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RESEARCH ARTICLE

Risk factors for mental health and wellness: children's perspectives from five Majority World Countries

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Abstract

Several risk factors for children's mental health and wellness have been established. These are compounded by inequalities, especially in Majority World Countries (MWC). As evidence is largely based on adult reports, we aimed to capture children's experiences of risk across five MWC resource-constrained settings (Brazil, Pakistan, Turkey, Kenya, and South Africa) during the height of COVID-19 pandemic. Participants included 36 children aged 8–10 years and 37 young people aged 14–16 years. We employed a thematic design using a participatory methodological approach in collecting data through diary entries, drawings, posters, focus groups discussions, and child-led interviews with elders. Two researchers integrated and analysed the data set through a thematic codebook framework. Three identified themes related to exacerbation of existing risks, disruption or loss of protective factors, and lack of access to structural supports. Children linked risk factors along their socioecology. The findings have implications in actively involving children as social actors in determining and addressing risk for mental health and wellness through child-centred and multi-sectoral policy and interventions.

Keywords: Child; wellness; mental health; risk; disadvantage; support; Majority World Countries

Introduction

Multi-level risk for children's mental health

In recent years, children's mental health and wellness has become a global policy priority (United Nations, 2014). In the absence of early intervention, mental health problems can result in negative psychosocial outcomes during childhood and adult life such as interpersonal difficulties, unemployment, drug use or criminality (Sellers et al., 2019). Both the

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development and continuation of child mental health problems is moderated by a range of inter-linked risk factors (Broadman et al., 2015). These risk factors are compounded by inequalities, especially in resource-constrained settings (Pearce et al., 2019).

Children living in Majority World Countries (MWC), many of which fall into the low/middle-income category, are faced with additional contextual challenges that heighten risk (La Maison et al., 2018). At the individual level, children can develop maladaptive coping strategies in the face of maltreatment or ongoing conflict (Samara et al., 2020). Gender can intersect with inequalities, age, and sociocultural expectations in, for example, depriving girls of education and future independence, and increasing their vulnerability to stressors (Jones et al., 2020). Family risk factors include disrupted attachment relationships, rejecting or harsh child rearing, domestic violence, and parental mental illness, which are often associated with poverty and child maltreatment (Patel et al., 2017). Socioeconomic inequalities are also strongly associated with community risk factors such as access to basic needs like sanitation, nutrition, and housing, unsafe neighbourhoods such as living in informal settlements, lack of social support, community violence, and exploitation (Bele et al., 2015; Lund et al., 2011).

Culture plays an important role in the conceptualisation of mental health and wellness, beliefs, and attitudes (Khalil et al., 2020). Stigmatising attitudes may act as further barriers to early recognition, help-seeking and receiving appropriate support, because of fears of mental illness or being ostracised by the community (Getanda et al., 2017). Previous research in MWCs has shown that conceptualisation is often confined to severe mental illness rather than to a spectrum of mental health needs, starting with wellness, which is important for the integration of preventative and responsive interventions to support systems (Tamburrino et al., 2020). Consequently, global definitions of mental health and wellness can result in tensions with cross-cultural communication, without co-produced awareness programmes and culturally acceptable services (Kohrt et al., 2014).

Children as social actors

This large body of mental health and wellness evidence (indeed wider public health research) is predominantly based on adult informants rather than children reporting on their unique experiences. 'Expert' configurations in relation to physical and mental health risk in the literature are predominantly based on adult social actors (for, example, Hautamaki, 2018; Kriger, 2021). Responses to risk for children have been found to be influenced by conceptions of childhood, adult fears of mental health stigma, and professional concerns in locating the risk within the child such as their disabilities (Spencer et al., 2016), thus reflecting a dominant protectionist rather than agency perspective.

Children are also often not heard, due to both their low developmental and socio-economic position (Haque et al., 2017). Crucially, however, adult views were often found to differ from those of children (Gulliver et al., 2010). When given the opportunity, children were shown to have the capacity to assess risk related to their wellness and to negotiate solutions (Christensen & Mikkelsen, 2008) following, for example, natural disasters (Muzenda-Mudavanhu, 2016), domestic and community violence (Devries et al., 2017), or exploitation (Mulugeta & Eriksen, 2020).

Contextualisation of risk for mental health and wellness in Majority World Countries

Most theories and studies on child-related mental and physical health risk originate from minority world countries, therefore their sociocultural approaches to risk are not necessarily universal or transferrable to majority world social, political and health contexts (Rudrum, 2017). Criticisms of such non-contextual transferability include the location of risk within certain type of north-western societies with post-traditional, secular, and liberal characteristics (see Brown, 2015), and the neglect of structural inequalities and service choices available in MWC (for example, Coxon, 2014).

These challenges were put forward by the influential 'risk society' framework (see Beck, 1992), which other researchers conceptualised as both universal and democratic. Globalisation was taken into consideration in the evolution of this theory that considered new risks and how these unequally impact on individuals (see Beck, 2010). The COVID-19 pandemic recently led to a collective traumatic experience that reflected such an emerging global reality.

Ongoing debates focus on global systemic risks such as climate change being viewed as 'equal' traumatic experiences, and on the assumption that perceptions of risk are globally homogenous; hence the importance of understanding local experiences of risk and interpreting those in conjunction with local social structures (for example, Van Voorst, 2015). In a study in Mozambique, Rodrigues (2016) found that three intertwined layers managed health uncertainties – trust in health systems, organisations, and providers, and personally and socially shared experiences. Consequently, Brown (2015) highlighted the need for approaches to understand uncertainty and risk within traditional societies and different modernities; whilst Desmond (2015) specifically advocated the development of cross-cultural linguistic and methodological frameworks to this effect.

As children's mental health needs in MWC resource-constrained settings are complex and compounded by a multitude of risks, it is important to understand how children themselves experience and report what constitutes risk, how different risk factors are inter-connected and, crucially, how they believe these can be mitigated, especially in a global context such as presented by the COVID-19 pandemic. These inter-connected research priorities informed the rationale for this study.

Methodology

The aim of this study was to establish how children experience risk to their mental health and wellness in the context of disadvantage across five MWC settings. The following research questions underpinned this aim:

(1) How did children in MWC contexts of disadvantage experience risk to their mental health and wellness during the COVID-19 pandemic along different life domains (individual, family, community, and support systems)?
(2) How can children's specific experiences be related to other circumstances of collective trauma exposure and adversity?

The social competence paradigm, which presumes children as competent to contribute and focuses on a positive positioning, informed the choice of methods (Laosa, 1989). The selection of five Majority World resource-constrained settings was informed by the risk society framework, in viewing the pandemic as an example of new global risk with unequal impact on children and communities (Beck, 1992; 2010), but arguably

to a greater extent within countries with lower resource to mitigate or manage them. To concurrently address multiple challenges such as children's developmental capacity, literacy barriers, and the cross-cultural sample, we combined a range of child-centric data collection participatory approaches, which we describe below. In designing the methods, we also drew on an interdisciplinary approach to working that forefronts children's voices and agency in relation to life domains across their socio-ecology (Bronferbrenner, 1979; Lakhani et al., 2012). To this effect, the research team incorporated knowledge in children's rights, ethics, psychology, child mental health, social geography, history, law, and child participation. We closely worked with partners and peer researchers in each country to adapt the methodological approach to local sociocultural contexts.

A macro-social-constructionist framework underpinned the social paradigm approach, because this position recognises that versions of reality are shared by participants through language and social interactions (Gubrium & Holstein, 2008) and through children's experiences and engagement with the world around them, recognising children's competency to create and participate (Fraser et al., 2004). Furthermore, macro-social-constructionism has a foundational commitment to socio-political and systemic interpretations as grounded in cultural, historical and contextual understandings of a phenomenon, which is pertinent to the risk society framework (O'Reilly & Kiyimba, 2015). Fundamentally, a constructionist epistemology is congruent with the specific type of thematic approach that we utilised, that is, a codebook style of thematic analysis (see Braun & Clarke, 2022).

Context and participants

We selected countries that were broadly representative of the socioeconomic spectrum across the Majority World (Organization for Economic Co-operation and Development OECD, 2016) – Brazil, Kenya, South Africa, Pakistan and Turkey. Within each country, a non-governmental organisation (NGO) acted as local project lead. These lead NGOs were identified through existing global child mental health networks by the central research team (Vostanis, 2019). Within each country, we selected an area of disadvantage, with the following characteristics:

Brazil: Rocinha is Brazil's and Rio de Janeiro's largest favela, with residents living in a tightly packed area, mostly due to rural-urban migration. The extreme lack of space forces families to build houses on top of one another. Whilst challenged by structural inequality, poverty, and poor service delivery, Rocinha has a relatively developed infrastructure and enjoys proximity to employment opportunities and services. The area does have transportation links or entertainment areas. Challenges include poor sanitation, with sewage running in a channel between houses, drug-related violence, and trafficking.

Kenya: Kiti is one of the poorest residential areas in Nakuru city. The poverty experienced in this area has been compounded by rural-urban migration and influx of refugees (primarily Sudanese) to Nakuru in search of better living standards. Many people face deprivation of basic needs (food, shelter, and clothing), social amenities (such as housing and electricity) and access to services.

South Africa: Emandleni and Wattville are neighbouring areas in the Gauteng Province of Johannesburg. The former is made up of informal housing, whilst the latter is an established township with a mix of informal and built houses. Emandleni has

regular water supply, low-cost electricity, and sewerage infrastructure, but no school. Wattville has infrastructure like access to water, electricity and sewage, and several childcare centres and schools.

Pakistan: Manzoor Colony Mehmoodabad is an underprivileged neighbourhood of Karachi East district. Fathers are mostly employed as labourers or work in low paid jobs. High rates of domestic violence, street crime, cultural conflict and abuse are frequently reported. Like many resource-constrained areas in Karachi, most of the population depend on mobile data for internet connections, but very few have access to community services.

Turkey: Karatay and Selcuklu areas are based in the city of Konya. Karatay has informal dwellings and apartments, and a high crime rate. Selcuklu is a more affluent area, with new developments, and families of both low-medium and high socioeconomic status. Both areas have large numbers of refugee families.

At the next stage, we adopted a purposive sampling strategy. Each host agency, through their local networks, invited children aged 8–10 and young people aged 14–16 years through their parents. These age groups represented different developmental stages of childhood and adolescence, but for simplicity representing under 18-years are referred to as 'children' throughout this paper. In total, 36 8–10-year-olds and 37 14–16-year-olds took part in the study. The Psychology Research Ethics Committee of the University of Leicester in the UK granted ethics approval. Parents provided written consent and children gave additional verbal assent. The NGO leads acted as gate-keepers to the study, taking into consideration local ethics and child protection jurisdictions.

Data collection

In recent years, children have been increasingly viewed as key stakeholders in designing and implementing research and interventions that impact on their lives (Skauge et al., 2021). Consequently, a range of participatory approaches take into consideration children's developmental capacity. These approaches include a combination of individual interviews, focus groups, creative activities such as drawing and storytelling, social geography, and ethnography (Horgan, 2017). As some of these data collection strategies (such as drawing) do not rely on verbal communication (like interviews or focus groups), they can be readily applied across sociocultural groups, including in MWC (Vostanis et al., 2020).

To this effect, we facilitated a total of 20 *focus groups*, two per age group, at two time points in each country. The focus group topic guides explored children's experiences of how their life had been affected during the pandemic along different domains across their socioecology (individually, family, peers, education, neighbourhood, leisure, technology, and support systems). Particularly in relation to individual experiences, children were encouraged to explore emotional impact and responses. These were subsequently linked to other needs (social, physical health, educational), as appropriate. Facilitators asked children to alternatively consider peers or other children. This interviewing technique of 'indirectly' exploring issues in relation to their peer group or other children, rather than directly asking about their experiences from the outset, can be more engaging for child participants, encouraging them to reflect upon and share mental health issues. Overall, experiences of their mental health and wellness were not introduced at the outset, but rather emerged during the interviews. In addition, children were asked to contrast the

pandemic period with other stressful circumstances they may have experienced before, and to conclude by advising on what lessons we could take in helping them or other children cope with emerging adversities in the future.

During the focus groups, researchers also generated data by using the *draw and talk* method. This creative approach can elicit rich visual and verbal data, and encourage active participation (Angell et al., 2015). It is particularly engaging for children, as it is enjoyable and allows participants to guide the session (Dodkowsky et al., 2010). Visual participatory methods position researchers and participants as collaborators, by minimising power differences between them, and respecting participants as knowledge holders and producers (De Lange, 2008). These methods create opportunities for participants to express, enhance, share, and analyse their knowledge and experiences, and to plan and act upon those (Mitchell, 2008).

To further enhance our engagement with participants and allow them some control over the data process, we asked children to keep a *diary* over a period of one month. The diary captured real time experiences and was used to elicit and stimulate a discussion during the focus group discussions. Participants were encouraged to write, draw, or use stickers into their diary. Between the two focus group time points, children were prompted to *interview elders* (grandparents, other family elders, or neighbours) on their own experiences in dealing with adversities.

Participating children interacted with researchers via in-person sessions as well as online (in Brazil), because of COVID-19 pandemic health and safety guidelines at the time. We assured sampling adequacy within and across countries and groups, so that no new themes would arise in the overall as well as each country dataset (Hancock et al., 2016). Table 1 below provides a summary of the sample, data collection process and venue.

Data analysis

Diary textual and focus group audio-recorded transcribed data were collected in children's language, and subsequently translated to English. We utilised thematic analysis to attend to the focus group and diary data (Braun & Clarke, 2006). We engaged with a codebook form of thematic analysis to allow for the combining of inductive (from textual, drawings/visual data and recorded data) and deductive (according to the socioecological framework of exploring risk at different life domains) coding

Table 1. Characteristics of participating children and youth, and data collection process.

	Brazil	Kenya	Pakistan	South Africa	Turkey
Children 8–10 years ($n = 36$)	8	4	9	7	8
Children 14–16 years ($n = 37$)	7	7	10	7	6
Where/how data was collected	Online – Zoom	In-person at local meeting venue	In-personat NGO centre at NGO centre	In person at community-based organisation	In-person at educational institution

processes and ensured coder collaboration through a multiple coding process. We utilised this codebook approach to thematic analysis because it provides some structure to the coding process, whilst maintaining the constructionist qualitative theme development process that allows the analyst to stay faithful to qualitative theory (Braun & Clarke, 2022). Drawings from children's diaries and focus group discussions were interpreted in relation to the accompanying written or recorded/transcribed text (see Figures below). We integrated both verbal and visual data in the coding process. Two coders independently coded data collated and transcribed from all the contexts. The authors then subjected all data to a thematic mapping team consultation process and agreed upon conceptual categories.

Although we did not frame this study as a comparative research design, the inclusion of five MWC sites could enable the identification of emerging cross-cutting or context-specific themes to inform child-centred interventions in other MWC settings. Whilst we use the term 'child' throughout the paper to cover a broad developmental age range, in the findings section, we will refer to 'child' and 'young person' quotes and drawings, to specify whether they were 8–10 or 14–16 years respectively.

Findings

In Table 2 we present the themes and sub-themes which we identified through the analytical processes outlined above. Overall, the key finding was the overlap and interlinkage between children's experiences on how trauma exposure related to the COVID-19 pandemic enhanced risk, disrupted protective factors, and compounded the already limited infrastructure and external supports. Children generated their views on other types of adversities and contexts. Trauma exposure and responses appeared similar across cultures ('etic'), as there were limited context-specific representations, namely in relation to past conflicts in South Africa and Kenya.

Theme 1: Exacerbation of risk

Children described exposure to various hazards in their living environments. Poor sanitation was frequently mentioned.

> A friend of mine that lives in a shack, and the shack has a lot of holes . . . so, if it rains, there are leaks and it's also not very clean.
>
> Focus group, child 3, South Africa

Table 2. Emerging themes and subthemes (36 children and 37 youth).

Themes	Subthemes
Exacerbation of risk	Living conditions
	Economic impact
	Intergenerational hardship
Disruption or loss of protective factors	Social connections
	Environmental spaces
Lack of access to structural supports	Educational provision
	Health services
	Digital divide
	Transport

Figure 1. Drawing by young person 3, Pakistan (linked to diary entry).

> The sewage water in the area is really bad, it gives bad impression of the area. Even some people in the area don't take care of water which leaks out from their house.
>
> Figure 1 and data entry, young person 3, Pakistan

In conjunction, children reported lack of basic needs, predominantly food, which they linked to parents' unemployment.

> I was very sad because we did not have anything to eat for breakfast. When I asked dad to give us some money, he said he was broke. My other siblings were crying because they were hungry.
>
> Diary, young person 6, Kenya

> Money was scarce and sometimes we did not have enough food. Our parents lost their jobs, they had to go to a loan shark to borrow money, but they did not have the money to pay those loan sharks, because they were unemployed.
>
> Focus group, young person 2, South Africa

The pandemic appeared to increase unemployment and resulting lack of basic needs, whilst hazards were exacerbated by implementation of COVID-19 related health and safety measures. These deprived children of factors that promoted their wellness.

> Since this COVID came, our parents lost their jobs. We can't eat as much as we want, because it's hard to get food because of the lockdown. We can't even go outside for fresh air because there are soldiers everywhere. I hate this Corona; I want it to go away.
>
> Focus group, child 2, South Africa

In contrast, some children perceived the direct influence of deteriorating poverty on wellness and mental health.

> I got to know few cases people were doing suicide, because of financial issues.
>
> Focus group, young person 4, Pakistan

An interesting finding, which was facilitated by the methodology, was children's realisation of conflict and hardship across generations within their families and communities. Some of these conflicts were contextual to their country. Particularly in South Africa, memories of apartheid suppression were vivid for children who were born well after the fall of that regime.

> Why were they allowed to be treated as slaves? How did whites become dominant?
>
> Focus group, young person 4, South Africa

Elders impressed on children risks for their generation, especially for girls, such as extreme poverty, working from childhood, young marriage age, lack of health facilities, and exclusion from education.

> My grandmother could not go to school. Therefore, she is illiterate. It is hard for her to learn how to read and write now because she's old. My grandfather knows some things, but he also has difficulties.
>
> Focus group, child 8, Turkey

> I interviewed my (elder) neighbour . . . she was sent to a house in Brasilia, she had to clean everything, she couldn't study, she couldn't play. She thought the solution would be to get married, but she was not treated very well by her husband. She had two children in (name) and both died when they were babies, because it was a small town and there was no health centre nearby. The public hospital was not good . . . she had another daughter who died at the age of 20, also in the public hospital. She died choking on her own vomit, she was unable to get up. And her husband died of tuberculosis.
>
> Focus group, child 7, Brazil

Nevertheless, despite more pronounced risks among previous generations, several elders viewed current urban communities as more unsafe for children.

> My grandparent said that in their era the surrounding was safe, not like today. He said that, whenever they wanted to go out, they were allowed to go. When they used to come back from school, they used to go with friends. They had freedom. But now in this era we can't roam freely, there are kidnappers and snatchers around us.
>
> Focus group, child 3, Pakistan

Overall, children were conscious of how the pandemic compounded previous risk in relation to accessing basic needs, safety, and their neighbourhood. They also perceived indirect influences on their parents through increased unemployment. Talking to elders gave children a wider perspective on how adversity affected previous generations. These

experiences are congruent with exacerbated inequalities in both the national and international sphere, unequal exacerbation of natural events and effect on children, and interconnection between natural and economic risk (Beck, 2010).

Theme 2: Disruption or loss of protective factors

Compounding previously described risk, children described how changes in their environment had deprived them of already limited resilience-building connections. Their life structure and routines were often lost, keeping them apart from friends and relatives. Social opportunities through school and community were no longer available or easily accessible.

> . . . got bored, sometimes I would stand near the window and recall the times when I could go out and play in the park with my friends.
>
> Figure 2 and diary entry, child 7, Pakistan

Churches and temples were often closed because of fears of spreading the virus, hence children and families could not as easily draw coping strategies from their faith and within their communities.

> I could not go to church. You know, when you go to church you have an assurance that God is right next to you, and even when you pray. When you are at home, you think about what you are going to eat, so when you are at church you do not think much about those things. It affected me because I did not go to church.

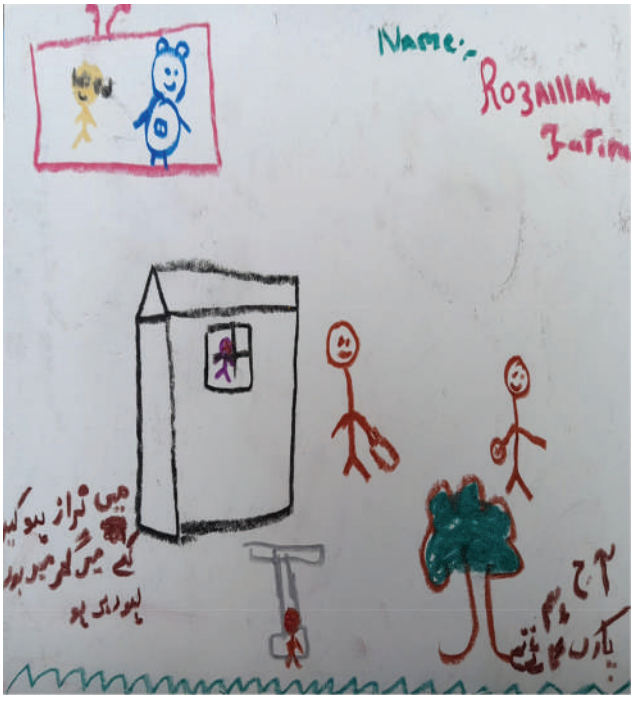

Figure 2. Drawing by child 2, Pakistan (linked to diary entry).

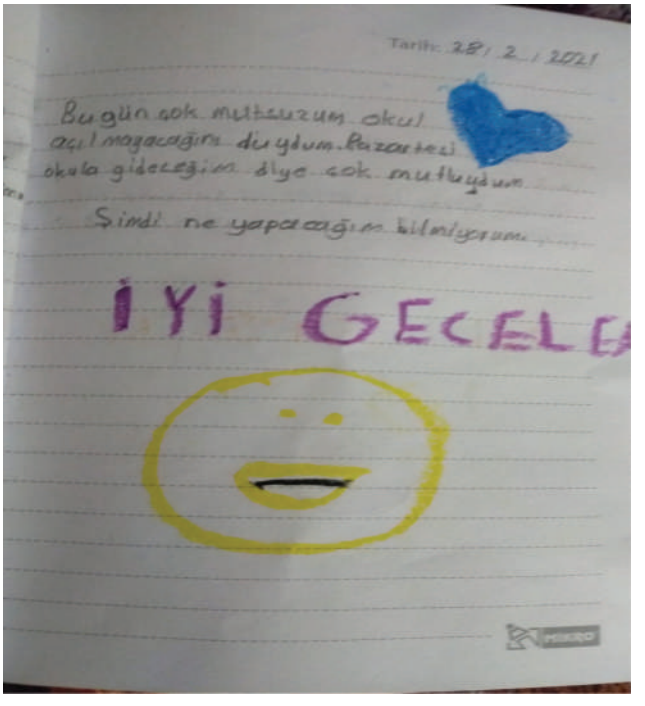

Figure 3. Diary drawing and text by child 5, Turkey (linked to diary entry).

> Focus group, young person 1, South Africa

Children viewed lack of life structure and social connections, especially school closures, as affecting their wellness through isolation and loneliness.

> At first, I thought I would be able to go back to my routine soon, but then months and a whole year went by, and the schools continued closed, nothing went back to normal. My head was getting a little confused because my whole routine was a mess.
>
> Focus group, young person 3, Brazil

> Hello my diary. Today I want to tell you about the negativity around me. Unfortunately, I am having difficulties, because I have not been able to leave the house due to the pandemic for the last one year.
>
> Diary, young person 6, Turkey

In addition, loss of protective 'buffers' also affected children's emotional state, as disruption became prolonged in their communities.

> I was a little sad because we were closing school.
>
> Diary, child 3, Kenya

> I'm very unhappy today. I learned that the school will not open.
>
> Figure 3 and diary entry, child 5, Turkey

Children in this study already lived in deprived environments. The pandemic further exacerbated negative emotions by restricting their quality of life at home and in the community.

> Very angry and annoyed because there was no electricity from morning and waited for it for whole day. Feeling so bad because of the hot weather and wanted to sleep but couldn't.
> Figure 4 and data entry, young person 2, Pakistan

Children overtly linked the disruption or loss of protective factors to adversely impacting on their wellness. Losing routines and structure in relation to education, socialisation and faith appeared to deprive children of both support networks and coping strategies. These responses speak to unequal increase of social vulnerability in conjunction with reduction in coping means, and unequal state preparation and responsiveness to risk (Beck, 2010). In this way, children's vulnerabilities, status within their communities, and loss of protective factors compounded the consequences of their exposure to such risk.

Theme 3: Lack of access to structural supports

In previous studies, we established that external structural supports are limited in MWC resource-constrained settings (Vostanis et al., 2020). In this study, children demonstrated awareness of reasons behind barriers to service access. In the COVID-19 context, government schools did not have easy availability of health

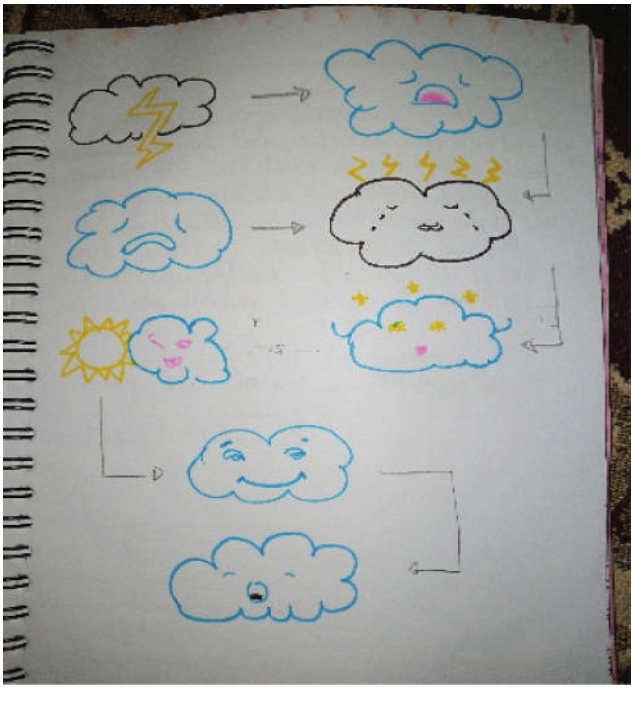

Figure 4. Drawing by young person 2, Pakistan (linked to diary entry).

safety equipment such as sanitisers and masks. Young participants reported several examples of not affording or accessing health prevention or treatment. Health facilities were usually based outside areas such as informal settlements, and the same applied to newly established points for vaccination. Children felt unsafe by not affording sanitisers, masks, or usual medicines.

> … yeah, grocery packets distribution happened but need safety equipment … masks, sanitisers were not for free, they were expensive.
>
> Focus group, young person 2, Pakistan

> I wish my neighbourhood had a vaccination centre.
>
> Focus group, child 1, Brazil

Overcrowding accentuated this sense of risk, at a time when communities followed safety guidelines to implement social distancing.

> Where I live, people are congested. So, it's very easy to get the corona.
>
> Focus group, young person 6, Kenya

There also appeared a lapse in child protection procedures in some areas, with children in South Africa reporting corporal punishment incidents by teachers if they had not completed their homework, despite government guidelines.

> Yes, it is painful, but the pain goes away eventually … it becomes better when you hide with your friends, or when they hit the whole class.
>
> Focus group, young person 6, South Africa

Technology was particularly important for information, online learning, and social connections during the pandemic. Children in some of the participating areas felt excluded from education by not accessing equipment (mobiles, tablets, or laptops) through schools, families, and communities. They often relied on one mobile from their parents or neighbours – or an old piece – which they had to share for online learning with their siblings. Internet access and connectivity usually was neither available nor affordable.

> My brother has a friend in his class, and he is a Syrian (refugee) too. Only his father had a cell phone. He could not attend online classes because his father is at work during school times.
>
> Focus group, child 2, Turkey

> We did not go to school, and in my school, there was no online learning.
>
> Focus group, young person 7, South Africa

Both informal and formal supports were constrained by transport availability. Children reported lack of public means in some areas, no routes in proximity, and prohibiting costs.

> There are many people who live far away, who can't afford motorcycle taxi or bus fares every day.
>
> Focus group, young person 1, Brazil

Children did not appear aware of welfare or health services. Instead, they felt the immediate impact of the pandemic on learning and physical health, and clearly highlighted limited access to recommended vaccination and health safety measures, online learning and other digital technology. Their responses highlighted the deterioration of already limited structural support, in relation to both affluent communities within their society and affluent societies. This was defined by Beck (2010) as double exclusion ('exclusion of the excluded' - p.167), which further highlights lack of or unequal state responsibility.

Discussion

The literature has established a range of factors that hinder children's mental health and wellness, several of which are accentuated by socioeconomic disadvantage (see Dornan & Woodhead, 2015). These risk factors are compounded in majority world societies, especially in disadvantaged communities, because of a lack of access to basic needs, resources, and structural supports (Patel et al., 2018). Despite children being central in the understanding of how risk can adversely affect their mental health and wellness and, consequently, how they can cope more effectively, their voices are seldom heard across research, policy, and service development. This is despite significant efforts to hear children's voices in research and practice, through endeavours such as the UN Convention on the Rights of the Child (United Nations, 1989), and advances in research methods towards inclusion, co-production, and empowerment (O'Reilly et al., 2013). In this study, we used an innovative methodological strategy, combining participatory techniques with traditional qualitative methods to capture children's voices in ways congruent with the social competence paradigm. We recruited children in five MWC resource-constrained settings on how they experienced risk in relation to the COVID-19 pandemic and other adversities. The key finding of this study was that collective and prolonged adversity can dynamically enhance risk, disrupt protective factors (which do not constitute mere absence of risk) and impair structural support for children's mental health and wellness. Crucially, risk for both mental health and COVID-19-related risk (indeed for other health and welfare outcomes too) can be explained by the same underpinning factors of socio-economic inequalities.

Such an impact is particularly pronounced in MWC contexts of disadvantage. Adult-centred studies predominantly established the risk of financial hardship, ill physical health or stigma for mental health (Kuang et al., 2020; Ssebunnya et al., 2009). When given the opportunity in this study, children as young as 8 years old were also able to communicate influences along several life domains on their socioecology. Their views indicated similarities with those of adults in identifying risk. However, in contrast to research with adults in MWC, who usually focused on mental health problems and illness (Ng'oma et al., 2019), children related risk to their everyday life and sense of emotional and social wellness. In this sense, although the study originally focused on the relatively narrow concept of 'mental health', it shifted to the broader focus of 'wellness', as young participants addressed the impact of several socioecological factors on their everyday functioning. Such a focus on wellness was consistent between our two age groups, although adolescents referred more to impact on social and peer-related activities outside the family environment.

Interestingly, children defined risk in the face of collective trauma (in this case, the COVID-19 pandemic) as disruption of protective factors, especially social connections,

and lack of access to already limited structural support. Children's views highlighted the inter-linkage between different risk factors on their socioecology. Their perceptions highlighted the interplay between embodied experiences and social representations (see O'Connor, 2017). In particular, the findings support theory and evidence on the relationship between intergenerationality; past, anticipated and future bodies; connections to distant and proximate others; and children's emotions (for example, Evans et al., 2011). This could, however, also partly be explained as an artefact of the data, as children were encouraged to interview and thus delve more into these terms and underlying issues. In this study, children attending schools in disadvantaged areas were less likely to afford equipment and access to technology, which further hindered their learning and social connections. These implications placed more pressure on parents who had lost their jobs, consequently on their parenting capacity and safeguarding. Living in neighbourhoods with poor infrastructure and opportunities, and increased criminality, enhanced strain on families and risks for children.

Before considering the contribution of these findings to risk theory and implications for research, policy, and practice, it is important to acknowledge certain limitations of this research. Selected sites and young participants were not necessarily representative of other communities of the included countries, or MWC globally, hence the transferability of the work is limited in relation to other resource-constrained settings. Nonetheless, these developed issues at stake from the data do highlight some of the important areas for exploration and highlight some important challenges that these children faced. The context of the COVID-19 pandemic was both unique and unprecedented, therefore it would be interesting to replicate the studies in other contexts of exposure to collective trauma such as following natural disasters or political conflict. A multi-informant mixed methods approach would complement children's views with those of adults, as well as with quantitative measures of risk and psychosocial functioning.

These findings from children in five MWC are consistent with the risk society framework, particularly in a globalisation context (Beck, 2010). To this effect, risk for children's mental health and wellness is embedded in global societal inequalities. Risk thus needs to be understood within and across national boundaries, as well as the increasing inter-connection and inter-dependence between socioeconomic and environmental factors. In the light of broad similarities of children's experiences and perspectives across the five MWC, one could extend their future contribution as 'global' actors. As risks like climate change increase, children are crucial agents in understanding, anticipating, and implementing actions around vulnerabilities that are increasingly pertinent to their generation. Such global actions are not mutually exclusive with context-specific local implementation. The findings indicate that risk and uncertainty in response to ongoing trauma exposure such as through war or environmental hazards should be understood and addressed in relation to local social structures, which are likely to be disrupted (Van Voorst, 2015), especially in the majority world. These include both informal (family and community) and structural (schools and services) support that may also face systemic risk and uncertainty, thus need strengthening.

The findings also support the positioning of children as autonomous social actors (rather than via their parents and other caregivers) in conceptualising risk for their mental health and wellness through their experiences, thus befitting an embodied approach (see Kriger, 2021). Their unique knowledge and expertise should inform policy, service design and interventions to minimise and address risk. As evidenced by many studies, children can extend their contribution as co-researchers (Cuevas-Parra, 2020).

Children elicited an interesting finding in this study on the intergenerational transmission of risk (see Najman et al., 2004) by interviewing their grandparents or other elders. Elders supported such intergenerational transmission, however, they also provided children with experiences of resourcefulness and a more adaptive perspective of facing new adversities. This transfer of both positive and negative assets is consistent with Bird and Higgins' (2011) proposed framework for multi-sectoral policy and interventions to increase protection and mitigate risk at critical life-points and from an early age. Such a policy recommendation is also consistent with children's experience of risk being dynamically linked across their socioecology.

The multi-layered participatory methodology was central to the design, delivery and dissemination of this study. This led to several lessons on potential benefits and future development. Unlike our previous research on children's help-seeking and psychosocial support (Haffejee et al., 2022), we did not confine this approach to one time point, which would hinder engagement and sharing. Instead, we collected data over a period of one month, and combined children's descriptions of everyday life activities and targeted discussions. The integration of textual, visual and verbal tools, albeit within a participatory framework and using creative techniques, was important in bridging cultural, language and literacy barriers, by adapting to children's developmental capacity and sociocultural context. This was facilitated by close collaboration between the interdisciplinary research team, local partners and peer researchers. Actively involving children as researchers in interviewing grandparents and other elders was positively received and led to interesting intergenerational findings. This approach could be extended to other aspects of future research. It could also help address a notable gap in this study of not focusing enough on mental health concepts and services. Co-production of more targeted mental health and wellness scenarios and activities with children from the design stage could also be complemented by their own interpretation of the emerging data.

Conclusion

Through a participatory approach that integrated data from diary entries, drawings, posters, interviews and focus group discussions, we explored how children living in five resource-constrained MWC communities interpreted their experiences of risk for their mental health and wellness along different life domains. Children identified risk consistent with the literature at all levels of their socioecology (individual, family, school, community, services, and societal level). Their experiences related to both exacerbation of existing risk and disruption of protective factors, especially social connections. Risk factors were interlinked, and findings were broadly similar across age groups and country sites. These findings add weight to arguments for involving children as social actors in determining risk for their mental health and wellness, and in formulating child-centred solutions on addressing current and new risk. Multi-sector policy and interventions should concurrently tackle risk at different levels. Participatory methods involving verbal and creative tools can engage children and facilitate cross-cultural research.

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