialists (both provincial employees and those jointly appointed with universities), a Strategic Health Manager, and a manager in a sister department responsible for economic development, formed organically. Under the leadership of the health manager, who was the former Head of Health, the collaboration was a programme of engagement with other sectoral actors to optimise and co-ordinate COVID-19 responses.

Engagement took place with a range of entities and departments, but most principally with the South African Police Service (SAPS), Department of Correctional Services (DCS), Department of Education (DoE) and Department of Economic Affairs and Tourism (DEDAT), the latter being the main conduit to the business sector. Table 1 summarises the sectors, engagements and activities undertaken with other government departments. Regular meetings were convened between the support team and individual sectors, proactively addressing a range of technical and logistical support issues, while also being responsive to specific needs and challenges as they arose. The Department of Community Safety (DoCS) played a key brokering role in engagements with the law enforcement sectors – SAPS and DCS – which are national competencies. In addition to these ongoing interactions, the support team fielded a range of once-off requests from, inter alia, State-owned enterprises (Eskom and Transnet/port terminals) and private security companies. Finally, the DoH also directly engaged with private schools and the private health sector to share COVID-19-related data and policy support.

Table 1: Intersectoral engagements and activities between the WC-DoH and other government departments

Department	Sector (sphere)	Activities
South African Police Service	Police (national)	• Provision of detailed infection prevention control (IPC) guidelines which were tailored for and could practically be implemented in various contexts • Provision of comprehensive advice on isolation and quarantine • Assistance with implementing IPC guidelines • Practical assistance with isolation and quarantine • Sharing of concerns and good practices through open-ended meetings • Assistance with data management • Information-sharing, particularly provision of COVID-19 information on infection hotspots • Assistance in accessing COVID-19 test results for the sector's staff when delays were experienced • Provision of tools and communication briefs • Access to a user-friendly online COVID-19 reporting tool • Access to a forum for frequently asked questions (FAQs) on COVID-19
Department of Correctional Services	Prisons (national)	
Department of Education	Schools (provincial)	
Department of Economic Development and Tourism	Business (provincial)	
Department of Community Safety	Community Safety (provincial)	Brokering role with national law enforcement sectors, especially the SAPS and DCS through the regional structures in the province

Over a period of four months, corresponding mainly to the first COVID-19 wave, the multiple engagements with partners ensured effective mainstreaming of the province's COVID-19 response in non-health sectors. The achievements and limitations of this cross-sectoral programme are outlined in Table 2.

Table 2: Achievements and limitations of intersectoral action with other government departments

Achievements	Limitations
Organisations successfully adopted a range of safety measures, improved internal communication to staff, and involved staff in mitigating risk.	Over-reaction to the presence of COVID-19 infections among staff unnecessarily closed organisations for prolonged periods.
Facilitation of access to test results helped to support effective staffing contingency planning.	Inability to test all staff with COVID-19 symptoms later in the epidemic resulted in increased absenteeism, which adversely affected the viability of businesses.
Customising information materials for different business sectors improved effectiveness of infection prevention; materials were provided through a website repository.	The DoH and DEDAT did not have sufficient capacity to support all organisations and businesses.
The DoH was able to address frequently asked questions (FAQs) in ways that reassured users, reduced anxiety, and inspired confidence among organisational management.	Efforts to replicate 'learning spaces' achieved in the health sector could not easily be carried over to other sectors.
The Department of Health became a trusted partner.	Changes in testing policy confused many members of organisations who had used testing as the basis for case management.
All organisations strengthened their capacity to manage their outbreaks, particularly where they had some form of in-house health service (e.g. prisons).	COVID-19 was reported as blocking or limiting access to care for non-COVID-19 cases, although emergencies were catered for.
Previously much neglected, Occupational Health and Safety (OHS) was recognised as critical. At least for some organisations, capacity to address OHS and infection prevention and control improved.	Not all organisations were able to translate the new resilience into strengthening their systems for future stresses.
In some sectors, on-the-ground engagement with DoH structures was substantially strengthened. The relationships and partnership with Environmental Health Services in local government proved impactful.	On-the-ground engagement was not achieved with public schools where School Health remained a peripheral layer in the COVID-19 response.
Workplace labour relations improved as employers were seen to be acting to protect workers' health and safety.	Gaps to be explored include stronger engagement with trade unions and the Department of Employment and Labour.

Echoing factors reported in the literature,[2–4] the key lessons to emerge from this programme of health sector support to mainstream an epidemic response in other sectors were as follows:

- The moment was such that each sector recognised the need to help urgently and the DoH could rapidly assist, hence trust was built.
- Early involvement was critical for steering the course of the epidemic. Early communication and distribution of materials made a marked difference to enlisting co-operation.
- Responses were tailored to the direct needs of organisations, assisting them to remain functional whilst preventing further spread of COVID-19, which generated tangible operational benefits.
- Responses sought to enable organisations to take responsibility for building their own capacity, thus reducing future dependency.
- Guidelines were developed for broadly varied contexts, enabling adaptation to specific contexts and sharing of resources, which was particularly evident within government sectors.
- Through the engagements, many organisations within sectors began to appreciate that an Occupational Health and Safety service is central to effective functioning, rather than an added burden.
- The ability of the DoH to provide data to the sectors – such as on the levels and distribution of infection, hotspots and projected trends – enabled informed responses.
- Where implemented, sharing of good practice was well received (e.g. in schools).
- Open-ended discussion (and listening) – with the health team not being prescriptive in its interventions – meant that sectoral partners were free to take up recommendations or not, thereby facilitating effective communication and enabling trust.
- Collaboration worked well when engaging with senior heads who acted as points of liaison; high-level support from senior staff (including the former Head of Health) made a notable difference as it underscored the importance of the process.
- It was important to recognise and work with the various cultures of different departments and sectors, as some had more inward-looking orientations than others.

Health sector experiences with the Joint Operation Centres in rural districts

In terms of the Disaster Management Act, Joint Operation Centres (JOCs) were established as intersectoral governance structures at various levels of government, including one for the City of Cape Town (Metro) and in the five rural districts of the Western Cape. In the rural districts, JOCs were also formed in all the local municipalities/sub-districts making up the five districts. These JOCs were mandated to bring together the three governance spheres – national, provincial and local – to implement, among others, national directives and Regulations on COVID-19 emerging from the Central Command Council. The JOCs operated alongside other locally and provincially driven intersectoral processes responding to the rural COVID-19 crisis (such as the Hotspot Strategy, and engagements with the private health sector and farming communities).

This section describes the health sector's experiences of the rural JOCs as local mechanisms of intersectoral governance, based on a semi-structured questionnaire completed in April 2021 by nine rural health managers, including four District Health Managers. The managers were asked to describe and reflect on the structures, roles and functioning of the JOCs in the previous 12-month period and the likelihood of the collaborative processes being sustainable.

The JOCs were convened by district and municipal authorities in terms of the Disaster Management Act, and were chaired by a senior manager, including in some instances the Municipal Manager. The leadership of the JOCs was stable in all but one of the districts over the period. JOC membership included local authorities, a range of provincial sectors and national departments spanning both political (especially in the early stages) and administrative/bureaucratic layers, and selected private sector players. With time, some of the JOCs became more diverse, drawing in players beyond government to adopt a whole-of-society approach. At the start of the epidemic, these stakeholders met frequently (daily or weekly), later settling into a rhythm of bi-weekly or monthly engagements, and picking up again during the periods of resurgence.

The key functions and activities of the JOCs were described by the managers as encompassing a range of health, humanitarian, enforcement and economic themes, among which were:

- interpreting and implementing changing national directives and policy at various Alert Levels;
- providing a humanitarian response, ensuring food relief for communities and support for the homeless;
- local enforcement of Regulations, such as those pertaining to alcohol sales and gatherings, and in essential services and businesses;
- sharing of information on COVID-19 cases, health and other sectoral plans and the activities of different departments; and
- co-ordinating and managing the COVID-19 response plans, including community screening and testing, quarantine and isolation placements, local outbreaks, and the vaccination roll-out.

The consensus among managers was that relationships between participants in the JOCs had evolved positively, especially as an understanding of respective roles and functions improved. Health managers' perceptions regarding collaboration between different interfaces are presented in Figure 1. The managers rated collaboration between provincial sectors most positively, followed by the collaboration between local government and communities, whilst ratings of collaboration with between provincial and local government, and between the national and other spheres, were more mixed.

Figure 1: Manager perceptions of collaboration across key interfaces (n=8)

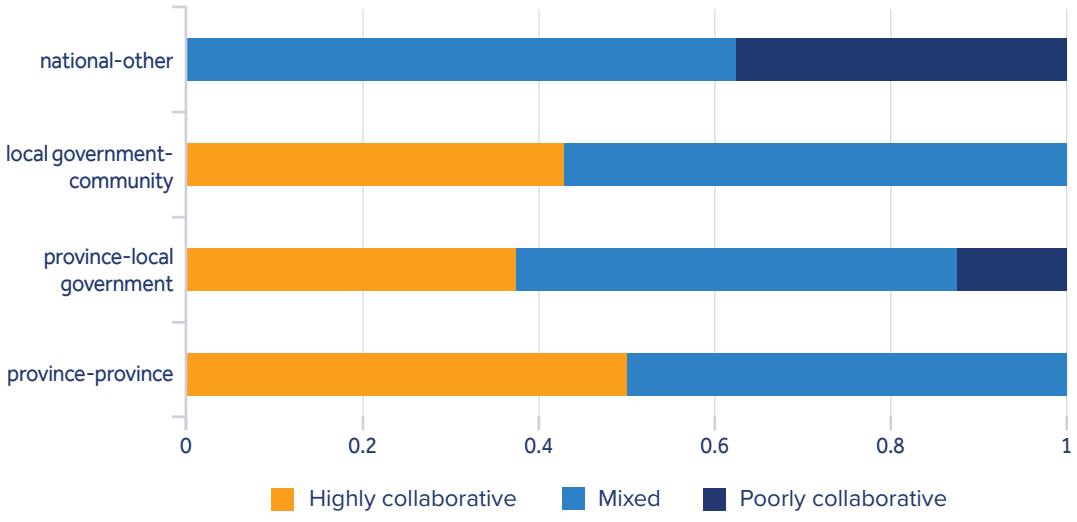


Figure 2 shows the ratings of the culture of the JOCs by the four District Health Managers and one Deputy Director (n=5) in the sample. Respondents were asked to indicate, on a five-point scale, the degree of hierarchy, trust, support, synergy and action orientation of the district JOCs. Their ratings reflect considerable variation in perceived functioning of the JOCs, which may be a reflection of true functioning or of different expectations on the part of managers. However, the recorded perceptions also suggest a positive view in some districts, which may hold potential for future ISC. Five of the nine managers indicated that the mandates of the JOCs had been 'definitely fulfilled', three managers responded that 'some [were] fulfilled, some not fulfilled', and one respondent (at Deputy Director level) indicated that she/he was not able to judge. The fulfilment of the JOC mandates was linked to a high level of participation in the JOC structure by all stakeholders and partners. This was enabled by a common goal, good leadership, commitment, and effective communication and relationships among sectors, along with continuity of membership.

JOCs were undermined when there was perceived poor commitment and leadership from the district municipality, and tensions between local and district municipalities. Some JOCs were information-heavy rather than action-oriented, with participants not having with sufficient decision-making powers. Other constraints included community resistance to protocols and Regulations, and the ever-changing and complex Regulations associated with various Alert Levels.

Figure 2: Ratings of the JOCs by district managers in the five rural districts (n=5)

The managers proposed some areas for strengthening of the JOCs:

- The establishment of mandates at all levels, with representatives having decision-making powers and with better alignment of roles and functions, would improve responsiveness and reduce unnecessary bureaucracy.
- District health (and other provincial sectoral) managers should be given the authority to liaise directly with their counterparts in local government or other provincial departments on transversal matters emanating from JOC meetings. The possibility of direct engagement at the Deputy Director level was also considered to be very important.
- Attention to planning should entail agreement on transversal strategic imperatives, clarified terms of reference, and project management with actions and timelines to enable operationalisation of plans.

While the views on the JOCs were largely favourable, it was acknowledged that JOCs fulfilled a common and urgently felt need, and that without this sense of crisis, future sustainability was not guaranteed. JOCs were perceived as disaster management structures, and the sustainability of collaboration would hinge on the ability to shift from a reactive to a more proactive approach to addressing societal problems. Those with prior experiences of WoSA in the province recommended this approach, emphasising the importance of communication and building trusted relationships, openness, transparency, role-clarification and learning. This required a 'value-driven approach', enabled by planning, data and evidence, and which avoided 'pilotism' and 'template-ism', with these being seen as the hallmark of current governmental planning frameworks.

A whole-of-society approach to 'safety' as one of the key priorities in the Provincial COVID-19 Recovery Plan

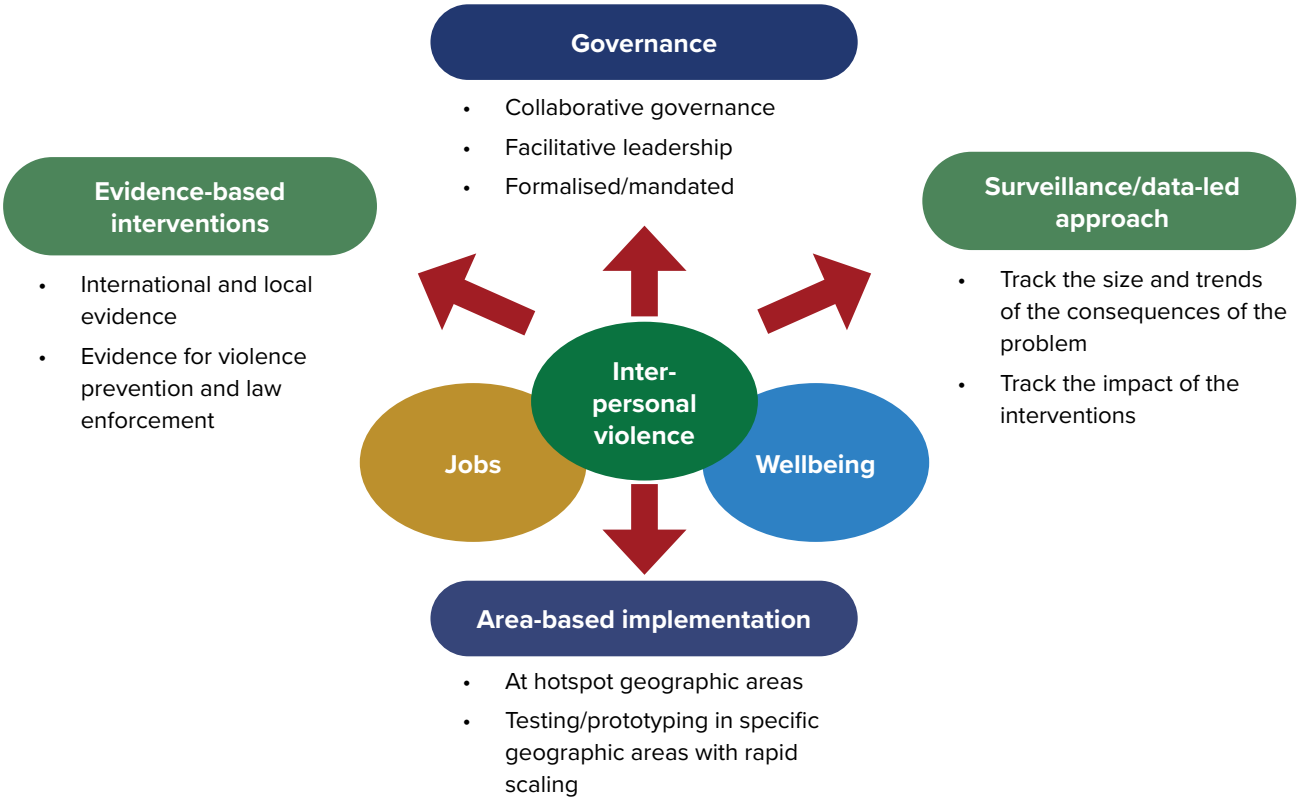
In March 2021, the Western Cape Government published a COVID-19 Recovery Plan in line with the Provincial Strategic Plan 2019–2024, recognising the need for whole-of-government and whole-of-society interventions to achieve three overarching recovery goals: enabling job creation, ensuring safe communities, and promoting the wellbeing of communities.[5]

This section reflects on plans for the 'ensuring safe communities' component of the Recovery Plan and the key prior learnings on ISC that have shaped this component. The Safety Priority seeks to address the intractable problem of violent crime, including gender-based violence, declining public trust in law enforcement, and poor-quality public spaces that enable criminality and undermine social cohesion. In response to these safety risks, the focus areas of the Safety Priority are to enhance the capacity and effectiveness of policing and law enforcement, reduce exposure and experience of violence by children and caregivers, and increase the safety of public spaces through spatial planning and infrastructure.[5]

The Safety Priority goals will be addressed through four mechanisms (Figure 3). These are, firstly, to draw on what has been shown to be effective for violence prevention and law enforcement locally and internationally and secondly, developing a safety surveillance system that integrates data from different government departments, and that can identify violence hotspots, track the consequences of crime and violence, and monitor the impact of interventions. The third mechanism involves implementing and co-ordinating interventions through 16 area-based teams, constituted in 11 urban neighbourhoods (selected on the basis of crime statistics) and five rural sub-districts/local municipalities. Fourthly, the three mechanisms will be enabled by collaborative governance processes and facilitative leadership. The governance mechanism comprises a steering committee, three technical working groups addressing law enforcement, social cohesion and urban design, and technical working groups in the 16 areas. The working groups consist of actors from the Departments of Health, Education, Social Development, Community and Safety, Transport and Public Works, and Arts, Culture, Sport and Recreation.

Prior to the COVID-19 crisis, emerging lessons from the WoSA sites had shown the combined value of collective action on complex socio-economic challenges of the life-course frame as a way to forge common visions, area-based approaches to programming, and methodologies of collaborative governance.[10,11] The lessons from WoSA and other similar initiatives have thus shaped the design of the Safety Priority, modelled around a developmental and collaborative approach that is different to the more militaristic 'command-and-control' intersectoral response to the COVID-19 emergency. WoSA requires paying attention to processes of mutual discovery, generating consensus on problems, and co-design of responses among stakeholders. The health sector's legitimacy in navigating the COVID-19 response has enabled it to shape the design and processes of the Safety Priority in the Recovery Plan, while also capitalising on the prior DoH role and networks in the WoSA initiative.

Figure 3: The design features of the Safety Priority



Source: Western Cape Recovery Plan, 2021.[5]

Discussion

Implications for collaborative governance

The three case studies illustrate the manner in which the COVID-19 crisis required intersectoral action as a central tenet of activities over 2020/21 and how this generated a willingness to collaborate. Several forms of ISC emerged during COVID-19 – some nationally mandated, others province-specific, and with different roles for the health sector. The trust relationships, governance structures and common data systems established through these processes could be leveraged for future ISC.

A common crisis or perceived need is often the catalyst for collaborative action and provides stakeholders with the necessary incentives to advance the collaborative process.[12] ISC in the WC was driven by the uncertainty prevalent during the epidemic and the sense of interdependence that this created. For example, the need for an Occupational Health and Safety service became evident across workplaces facing COVID-19, and favourably positioned the health sector to respond to this need. In the case of the WC, consensus on the nature of the crisis and responses was greatly facilitated by the availability of timeous, good-quality data that promoted a joint understanding of the problem and evidence-based guidance that pointed to possible interventions.

The evidence from other contexts is that advancing action on the social determinants of health may raise difficulties in countering economic and other interests.[13] It is therefore important to recognise and capitalise on the window of opportunity gained by the legitimacy of and rapid health sector action on COVID-19 in the WC. Having said this, provincial health sectors are comparatively powerful players relative to other governmental sectors, and the case studies demonstrate the importance of appreciating this in intersectoral engagements. In the WC, the key to mainstreaming the COVID-19 responses in other sectors was approaching engagements in a way that prioritised open engagement and encouraged listening, flexibility and humility. The early ISC entailed mostly responsive information-sharing, considered as lower levels of integration compared to the type of collaboration required for more complex problem-solving.[14] However, these engagements established systems and relationships that may set the stage for future ISC. For example, the Safety Priority could be a platform for continuing the information-driven engagements between health and law enforcement sectors; additionally, introducing prevention and control of tuberculosis and non-communicable diseases in correctional service facilities and businesses could permanently elevate OHS services on the agendas of public and private institutions.

ISC requires appropriate governance structures and processes. Compliance with the Disaster Management Act and implementation of accompanying JOC processes played a role in mandating collaborative endeavours to respond to the crisis of the epidemic. As the JOC experience shows, this approach can be effective in emergency situations. However, sustaining such collaborative arrangements may prove difficult over time, as the nature of governmental organisation is to promote functioning in silos, including accountability channels and reporting. The risk is of rapid reversion to type, once the crisis is over. Nurturing new collaborative spaces such as the safety platform will therefore require navigating existing bureaucratic modes of functioning.

Two different approaches to fostering enabling environments for ISC are evident in the literature, and emerged in the Western Cape in response to COVID-19. One approach emphasises deliberate, formal planning that includes clear objectives as a precursor to success, especially when the collaborative process is mandated.[15] This approach, as seen in the JOC reflections, runs the risk of turning collaboration into 'tick-lists', where officials focus on meeting legislative compliance requirements that are decoupled from their original purpose. Moreover, as the JOCs demonstrated, collaboration driven by legislation could be hindered by the multiple governance interfaces involved, from national to local spheres, and the complexity of ensuring clear communication across levels.

The second approach argues for an emergent stance, where a shared understanding of the goals and activities of the collaborative network evolves over time and follows 'principled engagement' processes and deliberation among stakeholders.[2,16] The emergent approach, which was evident in the WoSA initiative, seems most feasible when collaboration is not mandated and a bottom-up approach and local ownership of the process can be stimulated. This requires working with local actors as co-producers of the collaborative process through deliberate design and area-based approaches. Allowing for emergent goals requires time and facilitative leadership that motivates ownership of the collaborative process among stakeholders, especially in the early stages of forming collaborative networks. Efforts to address broader societal determinants, as the Safety Priority intends to do, will require a shift from a short-term disaster-driven stance to longer-term developmental mind-sets. However, the risk associated with the emergent approach is that without formal mandates in governmental systems, the momentum may not be maintained. A mixture of both top-down and bottom-up governance might therefore be required to ensure the sustainability of collaborative processes.[17]

Regardless of the approach taken for the collaborative process, the necessary conditions for success include role clarity, relationships of trust among stakeholders, the capacity to manage conflict, and integrated learning within the collaborative network.[17] Most crucially, ISC requires distributed leadership – senior leaders who are willing and able to establish organisational mandates and cultures, middle-level leaders that enable and support progress, and champions and boundary spanners who serve as nodes between the network and its environment to drive collaboration.[18]

Conclusions

The COVID-19 experience in the Western Cape demonstrates that intersectoral engagements are possible. This presents an opportunity to capitalise on the relationships and trust created to develop common agendas around other mutually important health needs, while drawing on the historical experiences of ISC and whole-of-society approaches that preceded the epidemic. The challenge remains how to shift from legislated collaborative processes linked to an emergency to a bottom-up collaborative approach to address broader social determinants of health and wellbeing.

Recommendations

The key lessons from the WC's experience during COVID-19 for health sector actors seeking to advance intersectoral governance for health and wellbeing are to:

- recognise windows of opportunity (often reactive but possibly proactive) for advancing ISC and act on them early;
- adopt value-driven approaches, building trust, with the health sector as a 'humble leader' fostering collaboration and building understanding of the 'other' in engagements;
- develop common data platforms and communicate evidence-informed approaches that shape a joint understanding of problems and solutions;
- seek to meet practical needs in a responsive fashion while advancing proactive agendas;
- foster inclusive spaces of participation premised on equality that include community stakeholders;
- learn from experience, and build more complex forms of collaboration based on established relationships;
- shift from reactive to proactive approaches and from disaster management to developmental mind-sets;
- recognise enablers and constraints:
    - collective and distributed leadership
    - clear political mandates and reporting that simultaneously enable local decision-making space and flexibility
    - the limits of top-down legislative processes, and the complexities of inter-governmental co-ordination across the three spheres of government
    - the silos inherent in current forms of governmental planning, reporting and accountability frameworks.

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