Wellbeing in Mamelodi: Community engagement, social support and mental health in *Kasi* (township) South Africa.

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HREC Protocol Number: ANTH20/05/01

Final Masters Submission of Corrected Research

Date: 09/07/2021

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Acknowledgements

I would like to extend my greatest and most humble gratitude to the following people who selflessly carried me throughout this study:

Prof Lenore, I'm truly honoured to have been under your supervision. Thank you so much for everything; your expert advice, unwavering support and invaluable insight have transformed me and I'll forever be grateful.

CLT Wa Afrika, thank you for investing so much of yourself in my study. I'm thankful for every single one of my participants, without whom there'd be nothing to write about.

My father, Papa thank you for being there for me, your support means the world to me. I wouldn't have made it without you.

My mentor Thad, I don't know what I've done to deserve you but I'll forever be grateful. Thank you for being the best mentor ever!

ABSTRACT

Although a vital part of wellbeing, poor mental health and mental illnesses in low-income areas are not treated the same way as other illnesses. Unlike acute illnesses that are usually responded to with urgency, mood disorders and other mental illnesses generally do not include physical symptoms, and they are therefore more likely to be ignored, disregarded or dismissed. How people understand and respond to mental health crises are influenced by whether or not they are also encountering major difficulties within the family and/or community, or threats to the family and/or community, due to deficient resources such as healthcare, low income, and lack of knowledge on mental health. In addition, considerable stigma is still attached to mental illnesses, often reflecting people's lack of knowledge but also their discomfort with people who are emotionally labile, incoherent or confused. This makes addressing mental health issues particularly challenging. This study is located in a poor urban area which I refer to as Kasi. Focusing on one community organisation, I look at the role of community engagement in supporting individual wellbeing and addressing mental health in Kasi.

Data were collected through focus group discussions and in-depth interviews with people belonging to a contemporary community group, with both focus groups and interviews hosted via WhatsApp over a period of three months. The data gathered through these methods indicated the benefits and advantages of belonging to and participating in community organisations; participants recalled personal experiences of belonging to the group, elaborating on how wellbeing is defined, and explained how mental health and mental illnesses are perceived in Kasi. The findings in this study suggest the need for further research to examine and analyse notions about mental health which make it difficult for individuals, families and health professionals to address mental health issues in low-income settings. The findings also suggest the value of looking further into the power of community engagement in enhancing wellbeing within marginalised groups.

Note from the author

The title of this study was later altered and thus the title stated in the appendices reads slightly differently to the final title as currently stated.

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Chapter 1: Study Background

Writing about community engagement and ethical global health research, Adhikari and colleagues (2019) argue that there is an increase in the recognition of the value of community engagement as an effective support system for many individuals. They argue that community engagement can bring broad benefits, such as building health or research literacy, and that engagement also offers social support and networks with positive effects for those who participate in it (Adhikari et al., 2019:3). This sets a solid ground for my research and my exploration of the role of community engagement in addressing mental health.

In this chapter, I provide an overview of research on community engagement, social support, wellbeing and mental health, and introduce my own work on these issues from a South African township perspective.

Introduction

Mental illnesses have been characterised as a neglected and increasingly burdensome problem affecting all segments of the population in African countries; mental illness is increasingly described as a silent epidemic across the continent (Monteiro, 2015:79). Bantjies (2011) argues that forms of inequality which persist in South Africa as elsewhere, such as poverty, racism and sexism, all contribute to stress and can exacerbate psychological problems. Swartz (1996), in his work on culture and mental health in South Africa, suggests that cultural differences were used to legitimise discriminatory apartheid practices, and that, as a result of apartheid, many South Africans have been involved in various social, economic and political shifts which have affected their living conditions. This includes people with mental illnesses: under apartheid, for many people inadequate and discriminatory services to meet mental health needs were justified on the basis that different cultures had different needs (MacGregor, 2018; Swartz, 1996). According to Carpenter-Song and Snell-Rood (2016), medical anthropological research has illustrated how sociocultural contexts shape meanings of illness and help-seeking behaviours, but this does not indicate the absence of the need for support to address suffering from poor mental health.

Study Aims

My study contributes to this discussion by looking at how mental health is understood in relation to the way in which it is addressed by people who participate in specific communities and/or belong to the same community.

Structural barriers including racism and poverty, and systemic barriers such as inadequate health care infrastructure, an insufficient number of mental health specialists and services, and difficulties in accessing all levels of care, all inhibit care seeking and appropriate support. The burden of mental health disproportionately affects people in low-income areas, where poverty prevails along with a lack of psychiatric specialists and allied health professional support, affordable and accessible medication, and responsive community-based services. MacGregor (2018) argues that the difficulties associated with the experience of mental distress can be particularly acute for people living in low-income areas; these difficulties include multiple individual and community level factors such as the lack of infrastructure and resources such as psychiatric health care institutions, legislative, policy-making, institutional, organisational and community problems, and psychosocial and socioeconomic problems affecting individuals and households (Monteiro, 2015:81; MacGregor, 2018:597).

Hawkins and colleagues (2020) argue that socio-economic factors are influential in determining both mental health disorders and the effectiveness of mental health policies and services. According to Monteiro (2015), various challenges that contribute to mental health care disparities are related to economic and development inequalities. In an article published in *The Conversation Africa,* Bezuidenhoudt (2016) from University of Pretoria also argues that poorer areas have unique challenges which either lead to or worsen mental health disorders, or prevent appropriate care. These challenges include high levels of injury, trauma, violence, harsh economic circumstances and poor living conditions.

In addition, lack of knowledge about mental health disorders may help explain what happens to people when they experience a mental health problem. I argue that lack of mental health literacy, especially from a South African context along with abuse, limited social support and lack of supportive networks and formal healthcare services, combine to contribute to and/or exacerbate poor mental health. The South African College of Applied Psychology (SACAP), which trains and accredits psychologists, noted a statement by the Director of Operations at the South African Depression and Anxiety Group (SADAG), that there is no word for 'depression' in isiZulu. There appears to be no direct translatable term for depression in any South African language other than Afrikaans – '*depressie*' – although in other languages, there may be terms with similar definitions, e.g. '*ho tetebela maikutlo*' in Sesotho. The same applies to other mental disorders such as schizophrenia, anxiety, and neurological and behavioural differences such as ADHD. Drawing on Lutz (1985), White and Sashidharan (2014) propose that the reason depression has no exact equivalent in some non-Western cultures is because not all people define emotions as internal, or differentiate between the physical body and mental states. However, the lack of direct translatable mental health terminology – that is, ways of referring to and classifying disorders -- does not mean that such disorders do not exist in other languages or cultures.

Idioms of distress encompass distinctive cultural norms, values, and health concerns (Meili and Maercker, 2019:1057). Meili and Maercker (2019) argue that exploring culturally shared metaphors that give rise to and reflect local ontologies will enable researchers to gain a better understanding of the cultural beliefs about health concerns. These understandings are reflected in local ideas of anomalous cognition, behaviour and suffering, and this may influence understandings of medical, religious and other approaches to recovery. In a systematic review of the idiom of distress in Sub-Saharan Africa, Backe and colleagues (2021) argue that people use different social, somatic, and ecological frames to explain the idiom 'thinking too much', and through this, they illustrate the sometimes catastrophic consequences of thought patterns that tend to overwhelm individuals and communities. Meili and Maercker (2019; see also Nichter 1981) describe idioms of distress as culturally specific modes of expressing distress which are often indirect and metaphorical. The idiom 'thinking too much' can be a result of previous traumatic experiences or ongoing circumstances such as poverty, unemployment, chronic illnesses, and financial restrictions which both exacerbate hardships that contribute to distress and limit the ability to afford appropriate treatment, and stigma. The use of this idiom allows individuals to express experiences of emotional distress and to explain that distress in a culturally acceptable manner (Backe *et al.*, 2021:11-12). The idiom illustrates that just because there is not a lexical equivalent (a word or a phrase) that is the direct equivalent of an English language term, in this context, for depression, this does not mean that people do not recognise the experience within their culture.

According to Kpanake (2018), cultural systems influence individual behaviour through their effects on the individual's way of being-in-the-world; further, cultural and social patterns are associated with characteristic ways of being an individual in the world, and culturally constructed patterns arise from living one's life in a particular context. Further, Swartz (1996) asserts that cultural difficulties should be considered central to experiences of exploitation as this would mean that mental health research was culpable in defocusing from patterns of political and socio-economic abuse. Culture plays a significant role in defining the way(s) in which individuals lead their lives. Janse van Rensburg (2014) argues the importance of the actual context of psychiatry in Africa, with the distribution and presentation of mental health problems reflecting sociocultural and tribal diversity as well as poverty, violence, and suffering.

Meili and Maercker (2019:1057) explain that cultural differences have been emphasised to explain how people deal with distress, trauma, and recovery; individuals' ability to respond to adversity in a psychologically adaptive way is strongly influenced by culture; and that cultural, ethnic, religious, and linguistic differences between villages and cities influence how individuals address the idea of 'thinking too much' or manage other shifts in emotion and mood. In addition, the relationship between efforts to understand the cause(s) of illnesses and care-seeking is very complex. The processes involved are interrelated and are framed by local understandings of causation and care. In addition, as already suggested, they are influenced by access to services. At the same time, cultural responses to mental illnesses are fluid, interactive constructs shaped by history, politics and society (Backe *et al.*, 2021:2-3, Subandi *et al.*, 2020:1). In their discussion of culture and mental health in Nepal, Chase and colleagues (2018:2) hold that failure to adequately address the social and cultural contexts of mental health may limit the effectiveness of interventions and have negative effects such as the promotion of medicalisation of social suffering and overlooking indigenous knowledge and support systems.

Study Rationale

According to SACAP (2019), mental health in South Africa requires a “uniquely South African” response, and to facilitate this, the problem needs to be explored locally. This is necessary to address language barriers, given the limited vocabulary on mental illness; to understand local responses to distress and suffering; and to ensure the availability of resources and to support people to access resources. Janse van Rensburg (2014:136) argues that as a specialist medical discipline, in terms of the teaching and training of psychiatry, South African psychiatry must bring together the multicultural, multireligious, and spiritually diverse reality in which daily practices occur. Swartz (1996) claims that black South African psychologists had been quick to recognise the psychological centrality of black experience, and the possibilities that the recognition of this brings for care, and for personal and political transformation.

Cogliero (2020:683) states that depression affects millions of people worldwide, although the majority are not formally diagnosed, and fewer than half of those diagnosed are treated, largely because of lack of appropriate services and barriers to care, including stigma and resistance to modes of treatment including therapy. According to Hawkins and colleagues (2020), stigma exists at various levels including institutional, community and family levels, and this results in further economic exclusion of individuals with mental health disorders, which in turn may exacerbate the initial mental health issue. Also, individuals may be reluctant to be seen seeking mental health services, and cultural values of stoicism and resilience may shame people to address their problems on their own (Carpenter-Song and Snell-Rood, 2016:1). Further, Kohrt and colleagues (2020) argue that individuals with psychiatric disorders often bear the burden of healthcare providers’ prejudice and discrimination.

Mental illnesses are often regarded as fabricated or imagined, due to the usual absence of physical symptoms; they may be seen as a figment of the imagination or as indicating laziness or recalcitrance (SACAP, Aug 2019). SACAP (2019) points to stigma as a major stumbling block in treating mental ill health. People who experience mental health problems are sometimes referred to as *di gafi/magafa* or *batho bago gafa* (mad/crazy people, in Sesotho, Setswana and Sepedi) in South Africa, and such people are sent to *sepetlele/ sa magafa, di gafi* (hospital for mad/crazy people). Being mad/crazy implies a weakness or flaw in character, and thus people fear being stigmatised and being discriminated against, should they admit to having a mental health problem. In their study exploring urban health in Cape Town, Mumm and colleagues (2017:17) argue that there is discriminatory access to mental health services for black and coloured people versus white people, and for women versus men, with greater stigma and discrimination and greater barriers to access mental health services against women, black and coloured people. Mumm and colleagues (2017) also again identify language discrimination and low mental health awareness in individuals and in communities, and widespread stigmatisation of mental disorders within the general population, as explaining reluctance of people to seek treatment.

Bezuidenhoudt (*The Conversation Africa*, Oct 2016) claims that while policies exist for mental health care, the implementation of these policies remains a challenge and the management of mental healthcare in poorer areas has not changed. Again, as previously mentioned, mental health care is neglected when it comes to resource allocation, with priority given to infectious and non-communicable diseases (Bezuidenhoudt, 2016). Mumm and colleagues (2017) argue that there are huge inequities in the accessibility of mental health services in Cape Town, and report that specialist mental health services are especially difficult to access for people living in informal settlements. With SADAG and Bezuidenhoudt (2019), they argue that a lack of trained healthcare professionals results in limited attention, and public sector mental healthcare services are not accessible to the country's most vulnerable populations. Thus, 'modern' intervention models (including therapy and pharmaceuticals) are not necessarily practical or affordable (Bantjies, 2011:1), and one-on-one biomedical modes of intervention, psychotherapy and psychiatric care are inadequate. For some people and in some contexts, too, the approach may be inappropriate, for example, to address personal problems which are social and political in their nature, and may be combined with challenges such as poverty.

Carpenter-Song and Snell-Rood explain that the clinical understanding of mental illnesses often clashes with community perspectives that attribute distress to problematic familial, moral, religious and even societal pathways; they further argue that such divergent perspectives may discourage help seeking if individuals, their families and communities believe that available services do not attend to their specific needs (2016:1). White and Sashidharan (2014:230) define culture as a set of institutional settings, formal and informal practices, ways of making sense and presenting one's experience in forms that will influence others. They argue that it is important to consider that biomedical explanations of mental health problems are cultural constructs, and therefore, that psychiatric diagnoses may not be valid to people of non-Western cultural background (White and Sashidharan, 2014:230).

Accordingly, mental health interventions may need to be designed specifically for South African populations, taking into consideration the history and diversity of the country and its populations. The legacy of apartheid has affected many (Bantjies (2011). This includes due to the lack of available psychosocial services, prior experience of discrimination and the lasting effects of violence and oppression. This also provides an important rationale for improving access to psychosocial services, as current social and economic factors reinforce the importance of extending psychosocial and other support services to marginalised and disadvantaged populations.

Pham and colleagues draw attention to what they refer to as the 'mental health treatment gap', which they explain as the disconnect between the number of individuals suffering from mental illnesses and the number of individuals who actually seek treatment (2020:9). They argue that understanding and acknowledging the contributions and value of traditional healing to individual, family, and societal wellbeing and mental health is pivotal, and should not be sidelined in efforts to reduce the biomedical treatment gap. Addressing cultural belief systems could contribute greatly to help patients and their families to deal with mental health issues. Chambers (SACAP, 2019) claims that South Africa does not use indigenous knowledge systems and resources, such as traditional healers for primary intervention. However, this is only in terms of state programs, as people routinely resort to traditional healers for a variety of conditions. Chambers further argues that it would be beneficial for the country to look more into such an intervention as this is a resource which could be harnessed. Chambers (SACAP, 2019) also argues that interventions which focus on organisations and local institutions, implemented at community levels, can be effective in mental health promotion, and in caring for people experiencing distress. Community-based participatory approaches may also be better suited to designing mental health programs which incorporate traditional healing (Bantjies, 2011; Pham *et al.*, 2020).

As Hawkins and colleagues (2020:2) argue, accessible and cost-effective mental health interventions need to respond to an evidence base of contextual considerations. Social interventions may also support social cohesion, and through this, they provide social mechanisms that might reduce the burden of mental health distress in South Africa. To further explore this, in this study, I focus on the role of contemporary community organisations, but not necessarily in relation to traditional healing. I am interested in the positive role of community groups in supporting wellbeing and providing social support, as a way to address mental health problems through a cost-effective and strengths-based approach as well as to avoid problems of stigma. As advocated by De Silva and colleagues (2005), building and/or sustaining healthy communities has been considered to have a positive effect in state strategies to prevent mental illness. Based on their research on the psychosocial wellbeing of a “forgotten” South African community in Ndumo, KwaZulu Natal, Nell and colleagues (2015) argue that the psychological wellbeing of communities includes emotional, social and psychological wellbeing. Therefore, evaluating community wellbeing is important in ensuring the success and sustainability of community development initiatives. As Meili and Maecker (2019) argue, in some cultures, resilience is seen as an important trait needed to overcome adversities; thus, nurturing and building on community resources to optimise resilient living would present a cost-effective approach for enhancing psychosocial wellbeing (Nell *et al.*, 2015:179).

Research Problem

According to Nell and colleagues (2015), community wellbeing is relatively understudied and undertheorised, with limited research conducted especially in remote, rural and marginalised communities in sub-Saharan Africa. This includes little research in South

Africa or elsewhere to describe community-based perspectives on factors that either support or detract from residents' psychosocial wellbeing (Nell *et al.* 2015:179). I suggested above that various personal factors such as lack of insight, and interpersonal factors including social support – defined by Wang and colleagues (2017) as the functions fulfilled by social relations -- and the existence, quality, and practices of social relations, may all contribute to, cause or worsen mental health problems in lower and middle-income countries. Thus, I will be looking at community engagement and social support as a way to address mental health and enhance wellbeing amongst individuals, especially those who live in low-income areas.

Post-apartheid in South Africa, at a time when people had hoped that race-based inequalities would dissolve, social inequalities continue to be prevalent. Changes in family structure, disruptions in residential patterns, and skipped generations have occurred due to household members relocating to urban areas in pursuit of a better life (to work or study) amongst other reasons, and as a result of HIV deaths from the 1980s to mid-2000s (Mkhwanazi and Manderson, 2020). Further, MacGregor (2018:597) argues that legal oppression, migrant labour, and influx control regulations under apartheid all had harsh effects on kin bonds as dependents were dispersed through movement between households. Furthermore, extreme poverty, marginalisation, and migration impacted how relatedness came to be understood and constructed (Mkhwanazi and Manderson, 2020). People who migrated alone left behind networks of support. According to Geffen and colleagues (2019:2), health, physical activity, social integration, connection, relationships and social support are all important factors influencing wellbeing in the elderly. I argue that these factors influence the wellbeing of everyone, not just the elderly; as I illustrate, they are absent for many of the participants in my study. The disruptions to kinship and residence have left generations of people without strong social networks for support.

The importance of wellbeing and good mental health outcomes call for an anthropological study that explores community-centred and community-controlled interventions, with attention to how community members perceive these interventions. Writing about the impact of social change on mental health and mental health care, Carpenter-Song and

Snell-Rood (2016) argue that fresh perspectives are needed to generate promising avenues for the development of effective treatment and policy interventions for dynamic, deepening mental health disparities. For my study, I drew on MacGregor (2018) and her study of urban life, entitled Mental Health and the Maintenance of Kinship in South Africa. In this study, she examines the experiences of mental disturbance and distress within a context of poverty and economic marginality, a particular social and cultural world, and networks of kinship, relations of support and reciprocity. MacGregor's analysis of how kinship and social networks were constructed in Khayelitsha (Cape Town, South Africa) is influenced by literature suggesting the often contingent and fluid process of fostering relationships. In addition, MacGregor specifically considers the implications of being labelled as mentally ill for social relations, residence arrangements, and the forms of reciprocal assistance involved in cementing social bonds (2018:597).

Research Questions

In my research, I postulated the following questions from a *kasi* (township) perspective: What informs the ways in which people address mental health problems? How do people experience wellbeing, including good mental health in a social group? What are the practical values of being in a social group? How might community engagement and involvement provide social support to contribute to wellbeing and good mental health? To address these questions, I referred to Carpenter-Song and Snell-Rood (2016), who argue that documenting informal conversations about mental health and inequality along with everyday practices within community settings can reveal if depression is normalised, and help identify the extent to which experiences of demoralisation are identified and treated as mental health problems. They also argue that ethnographic research can examine how individuals and communities respond to mental health challenges and can identify the forms of coping mechanisms that are deemed acceptable or unacceptable (Carpenter-Song and Snell-Rood, 2016:2).

The purpose of this study was to explore the value of community organisations and involvement as coping mechanisms, including how informal friendships that emerge from common interests provide social support which contributes, in turn, to wellbeing and good mental health. I was interested in the role of social connection in addressing general wellbeing among study participants who live in poor areas (*kasi*), and in particular, in the role of community organisations in providing the context for (indirect) care and support for good mental health. Understanding how communities of practice provide social support could positively contribute to the wellbeing of community members. Objectives of the study included uncovering the benefits and advantages of being in a social group; identifying whether group membership is seen by individuals to improve their wellbeing; exploring how communities of practice (groups of people who share a common interest or goal) extend social connections; and identifying how this helps to support good mental health.

Historical background of Mamelodi

'*Kasi*' is an isiZulu term defined by Lexico.com as a city or an area around a city predominantly occupied by black South Africans. I chose this term to reflect the focus of my study, as the term is popularly used to refer to townships in South Africa. The specific setting for my study is in Mamelodi. This township is located in the eastern part of the City of Tshwane Metropolitan Municipality, also known as Pretoria, in Gauteng, South Africa. Mamelodi is currently divided into two parts, Mamelodi West and Mamelodi East. "Mamelodi" is a Sepedi/Northern Sotho word which translates to 'Mother of Melodies' with the word "Ma" meaning mother and the word "melodi" meaning whistle. According to the South African History website (www.sahistory.org), the township is said to have been established in the 1950s and at last census (2011), it had a population of 334,577, with 98.9% of the population being black Africans, 0.4% being Coloured, 0.2% being Indian/Asian, 0.1% being white and 0.3% defined as other. Sepedi, Setswana, isiZulu, TshiVenda and Xitsonga are all commonly spoken languages in Mamelodi.

I chose this particular township as I was initially interested in how mental health institutions are perceived in townships. My point of reference was the Itsoseng Psychiatric Clinic in Mamelodi. The clinic is located within the premises of the University of Pretoria at the Mamelodi campus (also known as Vista) in Mamelodi East. Itsoseng is situated on Hinterland Avenue, which can get very busy, especially on weekends. For example, on Saturday mornings funerals often take place and the street leads to a cemetery in the area; as a result, there's a lot of hooting going on, although this happens all the time as taxi drivers drive up and down looking for people in search of rides, with frustration with the convoy caused by cars going to and from the cemetery.

Although the clinic has been at this location for over 21 years (www.psyssa.com), judging from the difficulty I encountered in locating it and my experience of talking to several people about it, it seems that few people, even those who live nearby, know about it. There is no board or sign anywhere around the campus that indicates that the clinic is located inside the Vista premises. There is no sign outside the campus that explains any of the many services offered within the premises; these include tutoring for high school learners, sporting activities for young children, and of course the clinic and clinical services. Speaking to one of the guards, I was told that the people who visit the clinic are patients who have been referred there from other institutions, said patients would be given clear and direct instructions on how to get to the clinic. However, the clinic is open for outpatient care to all members of the community.

The next chapter (2) will be the literature review of the study, in which I discuss some available literature on community engagement, social support and mental health in various settings. In the methodology section (Chapter 3), I return to the clinic in the context of the methods and selection of the study population.

Chapter 2: Literature Review

According to Carpenter-Song and Snell-Rood (2016), partnerships with community-based organisations enable researchers to draw together diverse coalitions differently affected by social changes. These aspire to develop sensitive individual, family, community, and policy strategies to engage with multiple factors that contribute to distress. They further argue that research on such topics will not only inform educational interventions, but will also shape strategies for outreach programs on mental health problems (Carpenter-Song and Snell-Rood, 2016:3). Manderson and Vasey (2009) assert that individual wellbeing is closely linked to community inclusion, the strength of collective identity, the extent of mutual support, and everyday social interaction.

In this chapter, I engage with some of the available literature on community engagement and social support with regards to wellbeing, including mental health.

Social capital in promoting health

Sanchez (2016:1) defines social capital as the resources that an individual or a community can access through social networks; social capital, trust and reciprocity are the main outcomes of the relations generated through these networks; this in turn enables resilience. McKenzie and colleagues (2002) refer to the work of sociologist Emile Durkheim (1951), as one of the first people to argue that societal structure had a strong impact on psychological health. Social relationships also build social capital through which individuals and communities can access resources.

McKenzie and colleagues (2002:280) explain social capital as constituting the forces that shape the quality as well as quantity of social interactions and social institutions. They draw on Putnam (1996), who described social capital as a combination of life-networks, norms, and trust that enables people to cooperate to pursue common objectives. Manderson and Vasey argue that social capital protects and/or enhances good mental health, wellbeing and overall functioning; in contrast, low levels of social capital can result in poor mental health in individuals and an increase in vulnerability and social tension in communities (2009:230). Applied in a health context, social capital may determine how different aspects can have positive effects on physical and mental health, or provide essential support when there are changes to health status. South and colleagues (2015) argue that knowledge and skills, social networks and community organisations are all assets within communities which can serve as building blocks for good health.

According to Burnett (2006:283), the concept of 'capital' carries the weight of being a resource that renders some form of utility value to individuals or groups within a society, and relates to the sum of resources (actual or virtual) that accrue to an individual or a group by virtue of providing strong network value with more or less formal or informal relationships of mutual acquaintance and recognition. Burnett (2006:283, citing Smart [2000]) argues that social capital should not be defined in economic terms, but should instead be viewed as advantages gained through social connectivity. Having supportive networks is considered important for both physical and mental wellbeing and this is seen through studies indicating that social capital (represented by the presence of trust, reciprocity, and connectivity in a community) contributes to health enhancement in many ways (Hirsch *et al.*, 2016:64). Within a community context, this connectivity has the potential to translate into different acts, like reciprocity, building relationships, developing social and emotional skills, and enhancing social participation.

Campbell and Jovchelovitch (2000; 2007) argue that people are more likely to be healthy in communities that are characterised by high levels of social capital; they note that an important determinant of the success of participatory health promotion interventions is the extent to which they drive or create social capital. Social capital has been considered to be important for health promotion for the following reasons. Firstly, communities that are rich in social capital are said to provide a supportive context within which people can collectively renegotiate social identities in ways that promote the increased likelihood of health enhancing behaviours. The emphasis on social identity is important considering that health enhancing behaviours are determined by collectively shaped social identities rather than by individual rational choice, as assumed in traditional information-based health education in the context of neoliberalism. Secondly, residents of communities with high levels of social capital are most likely to have high levels of perceived control over their lives. This is important for health, considering that people who feel in control of their lives in general are more likely to take control of their health, through health-enhancing behaviours, and through the speedy and appropriate accessing of health services (Campbell and Jovchelovitch, 2007:4, drawing on Campbell 2000).

As Campbell and Burgess (2012) argue, social participation has the potential to advance a sense of coherence and positive social connectedness. This is instrumental to good mental health, and to the way in which community health competence is conceptualised (2012:388). They further argue that social participation has direct and indirect influences. Directly, social participation increases access to information (including on health problems, prevention and response), better access to practical, emotional and material support for those who are ill, and the confidence to cope with or challenge stigma. Indirectly, social participation may be associated with various forms of empowerment such as an increase in income generating opportunities, enhanced social recognition, and opportunities for community activism; these may lead to an increase in opportunities for health at individual and collective levels (Campbell and Burgess, 2012:387-8).

Burnett (2006) holds that social capital is beneficial for marginalised communities where mutual trust and shared values build relationships to produce social gain based on reciprocity and expectations. Individuals stand to benefit from social networks through gaining returns in instrumental actions such as finding jobs or acquiring access to power or status. Expressive actions mobilise contacts to obtain personal benefits in terms of health or life satisfaction (Burnett, 2006:284), and so also contribute to wellbeing. In their study of the stress-buffering hypothesis, Mandelbaum and colleagues (2018) argue that social resources can either prevent or attenuate the impact of stress on health. It is further argued that individuals with access to more social resources, particularly social support (which refers to the emotional, instrumental, or informational assistance available in a person's life) have more favourable health outcomes than those with fewer resources (Mandelbaum *et al.,* 2018:1).

Geffen and colleagues (2019) suggest that people tend to live longer when they are socially engaged and maintain frequent contact with family and friends. I will be looking into social capital as a potential intervention to support wellbeing and good mental health, by uncovering the benefits of belonging to a common group and examining how that allows for comfort which is not necessarily available elsewhere. Geffen and colleagues (2019:2) define loneliness as a “subjective experienced aversive emotional state,” and argue that this is related to the perception of unfulfilled, intimate and social needs; they argue too that loneliness occurs through isolation and physical loss, and this can also occur through the absence of a reliable attachment figure. Although these are psychological understandings of loneliness, they point to the social factors that influence wellbeing. In contrast, social capital is associated with connections and trust in others. A sense of belonging is also associated with mental wellbeing (Sanchez, 2016:1), and strong social capital will serve one’s health positively. McKenzie and colleagues (2002:282) suggest that a better understanding of social capital, the nature of its determinants, and associations with physical and mental health will greatly contribute to explanations of health inequalities. In supporting social capital as a way to address mental health issues, Geffen and colleagues (2019: 2-3) argue that peer-to-peer programmes are effective in providing emotional, informational and appraisal support; furthermore, peer-to-peer support groups present a low-cost of supporting mental illness. Drawing on anthropological methods and analysis, through a case study of one community organisation, in my study I focus on the advantages of belonging to a social group as a way to support mental health, and the value of building or supporting social capital among vulnerable communities.

The value of community engagement

South and colleagues (2015) use the term ‘community’ as a shorthand for the relationships, bonds, identities and interests that join people together, enabling them to have a shared stake in a place, service, culture or activity. However, distinctions are often made between communities of location/geography and communities of interest or identity; as a result, strategies for engaging people can vary accordingly. Furthermore, communities are dynamic and complex, and people’s identities and allegiances may shift over time under different social circumstances (South *et al.*, 2015:7).

Castillo and colleagues (2019) argue that families, places of work, social services, institutions and communities are all potential resources to support health. Community engagement is a strong force for bringing about environmental, social and behavioural changes to improve the health of a community and its members. The National Institute for Health and Care Excellence (NICE) in England has endorsed community engagement as a strategy for health improvement based on substantial evidence found in community participation and empowerment on health benefits. The Center for Economic and Community Development (CEDC online, 1997) defines community engagement as the process of working together with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting their wellbeing; further defined, community engagement is an umbrella term encompassing a range of different approaches that involve communities of place and/or interest in activities, with the aim to improve health and reduce health inequalities (Attree *et al.*, 2010:251). Community organisations are part of a long-standing health system, and therefore, along with individual-level approaches to health and care, have a vital contribution to make to improving health and wellbeing (South *et al.*, 2015:8).

Health behaviours, health status and health outcomes are determined by various factors, including the influences of the people around us. Therefore, community engagement and outreach often serve as a pivotal component of behaviour change and social interventions, with support from peers who share similar life experiences being important for improving and maintaining health (South *et al.,* 2015:11). According to Attree and colleagues (2010), community engagement is a key component of most contemporary strategies to promote health and wellbeing, and reduce health inequalities; this is also a component of various health interventions in disadvantaged populations. Attree and colleagues further argue that in low- and middle-income countries, community engagement plays a vital role in supporting public health, as a means of tackling underlying social determinants of health (2010:251). South and colleagues (2015:5) argue that connected and empowered communities are healthier than those that are not; in communities that are well networked and supportive, members look out for each other; and membership has a positive impact on people's health and wellbeing. Individuals from economically challenged groups participating in community engagement report positive experiences in terms of personal benefits, including getting out into the community more often, enjoying greater involvement in local groups, and expanding social networks (Attree *et al.*, 2015:257). Community engagement also positively impacts individuals' personal empowerment such as feeling useful to others, and it expands access to social resources including social networks, communal capabilities and resilience. This in turn can have practical and material benefits. Active engagement in community initiatives may have valuable psychosocial benefits for participants, including boosting self-confidence and improving self-esteem (Attree *et al.,* 2010:256; South *et al.,* 2015:11).

Community participation may include the active involvement of people in either formal or informal activities, programmes, and/or discussions to bring about planned change or improvements in personal or community life, services and resources. The approach has long been central to public health and promotion (South *et al.,* 2015:8). This suggests emphasis on the formal mechanisms of engagement. In their study of the role of communities in advancing the goals of the Movement for Global Mental Health, Campbell and Burgess (2012) argue that there is growing evidence supporting the direct and indirect health-enhancing impacts of positive local participation in both formal and informal networks related to friendship, leisure, faith, and community activism, including health-oriented projects. Others argue that participatory approaches directly confront the powerlessness and low self-esteem that are often associated with structural inequalities such as those of class and race. They also help improve access and uptake of support among members, and they allow those who face the risk of social exclusion to be involved in designing as well as delivering solutions that address inequalities that affect their health (South *et al.,* 2015:11). Further, community participation increases the reach of services, with community members often being the best able to identify and support members of vulnerable groups who are least able to access and use services. Community participation is therefore vital in developing health-enhancing community contexts which support the possibility of effective prevention, care, treatment and local advocacy (Campbell and Burgess, 2012:387).

The invaluable contributions and experiences of members actively involved in their own communities are rarely taken into consideration as part of the evidence base of health and wellbeing enhancement methods. However, Campbell and Burgess (2012:388) view communities as experts in their own cultural paradigms, and argue therefore that community members are best qualified to assess how biomedicine can intervene in their daily realities and survival strategies. Community members are regarded as crucial partners in dialogue with biomedicine, as well as agents in promoting community mental health competence. In addition, South and colleagues (2015:9) argue that there is a need for a flow of new ideas and intelligence from local communities to give a full picture of what is best or most effective; thus local governments and clinical commissioning groups ought to involve communities in developing locally tailored interventions. According to Petersen and colleagues (2012), community members can provide meaningful insight and local knowledge on ways to mediate achieving wellbeing within their communities. They argue that there is practical value in the participation of community members in self-help groups with respect to community control, and that community participation provides opportunities for greater individual and collective control of mental health (2012:419). South and colleagues (2015:9) suggest that there needs to be a shift to more community-centred approaches to health and wellbeing, ensuring that people have a greater say in their own health and lives. Greater equity, they argue, could lead to a reduction in avoidable inequalities, and enhance social connectedness, and thus result in healthier and more cohesive communities.

Supportive social networks built through self-help groups also provide opportunities for increased social support and personal empowerment which is protective of general wellbeing. This is documented in an article by Hirsch and colleagues (2016), with respect to a program to enhance individual youth and community resilience among the Inuit community of Nain, Nunatsiavut (northeast Canada). The program was developed to build the resilience of a group of youth to better adapt to social, environmental and cultural change, with its goals being to enhance mental, physical and spiritual health, build social connections between the youth and other community members, and for elders to transmit skills, knowledge and values to the youth. Hirsch and colleagues (2016) drew on Kriel and colleagues (2011) to argue that the deterioration of family bonds and other social relationships are recognised as risk factors for mental health issues such as depression, substance abuse and suicide. This strongly suggests the value of enhancing the quality of community life, social support and social networks as factors that can positively influence individual and population physical and mental health (Petersen *et al.*, 2012:420, drawing on Rappaport 1985; South *et al.,* 2015:11).

Social capital is defined by Wang and colleagues (2017) as a series of resources that individuals earn as a result of their membership in social networks, and features of those networks facilitate coordination and cooperation for mutual benefit. Similarly, drawing on Putnam (1993; 2003), Woolcock and Manderson (2009) define social capital as the ‘glue’ that holds societies together, the glue in this context being social relationships and institutions made up of formal and informal associations as well as norms and values. This can result in and can derive from an increase of social networks (Wang *et al.* 2017).

South and colleagues (2015:5) assert that amongst communities that are placed-based and among those who share a common identity or affinity, individuals have a vital contribution to make to health and wellbeing; they further argue that community life and social connections are factors that underpin good health. However, inequalities especially in marginalised communities persist, and too many people experience the effects of social exclusion or lack of social support which can lead to emotional ill health and other health concerns.

Through community membership, individual connections with others may provide opportunities for social leverage and this may assist in successfully addressing the social determinants to support mental health for individuals. Membership may also promote social inclusion by creating opportunities to develop new skills, resulting in income-generating opportunities. The collective engagement of community members in thinking, discussing and helping one another occurs informally through shared activities and friendship, and by building ways to address social problems and strengthen wellbeing. This may result in the development of collective agency to act on their problems and environment, thus developing greater efficacy to support good mental health individually and with others (Petersen *et al.*, 2012:420).

Approaches that are community-centred are not necessarily just community-based; they can also involve mobilising assets within communities, promoting equity and giving people more control over their health and lives. Community-centred approaches represent some of the available options to improve health and wellbeing which South and colleagues (2015) categorised in four strands. Three of these are most applicable to this research. The first strand is strengthening communities wherein approaches involve building on community capacity to collectively take action on health and the social determinants of health. The second strand includes volunteer and peer roles where approaches focus on enhancing individual capabilities to provide advice, information and support to organise activities around health and wellbeing in their own or other communities. The third strand is access to community resources, where approaches connect people to resources, provide practical help, group activities and volunteering opportunities to meet people's health needs and increase social participation. The fourth strand, not necessarily relevant to this study, refers to collaboration and partnerships with local services, including collaborating at any stage of planning cycle, from identifying needs through to implementation and evaluation (South *et al.,* 2015:6).

There is growing evidence that enhanced social capital results in improved mental health status; conversely low levels of social capital have been linked with poor infrastructural capital, low residential stability, and social distress. Furthermore, there is evidence of the role of social support in promoting mental health, by providing emotional support, empathy and caring; instrumental support such as lending resources; informational support in the form of distributing information, suggestions and advice; and what Petersen and colleagues (2010; 2012) refer to as appraisal support in the form of constructive feedback.

According to Petersen (2010), behavioural health has often been linked to mental health; the term in this context refers to behaviour that influences people's health and functioning. Mental health cannot be easily defined and definitions vary widely among individuals and cultures. Even so, commonalities in explanations do exist. Mental health includes various dimensions such as people's intellectual wellbeing, capacity to think, perceive and interpret with adequacy, their psychological wellbeing, their belief in their own self-worth and abilities, their emotional wellbeing, their affective state or mood, their social wellbeing, and their ability to interact effectively in their social relationships with other people (Petersen *et al.* 2010:3).

Domestic conditions and relationships play vital roles in shaping good mental health, and may also contribute to shaping perceptions of poor health or limits to wellbeing (Gammeltoft & Oosterhoff, 2018:534). Mutyambizi and colleagues (2019:2) indicate that there is compelling evidence of the positive and reciprocal association between compromises in wellbeing and poverty or overall low socioeconomic status. With harsh economic circumstances and poor living conditions, trauma, injury, violence and substance abuse are common.

Gammeltoft and Oosterhoff (2018:534) argue that societal conditions (including political conflicts, economic shocks, limited employment possibilities or constrained access to healthcare) are filtered through socio-moral dynamics that characterise families and households. Furthermore, Hirsch and colleagues (2016:64) argue that dispossession from social and ecological support systems is a major concern for indigenous communities. In response to community health challenges in various settings, community-based interventions have proven to be highly effective in enhancing health.

Wellbeing and health in low-income areas

South and colleagues (2015) argue that wellbeing is a key concept for a functioning and flourishing society, with community life, social connections and active membership all perceived as factors that enhance wellbeing; further, societies that are socially cohesive are presumed to have a high level of wellbeing (Manderson and Vasey, 2009:230). In their attempt to build their own explanation of wellbeing, Watson and colleagues (2012) argue that wellbeing is not about the notion of giving but rather about engaging with people in meaningful dialogic ways. They further argue that wellbeing is not only concerned with the analysis of human nature, needs and even capabilities; it is deeply connected with questions of intersubjectivity and inter-relationality in all human encounters. Wellbeing is not to be understood in terms of individual desire or satisfaction, even where the desires are both informed by and are of major significance in a person's life. According to Watson and colleagues (2012:225-6), wellbeing is embedded in cultural and social experiences, and built around things that people can do and experience.

According to the National Institute for Health and Care Excellence in the UK (2017, 2019), people in low-income communities are most likely to experience a range of barriers such as low income, literacy and poor numeracy, language and communication difficulties, poor access to transport and childcare, digital exclusion, and many other factors that prevent them from taking part in setting priorities for health and wellbeing initiatives. Addressing these barriers will aid in supporting people to engage in more initiatives and also increase equity.

In the introduction to *Rethinking Wellbeing*, Manderson (2005) argues that social, economic and political circumstances, class, age, gender, family structure, support networks and community capacity (including social capital) all influence the way in which people respond to illness, psychological adjustment, and to physical management and care. These factors come together to fundamentally affect how wellbeing is conceptualised. Furthermore, wellbeing includes more than physical and mental health; it is also inclusive of a sense of satisfaction, contentment, personal fulfilment and existential calm. Therefore, wellbeing is more of a social construct than an indicator or outcome of health (Manderson, 2005:4).

According to Campbell and Jovchelovitch (2007), the poorest people in the world are also those with the poorest health, although not necessarily the worst mental health; poverty and other forms of social exclusion are the main determinants of health inequalities worldwide. Community participation could play a major role in policies and interventions that seek to reduce health inequalities, especially in low-income areas (Campbell and Jovchelovitch, 2007:2). It has been argued that the pathways in which inequalities impact on health vary in complexity; apart from the direct effects of socio-economic deprivation on health, members of marginalised groups often lack either the material and/or the symbolic resources to deal with health damaging stress. Social exclusion undermines people's access to health-related knowledge and it impacts on the value that people place on local health-related knowledge and skills (Campbell and Jovchelovitch, 2007:2-3). People who lack the power or motivation to shape their life course in significant ways are less likely to believe that they can be in charge of their health and are less likely to engage in health-promoting behaviours. Thus good social relationships and engagement in community life are essential for good mental health as they may offer protection in adversity or in contexts where there is exposure to stressors (South *et al.*, 2015:11).

In the public health and related literature, there has been a growing shift away from biomedical and behaviourally oriented interventions towards a community development perspective driven by the insight that it is only through the engagement and representation of local communities in planning and implementing health interventions that such interventions will have a solid impact (Campbell and Jovchelovitch, 2007:2). There is growing recognition of the need to involve local community groups in operational decisions regarding health service design and delivery; this is pivotal for acknowledging and addressing issues such as differential access, cultural differences, racism, and communication difficulties which can undermine the level of health service provision which people in marginalised groups can access. Further, local community groups should have the power to design and implement grassroots initiatives to promote healthy behaviours, because people are most likely to change their behaviours if they see fellow members or trusted peers changing theirs (Campbell and Jovchelovitch, 2007, drawing on Dube and Wilson [1996]). There is also a growth in the recognition of the influence of local community conditions on health; studies show that social cohesion along with strong local networks are beneficial to health in various ways. Taking this into account, health promoters (in NGOs and governments) are becoming more involved in community-strengthening initiatives seeking to promote health-enabling communities that are characterised by trust, mutual support and high levels of involvement in local organisations with common interests, that is, by strong social capital (Campbell and Jovchelovitch, 2007:1-2).

According to Campbell and Jovchelovitch (2007), low-income communities have a long tradition of coping and creating resources to respond to the severe absence of information, government support and welfare. Community and development workers have come to acknowledge that peripheral communities have developed their own survival strategies based on cultural traditions and local insight to the urgent needs that they face. Local knowledge affords people with beneficial arrangements to better cope with daily challenges; it also provides resources that are expressive of both cultural traditions that may be central to community identity and addresses the pragmatics of everyday life, where the effects of poverty and exclusion produce their own responses to alleviate experienced hardships (Campbell and Jovchelovitch, 2007:3). There is a need for a strong focus on the mechanisms whereby community level factors are shaped by broader macro-social relationships, especially in socially excluded communities with the poorest healthcare services.

The following chapter (3) is a discussion of the methodology applied to build and formulate the study.

Chapter 3: Methodology

In this chapter, I discuss how I went about putting the study together with reference to the fieldwork location, data collection methods, participant selection as well as interaction with participants and I conclude the chapter with the study limitations and challenges of the study.

Bernard (2011) argues that the credibility of research results comes from the power of the methods used in measurement; that good measurement is the key to external validity; and that the correct method of sampling is the key to external validity. I used purposive sampling to access my participants. I had initially intended to conduct an ethnography, but with the global pandemic Covid-19 and consequent restrictions on physical interactions during the national lockdown, I had to alter my data collection methods. I ultimately moved the study online, to make it a virtual ethnographic study. Taking this into consideration, below, I describe how my study unfolded.

In 'The Anthropology of Online Communities', Wilson and Peterson (2002) assert that internet-based information and communication technologies have enabled the emergence of new sorts of communities and communicative practices worth exploring by anthropological researchers. They further argued even then, two decades ago, that the growth of the internet had facilitated the rapid emergence of online interactions of dispersed groups of people with shared interests. These groups exhibit a wide range of characteristics and they serve a variety of purposes, from small groups engaged in tightly focused discussions of specific topics, to complex created worlds with many simultaneous participants, to millions of users linked by an interest in markets or exchange networks for goods and information (Wilson and Peterson, 2002:449).

Having never conducted virtual fieldwork, I drew on the work of several researchers (Garcia *et al.*, 2009; Morgan and Lobe, 2011; Watson et al., 2006; Wilson and Peterson, 2002; Snodgrass, 2014), whose methodological reflections on online research and virtual ethnographies provided guidance in successfully executing an anthropological study online. I explain in this chapter the kinds of methods I used to conduct this study, and I address the challenges, restrictions and limitations of the study taking place online.

According to Wilson and Peterson, anthropology is uniquely suited for the study of socioculturally-situated online communication; this is because anthropological methodologies enable the investigation of cultural, multileveled and multi-sited phenomena; emerging constructions of individual and collective identity; and the culturally embedded nature of emerging communicative and social practices (2002: 450). Gupta and Ferguson (1977:101) assert that fieldwork is what makes one a "real anthropologist" and that anthropological knowledge is widely understood to be "based" on fieldwork. Kerschbaumer (2016) argues that the aim of anthropology is to explore human interaction in all kinds of environments, including virtual/online[1] worlds. According to Garcia and colleagues (2009:52-3), the distinction between online and offline worlds is becoming less visible (and so, less important in some respects), as engagements in these realms become more merged within society; the two spaces interact with and transform each other. They further argue that much of the communication that used to take place face-to-face is now conducted electronically in the workplace, within a range of public and private organisations and other formal and informal institutions. The revolutionary role of information communication technologies has been powerful in creating new online methods of collecting data; this means that Web surveys, online qualitative interviews, and virtual ethnographies are now joining more traditional forms of research (Garcia *et al.*, 2009:57; Morgan and Lobe, 2011:199). This was particularly important in the year 2020 when face-to-face social interactions were prohibited as part of the lockdown rules due to Covid-19; the epidemic impacted many forms of research, especially the kind of research that is centred on physical interaction (Prommegger et al., 2021).

Garcia and colleagues (2009) argue that some of the main and enduring concerns of ethnographic research include the nature of specific social worlds and subcultures; the construction of identity; the beliefs, values and worldviews which underlie human action, social life and the overall experience of everyday life. Getting access to the research setting, building rapport with research participants, and getting volunteers for interviews are considerable issues for both traditional and online ethnography. Writing about the

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[1] I drew on various researchers who used different words, but these have the same meaning and hence I use the words virtual and online interchangeably.

analysis of interaction in online focus groups, Watson and colleagues (2006) argue that online studies are only appropriate for particular types of research and are not necessarily inclusive, but they also have the potential to overcome some of the limitations of the traditional studies, as I discuss later in this chapter. In online ethnography, the resources and challenges involved in obtaining data differ as ethnographers cannot rely on their physical presence, appearance, interactional style and conversational competence to help them gain access (Garcia *et al.*, 2009, citing Mann and Stewart [2002]). While the nature of online interviews may differ from face-to-face interviews, this does not, by any means, make them less valid (Garcia *et al.*, 2009:67).

Due to the multimodal nature of online communication, researchers and research subjects often find themselves trying to describe visual, aural and kinetic observational data in verbal form. The technologically mediated environment does not enable researchers to directly interact with and observe participants. Direct interaction is replaced by computer/cell phone/mobile notebook-screen data, which are mostly textual but can include combinations of textual, visual, aural and kinetic components (Garcia *et al.*, 2009:52-64). Online environments require alterations and adjustments in how ethnographers define their research setting, conduct participant observation (to the extent possible), obtain access to research subjects and conduct interviews, and deal with the ethical dilemmas such as privacy issues posed by such platforms. However, drawing on Thomas (2004), Morgan and Lobe (2011:216) argue that there is no need to invent new ethical rules for online research or try to reduce ethical behaviour in internet or any other research; instead, they suggest that increased awareness of and commitment to the already established ethical principles applicable across traditional research methods.

Online ethnographers must learn how to engage with participants without a physical presence in the field, and must develop new skills and procedures for collecting and analyzing data. These include recording fieldnotes and reporting on the results of their analysis (Garcia *et al.*, 2009:66). According to Morgan and Lobe (2011:210), the research design for any social science project needs to begin with an emphasis on meeting the goals for the project, but it must also take into account the more practical concerns of both the researcher and the participants. Garcia and colleagues (2009) argue that the blurring of public and private in the online world inevitably raises ethical issues around access to data and techniques for the protection of privacy and confidentiality. They therefore advise ethnographers to define the field or setting of their research on the basis of their research topic and to apply standard principles of human subject protection to the research environment. This environment fundamentally differs from any face-to-face research context (2009:54).

Fieldwork location

The fieldwork for this study was intended to be in Mamelodi, particularly at Ikageng section in Mamelodi East, where Itsoseng Psychiatric Clinic is located; as already discussed, I use the term *kasi,* as it is a common informal word used to refer to townships throughout South Africa; I also refer to the place as Kasi. As mentioned previously, the clinic is situated within the University of Pretoria premises at the Mamelodi campus, also known as Vista. This is where I met 33-year-old Thabo[2], who was at the time studying Communication Sciences; he is also a performing artist with a special interest in poetry. Thabo and I met during a fieldwork observation exercise which I undertook in March 2020 before the national lockdown was implemented; he was at the University of Pretoria premises using the free Wi-Fi there. He sat close to me and we spoke briefly about my research; he was very interested in the topic of mental health and he invited me, once I started with fieldwork, to come and speak to members of a group he had founded. Thabo and I exchanged contact details and he came to be my key informant.

Thabo founded of an arts organisation (which he and fellow members refer to as a movement)[3] in 2011. The organisation is made up of various artists including performing artists (musicians, producers, presenters, poets, etc.). They meet on Wednesday afternoons, when they have group or individual events. Group events include group performances and individual events in which one artist showcases their own work.

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[2] All participants including Thabo, were given pseudonyms

[3] For that reason, I use the words group/organisation and movement interchangeably throughout the study.

Members get together to show each other support. All group members knew and/or were familiar with each other even though they were divided into three different sub-groups during the focus group discussions of my study.

Although the focus of my research was not about life online, much of the interactions of the members of Thabo's group occurred online throughout 2020. In "Ethnography of Online Cultures," Snodgrass (2014:465) provides insight on how to ethnographically document the social activity of groups whose members communicate and interact through the use of computer-mediated technologies; he reveals how digital technologies can enhance and complement traditional (offline) ethnographic practices. Snodgrass suggests that ethnographers of life online need to adjust standard anthropological methods and perspectives to the unique technologically mediated nature of the internet (2014:466-7, drawing on Boellstorff [2012] in "Ethnography and Virtual Worlds," and Kozinets [2002, 2006a, 2006b].

Snodgrass (2014:468) suggested that ethnographic field sites are, in some important sense, constructed rather than discovered, and this reinforces the idea that there is no single rule as to how ethnographers of life online should construct their mix of online observations as compared to offline observations. However, Garcia and colleagues (2009:56) suggest that rather than deciding in advance to conduct an online ethnography, the ethnographer should first choose their topic of interest, and then define the field in terms of whether and how that topic involves different modes of communication or technological locations; thus, it is incumbent on the researcher to think about the nature and habits of their participants and to think about their research question.

Snodgrass (2014:465) explains that, by the early 1990s, a science and technology studies offshoot of anthropology had already begun to document the social life of the internet ethnographically. More recently, anthropologists have documented the many ways in which computer mediated interactions transform and reaffirm offline experiences, including in providing and receiving care. In 'Frequent Callers: "Good Care" with ICTs in Indian Transnational Families', Ahlin (2020) documents a study exploring frequent calling as one aspect of transnational care collectives of migrating nurses and their parents where within the transnational care collective, Information and Communication

Technologies, provided a technological infrastructure to support caring relations among family members who are geographically dispersed. Ahlin (2020:71) describes how frequent calling via the phone and webcam can be seen as a practice of enacting good care amongst Indian transnational families.

Watson and colleagues (2006) argue that although online communication relies a lot on words and symbols typed on a computer (or on the keyboard of a cell phone or mobile notebook), the written word should not be underestimated in its capacity to induce or evoke strong feelings and reactions. They further argue that in the absence of other stimulation such as physical observation, the written word can heighten other senses (Watson *et al.*, 2006:552). Snodgrass (2014:465) further argues that ethnographers now regularly document social networking sites like Facebook, and other social networking media, such as blogs, webcasts, fan-sites, games, chatrooms, and bulletin boards, all of which intersect with each other. I documented my study using one online tool, WhatsApp, as I discuss later.

To answer my research questions, I wanted to study young black males and females who are from or live in Kasi. To have a better understanding of the value of community engagement, I wanted to talk to people who were part of a social group, and/or those who had experience of being in a social group, to explore their personal experiences of being in the group. I wanted to also understand the role of social support in addressing issues relating to mental health. I wanted to talk to people who live in Mamelodi about their understanding and experience of mental health from a kasi perspective. I was interested in understanding how and what influences their perspectives and responses to mental health illnesses. As Garcia and colleagues (2009) argue, once the ethnographer has defined the field or setting of his/her research, he/she must then make adjustments to data collection and analysis.

Data collection methods

In choosing the tool for data collection, I drew on Lo Iacono and colleagues (2016). In their research article entitled ‘Skype as a Tool for Qualitative Research Interviews’, they assert that Skype can be a useful tool for some interviewees to feel more at ease than they would when interacting with researchers in person. They further argue that Skype and other Voice over Internet Protocol, better known as VoIP methods offer a viable option as a research method for those who feel that offline face-to-face interviews do not suit their specific interview style; they advocate for the use of Skype (a global online networking medium) as a viable tool for collecting data as it opens up new possibilities by allowing researchers to contact participants worldwide in a time efficient and financially affordable way (Lo Iacono *et al.*, 2016:10-11). Lo Iacono and colleagues (2016:1) also explain that although VoIP mediated interviews cannot completely replace face-to-face interaction, they work well as alternative and/or complementary data collection tools for qualitative research. They further argue that within academia, online technologies are becoming more common as research aids, with the internet now being a powerful tool for future research and providing new horizons for researchers (Lo Iacono *et al.*, 2016) see also Illingworth (2001) and Coomber (1997). Skype has partly been superseded by media such as FaceTime, Zoom and WhatsApp which are compatible with a lot of devices, are cheaper, and thus are more convenient.

Platforms such as Skype, Facebook, WhatsApp, and so on are invaluable for research topics that involve different cultures. These platforms are not limited by territorial boundaries, and they allow researchers to engage with participants anywhere in the world. As Lo Iacono and colleagues (2016:3) argue, a great advantage of using Skype and related tools as qualitative research tools is that they allow researchers to transcend geographical boundaries by disregarding distance and eliminating the need to visit an agreed location for an interview. While focus group discussions would have been held at a community centre in Mamelodi, had the research been conducted face to face, I would still have needed to find appropriate locations to meet with participants for in-depth interviews. Such logistics were nullified by the use of an online communication tool. The absence of the need to find a specific venue for interviews saves researchers and participants from certain financial and practical issues; using online tools, interviews can easily be conducted from the comfort of one's home and thus they ensure safety for both the researcher and the participants. Tools such as Skype and WhatsApp not only provide an opportunity to talk to otherwise inaccessible participants; they also give participants greater freedom to participate in research if they want to, without the need to travel.

Online settings offer ethnographers a variety of communication technologies like email, bulletin boards, chat channels and rooms, social networking programs, instant messaging and VoIP (Voice over Internet Protocol). As I have already noted above, for my study, I used WhatsApp, a social networking and instant messaging mobile application; I used this particular application as not only is it cost-effective and widely accessible, it also allowed me to host virtual focus groups, with capacity for me as a researcher to ask questions and to generate meaningful interaction between me and the participants. To obtain data and accumulate content, I used qualitative research methods using WhatsApp as the platform of communication. Over a period of three months (July-September 2020), I hosted three online focus group discussions and seven one-on-one interviews. Watson and colleagues (2006) describe focus groups as a well-established qualitative research method used to gain insights into people's experiences. They provide a glimpse into the worlds of others, and most importantly, as applicable to my study, focus groups can be used to explore how individuals' attitudes and beliefs are formed and what influences their thinking (Watson *et al.*, 2006:551). Focus groups have been proven to be a highly flexible and adaptable tool to collect data across a wide range of research topics and cultural settings; also, the main approach to creating online focus groups has been to adapt the method to existing software, with the assumption and hope that participants will use the forum to interact in ways that will produce useful data (Morgan and Lobe, 2011:199-200).

Morgan and Lobe (2011) assert that the hallmark of focus groups is their explicit use of group interaction to produce data and insight that would be less accessible without such interaction. They argue that larger groups create the possibility for a sequential pattern of interaction. Comments from several individuals with some awareness of the topic can stimulate a number of more wide-ranging responses from other members of the group, which will ultimately produce the desired degree of interaction (Morgan and Lobe, 2011:214-15). Wang and Liu (2021) argue that social media platforms can trace almost every virtual aspect of social life; however, researchers need to bear in mind and consider the limit as well as partiality of what they are able to know about the virtual social world and to ensure this, it is advised to access a sizable sample for achieving more comprehensive findings (Wang and Liu, 2021:2). Based on this insightful information, my first focus group discussion had eleven participants, the second group discussion had eight participants, and the third and last group had fourteen participants. In total, I engaged with 33 black participants, fifteen men and eighteen women aged between 21-34 years. I used one-on-one interviews as a follow-on from the group discussions, to further understand the personal experiences of some of the participants with regards to belonging to a social group, and to further talk about their understanding of mental health.

According to Snodgrass (2014:471), online worlds offer researchers the possibility of accessing detailed social and behavioural data with little to no actual participation, and non-participant observation can be carried out relatively easily in online as compared to offline contexts where one's non-interacting presence is more visible and could compromise naturally occurring behaviour. Being able to conduct the study online enabled me to bring together geographically dispersed people at a relatively low cost. However, a shortcoming of online ethnographies is that ethnographers are not physically co-present with their research subjects; they are unable to use their interpersonal skills to access and interpret the social worlds that they are studying (Garcia *et al.*, 2009:54).

Garcia and colleagues (2009) argue that when conducting a study online, impressions about the researcher are communicated by both textual and visual material presented to the potential participants, rather than by voice, mannerisms and the physical presence of the researcher him or herself. They advise online ethnographers to carefully consider their initial presentations of themselves to their research participants (Garcia *et al.*, 2009: 73). Snodgrass (2014: 474) asserts that ethnographers should consider all aspects of their research, including small details like their username or avatar name, since these choices will impact respondents' impressions of the researcher and thus shape the information they provide. It is therefore important for ethnographers to choose names both in accordance with the image they wish to project and in conformity with community standards. With that in mind, I did not use a profile picture (avatar) during my research but rather, I sent a casual image of myself, along with a detailed introduction of myself and the intentions of the study, consistent with ethics requirements (see Appendix 11). Participants referred to me as Dezz (my nickname), but were fully aware of my full name and surname, as mentioned in my introduction to them.

Advantages of online ethnographies for participants include the elimination of issues relating to transport arrangements and costs; they minimise the need to juggle schedules; and concerns about personal appearance can also be avoided. For the researcher, online studies that enable many-to-one forms of contact reduce costs and effort by eliminating the complexity of arranging meetings (Morgan and Lobe, 2011:201). Watson and colleagues (2006) argue that a major advantage of online studies is that text-based social interactions generated can be captured and recorded free of transcription errors; this however is balanced by disadvantages of online groups: because no one is physically present, this results in the loss of body language such as reassuring smiles, visual expressions of encouragement, confusion, enthusiasm, boredom, sadness, raised voice and eye contact (Peacock and Jones, 2006:552). Not being able to observe and describe spaces is also a loss with online studies, and face-to-face interaction in some cases remains valuable to get a holistic impression of the field (Kerschbaumer, 2016:101).

Garcia and colleagues (2009:75) argue that there is some concern among online researchers that the technology makes it difficult and almost impossible to guarantee anonymity of online participants, in focus groups because of interactions, but also because of technologies such as cookies, IP addresses and Internet server log files; for this reason, all participants were given pseudonyms throughout this study. Online groups therefore present considerable ethical issues. Firstly, they pose a greater risk to individual privacy and confidentiality due to the enhanced accessibility of information on the internet, including because skilled hackers can still penetrate even relatively high-level security procedures. Secondly, researchers may face a greater challenge in obtaining informed consent.

In my case, I was not able to distribute the formal consent forms person to person. Hence, I asked participants to write a note acknowledging consent with a photograph of the note, and privately send this to me. Another ethical issue specific to focus groups involves the things that the participants learn about each other during the course of the discussion. Although the researcher can create procedures to assure confidentiality of the data collected – I was guided by the Anthropology Ethics Committee constituted under The University of the Witwatersrand Human Research Ethics Committee – there is essentially no way to keep participants from violating each other's privacy at any time during or after the discussion. This can be a serious concern for online groups where it is often possible for the participants themselves to capture the text of their discussions by taking screenshots of the conversation; WhatsApp also has the option to export chats (discussions) to plain text which can be shared via email. The most common way to deal with this issue is to address it explicitly during the initial instructions. However, this only addresses the issue; it does not, at all, resolve it (Morgan and Lobe, 2011:216). For my study, I explained in the Ethics Form that all information obtained digitally would be stored on my password-protected Google Drive account and that other materials such as notebooks will be kept in a locked credenza placed privately in my home.

Taking all this into consideration, the best and most convenient data collection tool was WhatsApp, an international social networking mobile application used by many people, especially young people, as an affordable means of communication. The application uses phone data and does not necessarily require access to the internet. WhatsApp enabled me to engage with all my participants in groups as well as individually. Unlike other communicative platforms which usually require a fairly active profile (i.e., Facebook), WhatsApp is a lot more manageable and private as its messages are end-to-end encrypted, meaning that no one outside of a given chat has access to the conversations, thus withstanding the possibilities of hacking and copying. WhatsApp allows for both private conversations and group discussions through texting, audio exchange/voice notes, voice and video calling. I communicated with all participants via text; however, they would sometimes respond using audio by means of voice notes which I was able to transcribe with ease.

As noted above, I also conducted in-depth interviews which followed from and built on the group discussions. I approached two to three individuals from each group to have further discussion with me privately. I selected individuals who were most vocal and interactive about everything that was discussed in the groups, so as to maximise rich interviews and therefore rich data. With both the focus group discussions and in-depth interviews, I relied on the method of probing to stimulate participants to produce more information. In particular, I used the Echo Probe method when an informant is describing a process or an event, and the Tell-me-more Probe, which I used to probe for more details by simply encouraging the participants to tell me more (Bernard, 2011:161-3).

In the focus group discussions, we spoke at length about the benefits of being in a social group; we spoke about wellbeing and how it is defined in Kasi; we spoke about mental health and how mental health illnesses are addressed in Kasi. We also spoke about the stigma attached to mental health illnesses and the role it plays in the way in which people respond to mental health illnesses.

In the in-depth interviews, I spoke to individuals about their experiences of belonging to a social group with reference to the kind of support they received from the group. We also spoke about their own understanding of wellbeing and about mental health and how they understand mental health illnesses. I include in Appendices 3, 6 and 9 the question guides for all discussions and interviews. Although English was the most commonly used medium of communication, participants did use Setswana, Sepedi, isiZulu and isiXhosa at times; fortunately, I have a solid understanding of all these languages.

Interaction with participants

According to Snodgrass (2014:467), ethnographies of life online can take form in different ways, depending on a researcher's agenda. He notes that ethnographers of life online need to make tactical decisions about how best to track their research subjects, wherever their subjects might be. In my study, I did not have to actually track people; instead, I only needed to maintain a communication link in case I required more information or if my participants wanted to add more. Thabo connected me with all participants as he was already in contact with them, mostly through Facebook and WhatsApp. Participants were in various locations during the lockdown; most of them had returned to their original homes and families all over the country – Limpopo, Mpumalanga, Eastern Cape, North West and Gauteng.

Thabo connected me with all of the participants; he had briefly spoken to them about my study, so all were familiar with some of the content of my study and had agreed to participate prior to me adding them to the WhatsApp group. However, in addition, I explained everything to them in greater detail at the beginning of each discussion, and fortunately, they all consented to partake still. Thabo would send me a list of names and WhatsApp contact numbers via SMS one group at a time, and I would inform him as I was nearing the end of each focus group discussion for him to get ready with the next list of participants; this continued until I was done with all three groups. I believe he selected participants on an arbitrary basis, although not using formal random methods; as already mentioned, he had previously spoken to all participants about me, my study and its aims; however, I also personally introduced myself and thoroughly explained my study.

The focus group discussions and the in-depth interviews were conducted at different times as per the participants' availability. The focus group discussions were a lot easier to maintain as I would suggest a specific time when we could all be online to have our discussions. Each group discussion took place every other day, and each lasted between six to seven days at most. The most common times for group discussions were between 18h00 and 19h00; although the intended duration of each focus group was an hour per discussion, the discussions mostly extended beyond 19h00 and we would often close the chat around 22h00 or 22h30, thus discussion extended for 4 or more hours per day, over a period of six or seven days. In total then, each focus group extended for a total of about 144 hours, although with most of the discussion concentrated in about 7-10 hours. This is clearly a very different form of interaction to physical focus group discussions which might typically last between 60-90 minutes per session and for each group, would be held for one session only.

The in-depth interviews were slightly different as they took place at specific times as per the individual's availability. I asked participants to suggest a suitable and convenient time for me to interview them, and the interviews lasted between one and two hours across two to four days. As argued by Watson and colleagues (2006), the flexibility of asynchronous online discussions allowed participants to respond at their own convenience and for longer periods, and this may have contributed to more in-depth perspectives. Over several days people gained and provided an increasing number of ideas about the topic, they continually worked on the ideas provoked by interview questions, and this resulted in more measured responses.

Reflexivity

Reflexivity is an important aspect of any ethnographic research study since who we are shapes our understandings of the research process and question of enquiry, and the people with whom we work. Similarly, our own identity informs how people interact with us (Reyes, 2018:222). This was especially important because of the sensitivity of the mental health component of my study, and my own concern with people's willingness to reveal their experiences in the context of stigmatism and exclusion.

Mental health is a sensitive topic that needs to be approached with adequate insight. I hold a BA degree in Psychology and I was able to apply my knowledge from the degree in approaching the topic of mental health with the necessary respect that it requires. Shai (2020) holds that in the fieldwork stage, interaction with participants becomes a critical channel through which the researcher's stance is conveyed along with a base for learning how to account for participants voices in the study.

During the 'fieldwork' process, I was aware of my stance as a young black woman undertaking a Masters' degree, able overcome many challenges that others were unable to overcome. As Shai (2020) argues, the positionality of researchers may influence the development of a research partnership with participants, the research process as well as the research outcomes. Writing about the social dynamics of interviews, Manderson and colleagues (2006) argue that age and class form part of the factors that structure social relationships including those that develop in research settings. I was mindful of how I might be perceived by my participants who were around my age, some of whom were far less academically qualified; I understood that some participants might feel pressured to know more than they knew on the topic of mental health, hence it was very important for me to present myself along with my intentions as transparently as possible.

Being able to present myself in a professional but yet relatable manner enabled us to engage freely and openly with each other in the focus groups and in one-on-one interviews. I had grown up in a rural area myself and later moved to kasi, and I was intrigued by the similarities between many of my own and others' experiences as relayed in focus groups and interviews. I appreciated how understanding all participants were of each other’s stories, and how everyone seemed to open up with ease due to the high levels of relatability of their stories. There was unity, sensitivity and compassion throughout the discussions, and this was especially heart-warming considering the difficult time during which the study was taking place.

Understanding vernacular and being able to communicate using local languages including Sepedi, Sesotho, Setswana, IsiZulu and IsiXhosa as well as a a kasi mixed vernacular, even on text, helped me to gain a thorough understanding of the experiences that were relayed to me; I also appreciated being able to understand vernacular mostly because of the way in which it enabled participants to give me a clear context of their experiences. As a black African person, I know how complex and difficult it can be to articulate a story in English, when the lived experience and prior narratives were in an African language. My home language is Sepedi and I understand how sometimes, meaning can be lost in translation.

During the discussions and interviews, there were things I found to be helpful, which initially I had not considered. For example, the use of emoticons/emojis helped bring a better understanding of the feeling that was explained at a particular moment. While I was not able to see participants’ expressions, but the use of emoticons gave me a good sense of what was being felt during the discussions. The use of voice notes also came in handy as participants would sometimes respond using voice notes instead of texts, I was able to hear their voices and get a clear picture of what they were saying through the tones of their voices.

Researchers are advised to move away from relating one or two of their demographic characteristics with participants and this is because this type of reflexivity can become a form of self-stereotyping (Reyes, 2018:223). While I aimed to be as relatable as possible, it was very important for me to position myself firmly and to maintain control of the discussions and interviews. In my BA Honours research, entitled “The Cost of Beauty”: Factors that lead young women to disregard the ill-effects associated with beauty-enhancing products: The case of Tshwane CBD,” I learnt that some participants would seek friendship or support from me. My stance in this thesis, in which I maintained some emotional distance and was not submerged in participants' experiences, helped me to direct participants to the relevant places where they might find help (i.e. Mental Health Helplines, see Appendix 10).

It has been argued that a researcher is the instrument of translating the voices of research participants from the field into intellectual formats and that it is therefore important to engage in reflexivity in order to be able to clarify aspects of themselves that have the potential to influence the research implementation and findings (Shai, 2020:2). I knew that the findings of the study would be of interest to many as they would also inform other research studies, so it was important to report everything precisely, with great appreciation and respect to each and every single one of my participants who took time to participate in my study voluntarily

Study limitations and challenges

The advantages of WhatsApp and similar technologies as research tools are many: for example, non-participating observation is easy to do as it is relatively unobtrusive and does not require a lot of investment in terms of money and other logistics. However, these tools also have serious limitations. For example, many communities lack access to the internet, despite that the situation is rapidly improving as Lo Iacono and colleagues (2016) have noted. In addition, some people lack access to a computer or cell phone with the necessary software, lack the ability and/or the will to use this technology, or may lack the funds to buy data and use it at a given time. Some people may be reluctant to embrace technology, especially those of an older age with limited prior familiarity with such technologies. Others are/or may be a bit wary, suspicious or paranoid, especially those who might have had bad experiences with online platforms (such as being bullied, scammed, or being hacked and having their private information leaked). Although the use of Skype and WhatsApp is not usually an issue for young people, it could be an issue for those who struggle to get connected or cannot afford the data to stay connected.

During my research, I did not encounter severe challenges or major stumbling blocks which might have led to a delay along these lines. The challenges I encountered were minor and relatively easy to overcome. One of the issues I faced with participants was that of network and connectivity issues, especially when participants experienced random shifts/cases of load shedding as is relatively common in South Africa. Participants often did not know when they would experience load shedding as they typically received no warning from their electricity providers. This served as a challenge only when I had scheduled in-depth interviews with some participants and I was unable to conduct the interview at the agreed time. Participants were able to let me know whenever they were available for the interview and we would resume from wherever we had paused. One participant in particular experienced load shedding during the week, and on weekends, she was based at a farm where she had no network. We managed to conduct the interview bit by bit until we concluded the interview successfully. Lo Iacono and colleagues (2016) drawing on Seitz (2015), argue that technical difficulties may create a loss of intimacy between the interviewer and the interviewee, if, for example, the connection is lost during an emotional conversation. This disruption can be hard to reverse. Fortunately, in the context of my research and engagement with participants, such an incident was not encountered.

A minor challenge I faced was with the lack of data which enabled participants to be online using WhatsApp. Data requires money, and not everyone would have sufficient funds on all occasions. Various participants reported not being online during the agreed meeting times as they did not have data during those times; they would therefore respond as and when they had data, usually about a day or two and sometimes even three days later. Other participants would respond at midnight and reported using/only having night-mode data, able to be used only between 12h00 am and 05h00 am. Participants always responded as and when they could and for the most part, they would adhere to suggested times and responded enthusiastically in the conversations. This brings in Lo Iacono and colleagues (2016), who assert that online communication tools can be especially useful for some interviewees to feel more at ease than they would when interacting with researchers in person.

In the following chapters (4-6), I report on the findings of the study, starting with the benefits/advantages of being part of a social group, followed by the way in which wellbeing is defined in Kasi, ending with the role played by stigma with regards to mental health.

Chapter 4: Practical benefits of community engagement

In this chapter, I discuss the findings predominantly gathered from in-depth interviews, with additional material gathered from focus group discussions. I discuss what I found in my quest to explore community engagement as a way of promoting wellbeing and addressing mental health challenges. In particular, I draw on my interview with Thabo as a founder of an art group, who introduced me to all the participants. I discuss the advantages or benefits of belonging to a social group and then discuss the findings on addressing mental health in a group. As I illustrate below, participants reported finding cathartic value in sharing experiences with others; affirming their own identity through the sense of belonging they got in the group; and practically gaining through connections which allowed them to develop some aspects of their lives, for example, extending their networks to other regions, enhancing their skills and improving their social experiences.

Raised by a single mother and grandparents, Thabo was born and bred in Xanthia, a village in Bushbuckridge, Mpumalanga. The 33-year-old poet studied performing arts at Montage Artworks College and is currently studying Communication Science at the University of South Africa. Thabo established his own art movement in 2011; he recalls the movement as something he had been interested in building from back where he grew up in Bushbuckridge. He explained that he had always tried to unite artists and create a platform where all artists from around the community could work together, share their work with ease, and be better acquainted with one another. Thabo reported that he established the movement because he did not know of any that existed around his area but most importantly, he believes that an individual can only do so much on their own, and that a lot more could be done as a collective. He explained:

> There are techniques that one could learn from others, so this always enables all different types and kinds of artists to never struggle with what they want to know and where to find what they need and who to consult. Art is a broad band of interconnected systems that requires teamwork to pull together.

When asked how and with whom he maintains the group, Thabo explained that he works with fellow members, who are also artists, to help him maintain the group, but asserted that he lets everyone in the group feel free to become part of the bigger vision. With regards to marketing and promoting the group, Thabo reported that they host different sessions from kasi to kasi and also use social media platforms: “Marketing requires dedication and someone who really understands and loves it, but we keep doing our best every day to ensure that we reach as many people as possible.”

I observed a lot of the digital posters he posted on his WhatsApp status, which mentioned Facebook, Instagram and YouTube; the posters generally listed the performing artists, the date and venue of the events, and the contact details which were those of the organisers. During lockdown with higher restrictions, events were hosted virtually through Facebook and YouTube Live. Other participants often shared the same posters, and once the country had dropped to Level 1 of the lockdown, they (participants) posted posters with various locations where they hosted multiple events, including individual gigs, that is, events that are centered around one performing artist.

Thabo maintained that while anyone with an interest could join the group, commitment to staying in it is not always high, as art does not usually produce a stable income: “You see art hardly generates income as compared to other streams, so some people give up along the way in searching for better ways of changing their status quo, but I make joining the group as easy as ABC.”

I spoke to Thabo about the support provided by members of the group when a member is going through a difficult time. Referring to the concept of *ubuntu,* he replied, “*Mmm* deep one…but it always has been about walking the saying that says *Umntu ngumntu ngabantu.”*[4] *Ubuntu,* a Zulu term which translates to ‘personhood’ or ‘humanness’, is a fundamental value system promoted by various African countries including South Africa, Lesotho, Zimbabwe, Malawi, Swaziland, Botswana, and Mozambique (see Sambala, Manderson and Cooper, 2020 in *The Conversation Africa*). The concept of ubuntu positions the self in relation to the collective: individuals are perceived not as entities that are independent from one another, but as a part of an interdependent communal system (Kpanake, 2018:201). As Thabo recalled:

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[4] “A person can only be a person through other persons,” or “I am because we are.”

> You know to be honest, listening is crucial but understanding heals. There are moments where we can do nothing but listen to people when they speak to us and understand how they are feeling and that sometimes it's enough. We normally sit in a circle every time we meet and get to share our daily experiences, we meet on Wednesday afternoons but we also see each other a lot whenever we have gigs.

Catharsis: *Psychological relief through the open expression of strong emotions*

Participants highlighted the positive experiences they had once they joined the group; for the most part, they reported that they appreciated the freedom of expression found in the group. They enjoyed being able to express themselves and share their work with hopes of making others feel better about themselves. Faith, a 23-year-old construction worker, described herself as shy and introverted, and came across as reserved. But she was very engaging in both the focus group discussion and the in-depth interviews. She explained that her thoughts could get very toxic at times, and she tends to be very hard on herself, so if she stays too long with them, she ends up with what she thinks are suicidal thoughts. She therefore shares a lot of her work to heal herself and others who can relate to her. She mentioned: "I've had so many people tell me that they love my work because they can relate to what I write." Faith went on to explain that she had difficulty opening up to others so she writes down her emotions and experiences, as she recalled:

> I always wrote when I had a pen and paper, and I realised that whenever I write, I feel better. Then I wrote some more. I was not even into sharing my poetry until I shared, and a lot of people said they relate and some healed so I just shared some more.

Faith highlighted that she benefited from being in a group with people who seem to be like her. She and others in the group explained that the group supported a range of activities that are healing/supportive. Writing about cultural perspectives on positive responses to extreme adversity, Meili and Maecker (2019) argue that at a collective level, the main route to recovery seems to be through agency and communion with individuals who share similar collective beliefs and values; they further argue that rather than seeking to directly improve their own state of mind, individuals from more collectivist cultures may strive for social integration when faced with adversity (Meili and Maecker, 2019:1069). When asked how different her life would have been without the support that she gets from the group, she said: “Not so different (inserted a covering face emoji) but I know I would have long went into deep depression.”

Melinda, a 25-year-old day-care teacher by profession, introduced herself in the group discussion as a writer, designer and spoken word artist; she recalled having experienced a lot of emotional abuse and she resorted to writing as an escape. Melinda mentioned that she did not know that what she was writing was in fact poetry; she only realised this when she joined the art movement in 2011. As she recalled, the movement presented her with a platform on which she could share her work. As Melinda explains, the art movement’s aim is to unify various art types and forms, including visual and performing arts. Petersen and colleagues (2012) note, in writing about community organisations, that membership can promote social inclusion by creating opportunities for members to develop new skills, resulting in income-generating opportunities. In addition, individuals from economically challenged groups participating in community-based activities reported positive experiences in terms of personal benefits, including getting out into the community more often, enjoying greater involvement in local groups, and expanding social networks (Attree *et al.*, 2015:257).

The connections established through the movement were also central to Melinda’s process of using art to deal with emotional distress and ultimately, in finding emotional healing. The collective engagement of community members in thinking, discussing and helping one another occurs informally through shared activities and friendship, and by building ways to address social problems and thus, to strengthen wellbeing. This may result in the development of collective agency to act on their problems and environment, thus developing greater efficacy to support good mental health in their communities (Petersen *et al.*, 2012:420).

In addressing the emotional support that she was getting from the movement as well as how different her life would be without the movement, Melinda maintained that she highly values the sense of joy that art brings to her and that she would be quite miserable without the movement; as she already mentioned, art serves as an escape for her. “Art in itself is healing (inserted a smiley emoji) so emotionally, art spaces are an escape for me and through other people's work, I heal too." This reminds us of Petersen and colleagues (2012), who argue that community participation provides opportunities for greater individual and collective control of mental health; and Manderson and Vasey (2009:245), who argue that social capital incorporates social structures, and that the work that this does provides people with opportunities to engage with others while also offering a sense of belonging. It allows people ways to maximise social opportunities. Furthermore, supportive social networks built through self-help groups can provide opportunities for increased social support and personal empowerment, and this is protective of general wellbeing (Petersen *et al.*, 2012: 419-420).

Cynthia, 22 years old, came across as very vibrant and bubbly. She reported that she was introduced to the movement when she took a gap year after her matric. Cynthia recalled that she was always complaining about being bored and not having much to do, so, one day a friend of hers who was a poet invited her out to a poetry session and that's how she met Themba. In very enthusiastic voice note, Cynthia recalled:

> I'm one that likes to talk, I'm very like…*kea engage'r* (I engage). I came a lot to these sessions because I loved the talks, we used to talk about so many things *yho*! So personally *vele*[5] I've always been one to write, especially my own feelings and things like that you know, I didn't think it was poetry or something, it was just journaling you know. So *uhm*, as the time went by, I shared what I wrote with a friend of mine who is a poet and he was like 'damn, you know how to write' and things like that you know (chuckles), and I'm like *huuh*, really? And he was like 'yeah' and I'm like, okay cool, and I got on stage one day and (laughs a bit) and recited whatever that I wrote and yeah people clapped and were like 'you know how to write' and then soon after, a friend of mine and myself started this other session, poetry sessions and yeah, people started coming and yeah I was just into it (chuckles) and yeah, it was a bonfire kind of session and we would have talks , it was more of talks and poetry at the same time you know, anything that anybody wants to speak about, it can be just theories or whatever, that's how I got into the

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[5] South African slang used to emphasise an action.

> culture of poetry. I used to write when I was a bit sad in my life like you know, so yeah.

Cynthia spoke with much enthusiasm throughout her voice notes, and was persuasive when speaking about how much she enjoyed the talks that were held during the poetry sessions. When 30-year-old Sizwe, who was unemployed at the time of the interview, told me his story, he reported that he always had the 'gift' of writing but became aware of poetry through a woman friend who was interested in poetry. In a voice note, he recalled:

> So what happened is that I, out of the blue, I freestyled for her, I freestyled a poem for her and she told me that *eeh*, I should take poetry seriously, I should do poetry coz *uhh* I'm good in poetry, so *uh* but I took that as sort of like a joke. So I went to Durban, I schooled there in Christian High. There was a girl there, like *yho*, I was into, I had a huge crush on her, she was one of those poetic conscious chicks, she was into like serious conscious poetry, so I had a crush on her and I was the awkward guy, I was the looser, the nerd'*yabona* (you see) so what happened is *ehh* this girl when I tried to get her attention but she didn't reciprocate so I thought and thought and thought and I asked my uncle, my uncle asked me to tell him about the girl, so I told him that, that the girl is into poetry, she's a beautiful chick, so the uh, my uncle said that I should get into poetry also in order to garner her attention, so that's how I tried to impress the girl, unfortunately, I didn't get her attention but I did not stop with poetry, it was good for me.

Sizwe reported that by being in the group, he gets to be free: "I get to open my closed chakras, I get to meet and converse with various people. Get illuminated. Heal myself and thus others." He further reported that without the support of the group, he would probably be dead or an alcoholic or a drug addict: "Like I said, poetry is like a therapy session for me."

Affirmation: *a sense of belonging*

A lot of the participants reported feeling valued and appreciated by members of the group. They reported that the constant validation they got from others made them feel good about themselves and that being in the group boosted their confidence in many ways. One participant reported that belonging "makes me feel important, like I'm somebody, *mahn wabona* (man, you see) … *yah* like, it gives me confidence to believe in myself."

Thabiso, a 29-year-old engineering graduate, reported that without the support of the group, he might have probably attempted to commit suicide; he recalled to me: "I think I might have been part of the suicidal stats … Attempted or no more." Thabiso went on to explain how the support that he gets from the group is central to defining him as an individual: "I think there's who I am because of them. Who I've come to be. No them, no me. They give me the sense of belonging. Direction. And also importantly … peace." I asked Thabiso if he meant that he can't see himself without them, and he replied "Yes, exactly."

Faith explained that she managed to find herself and also learnt a lot about herself as a person, "I connected with people, also, I realised I was an empath through poetry." She further explained that "with poetry, that's where I am myself. I would cry and be sad and still not talk about it but once I write, I take it all off. I become naked so it is very important."

The strong sense of self-worth reported by the participants shows that being in the group served them well. It has often been argued that people who feel valued and appreciated will always do more than what's expected from them, and this is because they believe more in themselves and thus feel encouraged to do more. Being validated also empowers people. This was evident among participants who reported that they had become more open and started sharing more of their work as they saw it being received positively. Whether it was seeing people warming up to their work, receiving good remarks, being encouraged to take their work and themselves more seriously, meeting people who related to their work and/or healing themselves and others – all these kind gestures contributed greatly to their confidence and made them all feel good about themselves.

Advancement of Connections

Along with the sense of belonging and the cathartic value of opening up that group membership offered them, participants reported the value of the enhanced network. They reported having benefited in various ways from being in the group. Asked what kind of connections she had established, Melinda replied: "I met a lot of people who honed my skills because I had never contacted any formal training so I learnt a lot through that movement, even got a course on getting proper lessons on making jewellery." She further reported that having connections benefitted her by getting referrals whenever there was a gig somewhere; she hears about the gig through the movement and is able to participate. Melinda reported that these were not the only benefits she was getting from being in the group; Melinda further reported that through the art movement, she was given a lot of exposure and was therefore able to participate in carnivals which she wouldn't have known about outside the movement. She recalled:

> Well joining the art movement, I was merely blank (I only believed myself to be a little talented), so the art movement provided me with skills to enhance my talent and that enriched my growth as an artist (learning from people around me) And opportunities that challenged me to dig deeper e.g. being a part of carnivals helped me tap into various art forms and see how colossal art is, because of the movement, I've been able to be a part of carnivals (which on my own, I wouldn't even know how to crack into those spaces).

I then asked her if there were any other benefits/advantages and she said, "YES! Paying gigs" (inserted the laughing emoji).

Like Melinda, Sizwe reported having met likeminded people who wished to help him with a project he plans to build in Lusikisiki (rural Eastern Cape), which is where he comes from and where he was based during the lockdown. He plans to open an art movement with which he plans to end social struggles faced by youth in Lusikisiki:

> The youth this side fall prey to drugs, fall prey to blessers, crime etc. I hope to curb that high rate and keep the youth busy for they are very talented, we have poets in abundance, poets, writers, dancers, singers etc., we need sort of a creative hub so that youth who are creatives won't have to go far places like joburg for exposure.

He mentioned that the connections he has made have been very helpful and that he loves the energy.

Thabiso reported that he had developed networks in other cities and provinces. He reported having met and known poets in those places; that he had received invitations to their events to watch and to perform, and through that, he had developed his craft … "much credit is due to the fellow homestead poetry circles." I asked him if he would recommend that there be more of such groups. He replied: "A lot more, you should see the impact post each session, you then realise there's a great need for more." Thabiso reported having received moral, spiritual, mental and financial support from fellow group members.

Like Thabiso, Cynthia reported that she would recommend that there be more of these groups. However, her reasons differed. She enthusiastically said:

> Yes, yes, I would, uhm yes, I would, I think I would recommend it, it can practice, like it can be a, it can be helpful in so many ways like okay, for me like I said, it, it was a practice of my social, what's this, my social, what do you call it like being able to be social with people, uhh yes, that. Uhm so yeah it carries a lot of, what's this, positive relations with people *uhhm* yeah.

I witnessed the power of these extended connections during two of the focus group discussions that I hosted. In the first group, one participant raised that she had written a book and did not know how to go about getting it published; in response, a number of people in the group instantly reached out to her offering help. My research was put on hold for some time – about 20 minutes – as everyone chimed in to get her on the right track. A few weeks later, she texted me directly and told me that she found a publisher and that they were in talks to publish her book. She mentioned that she struggled to get help from her family and friends so the group did a wonderful thing for her. Another participant forwarded a poster to the group inviting people to apply for nursing training and a lot of people responded positively to the post; some mentioned that the poster would go a long way amongst many unemployed friends and family members.

Mental health addressed collectively

When discussing how easy it is to address mental health issues with fellow group members, various interrelated views were raised. For example, in the focus group discussions, a lot of the participants reported that it was easier to talk about mental health problems with fellow group members than it was talking about it at home, especially because they were already aware of the struggles at home and did not want to further burden the family by bringing up something as "simple as mental health" – *Ko gae mathata ke ama nchi jo* … so at least *gao bolela le dichomi* (at home, the problems are too many … so at least when you talk to friends), it's better *coz* (because) you talk about it and later when you go home you don't have to take out your stress on your family *wa bona, yah* (you see, yeah) so with friends, it's better." A lot of people replied to this comment in support of it; for example, there were a lot of comments along the lines of: "Yeah hey," "*Eish* exactly," "I agree with this." From the focus group discussion, people explained their reluctance to talk about mental health issues at home as they were "protecting" the family by doing so; however, a lot more was revealed later on during the discussions; I return to this presently.

In in-depth interviews, some participants reported that talking about mental health in the group was easier because people in the group often related to each other's struggles and thus were not judgmental when someone raised a particular mental health concern. One participant reported that it was easier to address mental health issues in the group as the people they talk to don't know a lot about them so they know that they won't tell other people their difficulties "see unlike talking to a family member or a friend, these people don't really know me like know me so I know they don't have the power to go around spreading my business." Thus, although the group is open to anyone interested in joining it, it is still closed to the extent that allows its members to build an atmosphere of trust. This gives people the opportunity to confide and be open about their own mental health problems as well as to disclose their hardships to people they trust without necessarily being open about other aspects of their lives which they share with family and close friends who are not in the group.

Melinda, on the other hand, remarked that she did not think that "people are comfortable with talking about where they are mentally as yet because there are stigmas attached so it's seldom that we ever discuss our own mental health." She referred to a time, in 2018, when a South African Hip Hop artist passed away and it was alleged that he died from depression. Melinda recalled how the artist's cause of death "was such a topic for the longest time" in the movement and that a lot of people made jokes about the artist dying from depression. In a voice note, she said "this one guy even made a very stupid joke and others laughed, he said, *aah mara daai man, sdudla sesi kana sa bolaya ke depression, depression? Aowa jo nna ka gana"* (oh but that guy, such a fat/big person being killed by depression, depression? No man, I refuse [reject this]. Melinda reported that the more the media spoke about depression amongst artists, the more they spoke about it in the movement but the conversation stopped "when the media moved on to the next thing that was trending." Melinda reported that "we always talk about these things but you never hear people talk about their own experience, it's always about other people's situations and I think it's because people talk about it making jokes so they don't want their personal stuff to be laughed at."

According to Attree and colleagues (2010), community engagement is a key component of most contemporary strategies to promote health and wellbeing, and reduce health inequalities, and is a component of various health interventions in disadvantaged populations. All participants' experiences of being in an art movement capture the benefits/advantages of having connections established through engaging with other people. This sets a solid ground on which to explore the positive side of community engagement and community-based organisations whose initial aim might be simple (or even singular). But through building relationships, connections are established, serving members in various beneficial ways. As Manderson and Vasey (2009) argue, people survive or even thrive depending on the robustness of their social capital, and the extent to which they are able to use it (social capital) to their advantage. Further, rich and diverse social networks, various social connections and wellbeing are all closely linked; thus, high social capital ensures the social inclusion of people regardless of physical health status and/or other personal factors (Manderson and Vasey, 2009:230).

I refer to the notion that collective approaches to addressing and overcoming hardships call into question the modern, individualist idea that adversity and wellbeing are mainly functions of the individual, and to a neoliberal emphasis on individual autonomy, self-efficacy and self-improvement (Meili and Maecker, 2019:1067). Many positive experiences reported by my research participants were about being in a social group or reflected. Participants reported highly valuing the way that being in the group made them feel; they reported finding it easier to talk about mental health problems within the group than elsewhere. They also valued the skills that were shared and the connections they made through the group: these have served them in diverse ways. Although I spoke to people who were very different from each other and sometimes had different views, most people had been in the group for five years or more, and they were still very enthusiastic about it. Their commitment to the group is reassuring, in that it presents hope for potential intervention methods which are at the moment possibly under explored.

Chapter 5: Wellbeing Monetised

In this chapter, I report on the findings gathered in both focus group discussions and in-depth interviews regarding how wellbeing is defined in Kasi. From the findings, I define wellbeing with respect to two distinctive versions which I call 'emotional wellbeing' and 'materialistic wellbeing'. Many participants identified and reported financial stability as the most common factor which determines wellbeing. Acquiring or being able to acquire certain material things was included in some definitions of wellbeing. However, not all participants defined wellbeing through financial stability; a few of the participants reported that having family, friends and people to turn to during difficult times contributes greatly to their wellbeing. I therefore draw on various case studies based on discussions where explanations were given on why and how wellbeing was defined by the availability of emotional support as well as how wellbeing came to be defined by financial wellbeing in Kasi.

Emotional wellbeing: *Family, friends and everything in-between!*

Although a lot of what was discussed in the in-depth interviews developed from the focus group discussions, participants individually reported on wellbeing in different ways and their definitions were a lot more personalised. For example, Samkelo (28) reported that she valued loyalty and having someone to count on in times of need, as this afforded her a peace of mind which in turn contributed greatly to her wellbeing. Blessing (25) reported that good health and friendships defined his wellbeing.

In explaining what wellbeing meant to her, Melinda stated that wellbeing involved "a sense of serenity in one's soul, where one can encounter powerful resonance with their minds, where there is no amount of insufficiency overwhelming us. Wellbeing is being in pure control of your minds and your inner self without losing your sanity." Melinda takes pride in expressing herself, and says that she is not interested in what other people think about what she does or says, especially on social media. Melinda, like other participants, was interviewed during lockdown when social media engagement was really high, and her particular reference to social media was arguably influenced by what was happening at that time. Faith gave her explanation of wellbeing in a voice note and said:

> Wellbeing is an involvement of mental and emotional health at a level of stability, like a certain type of stability takes place in a human being, so I would actually consider it to be something like that, having a stable mental and emotional health that is… a person's wellbeing you know. Maybe I would include spirituality but I wouldn't wanna dig deep into that because emotional health and mental health are more of a bigger character when it comes to our wellbeing as humans.

Sizwe gave a very brief description of wellbeing, explaining that "wellbeing is when you at perfect peace with yourself, not trying to hide and not try to fit in with other people's illusion of what normalcy is."

Cynthia gave a similar explanation with a bit more detail. She recalled that for her, wellbeing meant being able to respond positively and being optimistic about life experiences; she also mentioned that she loved being able to help herself and others as that adds value to the society. She further reported that self-introspection and cutting off bad habits were central to her in order to achieve wellbeing; she therefore developed new habits which were healthy and interactive. As she recalled in a voice note:

> I didn't know what to do next after changing my bad habits I started developing some new ones *uhhm*. I started doing Yoga, I started jogging, I started reading a lot often and writing reviews… it was just developing a routine that works for me. I have a routine that works for me and stuff like that, just making sure that each and every day, I add value to myself and others, and I utilise my days as an opportunity to better myself every day, *uhhm*, … Yes routine, switching bad habits with good habits *uhm* and adding value every day to myself and to other people.

What this tells us is that unless declared otherwise, people are capable of securing their own wellbeing (to a certain extent) in a way that they themselves understand. When people are able to recognise their needs and are able to identify ways to address their needs, securing wellbeing might in fact be easier.

Materialistic wellbeing: *Financial stability – a job, a car and a house!*

Although people acknowledged emotion, they emphasised material items as central to defining wellbeing. When I asked participants in the focus groups to define their personal understanding of wellbeing, Faith asked if she could explain it from a village perspective, since she was at home in the village during lockdown. She wrote:

> Villages are like super backward or slow. So having your wellbeing is not very important. 365 days is just the same thing every day. You end up living in your head, unless you have friends. Or even though you have them they won't always keep you busy. For them being on a well-balanced weight with a job, nice house and maybe a car, it is how wellbeing is defined.

Lawrence (29), responding to Faith's remarks, stated that the very same notion applied in Kasi; he asserted that "financial success is synonymous with wellbeing; if you're seen as successful then people assume that your wellbeing is fine." Other participants voiced their agreement with this statement. In another focus group discussion, participants suggested and implied that having a formal qualification meant that one would have wellbeing because "for one to have a proper or stable job, u nid a qualification. Dats when u will be financially stable" (Kabelo, 24). I then asked Kabelo if being financially stable guaranteed wellbeing, and he replied with "Yes, exactly." A stable job, a car and a house, these were popularly listed as things possessed by someone whose wellbeing was then considered to be assured. It all starts with being or looking "successful." Success is defined and the criteria is met by someone who has gone to school and is well educated *o rutelige,* meaning one is academically qualified, referring to someone who went on to obtain a formal qualification post matric. Such a person, participants reiterated, would be able to get a stable job, a house, a car, and perhaps even get married; ticking every one of these boxes meant that the person was successful and happy, thus their wellbeing was assured. Mathapelo (29) explained the following:

> You know, we grow up thinking that people are happy when they work and are living a good life. When they afford everything and have nice cars and nice clothes and bigger houses than everyone, even in the rural areas it is just like kasi. We grew up

> seeing teachers having nice houses and we thought they are happy so we aspired to be like them.

A lot of participants concurred with this statement, leading to a lengthy conversation about how people who are seen as successful are always given "special treatment" and are treated with more respect than others. Kgotatso (30) wrote:

> When we have ceremonies at home, the aunts who have husbands that work and have nice jobs do all the easy jobs like making salads and cooking on the gas stove, they are not outside cooking at the fire with all the ones who didn't go to school.

Lebo (21) added to Kgotatso's statement, and said, "Yes, even the aunts who work and are nurses and teachers, they also don't touch the dirty things, we think because they went to school so they know how to make the nice salads." Following Lebo's comment, Khathu (26) recalled the following in a voice note:

> I know of some aunts that went to school but are very bad at cooking and there are some that didn't go to school but are very good at cooking. There's this aunt of mine, they have like a society, they call it a social club with her rich friends and every month they visit a different lady, every time it's her turn, she calls my sister who didn't go to school to come and cook for her and then she tells people that she is the one who cooked *mxm* [6]...

Many of us reacted to this particular voice note with laughter emojis. Stacia (25) added: "Yes, we think because they are educated, they know everything and we even treat them with more respect." Josh, also in a voice note, then told us about his aunt. He recalled:

> I know of my aunt who was married, her husband used to work at the mines and they had a lot of money, wore nice clothes, and she used to only wear clothes from Truworths, this was a very big deal when I was growing up, she even used to buy food at Spar and people used to say Spar is expensive back then. She was very respected in the family, *abantu bamthanda nje bam hlonipha kabi,* (people loved

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[6] Slang used mostly to express anger or frustration

> her, they respected her a lot) we would all run to carry her bags whenever she came when there was like *umsebenzi ekhaya* (ceremony at home) everything was done for her, even pouring her water to bath. And *shem* (shame) her husband treated her like a queen. And then there was a time when we started hearing stories about how the husband was cheating on her and soon we heard that he was no longer working. Now no one treats her like she's special, she doesn't even dress nicely anymore, it's like she gave up on herself. People are saying *owele* (fell from grace) because now she even sits with the people who are not successful, I once saw her cleaning and washing *mogodu* (tripe), and I was like *yoh*, *yah* neh ... it's really bad.

Because all the stories reported were headlined by women, I could not help but ask if men had the same experiences and answers flooded in saying yes. Some of the men in the group explained that men who don't work had it harder than women; they reported that not having a job or money is an "ego-killer" amongst other men as well as within society in general. In a voice note, Karabo (28) said, "*Heeh*[7] guys it's tough out here, you see young boys treating old men like little kids because they don't have money." Khathu replied, and said "*lol, bo moreki.*"[8] Karabo then replied, "yes you see an old man running around being sent by a young boy just because he can buy him beer or give him a pair of label takkies (sneakers) or jacket when he leaves."

Kabelo further maintained that "no one respects you when you're a guy and you don't work, it's even difficult to get a girl, coz girls want men with cars and money." A reply came in saying, "yes, and they want someone who has their own place ... imagine taking a girl to your mom's house and now you have to sneak her in because you don't want others to see her and you have to make sure you get her out very early before everyone wakes up *eish*." Again, many people in the group laughed, possibly because the scene was so relatable and familiar in that it is very common. Tsakani (31) told us a story about her brother, who once brought his girlfriend home. When her mother saw them, "she shouted at both of them in front of us. She told my brother that he is disrespectful and that people his age are working, she was like *di thaka tsa hao dia bereka, ba bang baile go marketa*

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[7] Expression implying pity

[8] Sepedi words referring to those who buy the alcohol during social gatherings

*wena o ntse moh ontlisetsa dichila kamo ntlung yaka (*people your age are working and others have gone to look for jobs while you're sitting here bringing dirt in my house) and she told the girl that if she falls pregnant then she's on her own because she is busy opening her legs to *mahlalela."*[9] Stacia asked if the relationship survived after such an embarrassing incident and the participant replied, *lol*[10] yes *ba shap nou* (yes, they're fine now) they both work and have their own place." A reply came in, saying "*eish* thanks God hey, that's true love – *shem* she really loved him."

These stories speak to the role that money and status play in defining success and meeting socially constructed expectations whereby as an adult, one is generally expected to take full responsibility for oneself by acquiring and securing certain things like a job and one's own house. Failure to meet these expectations will most likely result in one being on the receiving end of unpleasant name calling such as *mahlalela* and also, to not be treated with the same respect as someone who has money. This emphasises the point raised in discussions that it is hard to not have a job or money; there is a lot of pressure to meet certain expectations as an adult and not being able to do so can cause worry and worse, and such stress which might lead to depression and therefore compromise one's wellbeing.

What was mostly highlighted in the discussions about wellbeing was that a person who seems to be financially stable is one whose wellbeing is considered to be intact; therefore, being successful, including having gone to university and having a formal qualification, having a job, a car and a house, were seen as a way to go about securing wellbeing. Many participants referred to having grown up to seeing wellbeing as defined by financial stability or being successful. "We grow up thinking that people with big houses and cars are fine and happy so we grow up wanting to be like them." There was also the notion of marriage or being married that gave the impression that getting married to a man who works and had money meant that the woman was successful and happy, and thus that their wellbeing was intact. As Faith rhetorically asked, "but coming to think of it, can one actually be happy and have wellbeing without money?"

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[9] Slang used to refer to an unemployed person (especially men) who spend their days at home

[10] Laughing out loud

Many things in society have become monetised, access to financial resources is a precondition and money is extremely essential. There are a range of things that require money including the very basic things; one needs money for such things as food, rent, electricity, clothes, health care, and transport. Ultimately, too, one needs money to cater for unforeseen emergencies and circumstances such as a house member from an already struggling (financially) household falling sick in the middle of the night and requiring health care in a resource deprived area, or alternative ways to manage load shedding (for example, buying already cooked food, candles or lights that are battery operated, gas stoves, and so on).

Unemployment and financial instability compromises wellbeing. Being unable to meet basic needs inevitably brings worry which ultimately leads to stress; so lack of money impacts people both materially, through a lack of resources including no food, proper/enough housing and mentally – worry and concern over not being able to provide and maintain basic living standards. The context of everything is the high rate of unemployment, especially for young black people in South Africa.

Materialistic wellbeing vs. emotional wellbeing

Wellbeing was described in two slightly distinctive versions, as noted above. The first version, which was rather brief, is emotional wellbeing and it focused on wellbeing with respect to emotion and mental health. During the in-depth interviews, participants further explained what wellbeing meant for them. In these conversations, what was highlighted was that wellbeing had more to do with personal experiences and lifestyles. Various understandings were reported, all of which reflected values, interests and individuals' state of mind. The second version which is materialistic wellbeing, focused on a shared view maintaining that money was central to defining wellbeing in *kasi*. Throughout the focus groups, there was overall agreement based on similar experiences which individuals had. Most of these experiences reflect what people saw when growing up; these same experiences are reported to be still taking place today in *kasi* and in the villages.

The point emphasised in the group discussions was that wellbeing was determined by financial stability and being seen as successful, with success being defined as having gone to school and obtaining a qualification, having a job, a car, a house and perhaps even getting married. Here success and wellbeing converged, more to having money - people are held in esteem and recognised by others as having high status and being prestigious. So, wellbeing was about status obtained by having money – that is, money gave them a way to gain and express power amongst friends and families in their communities. This brings in Kpanake (2018:199), who asserts that cultural systems influence individual behaviour through their effects on one's way of being in the world and that through the process of enculturation, the individual as a biological entity becomes a culturally meaningful being who is recognised as a person.

Chapter 6: Mental health stigma in Kasi

Witchcraft: *What does it have to do with mental health?*

Drawing on research from people of American Indian, Asian, African, Latino, Middle Eastern, and European descent, Abdullah and Brown (2011) argue that there are cultural differences associated with racial and ethnic group membership in stigmatising attitudes towards mental ill health; this speaks to the different ways in which people stigmatise mental health illnesses, that are concordant with their cultural understandings and experiences. In this section, I report on various incidents where witchcraft was used to explain behaviours that depicted mental health disorders.

Lihle recalled a story about his neighbour's claustrophobic niece who once had a very sad and frightening experience. The niece, from rural Lusikisiki in Eastern Cape, had visited an uncle who lived in a highrise apartment building in Gauteng. The niece was mistakenly locked in a bathroom, it was the smallest bathroom in the apartment; she desperately wanted to escape and was found hanging outside the window in an attempt to jump out. She did sustain some injuries, although not severe, and she survived. Lihle explained that the uncle mentioned how it was a good thing that the incident had occurred in Gauteng in a modern area "where people understand these things," and not back at home in a rural area where people would say that the child was bewitched or even worse, accuse the child of acting in a way that meant she was performing witchcraft sent by the family.

There is no direct translation for disorders such as claustrophobia in most South African languages, including isiXhosa which the niece speaks. It would not be easy to explain the child's condition to people who are not familiar with the disorder and, it made sense that those who do not know about the disorder, would resort to other explanations such as witchcraft which is mostly used to explain unusual behaviour. The niece jumping out from a window would be seen as more of unusual as opposed to the niece presenting hysteria which could also be explained as '*goba le moya/ goba le badimo*' meaning to be spiritually possessed in Sepedi or '*ukuba nelifa*' in isiXhosa in which case a traditional healer or a pastor can be called in to intervene; as Igreja (2018) argues, spirit possession is mostly highlighted in societies where it is believed that an individual's body can be controlled by deities and spirits. According to Igreja (2018), spirit possession is a multifaceted phenomenon which can cause ill-health and suffering; it is also a source of knowledge and explanation regarding ways of tackling social and health problems. Drawing on Stoller (1995), Igreja (2018:1) further defines spirit possession as an embodied phenomenon which transcends the directly affected individual and becomes part of the group.

The uncle's relief at having experienced this in a place where the niece was extended sympathy, because people were more knowledgeable of mental health and psychiatric disorders than in a place where the response would have been rather negative, accusatory and not so sympathetic, reflects the importance of the alternative explanations that people offer about mental health issues and the ways in which they understand them. According to Igreja (2018), cultures differ in their tolerance for actions associated with extrinsic agencies and the varying degrees of tolerance are determined by how expansive or restrictive societies allow alternative identities (i.e. spirits), to be heard and/or respected. People hold various notions about mental health issues which inform the ways in which they respond to them.

Witchcraft prevailed as a common explanation for mental health behaviours, especially those behaviours that were uncommon and with which many people were not familiar with. Part of the answers to the question of how mental health was addressed in Kasi pointed directly to witchcraft.

People's responses varied between "I think in our culture it's all about being witched but in western culture it's all about depression and stress," "mental health hasn't quite become a norm that it actually exist ... it's still a foreign thing from our white counterparts, we tend to conclude all forms of mental health as *oa hafa* and that's it, "most people understand mental health in a different way, others they misinterpret it bcs of lack of knowledge…some believe that ppl are bewitched…wen someone is mentally disturbed, ppl say he or she is bewitched so ppl they don't disclose or talk about it cz dey afraid of stigma," "it's something that involves/is associated with witchcraft and people fear witchcraft, so they rather not talk about it" and "people may say is because of something you did and you were bewitched."

During my individual interview with Josh, he recalled his very unfortunate experience with mental health problems. He had attempted suicide several times due to depression. I asked him to explain how people responded to his experience. He recalled:

> They could not care less, they said I am a demon possessed and seeking attention so I only had myself…on various accounts, Nkosazana (princess- referring to me), they used an angry tone with me and they even called pastors to pray for me…The first time this happened I was 16, it was very traumatic, Nkosazana. I was chilling at home from school then *umfundisi* (pastor) came *coz mn*a (because I) I loved *ukuhlala ndedwa* (sitting alone) and sometimes I would slit my wrists, I had anger issues. I would like hit walls and kick doors…people said horrible things, even my neighbour, my sister and many other people except my queen mother, she was my rock, when she passed away I wanted to kill myself…they would say things like "Josh *ungumntana osisqhalekiso kutheni utshaya iziyobisi, yiya ecaweni uphethwe ngama demon, kutheni uhlala wedwa ucime endlini yakho authethisi mntu*" (you are a curse child why do you smoke drugs, go to church you are possessed by demons, why do you live alone and turn off your lights and not talking to anyone), *bethetha bekwatile bebomba nkosazana* (they spoke with anger, they were infuriated) .

Josh explained that this went on for a very long time, until he decided to learn about what was going on himself. Things became much better for him when he started writing poetry and engaging with other poets. There, he had finally met people who understood him and for the first time, he felt like he belonged in the world and that he was finally being accepted for who he was.

Experiences of mental health stigma in Kasi

Kleinman and Hall-Clifford (2009, drawing on Goffman [1963]) to define stigma as a process based on the social construction of identity. Stangl and colleagues, (2019) define stigma as a barrier to health seeking behaviour, engagement in care and adherence to treatment across various health-related conditions; further, stigma is explained as a distinguished and labelled difference that enables varieties of discrimination which deprives those suffering from certain health conditions of full social acceptance, reduces their opportunities and fuels social inequalities (Stangl *et al.*, 2019:1). According to Stangl and colleagues (2019), stigma affects population health outcomes in a negative way as it worsens, undermines and/or impedes a number of processes including social relationships, resource availability, psychological and behavioural responses which ultimately exacerbate poor health.

Part of the group discussions covered stigma and the role it plays with regards to the way in which people address mental health and seek mental healthcare in Kasi. As I illustrate below, starting with a scene I observed many years ago, there are various challenges that people encounter when it comes to addressing mental health. Participants reported the fear of being labelled mad/crazy as this gives an unlikeable impression about an individual and it brings about negative repercussions on one's general livelihood. Participants also reported a fear of stigma attached to mental health institutions as well to people seen going to these institutions, and referred to 'insensitive' health care providers whose attitudes hindered people from seeking mental healthcare.

In 2006, I witnessed a scene that would many years later lead me to wanting to explore perceptions on mental health. It was on a Tuesday afternoon in Naledi (Soweto); a teenage boy (Leon) was playing around with his friends on the street just outside his home. He had just gotten back from school and hadn't taken off his school uniform yet. While standing next to the street light with one of his friends, his parents showed up in their car from work. He ran home very quickly, he looked very scared; his mom had started shouting and swearing at him while driving towards the gate. Leon's friends quickly disappeared while his mother continued to shout and swear at him. His father seemed to not want to be involved; as it turns out; Leon was being shouted and sworn at for being outside and playing with his friends. However, the shouting and swearing seemed too harsh given this reason.

A while later, speaking to their neighbours, Leon's mother mentioned that people kept saying that she shouts a lot *batho barena kenale mashata* (people say I'm too loud) and that she is too harsh, especially on Leon. She went on to say that some people have even advised her to see someone about this: *na nkase bone psychologist, batho bao ba deal'a* *ka batho bago gafa ene nna ke normal, ake gafe, nka seye spetlele sa magafa* (I won't see a psychologist, those people deal with crazy people and I'm normal, I'm not crazy and I won't go to a hospital for crazy people). I was touched by this scene, but it also drew my attention to mental health issues. Reflecting back, the scene captures the socially constructed and misinformed notions that people have about mental health.

The often misinformed notions about mental health problems also contribute to how mental health illnesses and how institutions become stigmatised. Weiss and colleagues (2001:5) hold that focusing on cultural perspectives of mental health confronts the complexity of stigma and its implications; therefore, examining indicators locally would useful when implementing interventions as there needs to be appropriate and accurate information on which to work for appropriate and accurate interventions (2001:5).

The "cost" of being labelled mad/crazy

During group discussions, I asked participants if public opinion influenced the way in which people address mental health. Some of the participants replied with yes; several others claimed that not everyone in Kasi addresses mental health. I then asked how public opinion influences the way in which mental health is addressed in Kasi. Temo (29) claimed that people actually hide their mental health problems from the public, including their family members, and they do so to avoid being called attention seekers. As she explained:

> It begins with them dismissing you after you tell them that you have a mental health problem. Their responses would go something like, "what are you talking about, have you gone crazy?" (inserted an eye-rolling emoji). The more you keep pushing the convo (conversation), they end up thinking that you either joking or just looking for attention.

What Temo refers to is similar to what Shittu and colleagues (2014) refer to as self-stigma, which they define as the prejudice which people with a mental health condition turn against themselves; self-stigma includes the internalisation of shame, blame, hopelessness, guilt and fear. Similarly, Stangl and colleagues (2019) refer to what they call anticipated and perceived stigma which is explained as the fear of acknowledging one's mental health issue which can possibly lead to shame and avoidance regarding seeking mental healthcare.

Kleinman and Hall-Clifford (2009) argue that people who become associated with stigmatised conditions move from being 'normal' to being discredited or having a discreditable social status. In their discussion of socio-economic factors associated with mental health, Hawkins and colleagues (2020) documented the experience of a former in-patient of a mental health unit. She recalled her challenges with getting a job, as a result of the stigma she faced because she had been in a mental health unit. This in turn impacted on her mental health: "In my family there's some stigma, they know I'm not getting a job, so they look down on me...when people know you're mentally sick, they won't give you a job" (Hawkins *et al.*, 2020:4-5). According to Stangl and colleagues (2019), practices of stigma include stereotypes, prejudice, stigmatising behaviour and discriminatory attitudes, all of which fuel social inequalities. People with mental health issues are often considered to be incompetent and unable to work or even live independently (Stangl *et al.*, 2019:4). Further, Egbe and colleagues (2014) argue that people who suffer from mental health illnesses often face the social, psychological and economic consequences of stigma including low self-esteem, marginalisation from society, social isolation, poor social skills and poor social support. This in turn results in strained relationships and unemployment.

Hawkins and colleagues (2020) also discuss the concepts of madness and craziness; they refer to the word *mulalu* which is used to refer to people with mental health illnesses in Uganda. '*Mulalu*' literally translates to "mad," "crazy" or "insane," and people who are considered to be mulalu often struggle to be employed and educated. This consequently prevents them from living a progressive and productive life (Hawkins et al., 2020:4). The words 'mad' and 'crazy' occurred many times throughout the group discussions and during the last discussion, I asked participants how they understood the terms 'crazy' and a 'crazy person'. As Zama (30) recalled: "My understanding is one thing, crazy is usually the name used like mad. Den mental health is usually used as a medical term. But it refers to one thing." In response to Zama, I asked if craziness is another way of saying madness, and that mental health was the clinical (or formal) term; the majority of the participants replied with yes!

I then asked them again what exactly a crazy person was. Their responses were somewhat similar, and included: “people who can talk on their own but not making sense,” “seeing things that other ppl don’t see, changing behaviour and isolation,” and “someone who is not fit to be with or around people who are fit because that person might be dangerous.” Following these responses, I asked how people got to be stigmatised. Their responses included “being taken to specific schools or facilities can cause stigma,” “attending to special clinic and isolated hospital,” and, in elaborating on this, one participant remarked that “crazy people are taken to facilities where they meet with others of the same state and live there.” In response, one participant replied: “yes cz if you not mentally ill, u won’t be attending to that clinic or that identified hospital.” Participants further reported that there is a stigma attached to mental health institutions as a place as well as to people who are patients of those institutions.

People considered these institutions as specifically for crazy people and therefore, people who attend are automatically considered to be crazy. Hawkins and colleagues (2020) also documented the challenges of a young man who had used the service of a mental health institution; his challenges included not being to find a job. As he recalled:

> “The jobs are not easy to get and people are stigmatising…the community is not good for me…when you overhear them talking about you…the moment they know that you have stepped in a hospital for “mad” people; they know that you are “*mulalu*”… they wouldn’t even think I could spend an hour working.”

In discussing whether or not it might be easier to address mental health in a group, many of the participants reported that this was the case, as one gets to hear about other people’s experiences and through that, learns more about mental health issues. Also, by addressing mental health in groups, people are given the opportunity to debrief without being judged by those with misconceptions about mental health. Mpumi (25) explained:

> Groups can be effective to a certain level, the fact that one will be around people who are going through the same/similar situations, there’s no judgement and it can be encouraging to be more transparent about mental health illness.

Lady-Q (27) reported that public opinions, including negative judgements and being mistreated, often stopped people from seeking help; as Kgotso put it, “the fear of being treated differently once society is aware of their mental conditions.” Lwazi (31) replied to Kgotso’s comment, and said:

> Yes, they are being judged *frm* (from) their actions on whatever they do or say whether its ryt or wrong...some people mistreat them as if they are useless *cause* (because) of their condition, they don’t take anything serious frm them, forgetting *dat* (that) their human beings.

In response to Lwazi, Simz (29) wrote:

> I think to avoid judgement and being mistreated, depending on what their beliefs are, they can find help at church or at a sangoma...there is no stigma there. People won’t know their reasons for consulting at church or at a sangoma but for special hospital, they will know!

Burgess (2016) argues that in South African settings, church groups have been identified as providing important coping strategies for women with mental health problems and that utilising churches as spaces and collaborators for mental health treatment has the potential to provide further spaces for women to express the complex realities surrounding their experiences of mental distress.

With reference to the stigma attached to mental health institutions, Mpumi made a lengthy comment which many other participants seemed to agree with. She wrote:

> Those who do seek help *moh kasi* (here in kasi), do they usually succeed?? Can they receive the kind of help they need *moh* kasi? ... I’ve personally seen people with mental illnesses being treated badly moh di clinic, it’s like nobody takes them seriously, nurses always saying “*wagafa o, ska motseang serious*” *(*This one is

> crazy, don't take him/her seriously), even shouting at them and not addressing them in a respectful manner. I think it can be discouraging to go and receive treatment...I mean I do believe that health workers are given adequate training so they are knowledgeable but maybe they just decide to be ignorant, or maybe it's the fact that we are kasi *peeps* (people) so the level of respect is just low.

There were no direct answers to Mpumi's questions; however, many of the responses that came through were in agreement with what she was saying. The conversation led to a general complaint about the kinds of service that people receive at public healthcare institutions; many participants recalled experiencing and/or witnessing bad treatment from public healthcare workers, mostly nurses. As Burgess (2016) argues, stigma among healthcare workers is integral in community care. Many of the participants agreed that poor treatment and overall bad service from public clinics and hospitals contributed to discourage people from seeking mental healthcare, at least at mental health institutions. Shittu and colleagues (2014) argue that stigma surrounding receiving treatment was part of the reasons that discourage people from seeking treatment. Writing about the complexities of a primary mental health care model in a rural South African setting, Burgess (2016) reported that the presence of stigma, especially among mental healthcare workers is in fact well known and has been linked to poorer quality care.

Weiss and colleagues (2001) argue that although the functional capacities of people with serious mental health illnesses may be compromised, not using treatment and having effective control on the illnesses, denying opportunities based on incorrect assumptions of reduced capacities will not make matters any easier. In fact, or rather, consequently, people who experience, internalise, perceive and/or anticipate health-related stigma face a range of possible outcomes including a delay in receiving treatment and poor adherence to treatment which may exacerbate their health and wellbeing (Stangl *et al.*, 2019:4).

Hawkins and colleagues (2020) hold that stigma at an institutional, community and family level could result in further economic exclusion of people with mental health illnesses, and this can lead to a worsening of the initial mental health problem; they further argue that the relationship between mental health problems, poverty and stigma is a vicious cycle as poverty can cause or exacerbate mental health problems, mental health problems can elicit stigmatisation which can cause poverty and prolong mental health problems (Hawkins *et al.*, 2020:6). According to Weiss and colleagues (2001), people generally rely on their social standing and on their connections within social networks. As such, social esteem is valuable as a determinant of self-esteem, and as a prerequisite for self-respect which is required for effective functioning in the community. Similarly, Kleinman and Hall-Clifford (2009) argue that the moral standing of an individual or a group is determined by their social world, maintaining the moral standing is dependent on meeting certain social obligations and norms, unfortunately, people who suffer from or are associated with stigmatised health-related conditions may not be able to meet these obligations. Ultimately, stigma deprives people with the opportunity to hold onto things that contribute to, at least, a decent living including relationships, education and employment.

Conclusion

Nell and colleagues (2015) hold that nurturing and building on community resources to optimise resilient living presents a rather cost-effective approach for enhancing psychosocial wellbeing. Allowing for research to look into the way(s) in which community engagement and social support through community organisations can enhance individual wellbeing in kasi reveals the important and positive role that social capital plays in people's lives; it reveals how effective social capital can be in helping people overcome adversities and face social inequalities. Through the participants' experiences of belonging to a social group, we see how resilience and unity is built through mutual trust and support amongst people with common goals.

The practical benefits of belonging to a social group include the advancement of network and connections, skills and knowledge expansion, and income generating activities. These benefits are very helpful to individuals, considering the low employment rate in South Africa, and the many collaboration opportunities are proof of the tangible value of community organisations. This suggests the need to explore further how community engagement and associations can contribute to individual wellbeing. In addition, such organisations provide opportunities for catharsis and affirmation, replacing feelings of loneliness and isolation with a sense of belonging that participants reported finding in social groups. These all have a positive effect on people's wellbeing, including their mental health.

How some participants perceived wellbeing is informed by their historical background and what they witnessed or experienced in their upbringing. Most participants defined wellbeing in materialistic terms as this is what they witness within their own environment: an individual's wellbeing is considered to be intact based on their lifestyle, wealth or income, educational background, and other accomplishments including material possessions. The more 'successful' an individual is considered to be, the less concern there seems to be over that person's wellbeing. This again speaks to the role played by cultures with regards to how people come to perceive certain aspects and situations of their lives. However, not all participants defined wellbeing based on financial stability; others reported the importance of family, having a sense of peace and having control over one's feelings as very important aspects of their wellbeing. The more emotion-bound definition of wellbeing was reported by individuals – while comments about material wellbeing were alays acclaimed by others.

I have argued that community organisations can support people with mental health problems, including by providing them with general support and affirmation. Based on what people have experienced and/or have witnessed, seeking mental health care can be discouraging due to the considerable stigma attached to mental health institutions. Negative attitudes to these institutions, along with poor quality services and lack of care from certain healthcare workers, are also reasons why people are often reluctant to admit to having mental health problems and help explain their reluctance to seek care. This encourages the use of alternative methods such as churches and/or *sangoma* (traditional healer), in which case there is no stigma attached, as nobody would know the reason(s) for consulting at a church or a *sangoma*.

The research above indicates the complexity of the words 'mental health' and the meanings attached to this. A lack of knowledge and language barrier(s) is reflected through the way in which people explain and understand mental health. There are also cultural perspectives which inform how people respond to mental health illnesses, with witchcraft often raised as an explanation for mental health illnesses. Considerable stigma informed by various notions and sometimes misconceptions is also revealed as a barrier to help seeking behaviours. Labelling plays a significant role in inhibiting stigma. There are unfortunate implications that come with being labelled/or associated with mental health illnesses, as argued by MacGregor (2018), through looking at the implications of being labelled as mentally ill on social relations. Being labelled mad or crazy impedes on an individual's ability to foster relationships and maintain a fully functional social life. When labelled 'mad/crazy', it is also difficult to secure employment and not being able to generate an income and afford basic needs is already a struggle without having to deal with being stigmatised and suffer from social exclusion which can cause or exacerbate an individual's mental health and wellbeing.

There is great value in people being together; the strength of community groups as seen through the participants' experiences reflect how effective groups can be in enhancing individual wellbeing. Having a support system by means of group membership and participation builds resilience, which in turn results in individuals being able to face adversities easier than would be the case if one were alone with no one to turn to for support and comfort.

Covid-19 presented many challenges. Witnessing how the group members stayed together and supported one another during the lockdown, when people were forcefully isolated and may have been facing major difficulties including stress and anxiety, further supported the strength and value of community groups.

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"I think there's who I am because of them. Who I've come to be. No them, no me. They give me the sense of belonging. Direction. And also importantly … peace."

_Thabiso

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Appendices

1. UNIVERSITY OF THE WITWATERSRAND

PARTICIPANT INFORMATION SHEET FOR FOCUS GROUP DISCUSSION

Wellbeing in Mamelodi: Community engagement, social support and wellbeing in Kasi (township) South Africa

Good Day,

My name is Desiree Malope. I am a Master's student in the Department of Anthropology, University of the Witwatersrand. I am undertaking research to investigate the value of community organisations and the involvement of their members, including how informal friendships that emerge from common interests provide social support which contribute to wellbeing and good mental health. I am inviting you to take part in this research study as a community member along with other community members. Before you decide whether to participate, I would like you to understand why the research is being done and what it involves.

What I am doing

I am interested in learning more about how and why people join community organisations, and what they gain from them in terms of their general wellbeing. I am conducting focus group discussions on WhatsApp with community members, and in addition, I will also be conducting a series of in-depth interviews. In focus group discussions, I will encourage participants to share opinions, general experiences and ideas.

Your participation

I am asking you to participate in a focus group discussion about the value of community engagements. If you agree, I will ask you to engage in the discussion with me and around eight other participants (fellow group members) that will last for 1 hour , a convenient time of discussion will be established in the group with the rest of the participants. I might ask to speak with you again on another day to follow up any specific points in the discussion. During the group discussion, we will talk about the benefits of belonging to a social group, and how group membership supports people in different ways. I am interested in the ways in which people gain information, advice and support from groups for personal reasons as well as for the specific activities of the group.

Due to the coronavirus pandemic and its restrictions, the group discussion will be conducted online using WhatsApp and you will be responsible for your own data costs.

Risks/discomforts

The focus group discussion is concerned with the value to you of belonging to a community group, and you should experience no distress greater than that in everyday life. However, it is possible that some themes discussed may cause you distress. Should you have any discomfort, I will provide you with available counselling contact information.

Benefits

You will not benefit directly from participation in this study. However, this study will be extremely helpful in learning more about how to support people, and how community members find ways informally to do so. I also expect that the findings from this study will inform future efforts to improve the resources when addressing interventions to support wellbeing and strong mental health.

Voluntary Participation

Your participation is voluntary. You are free to refuse to answer any question that is asked. The choice of whether to participate, or not, is yours alone. If you agree to participate, you may stop participating in the research at any time and tell us that you don’t want to continue. If you choose not to take part, you will not be affected in any way whatsoever.

Due to the coronavirus pandemic and its restrictions, the focus groups will be conducted online using WhatsApp. I will take notes when we are talking, and if possible, audio-record this so that I have an accurate and complete record of our discussions.

Confidentiality

Your consent to participate will be kept separate from records of the discussion. Any study records that identify you, and that include your views and opinions, will be kept confidential to the extent possible by law. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including my supervisor and by members of the ethics committee at the University of the Witwatersrand. (All are required to keep your identity confidential.) In focus groups, people share their ideas, and participants will be requested to not record or forward information from this discussion.

My phone is password protected, and I will use this to record the focus group discussion. As soon as we have concluded the focus group discussion, I will transfer recordings and notes from the WhatsApp record on my phone to my computer, and I will delete the record on the phone. All identifying information will be kept on a password protected Google Drive and physical notes will be kept in a locked file cabinet and will not be accessible to others.

Although the study will be conducted on WhatsApp, the information that you provide will only be used for research purposes. Your personal/identifying information will be removed from the findings.

This study protocol has been approved by the University of the Witwatersrand’s Human Research Ethics Committee (HREC).

If you have any queries, concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee via email: Shaun.Schoeman@wits.ac.za.

You can also contact my supervisor, Professor Lenore Manderson, who plays an oversight role on behalf of the University of the Witwatersrand at lenore.manderson@wits.ac.za or 011 717 34 30.

In case you need to contact me please do so using the following contacts: Cell: 076 250 9048. Email: DESIREEMALOPE1@student.wits.ac.za

Thank you for reading this information sheet and for considering to take part in this research study. If you agree to participate, you will be provided with a copy of this information sheet and a signed consent form to keep.

2. UNIVERSITY OF THE WITWATERSRAND

CONSENT FORM FOR FOCUS GROUP DISCUSSION

Wellbeing in Mamelodi: Community engagement, social support and wellbeing in Kasi (township) South Africa

You are invited to participate in a focus group as part of a research study conducted by me, Desiree Malope. I am a student in the Department of Anthropology at the University of the Witwatersrand. The purpose of the study is to investigate the value of community organisations and members' involvement, including how informal friendships that emerge from common interests provide social support which contribute to wellbeing and good mental health. If you sign this consent form, you are giving me permission to collect and use the information you provide me. Signing this consent indicates that you understand what will be expected of you and are willing to participate in the focus group. This consent form will be stored separately from the record of the focus group to ensure confidentiality.

I declare that:

● I have read the information, or it has been read to me.	Yes	No
● I have had the opportunity to ask questions about it and my questions have been answered to my satisfaction.	Yes	No
● I consent voluntarily and understand that I have the right to withdraw my consent without this affecting neither the current research study nor me personally.	Yes	No
● I agree to an interview being recorded on this password protected cell phone.	Yes	No
● I approve of the use of anonymised quotes.	Yes	No
● I give permission for direct quotes to be used under a pseudonym, unless specified otherwise..	Yes	No

Respondent name and signature (or fingerprint): _________________Date: ___ / ___ / ___

Researcher's Name and signature _________________________ Date: ___ / ___ / _

3. UNIVERSITY OF THE WITWATERSRAND

Question Guide for Focus Group Discussions

Study title: Wellbeing in Mamelodi: Community engagement, social support and wellbeing in Kasi (township) South Africa

Hello everyone. As you know, my name is Desiree Malope and I am interested in your perceptions on community engagement and the benefits of belonging to a social group.
The purpose of the focus group discussion is to explore what it means to belong to a social group and to see how belonging to a group can help improve one's well-being and mental health. I am also interested in the benefits and advantages of social support found in a community social group.

A focus group allows you to share your own views. There are no right or wrong answers. All your opinions are welcome.

Let me now ask you the first questions:

> Can you tell me what you like about this group? What do you think encourages people to join the group?
> What is the overall relationship like among fellow group members?
> What kinds of support does the group offer?
> What are the plus-sides of being in this kind of group?

I would like to now ask you some questions about attitudes on mental health as part of general wellbeing:

> Does being in the group bring emotional support that people may not be able to find anywhere else?
> Does public opinion influence the way in which people address mental health. If so, how?
> Is there less stigma attached to mental health issues when addressing them as a group compared to addressing them individually?
> Are there public opinions or ideas of mental health distress that stop people from seeking mental health support? What are they?

There are two more questions I would like to ask you.

> How easy is it to address mental health distress, or anxieties or concerns, in a group with people you have something in common with, compared to talking about it with people you're not familiar with?
> And lastly, does belonging in this group make it easier to deal with and withstand certain problems like emotional distress?

Thank you all for your participation. Your input, time and effort are highly appreciated.
Good luck for the future and I wish you all well.

4. UNIVERSITY OF THE WITWATERSRAND

PARTICIPANT INFORMATION SHEET FOR IN-DEPTH INTERVIEWS

Wellbeing in Mamelodi: Community engagement, social support and wellbeing in Kasi (township) South Africa

Good Day,

My name is Desiree Malope. I am a Master's student in the Department of Anthropology at the University of the Witwatersrand. I am undertaking research with a purpose to investigate the value of community organisations and involvement, including how these informal friendships that emerge from common interests provide social support which contribute to wellbeing and good mental health. I am inviting you to take part in this research study as a person who is a member of a community social group. Before you decide whether to participate, I would like you to understand why the research is being done and what it involves

What I am doing

I am interested in learning more about your experiences of belonging to a social group and the kind of support you have found in the group which has contributed to your general wellbeing including good mental health. I am conducting focus group discussions on WhatsApp with community members, and as a continuation, I will be conducting a series of in-depth interviews with specific focus on personal experiences.

Your participation

I am asking you to participate in an interview about perceptions of community groups as someone who belongs to one. If you agree, I will ask you to engage in a one-on-one discussion with me that will last for 45 minutes at a time that is convenient to you; I might ask to speak with you again on another day to continue our discussion. During our conversation, we will talk about the benefits of belonging to a social group, and how group membership has supported you. I wish to gain insight on the kind of support that you find in the group and the impact it has on your wellbeing and mental health. I am interested in your opinions about being part of a social group as well as the advantages and benefits of this.

Due to the coronavirus pandemic and its restrictions, the in-depth interviews will be conducted online using WhatsApp and you will be responsible for your own data costs.

Risks/discomforts

It is possible that some themes discussed during the interview may trigger your emotions and cause you distress. Should you have any discomfort, I will provide you with available counselling contact information.

Benefits

You will not benefit directly from participation in this study. However, this study will be extremely helpful in learning more about the roles of community groups and about people's perceptions of mental health and wellbeing. I hope that the findings from this study can inform future efforts to improve community wellbeing including to support good mental health.

Voluntary Participation

Your participation is voluntary. You are free to refuse to answer any question that is asked. The choice of whether to participate, or not, is yours alone. If you agree to participate, you may stop participating in the research at any time and tell us that you don't want to continue. If you choose not to take part, you will not be affected in any way whatsoever.

Due to the coronavirus pandemic and its restrictions, the interviews will be conducted online using WhatsApp. I will take notes when we are talking, and if possible, audio-record this so that I have an accurate and complete record of our conversation.

Confidentiality

Your consent to participate will be kept separate from records of the discussion. Any study records that identify you, and that include your views and opinions, will be kept confidential to the extent possible by law. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including my supervisor and by members of the ethics committee at the University of the Witwatersrand. (All of them are also required to keep your identity confidential.)

My phone is password protected, and I will use this to record the in-depth interview. As soon as we have concluded the in-depth interview, I will transfer recordings and notes from the WhatsApp record on my phone to my computer, and I will delete the record on the phone. All identifying information will be kept on a password protected Google Drive and physical notes will be kept in a locked file cabinet and will not be accessible to others.

Although the study will be conducted on WhatsApp, the information that you provide will only be used for research purposes. Your name, cell phone number, and other personal/identifying information will be removed from the findings, and a pseudonym will be used, unless you specify otherwise.

This study protocol has been approved by the University of the Witwatersrand's Human Research Ethics Committee (HREC).

If you have any queries, concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee via email: Shaun.Schoeman@wits.ac.za.

You can also contact my supervisor, Professor Lenore Manderson, who plays an oversight role on behalf of the University of the Witwatersrand at lenore.manderson@wits.ac.za or 011 717 34 30.

In case you need to contact me please do so using the following contacts:
Cell: 076 250 9048

Email: DESIREEMALOPE1@student.wits.ac.za

Thank you for reading this information sheet and for considering to take part in this research study. If you agree to participate, you will be provided with a copy of this information sheet and a signed consent form to keep.

5. UNIVERSITY OF THE WITWATERSRAND

CONSENT FORM FOR IN-DEPTH INTERVIEW

Wellbeing in Mamelodi: Community engagement, social support and wellbeing in Kasi (township) South Africa

You are invited to participate in a research study conducted by me, Desiree Malope. I am a student in the Department of Anthropology at the University of the Witwatersrand. The purpose of the study is to investigate the value of community organisations and involvement, including how these informal friendships that emerge from common interests provide social support which contribute to wellbeing and good mental health. If you sign this consent form, you are giving me permission to collect and use the information you provide me. Signing this consent indicates that you understand what will be expected of you and are willing to participate in this survey. This consent form will be stored separately from interview data to ensure confidentiality.

I declare that:

● I have read the information, or it has been read to me.	Yes	No
● I have had the opportunity to ask questions about it and my questions have been answered to my satisfaction.	Yes	No
● I consent voluntarily and understand that I have the right to withdraw my consent without this affecting neither the current research study nor me personally.	Yes	No
● I agree to an interview being recorded on this password protected cell phone.	Yes	No
● I approve of the use of anonymised quotes.	Yes	No
● I give permission for direct quotes to be used under a pseudonym, unless specified otherwise..	Yes	No

Respondent name and signature (or fingerprint): _________________Date: ___ / ___ / ___

Researcher's Name and signature ________________________ Date: ___ / ___ / ___

6. UNIVERSITY OF THE WITWATERSRAND

Question Guide for In-depth Interview

Study title: Wellbeing in Mamelodi: Community engagement, social support and wellbeing in Kasi (township) South Africa

Introduction by me to participant

Good day,

Thank you for the chance to talk to you further about your experience in a community engagement belonging to a social group. In the Focus Group Discussion, we spoke about the advantages of community engagements and the benefits of belonging to a group which contribute to wellbeing and good mental health. In this conversation, I'd like to ask more about this. I would like to hear from you what your experience of belonging to a social group has been like.

This is a discussion of your own perceptions and there are no right or wrong answers. All your opinions are welcome.

I'd like to know: how did you come about joining this group, where did you hear about it?

I'm also interested in your experience of being in the group. What is involved?

What kind of connections have you established through this group?

How helpful is it for you to have connections through this group?

Now, I'd like us to talk about your perceptions of mental health and well-being.

What is your understanding of mental health?

How did you learn what you know about mental health?

How much would you say you know about mental health?

What would you consider to be well-being?

I have a few more questions. I'd like us to talk about the benefits of being in the group.

Does the group provide support that you were not able to get elsewhere?

What about emotional support?

Are there other advantages?

How easy is it to talk to other group members about personal problems such as mental health distress? What is it that makes it easier to be open to them?

How different would your life be without the support of the group? What would you miss about the group?

How much do you value the connections within the group?

Last question from me:

> Based on the amount of support you've received in the group, would you recommend that there be more of them?

Before we go – is there anything you would like to ask me?

Thank you very much for your participation, that is all from me. Your input, time and efforts are highly appreciated.

Have a good day.

7. UNIVERSITY OF THE WITWATERSRAND

PARTICIPANT INFORMATION SHEET FOR KEY-INFORMANT INTERVIEW

Wellbeing in Mamelodi: Community engagement, social support and wellbeing in Kasi (township) South Africa

Good day,

My name is Desiree Malope. I am a Master's student in the Department of Anthropology at the University of the Witwatersrand. I am undertaking research to investigate the value of community organisations and people's involvement in them, including how these informal friendships that emerge from common interests provide social support which contribute to wellbeing and good mental health. I am inviting you to take part in this research study as a person who founded and runs a creative community. Before you decide whether to participate, I would like you to understand why the research is being done and what it involves.

What I am doing

I am interested in learning more about your group; when and how it was established, and the kind of support it provides its members. I hope to be able to have online focus group discussions and in-depth interviews – like conversations – with some of the people who belong to a social group. But I am also very interested in your role as the group founder.

Your participation

I am asking you to participate in an interview about your role as a founder of a community social group. Your participation is entirely voluntary and you are welcome to withdraw at any time. You will not be penalised in any way should you decide not to participate or to withdraw from this study.

If you agree, I will ask you to have a conversation with me that will last around 45 minutes at a time that is convenient to you. I might ask to speak with you again on another day for about the same amount of time to continue our discussion. During our conversation, we will talk about when the group was established, the kind of support offered in the group, and the plans that you have for the group in future. I am interested in your opinions about the group.

Due to the coronavirus pandemic and its restrictions, the interviews will be conducted online using WhatsApp and you will be responsible for your own data costs. I will take notes when we are talking, and with your permission, if possible, audio-record this so that I have an accurate and complete record of our conversation.

Risks/discomforts:

This study is conducted solely for the purpose of a research module that I am doing. Our discussion will only be used in the production of the research report. We will only be talking about the group, how it was established and the kind of support it offers to its members. There should be no risks in talking about how the group was established.

Benefits

You will not benefit directly from participation in this study. However, this study will be extremely helpful in learning more about people's perceptions of mental health distress. I also expect that the findings from this study will inform future efforts to improve the resources to support community wellbeing including mental health interventions.

Voluntary Participation

Your participation is voluntary. You are free to refuse to answer any question that is asked. The choice of whether to participate, or not, is yours alone. If you agree to participate, you may stop participating in the research at any time and tell me that you don't want to continue. If you choose not to take part, you will not be affected in any way whatsoever.

Confidentiality

Your views and opinions will be kept confidential to the extent possible by law. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including my supervisor and by members of the ethics committee at the University of the Witwatersrand. (All of whom are required to keep your identity confidential.) Otherwise, only I will be able to listen to our interview and read notes from it along with our WhatsApp conversations which will be protected on my password protected phone.

All identifying information will be kept on a password protected Google Drive and physical notes will be kept in a locked file cabinet and will not be accessed.

Although the study will be conducted on WhatsApp, the information that you provide will only be used for research purposes. Your name, cell phone number, and other personal/identifying information will be removed from the findings, and a pseudonym will be used in anything I write unless you specify otherwise.

This study protocol has been approved by the University of the Witwatersrand's Human Research Ethics Committee (HREC).

If you have any queries, concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee via email: Shaun.Schoeman@wits.ac.za.

You can also contact my supervisor, Professor Lenore Manderson, who plays an oversight role on behalf of the University of the Witwatersrand at lenore.manderson@wits.ac.za or 011 717 34 30.

In case you need to contact me please do so using the following contacts:
Cell: 076 250 9048

Email: DESIREEMALOPE1@student.wits.ac.za

Thank you for reading this information sheet and for considering to take part in this research study. If you agree to participate, you will be provided with a copy of this information sheet and a signed consent form to keep

8. UNIVERSITY OF THE WITWATERSRAND

CONSENT FORM FOR KEY INFORMANT

Wellbeing in Mamelodi: Community engagement, social support and wellbeing in Kasi (township) South Africa

Good day,

You are invited to participate in a research study conducted by me, Desiree Malope. I am a student in the Department of Anthropology at the University of the Witwatersrand. The purpose of the study is to investigate the value of community organisations and the involvement of members, including how informal friendships that emerge from common interests provide social support which contribute to well-being including good mental health. If you sign this consent form, you are giving me permission to collect and use the information you provide me. Signing this consent indicates that you understand what will be expected of you and are willing to participate in this study. This consent form will be stored separately from interview data to ensure confidentiality.

I declare that:

● I have read the information, or it has been read to me.	Yes	No
● I have had the opportunity to ask questions about it and my questions have been answered to my satisfaction.	Yes	No
● I consent voluntarily and understand that I have the right to withdraw my consent without this affecting neither the current research study nor me personally.	Yes	No
● I agree to an interview being recorded on this password protected cell phone.	Yes	No
● I approve of the use of anonymised quotes.	Yes	No
● I give permission for direct quotes to be used under a pseudonym, unless specified otherwise..	Yes	No

Respondent name and signature (or fingerprint): ______________Date: ___ / ___ / ___

Researcher's Name and signature _________________________ Date: ___ / ___ / ___

9. UNIVERSITY OF THE WITWATERSRAND

Question Guide for Key Informant Interview

Study title: Wellbeing in Mamelodi: Community engagement, social support and wellbeing in Kasi (township) South Africa

Good day,

Thank you for engaging with me. As you know, my name is Desiree Malope and I am undertaking a case study for my research project on community engagements, social support, and the role of community organisations in supporting wellbeing, including good mental health among young adults.

I am interested in your group as part of a community, and I would like to explore the advantages of social groups in providing support.
The purpose of this interview is for me to know more about the group from you as the founder. I would like to ask you questions about how you and why you started the group.

I would like to begin by asking you to tell me about the group:

Firstly, when was the group established?

Why was the group established? What encouraged you to start the group?

And what was the goal behind establishing the group, what need did you see for it?

What goes into maintaining the group, how do you manage the group and do you do it alone or do you have other people helping you?

How do you recruit members of the group, how to promote and market the group to make it available/accessible to members of the community?

Who do you allow to join the group, are there specific requirements to be in the group or do you welcome anybody with an interest to join?

Can I now ask you specifically about the support of the group if someone is having a difficult time:

What kind of support did you aim for the group to offer to its members?

What role do you play in offering support to members of the group?

How many other groups do you know that are similar to yours?

My last question to you is, what are your overall plans for the group, including providing support to the group members?

Is there anything you would like to add?

Thank you very much for your participation, that is all from me. Your input, time and efforts are highly appreciated.

I wish you the very best and may you achieve everything you wish for the group.
Have a good day!

10. Contact information (helplines) for mental health institutions

Name of Organisation	Contact Number	Email address/SMS line
Itsoseng Psychiatric Clinic (located in Mamelodi at the University of Pretoria-Mamelodi campus:also known as Vista)	012 842 3515	itsoseng.clinic@up.ac.za
South African Depression and Anxiety Group	24hr helpline 0800 465 789	
Adcock Ingram Depression and Anxiety	0800 70 80 90	
Department of Social Development- Substance Abuse	24hr Helpline 0800 12013014	SMS-32312
Suicide Crisisline	0800 567 567	
South African Depression and Anxiety Group Mental Health	011 234 4837	
Akeso Psychiatric Response Unit	24hr 0861 435 787	

11. Picture of me presented to all participants