Understanding self-care perceptions and behaviours of community care workers in Cape Town to develop and assess a self-care intervention

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ABSTRACT

Community care workers (CCWs) play a crucial role in supporting disadvantaged populations, yet there is insufficient research on how these demands affect their well-being. Burnout among CCWs can lead to diminished performance, impacting their well-being as well as the well-being of the communities they serve. This study used a multi-stage approach, with an interpretivist and constructivist qualitative lens, to explore the self-care needs of CCWs, develop a self-care intervention, and test the feasibility of this intervention. Community-based participatory research (CBPR) principles were employed throughout the study, conducted within an established community organisation, Outliers. Stage 1 involved interviews with 21 CCW team leaders and revealed six key themes that helped understand self-care behaviours and perceptions in CCWs: the demanding nature of community work, attitudinal and practical barriers to self-care, the importance of a personal understanding of self-care, and the need for routine and community support in establishing self-care habits. Based on these findings, a two-session WhatsApp group intervention was designed in collaboration with the team leaders. In Stage 2, the intervention was delivered to 16 CCWs from three organisations. Two post-intervention focus groups with 10 participants reported increased self-awareness, shifts in attitudinal barriers, changes in self-care behaviours, and several barriers to adopting self- care. The use of WhatsApp found to be effective for facilitating training, reflection, and peer support. The findings of this research support the potential of co-designed, community-based participatory approaches to create culturally relevant and impactful interventions for CCWs.

Keywords: community care workers, community-based participatory research, self-care, WhatsApp intervention

TABLE OF CONTENTS

LIST OF TABLE AND FIGURES

CHAPTER ONE: INTRODUCTION

The phrase community care worker (CCW) describes individuals who either on their own or through community-based organizations (CBOs) seek to improve and empower those in their communities (Fawcett & Hanlon, 2009; Harker et al., 2016; Nzimakwe, 2008). CCWs are often from under-served populations. This proximity to adversity gives them a unique understanding of their community, enabling them to provide relevant and accessible support (Nzimakwe, 2008). The contributions of CCWs in under-resourced communities in South Africa are vital (Kajiita & Kang'ethe, 2017) and their continued well-being ensures that under-served populations can receive care and support (Hatzipapas et al., 2017; Mampane & Omidire, 2018). For human service professionals or helping professionals, burnout often feels like an inevitable part of the job (Miller & Grise-Owens, 2019); this is true for non-professionals who work in a helping role as well (Sips et al., 2014; Vawda, 2014). CCWs are especially susceptible to stress burnout and mental health issues because they share the same challenges as the community they are working to support, making them particularly vulnerable to stress, burnout and mental health difficulties (Benjamin & Carolissen, 2015; Booysen & Kagee, 2021; Hatzipapas et al., 2017; Mampane & Omidire, 2018).

Self-care refers to specific actions people deliberately take to lower stress, encourage happiness and enhance their quality of life (Bloomquist et al., 2016). Self-care relies on individuals to use personal resources (instead of formal services provided by the government or private agencies) to improve their everyday behaviours and promote their general well-being (Levin, 1977; Miller et al., 2019b). The COVID-19 pandemic highlighted the importance of self-care for caregivers as the world witnessed the emotional and physical burnout experienced by healthcare workers (Peñacoba et al., 2021). Consistent self-care is crucial for preventing burnout, compassion fatigue and disengagement for human service workers (Martínez et al., 2021; Santana & Fouad, 2017). Improving self-care practices in

CCWs would ensure their well-being and capacity to continue supporting their communities.

The adoption of self-care behaviours is, however, dependent on personal perspectives of self-care, which are shaped by experiences and context (Bloomquist et al., 2016; El-Osta et al., 2019; Miller et al., 2019a). International research indicates that human service professionals struggle to prioritise their own needs above others, making it challenging for them to adopt and maintain self-care behaviours (Barnett et al., 2007; Colman et al., 2016; Foster, 2004; Jiang et al., 2020; Lee et al., 2019; Mills et al., 2015; Wise et al., 2012; Wright, 2020). However, limited research has explored the attitudes of non-professional CCWs towards self-care and the factors informing these perceptions (Booysen & Kagee, 2021; Hatzipapas et al., 2017). Cultural norms, contextual adversities and organisational factors may influence CCWs' views on self-care and subsequently, their practice of self-care (El-Osta et al., 2019). As such, an ecologically grounded exploration is critical (Larkin et al., 2006). By understanding the self-care perspectives and needs of CCWs living and working in South African communities, contextually responsive interventions can be developed to address attitudinal and practical barriers to self-care and offer effective support for adopting and sustaining self-care practices.

1.1 Aims of Study

This study aimed to inductively explore how CCWs in the South African context perceive self-care and its potential role in sustaining their work. This formative research was then used to design a group-based intervention, and to conduct a small acceptability and feasibility study of this intervention.

The first stage of the study aimed to answer the following research question: What are the current self-care attitudes, practices and needs amongst CCWs in Cape Town non-profit

organisations (NPOs)? Based on the findings, and in collaboration with Stage 1 participants, a group-based self-care intervention for CCWs was then developed.

In the second stage of the study, this intervention was piloted with a small sample of CCWs to answer the research question: Is the pilot intervention feasible and acceptable to CCWs and how could it be improved in future iterations?

1.2 Dissertation Structure

The dissertation begins with a review of the literature on self-care and CCWs, highlighting the importance of self-care for care workers. Chapter 3 presents the methods used for implementing the two stages of the study. Chapter 4 presents the findings of the thematic analysis of the focus group discussions to understand the perceptions and current self-care behaviours of CCWs. Chapter 5 presents the design of the self-care intervention, and Chapter 6 reports the thematic analysis of the intervention participants' focus group data to provide insight into the feasibility of the study. Finally, Chapter 7 discusses the learnings of the study, and how these can be used to help CCWs. Future implications of the findings are also presented.

CHAPTER TWO: LITERATURE REVIEW

This chapter begins by examining the evolution of self-care from a predominantly medical concept to a more widely applied term across other fields. The chapter will also review the existing empirical literature on self-care among carers in the human service professions, focussing on service personnel in high-trauma, low-resourced environments. It also considers the literature on non-profit organisations and non-profit workers to explore barriers to accessing self-care. Finally, the chapter examines self-care theories that can be used to inform the development of a self-care intervention.

2.1 Origins of Self-Care Practices

The practice of self-care has been present in all cultures, originally describing the rituals, customs and behaviours that ensured basic survival (Godfrey et al., 2011; Levin, 1977; Martínez et al., 2021; McCormack, 2003). By the end of the 19th Century, self-care was incorporated into formal medicine to ameliorate the strain on the healthcare system (Levin, 1977). With the development of vaccines, antibiotics and sterilisation practices, acute diseases, such as smallpox, malaria, cholera and tuberculosis, posed less of a threat, and medicine shifted to managing chronic illnesses (Levin, 1977; Sakai & Morimoto, 2022). Medical professionals who involved the patient as an equal partner in their well-being could reduce reliance on medical staff and resources while ensuring that individuals with chronic illnesses lived well and age well (Levin, 1977; Riegel et al., 2012). By the mid-20th century, patient self-care had become an essential medical tool that referred to any actions administered by non-medical individuals, including the patients themselves, to maintain patient health outside medical facilities (Riegel et al., 2021).

Social support is an essential part of maintaining well-being (Moser et al., 2017). To sustain self-care over the long term, patients with chronic illnesses were encouraged to participate in support groups (Bloye et al., 2023; El-Osta et al., 2019; Godfrey et al., 2011).

Support groups build communities that encourage healthy lifestyle practices, enabling individuals to maintain their wellness when outside of the direct care of a physician (Bloye et al., 2023; Chien et al., 2010; Chien et al., 2011). These support groups make a pivotal contribution to the healthcare system by helping people understand their illness, develop coping skills and receive ongoing support, all whilst reducing the burden on medical human resources (Lyons et al., 2021). Alcoholics Anonymous (A.A.), established in 1935, remains one of the most famous support groups arising out of the self-care paradigm. Sustained by volunteers and community resources, A.A. invites people going through similar experiences to share with and learn from each other (Kelly et al., 2020; Munn-Giddings & McVicar, 2007). In this way, non-professionals were empowered to support each other in their well-being journey (El-Osta et al., 2019; Godfrey et al., 2011; Martínez et al., 2021).

The increased interest of individuals in their healthcare meant that individuals could be educated and encouraged to adopt healthy behaviours that prevented chronic health issues altogether (Levin, 1977; Shenkin, 1978). Self-care has gradually shifted from focusing on activities that manage existing medical issues to including those that promote overall well-being, prevent illness, and maintain health (Godfrey et al., 2011), such as healthy eating, exercising, being with loved ones, meditation, or engaging in a hobby (Kelly et al., 2020; Martínez et al., 2021; Miller & Grise-Owens, 2019). The expansion of self-care has equipped individuals to take charge of their health by making choices, in line with their preferences and priorities, to address or prevent medical issues (Godfrey et al., 2011; Levin, 1977; Martínez et al., 2021; Shenkin, 1978). This has been empowering for groups with limited access to formal healthcare options, as self-care gives vulnerable and marginalised communities the agency to care for themselves (Levin, 1977). Populations that have had services withheld from them could now take active roles in remediating their health. For many, self-care was essential to surviving oppressive systems (Prilleltensky, 2003; Wyatt & Ampadu, 2021). For example,

self-care was seen by women's movements as a means to gain autonomy over their bodies and direct their healthcare (Martínez et al., 2021). During the civil rights movement, self-care was used as a tool for social justice that showed people how to maintain physical health despite unjust and inequitable healthcare options (Wyatt & Ampadu, 2021). Self-care has also played an important role in liberation psychology, encouraging black people to see and value their bodies (Miller et al., 2019b; Prilleltensky, 2003; Wyatt & Ampadu, 2021). By valuing themselves and their contributions to society, people from marginalised groups understood the impact of caring for themselves as something beyond maintaining physical health (Lorde, 1988/2017). Instead, making decisions to care for self could also be viewed as an act of defiance against systems that are intentionally designed to disfavour, disempower and subdue black people (hooks, 1999, 2014; Lorde, 1988/2017; Sheehy & Nayak, 2020). This was a radical mind-shift for people historically treated as inferior, and self-care was promoted as an "act of political warfare" (Lorde, 1988/2017 p. 85).

After the COVID-19 pandemic in 2020 and ensuing lockdown protocols, there was a renewed focus on self-care (Aarts et al., 2021; Ben Gal et al., 2020). Particular concern was held for those in the human services field, who had been exposed to so much death and trauma (Mercado et al., 2022; Tosone, 2021). The well-being of those who work in the service of others has traditionally been overlooked, leaving those who support vulnerable people feeling overwhelmed and under-supported (Bressi & Vaden, 2017; Foster, 2004; Miller et al., 2019a). Rather than beneficiaries of self-care, they were primarily considered the promoters and enablers of self-care for others (Cilluffo et al., 2024; Granath et al., 2022). However, during the COVID-19 pandemic, the strain on the healthcare sector emphasised the importance of caring for these essential workers (Morelen et al., 2022; Peñacoba et al., 2021; Tosone, 2021).

2.2 Caring for the Carer

Human service work can be defined as any work that provides support and care to people in need (Bopp et al., 2019). This includes, but is not limited to, counselling, education and medical services. When workloads increase with no corresponding increase in support (e.g., finances, resources or training), human service workers are placed under intense pressure to meet unrealistic targets, placing them at high risk of burnout (Colman et al., 2016; Rantonen et al., 2019). Burnout is a psychological condition that includes debilitating emotional exhaustion, anxiety, detachment, and an incapacity to complete even basic tasks (Bressi & Vaden, 2017; Miller et al., 2019a). Burnout is more likely to occur in service workers constantly exposed to traumatic events (Colman et al., 2016; Thormar et al., 2010). Workers who do not engage in preventive or corrective behaviours and ignore symptoms of exhaustion can suffer physical and mental consequences in all areas of their lives (Foster, 2004; Hatzipapas et al., 2017). This can also lead to engagement in destructive coping mechanisms, such as abusing drugs or alcohol, which have far-reaching and long-term repercussions (Dattilio, 2023).

Self-care, on the other hand, allows individuals to take control of their well-being in a way that is cognisant of personal contexts and barriers (Levin, 1977; Miller et al., 2019a). Unlike medical self-care and the healthy management of chronic illness, self-care activities to prevent burnout help workers successfully manage the stress and pressure of their work so that they can continue to support others (Barnett et al., 2007; Kello & Allen, 2022). The Self-Care Matrix (SCM) summarises seven categories of self-care activities: basic knowledge of health, mental well-being, physical activity, healthy eating, eliminating risky behaviours, good hygiene and making use of available services (El-Osta et al., 2019; Kello & Allen, 2022). Self-care activities should be easy to implement, within the control and capabilities of the individual, and part of the daily activities of a well-functioning service worker (Barnett et

al., 2007; El-Osta et al., 2019; Kello & Allen, 2022).

Adopting self-care activities has been found to reduce burnout in human service professionals such as community health workers (Booysen & Kagee, 2021), aid workers (Dewar et al., 2023), nurses (Foster, 2004; Mills et al., 2015), social workers (Bressi & Vaden, 2017; Jiang et al., 2020; Martínez et al., 2021), and psychologists (Barnett et al., 2007; Colman et al., 2016; Dorociak et al., 2017; Wise et al., 2012). Adopting self-care not only lowers stress but creates awareness about stress that can help professionals recognise the signs of burnout (Martínez et al., 2021). Professionals unable to recognise these signs are at risk of suffering negative mental and physical consequences that reduce their ability to continue their work (Barnett et al., 2007; Foster, 2004; Jiang et al., 2020; Miller et al., 2019a; Wise et al., 2012). This is not only dangerous to the professional but may also impair or disrupt care to the communities they support (Barnett et al., 2007; Bressi & Vaden, 2017; Wise et al., 2012), making self-care a moral responsibility for human service professionals (Barnett et al., 2007; Foster, 2004; Hatzipap.as et al., 2017; Jiang et al., 2020; Wise et al., 2012; Wright, 2020). With support and training, professionals can establish routines that replenish themselves to engage with clients safely and empathetically without becoming overwhelmed (Bressi & Vaden, 2017; Dattilio, 2023; Jiang et al., 2020). This can be difficult for those who dedicate their time to the service of others as the term self-care has been co-opted by lifestyle sectors and popularised by expensive activities that can appear indulgent (Fuller, 2018). However, self-care is not a luxury but a requirement for adequate, sustainable and professional care (Barnett et al., 2007; Hatzipapas et al., 2017; Mills et al., 2015; van Dierendonck et al., 2001; Wise et al., 2012; Wright, 2020).

The human service sector also includes the work of charities that offer services to vulnerable populations through non-professional carers (Brown et al., 2019) and caregivers who operate alongside welfare services, such as foster parents (Miller et al., 2019a). These

workers endure traumatic and highly emotional environments without benefiting from formal training for their vocation. Without training, carers can over-identify with beneficiaries, making it harder for them to disengage or be impartial (Cobbing et al., 2017; Folorunsho & Tanga, 2021; Martínez et al., 2021; Miller et al., 2019b; Peltzer & Davids, 2011). Personalising the struggles of beneficiaries leads to compassion fatigue and burnout, limiting the impact of the care these workers provide and putting their well-being at risk (Booysen & Kagee, 2021; Hatzipapas et al., 2017; Miller et al., 2019b).

2.3 Community Work in South Africa

Community care workers (CCWs) are non-professional workers without formal qualifications who are affiliated with non-profit organisations (NPOs), where they play a crucial role in delivering resources and expertise to people in under-served communities (Hatzipapas et al., 2017; Makoba, 2002; Mampane & Omidire, 2018; Ngandu & Motala, 2019). NPOs are involved in various fields as activists, researchers, service providers, and coordinators of humanitarian aid in disasters (Volmink & van der Elst, 2017). Government services, particularly in lower-income countries, are often inadequate to meet the needs of every community and governments rely on NPOs to either take their services into communities or provide augmented support to under-served populations (Abegunde, 2009; Makoba, 2002; Ngandu & Motala, 2019; Sithole et al., 2024; Volmink & van der Elst, 2017). As such, the NPO sector in South Africa is allocated government funding at both national and provincial levels (Ngandu & Motala, 2019) and, as in many other countries, their contribution is financially acknowledged through tax benefits (Gupta & Spreen, 2023; Sithole et al., 2024; Steenkamp, 2014; Weisbrod & Mauser, 1991; Zare et al., 2021).

However, not all NPOs benefit equally from financial support. The South African NPO sector is unequally balanced, compounded by the lengthy process to receive tax benefits and qualify as a public benefit organisation (Sithole et al., 2024). This tax benefit status,

along with powerful branding, celebrity endorsements and healthy financials, is how 10% of NPOs dominate the funding opportunities in South Africa (Ngandu & Motala, 2019). The remaining 90% of NPOs, many of which are faith-based and community-based organisations (CBOs), are severely underfunded and under-resourced.

Notwithstanding this lack of resources, these CBOs, run by community members, continue to offer readily adaptable solutions due to their proximity to the people they serve (Abegunde, 2009; Makoba, 2002; Volmink & van der Elst, 2017). Consequently, CBOs contribute significantly to the economic improvement and development of communities (Hatzipapas et al., 2017; Makoba, 2002), with many vulnerable communities, such as informal settlements, receiving most of their daily support from CBOs (Abegunde, 2009). The operational capacity of these CBOs is directly dependent on the capacity of their staff, who are typically unpaid or stipended CCWs, to provide cost-effective service delivery to marginalised populations (Makoba, 2002; Volmink & van der Elst, 2017). However, despite their role in supporting the most at-risk and inaccessible people in the NPO sector, CCWs are a continuously overlooked cohort (Hatzipapas et al., 2017; Mampane & Omidire, 2018).

Research with workers in the human service sector typically focuses on professionals (those with formal qualifications and training) and excludes non-professional service providers. Most articles on care workers in South Africa focus on community health workers (Cobbing et al., 2017; Hand et al., 2021; Lorenzo et al., 2015; Murphy et al., 2020; Swartz & Colvin, 2014). These workers are trained specifically for a particular health-related care activity, such as HIV/AIDS counselling (Campbell & Baernholdt, 2016; de Neve et al., 2017; Engelbrecht et al., 2017; Nair & Campbell, 2008), rehabilitation care (Motswasele-Sikwane et al., 2020; Scheffler & Mash, 2023) or tuberculosis (Ahmed et al., 2021; Okeyo & Dowse, 2016; Uwimana et al., 2012). Some are associated with NPOs and work in the community they serve but are supervised, trained and paid by a higher health body and/or provincial

government agency (Motswasele-Sikwane et al., 2020; Schneider & Nxumalo, 2017). A smaller portion of studies focus on community development workers, a subset of community workers who partner with local governments that supervise, pay and train them to perform specific roles (Gray & Mubangizi, 2010; Mundau & Tanga, 2017).

In South Africa, some CCWs are solely affiliated with CBOs and are not supervised, trained or paid by the state or local government. There is a notable lack of research on this care worker cadre; a literature search yielded fewer than ten studies. These CCWs live in the communities they serve and face unique challenges and self-care needs, often experiencing many of the same traumas as those they assist (Benjamin & Carolissen, 2015; Booysen & Kagee, 2021; Hatzipapas et al., 2017; Mampane & Omidire, 2018; Sips et al., 2014). Though this shared experience can contribute to developing efficient and effective solutions, it can also lead to additional stress (Hatzipapas et al., 2017; Mampane & Omidire, 2018; Sips et al., 2014). CCWs living in the communities they serve often have deep emotional connections and firm commitments to their beneficiaries, making it challenging to set boundaries regarding time, availability, and emotional investment (Hatzipapas et al., 2017; Mampane & Omidire, 2018). Unable to distance themselves, CCWs frequently jeopardise their well-being to meet the needs of others, which can lead to financial difficulties (Booysen & Kagee, 2021; Sips et al., 2014) and high emotional costs as their own trauma is compounded by the suffering around them (Booysen & Kagee, 2021; Hatzipapas et al., 2017; Mampane & Omidire, 2018). This can impose significant burdens on CCWs, who often belong to marginalised groups, typically women, and are unpaid and economically disadvantaged (Sips et al., 2014).

There is little job or salary security in CBOs, which results in high support team turnover as the stresses of the work often outweigh financial compensation (Skhosana, 2020). CCWs who run their organisations, however, usually find it difficult to walk away from their

work and, instead, build long-lasting relationships with beneficiaries (Hatzipapas et al., 2017; Sips et al., 2014). Their experience and longevity mean that even established organisations rely on them to support their trained staff members (Mampane & Omidire, 2018). This connection to their beneficiary often leads CCWs to go above and beyond the limits of their organisation's resources to carry out their duty to their community (Cobbing et al., 2017; Mampane & Omidire, 2018).

The distinction between unpaid work and voluntary work is important to highlight when considering CCWs. Where all NPOs rely on voluntary work, volunteers are traditionally regarded as people from affluent communities who give their free time in communities other than their own (Williams, 2001; Windsor et al., 2008). CCWs' responsibilities are more accurately considered “unpaid care responsibilities, which go beyond what is understood to be voluntary work” (Ngandu & Motala, 2019, p. 34). This burden of care stems from the regard for their work as a vocation (Booysen & Kagee, 2021; Hatzipapas et al., 2017; Mampane & Omidire, 2018). The calling they feel for their work means they enter the field through informal pathways and some never get the chance to be formally trained (Nzimakwe, 2008; Simsa, 2003; Thormar et al., 2010). They are considered non-professionals (Mampane & Omidire, 2018), community members (Hatzipapas et al., 2017), volunteers (Sips et al., 2014; Vawda, 2014) or non-specialists (Booysen & Kagee, 2021). There is a direct financial consequence to this, as untrained community workers are paid less than trained staff (Volmink & van der Elst, 2017). However, there is also a considerable emotional and capacity cost. Training is necessary to develop practical work skills as well as much-needed coping skills to manage the personal cost of caring for others (McSweeney & Alexander, 1996). Untrained community workers often feel helpless and overwhelmed and are at high risk of vicarious traumatisation and burnout (Booysen & Kagee, 2021; Hatzipapas et al., 2017; Kuenzi et al., 2021; Mampane & Omidire, 2018; Vawda,

2014).

As with healthcare professionals, self-care for CCWs should be an ethical imperative, as emotionally exhausted CCWs cannot effectively fulfil their roles, which places both them and their beneficiaries at risk (Hatzipapas et al., 2017; Mampane & Omidire, 2018). Routine self-care would help ensure CCWs do not experience burnout and continue to have reserves to tend to the people around them (Moss, 2023). Without access to self-care training as part of their preparation for community work, CCWs are left ill-equipped for their vital but demanding role.

2.4 Barriers to Self-Care for Community Care Workers

Accessing mental health care depends on the political, cultural, and personal beliefs individuals hold (Miller et al., 2019a). In South Africa, seeking mental health support is still stigmatised and viewed with scepticism and distrust in communities that have never had equal access due to historical and ongoing healthcare inequities (Coates et al., 2018; Lund et al., 2012). Though work is being done to make psychology more relevant to under-served communities, there remains a lingering inaccurate understanding of mental health and mental illness, and of what mental health support is (Bradshaw et al., 2006; de Kock & Pillay, 2016).

Attitudes regarding mental health impact the understanding of self-care. In times of economic deprivation, taking care of oneself may be considered selfish (Fuller, 2018; Mills et al., 2015) and a luxury that only the affluent may indulge in (Yen, 2016). These beliefs are reinforced by community and cultural norms that consider self-care to be inconsistent with the ubuntu philosophy, which emphasises the needs of the community over those of the individual (Haine et al., 2022; Swartz & Colvin, 2014). Additionally, narratives about community care work often depict sacrifice as heroic (Adamson & Arévalo, 2017) and deny the emotional toll of working in high-trauma environments (Kosny & MacEachen, 2009; Prilleltensky, 2003). CCWs are encouraged to be resilient rather than to acknowledge or

address their suffering and the systemic inadequacies that contribute to it (Adamson & Arévalo, 2017; Diprose, 2015). When resilience is synonymous with strength, then fatigue and burnout is synonymous weakness. These beliefs are widespread in African carers, who often suppress their own emotional and physical needs in service of others (Hatzipapas et al., 2017; Mills et al., 2015). Black women often grow up with narratives that valorise self-sacrifice, praise martyrdom, and frame struggles as tests of personal resilience (Diprose, 2015; Lorde, 1988/2017). Falling short of such expectations can lead to feelings of worthlessness and further self-neglect (Baloyi, 2020). These socially and historically rooted attitudinal barriers can prevent CCWs, especially women, from prioritising themselves over their work. Recognising these intersectional influences on constructions of self-worth, acts of self-care by members of marginalised and historically oppressed communities, particularly black women, have been positioned as radical acts of opposition against dominant narratives (hooks, 1999, 2014; Lorde, 1988/2017; Michaeli, 2017; Wyatt & Ampadu, 2021).

Along with attitudinal barriers, self-care has also been inhibited by a critical shortfall in the human, financial and infrastructural resources available to vulnerable South African communities (Booysen & Kagee, 2021; de Kock & Pillay, 2016; Henning-Pugh et al., 2023; Lund et al., 2012; Vawda, 2014). CCWs living in rural areas have little to no access to well-being support (Bradshaw et al., 2006; de Kock & Pillay, 2016). Additionally, there is little research in this area, with only one documented trial of a self-care intervention with this cohort in South Africa (Hatzipapas et al., 2017). In this trial, a specialist conducted sessions in laughter therapy at the organisation where the CCWs worked. The intervention reported positive impacts: increasing positive emotions, building stronger connections with peers, making CCWs more aware of stressors and ultimately improving their care work (Hatzipapas et al., 2017). While the supervised intervention was effective, CCWs lost access to support once the study concluded, and no follow-up was put in place to support what they had learned

or assist in applying self-care skills beyond the study's framework. The study was conducted in person using the organisation's venue. This was to remove a practical barrier to access, as participants could get to their organisation (Hatzipapas et al., 2017). However, this might not solve the problem for all CBOs, who are reliant on the goodwill of others for a venue, or do not have a big enough space for training (Abegunde, 2009). Additionally, the ability to get to a location at a specific time is a common barrier to accessing care (Kyei-Nimakoh et al., 2017). Emails, phone calls and online platforms have been trialled as alternatives to in-person meetings to increase accessibility; however, lack of familiarity and awareness limits engagement (Atherton et al., 2018; Brant et al., 2016). Self-care mobile applications suffer these same barriers along with additional ones such as inaccurate or insufficient information, unclear credentials, privacy concerns and lack of user-friendliness (Tofighi et al., 2019).

In sum, self-care has been shown to alleviate stress and prevent burnout in traumatised, overwhelmed and under-resourced professionals (Booysen & Kagee, 2021; Bressi & Vaden, 2017; Dewar et al., 2023; Jiang et al., 2020; Martínez et al., 2021; Miller et al., 2019a). It is likely that CCWs would benefit from accessible self-care options tailored to their unique stressors and challenges, which would enhance their ability to continue providing essential support to those in need (Hatzipapas et al., 2017; Mampane & Omidire, 2018).

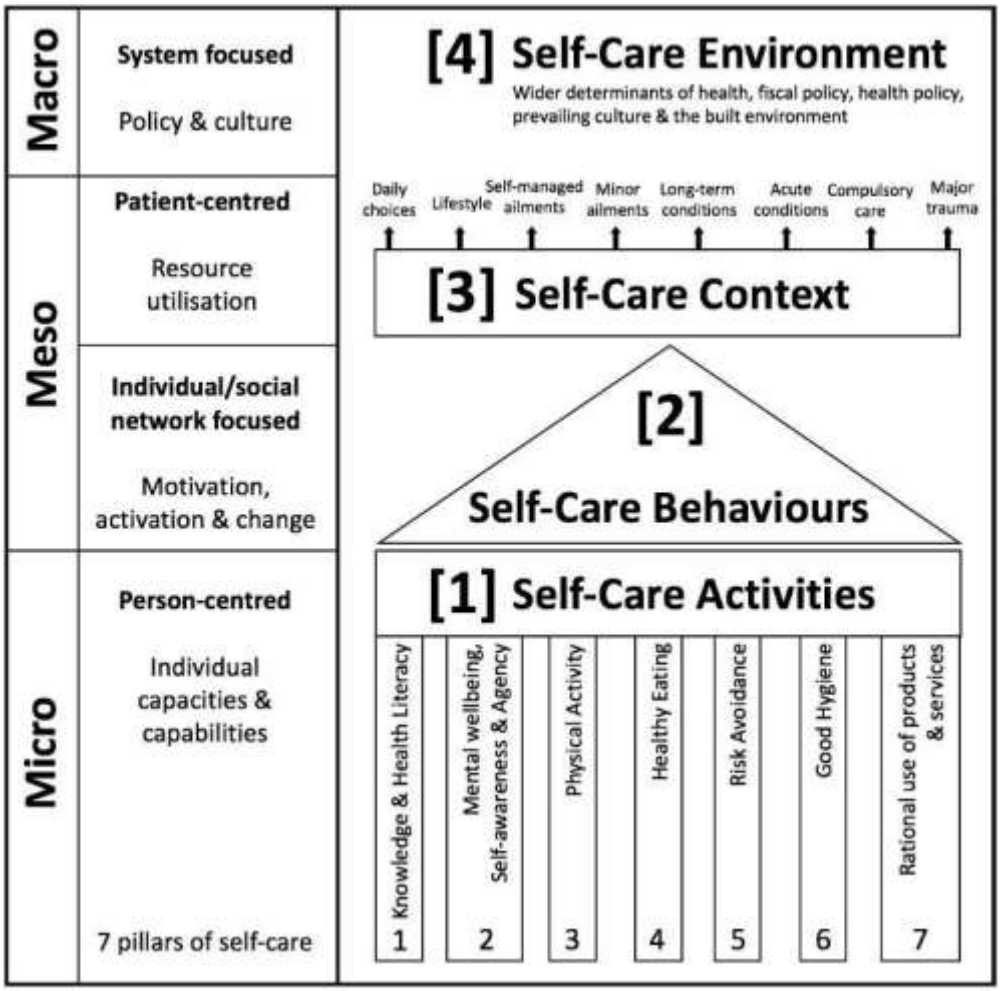
2.5 Theoretical Frameworks

Self-care models provide valuable frameworks for understanding the factors that influence an individual's ability to engage in self-care practices. The Self-Care Matrix (SCM; El-Osta et al., 2019) reviewed 32 different self-care models to create a single matrix to illustrate the full context in which self-care interventions sit (Figure 1). The matrix considers how personal abilities, surrounding society and political influences impact self-care by organising self-care into three levels: micro, meso, and macro (El-Osta et al., 2019).

Together, these levels provide a comprehensive framework to understand and support self-care, linking individual actions to broader systemic and environmental contexts. Though interventions might be aimed at a single level, the SCM highlights how micro-level activities (i.e., the adoption of self-care activities) are influenced by meso-level resources (e.g., social support) and macro-level environments, policies, infrastructure and culture (El-Osta et al., 2019).

Figure 1

The Self-Care Matrix (SCM) (El-Osta et al., 2019).



The micro level focuses on what actions an individual has the capacity for. Using seven pillars of self-care, these activities range from increasing self-care knowledge to utilising services in one's environment (El-Osta et al., 2019). The meso-level considers the behavioural and contextual requirements to sustain healthy habits and lifestyle choices. Social networks and improving access to resources can support self-care in ways that go beyond the individual (El-Osta et al., 2019). The final level examines the broad systems that facilitate or inhibit self-care. The public health landscape is highlighted in the macro-level impact which shows how societal attitudes and policy affect individual self-care behaviours (El-Osta et al., 2019).

Adopting a more person-centred perspective, the Foster Parent Model (FPM; Miller et al., 2019a) of self-care was developed to explore how foster parents engage in self-care and to identify strategies to support them in fulfilling their vital roles. The FPM suggests that self-care is a journey that needs to consider context, current behaviours and beliefs, support systems and resources before eventually adopting self-care actions (Miller et al., 2019a). The model acknowledges that expecting foster parents to make this journey in isolation is unrealistic. It suggests that training and support are needed to help untrained carers build knowledge and develop skills to care for themselves (Miller et al., 2019a). In this way, the model leans less towards adopting a specific self-care behaviour and more towards aiding carers to develop self-care skills such as self-awareness and reflexivity (Miller et al., 2019a). Much like CCWs, foster parents are often overlooked and stretched beyond their capacities, needing to rely on their own agency and resources to ensure their well-being (Miller et al., 2019a). Because of this, the FPM is not prescriptive in the self-care behaviour that should be adopted; instead, it suggests that these should be self-selected behaviours suitable to the individual, dependent on their context and resources (Miller et al., 2019a). Though an individual decision, FPM advocates for guidance when choosing relevant and meaningful

self-care behaviours, as well as support from friends and family to maintain the behaviour (Miller et al., 2019a). The FPM emphasizes that having transferable self-care skills and long-term support allows carers to develop sustainable self-care habits that can adjust to their unpredictable lifestyle (Miller et al., 2019a).

The Middle Range Theory of Self-Care (MRT; Riegel et al., 2012) expands on the importance of continually assessing needs and refining self-care actions. Developed specifically for patients with chronic illnesses, it proposes that self-care can be effectively implemented over a lifetime if patients are taught how to monitor, assess and adjust behaviours, resources and support (Riegel et al., 2012). The MRT encourages individuals to continually assess their needs and refine their actions based on their current motivation, beliefs, values, skills and capacity (Riegel et al., 2012). The ability to monitor, reflect and adjust helps an individual to maintain relevant and impactful self-care actions over a lifetime (Riegel et al., 2012).

Finally, the Behaviour Change Wheel (BCW; Kaur et al., 2022) offers different strategies that can be used within an intervention. These are “education, persuasion, incentivisation, coercion, training, enablement, modelling, environmental restructuring, and restrictions” (Kaur et al., 2022, p. 148). The BCW further provides the APEASE (Acceptability, Practicability, Effectiveness, Affordability, Safety, Equity) criteria to assist in selecting the most appropriate intervention strategy (West et al., 2019). Interventions designed to promote self-care among CCWs need to consider their unique context and the barriers they face. The SCM emphasises that an individual’s ability to access self-care depends not only on their personal capacity but also on their community and broader society. Where the SCM looks outward, the FPM and MRT focus inward. These models take advantage of the personalisation of self-care, championing the development of transferable self-care skills that can be applied across various situations to ensure lifelong self-care

behaviours tailored to the individual.

2.6 Conclusion

The history of self-care highlights its essential role in promoting health and well-being. From its origins in survival rituals to its incorporation into modern healthcare systems, self-care has empowered individuals to take control of their well-being. Self-care has also distinguished itself in the human service sector. Though CCWs in South Africa provide essential services to socioeconomically marginalised communities, they remain an invisible cohort within this sector. This lack of representation has consequences not only for CCWs but also for the communities they serve. Self-care potentially provides an accessible way for CCWs to prevent burnout, manage stress, and renew their passion for their work. However, self-care theories propose that effective interventions need to be culturally sensitive and context-specific and, further, must equip participants with transferable skills that can maintain life-long self-care behaviours. Developing a feasible and effective self-care intervention for CCWs in South Africa requires careful engagement with these principles.

CHAPTER THREE: METHOD

This study is divided into two stages. The first stage explores self-care attitudes, practices and needs among CCWs working in Cape Town NPOs. This step aimed to uncover how self-care is perceived in socioeconomically marginalised South African communities and identify ways to support the adoption of accessible self-care behaviours. This qualitative engagement with CCW team leaders was essential to understanding their perspectives on self-care, shaped by their unique cultural, historical, and social contexts. Building on these insights, an intervention was designed based on the lived experiences of the CCW team leaders. Stage 2 addressed the second research question, assessing the feasibility and acceptability of the newly designed intervention through qualitative engagements with a small group of participants who took part in the intervention.

This chapter presents an overview of interpretive and constructivist qualitative research and community-based participatory research (CBPR), highlighting how these principles influenced the study methods. It then examines each stage of the research process in detail, including the sampling, data collection, and data analysis. Lastly, it outlines the ethical considerations associated with the research.

3.1 Study Design

An interpretivist and constructivist qualitative approach was used in this study. Interpretivism emphasises understanding phenomena from the viewpoint of participants and its foundation lies in the idea that reality is subjective and socially constructed (Alborough & Hansen, 2022; Larkin et al., 2006; Lin, 1998; Smith, 2008) This paradigm emphasises the contextual and complex character of human experiences which makes it especially appropriate for this study which seeks to precisely comprehend the individual and group self-care experiences of CCWs in their setting. This paradigm acknowledges a "double

hermeneutic" (Smith, 2008, p. 53), where participants interpret their own experiences, and the researcher further interprets these insights to establish a well-rounded understanding (Larkin et al., 2006; Smith, 2011). The constructivist paradigm values the voices of the participants and aims to create spaces for them to explore, reflect and collaborate to co-construct their knowledge and find meaning in their experiences (de Oliveira, 2024; Larochelle & Bednarz, 1998), but also recognises the influence of the researcher in shaping qualitative data collection and interpretation (Larochelle & Bednarz, 1998; Sheikhbahaeddinzadeh & Ashktorab, 2022).

Additionally, this study used CBPR principles that depend on mutual respect and trust between the researcher and community members to accurately translate findings into changes that can be implemented to meet community needs (Stanton, 2013). CBPR prioritises bi-directional learning, recognising the value of community knowledge and lived experiences (Anderson & Cidro, 2019; Springer & Skolarus, 2019; Stanton, 2013). As such, the CCW team leaders in Stage 1 were involved as designers, which ensured that intervention was directly informed by community needs and delivered in an accessible, culturally relevant manner (Anderson & Cidro, 2019; Springer & Skolarus, 2019). However, meaningful input is only possible through trusting relationships and honest engagement (Stanton, 2013). For this reason, the study was conducted in partnership with Outliers NPO (outliers.org.za), co-founded by the researcher in 2014, which supports after-school programs in lower-income Cape Town communities by training CCWs and providing them with resources to create safe after-school programs for young people. By working within an established organisation, the study highlights how important trust and sustained support are to establishing the groundwork for long-lasting self-care practices that will help CCWs long after this study is over (Stanton, 2013). By following CBPR principles community interests were always prioritised and collaborations came from sincere, established relationships between the researcher and

participants (Stanton, 2013).

The ontological tenets of constructivism, interpretivism and CBPR all support qualitative research aimed at understanding and resolving intricate social issues. Interpretivism and constructivism provide a philosophical foundation for CBPR by valuing subjective knowledge, relational dynamics, and co-created meaning (Alborough & Hansen, 2022; Bagnoli, 2022; von Glasersfeld, 1998). CBPR gives collaborative, community-centred action to these paradigms through its commitment to equitable partnerships, community needs, cultural relevance, and practical, implementable outcomes (Anderson & Cidro, 2019; Springer & Skolarus, 2019). Ultimately, it encourages community members to contribute by enabling them to both frame the issues they encounter and come up with solutions. By employing these strategies the study sought to produce contextually grounded and nuanced insights that would guide a customised self-care intervention for CCWs in the Outliers network.

3.2 Stage 1 Methods

Stage 1 of this study explored how CCW team leaders in the Outliers community perceive self-care and self-care behaviours. This knowledge and insight then informed the development of a self-care group intervention to promote and develop[[self-care in CCWs working for these organisations.

3.2.1 Sample

The Stage 1 sample consisted of 21 CCW team leaders from NPOs affiliated with Outliers. A team leader is a CCW who oversees a project and may coordinate a team of CCWs. As such, these leaders are representatives of the experiences of CCWs in their community. As leaders of their programmatic response, these CCWs regularly contribute to and participate in the training offered by Outliers. Since an NPO may have multiple programmes, some organisations have more than one team leader. A total of 37 organisations

had signed up with Outliers in 2023, with 58 team leaders. To ensure that the most "authentic and legitimate community representatives" contribute to the co-design of the intervention (Smith & Blumenthal, 2012, p. 78), only team leaders who lived in the community they serve were invited to participate in Stage 1 of this study. Team leaders who did not live in the community were excluded (seven organisations, 10 leaders). CBPR relies on trust for honest engagement. This takes time to build and, for this reason, leaders who had started their affiliation with Outliers in 2022 were excluded (four organisations, seven leaders). Organisations with less than three CCW team members were also excluded from this study, as the aim was to develop a group-based self-care intervention rather than an individual one (one organisation, one leader).

Using these selection criteria, 40 eligible team leaders were identified, representing 25 organisations. Each team leader was invited to participate in the study via WhatsApp (Appendix A). Of the 40 leaders, 26 expressed interest and completed the consent form (Appendix B). The remaining leaders were unable to participate due to prior commitments. To increase accessibility and minimise travel costs, the 26 leaders were divided into five groups based on their geographical location and proximity to a secured venue to host sessions. Of the 26 leaders, 15 were able to attend in-person sessions. To increase participation for the remaining CCWs, an online group session was hosted with four leaders, and individual interviews over telephone calls were held with two leaders. A total of 21 team leaders from 16 organisations contributed to the discussions. The remaining five leaders could not make the scheduled times for focus groups, online groups, or telephone calls, and they were handed over to Outliers for follow-up. The demographic information of the 21 participants is presented in Table 1.

Table 1

CCW Team Leaders in Stage 1

Discussion format and venue	Community served	Gender	Home language	Experience in community work (years)
In-person: Delft	Goodwood	Female	English	30
In-person: Delft	Goodwood	Female	English	5
In-person: Delft	Delft	Female	English	7
In-person: Delft	Delft	Female	English	10
In-person: Delft	Belhar	Female	English	20
In-person: Delft	Belhar	Female	English	16
In-person: Philippi	Gugulethu	Female	isiXhosa	12
In-person: Philippi	Gugulethu	Female	isiXhosa	22
In-person: Philippi	Philippi	Female	isiXhosa	15
In-person: Philippi	Philippi	Female	isiXhosa	18
In-person: Philippi	Nyanga	Female	isiXhosa	20
In-person: Nyanga	Nyanga	Female	isiXhosa	30
In-person: Nyanga	Nyanga	Female	isiXhosa	30
In-person: Nyanga	Nyanga	Female	isiXhosa	5
In-person: Nyanga	Nyanga	Male	isiXhosa	15
Telephone call	Ocean View	Female	English	13
Telephone call	Strandfontein	Female	English	30
Online focus group	Khayelitsha	Female	isiXhosa	20
Online focus group	Langa	Female	isiXhosa	10
Online focus group	Delft	Male	English	4
Online focus group	Gugulethu	Female	isiXhosa	20

Of the 21 participants, 90% were female and 10% were male, reflecting the extant skewed gender representation of CCWs more broadly. The predominant home language of team leaders was isiXhosa (57%), followed by English (43%). Though their experience ranged from four to 30 years, the median of 16 years, with average of 16.2 years, reflects a more typical level of experience, which was slightly skewed by long-serving participants.

3.2.2. Data Collection

Stage 1 of this study used exploratory, qualitative research methodology to understand how self-care is understood and experienced by team leaders through focus groups and semi-structured interviews. Data collection methods such as interviews, focus groups, and observations align well with an interpretivist approach, as they enable in-depth exploration of the lived experiences of participants and the meaning they attach to them (Alborough & Hansen, 2022; Lin, 1998). During these interviews, the researcher offers guiding questions but does not direct the conversations towards a predefined agenda or pre-existing framework (Larkin et al., 2006; Smith, 2011). A sociodemographic questionnaire was included with the consent form sent to CCW leaders and collected using REDCap forms (Appendix B). These questions were included in this stage to highlight the contribution of black female voices in this study.

The researcher designed semi-structured interview questions to guide the focus groups and individual interviews (Appendix C). This allowed each conversation to be guided by the same questions whilst still providing the flexibility needed for participants to explore ideas and engage authentically with each other (de Oliveira, 2024; Sheikhbahaeddinzadeh & Ashktorab, 2022). The guiding questions were developed to: a) elicit current self-care perceptions and behaviours of CCWs, and b) determine how self-care behaviours could be encouraged in CCWs. The questions were deliberately broad and open-ended to encourage storytelling and detailed responses (Larkin et al., 2006; Smith, 2011).

Focus groups provide an open space for meaningful participant engagement while minimising researcher influence, allowing knowledge to emerge from team leaders' lived experiences and perspectives (Wilkinson, 1998). This input gave authenticity to the data that informed the co-design of the subsequent intervention (Carolissen et al., 2010; Wilkinson, 1998). Focus groups offer participants a space to listen to one another, which enhances their understanding and helps them co-create their experiences of self-care (de Oliveira, 2024; Wilkinson, 1998). Focus groups allow participants to share experiences, interact socially and co-learn, which aligns with the constructivism paradigm and CBPR values (de Oliveira, 2024; Stanton, 2013). Outliers often employs this style of sharing in group facilitation, as it affords diverse perspectives to be included within training sessions. This method would therefore be familiar to team leaders, who would feel comfortable to share. Since Outliers works in a multilingual setting, focus groups also allow participants to communicate in their home language as other participants can act as interpreters, ensuring that participants are not excluded due to language differences (Wilkinson, 1998). During the focus groups, leaders mostly communicated in English. Occasionally, a colloquial term or cultural experience needed to be expressed in their home language. In these cases, the idea was expressed to others in the room and, collectively, they interpreted it into English or found analogies to explain it to the rest of the group and facilitator. Focus groups made up of trusted participants meant that no idea was silenced.

Although focus groups were the preferred data collection method, semi-structured interviews were also conducted to gather insights from additional participants who could not attend the groups. The researcher used the same focus group questions for two telephonic interviews, maintaining a non-directive approach to allow participants to share their experiences in their own words (Brocki & Wearden, 2006). Each session concluded with a summary by the researcher to provide the participants an opportunity to correct any

misunderstandings and raise additional points (Brocki & Wearden, 2006). All focus group discussions and interviews were audio-recorded using two mobile devices owned by the researcher and saved as mp3 files.

3.2.3. Procedures

The researcher invited eligible team leaders to join the study via WhatsApp. The researcher followed up with a telephone call to leaders who expressed interest and explained the full scope and purpose of the study. Specifically, team leaders were asked to commit to attending one focus group session, to share knowledge to help design an intervention, and to then invite members of their CCW teams to participate in a small feasibility test of the intervention. Team leaders willing to participate were sent a link to a consent form prepared on REDCap. Of the 40 team leaders invited, 26 filled in the consent form and agreed to participate in the study. To increase accessibility and minimise travel costs, team leaders were divided into groups based on their geographical location. Five groups were created: Delft, Philippi, Nyanga, Khayelitsha, and Strandfontein. WhatsApp groups were created to coordinate the logistics of each focus group session. These were hosted at various organisations depending on the group. The Nyanga host operated out of their founder's home, and the group met in her living room. The Delft host had use of a church room from which they operated their organisation. The Phillipi host was the most resourced, and we met at the organisation's premises in a training room. Online platforms and telephonic interviews were used when leaders could not attend in-person sessions. Ultimately, three in-person focus groups, one online focus group, and two telephonic conversations with individual leaders were conducted. The online group was conducted over a WhatsApp video call.

The researcher facilitated each 90-minute focus group. Sessions were introduced with an explanation of the scope and purpose of the study and a request for permission to record the session. The researcher explained her commitments to the group, as detailed in her

confidentiality agreement (Appendix D), and ensured sufficient time was given at the end of the sessions for further questions or comments by participants.

Data collection yielded a total of six audio files, comprising 383 minutes of recorded discussions from the focus group sessions and individual conversations. The audio files recorded in each session went through a first round of transcription using the transcription software Otter.ai. The researcher reviewed and edited the initial transcription on Otter.ai by listening to the original files alongside the transcribed data. At this point, any identifiable features in the data, such as names, personal descriptions or organisational descriptions were removed from the transcripts. Text files were then downloaded from Otter.ai and deleted from the online program. This textual data was saved in both MS Word and PDF format and uploaded, along with the audio files, onto secure cloud storage owned by UCT. UCT OneDrive storage complies with POPIA legislation, is accessible only to the researcher, and is password protected. This data will only be stored for the duration of the researcher's time at UCT. The audio files, MS Word and PDF copy of each focus group were also saved on a password-protected computer owned by the researcher in a password-protected folder.

3.2.4 Data Analysis

Reflexive Thematic Analysis (RTA; Braun & Clarke, 2021) was used to explore themes that emerged in the focus groups, using a six-step process. RTA is a flexible approach that considers the reflective interaction of the researcher with the data as a resource in identifying themes from a dataset that addresses the research question (Braun & Clarke, 2021).

In step one, the researcher immersed herself in the data by listening to recordings immediately after each session and then reviewing the automated transcriptions created by Otter.ai for accuracy against the audio files. This enabled the researcher to familiarise herself with the entire data set before starting the coding process (Braun & Clarke, 2021). In step two, the transcripts were coded line by line. Every contribution relevant to the research

question was assigned a code to capture its meaning (Braun & Clarke, 2021). Each identified code was listed on an Excel spreadsheet, and codes were compared across the six conversations. After each transcript was analysed, the data were compared with existing codes in the spreadsheet from previously analysed transcripts and, where a novel code was identified, it was added to the spreadsheet. In step three, codes that shared a similar underlying concept were grouped into distinct sub-themes and then merged into higher-order themes (Braun & Clarke, 2021). This third step took several refinements to identify themes that best represented the data and provided meaningful contributions to the research question. In step four, core members of the Outliers team reviewed the themes, guided by the five questions provided by Braun and Clarke (2021):

1. Is this a theme or merely a code?
2. If it is a theme, does it offer new insights?
3. What does this theme encompass and omit?
4. Is there sufficient evidence to support this theme?
5. Is the data within this theme consistent and cohesive?

The rationale behind the themes was interrogated to determine if there were clear patterns in the groupings, if the themes accurately captured all the coded contributions from the six conversations, and how the themes related to each other. In step five, themes and sub-themes were assigned a broader name to accurately capture what they represented, and a definition for each theme was generated (Braun & Clarke, 2021). In the final sixth step, the themes and sub-themes identified were organised in a table, with a description of each and a record of how many times it was mentioned across all the focus groups and interviews (see Chapter 4, Table 3).

In light of Braun and Clarke's (2021) discussion on research quality in reflexive thematic analysis, it is critical to recognise that quality in qualitative data is not guaranteed by

rigid adherence to procedure, but by the depth of reflexive engagement with the data and its interpretation. Themes are crafted through a thoughtful and reflective interaction with the data, ensuring they capture clear patterns of shared meanings. This approach highlights the researcher's interpretative role as essential in shaping those meanings. It involves a thorough exploration of the subtleties, contradictions, and complexities inherent in participants' perspectives, while also recognizing that researchers contribute to the meaning-making process. By grounding interpretations in context and self-awareness, this method enhances the credibility and richness of the findings.

This analysed data was used to inform the design of a self-care intervention for CCWs. The finalised thematic analysis, alongside a draft of the intervention, was sent via email to all the team leaders from Stage 1 along with a Google Form to collate feedback (Appendix E). Leaders were asked to evaluate if their input had been accurately captured in the themes and if the proposed intervention effectively targeted each issue raised. Leaders appreciated the capturing of their ideas within the themes and how these were represented in the intervention content, no adjustment to the themes were needed. One leader expressed concern that there was no clear representation of how faith played a role in self-care. This leader was contacted and the details of the session were explained to her, clarifying how connection to God would be represented in the intervention. She appreciated this input and no adjustment to the content was needed. Additionally, leaders were asked to provide logistical input on the intervention regarding session length, timing, ideal number of participants, and how to create a safe space for sharing. This input was used to tailor the draft intervention to the needs of CCWs, specifically in terms of timing and guidelines to ensure a safe space was created.

3.3 Stage 2: Feasibility Study

Feasibility studies are conducted to assess the viability of interventions before larger-scale research is undertaken (O'Cathain et al., 2015). These studies explore best practices, provide evidence-based refinements, and involve community participants throughout (Bowen et al., 2009; O'Cathain et al., 2015). A feasibility study was required for this research as the intervention was newly designed to meet the needs of a unique population, on which limited research had been done (Bowen et al., 2009). Feasibility studies also provide essential input into anything that needs to be changed and how that change could happen to best benefit the participants (Bowen et al., 2009).

Specifically, this stage aimed to explore the accessibility, acceptability and potential benefits of a proposed intervention (Drummond, 2017) by considering a) participants' experiences of accessing and engaging with the intervention, b) any perceived intervention benefits, and c) adaptations needed to make the intervention more acceptable, accessible and beneficial.

3.3.1. Sample

All 21 team leaders who participated in Stage 1 and their CCW teams were eligible for Stage 2. Like their leaders, CCWs in the Outliers community are primarily women of colour from low to no-income households and usually volunteers. Some volunteers receive a stipend, which a team leader will access through a government fund. However, financial instability is high in CCW teams, which accounts for the high turnover of staff (Skhosana, 2020). Ideally, 10 to 20 CCWs would be needed for the feasibility study to provide beneficial input on the intervention (O'Cathain et al., 2015).

Team leaders from Stage 1 were sent an advert on WhatsApp to share with their CCW teams, inviting them to participate in the co-designed intervention (Appendix F). Interested CCWs were given a link to a consent form to sign up for Stage 2 (Appendix G). Since the

content of the sessions would be particularly sensitive, and participants easily identifiable given the small sample size, no sociodemographic information was collected from participants to ensure their anonymity.

A total of 19 CCWs from four organisations opted into the feasibility study, including five team leaders from Stage 1 (Table 2). Organisation D had only one participant from their team sign up. As this was a group session, this participant was excluded from Stage 2, and follow-up was handed over to Outliers instead. The three remaining organisations represented three different communities in Cape Town. During the scheduling of the intervention sessions, two participants from Organisation B could not make the scheduled times and were placed on the waiting list to receive the intervention at a later date. The remaining participants from Organisation A and B, comprising 10 participants in total, completed all components of the intervention (see section 5.3, Table 5), including the post-session observation weeks. Organisation C could not participate in the second session and their intervention was paused (see 3.3.3 Procedures section below). Participants from Organisation C were, therefore, not included in the feasibility study focus groups. An advert was sent to Organisations A and B on their intervention WhatsApp group, inviting them to a post-intervention focus group (Appendix H). Interested participants completed a second consent form specifically for the focus group (Appendix I). Two focus groups were held with all ten participants.

Table 2

Participants in Stage 2

Community	Organisation	Intervention progress status	Post-intervention focus group
Belhar	A	Completed	Focus group 1
Belhar	A	Completed	Focus group 1
Belhar	A	Completed	Focus group 1
Belhar	A	Completed	Focus group 1
Belhar	A	Completed	Focus group 1
Strandfontein	B	Completed	Focus group 2
Strandfontein	B	Completed	Focus group 2
Strandfontein	B	Completed	Focus group 2
Strandfontein	B	Completed	Focus group 2
Strandfontein	B	Completed	Focus group 2
Strandfontein	B	Could not attend	N/A
Strandfontein	B	Could not attend	N/A
Delft	C	Session 1 only	N/A
Delft	C	Session 1 only	N/A
Delft	C	Session 1 only	N/A
Delft	C	Session 1 only	N/A
Delft	C	Session 1 only	N/A
Delft	C	Session 1 only	N/A
Goodwood	D	Not eligible for inclusion	N/A

3.3.2 Data Collection

Data was collected from the post-intervention focus groups made up of CCWs who had completed all components of the intervention. Intervention participants completed a consent form using REDCap forms. Feedback from participants was collected using semi-structured interviews in two focus groups. The guiding questions for the focus group (Appendix J) were developed to explore: a) any changes in self-care perceptions that occurred through taking part in the intervention, b) changes in self-care behaviours that developed through taking part in the interventions, and c) the acceptability and accessibility of the content and delivery platform. All focus group discussions were audio-recorded using two mobile devices, both owned by the researcher and saved as mp3 files.

3.3.3 Procedures

In Stage 2, two distinct procedures were conducted: delivering the co-designed intervention and evaluating participants' experiences after the intervention was completed in a post-intervention focus group.

Procedure for Intervention Delivery. All 21 team leaders who had participated in the focus groups in Stage 1 were sent an advert for the intervention for forwarding to their teams. Nine leaders expressed interest and communicated the opportunity with their teams using the advert provided. The remaining leaders cited workload, organisation events and illness as reasons for being unable to participate at this time. The advert contained an introduction to the study, contact details of the researcher, and a link to the Stage 2 consent form.

The researcher followed up on WhatsApp with each of the CCWs who filled in the consent form to ensure that they understood their rights as participants in the study and to clarify what would be required of them during the study. While team leaders had already agreed to participate in this stage of the study, informed consent needed to be obtained from

each team member. Due to the timeframe of this study, sign-up for the feasibility study was closed after two weeks. In this time, 19 CCWs chose to be involved and completed the consent form. Any CCW who signed up after this time was contacted by the researcher and placed on a waiting list. All CCWs on the waiting list were given the South African Depression and Anxiety Group (SADAG) hotline number for NPO workers, a 24-hour hotline where CCWs could receive counselling services, and informed of SADAG's support groups and online resources These participants were told that their intervention would be scheduled at a later date, outside of the scope of this study. The 19 CCWs represented four different organisations. However, one organisation only had a single CCW sign-up. This CCW was contacted by the researcher and informed about the group-participation aspect of the study, and that no other members of her team had signed up. They were given the details of SADAG and agreed to be placed on a waiting list. The CCWs on the waiting list were shared with the Outliers team who were able to follow up with each CCW individually.

As the intervention would be run with each organisation separately, three WhatsApp groups were created to host the remaining 18 CCWs. The intervention required participants to engage in two facilitated WhatsApp sessions. Each group was sent a WhatsApp poll to determine a suitable time to host their intervention sessions. Unfortunately, two CCWs from organisation B could not attend their group's preferred session time and were removed from their WhatsApp group and added to the waiting list. Appreciating that these CCWs had shown interest in addressing their mental well-being, the researcher followed up with each of them telephonically and provided them with SADAG resources.

Individual session times were established for Organisations A, B and C. Organisation A opted for a Monday morning, Organisation B selected a Wednesday afternoon, and Organisation C chose a Friday morning. The researcher facilitated the first session with each organisation (see section 5.4). During the first homework week, the team leader of

Organisation C contacted the researcher and explained that the team would be unable to participate in their scheduled second session. An alternative time could not be scheduled for this team, and their intervention progress was paused. Organisations A and B continued with their second session as scheduled, along with their second homework week and observation period.

Procedure for Evaluation of Participant Experiences of the Intervention. Upon completion of all intervention components, CCW participants from organisations A and B were invited to attend an in-person focus group facilitated by the researcher. Each organisation hosted their own focus group at their organisations in Belhar and Strandfontein, respectively. All 10 intervention participants completed the consent form using REDCap. Using the intervention WhatsApp group, a WhatsApp poll was sent to participants to determine a convenient time for their focus group to meet.

During the focus groups, participants discussed their experiences of the intervention, guided by questions set by the facilitator. At the end of the focus group, the researcher congratulated the teams and encouraged them to continue supporting each other using the intervention WhatsApp groups.

The researcher recorded each focus group session on two mobile devices. The audio files were transcribed and stored as described in section 3.2.3 above.

3.3.4 Data Analysis

The researcher used RTA, as described in section 3.2.4, to interpret patterns in the dataset and present emerging themes

3.4 Ethical Considerations

The study was granted ethical approval from the Faculty of Humanities at the University of Cape Town (PSY2023-034).

3.4.1 Informed Consent

In both Stage 1 and Stage 2, any CCW who expressed interest in being a part of the study was given a consent form to complete via REDCap. The form highlighted that participation was voluntary, that it did not impact their relationship with Outliers, and that participants could withdraw from the study at any time. Additionally, any CCW who filled in this form was then contacted either telephonically or through WhatsApp by the researcher so that the full scope and purpose of the study could be explained.

3.4.2 Confidentiality and Anonymity

To protect the anonymity of CCWs, the transcripts for the Stage 1 and Stage 2 focus groups and interviews identified CCWs only by a participant code. No names or identifying details were included in the downloaded transcriptions or write-ups of findings. The focus group and interview transcripts were not uploaded to any open-access data repository to protect the identity of the participants.

With regard to confidentiality, all participating CCWs signed a confidentiality agreement, stating that they would respect the confidentiality of the group and not disclose matters discussed in the group to outside parties. The researcher also signed a confidentiality agreement. The rules for group engagement (see section 5.4.1, Figure 3) were presented in the WhatsApp groups, along with any necessary terms for engagement (Bouter et al., 2020; Doğan, 2019). These were sent before the session times so that participants could consider the rules, ask questions and add to them if necessary. Participants indicated that they had read the rules and agreed to the protocol set by responding to the rules with an emoticon.

3.4.3 Risks and Benefits

While there was minimal risk to participants in Stage 1, in Stage 2, participants were challenged to confront difficult beliefs of themselves and others. This reflection led to many personal revelations and occasionally triggered painful memories. Recognising the limitations

of the intervention in addressing mental health issues, the researcher sent each participant the contact details for the NPOwer helpline over WhatsApp before the first session, with an explanation about who they were and how their hotline worked. The researcher also explained how the session content might trigger emotional responses outside of session times and how the helpline could be useful. NPOwer is a SADAG-run 24-hour, multilingual free hotline dedicated to helping NPO workers deal with mental health problems. The helpline number was again given after each facilitated session and at the end of the post-intervention focus groups.

In addition to the possible risks, there were a number of potential benefits to participating in Stages 1 and 2. By participating in this study, CCWs had access to self-care information and support as well as tools to help them in their daily lives. In addition, the team leaders had invested in the sustainability of their CCW teams, which could increase team cohesion and motivation.

3.5 Conclusion

This chapter presented the multi-stage study methods embedded within a CBPR framework. Stage 1 explored the self-care needs of CCWs working in communities in Cape Town to develop a group self-care intervention for CCWs with CCW team leaders. Stage 2 tested the feasibility and acceptability of this intervention. The next chapter presents the findings from Stage 1 of the study.

CHAPTER FOUR: SELF-CARE ATTITUDES AND PRACTICES

This chapter reports the findings from the data analysis of the four focus groups and two interviews conducted with CCW team leaders exploring their self-care perceptions, behaviours and needs. Six themes emerged from the thematic analysis, relating to three broad areas: the need for self-care, barriers to accessing self-care, and tools needed to support self-care. In this chapter, each theme and its sub-themes will be presented, with illustrative quotes from team leaders as supporting evidence.

4.1 Identification of Themes to Inform the Design of a Self-Care Intervention

Analysis of the transcripts initially identified 320 unique codes. These codes were numbered and captured on an Excel spreadsheet to be compared across groups. A count was recorded each time a code was mentioned in a transcript. These codes were then refined by combining codes with a similar meaning to reduce any redundancies. This produced 264 unique codes. The researcher then interpreted the codes and their relationship to the research question and grouped them into distinct categories based on shared conceptual characteristics. For example, the code “you forget about yourself” and the code “I don’t think it’s possible to give 100% to yourself” were combined together with several similar codes under the category “CCWs prioritise the needs of others”. These categories were then organised into six overarching themes that built a meaningful narrative that helped to understand how CCWs currently engage with self-care and how to encourage self-care behaviours in CCWs. Themes with their associated sub-themes and the number of mentions across the six groups are summarised in Table 3 below.

The six themes were expressed in all the groups and interviews. The first highlights the importance of self-care for community workers. The next two themes focus on the barriers that prevent CCWs from adopting self-care behaviours. The final three themes give important insight into what is needed for CCWs to adopt self-care. Each theme and subtheme

is discussed below, with direct quotes from team leaders to illustrate each.

Table 3

Themes from Stage 1 Focus Groups and Interviews

Theme	Subtheme	Number of mentions
Need for self-care	1.1 Community work is demanding	48
	1.2 Costs of not practising self-care	14
Attitudinal barriers to self-care	2.1 CCWs prioritise the needs of others	102
	2.2 CCWs feel pressured to meet cultural expectations	80
	2.3 Care is given to others, not to self	45
	2.4 CCWs expect a lot of themselves	13
Practical barriers to self-care	3.1 Not enough time for self-care	12
	3.2 Environments in which CCWs live limit self-care options	20
Perceptions of self-care	4.1 CCWs struggle to relate to self-care activities	46
	4.2 Self-care activities are about feeling not doing	74
	4.3 Self-care is unique to the individual	85

Theme	Subtheme	Number of mentions
Adopting self-care activities	5.1 Make the decision for yourself	36
	5.2 Create a habit around self-care	33
	5.3 Choose activities that work with time and resources	22
Community support for a self-care journey	6.1 Sharing as a form of self-care	79
	6.2 You need trust before you can share	9
	6.3 The importance of support in behaviour change	35

4.1.1 Need for Self-Care

Leaders recognised that community work was demanding and that CCWs needed self-care to sustain their role. Community work requires CCWs to address the needs and well-being of those around them. Leaders expressed that CCWs need training and resources to maintain their personal well-being as they support others. When this is not in place, CCWs feel obligated to continue serving others, even when it is detrimental to themselves. This leads to feelings of exhaustion and overwhelm and builds resentment.

Community Work is Demanding. Most of the leaders had not accessed training, support or resources before beginning their work in the community. The leaders recognised a need in their community and spontaneously responded to it. Once established as a caregiver in their community, beneficiaries placed more demands on them, and their workload increased. Once in the position of being a full-time community caregiver, they often felt ill-equipped to sustain their level of care but were unable to step away.

> I had no clue what community work was. When you start community work there's no guidelines; you kind of fall into it. Because it's your community and you do the work. So, you don't get told things like, you're going to be burnt out. You're going to want this to stop. But you're not going to stop. Because you're going to know that your community is more important than you. (L3)

> I didn't have the tools; I didn't have the know-how to do it. When I went on to community work the focus was just, what to do in the community. Fix sort of, like, fix what was out there. And then I realise, this could possibly be an injury to me. (L4)

These leaders capture how unintentional the first step into community work is for many CCWs. The lack of structure, along with the fact that they live in the communities that they serve, meant leaders were continuously meeting the needs of those around them without adequate support to look after themselves. As L6 explains, "We work so hard because we want this work to succeed, you want to see this happen, we work ourselves to a pulp." Knowing that their work was important and seeing their positive impact on others made it even harder to take a break, even when they wanted to. "No one tells you about wanting to stop" (L19) one leader mentioned. Another genuinely asked, "but am I allowed to say no?" (L12).

Costs of Not Practising Self-Care. When the leaders began to talk more about how they gave to others, they began to recognise how little support they received in return and how this had consequences on their own health. "It's making me feel like we're just being used", L6 realised during her group discussion. This neglect of self has also led to physical and mental problems. Leaders complained about their fatigue, forgetfulness, and irritation.

> We are taught that you need to learn to share, but at the same time, everybody must. You always were taught that lion's share is not right. But now, people are... They want more than they give. (L14)

> We don't take lunch. No one ever said not to take the lunch break. But we don’t, or we eat at our desk. (L10)

> You are not focussed, you are not positive, you cannot come up with any ideas. And you realise, what is happening? You feel like you are moving backwards. Then you realise uh ah, you are not you. You have lost yourself somewhere on the way. We are being selfish to ourselves. (L18)

> I can be very forgetful. It was actually quite scary for me. That's obviously not where I want to be in all of that. And I was saying also, like, you always hear about these things. But then you don't like I don't know; you don't see it when it happens to yourself immediately. And like I was thinking about the past few days. And I'm like yeah, I did become a bit forgetful and like about simple things man. So, I know that is a change that needs to be made. Yeah, I don't feel good about whatever's happening in my mind. (L2)

4.1.2 Attitudinal Barriers to Self-Care

While leaders recognised the need for self-care, there were many reasons why self-care had not been taken up previously or had failed to be sustainable. Chief amongst these was prioritising the needs of others above their own. This stemmed from beliefs instilled through cultural norms and reinforced by their own unrealistic expectations of themselves.

CCWs Prioritise the Needs of Others. The main barrier to self-care was the leaders' belief that others were more important than themselves. The willingness to push themselves to the extremes for others seemed to be a defining characteristic of a CCW. This focus on others was so pervasive that they continually neglected, or failed to recognise, their own needs. The realities of their work and the vulnerability of the populations they serve often make this prioritisation a rational choice. "We must give to the children," L21 said, sharing a sentiment that every leader resonated with. However, so caught up in their work, they did not know how to attend to their own needs.

> You do it without even noticing that you are putting yourself last. Because you are always focussed on helping. What you are doing, it demands a lot of time. To always want to be there, you always want to assist, you always want to help. You always want to make sure that we provide the best services. You always want to make sure these kids are provided. (L17)

> We do get to the point, so often, every so often, that we are burnt out, and we still push ourselves to the brim. Because our aim is to heal out there, you understand? (L6)

> You have a passion that drives you, that pushes you. You are like a horse you're blinkered. You are not looking anywhere. You want to see those kids; you want to see them progress in life. (L8)

> We forget ourselves, because we focus on a lot, and we don't see ourselves. This is where we forget because we've prioritised things that are more important than ourselves. (L4)

> Kids come back with the problem. Now what do you have to do with it now? So, what do you do? You have to deal with it, because then the Kids-Come-First policy. Even if you don't have to do it yourself, you have to do something with them. And you're still involved with that referral. Because the kid comes to you. But everything else stops exactly during that situation. It's hard to have enough when kids come in and out the whole day. (L9)

These comments illustrate how part of the way that leaders show love and feel valued is through the work that they do. Leaders found it difficult to rest, even when they were feeling depleted, because they found their work meaningful and believed that their efforts made a difference. One leader used her colleague as an example of this:

> Because when she sees the results at the end of the term, it makes her feel good that she put in that extra hours. Once she spent two hours with the children. And I'm like, Are you really mad? You're not getting through to her. But you know, that's what she does. And that's what she wants to do. And even if she sees the slightest improvement in them, it does make her feel it was worth it. (L3)

These extra hours came at a cost because the leaders did not feel able to rest. They were always putting others first and could not prioritise their own needs. "I don't think you can get people to put themselves first", L15 said considering her team of CCWs. They continued, "it's difficult for people to change now."

> FACILITATOR: What would that look like to give 100% to yourself? L14: 100% to yourself? I don't think that this is possible.
>
> FACILITATOR: But you can give 100% to other people?
>
> L14: To other people. To yourself I don't think, maybe 60 or 40? Yeah, sometimes.

The leaders did not take time to consider self-care because they believed that giving to others was their highest priority. CCWs who have convinced themselves that they need to give 100% to others will not be able to prioritise themselves. One leader plainly stated, “it’s just not going to happen” (L11). This clear dismissal of self-care options acknowledges how difficult it might be for CCWs to take on self-care behavioural changes.

CCWs Feel Pressured to Meet Cultural Expectations. Community and cultural norms and values have shaped their understanding of their role in their community. As community leaders, they have seen others in their position give of themselves and make sacrifices to meet community expectations. Prescribed gender roles also impacted their expectations for themselves in their work.

> You see this one's grandfather, who was a preacher, L15's grandfather. He preached everywhere, everywhere, every house. When there is death in the family, we were not struggling to find a preacher. And his father. They go preaching to all the houses. And we grew up like that. (L14)

> I was even scared to even communicate with my mother as a kid, because I know I wouldn't get anywhere. But she was raised like that by Gran, by my grandmother. And this is how it went on from one generation to another. (L6)

> I see also the contribution of the environment we live in. Because we look in our environment in this neighbourhood you always have to put people first. Because there is that mentality that if you don't attend other people’s, you know? You're a loner or you think you're better than them. So, in our community, you have to put people first if there is something happened, happening in that house opposite house, then you have to jump and sometimes it's not your concern. You don't have any contribution

> that you do in that family. Just you just have to be there to stand. You see? So now you neglect the other things that you're supposed to do for yourself, just to be there, just to be there. (L13)

> Now, society, here, sometimes, most of the time, it takes. So, if you're gonna start to be self-caring, so you're working against the grain now. So, people will start to say: Okay, what is this one about? Who does she think, or he think he is? So, you've got even your family. You start to work against them. So, you've got a struggle that you're gonna be working against. (L15)

Cultural traditions are handed down through families, neighbourhoods, and religious groups. These traditions place expectations on everyone, particularly those in leadership positions. The leaders acknowledged some of these expectations and understood that they prevented them from adopting self-care behaviours. However, deviating from expectations was difficult because change would lead to "conflict with others" (L12).

> You put yourself first and then it ended up, when you see that there is this conflict, and you end up now put yourself behind. You say instead: Okay, let me help you now. Then I leave myself behind. (L12)

As women of colour, these leaders had grown up watching their grandmothers, mothers, and aunts serve others. They were proud of their upbringing and families, particularly the way their mothers had a role in their lives and those around them. However, they could see how certain behaviours were "programmed" (L11) by those around them, and it was difficult to break away from these conditioned behaviours.

> I grew up seeing my mommy go every Friday morning to the old age home. That was the example, and we were talking about it the other day. It's what you see, you

emulate. And so as early on as I was at school when I would see my mommy going to the old age home and making sandwiches. And we were a big family. But my mother always had money for that. So, I think that's where our love for community came from. (L1)

It was programmed on your head, all you need to do. Not knowing I was killing myself. To make sure even my husband when he was come from work, I must make sure this this this this this. There is food on the table. It's tricky this. This challenge is coming from an old family. (L11)

L3: I think we are all more worried about what other people feel.
L1: That's what she's saying is, as coloured women we don't know when to say no. It's true.

This subtheme highlighted the importance of culture and community. The leaders chose their vocation because they had seen behaviour modelled for them by the people most important to them. However, in modelling leadership without limitations, these leaders had not been provided with examples of self-care. This led to a construction of self-care as selfish, non-traditional, and going against the grain.

Care is Given to Others, Not to Self. The leaders expressed that their understanding of care was love shown to others. Care was described as a wholehearted service performed for others that required their time, energy, and attention. The leaders often described care as directional. "Reaching out there," L6 described it, further clarifying that "it's going out that way and not getting in."

Okay, with myself, looking at caring, there's always reaching out to others, and not thinking about yourself. When you know. And it gives a feeling of satisfaction? Yes.

> When you've assisted or cared for someone else. But then where does it leave you, you know? You forget to care about yourself. Because it's always reaching out there. And that is my understanding you know when you care. It's going out that way and not getting in. Okay. Yeah. (L3)

> I will say, care to me means whatever you do, you put almost 100% whatever you're doing. You don't take it casual. It is something you must do. To me when you say care, there's some kind of love of what you're doing. I have to do because I'm here now to do this. Especially in regards if you are working with kids. (L15)

> It's generosity going with the care when you care for the children, even for the other people. And the kindness. When you care, you have that kindness and then generosity to the people. Like you always want to take care of the people. Even if sometimes you don't feel like that. You feel for the person taking care of. You think: Okay, even if I don't have that energy to do that. But you push yourself. (L13)

> Taking the load off someone maybe. Being able to show them that I'm thinking about them. That, expressing that, maybe encouraging them. Doing something for them. So, like an act of service. Love languages come up from for me as well. … Those the kinds of things, being able to care for someone or knowing that if they express a need, and able to help them in the best way that I can. (L16)

The leaders described care as acts of service, words of affirmation, gift-giving, and time spent. They always framed care as love directed outward towards others. These conversations helped to understand why leaders had difficulties with self-care, which would be love directed inward and in service of the self.

CCWs Expect a Lot of Themselves. The leaders admitted that it was hard to stop working, take time off, and delegate. They were accustomed to ignoring fatigue or illness. With limited resources, both human and physical, the leaders could only rely on themselves to do the work. This, along with their unrealistic expectations, has left them feeling they are the only people who can help those in their community.

> You become aware that: Oh, I am neglecting myself. Then you realize that I need to take care of myself to be able to breathe. (L20)

> I can't stop thinking. I sit down, I think about what needs to happen next. It doesn't stop. It's always there, in my mind. Something to do. (L7)

> Part of the issue is that people only start to maybe learn these things when they burn out. So only when you've had too much do you realize I've taken on too much. (L10)

One reason for not being able to stop was guilt. The leaders strongly believed in their skill to understand what people needed and meet these needs. Because of this they found it difficult to say no when they knew their actions would help someone.

> I think we all have that feeling of not wanting to say no, because we think, and we feel about how the next person's feeling: how are they going to be? We look more to their needs and wants, actually. And that is when you actually neglect yourself. Because the emotion plays a role. (L5)

> You always consider the other the, you know, the opposite party, because that is what we all do. Is to consider the next person more than yourself. So, it's hard to say no and not feel guilty. (L6)

Since leaders have had to find ways to meet community needs independently, they struggle with perfectionism and control. Due to the intermittent nature of human resources, leaders have become accustomed to running entire programs with limited support. Leaders felt they could only rely on themselves to get work done and therefore found it hard to delegate tasks. Even when teams grew, the leaders found it difficult to trust others and relinquish control.

> I think it's pride. Sometimes, I think. I want them to ask me. That's when I realized. But it actually helped that afternoon, to have them do it and not me. I think she said before that you ask other people and they have a different way of doing things, because you always think you're doing it perfectly. And that's ultimately the test for trusting. Before it was all about me. (L9)

> I could have delegated that, but that would have put more pressure on me because I need to check if they right. Or to teach them it first, it's just more and more. (L17)

> So, I am away the one day, then the next, I'm on the phone all day. I was on the phone for all day calling trying to figure out did this happen? Did that happen? Who did this? Because at the end it's me, it's my work. (L7).

> In my organization, it's only me on to. I have volunteers. So volunteers, you know, they come when they have their available. So, when they are not available, it means I must be there. I cannot say: they are close today because there are no volunteers. (L18)

4.1.3 Practical Barriers to Self-Care

Leaders felt that their work and environment were not conducive to self-care activities. Living in the community meant that they were always accessible to their beneficiaries. As CCWs, the community expected them to attend community events, funerals, and meetings. As family members, they were also responsible for looking after their own children or parents. With all these demands on their time, adding a self-care activity seemed unrealistic, especially in the environments they lived in, where there was limited access to relaxing, safe spaces.

Not Enough Time for Self-Care. Community work does not have set boundaries, and leaders were in the habit of responding to needs whenever they came up. In addition to this, the leaders shared about their other commitments beyond their community work. With such an extensive list of things to do, even if they tried to include self-care, they could not maintain it for long.

> You try, by all means to make time for yourself, but they will come knocking and they will come up with their challenges. You cannot say you cannot refuse your ear to listen. We have to sit down, we have to listen, we have to act on whatever that is coming, is approaching you. So definitely time is not on our side. We try but we are not succeeding. (L19)

> We were to feed and entertain 2500 disabled and underprivileged children, and I'm the head. I mean, like people under me, it ended up we had 200 volunteers that had to train. … I had my aged mother-in-law. I had my [neurological illness] child. I have three other kids. I was on night shift radio station, as a presenter. And I was teaching at the [cultural venue]. (L6)

> Because now I can't just come and stop and do whatever, because my son, he says: No. And so now I must do whatever he wants. (L14)

> And then the other thing to consider then is obviously what's going to be practical, because it's like time, effort, cost, transport, whatever. Something that could fit in, into my day. In a sense that it doesn't take a long time, or it doesn't take work. … Especially biggie, on the days, obviously, there's days when my son goes to preschool and days when he's here or on the weekends he's with us. (L16)

Environments in Which CCWs Live Limit Self-Care Options. Leaders live in high crime communities with limited safe recreational spaces. In addition, the lack financial resources for activities that are not necessities. They make use of stipends and grants to fund themselves and their organisations. Leaders who are salaried are not in high income brackets. This limits the types of self-care activities they have access to.

> We don't have a heater. The houses, they are cold. So now you get, you say: It's cold today. And tomorrow again, it's cold, you end up losing your routine. So, the environment accounts. The suburbs, it works very well. Because the environment and their houses have the space. And even if it's cold, they have resources, things to make the house warmer. (L12)

> They say run or walk. No. You can't just walk here. You can be robbed anytime. You can't just walk. (L11)

> There's things you can have, and things maybe. Go see the psychologist, you say, every week, you say: What for? I am saying: What money? Go, go away, for that massage or even your nails! The people with money, they go out. (L13)

4.1.4 Perceptions of Self-Care

As seen above, the leaders understood care as something they gave to others, while self-care was going against the grain and could potentially lead to conflict with those around them. Additionally, they felt self-care was not possible for people in their living circumstances. This meant leaders had preconceived ideas about self-care that made it feel inaccessible. However, in delving into how self-care could make them feel, they realised many activities were available to them.

CCWs Struggled to Relate to Self-Care Activities. The leaders understood self-care activities in a very impersonal way. When listing what they believed to be self-care activities, such as exercise, walking, reading, and eating healthy, leaders were not excited to take on these tasks. This meant that asking them to add such tasks into their routine felt like an additional burden that could easily be neglected.

> L13: Okay, self-care... I said washing my body. Washing myself is self-care to me.
>
> FACILITATOR: Oh, yeah. Cos you're caring for yourself.
>
> L12: Eating well.
>
> L13: But I'm not really enjoying the things I am doing.

> So maybe this whole thing of like, okay, what are self-care... people often go towards that, like I immediately thought of all of those bigger activities and then it becomes unattainable, and you just don't do it. (L17)

> I don’t want to run! It’s not fun. Like I can walk in the stores, but go for a run? Why? No, no, no. (L21)

Self-Care Activities are About Feeling Not Doing. In redirecting their definitions of care towards themselves, leaders came to understand that any activity that showed love for themselves was self-care. This led to several new understandings of what a self-care activity could be, based on how the activity should make them feel.

> No, see, I was saying, instead of saying list self-care, it sounds complicated. What you think? But if instead: say something you enjoy. (L15)

> I think a feeling of loving kindness. It's to do with your soul. Who you are. So the care for yourself is, is a feeding of the soul. (L1)

> But then care for myself is, if I've been busy and I look at my daughter, and I say: Come, let's take a walk on the beach. We take our shoes off, we you know, worm our feet in the sand and we have fun and so on. And it makes me so energized because the atmosphere, the sound of the sea, the feel of the sand and so on. (L6)

This new understanding of self-care helped leaders relate personally to self-care activities. Leaders were able to identify feelings associated with self-care, which included:

Self-care is something you enjoy. Self-care feeds your soul.
Self-care makes you feel energised. Self-care makes you feel good.
Self-care is fun.
Self-care is love to self. Self-care is restoration.
Self-care makes me feel at peace.

Self-Care is Unique to the Individual. As the focus group discussions progressed, leaders identified unique and personal self-care activities that they could engage in to elicit the feelings described above. Being able to select these activities for themselves, based on

their own personal preferences and resources, meant they were much more interested in taking on the activity.

> But caring for myself is taking time out. What I've learned is that self-care means different things to different people. And so, she might think having hairdo or painting my nails, which I don't do, it's not important to me. But getting a nice book and having an hour to read is important to me. So that is self-care for me. (L1)

> But what brings me life is and what brings me enjoyment has a completely different answer for me than you. It's more unique to that person. (L17)

The list of activities could be grouped as either body, mind, or soul. Tasks associated with the body included physical activities and personal grooming. Tasks associated with the mind helped soothe thoughts through activities such as meditation, crafts, and reading. Tasks associated with the soul help break away from normal activities to reconnect with self or God. This final category resonated with many leaders, who felt that their faith was strongly linked to their purpose and work.

> Connecting with God. And I think that's the ultimate peace as well. So, whether it's spending time on my own or with God. I think like peace is probably the feeling that I look for when I’m trying to care for myself. (L16)

> I think another thing that you maybe should consider when talking about rest is your relationship with God or a higher power. I think if I didn't have a relationship with God, I'd never be doing what I'm doing. I never would have the courage to do what I do. (L1)

4.1.5 Adopting Self-Care Activities

The leaders understood that taking on self-care would not be easy. Even with meaningful self-care options, the leaders were still living and working in the same contexts with the same barriers. It was clear that self-care had to be chosen by the individual and not prescribed, but leaders also recognised that CCWs would first have to individually commit to embarking on a self-care journey before any support could be provided. CCWs would need confidence to establish a habit, where the self-care activity could fit into their daily routine.

Make the Decision for Yourself. Leaders expressed that it was important for CCWs to be ready to change and understand the difficulties that might come with change. The leaders knew that CCWs would need to have conviction in their decision to change to overcome the barriers that they would face.

> I think you must be there mentally; you want to do something about it. It starts with you. You are going to have to drive it. (L20)

> It's an end goal, knowing why you're taking the shot and knowing why this is important. And respecting that enough for you. For it to be enough. Without even someone else. (L2)

> I need to be there for myself. I should give myself that support. If I don't support myself, who else will support me? No one. I have to start by myself and then take it to others. (L8)

> It's up to the commitment. If we don't commit, we never do it. So, we must find a solution, a way on how can we commit ourselves. We know what we are doing it's too

demanding. But at the end, connect and fill up your cup. (L18)

Create a Habit Around Self-Care. The leaders felt that the only sustainable way to maintain self-care was to form a habit around the new behaviour. Leaders suggested starting small, and adding something that easily fitted into the rhythm of the day. It was important to start small and be consistent.

L4: Make a small little bit of excitement in that.

L2: Yes, you must know the goal. Where you want to see yourself or how you want to feel and that must drive you enough to make those hard choices and say no, I can't see right now.

L4: But have a short-term goal, you do it and you feel, and then you know the coffee time will be something exciting for you each day. Me-time for the day.

It's something that I guess that you can bring into your day to day. Like habit is also great because it's not like, it doesn't feel like another burden. Another thing you have to do. But it's part of your day-to-day rhythm. (L4)

Creating habits and working with current routines were important factors in adding a new sustainable self-care behaviour. Two groups mentioned using their cellphones to provide reminders to help them establish the habit.

If I really need you to do something, then I will put on the alarm. I can be with whatever and I know. I cut off from everything and I know that I have to do that. (L5)

You set a reminder on your phone. It's simple, it helps. You won't forget it; you won't be able to forget it. You have it all the time. (L12)

Choose Activities That Work with Time and Resources. The leaders were aware of the environment and workload that CCWs battle with. For a self-care activity to be sustainable, it needed to realistically fit into a busy CCW lifestyle. If it was going to happen as part of their working day, it needed to fit in with the programmes they were already running. If it happens outside of work, CCWs would need to carefully consider their other obligations. Leaders also suggested that tasks needed to be personal, meaningful, and fun. This way, CCW would be motivated to overcome barriers to do the activity.

> It needs to fit in with my other commitments. You know you need to do a spa treatment. Sure, that would bring you enjoyment, but that is not going happen in my day! (L10)

> If I think of it as what brings me life, then yeah, yes, I think the barriers, all those things before, it's easier to overcome. (L16)

> And then the other thing to consider then is obviously what's going to be practical, because it's like time, effort, cost transport, whatever. But if it's something like fun, then those things are more overcome-able. (L17)

4.1.6 Community Support for a Self-Care Journey

CCWs are community-based, and community focussed. Leaders felt strongly about the importance of creating a community around self-care so that no one would journey alone. Mostly, the type of support needed was a space to share. The leaders placed high value on sharing their lives with others and learning from each other. Particularly around self-care, leaders believed that they needed the support of those around them to help sustain new behaviours. Leaders were wary about the support they could access, and they needed to have trusted relationships before they were comfortable sharing with others.

Sharing as a Form of Self-Care. The leaders struggled to remove themselves from their work. Not having safe spaces to debrief meant the trauma they experienced at work could not be released. The leaders also lived in the communities they served and often lived with the same problems they were trying to support others through. In the focus groups, leaders found that by sharing with others, they not only unburdened themselves but could learn from the lives of those around them. As one leader put it, "sharing is self-care" (L13).

> People absorb the energy, and they don't know where to offload. I think that is why we are all here to learn. That's why we are here, we are hungry. (L18)

> We need our own space to take care of ourselves. So that whatever we give to these kids we give from a fresh body and a fresh mind. Because if I keep on saying: No, I'm okay, I'm doing okay, even though I know this is too much for me. I ended up giving these kids, the opposite. So, we really need to have our own space just to fill up our cups. (L21)

> We don't get everything, especially in our society, discussions like this. The more discussion you have about it. I think the more you decide to learn. But we don't get it. We don't get to sit and talk. Just talk. And listen. (L15)

> I think when you talk about something that brings some relief. Holding on and holding, it just bottles up and someone made a comment the coke bottle. I've learned through life, that the more you speak about it, the more you release. (L3)

> I do think it's important for organizational leaders or community workers to come together, for example, once a month, just to reflect and just share our stories and

> challenges that we face. Also discussing with other organizations, listening to their stories and their challenges and solutions together. It's important what is contained in those moments" (L20)

The leaders recognised that small group discussions could not only help to share the load, but also help to broaden ideas. In small groups CCWs can learn from and teach one another. "It's so rewarding like sharing life experiences," L6 said at the end of the session, "you learn so much. I can use that, or I shouldn't be doing that. You don't really get the opportunity to do that. Yeah, really learn to know one another."

You Need Trust Before You Can Share. The leaders tempered their need for debriefing with the proviso that it needed to be with people they could trust. Since the leaders dealt closely with community problems and worked with vulnerable children, they were cautious with whom they debriefed. There was value in having access to people in the same field dealing with similar issues.

> You must find the trustworthy person. The person you can share with. And then immediately after having shared, you feel different. I, personally, I feel different. (L3)

> It's likeminded people, who you grow close to. You share. In the work we do, we are doing it together, so we share. So yeah, I think that's what made us get close to each other. (L4)

> We can support each other so that we don't take all that other things that we are dealing with and take it home with us. Because once you take it with you, you will take it out on your family and then it will strain you. That's why we have to work as a collective. (L7)

The Importance of Support in Behaviour Change. Leaders expressed that they enjoyed the time together in the focus groups. This simple connection combated the isolation they often felt, as time is never set aside to intentionally connect with each other. The leaders also understood that changing behaviour would be difficult and needed to be supported by others on the same journey.

> We can make some sort of a group such as this one where we are meeting twice or once a month and reflect and motivated and encourage one another. Because if you are saying you are going to do it on your own it's impossible, you are not going to do it. (L21)

> I think you need a friend or someone who motivates you, encourages on a daily basis. (L4)

The participants were aware that meeting in person was difficult to maintain. Even organising a time for the focus groups to meet was difficult. Meeting in one place is not always possible for CCWs. But hosting several focus groups and the option to meet online allows people to join wherever they are.

> Now [colleague], she was supposed to come here for this as well. But she don't come today because the family. And I am thinking she must come. But she, then her family puts pressure, and she says: No, I must stay here not go to this [venue] today. (L12)

> FACILITATOR: I know we wanted to meet together, and maybe another time we can still do that.
>
> L18: This is okay though, we are here.
>
> L19: I am in the car! I am just saying, in case it goes away, I am in the car going to a meeting.

> I can't answer my phone all the time I get, maybe, to bed at night and answer [the WhatsApp group]. But it's nice that we just motivate each other, and we'll send stuff you know, pictures. (L1)

4.2 Conclusion

The themes emerging from the focus groups with team leaders indicate that CCWs are overwhelmed and exhausted by the demands of community work and need self-care. This is due to an understanding of community work that precludes setting boundaries and enacting self-care. The focus group discussions indicated that it would be valuable for CCWs to develop a clearer understanding of their role in the community and of the distinction between work and personal areas of life. CCWs would first need to recognise what they currently take on, as leaders voiced that they have become accustomed to doing unquantified work with minimal resources. Without self-care, they suffer from emotional, mental and physical fatigue.

There are many attitudinal barriers that contribute to why CCWs take on as much as they do. It is undeniable that CCWs do important work, but deeply ingrained expectations cloud their ability to acknowledge their limits. Constantly ignoring their limits has put CCWs out of touch with their own needs. The focus group findings suggest that CCWs will need to develop the skill to pick up signs of fatigue and burnout before it is too late. Attitudinal barriers appear to be a very powerful influence on CCWs' inability to recognise their need for self-care, suggesting that it is important for CCWs to interrogate the belief that care is uni- directional and to recognise that their value is not only in giving to others. Developing this self-compassion, which negates deeply held beliefs, will take time and practice. CCWs will need constant support and reassurance as they do this until they can build the self-assertiveness to help them uphold decisions that benefit themselves.

Attitudinal barriers affect how much time a CCW is willing to give to self-care.

Participants expressed that time is their most valuable resource, and for them to give their time to self-care, they need to view self-care as a priority. Time is not the only practical barrier that makes accessing self-care difficult. Each CCW faces their own set of barriers due to their commitments, environment and resources. Prescribing specific self-care activities and schedules for them, therefore, will not be sustainable. Each CCW will need time to consider their self-care options and select feasible tasks that fit with their circumstances.

Selecting a suitable task will come from a better understanding of self-care. A positive reframing of self-care can lead to CCWs finding meaningful activities that care for themselves. When leaders understood self-care as a feeling, it helped them identify actions that had meaning for them. Identifying meaningful actions made CCWs excited to do them. Without this understanding, self-care is an impersonal and burdensome task that is easily neglected. It cannot be assumed that CCWs will know what self-care works for them and so exploring self-care activities needs to be a guided activity. But even with meaningful activity options, participants were pragmatic in their approach to adopting new behaviours and understood it would take time and consistency to create any lasting change. It was clear from their contributions that change is a personal journey and CCWs need to be ready to take on self-care. CCWs need the freedom to opt into an intervention; it cannot be imposed on them.

Though individually driven, participants knew they would need trusted support along this journey. They expressed the need for a safe space to share the burden of their work. Constant access to a space like that would need to overcome practical barriers for it to be useful and accessible for different CCWs. This suggests that online support may be a convenient way for people to connect and share. An intervention that can be delivered through a low-data mobile device application could be particularly suitable; as P18 shared, “everyone's got their phone with them”.

The above input on the lived experience of CCWs, grounded within their specific

context, was used as the foundation for developing a self-care intervention specifically for CCWs working in these communities. This process is described in the next chapter.

CHAPTER FIVE: INTERVENTION DESIGN

This chapter presents the steps leading to the design of the self-care intervention and the details the content of the intervention. In developing the intervention, the researcher used a combination of self-care theories (see section 2.5) to address the self-care themes raised by participants in Stage 1. The draft intervention was then sent to the Stage 1 participants for review and comment and their input was used to further refine the intervention. This input also informed the length and delivery format of the intervention. The final intervention is presented in Table 5 (section 5.3).

5.1 Design of a Self-Care Support Group for CCWs

Given the emphasis placed by Stage 1 participants on community support for CCWs' self-care journey, a group intervention was deemed more suitable than one designed for individual CCWs. The inputs of Stage 1 participants also suggested that an intervention would be most accessible and feasible if it could be delivered digitally to CCWs via their cellphones, which would remove possible intervention barriers of transport, time and cost whilst still meeting the need CCWs have for peer engagement. A WhatsApp group chat was, therefore, chosen as the platform for delivering the self-care intervention. WhatsApp is one of the most popular applications in Africa due to its compatibility with most smartphones, ease of use and low data consumption (Pindayi, 2017; Thaba-Nkadimene, 2020). It has also been of interest in the education sector due to the ease of communication it allows between educator and learner as well as the wide variety of media that can be shared on its platform (Gcabashe, 2024; Thaba-Nkadimene, 2020; Venturino & Hsu, 2022). Further, a platform that supports various media formats allows the intervention to remain primarily text-based, minimizing data usage, while also offering additional communication options such as emoticons, GIFs, voice message, and images to enhance engagement. WhatsApp is also beginning to be used for delivery of mental health interventions in low-resourced settings

(Osborn et al., 2020) and for the self-care of medical patients (Alhazmy et al., 2024; Zou et al., 2023). While social media platforms were used to deliver mental health support to health workers during the COVID-19 pandemic (Serlachius et al., 2021; Thabrew et al., 2022), there is a lack of research on the potential of social media platforms generally, and WhatsApp specifically, for delivery of self-care support to human service workers more broadly.

To increase the likelihood that CCWs would benefit from a self-care intervention, the intervention would need to address the key underlying concerns raised by the CCW team leaders in their focus groups. The Foster Parent Model of Self-Care (FPM) advocates for external guidance to help individuals journey through attitudinal barriers and skills development to ultimately select self-care behaviours. The Behaviour Change Wheel (BCW) describes intervention strategies that can be employed by a facilitator to effect change, using the APEASE criteria for the selection of appropriate strategies (Kaur et al., 2022). From this model, education, persuasion, training, modelling and enablement were chosen as strategies to use within the intervention. Employing a variety of strategies allowed versatility in addressing different themes, as well as providing the opportunity to use more than one strategy to address a single theme (Kaur et al., 2022).

Each theme from Chapter 4 was analysed to determine which strategy could be employed. Educational content about self-care would be given in short, simple text and balanced with engagement through questions to the participants. Training provided would then impart skills to participants building on the knowledge gained through educational input. Activities done during the facilitated sessions would help to embed these new skills. Group engagement would be a vital component throughout the facilitated sessions. Inviting participants to reflect and share would provide a space for engagement through personal experiences. Honest reflection and sharing can assist the positive messaging in the session content (persuasion)(Kaur et al., 2022). Input, questions, engagement and activities would all

build to a final action, or homework assignment, which gave participants a chance to embed knowledge and practice skills learnt during the session. Group support would be key during this time and the facilitator would encourage sharing. Participants sharing stories and encouraging each other would model positive behaviour (modelling) and provide ongoing support for others in the group, outside of session time (enablement) (Kaur et al., 2022).

The intervention questions and activities were largely based on components of contemporary transdiagnostic cognitive behavioural therapy, including metacognitive skills (thinking about how we think), increasing mindful awareness of emotions, and developing new, more adaptive behaviours that are self-reinforcing because they are meaningful (Schaeuffele et al., 2024). Due to the online WhatsApp format, the techniques chosen needed to have minimal resources and explanations. Instead, real-life analogies, through participant sharing, were relied upon to embed knowledge. More time was allocated to themes that had the highest number of mentions so that a variety of strategies could be used to address issues raised.

5.2 Formulation of a Draft Intervention

Attitudinal barriers emerged as a dominant theme in Stage 1, expressed in numerous ways by all team leaders in every group. For this reason, the intervention prioritised attitudinal barriers to help participants become aware of the roles and expectations they place on themselves. These barriers were intrinsically linked to identity. The Middle Range Theory (MRT) highlights awareness as a vital step in self-care to constantly monitor, assess and adjust self-care choices going forward. Readjusting these attitudes would be difficult, and CCWs would need to develop their long-neglected self-awareness and self-reflection skills to be able to recognise and assess their beliefs. CCWs would need tools to retrain themselves to reconnect with their feelings and needs. Only once CCWs gain an awareness of their self-care needs, will they be able to consider adopting self-care behaviours (FPM; Miller et al., 2019a).

Team leaders had described self-care as a journey an individual needed to take; this journey could be guided but not prescribed. As part of this awareness, CCWs will need guidance and support to uncover and address their perceptions of self-care and what it means in their lives.

In addition to external guidance, team leaders recognised the need for community support throughout the self-care journey. Time was dedicated to exploring the drivers that could motivate CCWs to adopt self-care behaviours. Skills are best learnt when they can be put into practice and refined to suit the individual's needs (Gul, 2015). For this reason, the intervention was divided into two sessions, with time in between to practice and refine skills learnt. In the time between sessions, the facilitator would send daily reminders to help CCWs use the WhatsApp group as a support group as they connected and shared their experiences. At the end of the second session, CCWs would have time to explore how best to continue the WhatsApp group outside of the intervention time. In the draft intervention presented in Table 4 below, the first session focuses on attitudinal barriers, whilst the second helps CCWs understand self-care within their contexts.

Table 4

Outline of Draft Intervention

Session one	Themes addressed
Aim: To help CCWs consider attitudinal barriers to self-care	
Who am I?	Attitudinal barriers
To uncover the roles and expectations we have of ourselves	
Who am I in society?	Attitudinal barriers
To consider how society informs how I see myself	
Valuing self	Attitudinal barriers
To recognise the need for self-compassion and valuing self	
Reconnecting with self	Perceptions of self-care
To identify how we feel when we stop and breath	
Daily rhythms	Practical barriers
How incorporating acts of self-care impact daily rhythms	
Sharing is caring	Community support
Exploring the role of a support group in for the week ahead	
Daily reminders sent out to help CCWs' implement skills learnt	Adopting self-care Community support

Session two	Themes addressed
Aim: To help CCWs select unique self-care activities	
My To-Do list To examine how we feel about what we take on	CCWs need self-care
My vision for me To imagine how we want to feel about our lives	Adopting self-care
The role of self-care To explore self-care and self-care activities	Perceptions of self-care
Setting goals To set and share achievable targets	Perceptions of self-care Adopting self-care
Sharing is caring To explore the future role of the support group	Community support
Daily reminders sent out to help CCWs' implement skills learnt	Adopting self-care Community support

5.3 Collating Design Input

The draft intervention, along with a summary of the thematic analysis (see section 4.1, Table 3), was sent to each of the team leaders from Stage 1 for their consideration and input. A Google Form was designed to collect feedback. The team leaders were asked to comment on whether or not the content of the sessions in the draft accurately represented their input during the focus group discussions and to give feedback if they noticed any omissions or felt certain themes were inaccurately represented. Of the 21 participants, 14 team leaders provided feedback.

The team leaders felt the proposed design accurately captured all their contributions. One leader highlighted the significant role faith played in their self-care journey and that this was not reflected in the themes. The leader was sent the full analysis of the themes,

highlighting section 4.2.4 which discussed various ways CCWs could find meaningful self-care activities. In this section, connecting with God was included as one way in which an individual could care for self. When giving examples of self-care in terms of mind, body and soul, connecting with a higher power would be included. The leader recognised that her contribution had been included in this way.

Leaders appreciated the value that the sessions would bring to their teams, the importance of the space the WhatsApp group would create and that the two sessions took participants on a much needed but difficult journey. Several leaders commented that even though the groups would be made of team members, not all CCWs know each other or come from similar backgrounds. Efforts would still need to be made to welcome participants and make them feel comfortable. The leaders suggested that having clear rules for the WhatsApp groups would help preserve the purpose of the space. Additionally, keeping the groups relatively small would be easier for sharing. Most leaders agreed that a group of three to six participants would be the best size for a support group. Team leaders advised that sessions should be 60 minutes long and that seven days is the best period in between sessions.

All comments and input from CCW team leaders were considered and incorporated to refine the draft into an intervention. Keeping in mind that participants may not know each other, an introductory message was added. This message would be sent by the facilitator once the WhatsApp group was created to welcome and introduce everyone. This time could also be used to establish ground rules to ensure confidentiality, create a safe space, and keep engagement purposeful. Teams who had less than three CCWs sign up for the intervention would be excluded at this time. Teams with more than six would be divided into two separate WhatsApp groups. Taking into account that the sessions tackled hard topics, the researcher decided that participants should set aside 90 minutes for each of the two proposed sessions.

This would provide enough time to accommodate all the content, as well as provide adequate time for reflection and feedback.

In their feedback, eight leaders had expressed concern about what would happen once the sessions had concluded. It was possible that the two facilitated sessions could provide the foundation and impetus for a long-term peer support group, without the involvement of the facilitator. A transition stage was added to guide participants, using questions and polls, to determine what they wanted for the WhatsApp group going forward. Since participants could respond whenever convenient, this third session would not require a specifically scheduled time. Should the team decide to continue independently, the facilitator would remain in the group as an observer after this session to monitor engagement during this time. After a week of observation, the teams would be invited to attend a focus group to discuss their experience of the intervention. The WhatsApp group can be used to coordinate logistics of the focus groups. After the focus group session the facilitator would hand over to Outliers and exit the groups. The final intervention design is present in Table 5.

Table 5

Final Intervention Design

Session outline	Session details
Pre-session message	Confirm dates and times of the sessions Participants introduce themselves Set rules of engagement
Session 1: To help CCWs address attitudinal barriers to self-care	
Welcome	Introduction
1.1 Uncovering expectations	Uncover roles and expectations we have of ourselves and reflect on where they come from
1.2 Valuing self	Learning to reconnect with self
	Relaxation exercises
1.3 Homework	Schedule the relaxation exercise to fit daily routines
	Growing awareness
1.4 Close session one	Facilitator sets expectations for the week
1.5 Homework week one	Facilitator sends reminders
	CCWs are encouraged to share

Session outline	Session details
Session 2: To help CCWs select meaningful self-care activities	
Welcome	Welcome and check-in
2.1 Becoming aware of to-do lists	Acknowledge choices about habits, workload and responsibilities
2.2 Choosing how you engage with your life	Reimaging a joyful life
2.3 Exploring self-care	Exploring ideas of care and self-care Brainstorming meaningful self-care activities
2.4 Selecting a self-care task	Setting self-care goals
2.4 Close of session two	Expectations for the week
2.5 Homework week two	Share their self-care goal for the day
	Reflect on their day
3.1 Transition period	Choose purpose of the group
3.2 Observation	Facilitator observes groups

5.4 Final Design

The aim of session one was to help CCWs uncover, acknowledge and address attitudinal barriers to self-care. The session emphasised growing self-awareness, with the WhatsApp group serving as a platform for reminders and support. Session 2 focused on helping CCWs choose meaningful self-care activities, starting with an awareness of their daily responsibilities and habits, followed by visualising a joyful life and brainstorming self-

care practices. Input from the facilitator will be primarily via text, occasionally using images and voice message to provide a tool or resource. Throughout the two sessions, questions will be used to engage participants in the content. After each question participants have a personal reflection time followed by a voluntary group sharing time where participants could contribute via text or voice message.

Participatory pedagogy was used to ensure meaningful engagement. This approach actively involves participants in the learning process, encouraging them to draw on their experiences, share insights, and critically analyse their beliefs and practices (Andersen & Ponti, 2014; de Sousa et al., 2019; Tapp, 2013). As the participants engage with the educational and training content, they can build self-awareness and reflexivity. As participants learn from each other they can gain a broader understanding of ideas presented, co-creating meaning from shared experiences (Tapp, 2013). This gives the intervention content relevant context that will help sustainable and practical application of the knowledge and skills learnt. A detailed description of each session follows below.

5.4.1 Pre-Session Message

The facilitator will welcome everyone to the group and ask them to introduce themselves. The rules of engagement (Figure 2) will be sent out and time will be given for questions, clarifications, and additions to the rules. All participants are requested to accept and sign off on these rules by posting their agreement on the chat.

Figure 2

Terms of Engagement

Reminders will be sent a day before the intervention and 15 minutes before the scheduled start. This reminder will ask participants to find a private space, mute their cellphones, and have pen and paper available. Five minutes before the session, participants will be asked to check in for the session by sending an emoji so that the facilitator knows who is present. The message info feature on WhatsApp will act as the formal attendance register. The facilitator will welcome the group, explain how engagement will happen and start with an icebreaker question, e.g., using only emoticons, share with the group how you are feeling today.

5.4.2 Addressing Attitudinal Barriers to Self-Care

The focus group findings indicate that self-expectations about duty and purpose make it difficult for CCWs to prioritise their own well-being. They would need to accept a more realistic set of self-expectations before they could commit to self-care.

Uncovering Expectations. Participants will be asked to consider all the roles and responsibilities they are trying to live up to. They will be given time to consider what

standards they are trying to meet, where these expectations come from, and what the costs of these expectations might be.

Valuing Self. The facilitator will use the analogy of a water bottle (Figure 3) to help CCWs understand and monitor their levels of internal resources (energy, empathy, patience etc.). During the intervention, they will learn to recognise what it feels like to have a full water bottle, a depleting water bottle and an empty water bottle. Acknowledging that self-care is unfamiliar to most CCWs, the facilitator will introduce three different relaxation techniques (box breathing, visualising technique, and progressive muscle relaxation) as a tool to replenish their emotional water bottle. By introducing participants to short, easy to use techniques (each voice message less than three minutes long), participants will be provided with examples of self-care practices. The techniques will be shared by sending a previously prepared voice message.

CCWs will be asked to try each technique by listening to the guided voice message. CCWs will be given a chance to consider how they feel, in terms of water bottle levels, before and after each technique and assess which technique worked best for them.

Figure 3

Water Bottles

Homework. CCWs will be asked to choose one of the relaxation exercises to perform once a day. This will grow participant awareness of how self-care activities make them feel and set the stage for finding their own personal self-care activity in session two the facilitator will guide CCWs to consider attitudinal and practical barriers to this that might arise. As a

group, CCWs will be encouraged to share strategies to overcome these barriers. Alongside the exercises, CCWs will be asked to use the water bottle analogy to identify how they are feeling throughout the day.

Close of Session One. At the end of the session, the facilitator will provide the number for NPOwer and remain online for an additional 30 minutes in case any participants have questions or concerns.

Homework Week One. Every morning at 8 a.m., the facilitator will send a text asking CCWs to check their water levels and reminding them about their chosen relaxation exercise. Every evening at 6 p.m., the facilitator will send a text encouraging CCWs to share about their day, their water levels, and their relaxation exercise, via text or voice message. During this time, CCWs will be able to discuss problems they encounter when trying to rest in their context and encourage each other in their progress.

5.4.3 Selecting Meaningful Self-Care Activities

The findings from Stage 1 indicated that team leaders did not have a clear idea of self-care activities. This lack of understanding meant that leaders did not see self-care as a necessary or relevant part of their lives. However, once team leaders could understand self-care meaningfully, they found many interesting and personal activities to adopt. The second session will, therefore, focus on discovering a meaningful understanding of self-care to select a personal self-care behaviour.

Becoming Aware of To-Do Lists. Stage 1 findings indicated that CCWs have unrealistic expectations of themselves and take on exceptionally high workloads. In session two, CCWs will be asked to write down everything they have to do across work, home and social spheres and will be given time to reflect on the thoughts and feelings that emerge as they look at their lists.

Choosing How You Engage with Your Life. CCWs will then be asked to imagine the thoughts and feelings they would like to have about their work, home, and social spheres. In visualising this new way of being, they will be asked about the things they need to do to maintain that lifestyle and the things they need to stop doing.

Exploring Self-Care. Before tackling care directed at self, CCWs will examine what care means to them. By first understanding how they see care, CCWs can next confront the difficulties they have when directing this care inwards. In doing this, CCWs can see the imbalance of their actions and expectations.

Selecting a Self-Care Task. Leaders in Stage 1 shared several ways to identify self-care based on how it made them feel (see section 4.2.4). This gave a personal connection to self-care activities and made them meaningful. CCWs will be encouraged to put down their cellphones and, if possible, walk about. During this time CCWs will be asked to consider and write down activities that:

Give them joy. Energise them.
Make them feel good.
Give them a sense of peace.

CCWs will be asked to share some of the ideas they came up with during the above exercise. The facilitator will encourage CCWs to select and schedule one of these activities that is suitable to do every day. If CCWs struggle to identify an activity or cannot come up with an activity, CCWs will be encouraged to use their chosen relaxation tool from the previous week. They will be guided through considering the best time for their activity, the resources they may need and addressing the barriers that might come up.

Close of Session Two. CCWs will be encouraged to share when they will perform their self-care task. In this way, the WhatsApp group will be a space for accountability and motivation. Finally, the facilitator will again provide the number for NPOwer and remain online for an additional 30 minutes.

Homework Week Two. For the rest of the week, the facilitator will send a reminder at the beginning of the day to check water bottle levels and ask CCWs to share their self-care goal for that day. Each evening, the facilitator will ask CCWs to reflect on their water levels and consider the tasks that depleted and replenished them. An additional reminder will be given about the daily self-care goals, and participants will be prompted to share with the group about their experiences.

5.4.4 Transition period

Each Stage 1 focus group discussed isolation in community work and how sharing is a form of self-care. CCWs need practical, safe spaces to debrief and receive support. Having started a self-care journey together, the WhatsApp group could provide ongoing support without the facilitator post-intervention. To do this, the CCWs in the group will need to decide how to proceed.

Group Purpose. A week after the second session the facilitator will post a message inviting the participants to consider the next steps for the WhatsApp group. Should the team decide to continue independently, the facilitator will ask CCWs to create a new WhatsApp group name that echoes their desired purpose for the group. Since the facilitator will no longer be driving engagement in the group, CCWs will then decide on a new administrator for their new group. The administrator will ensure that the group adheres to their selected purpose. Though every CCW will be able to contribute to the group whenever they need to,

the administrator will be responsible for monitoring the group and contributing at least once a week to drive their selected purpose.

Observation. The facilitator will remain in the newly-named group as an observer for two more weeks. This time will be used to determine whether the group can function independently or needs further follow-up. This information will be fed back to Outliers.

5.5 Conclusion

This chapter has outlined the development process and content for a self-care intervention tailored to the needs of CCWs, integrating theoretical frameworks and Stage 1 input. By leveraging insights from self-care theories and themes identified in the qualitative analysis, the intervention was designed to address the unique challenges faced by CCWs in South Africa. Feedback from Stage 1 participants played a critical role in shaping the content, format, and delivery of the intervention, ensuring it remained contextually relevant and practical. The use of a WhatsApp-based platform was central to overcoming logistical barriers and fostering group engagement. The final design balances educational content with interactive engagement, offering a meaningful and practical pathway for CCWs to embark on their self-care journey. The next chapter presents how the intervention was implemented and evaluates its feasibility through focus groups with participants.

CHAPTER SIX: FEASIBILITY STUDY

This chapter describes how the intervention was delivered and presents an assessment of the intervention's acceptability, accessibility and usefulness through thematic analysis of focus group discussions. Carrying out feasibility and pilot studies before more extensive controlled trials allows critical elements of an intervention to be checked and refined, improving the chances of an intervention succeeding (Drummond, 2017; Orsmond & Cohn, 2015). This feasibility study aimed to assess several uncertainties in the intervention implementation namely: participant retention, content engagement, method of content delivery, WhatsApp as an intervention platform, and group engagement. It also assessed the preliminary effects of the intervention to determine whether or not it will yield the hypothesised results, i.e., shifts in attitudinal barriers, and shifts in self-care perceptions and behaviours.

The researcher led both the intervention sessions and the follow-up focus groups discussing the intervention experience. Five themes emerged from the analysis of the focus group data. The first three relate to the intervention's impact on increasing self-awareness, shifting attitudinal barriers, and changing self-care behaviours. The fourth theme examines the barriers CCWs faced when making self-care changes. Finally, the fifth theme shares the participants' evaluation of the WhatsApp platform, content and use of peer support.

6.1 Delivery of the Intervention

Three separate WhatsApp groups were created to coordinate logistics with the 18 CCWs from the three organisations (A, B and C) that were eligible for the feasibility study. Logistics for hosting the WhatsApp intervention sessions were determined using these groups. During this process two participants in organisation B could not attend the scheduled times and were removed from the group, to be followed up with by Outliers. The remaining

16 participants were made up of five participants in Organisation A, five participants in Organisation B and six participants in Organisation C.

Once groups and session times were finalised, the researcher provided a recap of the study and the confidentiality agreements via the WhatsApp groups. All participants were sent the terms of engagement for the WhatsApp group before their first session (see section 5.4.1, Figure 2). Examples of inappropriate engagement, which included sharing other members' telephone numbers, disclosing private information, and misuse of the group space (e.g., forwarding irrelevant posts from other groups), were highlighted. Participants were invited to add anything they felt might have been left out. Participants were asked to acknowledge these terms and that breach of them could lead to removal from the group. Participants acknowledged terms with either a text message or a thumbs-up reaction.

A reminder was sent out a day before each formal session to confirm that all participants could attend. Another reminder was sent 15 minutes before the session was due to start. The NPOwer hotline number was provided before each session, and its purpose was explained to the participants. Five minutes before the session started, participants were asked to sign in by choosing an emoticon given an icebreaker question. Participants responded timeously to the welcome messages and sign in requests (Figure 4). The researcher acted as the facilitator in these sessions.

During the two sessions, questions or tasks were sent via text messages or voice messages to the WhatsApp group. Once sent, the researcher allowed the group members to engage with the question or task and participants contributed with text messages or voice messages (Figures 5 and 6). At the end of the time allocated for the question, the researcher acknowledged the responses and reflected on the contributions. The message info feature on WhatsApp allowed the facilitator to keep track of who had received and read a message (Figure 7). In this way, the pace of the session could be adjusted to allow participants to catch

up if necessary. At the end of the session, the researcher provided the NPOwer hotline number again and remained on the group chat for an additional 30 minutes to chat with any participants who still had questions or comments (Figure 8). After each session, the researcher sent out prompts to encourage group participation and the application of the information received (Figures 9 and 10).

Figure 4

Example of Engagement Before the Session

Figure 5

Example of Engagement During the Session

Figure 6

Example of Engagement During the Session

Figure 7

Message Info Feature on WhatsApp

Figure 8

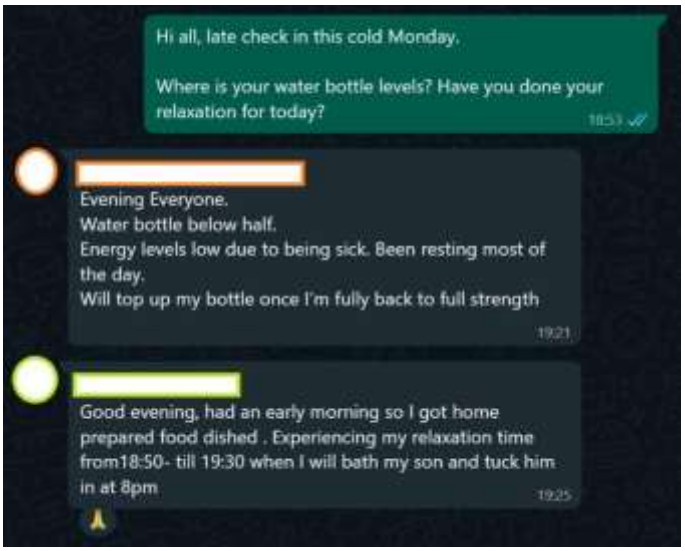
Example of Engagement After the Session

Figure 9

Example of Engagement Between Sessions

Figure 10

Example of Engagement Between Sessions



Organisation C could not attend their second session as their team was in the process of restructuring and this affected team dynamics. The team leader felt unable to continue with the group sessions without first addressing these internal issues. Since the study was set within Outliers, this team could be supported by the Outliers team outside the parameters of the study. The remaining 10 participants from Organisations A and B went on to complete their second session with no complications. Once the two formal sessions were completed, the group was guided to determine its purpose and a new administrator was appointed. The researcher monitored the groups without any engagement for a further two weeks. However, without facilitator input there was minimal to no engagement in the groups during this time. The group remains operational and has been handed over to Outliers for further engagement.

6.2 Assessment of the Intervention

The 10 CCWs that participated in all components of the intervention were invited to a post-intervention focus group discussion to share, in their respective teams, how they experienced the intervention. The invitation was sent to each WhatsApp group, which was then used to coordinate logistics for the hosting of the focus group sessions. All 10

participants attended. Two audio files, comprising 104 minutes of recorded discussions during the focus group sessions, were transcribed and analysed using the six-step process of RTA (Braun & Clarke, 2021). No translation was required and the researcher was able to clearly transcribe the data using Otter.ai. Any identifying features were removed from quotations used and all participants were assigned a unique identifying code.

Initially, 151 data items were identified, which were further refined into 135 unique codes. The number of times each code was mentioned across the focus groups was recorded. As shown in Table 6, these codes were combined into five representative themes, expressed across both focus groups, with sub-themes that describe the experience of participating in the self-care support group.

Table 6

Stage 2 Themes from Post-Intervention Focus Groups

Theme	Subtheme	Number of mentions
1. Increased awareness	1.1 Reconnecting with self	60
	1.2 Knowledge about self-care	14
	1.3 Self-care activities	27
2. Shifts in attitudinal barriers	2.1 I am not obligated to everyone	43
	2.2 I am worthy of care	23
	2.3 I can care for myself	36
	2.4 I do not need to work all the time	34

Theme	Subtheme	Number of mentions
3. Behavioural Changes	3.1 Self-reflection	20
	3.2 Prioritising self	21
	3.3 Adoption self-care behaviours	15
4. Barriers to self-care	4.1 Attitudinal barriers	13
	4.2 Old habits	15
	4.3 Asking for help	10
	4.4 Exhaustion	8
5. Intervention delivery	5.1 WhatsApp platform	29
	5.2 Content	35
	5.4 Peer support	21

Five themes were expressed across both groups. The first three themes illustrate the changes that CCWs experienced as a result of engagement with the intervention content and support group. The fourth theme highlights the barriers CCWs confronted whilst trying to implement the new skills learnt. The final theme summarises experiences of the chosen platform, content and support. Themes are discussed below with direct quotes from participants.

6.2.1 Increased Awareness

Training and education are essential when adopting a new behaviour (Miller et al., 2019a). The two facilitated sessions provided CCWs with specific information and tools to

build awareness and challenge beliefs, specifically around self and self-care. Participants acknowledged that their awareness grew, and they gained more understanding about themselves and their feelings. Sometimes, those realisations were joyous occasions, particularly when awareness allowed them to recognise and enjoy full water bottles, “I learnt what it felt to be green; it feels like inner peace” (P5). Sometimes, they were more sobering, “I notice when I'm drained one thing can knock me out” (P4).

> I didn’t always know if I was feeling good or bad at first. Like maybe I’d know I was a colour [referring to the water bottle analogy], but I wouldn’t know why. Then I find myself recognizing that I am drained at a certain point, I was red [indicating empty]. And then I looked again, and I would know why I was feeling things. (P8)

> I’ve grown in my awareness. I could tell when my bottle was empty. I could tell when it began to fill up. (P1)

> I knew what self-care was. But I didn’t know what it was for ME. And then I had this thought, you know: either I’m gonna make it or not make it, so I need to sit down. And that was it for me at the beginning. I chose me. That was self-care. (P1)

> I had had this yellow bottle after an exhausting day, but then, guess what?! I found something that gives me a feeling of relief and that is going for a run and afterwards, I took a bath. (P5)

> Taking time out is my self-care. It’s quiet and it’s calm and it’s just me. (P3)

All ten participants expressed that the session input provided them with skills to identify their feelings and monitor their needs. Participants were proud of their increased

awareness and deeper understanding of their emotional needs. As participants grew in their knowledge of self and self-care, they found ways to meet their own needs. “I am getting to know myself again,” said P9.

6.2.2 Shifts in Attitudinal Barriers

Input from Stage 1 leaders made it clear that attitudinal barriers around care stood in the way of CCWs prioritising self-care. Participants from the intervention groups began to see the discrepancies in how they cared for others compared to how they cared for themselves. These realisations were freeing when participants released some of the expectations they had unwittingly placed on others and demoralising when participants shared sadness that they may never get from others what they give out. However, some participants were able to realise that they controlled how they viewed and treated themselves.

> The idea that I am not obligated to everyone all the time. That was real. It still is. And then I can be obligated to myself as much as I am obligated to you. I can do that for me. (P1)

> I realised I was angry and disappointed that I give too much to others. Being someone always for others is draining. I was always the person that everyone needed. (P6)

> Never really thought about being able to serve needs to start with oneself. For when you serve from an empty cup then fulfilment can never take place. I see this now. I need to be a priority. (P6)

> I learnt what could work for me. If I know I am drained I can do something to get me through. That’s a good feeling, it’s comforting. (P4)

> This gave me a chance of not needing to live up to expectations: I don't have to live up to people's expectations. I'm forcing myself to do things out of my reach for others and that empties my bottle. I found a new love of the work I do. (P7)

A significant attitudinal barrier for CCWs is their belief that care is something they give to others. Having time to reflect helped participants to reconsider their thoughts about themselves and how they deserved to be looked after and cared for.

6.2.3 Behavioural Changes

Behavioural changes echoed the attitudinal shifts that participants were experiencing. Eight participants reported that they were engaging more with self-reflection, being curious about why they felt something and what they could do about it. P8 shared, "I keep doing it, you know, catching it, stopping, wondering why I think this or that. I take time to reflect; I didn't do that before". Participants began to make choices that prioritised their needs. For some, this led to the adoption of self-care behaviours. The box breathing technique, shared during session one, was a particular favourite with participants. "I do the breathing everywhere: driving, watching TV, or walking. I do the breathing exercise every chance I get," shared P1, highlighting the adaptability of simple techniques. Six participants reported that they began incorporating new self-care practices into their routines.

> I pause to think how I feel now, like why I feel it. I choose to stop living in autopilot and know why and feel why, that's important. (P6)

> I book days in my calendar for myself. I had to start removing what was exhausting me. (P8)

> I notice me saying to people who were sick: take care! But I didn't say that to myself. I was sick, so I told myself to take care. I put myself on the list. I take care, too. (P3)

During the intervention, participants began implementing new ways of doing things utilising the skills they were learning. These changes pay tribute to the journey of self-care described in the FPM (Miller et al., 2019a), that begins with awareness and reflection and ends with adopting self-care behaviours. As participants became more aware of what they needed they were able to prioritise themselves. The steps taken indicate an emerging sense of agency, control and intentionality about how they choose to spend their time and energy.

6.2.4 Barriers to Self-Care

Participants shared that it was still challenging to maintain self-care behaviours. Even when they had made changes and adopted new behaviours, participants acknowledged that stepping out of old ways of thinking and behaving was a daily struggle. As P2 expressed, "I forget sometimes about me, pleasing others comes so naturally. I'm just not used to looking after me." This resulted in daily internal conflict for participants as they fought against programming that demanded they prioritise others. When faced with these difficulties, participants struggled to express themselves to those around them and ask for support, unaccustomed to being the ones in need. Exhaustion compounded these difficulties, as participants often felt too tired to complete their scheduled self-care tasks. As P4 described, "sometimes nothing would help when I was empty."

> P6: Being the strong one, this always feels like a job we have to do.
>
> P10: Just being female, so many expectations.
>
> P8: Being a mother.
>
> P7: Being a wife
>
> P10: But being a woman, and then wanting to like, care for yourself you face judgement. As a woman, you are there for others.
>
> I still put everyone else first, it's so automatic. It's been almost 34 years not feeling anything for myself. (P6)

I don't give people a chance to help me. I'm not used to people building me up. (P8)

It’s one thing here. It’s another thing with other people. Here it’s almost like, we are here to talk about these things. It’s different with other people. (P4)

When I was red it was hard to use the tools. It's hard when you're tired. (P2)

It will take considerable time and support to help CCWs confront and navigate their skewed ideas of care, worth and expectations. Positively, when sharing these obstacles in the focus groups participants were able to be encouraged by others. Being able to acknowledge these barriers, rather than succumb to them, participants showed impressive self-awareness. This is an essential skill in the self-care journey, as described in the MRT. Sustainable self-care requires the ability to continually monitor, assess and adjust (Riegel et al., 2012). Additionally, by verbalising these barriers participants illustrated a capacity to share their needs with those who had a common agenda and shared experiences. This highlights the important role support groups play in creating safe spaces for CCWs to debrief.

6.2.5 Intervention Delivery

The participants discussed several ideas around the delivery of the intervention. They found that their familiarity with WhatsApp made it an easy platform to engage on. Making use of reactions and emoticons came naturally to them, as they felt like they were having a conversation with friends. WhatsApp also proved helpful as a way to send reminders, as participants appreciated the notifications that appeared on their home screens as a result of a message sent. Participants particularly enjoyed the session times, reflecting on the content and engaging with the questions. Participants found it helpful to hear how others connected with the information provided; sharing aided understanding. However, participants found the

group less helpful outside session times, often forgetting to share.

> I use WhatsApp a lot so I'm very used to it. And it was just like having conversations because I knew everyone. (P2)

> The check-in pops up and brings an alert. That was good. It made me think, and I think that made us all say something. It gave me a reason to think about my day. (P7)

> The group worked for me, I like hearing the others, what they thought about a question and how they interpreted it. (P10)

> I know more about this now. The information made sense and I can explain it to others, to the kids. I have words for it, I have things I can do about it. (P4)

> The group was such a positive place, everyone was so positive. Even when the day was rough, you'd say something and someone would be there. Probably because I don't have people building me like you're doing right now. (P4)

> Sharing made me appreciate things. I wanted to be positive. I wanted to share a good thing when you asked. But it's harder when it's not being asked when there isn't a question to answer. (P2)

> I'll be honest. I just forgot it sometimes. It helped when you saw your teammate and thought: oh water bottle! But we didn't always see each other. You always said it has to work in your life, with all the life things. I just forgot. Something was always happening. (P8)

Whilst engagement outside of session time, though appreciated, was not used as much, participants appreciated the facilitated session times. For some, the information was new or “eye-opening” (P5), while for others, it brought to light things that they knew but now had the language for. Engaging through chat was comfortable for them and “as easy as communicating with a friend” (P2). This suggests that structured, facilitated spaces are more accessible for busy CCWs, who are unable to create the time for reflection on their own.

6.3 Researcher Reflections on Intervention Delivery

Facilitating the self-care intervention for CCWs was both rewarding and challenging. It was gratifying to see that the content invited engagement, provided clarity and offered new ways of seeing themselves and others. Since most of the intervention required personal reflection, the fact that the platform was text-based did not slow down interactions. In fact, without prompting, participants gravitated towards using the reaction feature in WhatsApp when content was being delivered and responded with longer texts during the sharing times.

However, being limited to only text responses was challenging when participants were struggling with issues such as guilt and self-worth or sharing deeply personal experiences. It is the nature of group support spaces to share, not solve, and balancing the needs of the group with individual emotional responses was a delicate task that required thoughtful facilitation. The participants were so grateful for the input and guidance that there was a risk of breaking boundaries and getting overly involved. Having the support of Outliers and knowing the effectiveness of resources like NPOwer removed the inclination to shoulder all the issues that came up in sessions. This support was equally valued when recognising that behavioural change would require sustained effort and support beyond the scope of the intervention.

The WhatsApp platform proved an effective and accessible tool, and the scheduled times allowed for meaningful interactions. The WhatsApp message info feature was unexpectedly useful and helped keep track of participant engagement. However, sustaining

engagement during homework weeks and observation periods proved difficult. This revealed a dependence on the facilitator's presence to maintain momentum, which raises questions about how to build more intrinsic motivation for sustainable self-care practices.

Overall, participant feedback was affirming for the intervention, offering valuable insights for refinements. It also highlighted the preparation and boundaries one must set to address the emotional labour inherent in supporting others through transformative journeys.

6.4 Conclusion

This chapter reported on the process of delivering the intervention and participants' feedback regarding their experience of the content, platform and group dynamic. The process of the intervention highlighted a challenge of participant retention. The group dynamic of the intention requires teams to all commit to a specific time, realistically this means some team members may not be able to make a session. The unpredictable nature of community work also plays a role in commitment to the intervention, seen when Organisation C needed to excuse themselves from session two. Being able to rely on resources outside of the study, in the form of the Outliers team, ensured that these participants had appropriate follow-up and support.

The focus group themes indicate that the content provided was appropriate and accessible. The education and training provided was able to encourage and support a self-care journey, as participants moved from increased self-awareness to adopting small but meaningful self-care behaviours. The group dynamic was essential in supporting the information provided. WhatsApp was shown to be an effective platform for training and education around self-care, allowing participants to receive information clearly and participant easily. Outside of session times, however, engagement declined. Though WhatsApp was a suitable platform to convey information and effort had been made to create a safe environment for sharing, participants did not gravitate to it as a support space outside

of sessions. This highlights the need for alternative support systems to run alongside finite self-care interventions, which can sustain CCWs in the long term.

CHAPTER SEVEN: DISCUSSION

The chapter begins by summarising the findings from Stage 1, highlighting the role team leaders played in shaping the co-designed intervention. It discusses the important role of true collaboration, which is only possible with authentic communion with community partners. The chapter then evaluates the feasibility of the intervention delivered, examining the WhatsApp platform as well as its impact on self-care perceptions and behaviours. Finally, it examines the limitations of the study, offers recommendations for future research and shares final thoughts on the application of the findings.

7.1 Summary of Findings

This research aimed to understand the current self-care perceptions and behaviours of CCWs affiliated with the Outliers organisation in Cape Town, to design an intervention to aid the adoption of self-care behaviours. Stage 1 of the study revealed that attitudinal barriers posed the most significant obstacle to self-care for CCWs. The literature has identified attitudinal barriers to self-care that are rooted in mental health stigmatisation (Coates et al., 2018; Lund et al., 2012). However, the attitudinal barriers presented in Stage 1 were more personal and rooted in self-worth. For black women in particular, societal expectations often glorify martyrdom and resilience, making it challenging to prioritise self-care without feelings of guilt or inadequacy (Baloyi, 2020; Diprose, 2015; Haine et al., 2022; Lorde, 1988/2017; Prilleltensky, 2003; Swartz & Colvin, 2014). Though these barriers directly affected self-care, their impact was far-reaching. Additionally, a misperception of self-care rendered it unimportant and inaccessible to CCWs. When self-care is inaccurately perceived as selfish or as a luxury for the affluent, it gains a negative connotation, discouraging individuals from valuing or pursuing it (Mills et al., 2015; Yen, 2016). The contributions of participants in Stage 1 also highlighted the need for each CCW to identify self-care practices that give them meaning and joy, rather than prescribing a specific behaviour to be adopted.

Stage 1 participants were wary of barriers related to time, cost and transport, highlighting the need for an intervention format that accommodated these practicalities, but also enabled community support through the self-care journey.

The learnings from Stage 1 informed the content of the intervention delivered in Stage 2. A WhatsApp group was selected as a delivery format that could enhance accessibility while still offering group sharing and support. Rather than having behavioural change as the ultimate goal, the intervention focussed on recognising and addressing ever-present attitudinal barriers to eventually find meaningful self-care actions. The intervention used participatory pedagogy, a hallmark of the non-prescriptive approach used by Outliers organisation. Training and educational content were briefly presented and the intervention then relied on participants engaging with questions to co-create their own meaning. This method of skill-building focussed on asking open questions and setting aside enough time for participants to personally reflect and collaboratively share with others. Participants in the intervention reported increased abilities in self-awareness, self-care choices and self-care actions. Engagement using the WhatsApp group was invaluable in contextualising content, making it personal, relatable and easily applicable. However, outside of the session times, and after the facilitator handed over running of the group to the participants, engagement was not sustained. This raises concern over the longevity of the progress made and the sustainability of the intended outcomes.

7.2 Co-Designing Needs True Collaborations

CBPR emphasises the involvement of the beneficiaries, who will ultimately use the research, throughout the research process (Springer & Skolarus, 2019). Building trusting relationships between researchers and community participants is essential for understanding their needs and priorities, but because this process can take years it is often overlooked (Springer & Skolarus, 2019). This study embedded its research within an organisation

familiar to the community. Outliers had an established relationship with CCWs before this study, and will continue in relationship with them after it. This established, pre-existing relationship between the researcher and participants enabled authentic input, collaboration and feedback. Prioritising community participation led not only to a tailored, empathetic, and contextually responsive intervention, but also ensured all participants were treated as equal collaborators throughout the research processes.

Focus groups allowed small-group discussions, where community leaders could actively share perspectives, reflect on others' viewpoints and articulate their opinions. While small groups required less logistical coordination, accessibility challenges still arose, including scheduling conflicts and technical issues with online platforms. For instance, the first online focus group that was scheduled was eventually cancelled as four of the participants could unexpectedly no longer make the time. The second hosted only four of six participants, with two of them experiencing technical challenges. Supplementary telephonic interviews were included to gather broader input, though only two leaders could be condtacted within the timeframe. Though at first not the ideal method of data collection, these interviews provided deeply personal insights, which complemented the group discussions. The flexibility of online platforms and telephonic interviews helped accommodate leaders' busy schedules, increasing engagement and adhering to CBPR principles, which recognise the additional workload that research imposes on participants (Springer & Skolarus, 2019).

Importantly, the community leaders in Stage 1 were primarily women of colour, representing voices traditionally overlooked in the field of psychology (Lorde, 1988/2017; Seedat & Lazarus, 2011). This exclusion has resulted in interventions and theories that fail to address foundational needs of these populations. To create impactful interventions, it is essential to ensure adequate representation and the active, meaningful, and visible involvement of groups that are likely to be most affected by research findings (Moriah, 2018;

Onwumere et al., 2023). This intervention could target specific needs because leaders had been given the opportunity to consider their self-care, learn from others and give voice to what they needed and wanted.

CBPR ensures equitable collaboration that allows the unique strengths, challenges, and social contexts of the community to create interventions that are both impactful and enduring. This research relied on the lived experiences of community leaders and their contributions ultimately led to a unique and targeted intervention that, according to the findings in Stage 2, was able to address and support the specific needs of this sample of CCWs in terms of raising awareness of self-care and exploring how it could be enacted.

7.3 Understanding Current Self-Care Perceptions and Behaviours

Community leaders described overburdened and ill-equipped CCWs, constantly working to meet overwhelming needs while facing judgment if they paused. Women of colour excel in creating safe spaces and meeting the needs of others (Lorde, 1988/2017), but this dedication often comes at a personal cost, posing significant challenges to self-care. Conversations with leaders revealed six key themes that informed strategies to help CCWs adopt self-care practices. These themes highlighted skills to develop, mindsets to challenge, and practical barriers to overcome. Leaders articulated struggles with self-worth and the ingrained belief that self-care was secondary to caring for others. For participants, prioritising their well-being required reframing self-care as equal to, and indeed necessary for, sustaining their care for others. This perspective countered deeply entrenched cultural norms and self-evaluations shaped by the external, gendered expectations of their families, communities and society. This resulted in the intervention focussing on creating time and space for self-reflection to recognise and confront attitudinal barriers.

Self-care can be radically transformative for disadvantaged communities and has played an empowering role in women's rights and black liberation (Martínez et al., 2021;

Wyatt & Ampadu, 2021). However, an inaccurate or narrow interpretation of self-care meant that leaders often struggled to identify meaningful and enjoyable self-care practices. Instead, they associated self-care with stereotypical health activity examples such as hiking, maintaining hygiene or eating well. These they found to be inaccessible, unfulfilling or both. To find a more relatable way to ask about self-care, the researcher encouraged leaders to reflect on their broader understanding of care. As mentioned in previous chapters, these definitions shared the common feature of always being directed out to others. However, the researcher was able to use these words to challenge leaders on how they showed care to themselves, (e.g., how did they give 100% to themselves, love themselves, be generous to themselves). Though difficult at first, using their language to ask about how they cared for themselves got leaders to an understanding of self-care that was less about specific activities and more about feelings. Experts at meeting the needs of others, leaders were now able to consider how they could cultivate joy, energy, and love in their own lives. This emphasised the importance of redefining self-care terminology and aligned with voices like Davis (2023), who emphasises collective care and Kaur (2021, p. 310), who frames self-care as part of "revolutionary love", which involves loving others, opponents and self and can only be achieved in communion with others. Both perspectives draw from Lorde's (1988/2017) foundational work, underscoring self-care as a transformative and empowering practice. Without the team leaders' overwhelming descriptions of care being something that is extended to others but does not come in, alongside revelations around self-worth and duty, the intervention would not have adequately addressed this issue.

7.4 Self-Care Intervention Feasibility

The intervention was designed on WhatsApp, removing many practical barriers associated with access. Effective content delivery relied on information being clearly and concisely communicated and engaged with on WhatsApp. Peer engagement was also

essential to make sense of the content provided and provide a support system for CCWs when addressing barriers and adopting behaviours.

7.4.1 WhatsApp Platform

The use of WhatsApp as a training tool has been tested in the education sector due to its popularity and low data consumption (Gcabashe, 2024; Thaba-Nkadimene, 2020; Venturino & Hsu, 2022). Outliers has relied on WhatsApp to maintain communication with partners, as more CCWs have regular access to WhatsApp than to email. Outliers has also used WhatsApp groups as support groups for training sessions and social engagements. This familiarity with an online platform among the CCWs in the Outliers network made WhatsApp an accessible and familiar choice for the delivery of this intervention. The facilitated discussions in the two WhatsApp intervention sessions relied on personal, open and honest sharing. CCWs were placed in groups with colleagues but, as leaders pointed out in Stage 1, this did not necessarily mean team members knew each other or came from similar cultural backgrounds. Icebreakers that embraced the WhatsApp format (i.e., using emojis, GIFs and images), were employed to encourage engagement.

The intervention was designed so that facilitator input would be minimal. Though educational content around self-care was provided, it was always presented in a way that elicited personal reflection or in-session engagement. Input was provided in short messages, occasionally accompanied by an image. When input was longer it was broken up into several messages to minimise the amount of text that appeared on a screen. CCWs were then encouraged to reflect and share their experiences to grapple with and understand the content provided. Without this engagement, the education and training would not have been relatable and would have had less impact. The facilitator would occasionally use personal examples to illustrate and model activities, but personal contributions from the facilitator were kept brief

and only served to explain an activity, which then led to reflection periods or engagement with participants. As such, participant engagement was a significant component of the intervention and did not appear to be hindered by the digital WhatsApp format. It is even possible that this distance allowed for more honest and open engagement than might not have been possible in a face-to-face group meeting, the latter being more intimidating and exposing than posting on the WhatsApp group.

Participants kept up with the content provided, interjected when they needed to and made good use of the WhatsApp response feature, which enabled feedback without participants typing out messages. The message info function was used to track where each participant was and thus helped to maintain an appropriate pace for each session. This was particularly useful when participants would respond to different parts of the session at the same time. It was also possible to use reflection times to help participants catch up when needed. This flexibility meant participants were able to engage with every activity, as well as revisit activities outside of session times.

The findings from Stage 2 indicated that participants preferred the session time over the homework time. Assigning a dedicated 90 minutes to a session was much easier for them to commit to than the more ad hoc engagement in the homework week. Though prompts and reminders were given at the same time each day, participants were asked to schedule their activities on their own time and could respond when convenient for them. Participants were encouraged to maintain the same schedule, creating daily rhythms of reflection and self-care was difficult. Though disappointing, this was not completely unexpected when considering how difficult it is for CCWs to prioritise themselves. Participants found the prompts helpful and welcomed the messages that reminded them of self-care, however, they did not always engage with the messages. During the two-week post-intervention observation period, there was minimal engagement between participants in the groups. Incorporating self-care into

daily realities was difficult for participants and, with time not specifically set aside for engagement, it was difficult to take time to contribute to the WhatsApp group. However, it was useful to know that the prompts were welcome and that WhatsApp could be used to provide helpful tips and reminders.

Though team leaders had expressed a need to create accessible safe spaces to share and connect, maintenance of the WhatsApp group without an external facilitator was difficult for participants. The intervention lasted two weeks and by the end of the intervention period, participants were only beginning to address the internal challenges they faced around self-care. An independent support group put pressure on participants, new to self-care and struggling to articulate their needs, to regularly post on a WhatsApp group. It also required these depleted workers to come up with ways to support others. These findings indicate that CCWs need more guidance and support from a third party before they can be the driving force of their own self-care support groups.

Findings from Stage 2 suggest that the intervention content designed for the WhatsApp platform worked well. Educational content did not need to be lengthy as knowledge was gained through questions and reflections. Images and voice messages could also be used to provide variety to the presentation of content. No video content was necessary, nor links to other sites where additional data costs may be incurred. Input from participants gave context to the questions posed, immediately making content relatable and enhancing the content provided. WhatsApp was also useful as a reminder for CCWs. Messages sent to the group popped up as notifications on their cellphone, reminding them to pause and reflect.

7.4.2 Improving Self-Care Perceptions

Addressing attitudinal barriers in the first intervention session and dedicating time to reflection and sharing throughout the intervention was valuable to all participants and

provided the most significant impact of the intervention. For some, this led to behaviour changes and the adoption of self-care activities. For all, it led to attitudinal changes that supported new ways of thinking about others, their work, and themselves, an important precursor to attitude and behaviour change (Miller et al., 2019a).

Participants were weighed down by expectations, both internal and external, and felt obligated to fulfil every duty and meet every need. A leader in Stage 1 explained how, for years, she never realised how keeping up with the "programming" was affecting her. She was desperately trying to be everything to everyone, "not knowing I was killing myself." This awakening came with conflict as she made changes that inconvenienced others, but in the process, she was saving herself. To hear the same awakenings in the intervention participants was a powerful tribute to the radical nature of self-care described by Audre Lorde (1988/2017). Radical self-care has a political connotation. It is about self-preservation, understanding the need to survive when your environment considers your personhood unimportant (Kaur, 2021; Lorde, 1988/2017). Radical self-care involves restoring not only the body but also the soul by challenging historical narratives and imposed identities, empowering both the individual and their surrounding community (Wyatt & Ampadu, 2021). When considered in this light, the ability to become more self-aware, pause and engage in a simple breathing tool takes on new meaning; in fact, "breathing like this is a political act" (Kaur, 2021, p. 216).

The shifts in attitudinal barriers for participants show an important journey towards self-compassion that is still embedded within a deep compassion for their community. This helped participants come to terms with the idea of rest. A participant from the intervention explained that she "never really thought about being able to serve needs to start with oneself. For when you serve from an empty cup then fulfilment can never take place. I see this now. I need to be a priority." CCWs not only realised that it was okay to stop, but that stopping and

prioritising themselves should be the natural rhythm of how they worked.

7.4.3 Increasing Self-Care Practices

The behavioural changes seen were mostly around self-awareness shifts that helped participants to reconnect with themselves. Developing this reflexivity was an emotional process. Group sharing in this regard was deeply personal, emphasising the importance of creating a safe space and time for reflection. When a question was posed, participants first had to consider it for themselves. This resulted in periods of complete silence on the WhatsApp group as the facilitator deliberately stopped her engagement to allow participants to reflect. After this, participants were invited to share if they wanted to. Once again the facilitator did not intervene during this time, giving participants a chance to consider what they wanted to share on the group, if anything. For all participants, the language they learnt to describe what they were feeling was important. Being able to pause and reflect was not as helpful if they could not articulate their emotions to themselves, or others. The analogies used in the session were a useful starting point for communication. This helped them to monitor their energy and empathy levels and begin to give language to what different levels felt like. For some, this led to further reflexivity as they paused to reflect on why they felt certain things and what they could do to address feelings. This awareness meant that when they encountered barriers to self-care, they noticed and identified them. They were aware of the guilt they felt and why they were feeling it and they could see the times they slipped into old habits.

Long-term self-care will always encounter attitudinal and practical barriers and needs constant adjustment. Session 2 asked participants to seek out self-care actions and schedule them, thereby prioritising their care above others. Participants not only had difficulty scheduling self-care but struggled to find activities that they enjoyed. Participants from Organisation A, particularly, struggled to identify self-care tasks. Watching the group

flounder to identify activities that purely benefitted them highlighted how little CCWs consider themselves. Group support was helpful during these moments, but it was only during the homework week that all participants in this organisation eventually found an activity. “It was funny,” one of the women from this team expressed, “to be so good at caring for others but no good at caring for me.”

Though the intervention only lasted four weeks (two intervention weeks and two post-intervention weeks when the WhatsApp group was supposed to be run by participants rather than the facilitator) it was affirming to see positive shifts towards self-care practices. However, in this short time period, participants already found that their self-care tools did not have the anticipated effect when they were exhausted. The Middle Range Theory of Self-Care (MRT; Riegel et al., 2012) emphasises the importance of continuously refining self-care practices over time. For this to happen, CCWs would need to curate a range of resources that could form part of a comprehensive support system that worked alongside the skills developed through training and education. Additionally, CCWs already suffering from compassion fatigue and burnout need to rely on more than personally driven self-care to refill (Bressi & Vaden, 2017). This is where support networks could play an important role. A variety of support would help CCWs have options available to them with they are in burnout and unable to take action for themselves.

7.5 Researcher Reflexivity

I occupied a number of positions throughout the intervention: facilitator, co-founder of the organisation, and researcher. These overlapping identities both empowered and constrained the research process. Notably, my position allowed extended contextual knowledge and good participant rapport, which established trust and openness in most of the sessions.

Sustaining these obligations required ongoing consideration. There were moments

when I struggled with wanting to guide participants through reflective processes while requiring distance to observe and record their experiences for valid analysis. There were moments when my instinct as a community worker was to support participants emotionally. This came into conflict with my responsibility as a researcher to remain open to discomfort and not find solutions.

These positionalities and how they influence data collection, interpretation, and meaning-making should be kept in mind when considering the outcomes of this research. While I was careful to offer critical reflection and represent participant voices as centrally as possible, this research is inherently shaped by my own experiences, values, and perspectives, along with those of the Outliers organisation.

7.6 Limitations and Recommendations for Future Studies

How participants are introduced to the intervention and descriptions of what they are being asked to join needs to be carefully considered. Once involved, participants immediately felt the benefit of the intervention. But initially, engaging in an intervention that lasts several weeks could be seen as an impractical option for CCWs, who are predisposed to choosing their work over themselves. It is possible that using an in-person introductory session, much like the Stage 1 focus groups, would help participants experience the benefit of sharing and the need for self-care. The focus groups were not only essential to tailoring an empathetic and relevant intervention but also increased buy-in and encouraged participation. These introductory sessions could be held with larger groups at individual organisations and end with the offer for individual CCWs to sign-up for a longer intervention.

The trust relationship that the researcher had with the participants ensured honest input, however, the researcher was concerned that participants felt obligated to engage with the study due to their relationship with Outliers. One leader did acknowledge that the reason they said yes was because the researcher had asked, but further conversation indicated this

was less about obligation and more about trust and that involvement in anything associated with Outliers had positive implications for them. The camaraderie that the leaders shared with the researcher and each other made focus groups safe spaces for sharing and conversations were easy to facilitate. Future research would need these trust relationships for authentic sharing of perspectives, concerns and limitations. Contrastingly, the researcher acting as the facilitator could have led participants in Stage 2 to be influenced by social desirability motives and present an overly positive picture to the researcher. Having an independent researcher conduct the intervention and facilitate the feedback stage will be important in any future evaluations of revised versions of this intervention.

The adoption of new behaviours takes time. However, running a month-long intervention is not practical in community work. Recruitment for the invention was poor partly due to the time limit on sign-up but also possibly due to the time commitment. This is suggested by the fact that Stage 2 participants struggled with long-term engagement outside of the scheduled session times. The two weeks outside of the facilitated training times and homework weeks were underutilised by participants, suggesting it did not provide what participants needed at that time.

WhatsApp, however, was useful as a training platform and afterwards for reminders and prompts, future interventions should focus on this strength. One way of doing this would be to limit the intervention to session times only and consider alternative methods for following up, such as in-person meetings or suitable self-care applications. A second option is to extend the post-session period to provide prompts for a longer period of time. These could include using participatory pedagogy techniques to encourage daily group engagement. In addition to either (or both) of these refinements, future interventions should prioritise building a diverse network of support, including in-person connections to complement the WhatsApp group and resources like SADAG, ensuring participants have multiple avenues of

encouragement and reinforcement.

As mentioned above the timeframe of the study excluded a number of organisations from participating. Though feasibility studies are generally small, a larger sample would have given more data. Running more groups would have tested how robust the intervention was across different communities. Involving more participants would have also helped to test engagement with different genders, ages and cultural backgrounds. Since groups were put together by the researcher, different group combinations could have impacted engagement and impact. Additionally, both groups in the feasibility study had only five participants, which proved a comfortable number for the researcher to engage with. It is possible that with larger numbers engagement might have been more difficult to keep track of and negatively impacted group cohesion.

It is also noted that a number of participants that signed up that could not complete the sessions as intended. Organisation C was not able to attend the second session due to the impact of unexpected organisational changes. This suggests that some degree of organisational consistency and sustainability may be needed to provide a safe base for CCWs to embark on a self-care journey. Setting the research within a support system for the participants meant that Organisation C could be referred to Outliers and receive the operational support that they needed. Additionally, Outliers could follow up with the organisation and offer self-care support at a more suitable time for their team. This highlights the importance of an accessible support system that can meet the needs of the organisation, not just the individuals.

The feasibility study in Stage 2 relied on a single-arm pre-post qualitative evaluation design without any control group of CCW or quantitative evaluation of self-care outcomes. Should further iterations of the intervention be evaluated, this should ideally be done through a randomised controlled trial design that includes both quantitative and qualitative process

and outcome measures. This would help to ensure that any changes over time are due to the intervention rather than other factors and could establish the statistical and practical significance of any changes that occur over time.

7.7 Application of Results

This small, single-arm feasibility study is not able to draw any firm conclusions about the effectiveness of the intervention for CCWs in general, but the study does highlight the value of collaborating with beneficiaries to develop interventions that meet their specific needs. While a researcher may frame input within theoretical models, literature and validated tools, the interventions design should ultimately be led by those who will use it. Research that does not collaborate with beneficiaries cannot accurately understand community needs, nor formulate a representative intervention. Moreover, this involvement helps to create buy-in. The leaders involved in the co-design process understood the effort, motivation, and purpose behind creating this intervention. Seeing their contributions reflected in the final ensured ownership that translated into advocacy for participation.

Conducting this study from within an existing organisation had several benefits. Primarily, the foundation of trust essential for CBPR was already in place. Long-standing relationships between the community leaders and the researcher, through Outliers, meant that input was honest and heartbreakingly insightful. Secondly, it meant that all organisations were known by Outliers before the study began and would continue to be supported by Outliers after the study had been concluded. Too often, research can be conducted in a vacuum, with researchers engaging with research participants only within the study parameters. This disregards the impact of the study on participants. The researcher could depend on a team at Outliers to follow up with participants and check in, particularly with those outside the scope of this study.

As described by the FPM, self-care is a journey that eventually leads to new self-care

behaviours (Miller et al., 2019a). Any behaviour change will come up against challenges as individuals confront long-held habits and misconceptions. Education and training are essential components of this journey. The study presents WhatsApp as an accessible option for knowledge sharing and skills development when participatory pedagogy is employed. WhatsApp is designed for easy engagement and conversations. This capacity allowed for the presentation of substantial content in an accessible manner, because participants could engage in discussions that enhanced their understanding. However, refinements to this intervention going forward will need to explore, in collaboration with CCWs, how best to sustain engagement with self-care over time and embed it into daily consciousness and practice as CCWs continue to serve their communities.

7.8 Conclusion

Working within the context of Outliers proved invaluable in creating safe spaces for meaningful collaborations, which allowed CBPR principles to be effectively employed. The use of a platform like WhatsApp exemplified how prioritising accessibility for participants can lead to innovative ways of using existing technology to reach communities, create safe spaces and access training. These choices centred the participants within the research process, ensuring their voices and needs were not only heard but actively shaped the intervention.

The input from team leaders gave the intervention its focus and prioritised attitudinal shifts needed by creating spaces for reflection and self-discovery. The study findings highlight that CCWs are prone to neglecting their own self-care, often placing the needs of others above their own well-being. This tendency not only affects their personal health but also impacts their effectiveness and sustainability in their roles. The findings underscore the pressing need for interventions to examine attitudinal barriers in additional to engaging in the sustainable development of behavioural change.

Ultimately, the findings demonstrate that developing self-care amongst CCWs is a

journey. A two-session intervention can be the critical start of that journey to sustain CCWs in the long term because it provides an accessible, easy entry point into the self-care space, whilst encouraging participants to take further steps toward sustained well-being.

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APPENDIX A

Stage 1 WhatsApp Invitation

Dear _

I hope you're managing to keep warm and dry! I would like to ask you about something new we are doing at Outliers.

As you know, we talk a lot about making sure you take care of yourself. You carry a great burden as a community care worker. I want to create a **self-care support group** for our community that will help you and your team handle the **emotional stress** placed on you through your work.

I am doing this as part of my Masters degree and **need your input** on what to include in the self-care support group intervention, and how best to reach your teams.

If you're interested in helping to develop this support please let me know by <date to be added>.

Thank you for your interest! I would like to chat more about what is involved. For example, I will need

1. 2 hours of your time so you can share your ideas in a group with other team leaders and
2. your team's involvement in testing the self-care support group intervention we develop.

Please let me know when it would be convenient to call.

APPENDIX B

Stage 1 Consent Form with Sociodemographic Questions

You are invited to take part in a research study to develop and pilot a support group that will help community workers, like you, to prioritise self-care. We believe your insight will be valuable to developing this support and hope that you will consider participating in this study.

What will I need to do if I agree to take part in the research?

If you take part in this research, you will:

1. Attend a focus group workshop to share your thoughts on mental health and self-care for CCWs and to give input to help co-design a self-care support group intervention
2. Introduce the self-care support group intervention to their team of CCWs at your organisation and invite them to participate
3. Attend a feedback session to hear the key findings of the study (optional).

How will my confidentiality and personal information be protected?

A WhatsApp group will be created to decide on the location of the focus group. By joining the WhatsApp group, you commit to not sharing the cell phone number of any of the participants. The WhatApp group will be deleted once your focus group is over.

Your focus group will consist of Laura and 4 other community care workers. You will be expected to maintain the confidentiality and anonymity of the others in the study by not sharing what is spoken about in the session.

The focus group session will be audio-recorded. The recordings will be transcribed (written out) and analysed to provide information to co-design the support group. The audio

recordings and the transcripts will be stored on password-protected files on Laura's personal computer and will not be shared with anyone except the research supervisor.

When information you provided during the focus group is written up for Laura's thesis or any research publication, a pseudonym (or fake name) will be used. Any personal details that could identify you will be removed.

Do I have to take part in this study?

No. Your participation in this research is completely your choice. You may choose not to participate if you wish, and this will not affect your relationship with your organisation or the support you receive from Outliers. If you decide to take part in the study, you may choose to leave the study at ANY time without having to explain and without any negative impact. Should you choose to withdraw, Laura will not use any of the information you have provided without your prior signed consent.

Will there be any costs to me for taking part in the study?

You will need WhatsApp and data for communication about the location and time of the focus group. The most convenient location for all participants will be selected. This may require travel costs on your behalf and a travel stipend is available if needed.

Are there any risks to me if I take part in this study?

In this study you will be required to discuss self-care perceptions and behaviours. This might possibly raise some difficult emotions. You have the right to withdraw from the study at any time if you feel uncomfortable. Should you wish to speak to someone about these feelings please connect with NPOwer, a FREE 24-hour helpline on 0800 515 515, or speak to Laura who will try to connect you with other relevant support services.

What will happen to the information I give in the focus groups?

Laura will send you a copy of the transcribed (written out) focus group conversation that was recorded. You can check this version to make sure Laura has correctly written down things you have said. Based on the input provided by the group, Laura will draft the support group intervention. Laura will ask you to consider the draft intervention and give any suggestions and changes or point out anything that has been missed to help improve the proposed intervention. After the study, the group will meet again so that we can share the key outcomes of the study. Should you not be able to attend this session, Laura will send you a mini report on the outcomes. The main themes from the focus group, and the details of the intervention that is developed after the focus group, will be written up in Laura's Masters thesis and possibly also shared in research publications. As mentioned above, your name and identifying information will not be used. The completed Masters thesis can be sent to you once it has been completed.

Please contact Laura at any time during this research to ask questions or request further information: Laura Singh 0837005987 or laura@outliers.org.za

Please indicate below if you agree to each of the requirements below:

I agree to participate in one focus group (tick one) Yes No

I agree for this focus group to be audio-recorded Yes No

I agree to giving feedback on the draft intervention Yes No

I agree to inviting my team to participate in the intervention Yes No

I agree to being on a WhatsApp group for the duration of the stud Yes No

I agree that the transcript of the group can be distributed to other group members for checking. Yes No

I agree to maintain the confidentiality of what is spoken about in the group

Yes No

Name of Participant Signature of Participant Date

Name of Researcher Signature of Researcher Date

Organisation:

Contact Number:

Gender: Female – Male – Non-binary-Transgender – Do not wish to disclose Race:

Black – Coloured – Indian – White – Do not wish to disclose

Home Language:

How long have you done community work? Area where you live:

APPENDIX C

Stage 1 Focus Group Questions

The researcher will briefly outline the purpose and scope of the study and clarify any questions participants may have at this stage. The researcher will highlight the role of the focus group participants in helping to co-design the support group intervention.

1. How are you feeling?
2. Why did you say yes to this study?

Perceptions of self-care

Aim: to gain insight into how self-care is viewed in vulnerable communities in SA What does "CARE" mean to you?

How do you care for others? How do you care for self?

Self-care behaviours

Aim: to determine scope of self-care behaviours accessible to CCWs What are the different "self-care behaviours" that you are familiar with?

How accessible are these activities to you in terms of time, effort, cost, transport?

Facilitators of self-care

Aim: to prioritise the drivers that will motivate CCWs to adopt self-care behaviours

What kinds of support would prompt you to adopt and maintain more self-care behaviours?

APPENDIX D

Researcher Confidentiality

NAME:

ROLE IN STUDY:

CONTACT NUMBER:

I _____hereby declare to maintain the confidentiality and anonymity of all participants in this study. I declare to keep all data safe and to only share the relevant information as per the Data Management Plan.

SIGNED

DATED

APPENDIX E

Stage 1 Google Feedback Form

Thank you so much for helping to design the first version of the Outliers Self-Care for Community Care Workers session.

Many wonderful conversations were had in the focus groups. The same set of questions were asked in each group. Similar responses were grouped together to identify sub-themes, which could then be grouped into major themes. Themes represent conversations that happened repeatedly in every group.

The attached document summarizes all the conversations grouped into 6 major themes and their sub-themes. The major themes were used to determine the content and design of sessions on Self-Care for Community Care Workers. The format of the sessions is outlined in the attached document.

It is important that both the themes and sub-themes accurately reflect the conversations in the groups. If you feel any important ideas are left out, please let me know.

Thank you for making this possible.

1. **Do you think the focus group summary accurately captures your contributions in your group?**

Yes No

There are some other things to include. Please specify in Other below. Other:

2. Does the session's content address each of the themes raised in the focus group summary?

Yes, all themes are represented in the session content.

Some themes are not addressed enough times. Please specify in Other below.

Some themes were left out. Please specify in Other below.

Other:

3. How would participating in these sessions help you and your team?

4. The session requires that participants be added to a WhatsApp group. What is the ideal size of a group to engage meaningfully over WhatsApp?

3 - 6 participants

7 - 10 participants

11 - 12 participants

5. Please indicate up to 3 guidelines you think are needed to create a safe space in a WhatsApp group.

6. Given the content design, how long do you think the WhatsApp session should be?

60 minutes

90 minutes

120 minutes

7. How long do you think the break in between sessions should be?

at least 5 days

at least 7 days at least 10 days

8. **What step(s) do you need to take for this WhatsApp group to become an ongoing support group for your team?**

9. **How would an ongoing support group help you and your team?**

Thank you for your input.

APPENDIX F

Stage 2 WhatsApp Intervention Invitation

You carry a great burden as a community care worker. Outliers wants to see if a self-care support group is an effective way of improving self-care behaviours. To determine this, we would like some of you to engage in a support group (intervention group), and others to wait until after the study to be involved in a support group (control group). Both groups are very important. If you join this study, I do not know which group you will be allocated to, as this is done randomly using a computerised programme.

The support group sessions will be with our team and done via WhatsApp. If selected for the intervention group, you will need to have access to WhatsApp on a personal cellphone. Sessions will be facilitated by Laura Singh of Outliers (0837005987). This will form part of her Masters research study on developing an online self-care support group for community care workers.

It is your choice whether to join the study and help develop this intervention. Your decision will not affect your work in the organisation or your relationship with Outliers. If you are interested in joining the group, please click on the link below to fill in your details, and give your consent to take part.

APPENDIX G

Stage 2 Intervention Consent Form

You are invited to take part in a research study to develop and pilot a support group that will help community workers, like you, to prioritise self-care. We believe your insight will be valuable to developing this support and hope that you will consider participating in this study.

What will I need to do if I agree to take part in the research?

Should you wish to be part of the research study you will be assigned to either an intervention group (and receive the self-care intervention immediately) or a control group (and receive an intervention at a later date). Both groups are essential for the study.

If you take part in this research, you will asked to:

1. Participate in piloting the intervention as part of either the intervention or control group
2. Complete questionnaires at two different time points
3. Attend a focus group to share your experience of the intervention (optional).

How will my confidentiality and personal information be protected?

The scales you complete will be anonymous (no one will know how you responded).
The information will be securely stored using the University of Cape Town's software.

Should you be assigned to an intervention group, you will be added to a WhatsApp group. By joining the WhatsApp group, you commit to not sharing the cell phone number of any of the participants.

The WhatsApp group will consist of Laura and other members of your team. You will be expected to maintain the confidentiality and anonymity of the others in the study by not sharing what is spoken about in the session. The information you share on the group will never be used.

Do I have to take part in this study?

No. Your participation in this research is completely your choice. You may choose not to participate if you wish, and this will not affect your relationship with your organisation or the support you receive from Outliers in any way. If you decide to take part in the study, you may choose to leave the study at ANY time without having to explain and without any negative impact. Should you choose to withdraw, Laura will not use any of the information you have provided without your prior signed consent.

Will there be any costs to me for taking part in the study?

You will need WhatsApp and data to attend facilitator-led sessions and engage with self-care materials for a total of 8 weeks.

Are there any risks to me if I take part in this study?

In this study you will be required to discuss self-care perceptions and behaviours. This might possibly raise some difficult emotions. You have the right to withdraw from the study at any time if you feel uncomfortable. Should you wish to speak to someone about these feelings please connect with NPOwer, a FREE 24-hour helpline on 0800 515 515, or speak to Laura who will try to connect you with other relevant support services.

Please contact Laura at any time during this research to ask questions or request further information: Laura Singh 0837005987 or laura@outliers.org.za

Please indicate below if you agree to each of the requirements below:

I agree to complete the assessment scales at two time points (tick one)	Yes	No
I agree to attending the facilitator-led sessions	Yes	No
I agree to being on a WhatsApp group for the duration of the study	Yes	No
I agree to maintain the confidentiality of what is spoken about in the group	Yes	No

Name of Participant Signature of Participant Date

Name of Researcher Signature of Researcher Date

Organisation: Contact Number:

APPENDIX H

Stage 2 WhatsApp Post-Intervention Focus Group Invitation

Thank you for being a part of this study and completing the assessment scales. Your input has been very valuable. The study would be greatly improved by hearing more about how taking part in this support group has been for you.

If you are interested, please let me know if you can attend a group sharing session on <DATE> or <DATE> at <VENUE>.

Please note, space is limited.

If you wish to share but cannot make these dates please connect with me on 0837005987.

APPENDIX I

Stage 2 Post-Intervention Focus Group Consent Form What will I need to do if I agree to take part in the research?

If you take part in this research, you will be asked to:

Attend a focus group to share your experiences of the self-care support group intervention.

How will my confidentiality and personal information be protected?

Your focus group will consist of an external facilitator and several other community care workers. You will be expected to maintain the confidentiality and anonymity of the others in the study by not sharing what is spoken about in the session.

The focus group session will be audio-recorded. The recordings will be transcribed and analysed to provide information to help develop the support group further. The audio recordings and the transcripts will be stored on password-protected files on Laura's personal computer and will not be shared with anyone except the research supervisor.

When information you provided during the focus group is written up for Laura's thesis or any research publication, a pseudonym, (or fake names), will be used. Any personal details that could identify you will be removed.

Do I have to take part in this study?

No. Your participation in this research is completely your choice. You may choose not to participate if you wish, and this will not affect your relationship with your organisation or the support you receive from Outliers in any way. If you decide to take part in the study, you may choose to leave the study at ANY time without having to explain and without any negative impact. Should you choose to withdraw, Laura will not use any of the information you have provided without your prior signed consent.

Will there be any costs to me for taking part in the study?

The most convenient location for all participants will be selected for the focus group. This may require travel costs on your behalf. A travel stipend is available. The focus group will be limited to 2 hours.

Are there any risks to me if I take part in this study?

In this study you will be required to discuss self-care perceptions and behaviours. This might possibly raise some difficult emotions. You have the right to withdraw from the study at any time if you feel uncomfortable. Should you wish to speak to someone about these feelings please connect with NPOwer, a FREE 24-hour helpline on 0800 515 515, or speak to Laura who will try to connect you with other relevant support services.

What will happen to the information I give in the focus groups?

Laura will send you a copy of the transcribed (written out) focus group conversation that was recorded. You can check this version to make sure Laura has correctly written down things you have said. The main themes from the focus group will be written up in Laura's Masters thesis and possibly also shared in research publications. As mentioned above, your name and identifying information will not be used. The completed Masters thesis can be sent to you once it has been completed, if you would like.

Please contact Laura at any time during this research to ask questions or request further information: Laura Singh 0837005987 or laura@outliers.org.za

Please indicate below if you agree to each of the requirements below:

I agree to participate in one focus group (tick one)	Yes	No
I agree for this focus group to be audio-recorded	Yes	No

I agree that the transcript of the group can be distributed to other group members to be checked. Yes No

I agree to maintain the confidentiality of what is spoken about in the group (or whatever else you want them to agree to y way of confidentiality) Yes No

Name of Participant Signature of Participant Date

Name of Researcher Signature of Researcher Date

APPENDIX J

Stage 2 Post-Intervention Focus Group Questions

Breathing exercise and check in

1. How are you feeling?

2. Why did you say yes to this study?

Tell me about your experience of the self-care support group. What was it like for you?

Since starting the study, has your understanding and views about self-care changed in any way)?

Since starting the study, have your self-care behaviours changed in any way? What did you enjoy most or find most useful, and why?

What did not work for you, and why?

What was most effective to help you take up a new self-care behaviour? Why? How could the support group be improved?

How would you like to use the support group going forward (if at all)?