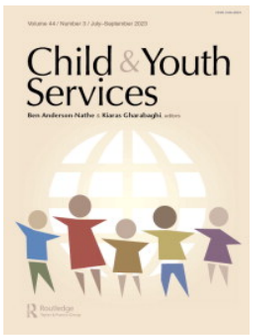

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Juxtaposing Disadvantaged Children's Insights on Psychosocial Help-Seeking with Those of Service Providers: Lessons from South Africa and Pakistan

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ABSTRACT

Children living in resource-constrained environments have high levels of unmet psychosocial needs. Through participatory focus groups, we juxtaposed the views of 55 children aged 7–10 years from resource-constrained settings in South Africa and Pakistan, with those of 96 service providers, focusing on available sources of psychosocial support. Children largely relied on individual and relational resources, with limited awareness of structural supports. Service providers focused less on children's capacity, instead viewing schools and community-based resources as essential sources for psychosocial support. Children's agency and capacity should be recognized and bolstered to inform service planning, community-based interventions, and systemic change.

KEYWORDS

Child mental health; Majority World countries; psychosocial; services; stakeholders

Introduction

Almost one-third of the world's children, or ~663 million, live in contexts characterized by socioeconomic disadvantage (UNICEF, 2020). Socioeconomic disadvantage is broader than just income. It encompasses deprivation in daily life, including poor living standards, inaccessibility of socially perceived essentials, and social exclusion (Saunders et al., 2008). Children in such contexts are familiar with malnutrition, sub-standard education, poor housing, and overcrowding. Further, such risk factors are associated with abuse, domestic violence, drug and alcohol misuse, child labor, and sexual exploitation (Bayer et al., 2011).

Ongoing vulnerabilities and associated complex traumatic experiences predispose children in these contexts to an increased risk of mental health problems, with findings suggesting that prevalence rates in disadvantaged communities are at least twice as high (20%) as in the general population

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(Reiss, 2013). Evidence, however, suggests that children living in disadvantaged communities have significantly lower access to mental health and other services providing psychosocial interventions (such as welfare, school-based, and non-statutory agencies) than children living in more affluent areas; consequently, they have higher levels of unmet mental health needs (Bornheimer et al., 2018). Barriers to service access include transport, social stressors, lack of awareness and information, limited providers, and distrust of the system (Bringewatt & Gershoff, 2010).

In the Majority World countries (MWC—Alam, 2008), also referred to as countries with low- and middle-income, there are additional challenges in accessing services. These include the stigma of mental illness, caregiver disengagement, lack of contextualized and culturally adapted interventions, and limited specialist resources (Patel et al., 2018; WHO, 2016). Child mental health inequalities are especially pronounced in resource-constrained informal settlements, also in terms of help-seeking and service provision (Heller, 2013). In response, some child mental health interventions and service initiatives have been built on existing community resources, such as faith-based groups, community forums, schools, and volunteers or paraprofessionals that can provide a first-level response (Van Ginneken et al., 2013). Psychosocial input in these contexts is usually integrated with the provision of basic needs, child protection, family support, and promotion of life skills and hygiene awareness (Healy et al., 2018).

Emerging knowledge on how child mental health services should be transformed in MWC contexts of disadvantage is largely based on adult stakeholders from different disciplinary backgrounds (Vostanis et al., 2018). Existing evidence on child and youth perspectives predominantly stems from Minority World or high-income countries and is in relation to specialist mental health settings. Findings suggest that service users value ease of access, youth-friendly approaches and environments, flexibility, building a relationship with professionals, being listened to, receiving individualized care plans, and being empowered as active agents in decisions about their care (Frauenholtz & Mendenhall, 2020; Loughhead et al., 2018). Similar evidence on indicators of youth-friendly healthcare emerges from studies on sexual and reproductive health services (Mazur et al., 2018). Negative experiences include lack of information on how to access services, being compelled to attend by parents or teachers, lengthy waiting times, poor communication, and staff changes (Persson et al., 2017).

Vulnerable youth in Minority Countries, such as refugee youth or youth in public care, additionally value continuity of care between staff and across agencies, services adopting broader criteria (i.e., not solely diagnosis-based), trust, empowerment, integration with practical and social supports, availability of culturally sensitive interventions, and inter-agency collaboration

(Davison et al., 2017). Although the youth mental health literature is largely based on adolescent perspectives from high-income countries, there have been some studies with younger children. Albeit limited, their findings show that when developmentally appropriate methods, like verbal and more creative modalities, are used to involve younger children, child perspectives of mental health services are consistent with those established in adolescent studies. Children also appreciate service characteristics, such as child-friendliness, preparation, accessibility, tolerance, and therapeutic engagement (Bone et al., 2015).

As psychosocial support is provided by a range of social care, health, and education agencies, rather than only by specialist mental health services, it is also important to consider the literature on children's broader help-seeking views, patterns, and underlying reasons for these. Overall, it has been shown that, before children and youth consider professional services, they feel more comfortable in seeking informal support, such as first talking to family, friends, and teachers, and/or looking for information by themselves (Heerde & Hemphill, 2018). These preferences center on their understanding of mental illness, fears of being judged, need for confidentiality and wish to be self-reliant (Del Mauro & Jackson-Williams, 2013). Attributing mental health problems to personal weaknesses, structural barriers, and negative beliefs of professional sources can act as deterrents to help-seeking (Velasco et al., 2020). Interestingly, professional services can be perceived as being set up for more affluent children by those living at disadvantage, who are instead more comfortable when psychosocial support is provided within their communities (Chen, 2018). Overall, evidence suggests that barriers and enablers to mental health help-seeking can be viewed at multiple and inter-linked levels (individual, interpersonal and structural), all of which are socially embedded (Planey et al., 2019).

Because of the service constraints and sociocultural differences already discussed, evidence from children in MWC, especially from marginalized MWC communities, should be viewed within that context. That evidence suggests that conceptualization of mental illness (Tamburrino et al., 2020) and fears of negative societal attitudes (Khalil et al., 2020) are prominent barriers to help-seeking. This evidence also shows that available informal and formal supports usually consist of extended family, community forums and networks, schools, social activities, sports, and primary health clinics or outreach (Clark et al., 2018; Panigrahi et al., 2018). Nevertheless, child and youth perspectives are rarely taken into consideration in service planning for children in disadvantaged MWC contexts. To improve psychosocial support and service provision in contexts of disadvantage, it is important to understand how children themselves view available and required sources of help, and how these views align or differ from those of service providers.

This important gap in linking child and adult perspectives on psychosocial supports and service provision in MWC contexts of disadvantage informed the rationale for this exploratory study.

Materials and methods

Research aims and questions

As indicated, studies exploring psychosocial help-seeking behavior with younger children are limited. Much of the research to date has focused on older adolescents' experiences of accessing mental health services, and most of these studies were conducted in Minority Country or high-income contexts. It is increasingly acknowledged that, if interventions and services are to be child-friendly, engaging, and effective, then it is important to establish younger children's experiences, perspectives, and wishes in relation to decisions involving their care and quality of life (i.e., decisions usually made by adults) (Chatterjee, 2017). When younger children are involved through developmentally appropriate approaches using participatory and creative techniques, such as play, drawing, and games, they can provide valid views and testimonies on how support and services should be shaped (Bone et al., 2015). The primary aim of this exploratory study was thus to establish the help-seeking views of children aged between 7 and 10 years in two resource-constrained contexts in South Africa and Pakistan. A secondary aim was to explore with adult service providers what services are available to children living in these two contexts.

The study, therefore, addressed the following research questions:

1. How do children living in resource-constrained communities in South Africa and Pakistan conceptualize sources of psychosocial support in response to common life stressors?
2. How do service providers from the same communities define available sources of psychosocial support for children?

Research design

Our qualitative study used participatory methods to engage both children and adult service providers. Given the wide range of participatory methods (e.g., arts- or drama-based participatory methods), and their flexible administration relative to participants' age, language skills, or other demographic factors, they are accessible to adults as well as children (Horgan, 2017). Moreover, participatory methods position researchers and participants as collaborators (De Lange, 2008). Collaborative methods minimize power differences between the researcher and the participants, and respect

participants as knowledge holders and producers. These methods also create opportunities for participants to express, enhance, share and analyze their knowledge and experiences, and to plan and act upon these as well (Mitchell, 2008).

In our study, both children and adults shared their experiences and generated insight into what is needed in terms of psychosocial support. As detailed in the data generation section, we used scenario-based participatory techniques with the child participants and facilitated these as focus groups. Given adults' more advanced cognitive development, it was not necessary to scaffold their data generation in the same way. Nevertheless, we still preferred a focus group modality, given its fit with collectivist culture's valuing of discursive, communal space. Both South Africa and Pakistan privilege collectivist cultural values (Abbas et al., 2019; Ramphele, 2012).

Context, participants, and research procedure

Similarities between South Africa and Pakistan include high inequality, poverty and associated risk factors, an increasing population of children and youth, and informal settlements characterized by inadequate service delivery and support (OECD, 2016). Potential differences include culture, nature of community supports and social networks, service systems, mobility within settlements because of the immigration/refugee population, and traditional sources of help for mental health issues (Shujaat, 2015; South African Child Gauge, 2018). Although this study was not framed as a comparative research design, the inclusion of two MWC sites could enable the identification of emerging cross-cutting or context-specific themes to inform service planning in other MWC settings. Data in both countries were collected during August 2019.

South Africa

Data were generated in a resource-constrained settlement on the outskirts of Johannesburg. The settlement began in the early 1990s and has expanded steadily since then. Given the fluidity of the population, exact population figures are not known but are estimated at ∼40,000, with 10,000 children and youth under 18 years. The majority of residents live in informal zinc structures. There is no electricity or running water in the area, and no schools, clinics, or other services. The settlement borders two older township areas established in the apartheid years. Townships, which are similar to favelas, are characterized by inferior housing, poor infrastructure, sub-optimal service delivery, and high levels of crime, violence, and disease (Steenkamp et al., 2014).

Child participants were aged between 7 and 8 years and were recruited through a community-based organization (CBO), according to their age range, living in the target area, and parents providing written informed consent. The CBO is a family-run charity that provides food and learning programmes for children, and parenting support groups. Invitations were shared with the whole community, rather than approaching families in receipt of some service. Twenty-two children (8 girls and 14 boys) participated in the study and were divided into four mixed-gender groups. Child participants knew one another, as they lived in the same community.

Two groups were facilitated at a time, with each group co-moderated by a researcher and a local peer facilitator. Local peer facilitators were older adolescent girls (just under 16 years). Both assisted the CBO with programmes and food distribution and were familiar with the children and their context. A safeguarding process ensured that their parents provided verbal consent, met the researchers and were in the vicinity during data collection. Peer facilitators provided verbal assent and ensured that children were at ease during the sessions. Children were encouraged to converse in a language they were most comfortable in, and mostly used isiZulu. Local facilitators communicated in isiZulu, often mixed with English words that the children readily understood. Two researchers with mental health expertise (psychology and psychiatry, respectively—SH and PV) were present during the focus groups. They and their local co-facilitators collaborated closely to ensure that the scenario guides were followed, children were engaged in invitational ways, and interactions were developmentally appropriate and respectful of local values.

A similar recruitment process was followed for service providers. A coordinating non-governmental organization (NGO) operating in this area identified all agencies in contact with children (from welfare, education, health, and non-statutory sectors), as well as community and religious groups. Some of these agencies were local, whilst others (e.g., care homes) were variably available to the target group of children but located in other parts of the city of Johannesburg. Selected representatives worked independently in their profession and role. All providers who agreed to participate were given the opportunity to attend the participatory focus group. For this reason, in South Africa, service providers' participation was higher than in Pakistan. A total of 75 stakeholders accepted the invitation to participate in the study. The service groupings and numbers of participants were local government (Department of Social Development—10 policy makers); seven community services (22 staff); three family support services (five staff); one family placement agency (two staff); nine NGO-provided care homes (20 staff); two statutory care homes (seven staff); one youth

custodial setting (two staff); three preschool day centers (four staff); and two schools (three teachers).

Pakistan

In Pakistan, a host NGO facilitated both children's and service providers' recruitment and participation. This NGO provides holistic support and services to vulnerable families across Pakistan, through communities, schools, and care homes. One NGO branch is devoted to psychosocial training for parents, teachers, and other professionals. Children and parents were approached through two schools in two Karachi informal settlement areas, according to the same recruitment criteria as in South Africa. In total, 33 children aged 7–10 years (22 girls and 11 boys) took part. Children were divided into six mixed-gender groups or three groups from each school. Children in each group thus knew of each other already and were aged 7–8 and 9–10 years in the two schools, respectively. Groups were facilitated in Urdu, the language of the participants, by two NGO professionals who had psychology and education backgrounds, respectively.

In relation to service providers, a total of 21 participants attended the participatory focus group. Stakeholders represented a range of professional disciplines, i.e., clinical psychology (four), psychiatry (two), pediatrics (one), education (teachers and principals—eight), educational counseling (two), occupational therapy (one), mentoring (one), and administration (two).

Data generation—participatory focus groups

Children

With the children, we used scenario-based participatory techniques and facilitated these as focus groups. The reason for this methodological choice was that previous studies suggested that children may not be familiar with or cognitively relate to pre-determined service concepts (Roose et al., 2003). For this reason, children were provided with three common real-life scenarios and were asked to conceptualize support, interventions, and/or services in relation to these scenarios and their underpinning stressors. Children were given the option to write or draw their responses before sharing them with the group. A few of the children chose to do this.

To elicit children's views, we posed one broad question to participants in relation to three scenarios. The question "what/who can help you feel better" was used to understand what resources children draw on when experiencing scenario-specific challenges. The scenarios were developed with an understanding of contextual risk factors and were informed by our previous study in other MWC contexts (Vostanis et al., 2020).

The scenarios tapped into (a) environmental constraints; (b) interpersonal conflict, such as bullying; and (c) familial or community violence. In their groups, children were thus asked to discuss the following questions:

What or who can help you or another child feel ok/better/stronger, when:

a. There is no water or electricity in the neighborhood?
b. Someone does something bad to you, like calls you names, fights with you, or hurts you?
c. People (grown-ups) around you fight with each other?

Focus groups were selected instead of individual interviews, to promote interactive activities and discussion, that lead to help-seeking solutions. Focus groups can engage young participants in "collective conversations" in relation to their experiences, insights, and perspectives (Adler et al., 2019). They are particularly important in capturing the voices of seldom heard and marginalized groups (Onwuegbuzie et al., 2009). As children lived in the same communities, scenarios were hypothetical and framed as "what would you do to get help or help a friend?" without discussing their own experiences related to stressors. As it was possible for them to relate their responses to their own experiences, facilitators reminded them of the task and diverted the discussion from personal issues. The host and recruiting NGOs and CBOs regularly operate in the participating communities, have stringent safeguarding policies, and routinely address sensitive issues, such as domestic or community violence, by protecting confidentiality whilst maintaining community trust. Children's responses were audio-recorded and transcribed verbatim. In general, their responses were brief. This is not uncommon when adult researchers interact with child participants in MWC contexts (Theron, 2016).

Adult service providers

Service providers also worked in small groups (Kidd & Kral, 2005). Authors (SH and SH) presented service providers with a child-focused psychosocial framework that was grounded in Bronfenbrenner's bioecological theory (Bronfenbrenner, 1979). This supported the establishment of a common understanding of mental health concepts, children's related needs (developmental, social, educational, and physical), and risk and resilience factors for mental well-being across all socioecological systems (Vostanis, Eruyar, et al., 2019). Participants could thus adopt a holistic perspective of children's psychosocial needs, based on which they would determine service provision. This was in contrast to providing them with a service checklist, which might be culturally discordant and/or based on other, predominantly

western, child mental health systems. Based on the above broad concepts and definitions, participants were asked to establish and map current resources (informal and formal), service gaps, and priorities in addressing children's psychosocial needs in the target areas (Rhodes et al., 2015). Data included the notes made by each group and the service maps that they co-produced during the participatory focus groups.

Data analysis

Children's and adults' data were analyzed separately, as they emerged from transcripts and maps/field notes, respectively. As mentioned, children were given an option to draw and or write responses before sharing with the group (Horgan, 2017). Visual outputs were not analyzed, as they were primarily used to structure the session and elicit responses. The analysis focused on the transcripts. Audio data from all children's groups were transcribed in their language (isiZulu and Urdu, respectively), translated into English, and reviewed by (SH and SH). Field notes (including researcher observations), as well as workshop notes (from adult participant mapping activities), were audio-recorded and similarly reviewed by (SH and PV). The researchers became familiar with both sets of data through repeated readings.

The research question that guided the analysis of data from the children was, "What/who supports children to be okay in challenging circumstances?" The research question that guided the analysis of data from the service providers was, "What resources are available for and could be accessed by children?" Data relevant to these questions were thematically coded (Braun & Clarke, 2006) using qualitative data analysis software, Nvivo for children and Atlas.ti for service providers, through a conflation of inductive and deductive coding processes. These encompassed the development of initial codes, followed by a process of identifying, reviewing, and defining themes (Braun & Clarke, 2006; Nowell et al., 2017). The authors (SH and PV) reviewed the themes. They had a psychology and psychiatry background, respectively, experience in qualitative methods with children, and contextual expertise in MWC research. Following Saldana (2009), all discrepancies were discussed until a consensus was reached. The use of thick descriptions of the research contexts and data triangulation further ensured the trustworthiness of the data (Nowell et al., 2017).

Ethics procedure

Ethics approval for the study was obtained from the University of Leicester Psychology Research Ethics Committee. In both countries, informed consent was obtained by the host organization, on behalf of the researchers,

from parents and/or legal guardians. Information letters, explaining the study as well as a consent form were discussed with the CBO/NGO, who subsequently shared them with interested families and obtained signatures. Children were asked if they wanted to participate, and what was required of them was explained in developmentally appropriate words, i.e., they provided additional verbal assent. Adult service providers in both countries were provided with the research ethics documents by the host CBO/NGO.

Results

The findings are presented separately for children and adult service providers. The emerging themes and subthemes are summarized in Table 1, both per stakeholder group and country. We have not a specified participant or focus group numbers on the excerpts used to illustrate the themes. To encourage spontaneous conversations and interactions between the child participants, we did not discourage them from talking simultaneously, thus it was sometimes difficult to identify a particular child participant when the focus groups were transcribed. Also, the child participants often gave brief responses, hence our listed excerpts. Even though we do not link these brief responses to a specific child or group, they were typically echoed by most child participants and/or met with non-verbal agreement from other group members (e.g., nodding in accord).

Children's perspectives

For participating children from the South African context, family level resources were the most frequently accessed, followed by individual and then community level resources. In contrast, children in Pakistan appeared to draw primarily on individual resources. In both contexts, children appeared to identify what resources were available to them, before navigating their way toward them.

Children's theme 1: Drawing on internal resources

As indicated above, children in Pakistan appeared to rely on themselves when faced with a challenging situation. They demonstrated different cognitive strategies in overcoming stressors (*"forgive"; "forget … ignore such happenings"; "divert our mind"*), whilst being able to self-regulate (*"I will accept my mistake or wrongdoing"; "play with a fidget hammer to overcome anxiety and stress"*). Children tried to address adversities by problem-solving *("we should make them* [adults fighting] *understand"*). Faith was also prominent in how children managed challenging situations, for example in response to scenario 1 (limited access to water) they said

Table 1. Emerging themes by children and adult service providers.

Themes	Children South Africa ($n = 22$)	Children Pakistan ($n = 33$)	Adult service providers South Africa ($n = 75$)	Adult service providers Pakistan ($n = 21$)
Internal resources	Capacity to take action Problem-solving skills Sense of self as able, not helpless	Capacity to take action Problem-solving skills Intelligence Mastery motivation Emotional regulation Planfulness Faith	Learning potential Creativity Participation	Learning potential Creativity
Family resources	Responsive parenting Within family support	Responsive parenting	Parent availability Parent-child relationship Parent empowerment Family connections	Parent availability Parent-child relationship Parent awareness Parent appreciation of learning
Community informal resources	Effective Well-functioning neighborhoods Absence of or control over violence and drugs Peer relationships Teachers and educators Community leader	Peer relationships School systems Community-based solutions	School Churches Community settings/forums Sports Open spaces Creative activities	School Teacher potential Madrassas Social networks Sports Open spaces
External formal resources	Police Community-based organization NGO		Resources (number of skilled staff) Response Emergency routes Social workers Joint working Case conferences	Resources (number of skilled staff) Response Emergency routes Mental health awareness Community volunteers Primary health care

"*we should recite Darood* [prayer]*" and "pray for rain";* and in response to scenario 2 (someone hurts or bullies you), they said, *"we will wait for judgement day and God will give punish that person"; "Allah counts sin for those who fight"*).

Children in Pakistan gave several examples of using intelligence, mastery motivation, capacity to take action, and problem-solving when faced with a community crisis, such as lack of water: "*we will take measures to purify water obtained directly from the sea by using pipes"; "we can submerge into water deep under the ground, by using pump"; "could be taken care by sea by the procedure of water cycle."* Despite their young age, children showed broad awareness of government structures *("we will write application to the government"*), their country and regional geography *("ask other countries to donate water"*), crucially linking solutions to environmental issues: "*we should grow more plants to improve the atmosphere/environment around us."*

They viewed themselves as able rather than helpless and devised active—and often planned—responses to help other vulnerable children (*"we will help the victim"),* or to take control over adults fighting at home: *"we will act up falling dizzy/sick to demand their very attention, which would automatically divert them from quarrelling any longer."* In response to the violence perpetrated by a teacher, one child stated: "*The teacher will hit her, but I will ask the teacher not to hit her… "* This demonstrates an ability to understand and problem-solve, and points to the support that children give each other.

These inner resources were also present in the South African participants; they were, however, not the primary and only means when faced with difficulty. Indeed, they reported several creative emotional regulation strategies in response to witnessing violence: *"add glitter in a glass of water, and mix and shake it, then we cool down"; "tear the paper and bring the anger down on it"; "drink cool water when we are in anger mood"; "count backward to calm down."* The capacity to take action was demonstrated in threatening circumstances, such as the second scenario of being threatened: *"we run away," "I hide under the table… under the bed… in the wardrobe," "we cover ourselves with our bedsheets."* The action was not always an escape from danger or helplessness: *"I was in the house, until a thief came and threatened me at gunpoint to give them money… I was able to get a phone to call the police."* Similar to children in Pakistan, the capacity to take action was demonstrated when faced with family conflict: *"Mum and dad, if you don't stop fighting, I'll leave."*

Children's theme 2: Family resources

Child participants in South Africa accessed help from various family members, including parental figures and siblings. For example, one child

indicated that, if someone hurts him, he will call his "Ubuthi" (brother). Another mentioned that she had called her mother, "Umama", once at school when another child was bullying her. Another participant from this context mentioned the support she gets from both her grandmother, "Ugogo," and her mother. These terms, which can have various connotations in isiZulu, were explained by the local peer facilitators to the researchers as denoting a positive family context.

Children would sometimes use internal resources to initiate family support: *"I'd tell my mum to write in my diary, so that I can tell my teacher"; "I'd ask my grandpa to go with me to see my dad."* Older siblings appeared to step in to support younger siblings by warning of the aggressor, or by physically deterring them: *"it's a friend from school bullying him, and then his brother is helping him with that, his older brother."* Children would seek help from extended family when their parents were fighting: *"he* (uncle) *tells them to not hit me"; "I speak to my other family, that they're fighting, my mum and dad."*

As mentioned, children in Pakistan appeared to draw more on internal resources to address difficulties. Here, however, there is evidence that children believed family members would be responsive to their agency: *"we should request our parents to give good advice, so the problems are resolved forever."* Several parental interventions were anticipated in response to bullying and other kinds of violence: "*I will take my father to her house to complain, and he will guide her that beating is a bad habit"; "mama, my friend is too bad, she regularly beats me. I taught her learn good lesson…. but she didn't listen to me. So, tell me some solution."* Elders also had an important role, particularly in the face of family conflict: *"we should complain to our elders at home and shouldn't handle that matter by ourselves."*

Children's theme 3: Community resources

In both sites, children viewed school as having a broader than educational role. Teachers were central in dealing with bullying incidents and resolving disputes within school hours: *"at school, I have to tell my teacher, because I wouldn't have a right to hit them… I'd have to get permission from my teacher first"* (South Africa). They often compensated for lack of family support: *"I'll ask her that teacher, kindly help us. We don't have water at home… she can even come at our home and solve it"* (Pakistan). Peer relationships were also common sources of support for both groups of children. Friends would sometimes substitute for lack of adequate adult care: *"yes, he will get me water without his mother being aware of*"; *"I will go and hide in her home"* (in case of violence within the family—Pakistan).

Children in the South African context appeared aware of resources that were available in the community, particularly if confronted with familial or community violence. They were especially conscious of the importance of safety in their neighborhood. When probed about exposure to violence (scenario 3), they referenced examples from their contexts, "*a father hit a mother"; "fighting for food"; "people get shot."* In these situations, they were aware that they could and should access help from other adults. Trust and safety thus often determined their choices: *"I'd call upon people I trust and tell them that my parents are fighting."* The community leader appeared to be the local authority figure, resolving disputes, responding to domestic violence, and liaising with local governmental structures. Ways in which he helped, included: *"he calls the police to come help us"; "he comes and checks on us"; "calls up a meeting."*

Children's theme 4: External formal resources

There was a limited reference to external services, with the police being the most commonly sought agency. Children often indicated that they would ask someone to seek law enforcement. Parents or elders were viewed as solving problems, predominantly lack of water or violence, jointly with authorities, such as local government or the police: "*the dad calls the municipality to come with the big water truck"; "police and daddy."* The police were mentioned several times by children living in the South Africa settlement, as having to intervene to break fights, with examples of being violent themselves: "*okay, so in his situation, it wasn't people fighting around him … it was him and his brother fighting, but then police were passing by and saw them; and so, they had to stop the fight between the two of them"; "the police shot a thief."*

Social workers were mentioned by South African children, again in contexts of violence or neglect: *"they would say they'd help me by phoning the social workers, so that the workers would say I'd be taken away if the fighting continued, which would scare my parents."* Children recognized the community-based and external child and youth care NGO operating in this South African settlement as a resource. No external services were reported by children in Pakistan.

Adult service providers' insights regarding supports and services available to children

Adult service providers emphasized the role that external systemic structures needed to play to support and ensure children's well-being, minimizing the onus on children. These external supports were largely school- and community-based, whilst limited family engagement was seen as a

significant challenge. Social work and primary health care were viewed as potential sources of psychosocial support in South Africa and Pakistan, respectively. Difficulties in accessing mental health services were acknowledged in both countries.

Service providers' theme 1: Children's internal resources

In Pakistan, participants acknowledged the agentic capacity of children in ensuring their own well-being. Adult service providers indicated that, despite living in adverse environments, children possessed cognitive ability *("active learners," "talent"),* curiosity and temperament (*"enthusiasm," "exploration,"* and *"confidence"*), and faith, to deal with challenging circumstances. Internal resources were, however, often constrained by environmental adversities, no intellectual stimulation, lack of support and role models, and developing emotional problems. Crucially, the main hurdle to children's well-being was *"seeing no future."* In South Africa, children's internal resources were acknowledged, albeit more in conjunction with the community and service themes, indicating adult responsibilities in tapping into e.g., children's creativity. Some stakeholders stated that decisions and care plans were usually driven by risk, rather than informed by children's abilities or with a holistic view of the child: *"placement for abuse, not potential."*

Service providers' theme 2: Family resources

Parental and family issues were largely seen as challenges rather than strengths in both contexts under study. In Pakistan, it was acknowledged that many parents were *"receptive to learning,"* which facilitated children's sparse educational opportunities and reduced the risk of exploitation through illicit labor. Family *"bonding"* was viewed as a key strength and important for recognition of child mental health problems and help-seeking. Participants in both sites acknowledged that parent-related difficulties should be central to therapeutic interventions. Thus, parents were described often as being *"unavailable for the child,"* with limited child-parent interaction and involvement, resulting in "*lack of foundations and routines."* Non-availability was often related to working long hours. Parents faced their own mental health needs, and children often experienced domestic violence. Parents' disempowerment, social disconnection, and lack of awareness of child mental health issues were viewed as key barriers to engaging with services.

Service providers' theme 3: Community informal resources

The community was viewed as the largest source of support in both countries. Stakeholders in Pakistan put a stronger emphasis on education, possibly reflecting the number of teachers in the sample. In South Africa, a

large number of community workers considered wider community settings and forums, such as sports and creative activities. The school was viewed as often being the main source of strengthening children's resilience, in the absence of external services. This provided a *"stimulating environment"* to counteract environmental constraints, and often enhanced the traditional educational curriculum with life skills and *"activity-based homework."* Teachers' dedication and commitment were acknowledged. Some teachers had training in pastoral or welfare support, but this was rather ad hoc and not built within bioecological systems, and most children could not access or sustain educational opportunities beyond the minimum curriculum. Life skills and *"therapeutic vocational"* training were reported as being essential, albeit limited, the extension of the curriculum in some schools.

Religious or faith groups, churches, and madrassas in South Africa and Pakistan, respectively, community centers, crèches, and social networks were strong resources for children, both in protecting them from adverse events and in initiating or providing help for those who developed mental health problems. Sports, with examples of soccer and boxing in South Africa, and cricket in Pakistan, were common activities considered essential for children's adaptive psychosocial functioning. Structured sporting activities demonstrated to children the importance of self-discipline, perseverance, discipline, and teamwork. Wherever possible, open spaces offered opportunities for such activities. Peer groups, children's forums, and creativity (drama, dance, and performance arts) were particularly highlighted by South Africa stakeholders. Religious leaders, youth, and community workers undertook mentorship roles, hence often providing parent models or *"substitutes"* for children. In South Africa, traditional healers were viewed as fulfilling an important function, although the discordance of their beliefs on mental health was also considered to be a barrier in discouraging help-seeking from mental health services. Stigmatizing attitudes toward mental illness were shared not only by the public but also by some mental health professionals.

Accessing and engaging with sources of psychosocial support was constrained by a range of environmental challenges, such as pollution, health hazards, and lack of electricity, which also hindered schools from accessing online materials. Compounded by the disruption of social networks, many children and youth were exposed to sexual and other kinds of abuse (*"grooming"*), child labor, drug use (*"drug culture"* in the community), and criminality. Refugee children were often *"undocumented"* in South Africa settlements. All these factors acted as a risk to children's mental health, and as barriers to accessing help. School placements were difficult for children with special needs, as were extracurricular activities because of limited staff and resources. Community organizations faced closures because of time-limited funding.

Service providers' theme 4: External formal resources

Overall, and unlike Minority World Countries systems, it was difficult to distinguish in service providers' definitions of available sources of psychosocial support between informal community sources described under the previous theme, functions of non-governmental organizations (NGOs), and the limited statutory or public services. An example was social work and child protection being provided both by NGOs and Social Services in South Africa. Interestingly, the police were not mentioned, given its prominence among children's reports. Participants in both countries acknowledged the limited availability of mental health services, in terms of infrastructure, staff numbers and skills, large caseloads, emergency routes, and time response ("*delayed appointments*"). Some mental health services operated outside the target settlement areas, but these were largely unknown and inaccessible to communities ("*no sign posting*"). Even limited access was constrained by stigmatizing beliefs and attitudes toward mental illness, in the absence of mental health awareness campaigns.

Community-based agencies, and NGOs, thus largely provided psychosocial support to children and families. Participants reported several "*good practice*" principles among community services in South Africa, including multidisciplinary working, setting common goals, stakeholder communication, holding case conferences, and, crucially, adopting a child-centered approach. Existing staff skills and experience, and some in-house training, were mentioned in both countries. Participants offered suggestions on how mental health input could be integrated into existing health care and other provision. For example, primary health services were already operating in the areas, and there were awareness programmes on hygiene. An interesting model in Pakistan consisted of trained community volunteers ("*lady health workers*") to provide health education and immunizations and, to a small extent, psychosocial support.

Discussion

The aim of this study was to establish and juxtapose the perspectives of children aged 7–10 years living in resource-constrained settlements in South Africa and Pakistan with those of service providers, on the resources they seek and use when faced with common stressors within their families and community. The implications of the key findings are discussed in the context of service improvement in similar settings of deprivation.

These findings need to be interpreted in the context of the methodological approach and constraints of this study. Although we used participatory methods with both children and adults, these were adapted to their developmental capacity and professional roles, respectively. This exploratory study

was not designed as a comparative or mixed methods research design to draw cross-cultural and generalizable conclusions, but rather to establish help-seeking and service provision trends in two urban communities that shared similar socioeconomic challenges. Findings could thus be different in rural settlements, or different urban areas of disadvantage within each country. Service providers could also vary, as in this sample there was an over-representation of community professionals in South Africa and educationalists in Pakistan, which may have skewed service mapping and resulting recommendations. There may have been a self-selection bias in both the child and adult participants who came forward. It is further possible that child participants had insights that they chose not to share, given that they knew each other and possibly wanted to preserve social or peer approval. Nevertheless, the participating groups provided unique insight into what constitutes psychosocial support for children in similar communities, including how different types of support are perceived by children of a relatively young age.

It is important to acknowledge a disconnect between the objective of understanding children's perspectives of mental health support and services and the actual findings. The latter is related to stressors experienced, coping strategies, and sources of informal and more logistical or instrumental support (mainly protection). This disconnect could be attributed to several reasons. As acknowledged by the adult participants and the literature in similar resource-resource settings, there is limited, if any, mental health provision. Consequently, children could only respond to the given scenarios with available services in mind—this is in contrast with western literature on children's experiences of mental health attendance (Bone et al., 2015). Stigmatizing attitudes and children's cognitive capacity could also have hindered children from conceptualizing mental health and linking to the scenarios, despite the participatory approach used. Additional focus group discussions or one-to-one interviews could help elicit such concepts from younger children.

Juxtaposing children's and service providers' perspectives is important for service transformation in similar resource-constrained settings. Priorities can be formulated at all socioecological systems levels. Children in both settings described a range of individual resources and strategies that they relied on to cope. In South Africa, children reported slightly greater access to and availability of family and community resources. Respective adult stakeholders reflected this variable balance. This may indicate that children in Pakistan were more reliant on internal resources and less on systems, whilst in South Africa, the two types of resources were more inter-linked. Such an interpretation would be consistent with a socioecological theory of resilience that explains positive adaptation as being

contextually and culturally determined, and dependent on the availability of systemic resources (Ungar & Theron, 2020; Ungar et al., 2015).

Although children of a young age demonstrated that they could provide valuable insight on what their daily needs are, as well as articulate solutions on the ground, service providers did not link children's specific internal resources with implications for psychosocial interventions, other than generally referring to their *"creativity"* and *"potential."* For example, children clearly described a range of resilience-building processes and skills, such as emotional regulation, cognitive reframing, making meaning, acting, and problem-solving. This rich knowledge can be incorporated in school- and community-based psychosocial programmes. The active involvement of peers in addressing stressors is consistent with the peer educator model which, however, would need to be supported and formally integrated into services (Mason-Jones et al., 2011).

Children and service providers perceived families as sources of both conflict and support. Such ambivalence of the family has been highlighted by reviews on what protects children exposed to maltreatment or domestic violence (Afifi & MacMillan, 2011). Consequently, parent awareness and engagement should precede setting up parenting skills groups or other interventions. Parenting programmes should be combined with practical assistance and support. Schools, community forums and networks, religious and faith groups, and community-based services all provide opportunities for awareness, involvement, and integration of psychosocial support.

Overall, children's recurrent reference to different types of domestic, school, and community violence was alarming. Although two of the scenarios were related to facing conflict, throughout all participatory groups, children spontaneously reported many incidents of often extreme, even life-threatening, violence. Considering their young age, they appeared to have processed such chronic exposure and adapted their own resources, as well as how and whom they approached, for support. In the not infrequent cases of domestic violence, siblings, extended family, peers, teachers or community leaders often stepped in. Children's help-seeking strategies were creative, planned, and active, demonstrating both cognitive and emotional regulatory processes to deal with adversities. Service providers also viewed community sources as central to providing psychosocial support in the face of ongoing conflict.

It was, however, telling that the police were the only external agency to be consistently mentioned by children but not by service providers and that children, their peers, or extended family had to instigate their involvement. Exposure to violence and feeling safe was clearly paramount to children's psychosocial functioning. In contrast with service providers, children did not appear aware of mental health services or other external sources of

psychological help, other than the community-based NGOs that operated within the South Africa settlement. This could be explained by the lack of operation of such agencies, conceptualization of mental health, or children reporting what was visible in their world (Khalil et al., 2020; Van Breda & Theron, 2018). With limited references to community workers, children primarily viewed them as sources of protection rather than promoting their well-being. Van Breda and Theron (2018) previously established that children in South Africa largely relied on personal and relational rather than structural resilience enablers, with similar findings by Qasim et al. (2016) following a natural disaster in Pakistan. Consequently, mental health services should be working closely with child protection and judicial agencies, including the police, in establishing local interdisciplinary networks, as discussed below (Odegard, 2009).

In contrast with children, who did not appear aware of external resources, adult stakeholders consistently highlighted the limited access to mental health services in terms of referral pathways, time response, emergency routes, and the number of skilled staff. This is consistent with findings from similar disadvantaged contexts globally (WHO, 2017). There were several recommendations for strengthening psychosocial systems through interdisciplinary working in South Africa and community volunteers, such as the *"lady health workers"* in Pakistan. Paraprofessionals provide health promotion and immunizations in many MWCs; and can engage parents and youth by simultaneously addressing stigmatizing attitudes about mental illness (Van Ginneken et al., 2013). Capacity-building was viewed as a priority by service providers at all levels (community volunteers, teachers and other frontline professionals, mental health specialists—WHO, 2013). These groups should be extended to include children and youth, thus actively engaging them in service planning within their communities.

Conclusions and directions for future research

The complex psychosocial needs of children living in MWC areas of disadvantage can be met through multi-modal interventions that bring together communities and agencies on the ground (Ungar et al., 2014). External structural supports should be integrated with internal and relational resources through a stepped-care approach (WHO, 2022). Children and youth have a pivotal role in informing service transformation as active agents. Future research should include the co-production, feasibility, and evaluation of such multi-modal interventions in different sociocultural contexts.

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