Journal of
Advanced Psychology
(JAPSY)

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CARI Journals

Journal of Advanced Psychology

ISSN: 2791-3244 (Online)

Vol.8, Issue No. 3, pp 11 - 28, 2026

www.carijournals.org

Psychosocial Impacts of Natural Disasters on Families and the Role of Churches in Building Resilience in Chikwawa District, Malawi: A Qualitative Needs Assessment

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Accepted: 30th July, 2026, Received in Revised Form: 10th August, 2026, Published: 17th August, 2026

Abstract

Purpose: To explore the psychosocial impacts of recurrent natural disasters on families in Chikwawa District, examine the role of churches in providing psychosocial support, and identify barriers and enablers of family resilience.

Methodology: A qualitative, participatory needs assessment was conducted with 52 participants representing affected families, community leaders, pastors, hospital workers, and disaster recovery personnel. Data were collected via semi-structured interviews, focus groups, and field notes, which were analysed thematically through the lens of Walsh's Family Resilience Framework, the Social Ecological Model, and trauma-informed care.

Findings: Families reported pervasive emotional distress, trauma, hopelessness, and loss of livelihood, with children, people with disabilities, and single-parent households disproportionately affected. Churches emerged as the most trusted support structures, providing spiritual and social support, but were constrained by low mental health literacy, a lack of referral pathways, and scarce resources. Consensus was reached on six core themes, including the need for integrated spiritual and psychosocial interventions.

Unique contribution to theory, practice and policy: The study provides localised empirical evidence from Malawi demonstrating that practical integration of mental health and psychosocial support into disaster risk reduction is both feasible and urgent. Expands existing literature by conceptualising churches not merely as informal, temporary emergency shelters, but as permanent, resilient structures capable of sustained formal partnership.

Keywords: *Mental Health Literacy; Family Resilience; Natural Disasters; Chikwawa District; MHPSS–DRR Integration.*

1. INTRODUCTION AND BACKGROUND

Climate-related extreme weather events are intensifying across sub-Saharan Africa, with Malawi sharing the impacts. These events exacerbate existing challenges for a population already contending with structural poverty, fragile health systems, and recurrent displacement (Codjoe & Atiglo, 2020; Moyo et al., 2023). Repeated exposure to such adversity has substantial implications for mental health, exceeding the capacity of local response mechanisms (Atwoli et al., 2022). In this context, Malawi's Lower Shire Chikwawa District, in particular, serves as a prototypical example of combined climate vulnerability, which is systematically devastated by even moderate flooding (Wouters et al., 2021).

Between 2015 and 2023, the Lower Shire endured at least four major flood-inducing cyclones in addition to annual seasonal flooding driven by upstream water release from Lake Malawi and the Shire River system (Mwalwimba et al., 2024). The single most destructive event was Tropical Cyclone Freddy in March 2023, which made landfall twice in southern Malawi and triggered a state of disaster across ten districts, with Chikwawa suffering the most (Kangoma et al., 2023; Mwalwimba et al., 2024). The reported toll from that event, approximately 679 deaths, 2,178 injuries, 563,602 displacements, and 511 persons reported missing (Mwalwimba et al., 2024) illustrates the magnitude of psychological as well as physical exposure. The recurrence of such events, often within a single rain season, has left the population in a state of chronic psychosocial strain rather than discrete recovery (Kangoma et al., 2023; Wambua et al., 2026).

Despite this, the formal humanitarian response in Malawi remains heavily oriented towards physical survival: food distribution, shelter reconstruction, water and sanitation, and basic medical care (Ban et al., 2022). Mental health and psychosocial support are systematically under-prioritised in Disaster Risk Reduction policy and operational response. The Sendai Framework for Disaster Risk Reduction 2015–2030 explicitly calls for "enhancing disaster preparedness for effective response and to 'Build Back Better' in recovery, rehabilitation and reconstruction," embedding health and resilience within Priority 4 (Corvalán et al., 2022). Nonetheless, the Mental Health and Psychosocial Support (MHPSS) field has been slow to integrate into formal Disaster Risk Reduction (DRR) (Galappatti & Richardson, 2016). Gray, Hanna, and Reifels (2020) have documented the persistent operational discrepancy between policy intent and field response, leaving families to navigate acute and chronic trauma with minimal formal psychosocial support.

The post-disaster mental health burden is well-evidenced globally. Systematic reviews indicate that floods and extreme weather events correlate with a high prevalence of psychological distress, anxiety, depression, and posttraumatic stress disorder, with women, children, adolescents, persons with disabilities, and the economically disadvantaged facing the highest risk (Karimi et al., 2021). In Malawi, pre-disaster baselines already show elevated distress: a nationally representative survey of adults reported past-year suicidal ideation at 7.2 per cent (Pengpid & Peltzer, 2021), while meta-analytic work on disaster-related suicidal ideation reports a pooled post-disaster prevalence of 12.9 per cent across several disaster types (Karimi

et al., 2021). These figures position Malawi and the Shire Valley as high-burden settings, in which the gap between MHPSS needs and provision is severe.

Faith-based institutions represent the most widespread form of community infrastructure in this context. In some resource-limited settings, over 40% of individuals experiencing mental health concerns reportedly seek help from clergy before consulting professional providers (Filiatreau et al., 2021). In Malawi, churches provide continuous access to trauma and emotional services even where responsible government institutions are out of reach. While religious communities offer essential social and spiritual support, they often operate with significant limitations, including low mental health literacy and a tendency to interpret symptoms of mental distress through theological and judgmental categories such as "weak faith" or "spirit affliction." These interpretations can delay help-seeking and reinforce stigma (Jordan, 2025; Kutcher et al., 2015). Evidence from Kenya (Puffer et al., 2016), the United States (Johnson et al., 2024; Riddick et al., 2024) and Nepal (Welton-Mitchell et al., 2018) indicates that faith-based interventions, when appropriately structured, can effectively reduce stigma and expand psychosocial capacity. However, these outcomes are dependent on addressing infrastructure barriers such as leadership turnover, funding cycles, and adoption of cascading in mental health literacy and interventions implementation, other than the myth of the one-day training by Horn and colleagues during the West African Ebola response (Horn et al., 2019), which limits sustainability in the absence of supervision and follow-up.

2. STUDY OBJECTIVES

This study tackles the gap between high psychosocial need and an under-equipped Church-based response in Chikwawa District, Malawi. Three distinct objectives guide the research:

i. To explore the psychosocial impacts of natural disasters on families in Chikwawa District;

ii. To examine the current contributions and limitations of churches as platforms for psychosocial support and strengthening resilience in the context of natural disasters;

iii. To identify the barriers to and enablers of family resilience in this context.

3. THEORETICAL FRAMEWORKS

The work is grounded in Walsh's Family Resilience Framework (Walsh, 2007), which foregrounds belief systems, organisational patterns, and communication and problem-solving processes as the levers of post-crisis family recovery (Walsh, 2003); it draws conceptually on the Social Ecological Model, trauma-informed care, human rights-based approaches, and Sendai Framework Priority 4 (Aitsi-Selmi et al., 2015). The participatory co-design, church-based mental health literacy intervention structure, four-stage cascade, and Module 2 pilot usability evaluation operationalise these findings into a five-module intervention. They are reported in a thesis the author is working on, titled "Developing a Church-Based Mental Health Literacy Intervention to Enhance Family Resilience to Natural Disasters in Malawi: A Participatory Qualitative Study."

4. METHODOLOGY

4.1 Study Design and Rationale

A qualitative, participatory research design was adopted to capture broad perspectives across stakeholder groups who share responsibility for post-disaster recovery but rarely occupy the same analytic frame. The design drew on community-based participatory research principles recognising affected communities as co-investigators rather than subjects while preserving the qualitative depth necessary for a substantive needs assessment (Israel et al., 1998).

4.2 Study Setting

The study was conducted in Chikwawa, a District located at the southernmost point of Malawi, bordering Mozambique along the Shire River (Wouters et al., 2021). Its position downstream of the Lake Malawi outflow and on the Shire Valley floodplain makes it one of the most flood-exposed districts in the country (Trogrlić et al., 2021, p. 102199; Wouters et al., 2021). Field sites focused on the Sekeni community in Traditional Authority Makuwila, which Tropical Cyclone Freddy and earlier events have repeatedly hit. Subsistence maize, rice, and livestock constitute the dominant livelihoods, systematically destroyed by even moderate flooding (MacPherson et al., 2022, p. 3; Gowelo et al., 2020, p. 196).

4.3.Inclusion Criteria and Sampling Strategy

Purposive maximum-variation sampling was applied across five stakeholder groups, with the explicit goal of representing the multi-sectoral reality of disaster response and giving voice to groups typically excluded from psychosocial research. The five groups and their respective inclusion criteria were:

Affected Family Members. Adults and grown-up children residing in households directly affected by recent floods or cyclones. Inclusion intentionally over-sampled female-headed, child-headed, single-parent, and orphan households, and households including persons with blindness, albinism, or physical disability.

Community Leaders. Formally or informally recognised leaders in Traditional Authority Makuwila, including the Group Village Head, chiefs' aides, a schoolteacher, and representative elders.

Pastors and Church Elders. Active clergy serving congregations in the area were deliberately targeted, including those with theological training (diploma, degree, or Master's level) and informally trained leaders.

Hospital Workers. Included those who had served during the 2023 Freddy response and outreach clinics.

Disaster Recovery Workers. Staff from the Department of Disaster Management Affairs (DoDMA) engaged in recovery operations.

Gatekeeper permission was sought from the chief, community leaders and the leadership of each participating church before data collection began.

4.4 Participant Composition

The total sample comprised 52 participants distributed as follows (drawn from the project data collection instrument):

- 27 affected family members from 10 households (including persons with blindness, albinism, or physical disability, and child-headed, single-parent, and orphan households);
- 9 community leaders (chief, aides, schoolteacher, and representatives);
- 10 pastors and church elders (4 with theological training; 1 with a Master's in Community Psychology);
- 4 hospital workers (clinical officers, nurses, and Health Surveillance Assistants);
- 2 DoDMA disaster recovery workers.

4.5 Data Collection and Saturation

Data were collected through semi-structured interviews, focus group discussions, and field notes, all conducted in Chichewa with real-time oral translation to support English-language transcription. Interview guides were developed by the researcher in dialogue with co-investigators. They were piloted with three non-study participants to improve the clarity, sequence, and cultural fit of the questions. Guides were scaffolded by Walsh's Family Resilience Framework (Walsh, 2007), the Social Ecological Model, trauma-informed care principles, and Sendai Priority 4 (Aitsi-Selmi et al., 2015); they addressed disaster experiences, coping strategies, MHL, perceived church capacity, and barriers and enablers. Interviews lasted approximately 15- 20 minutes per individual, while focus group discussions lasted 120 minutes each and were audio-recorded with informed consent, supported by field notes capturing contextual details.

Saturation was operationalised as the point at which no new themes emerged in two consecutive stakeholder-group interviews. Saturation was reached within the planned sample without expansion of the affected-family or pastor subgroups. This was signalled by repetition of themes and points already stated by previous interviewees.

4.6 Data Analysis and Theme Validation

Interviews were transcribed verbatim and analysed using a hybrid approach blending MAXQDA-assisted coding with manual open coding. The analysis followed a six-phase iterative thematic process: familiarisation, systematic open coding, theme generation, theme review, theme definition, and reporting, using a combined inductive (emerging from the data) and deductive (informed by Walsh's framework and Sendai Priority 4) stance.

To satisfy Lincoln and Guba's theme credibility criterion, member checking was performed using a printed graph and a tick-and-discuss procedure. The six emergent themes were printed on A4 sheets; participants in each stakeholder group were advised to tick themes that corresponded with their experience and reflected their voice. Discussions on the justification

for each theme were held before they were incorporated into the finalised structure. All six themes achieved 98.3% endorsement, with 80% (5 of 6) receiving 100% and 20% (1 of 6) receiving 90% from stakeholder groups, with no abstentions.

5. RESEARCHER POSITIONALITY AND REFLEXIVITY

The researcher occupies a dual position as insider (Malawian; embedded in the local theological and academic communities; trained in theology, education, and psychology) and as outsider (drawing on category systems from the international trauma and toughness literature). This twofold positioning enabled cultural fluency in interpreting theological framings and figurative language, but also introduced the risk that participants would frame their responses to match what they perceived as the researcher's expectations. Reflexive memos, debriefing with non-study colleagues, and audit trails were used throughout the analysis.

6. ETHICS

Ethics approval was secured from the Zambian Open University and the Malawi Assemblies of God University Research Committee, which is accredited to approve research protocols in Malawi. The clearances were obtained prior to data collection. To ensure the protection of all participants, written informed consent was obtained using Chichewa-language consent forms; for participants who could not read, the form was read aloud and a witnessed thumbprint supplemented verbal consent. Participant confidentiality was safeguarded through the pseudonymisation of names, the secure storage of audio files and transcripts on password-protected devices, and the aggregation of demographic details in reporting. Additionally, all participants were fully informed of their rights to withdraw at any stage, including after data collection, without consequence. These measures were implemented to uphold the highest standards of participant protection throughout the research process.

7. RESULTS

7.1 Demographic Profile

Table 1 below provides a detailed breakdown of the 52-participant sample, clearly illustrating its alignment with the multi-sectoral nature of disaster response in Chikwawa. The sample included affected family members from 10 households (n=27, 52%), pastors and church elders (n=10, 19%), community leaders (n=9, 17%), hospital workers (n=4, 8%), and DoDMA disaster recovery workers (n=2, 4%). Intentional over-sampling ensured vulnerable groups, specifically persons with blindness, albinism, and physical disabilities, along with child-headed, single-parent, and orphan households, were substantively represented in the analysis rather than included only nominally. This structured demographic presentation underscores the representation of key stakeholder groups and vulnerable household types.

Table 1. Participant Demographics and Stakeholder Group Composition

Stakeholder Group	N (%)	Key Vulnerable Subgroups Represented
Affected family members	**27 (52%)**	Blindness, albinism, physical disability, child-headed households, single-parent households, orphans
Pastors and church elders	10 (19%)	Theologically and informally trained; one with a Master's in Community Psychology.
Community leaders	9 (17%)	Group village headman, chief's aides, schoolteacher, elders
Hospital workers	4 (8%)	Clinical officers, nurses, health surveillance assistants

7.2 Psychosocial Impacts on Families

Six themes emerged and were validated through consensus and member checking: emotional distress and trauma; hopelessness and despair; loss of livelihood; vulnerability of special groups; low mental health literacy; and faith-based coping.

7.2.1 Theme1: Emotional Distress and Trauma

This theme encompasses five sub-themes derived from participant narratives.

Fear and Terror. Immediate responses to the onset of a flood were characterised by paralysing fear, often triggered by sensory cues: the sound of rapidly rising water, the roar of swollen rivers, the blackness that accompanied the loss of power. One affected family participant's account that *"the water came so fast… we thought we would all die that night"* captures the recurring pattern across this sub-theme, in which fear is bodily, time-compressed, and indistinguishable from imminent death.

Shock and Confusion. Following the immediate crisis, participants reported disorientation, impaired decision-making, and short-term memory difficulties. Several participants described being unable to recall basic household details in the days after the event or to locate family members due to displacement; community leaders described similar patterns of disorientation among their constituents.

Hopelessness. A pervasive sub-theme captured the loss of confidence in the future, especially among households that had previously recovered from earlier cyclones only to lose assets again. This hopelessness was particularly acute among the participants from households with multiple prior events, and pastors reported it as appearing in congregation-level withdrawal patterns.

Grief and Loss. Many participants described loss of relatives, neighbours, livestock (a critical livelihood asset in the Lower Shire), and household belongings. Grief responses were described in somatic terms (crying, sleeplessness, withdrawal) rather than formal bereavement vocabulary; community leaders and pastors confirmed that they often encountered bereavement responses they did not recognise as such at the time.

Physical Manifestations. Somatic symptoms were pervasive: headaches, palpitations, trembling, fatigue, dizziness, and sleeplessness. Many participants and community members attributed these symptoms to spiritual or witchcraft causes rather than trauma, which delayed help-seeking and reinforced theological stigma pathways that the intervention design later sought to interrupt (Jordan, 2025; Kutcher et al., 2015).

7.2.2 Theme 2: Extended Psychological Consequences

Four sub-themes from sustained post-event exposure overlap closely with the recurrent-exposure patterns reported in raw data.

Persistent Trauma and Flashbacks. Participants repeatedly described re-experiencing symptoms triggered by environmental indicators. One participant's account that *"even today, when I hear thunder, my heart races"* captures this trauma-reactivation pattern, in which commonplace sound signals produce acute escalations of distress and avoidance behaviours during minor rain events.

Hopelessness and Despair. Across stakeholder groups, chronic hopelessness was a near-universal theme. Affected families described the cycle of "rebuilding every year" eroding the motivation for long-term investment, planning, or savings. Pastors and community leaders reported that this chronic despair is causing substance misuse, marital conflict, and social withdrawal.

Behavioural and Social Changes. Participants reported irritability, social withdrawal, reduced productivity at work and school, increased domestic conflict, and a deepening mistrust of authorities who had promised but failed to deliver recovery assistance. Hospital workers described an increase in presentations they could not easily classify within biomedical categories.

Suicidal Ideation. Affected family members, particularly female heads of household and adolescents, reported passive and, in a smaller number of cases, active suicidal ideation tied to the inability to meet basic family needs. Pastors confirmed they had encountered congregants expressing hopelessness that, in retrospect, they recognised as possibly suicidal in nature.

7.2.3 Theme 3: Loss of Livelihood

Participants described near-total loss of crops, seed stores, livestock, and stored grain as a recurrent pattern. Recovering assets before the next flood was described as nearly impossible among households without external support, and several participants reported selling productive tools (hoes, fishing nets, bicycles used as taxis) to purchase food. The accumulation of repeated losses with compounding debt drove escalating hopelessness.

7.2.4 Theme 4: Vulnerability of Special Groups

Participants across all stakeholder groups identified that children (especially those heading households following parental death), persons with disabilities (blindness, albinism, physical disability), single-parent and orphan households, and older persons living alone were disproportionately exposed to harm and least able to access recovery resources. Inclusion of

these voices in the needs assessment was deliberate, with hospital workers and pastors characterising these groups as the least likely to be reached by formal MHPSS.

7.2.5 Theme 5: Low Mental Health Literacy

Low MHL, a theme spanning all five stakeholder groups, appeared as both a barrier to help-seeking among affected families and to the provision of psychosocial support among pastors and hospital workers. Pastors acknowledged that they could recognise obvious grief but not distinguish trauma reactions from "spirit affliction" or "weak faith"; one pastor observed that *"most people here do not know when someone is suffering in their mind… they think it is just being weak or under a curse"* (Jordan, 2025; Kutcher et al., 2015). Another pastor shared, "Sometimes when church members come with problems like sleeplessness or fear, we just pray, not knowing it could be trauma." Hospital workers confirmed they had received no mental health training in their professional preparation.

7.2.6 Theme 6: Faith-Based Coping

A pervasive theme across stakeholder groups was that prayer, scripture, and pastoral presence constituted the primary coping resources for affected families managing distress. Pastors described preaching, home visits, and prayers as their entire available support strategies. Faith-based coping was widely recognised as an important basis of comfort, communal solidarity, and hope, facilitating initial adaptation by providing meaning and lessening feelings of isolation in the aftermath of disaster. However, a subtler pattern appeared in which both clergy and congregants articulated the limits of exclusive reliance on religious coping. Participants noted cases where persistent symptoms such as nightmares, intrusive memories, or suicidal ideation did not resolve through spiritual interventions alone. For example, one affected family member emphasised, "We prayed and read scripture every night, but the fear and bad dreams stayed with us for months." At the same time, a pastor recounted, "Sometimes, I find I can pray with a member, but their pain does not go away, and I feel helpless." Rather than rejecting faith-based coping, stakeholders recognised its insufficiency for severe or prolonged trauma and expressed a repeated, explicit demand for complementary knowledge and skills. This dual aspect situates faith-based approaches as invaluable yet inherently limited when not integrated with evidence-based psychosocial supports.

8. THE ROLE OF CHURCHES: CONTRIBUTIONS, GAPS AND LIMITATIONS

Churches appeared across all stakeholder groups as the primary, and often the only, sustained social safety net in affected communities. Their inputs and limitations are organised below as two sub-themes.

8.1 Contributions of Churches

Spiritual Encouragement. Pastors highlighted preaching about hope, resilience, and divine providence as central to their post-disaster response. Affected families consistently reported that pastoral presence and prayer were meaningful acts of solidarity, with one participant noting that *"the prayers from our pastor made us feel we were not alone"*.

Social Cohesion. Churches functioned as de facto community centres, gathering congregants for shared prayer, testimonies, singing, and burial support. Pastors and elders described the church as a "family" whose cohesion mitigated the seclusion that often accompanies displacement.

Limited Material Aid. Some churches, particularly larger or more resourced congregations, distributed maize, flour, and clothing, funded by member contributions. Hospital workers and DoDMA staff observed that church-based material aid, while limited, reached households which formal distributions sometimes missed.

8.2 Gaps and Limitations of The Church's Role

Lack of Mental Health Literacy among Pastors. Pastors acknowledged that they could not dependably distinguish trauma reactions from spiritual afflictions and that they lacked frameworks for structured, evidence-informed support (Muthaih et al., 2026; Wang et al., 2003)

Inability to Resolve Specific Mental Health Needs. Across stakeholder groups, participants reported that pastors could not safely respond to suicidal ideation, severe depression, alcohol misuse, or psychotic symptoms; hospital workers confirmed the absence of any structured referral from churches to clinical services (Wang et al., 2003, p. 666).

Resource Restrictions. Church resources were repeatedly characterised as bound up in meeting their own members' basic needs. Pastors reported that they themselves were disaster-affected; matching resources to expanding needs was described as untenable (Grey, 2015).

Exclusion of non-members. Several participants (community leaders and a DoDMA worker) noted that church-based support was structurally limited to members, which excluded Muslim households, non-affiliated households, and households belonging to minority denominations.

9. BARRIERS AND ENABLERS TO FAMILY RESILIENCE

Walsh's Family Resilience Framework (Walsh, 2007) provides the analytic lens for this section, organised around the framework's beliefs, organisational patterns, and communication processes (Chow et al., 2022).

9.1 Barriers

Six barriers recurred across stakeholder groups:

Low mental health literacy. Across families, pastors, and hospital workers, MHL was low; symptoms were interpreted through theological or spiritual categories, delaying help-seeking.

Absence of specialised services. Hospital workers reported no mental health training and no psychotropic stocks; pastors reported no referral pathways and no clinical supervision infrastructure.

Institutional focus on physical relief. Across stakeholder groups, post-disaster aid was oriented toward food, shelter, and clinical care for injuries; MHPSS was consistently reported as marginal.

Stigma and misconceptions. Participants repeatedly equated mental distress with "weak faith," witchcraft, or moral failure categories, which strengthened silence and delayed help-seeking.

Vulnerability of specific groups. Children heading households, persons with disabilities, single parents, and orphans were identified as the most exposed and least reached by recovery support.

Recurrent disasters. The frequency of repeat events erodes hope and reduces the perceived value of recovery investment.

9.2 Enablers

Four enablers recurred across stakeholder groups:

Existing community trust in churches. Churches were identified as the most trusted community institution, and pastors as trusted first points of contact in times of distress, a position analogous to that documented in the global literature.

Strong family and community bonds. Family and kinship networks were repeatedly cited as the primary buffer against hopelessness; participation in extended-family decision-making mitigated isolation.

Demand-side desire for knowledge and skills. Across all stakeholder groups, there was a pronounced, expressed demand for additional knowledge and skills: pastors asked for training to recognise and respond to trauma, and affected families asked for help to support distressed members.

Recognition of integrated spiritual-psychological approaches. A consistent theme was that spiritual and clinical-psychological approaches must be integrated rather than opposed in pastoral practice.

10. DISCUSSION

This study supports global evidence that natural disasters in resource-limited settings create critical "tipping points" for vulnerable populations, manifesting as clusters of PTSD, depression, and suicidal ideation (Wambua et al., 2026; Karimi et al., 2021). In Chikwawa, trauma arises from both direct exposure to disasters and socioeconomic collapse, with the latter often resulting in more persistent effects (Kangoma et al., 2023; Wambua et al., 2026). Suicidal ideation is notable, reflecting Malawi's pre-disaster baseline (Pengpid & Peltzer, 2021) and broader post-disaster trends (Karimi et al., 2021). However, it should not be over-interpreted given the qualitative design. The consistent reports from pastors, hospital workers, and affected families indicate that suicidal ideation should be a routine consideration in pastoral MHPSS, with mhGAP-aligned supervision pathways available for cases that escalate.

The identification of churches in Chikwawa as "trusted but under-equipped" aligns with research from Kenya (Puffer et al., 2016), the United States (Johnson et al., 2024), and Nepal (Welton-Mitchell et al., 2018), which demonstrates that while faith-based platforms are well positioned for MHPSS advocacy, the persistence of "theological stigma", where symptoms are interpreted as moral or spiritual failings, remains a major impediment to effective support (Jordan, 2025; Kutcher et al., 2015). The present study builds on these findings by situating

them in a context where climate-related recurrent disasters are the primary drivers of mental health need and formal clinical infrastructure is minimal or absent. In this environment, the organisational, belief-system, and communication challenges that constitute barriers to psychosocial support converge. Walsh's Family Resilience Framework (Walsh, 2007) therefore provides a unified analytic structure that underscores how theological interpretations of disaster, a lack of referral pathways, and limited vocabulary around trauma within congregational contexts inhibit effective MHPSS integration. This framework informs both the analysis of barriers and enablers and guides the design of the intervention described in the companion paper, thereby addressing duplicated elements and presenting a cohesive rationale for intervention development.

The contribution of this article is to provide analytically dense, multi-stakeholder qualitative evidence that Chikwawa families experience trauma through both direct and secondary pathways; that churches occupy a trusted but under-equipped position; and that the field's documented barriers intersect with the structural context (compounded disaster exposure, low clinical capacity) to generate the converging picture reported here. This study clarifies how its findings integrate with and extend Walsh's Family Resilience Framework, the Social Ecological Model, trauma-informed care, and human rights-based approaches. Specifically, the findings highlight the practical ways in which belief systems, organisational patterns, and communication processes within families and churches mediate both disaster impacts and adaptive responses. By explicitly connecting these empirical results to the frameworks, the analysis illustrates that church-based interventions are not only relevant for addressing psychosocial needs but also operationalise key theoretical principles in practice. Furthermore, the study integrates the six validated themes with prevailing conceptual models from the MHPSS–DRR integration literature (Galappatti & Richardson, 2016; Grey et al., 2020) and family resilience frameworks, clarifying how the church-based intervention pathway is both evidence-based and theoretically coherent. The operational model described in the companion paper demonstrates how this integration can address the persistent gap between policy aspirations (such as those outlined in the Sendai Framework Priority 4 (Aitsi-Selmi et al., 2015), validated local needs, and actual practice. This provides a template for bridging DRR and MHPSS policy and practice both in this setting and potentially in other disaster-prone, low-resource contexts.

The transferability of these conclusions to other cyclone- and flood-prone African settings (including Mozambique, Madagascar, central Mozambique's floodplain regions, and other Shire Valley contexts) is plausible but bounded; denominational mix, theological orientations, and existing relationships between churches and clinical services differ across settings and would need to be characterised locally (Winiger & Goodwin, 2023). Key factors influencing transferability include the extent and continuity of church infrastructure and pastoral networks, denominational diversity within affected communities, the historical role of churches in local disaster response, patterns of collaboration between churches and health providers, and the presence or absence of existing faith-based training initiatives around psychosocial support. Instructors or programme planners seeking to replicate or adapt this research should critically

assess these structural and contextual conditions to evaluate generalisability and ensure the rigour of new applications.

11. STUDY IMPLICATIONS

The findings carry two main implications for policy and practice.

11.1 Formal Integration of MHPSS into DRR Policy

MHPSS is formally integrated into DRR policy in Malawi at the operational, not merely rhetorical, level. For effective policy implementation, clear procedural steps should be outlined: policymakers should draft and adopt explicit guidelines that require the integration of MHPSS activities into national-, district-, and community-level DRR strategies. The present study adds local evidence, demonstrating that these steps toward integration are both feasible and urgently needed.

11.2 Recognition of Churches as Formal DRR Partners

Churches should be recognised as such. This recognition requires a policy devotion to capacity building and supervision, not simply to informal consultation. Faith-based infrastructure often exhibits long-term resilience and presence (Grieve & Olivier, 2018, p. 110), and the gap labelled by Horn and colleagues as the "myth of the 1-day training" (Horn et al., 2019) can be avoided only through sustained capacity-building and supervision.

12. LIMITATIONS OF THE STUDY

The most significant limitations affecting the interpretation and transferability of this study are identified below, with each limitation accompanied by the specific mitigation strategies implemented to reduce its impact and uphold methodological transparency and analytic credibility:

The research was conducted in a single district (Chikwawa), which limits the generalisability of results to other regions. To mitigate this, the study provides a detailed context description, enabling readers to assess transferability. The paper encourages replication and adaptation in other settings to validate findings.

Some stakeholder groups, notably hospital workers and DoDMA staff, had small sample sizes. This may have limited the representativeness of these perspectives. The study addressed this by triangulating data across five stakeholder groups and using multiple qualitative methods (interviews, focus groups, field notes) to strengthen credibility and breadth.

The qualitative, cross-sectional design precludes causal inference and prevents tracking of changes over time. The study mitigated this by achieving thematic saturation and focusing on in-depth, context-rich accounts, while transparently acknowledging this limitation and recommending future longitudinal research.

Researcher positionality (insider/outsider) could have influenced data interpretation. To minimise this risk, the researcher maintained reflexive journals, conducted peer debriefings,

and kept audit trails during analysis. This systematic reflexivity aimed to reduce bias and enhance analytic transparency.

Lack of multi-site replication further constrains external validity, as local differences in church structure, community dynamics, or disaster exposure may yield different results elsewhere. The study mitigated this by fully describing the local context and explicitly encouraging future multi-site and comparative research. Methodological rigour and robust data analysis procedures were prioritised within the Chikwawa setting to maximise internal validity.

13. RECOMMENDATIONS

- Integrate mental health and psychosocial support (MHPSS) into disaster risk reduction (DRR) policy and operational plans at both district and national levels, ensuring dedicated funding and clear implementation guidelines.
- Recognise and formalise the role of churches as key partners in DRR, with a shift from ad hoc involvement to sustained, institutionalised collaboration.
- Mandate regular joint training for church leaders and health workers in trauma-informed care, mental health literacy, and referral protocols.
- Establish structured referral and supervisory mechanisms between churches and clinical services, drawing on WHO mhGAP guidance.
- Codify requirements for multi-sectoral coordination among churches, local government, health offices, and DRR agencies in disaster preparedness plans.
- Encourage replication and adaptation of these approaches in similar disaster-prone, resource-limited settings to strengthen family and community resilience.

14. CONCLUSION

This study confirms that households in Chikwawa District, Malawi, face a combined psychosocial burden of destroyed livelihoods, trauma, feelings of helplessness, and suicidal ideation, triggered by frequent climate-related disasters. While local churches are trusted and easily accessible actors within these communities, they cannot respond effectively to these needs, limited by insufficient mental health literacy, scarce resources, and the existence of stigma rooted in theological perspectives. However, if supported by structured evidence-based interventions, these churches can become key partners in resilience building, leveraging their core role in sustaining community cohesion. This study integrates Walsh's family resilience framework with participatory methods and proposes embedding mental health literacy building and referral pathways into religious platforms to fill gaps in formal support services.

15. FUTURE STUDIES

- Replicate this study in other districts of Malawi and in diverse disaster-prone countries to assess the transferability and adaptability of findings across cultural and contextual settings.

- Expand sample sizes for underrepresented stakeholder groups, such as hospital workers and disaster management staff, to capture a broader range of perspectives and context-specific challenges.
- Explore community-driven models for sustaining psychosocial support and resilience-building in resource-limited, disaster-affected regions.

16. DECLARATION OF CONFLICTING INTERESTS AND FUNDING

The authors declare no conflict of interest and no funding from any agency. This article is based on an original, ongoing PhD thesis titled: Developing a Church-Based Mental Health Literacy Intervention to Enhance Family Resilience to Natural Disaster Trauma in Malawi: A Participatory Qualitative Study.

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