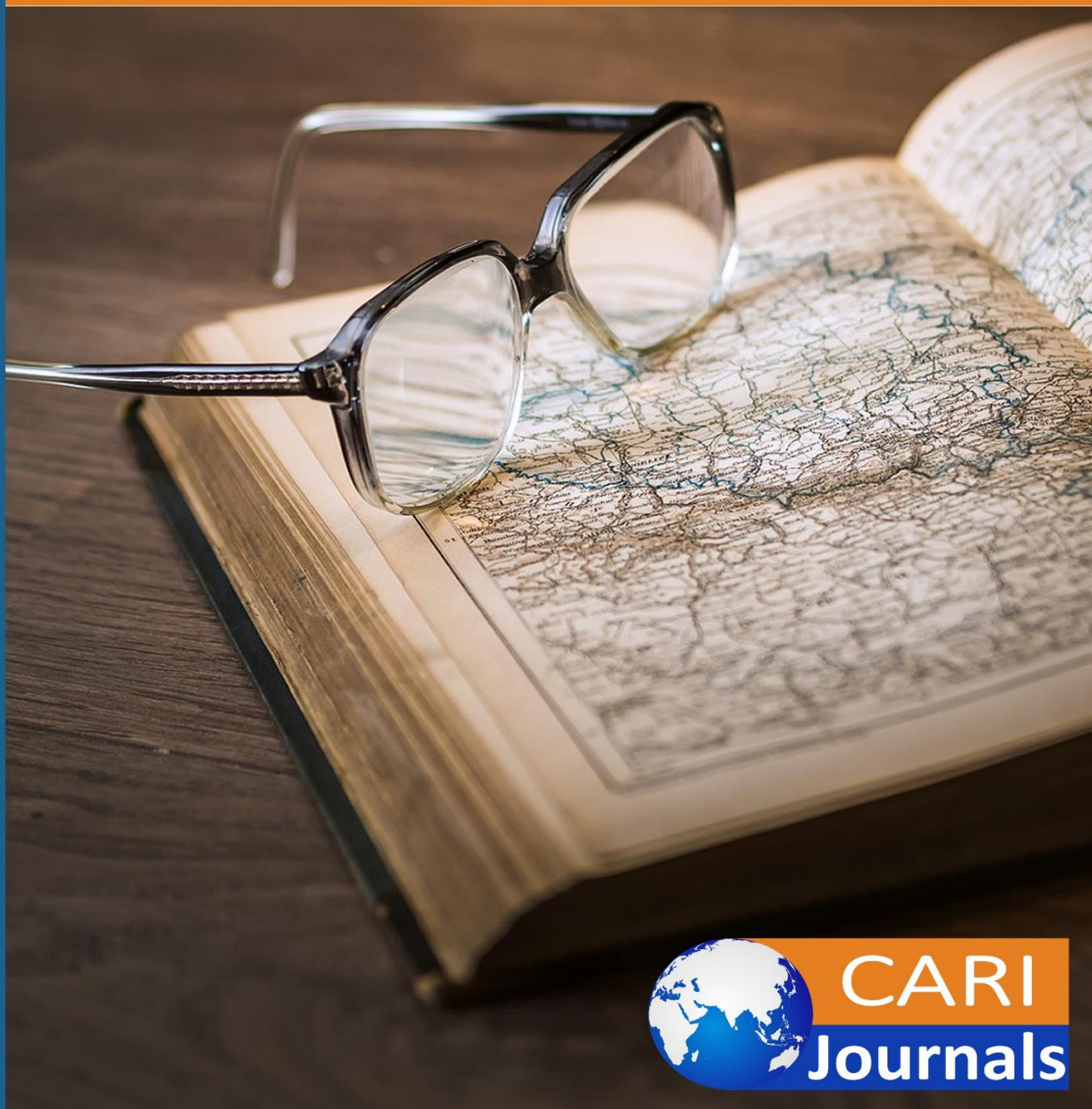
International Journal of
Humanity and Social Sciences
(IJHSS)

# Humanitarian Relief as a Barrier to Mental Health Literacy and Intervention during Natural Disasters: Empirical Insights from Chikwawa, Malawi



CARI Journals

International Journal of Humanity and Social Sciences
ISSN: 3005-5407 (Online)
Vol. 5, Issue No. 4, pp. 1 – 17, 2026
www.carijournals.org

# Humanitarian Relief as a Barrier to Mental Health Literacy and Intervention during Natural Disasters: Empirical Insights from Chikwawa, Malawi

**[1*]Bryce Joyex Maigwa, [2]Dr Edna Simwinga Chirwa**

[1]PhD scholar, Zambian Open University
[2]Head of Psychology Department, Zambian Open University
https://orcid.org/0009-0006-6884-4076

***Accepted: 24th July, 2026, Received in Revised Form: 4th Aug, 2026, Published: 18th Aug, 2026***

## Abstract

**Purpose:** This study investigates the impact of humanitarian relief on mental health and psychosocial support in Chikwawa, Malawi, exploring how the prioritisation of physical aid hinders the recognition and treatment of psychological trauma.

**Methodology:** This qualitative study, conducted using the Multidimensional MHL Framework, involved semi-structured interviews with 27 survivors and 7 stakeholders in Chikwawa. This involved individual and family interviews with survivors' families and disaster recovery specialists. Data were transcribed from Chichewa into English prior to manual thematic analysis, with a focus on indigenous knowledge and institutional gaps.

**Findings:** Results show a significant "literacy gap," with only 14.1% of participants correctly identifying clinical mental health disorders. Survivors are "literacy-locked" by a "material-first" relief paradox, in which urgent needs for food and shelter preclude engagement in mental health. Systemic neglect is evident, as literature shows that only 0.3% of national health facilities offer formal mental health services. Despite this, the indigenous philosophy of *Umunthu*, which emphasizes collective humanity, family and church-based coping strategies, remains a vital resource for psychosocial support.

**Unique Contribution to Theory, Practice and Policy:** The study contributes to the advancement of knowledge by refining frameworks and explaining phenomena. It also informs practice by improving frontline methods and tools for direct application. By decisions, influencing guidelines and resource allocation the study influences policies.

**Keywords:** *Mental Health Literacy, Chikwawa, Malawi, Natural Disasters, Humanitarian Relief, Psychological First Aid.*

## 1. INTRODUCTION

Natural disasters are not only physical crises but also profound psychosocial emergencies. Across Sub-Saharan Africa, climate-related events such as floods, droughts, and cyclones have become more frequent and severe. This makes shelter and infrastructure restoration central to disaster response, often at the expense of psychological support. This article examines how humanitarian relief inadvertently impedes mental health literacy and intervention in disaster-affected communities, drawing on empirical insights from Chikwawa District, one of Malawi's most climate-vulnerable regions. Through qualitative interview data, the study highlights the systemic neglect of psychosocial recovery. Drawing on survivor and stakeholder perspectives, it argues for a paradigm shift toward integrated relief models in which structured psychological support accompanies humanitarian relief.

In March 2023, the arrival of Tropical Cyclone Freddy redefined the scale of disaster in Malawi. The storm, which set records for its longevity and intensity, triggered unprecedented mudslides and flooding across the Southern region. Approximately 2.2 million people were affected, with over 650,000 displaced to temporary evacuation camps (Kangoma et al., 2023). In Chikwawa, Malawi, many villages were submerged, and public and private infrastructure was destroyed, leaving residents vulnerable and without access to basic human needs.

Chikwawa District, in Malawi's Lower Shire Valley, is among the most climate-vulnerable landscapes in Sub-Saharan Africa. The district is frequently subjected to extreme weather events, ranging from prolonged droughts to catastrophic flash floods. According to Khendlo et al. (2025), Chikwawa's location makes it a natural drainage basin, so even moderate rainfall in the highlands can cause devastating floods in the district. The floods and other natural disasters, such as cyclones, lead to the complete collapse of the local livelihood system rather than a temporary setback. This persistent instability has produced a population in a continual state of recovery, with recovery efforts remaining narrowly focused on material needs.

## 2. RESEARCH PROBLEM

The central issue examined in this article is the humanitarian sector's systemic failure to address the need for mental health literacy during and after natural disasters. In Malawi, current relief frameworks primarily acknowledge physical suffering in the disaster environment. This approach can create a barrier to survivors accessing psychological support. Understanding this dilemma through empirical insights from Chikwawa is essential to inform future scholarship and to adopt a framework that intentionally integrates humanitarian relief and psychological support during natural disasters.

## 3. LITERATURE REVIEW

### 3.1 Methodology of Literature Identification

The literature for this review was identified through an electronic search of peer-reviewed journal articles, grey literature, and policy documents published between 2018 and 2026. The databases included PubMed, Scopus, and Google Scholar. Inclusion criteria required that studies address mental health interventions and humanitarian relief in the recovery phase following natural disasters. Exclusion criteria included opinion pieces, editorials, and studies not available in English.

### 3.2 Disasters and Mental Health: The Global Evidence

The link between natural disasters and long-term mental health outcomes is well-documented in both international and local databases. Systematic mapping reviews indicate that survivors of major natural disasters like floods experience high rates of PTSD, depression, and generalised anxiety (Fernández et al., 2015). The indirect psychological impacts of disaster-induced economic instability and livelihood disruption often manifest as prolonged grief and hopelessness (Mpheza, 2023). Despite empirical evidence of a correlation between natural disasters and mental health needs, recovery interventions remain focused on humanitarian relief, leaving the associated mental health crisis to worsen. This oversight contributes to a ripple effect in which unaddressed psychological trauma exacerbates existing vulnerabilities and impedes long-term recovery efforts (Raphela, 2025). This pervasive issue highlights a significant gap in humanitarian aid frameworks, in which mental health and psychosocial support often receive inadequate attention relative to immediate physical needs, despite robust evidence of their importance in post-disaster recovery and resilience-building (Abidi, 2024; Dickson et al., 2024). This disregard for psychological well-being is particularly problematic given the documented increase in the frequency and intensity of climate-related disasters worldwide. It is estimated that during natural disasters, 20–40% experience mild psychological symptoms and 30–50% suffer from moderate to severe issues (Mahmud et al., 2021).

### 3.3 Mental Health Intervention: The Sub-Saharan African Context

Research from South Africa indicates that after natural disasters, women in low-income settings show significant increases in emotional distress and clinical PTSD (Nöthling et al., 2023). Despite these findings, regional disaster management remains predominantly focused on infrastructure and material and physical health. This approach overlooks the profound mental health consequences, particularly for vulnerable populations such as women, who face elevated risks of PTSD and anxiety following such events (Joshi & Kumar, 2020; Kangoma et al., 2023; Nöthling et al., 2023). Moreover, there is a significant mental health literacy gap in the region, with young adults in Malawi demonstrating particularly low scores in identifying mental health disorders (Chitalah et al., 2024). This gap exacerbates the challenges in addressing the mental health impacts of extreme

weather events, which are increasingly prevalent in Sub-Saharan Africa, particularly in Malawi, resulting in chronic psychological distress, anxiety, depression, and post-traumatic stress disorder.

### 3.4 Mental Health Literacy in Malawi

Malawi's mental health landscape is characterised by a severe lack of resources and a profound literacy gap. MHL is the foundational knowledge required to recognise, manage, or prevent mental disorders (Furnham & Swami, 2018). Recent assessments of young adults in rural and urban Malawi reveal that while 48% of the population acknowledges the problem of mental illness in their community, only 14.1% can specify which illness it is (Chitalah et al., 2024). This diagnostic ambiguity underscores a critical deficit in mental health interventions that exacerbates the burden of untreated mental disorders within the population (Cox et al., 2023). In Malawi, the prevalence of depression has been reported to be between 19% and 30% among adult primary care attendees (Chima et al., 2023). This prevalence shows an urgent need for enhanced mental health interventions in Malawi, especially in the disaster-prone areas.

This lack of knowledge is a primary barrier to help-seeking. If a survivor in Chikwawa experiences the symptoms of PTSD like flashbacks, hypervigilance, and emotional numbing, they may lack the knowledge to identify it as a treatable medical condition. Instead, they may interpret these symptoms through spiritual or cultural lenses, leading to social exclusion or reliance on ineffective coping mechanisms (Chitalah et al., 2024; Nyali et al., 2025).

### 3.5 The Disaster Risk Management Framework in Malawi

The Disaster Preparedness and Relief Act governs the legal and institutional framework for disaster response in Malawi. A 2008 situation analysis of DRM programmes in Malawi noted that the system is primarily designed to respond to interruptions of essential supplies and to the destruction of persons and property (Hay & Phiri, 2008). This policy vacuum ensures that mental health support remains an option rather than a core requirement in relief efforts. Similar challenges persist in other low-income countries, where the severe psychological and mental health consequences of natural disasters frequently go unaddressed due to a lack of awareness or governmental interest (Nahar et al., 2014). Despite these systemic challenges, some low- and middle-income countries have begun integrating mental health services into disaster response, although formal implementation remains a significant hurdle (Thompson-Assan et al., 2023).

## 4. THEORETICAL FRAMEWORK

### The Multidimensional MHL Framework

This study utilises the Mental Health Literacy framework proposed by Jorm and critically evaluated by researchers such as Coe (Coe, 2009) and Furnham & Swami. This framework evaluates MHL through six specific components, which can be categorised into three primary domains: Recognition, Knowledge, and Attitudes (Bahrami et al., 2019). The Recognition domain

focuses on the ability to identify the specific signs and symptoms of mental health disorders, which is essential for initiating the help-seeking process (Bahrami et al., 2019; Coe, 2009). The Knowledge domain encompasses several components, including understanding risk factors and causes (biological, psychological, and social contributors), awareness of self-help interventions, knowledge of available professional help, and the ability to seek reliable mental health information (Coe, 2009; Venkataraman et al., 2019). Finally, the Attitudes domain involves beliefs that facilitate recognition and appropriate help-seeking by reducing stigma and encouraging openness to professional support (Coe, 2009). In this study, the multidimensional framework is used to examine how the "material-first" focus of humanitarian aid in Chikwawa—where physical relief, such as food and shelter, is prioritised—affects the literacy and psychosocial recovery of survivors who may otherwise remain "literacy-locked" in addressing their mental health needs.

## 5. METHODOLOGY

### Research Instrument

The empirical insights for this study were generated from a data-collection instrument developed for the author's doctoral research on church-based mental health literacy and disaster resilience in Malawi. It comprises 32 items that combine closed- and open-ended questions to capture the multidimensional experiences of disaster survivors and stakeholders systematically. The questionnaire was designed to cover five domains: the psychosocial impacts of natural disasters on families, psychosocial support and promoting mental health literacy in disaster-prone communities, barriers and enablers to building family resilience, mental health literacy intervention aimed at strengthening family resilience, and evaluating the potential of church-led platforms in delivering sustainable mental health support and trauma recovery services. The instrument was piloted in a small sample prior to the main study to assess contextual appropriateness and clarity. Full psychometric validation is ongoing, and any limitations related to data reliability are noted in the discussion of study limitations. This approach provides transparency in the data collection process and reinforces methodological rigour for academic readers.

### 5.2 Qualitative Fieldwork and Sampling

Fieldwork was conducted in the flood-prone Traditional Authority Makuwira in Chikwawa. The study utilised purposive sampling to recruit participants with direct exposure to the 2023 flooding and Cyclone Freddy, with a specific focus on communities experiencing the highest levels of displacement and infrastructure damage. A total of 27 disaster survivors from 10 families, predominantly women aged 18-55 years, were selected from evacuation camps and affected villages. Inclusion criteria for survivors required that families had directly experienced the devastation of the natural disasters, either floods or Cyclone Freddy. Exclusion criteria included persons under 18, those with pre-existing severe mental illness, or anyone unwilling to provide informed consent. In addition, 4 relief stakeholders were purposively selected from the area

Disaster Management Committees, and 3 hospital workers also responded to structured interviews. Stakeholders were included if they had been directly engaged in coordinating and delivering aid in Chikwawa following the natural disasters. This approach ensured the collection of diverse perspectives regarding both the receipt and delivery of humanitarian and psychosocial support.

While purposive sampling enabled rich, detailed insights from those most affected by the disasters, the sample's characteristics may affect the transferability of the findings. The study's focus on women in a specific age range and on communities with acute levels of displacement may mean that the results do not fully capture the perspectives or experiences of men, older adults, or residents from less-affected areas. Additionally, the findings may be most applicable to similar disaster-prone settings in Malawi or Sub-Saharan Africa, rather than being broadly representative of all communities experiencing natural disasters. These considerations should be taken into account when interpreting the broader relevance of the study's conclusions.

### 5.3 Ethical Considerations and Trauma Sensitivity

Given the study's grounding in lived experience and its alignment with similar studies in Malawi, the do-no-harm principle was central. Formal ethical clearance was obtained from the Malawi Assemblies of God Ethical Committee (MAGUREC) (a committee accredited by the National Commission for Science and Technology to offer ethical clearance for research in Malawi). Another clearance to collect data from subjects in the area was obtained from the group village (GV) leader, Sekeni, who, upon consent, provided two of her assistants to accompany the researcher and help identify qualified research subjects.

Prior to interviewing each participant, verbal consent was obtained, and participants were informed of the study's purpose and their right to decline to participate or withdraw at any time. Confidentiality was observed, and during the interview, the chief's aides were asked to remain 50 meters from the interview site to avoid overhearing the responses. Names were not recorded, nor pictures taken.

During the interviews, 3 people manifested signs of trauma through crying and physical emotions; in that regard, the interviews were put on hold to let the participants recover. One of the interviews ended abruptly. In this situation, the researcher, who holds a master's degree in psychology, assessed the participants through observations to determine whether further psychological intervention or hospital referral was needed, but they all recovered within 10 minutes.

### 5.4 Data Analysis

The data from individual and family interviews were transcribed verbatim and manually analysed to identify what was relevant to this study, following Braun and Clarke’s six-step approach. The process began with familiarisation through repeated reading and systematic coding, leading to the identification of recurring patterns across survivor and stakeholder accounts. Codes were then organised into overarching themes that captured systemic barriers to mental health literacy,

including the dominance of material-first relief, cultural taboos surrounding psychological distress, and the absence of institutional psychosocial frameworks. Credibility was enhanced through triangulation of family interviews, individual interviews with survivors, and stakeholder input, ensuring consistency in theme development. This analytic strategy provided a rigorous account of both lived experiences and professionals' perspectives, illustrating the complex interplay between humanitarian aid and psychosocial recovery.

**Table 1: Coding Framework for Qualitative Data Analysis**

| Quote | First Order Code | Second Order Theme | Aggregate Dimension |
|---|---|---|---|
| "After the flood, I only cared about food and shelter." | Focus on immediate relief | Prioritisation of material needs | Relief overshadowing psychosocial recovery |
| "We do not talk about mental health here." | Cultural silence | Mental health stigma | Barriers to literacy and intervention |
| "I did not know where to get help for anxiety." | Lack of resource awareness | Low mental health literacy | Barriers to literacy and intervention |
| "Neighbours helped each other, but nobody mentioned stress." | Community support focus | Informal coping mechanisms | Community resilience without psychosocial framing |

## 6. RESULTS

### 6.1 Focus on immediate relief: Relief Overshadowing Psychosocial Recovery

During the data collection phase, it became apparent that some participants' indications of low mental health literacy were influenced by their immediate post-disaster priorities. Several respondents, when asked about mental health, redirected their focus to the urgent need for relief services, including food, shelter, and basic medical care. This observation was captured through both survey responses and qualitative interviews, in which participants explicitly stated that mental health was a secondary concern to securing essential resources. These contextual nuances were documented during data collection and subsequently taken into consideration in the analysis, ensuring that the measurement of mental health literacy accurately reflected the participants' situational priorities rather than solely a lack of knowledge.

### 6.2 Empirical Evidence Gap in Malawi: Barriers to Literacy and Intervention

The analysis revealed a profound lack of mental health literacy among disaster-affected communities in Chikwawa. Despite widespread recognition of psychological distress, survivors often lacked the vocabulary or diagnostic knowledge to identify specific conditions. One participant admitted, *"I did not know where to get help for anxiety,"* reflecting both limited awareness of available resources and the absence of culturally adapted interventions. Similarly, the statement, *"We do not talk about mental health here,"* illustrates how cultural silence and stigma reinforce systemic barriers to help-seeking. These narratives align with national data showing that only 14.1% of rural young adults in Malawi can accurately identify mental health disorders. Thematic coding clustered these accounts under the themes of low literacy and stigma, which together form a critical barrier to intervention. Without targeted efforts to bridge this evidence gap, humanitarian relief risks perpetuating cycles of untreated trauma and reinforcing taboos that prevent survivors from accessing psychosocial support.

### 6.3 Community Resilience without Psychosocial Framing

Participants frequently described how neighbours and extended family provided mutual aid in the immediate aftermath of Cyclone Freddy. This informal support was vital for survival, with one survivor noting, *"Neighbours helped each other, but nobody mentioned stress."* Such accounts highlight the strength of community solidarity in Chikwawa, where collective action ensured access to food, shelter, and basic needs. However, thematic analysis revealed that this resilience was largely material and social, lacking explicit recognition of psychological distress. Informal coping mechanisms—such as focusing on rebuilding homes or sharing resources—were valued, but emotional trauma remained unspoken. This silence underscores how community resilience, while effective in meeting tangible needs, inadvertently perpetuates the invisibility of psychosocial recovery. Without a framework that integrates mental health literacy into community support systems, resilience risks being narrowly defined, leaving survivors' psychological wounds untreated.

### 6.4 Stakeholder Blind Spots

Interviews with hospital workers and field workers involved in disaster recovery revealed a significant "blind spot" regarding mental health. It was revealed that these professionals were highly trained in logistics, physical first aid, Sanitation and Hygiene (WASH), and nutrition, but had no formal training in Psychological First Aid. Consequently, survivors exhibiting signs of trauma were often labelled as "difficult beneficiaries" rather than individuals in need of psychosocial support. This stakeholder gap reinforces the institutional invisibility of mental health in the disaster cycle (Hay & Phiri, 2008). This systemic oversight perpetuates a cycle where mental health issues remain unaddressed, contributing to long-term psychosocial morbidity within affected populations (Contreras et al., 2018). This underscores the critical need to integrate mental health literacy and psychosocial support into Malawi's disaster preparedness and response

frameworks (Kayuni, 2025). This highlights the urgent necessity for comprehensive interventions that not only address immediate physical needs but also cultivate robust mental health literacy among both affected populations and humanitarian aid providers to mitigate the enduring psychological sequelae of disasters (Chitalah et al., 2026; Goldsmith et al., 2026).

### 6.5 Gendered and Generational Priorities

Survivor narratives revealed that women and parents often placed the needs of their children above their own psychological well-being. This prioritisation reinforced the invisibility of adult psychosocial struggles in the aftermath of Cyclone Freddy. One participant explained, *"I was worried about my children's school, not my feelings,"* underscoring how educational continuity and material stability for children were perceived as more urgent than addressing personal distress. Thematic coding identified this as a recurring pattern: women, in particular, expressed heightened concern for family survival and children's welfare, while their own anxiety and trauma remained unacknowledged. This dynamic illustrates how generational and gendered responsibilities shape recovery priorities, further entrenching the neglect of adult mental health within humanitarian relief frameworks.

### 6.6 Relief Overshadowing Psychosocial Recovery

Survivor accounts consistently revealed that immediate material needs such as food, shelter, and schooling dominated their priorities in the aftermath of Cyclone Freddy. As one participant noted, *"After the flood, I only cared about food and shelter."* This emphasis reflects the humanitarian sector's material-first paradigm, which unintentionally sidelines psychosocial recovery. Thematic analysis showed that while relief efforts successfully addressed physical survival, they simultaneously reinforced the invisibility of psychological distress. Adults often deprioritise their own mental health, as illustrated by the statement, *"I was worried about my children's school, not my feelings."* These narratives highlight how disaster response frameworks, by centring material restoration, create systemic barriers to integrating mental health literacy and support into recovery processes.

## 7. DISCUSSION

To critically deconstruct how humanitarian relief becomes a barrier to mental health literacy and intervention, it is essential to explicitly link the data-driven findings from Chikwawa to the study's underlying theoretical frameworks: the multidimensional Mental Health Literacy (MHL) framework and the UNDRR Disaster Resilience Scorecard. The empirical evidence underscores that low levels of MHL recognition, knowledge deficits, and stigma core domains identified by Jorm's multidimensional model (Furnham & Swami, 2018) interact with the "material-first" paradigm entrenched in disaster relief practices. For instance, the specificity gap revealed among survivors, in which distress is expressed through culturally salient terms rather than recognised disorders, directly reflects the MHL framework's conception of recognition and of etiological

knowledge barriers. Stakeholder blind spots and the reinforcement of mental health stigma through both social and institutional channels compound this barrier. Further, the theoretical model identifies limitations on help-seeking attitudes and information-seeking behaviours.

Moreover, the Disaster Resilience Scorecard situates MHL as a critical bridge between social capital and institutional capacity (Khendlo et al., 2025). In Chikwawa, high levels of community solidarity (social capital) are insufficient to compensate for weak institutional mechanisms that support psychosocial recovery. The findings demonstrate that institutional responses, which prioritise physical infrastructure, overlook the crucial resilience essential to addressing long-term psychological fallout. Thus, the failure to integrate MHL within the resilience framework perpetuates unmet psychosocial needs and limits overall community resilience.

By explicitly mapping empirical data onto theoretical frameworks, it becomes clear that barriers to mental health support in humanitarian relief are not merely operational but are rooted in systemic gaps in literacy, institutional policy, and cultural interpretations of distress. This theoretical alignment elucidates why true disaster resilience requires not only material provision but also integrated interventions that address all MHL domains and actively bridge the institutional and community levels as indexed by the UNDRR Scorecard essentials.

## 8. POLICY AND PRACTICE RECOMMENDATIONS

### 8.1 Integration of Psychological First Aid

The most immediate recommendation is to make PFA mandatory for all humanitarian responders in Malawi. PFA is not a specialised clinical intervention; it is a set of skills that enables any responder to recognise distress and provide basic, non-intrusive support. Implementing this requirement is feasible, given the availability of brief, adaptable PFA training modules that can be embedded within existing humanitarian training programmes with minimal additional resource burden. Short-term training workshops, facilitated by mental health professionals or trained peer facilitators, could be delivered locally in Malawi, potentially through partnerships with NGOs, universities, or health departments. This foundational training can significantly mitigate the "stakeholder blind spot" identified in the findings, ensuring that frontline workers are equipped to address the immediate psychosocial needs of disaster-affected populations (Morganstein & Ursano, 2020). Moreover, integrating PFA into response protocols can foster a more holistic humanitarian approach, in which mental well-being is considered as fundamental as physical survival from the outset of an emergency (Corvalán et al., 2022). Periodic refresher courses and online resources can further support the sustainability and upscaling of PFA within the relief workforce, even in resource-constrained settings. This approach also facilitates the early identification of individuals who require more specialised mental health services, enabling timely referrals and preventing the escalation of acute distress into chronic conditions (Paul et al., 2025). Such proactive case identification and referral align with guiding principles for mental health and psychosocial support in humanitarian contexts (Patel et al., 2018).

Nevertheless, it is important to acknowledge that integrating PFA into existing humanitarian structures may encounter several barriers. Resource constraints, such as limited funding and shortages of qualified trainers, may pose challenges to widespread rollout, especially in rural or hard-to-reach areas. Additionally, cultural resistance can occur if mental health topics are considered sensitive or are not prioritised by community leaders or organizations. To address these obstacles, stakeholders should consider phased or pilot implementation, seek external funding or technical support where needed, and engage in dialogue with local leaders and communities to foster understanding and buy-in for PFA. Culturally tailored messaging and the inclusion of local champions can help reduce stigma and encourage participation. Building partnerships across sectors, including faith-based and community organisations, can also broaden access to PFA training and support the sustainable integration of PFA into disaster response frameworks.

### 8.2 Safe Spaces and MHL Hubs

Evacuation camps in Chikwawa should be required to establish "Safe Spaces" or "Listening Points." These should be separate from the chaotic aid-distribution areas and serve as hubs for basic MHL education and psychosocial disclosure. These spaces could also be instrumental in challenging cultural fatalism around mental health issues and in promoting self-help strategies and preparedness for future disasters (Ali et al., 2025; Hasan et al., 2020). Additionally, these MHL hubs could serve as platforms for co-designing culturally resonant mental health interventions, integrating clinical tools with spiritual care, and leveraging existing community structures, such as churches, for sustained mental health support (Maigwa Data Collection Questionnaire, 2026; Okunade et al., 2023). By fostering community engagement through these hubs, particularly among youth, future MHL initiatives can be developed using participatory approaches, leading to more relevant and impactful interventions (Jong et al., 2015; Jumbe et al., 2022).

### 8.3 Leveraging Faith Leaders for MHL

Given the prevalence of spiritual framing, disaster management plans must include faith leaders as "first responders" for mental health. Training pastors and imams in MHL can transform these influential figures from potential barriers into bridges for professional help-seeking. Such training should equip them to provide psychological first aid, identify acute distress, and facilitate referrals to formal mental health services, while respecting existing cultural and spiritual frameworks (Fernández et al., 2015; Nzayisenga et al., 2022). However, it is important to recognise the potential risks involved in this approach, as faith leaders may lack formal mental health expertise and could inadvertently reinforce stigma or promote interventions that are incongruent with evidence-based practice. To mitigate these risks, training initiatives should include clear ethical guidelines and foster ongoing collaboration with mental health professionals. Furthermore, leveraging these community leaders can promote collective resilience by encouraging participatory reconstruction efforts and creating spaces for communal healing and discourse, which aligns with evidence-based practices in disaster mental health (Cénat & Dérivois, 2023).

This integration also addresses the challenge of limited mental health professionals in low-resource settings, positioning faith leaders as crucial intermediaries in the mental health care continuum (Mchenga et al., 2024).

## 9. CONCLUSION

The findings from Chikwawa demonstrate that humanitarian relief, while essential for physical survival, currently acts as a barrier to the long-term mental health of disaster survivors. The 2023 Tropical Cyclone Freddy exposed the "neglected humanitarian crisis" in Malawi's Southern region (Kangoma et al., 2023). By prioritising material aid and ignoring the profound MHL gap, the current relief model ensures that the trauma of one disaster persists until the next arrives. For Malawi to achieve true disaster resilience, the definition of "relief" must be expanded to include the "invisible" wounds of the mind. Holistic disaster management in the Lower Shire Valley requires an integrated approach that includes preserving life and psychological well-being (Hay & Phiri, 2008; Jumbe et al., 2024; Khendlo et al., 2025). This shift has broader implications for both research and policy in low-resource, disaster-prone contexts: integrating mental health literacy and psychosocial support into disaster relief frameworks can serve as a model for other settings facing similar challenges. More comprehensive frameworks that acknowledge the interconnectedness of physical and mental health outcomes in post-disaster recovery are required, particularly in resource-constrained contexts such as Malawi (Kayuni, 2025). Such an approach would require decolonising existing guidance, building resilience through task-sharing, and establishing long-term funding streams for mental health initiatives (Rowe & Nadkarni, 2023).

## 10. LIMITATIONS AND RECOMMENDATIONS

While this study offers important empirical insights into the intersection of humanitarian relief and mental health literacy in Chikwawa, several limitations should be acknowledged. First, the qualitative research design relied on a purposive sample of 27 disaster survivors and 7 stakeholders; as such, findings may not be generalizable to the wider Malawian population or to other disaster contexts. Second, self-reported data from interviews and focus groups are subject to potential recall bias and social desirability bias, particularly given the cultural stigma associated with mental health. Fieldwork was conducted within select highly affected areas, which may further limit the diversity of experiences represented.

Furthermore, the focus on immediate post-disaster contexts may have precluded a fuller understanding of long-term mental health trajectories and the sustained effects of humanitarian interventions. To address these limitations, future research should employ larger, more representative samples from diverse regions, implement measures such as anonymisation and culturally sensitive interviewing to minimise bias, and utilise longitudinal or mixed-methods designs to better understand changes in mental health literacy and intervention outcomes over time.

## 11. POLICY AND PRACTICE RECOMMENDATIONS

### Integration of Psychological First Aid

- The most immediate recommendation is to make PFA mandatory for all humanitarian responders in Malawi.
- Incorporate PFA modules as a standard component in all pre-deployment briefings and induction training for new humanitarian staff.
- Develop a national PFA curriculum tailored to Malawi's context, translated into Chichewa and other relevant local languages, in collaboration with existing mental health professionals and local academic institutions.
- Identify and train PFA "champions" within each district who can serve as master trainers and provide ongoing mentorship to frontline responders.
- Establish routine, scheduled refresher sessions—preferably every six months—to reinforce PFA skills and update staff on context-specific psychosocial issues.
- Monitor and evaluate PFA uptake and effectiveness through simple checklists and periodic feedback from trainees and disaster survivors.

## 12. DECLARATION OF CONFLICTING INTERESTS AND FUNDING

The authors declare no conflict of interest, and there was no funding from any agency.

## 13. REFERENCES

Abidi, S. M. A. (2024). Beyond the Tragedy: Illuminating Challenges in Disaster Management and Mental Health Support in Resource-Constrained Environments. *Prehospital and Disaster Medicine*, *39*(6), 442–444. https://doi.org/10.1017/s1049023x24000657

Ali, B., Ghur, A., Khan, A., Sharif, J., Siraj, S., Fatima, M., Farid, Z., Ali, N., Khan, M., & Turab, A. (2025). 'We fear the rain': unveiling the silent toll on mental health and integration of mobile health services for psychosocial support to flood-affected rural communities of Pakistan. *BJPsych International*, 1–4. https://doi.org/10.1192/bji.2025.10061

Bahrami, M. A., Bahrami, D., & Chaman-Ara, K. (2019). The correlations of mental health literacy with psychological aspects of general health among Iranian female students. *International Journal of Mental Health Systems*, *13*(1). https://doi.org/10.1186/s13033-019-0315-6

Cénat, J. M., & Dérivois, D. (2023). Addressing the Mental Health Needs and Building Resilience of Populations Affected by the Earthquakes in Turkey and Syria: Lessons From Haiti and Elsewhere. *International Journal of Public Health*, *68*, 1605986–1605986. https://doi.org/10.3389/ijph.2023.1605986

Chima, T., Mkwinda, E., & Machaya, T. (2023). Employers' Feedback on Psychosocial

Counselling Graduates' Performance in Selected Healthcare Facilities in Malawi. *Journal of Multidisciplinary Healthcare*, 2513–2526. https://doi.org/10.2147/jmdh.s425614

Chitalah, B. C., Nanda, I., Chirwa, G. B., Nyali, J., & Jumbe, S. (2026). Assessing the mental Health literacy of young adults from rural and urban communities in Malawi. *BJPsych Open*, *12*(1). https://doi.org/10.1192/bjo.2025.10934

Chitalah, B. C., Nanda, I., Nyali, J., Chirwa, G., & Jumbe, S. (2024). *Assessing the mental health literacy of young adults from rural and urban communities in Malawi*. https://doi.org/10.1101/2024.12.03.24318388

Coe, N. L. (2009). *Critical Evaluation of the Mental Health Literacy Framework Using Qualitative Data*. https://doi.org/10.1080/14623730.2009.9721798

Contreras, C., Aguilar, Ma. de la L. M., Eappen, B. S., Guzmán, C. M., Carrasco, P., Millones, A. K., & Galea, J. T. (2018). Community strengthening and mental health system linking after flooding in two informal human settlements in Peru: a model for small-scale disaster response. *Cambridge Prisms Global Mental Health*, *5*. https://doi.org/10.1017/gmh.2017.33

Corvalán, C., Gray, B., Prats, E. V., Sena, A., Hanna, F., & Campbell-Lendrum, D. (2022). Mental health and the global climate crisis. *Epidemiology and Psychiatric Sciences*, *31*. https://doi.org/10.1017/s2045796022000361

Dickson, K., Ko, S. Y., Nguyen, C., Minchenko, D., & Bangpan, M. (2024). Mental health and psychosocial support programmes for displaced populations in low- and middle-income countries (LMICs): A systematic review of process, perspectives and experiences. *Cambridge Prisms Global Mental Health*, *11*. https://doi.org/10.1017/gmh.2024.56

Fernández, A., Black, J. J., Jones, M. K., Wilson, L., Salvador-Carulla, L., Astell-Burt, T., & Black, D. (2015). Flooding and Mental Health: A Systematic Mapping Review. *PLoS ONE*, *10*(4). https://doi.org/10.1371/journal.pone.0119929

Furnham, A., & Swami, V. (2018). Mental Health Literacy: A Review of What It Is and Why It Matters. *International Perspectives in Psychology*, *7*(4), 240–257. https://doi.org/10.1037/ipp0000094

Goldsmith, C., Nyali, J., Taniskidi, A., & Jumbe, S. (2026). Assessing the Cross-Cultural Applicability of a Mental Health Literacy Questionnaire for Young People in Rural Malawi. *SAGE Open*, *16*(1). https://doi.org/10.1177/21582440261420116

Hasan, M. T., Adhikary, G., Mahmood, S., Papri, N., Shihab, H. M., Kasujja, R., Ahmed, H. U., Azad, A. K., & Nasreen, M. (2020). Exploring mental health needs and services among affected population in a cyclone-affected area in coastal Bangladesh: a qualitative case study. *International Journal of Mental Health Systems*, *14*(1), 12–12. https://doi.org/10.1186/s13033-020-00351-0

Hay, E. R., & Phiri, M. A. (2008). *World Bank Global Facility for Disaster Reduction and Recovery Track II: Malawi Situation Analysis of Disaster Risk Management Programmes and Practices Final Report*. World Bank.

Horn, R., O'May, F., Esliker, R., Gwaikolo, W., Woensdregt, L., Ruttenberg, L., & Ager, A. (2019). *The myth of the 1-day training: the effectiveness of psychosocial support capacity-building during the Ebola outbreak in West Africa*. https://doi.org/10.1017/gmh.2019.2

Jong, J. de, Berckmoes, L., Kohrt, B. A., Song, S. J., Tol, W. A., & Reis, R. (2015). A Public Health Approach to Address the Mental Health Burden of Youth in Situations of Political Violence and Humanitarian Emergencies. *Current Psychiatry Reports*, *17*(7), 60–60. https://doi.org/10.1007/s11920-015-0590-0

Joshi, P. C., & Kumar, R. (2020). Mental Health Problems in the Wake of Disaster: A Gendered Perspective. *Rupkatha Journal on Interdisciplinary Studies in Humanities*, *12*(1). https://doi.org/10.21659/rupkatha.v12n1.14

Jumbe, S., Nyali, J., Simbeye, M., Zakeyu, N., Motshewa, G., & Pulapa, S. R. (2022). 'We do not ' Talk about it': Engaging youth in Malawi to inform adaptation of a mental health literacy intervention. *PLoS ONE*, *17*(3). https://doi.org/10.1371/journal.pone.0265530

Kangoma, M., Lubanga, F. A., & Bwanali, A. N. (2023). *Mental health impact of the 2023 Tropical Cyclone Freddy and Southern region mudslides on Malawian women: the neglected humanitarian crisis*. https://doi.org/10.1097/gh9.0000000000000306

Kayuni, S. M. E. (2025). Importance of Mental Health in Malawi. *Advances in Social Sciences Research Journal*, *12*(5), 73–79. https://doi.org/10.14738/assrj.1205.18809

Khendlo, J. N., Beeharry, R., & Goodary, R. (2025). Assessing the Resilience of the Chikwawa District in Malawi Against Hydrometeorological Hazards Using the UNDRR Disaster Resilience Scorecard Method. *Risks and Catastrophes Journal*, *35*(1). https://doi.org/10.24193/rcj2025_3

Mahmud, K. H., Ahmed, R., & Tuya, J. H. (2021). Geographic variability of post-disaster mental health: case study after the 2017 flood in Bangladesh. *Geospatial Health*, *16*(2). https://doi.org/10.4081/gh.2021.1018

Mchenga, M., Ndasauka, Y., Kondowe, F., Kainja, J., Mmanga, C., Maliwichi, L., & Nyamali, S. (2024). *Mental health is just an Addendum: Assessing stakeholder's perceptions on COVID-19 and mental health services provision in Malawi*. https://doi.org/10.1371/journal.pone.0305341

Morganstein, J. C., & Ursano, R. J. (2020). Ecological Disasters and Mental Health: Causes, Consequences, and Interventions. *Frontiers in Psychiatry*, *11*, 1–1. https://doi.org/10.3389/fpsyt.2020.00001

Mpheza, L. (2023). The Impact of Cyclone Freddy on Malawian Communities: Examining Truth, Resilience, Hope, Recovery for Victims and Recommendations. *Zenodo (CERN European Organization for Nuclear Research)*. https://doi.org/10.5281/zenodo.7813627

Mwalwimba, I. K., Manda, M., & Ngongondo, C. (2024). *The role of indigenous knowledge in disaster risk reduction and climate change adaptation in Chikwawa, Malawi*. https://doi.org/10.4102/jamba.v16i2.1810

Nahar, N., Blomstedt, Y., Wu, B., Kandarina, I., Trisnantoro, L., & Kinsman, J. (2014). Increasing the provision of mental health care for vulnerable, disaster-affected people in Bangladesh. *BMC Public Health*, *14*(1), 708–708. https://doi.org/10.1186/1471-2458-14-708

Nöthling, J., Gibbs, A., Washington, L., Gigaba, S. G., Willan, S., Abrahams, N., & Jewkes, R. (2023). Change in emotional distress, anxiety, depression and PTSD from pre- to post-flood exposure in women residing in low-income settings in South Africa. *Archives of Women s Mental Health*, *27*(2), 201–218. https://doi.org/10.1007/s00737-023-01384-3

Nyali, J., Chirwa, G., Chitalah, B. C., & Jumbe, S. (2025). Culturally Adapting a Mental Health Literacy Intervention with Youth (Stakeholders) for Implementation in Malawi Universities. *Mental Health Science*, *3*(1). https://doi.org/10.1002/mhs2.70007

Nzayisenga, E., Chan, C. W., Roome, A., Therrien, A., Sinclair, I., Taleo, G., Tarivonda, L., Tosiro, B., Malanga, M., Tagaro, M., Obed, J., Iaruel, J., Olszowy, K. M., & Dancause, K. N. (2022). Patterns of distress and psychosocial support 2 years post-displacement following a natural disaster in a lower middle income country. *Frontiers in Public Health*, *10*, 1017286–1017286. https://doi.org/10.3389/fpubh.2022.1017286

Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., Chisholm, D., Collins, P. Y., Cooper, J. L., Eaton, J., Herrman, H., Herzallah, M. M., Huang, Y., Jordans, M. J. D., Kleinman, A., Medina-Mora, M. E., Morgan, E., Niaz, U., Omigbodun, O., … Unützer, J. (2018). *The Lancet Commission on global mental health and sustainable development*. https://doi.org/10.1016/s0140-6736(18)31612-x

Paul, L., K, M. A., Kotian, S., & Shekhar, B. (2025). Post-disaster Mental Health Status: A Study of Women from Chooralmala Landslide in Kerala, India. *Research Square*. https://doi.org/10.21203/rs.3.rs-6695309/v1

Raphela, T. D. (2025). The ripple effect of flooding near one of the more prominent urban rivers in the Gauteng Province, South Africa. *Frontiers in Sustainable Cities*, *7*. https://doi.org/10.3389/frsc.2025.1656985

Rowe, O., & Nadkarni, A. (2023). Barriers and Facilitators to the Implementation of Mental Health and Psychosocial Support Programmes Following Natural Disasters in Developing Countries: a Systematic Review. *Cambridge Prisms Global Mental Health*, *11*, 1–40. https://doi.org/10.1017/gmh.2023.91

Sijbrandij, M., Horn, R., Esliker, R., O'May, F., Reiffers, R., Ruttenberg, L., Stam, K., Jong, J. de, & Ager, A. (2020). *The Effect of Psychological First Aid Training on Knowledge and Understanding about Psychosocial Support Principles: A Cluster-Randomized Controlled Trial*. https://doi.org/10.3390/ijerph17020484

Thompson-Assan, S., Aguadze, G. A., & Kaitoo, D. K. (2023). Integrated first-level psychosocial response to disasters in low- and middle-income countries. *Counselling and Psychotherapy Research*, *24*(2), 390–395. https://doi.org/10.1002/capr.12668

Wright, J., & Jayawickrama, J. (2020). *"We Need Other Human Beings in Order to be Human": Examining the Indigenous Philosophy of Umunthu and Strengthening Mental Health Interventions*. https://doi.org/10.1007/s11013-020-09692-4

Venkataraman, S., Patil, R., & Balasundaram, S. (2019). Why mental health literacy still matters: a review [Review of *Why mental health literacy still matters: a review*]. *International Journal of Community Medicine and Public Health*, *6*(6), 2723–2723. Medip Academy. https://doi.org/10.18203/2394-6040.ijcmph20192350