

Healing After Crisis: Basis for Community-Based Mental Health and Psychosocial Support Program in Transitory Shelters of Marawi City

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ABSTRACT

This study examined the socio-demographic characteristics, psychosocial condition, and access to mental health services among internally displaced adults residing in Sagonsongan Transitory Shelters (n=50). Findings showed that respondents were predominantly female (68%). Married (56%), and in early to mid-adulthood (mean age = 34.52 ± 12.04 years old), with universal Muslim affiliation. Economic vulnerability was pronounced, as 56% reported an average monthly household income below 5,000, far below the national minimum basic-needs threshold. Psychosocial assessment indicated generally moderate emotional well-being (mean = 3.62), with moderate levels of stress, sadness or hopelessness (mean = 3.31), alongside relatively strong perceived social support (mean = 3.70) and high perceived safety with the community (mean = 3.94). While 60% of respondents were aware of available mental health services, only 40% has utilized them, despite 82% of service users reporting cultural respectfulness and 84% believing that more adults in the community need counseling. Positive perceptions of counseling were reported by 74% of respondents, and 48% expressed strong willingness to participate in community-base counseling if offered. Key barriers to service access included lack of awareness (60%), stigma or shame (34%), and shortage of trained counselors (32%). Overall, the findings highlight a community experiencing significant economic hardship and moderate psychosocial vulnerability, yet demonstrating resilience, positive attitudes toward mental health services, and readiness for culturally grounded, community-based mental health and psychosocial support interventions.

INTRODUCTION

Crisis Situations and Interventions in Transitory Shelters of Marawi City

In May 2017, Marawi City in Lanao del Sur experienced a five-month-long armed conflict (Knight et.al., 2019; Curo, 2024) that resulted to the city in ruins (Divinagracia, 2018). According to Amnesty International as cited in the study of Curo, (2024), 1,780 hostages were rescued while 920 militants, 165 soldiers and 47 civilians were reported casualties. This resulted to cause a variety of negative implications in the lives of the residents, both psychological and physical (Mangondato et.al, 2025), and protracted crisis marked by persistent service gaps and socio-economic vulnerability (Balindong & Umpa, 2023).

While the provision of structurally sound shelters effectively addressed immediate housing needs, IDPs continued to experience crises related to inadequate social services, notably declining food assistance, limited access to healthcare and medicines, and insufficient livelihood opportunities, which undermined basic physiological and safety needs (Balindong & Umpa, 2023; Nassar et.al., 2018; Sarangani, 2021).

Psychological status of the Meranaw internally displaced persons (IDPs) is characterized by both acute and chronic trauma responses following the Marawi Siege. Survivors initially exhibited shock, fear, and helplessness, which later evolved into persistent symptoms such as anxiety, emotional exhaustion, feelings of insecurity, loss of dignity, and trauma linked to family separation and economic instability (Wapaño & Dagalangit-Pundato, 2024; Flores & Campado, 2025).



Bangcola & Pangandaman (2020) explored the role of spirituality in improving spiritual well-being among older displaced adults in Marawi, study revealed that stronger spirituality correlated with better mental health but noting the need for community-based spiritual support beyond reliance on religious coping. The interplay between faith, resilience, and trauma was further explored in Wapaño & Dagalanit-Pundato, (2023) qualitative study using IPA methodology with IDPs aged 18–40 in Sagonsongan. It illuminated how reliance on religious practices functioned as both a protective factor and coping mechanism but lacked evaluation of formalized community counseling practices. This is supported by the study of Schwalm et.al. (2022) and Lucchetti et.al. (2020), that religious coping is largely described as informal and self-directed or socially embedded, rather than as part of formal mental health or psychosocial counseling programs delivered systematically within communities.

A broader inquiry by Pangandaman et.al. (2019) surveyed 366 displaced Meranaw adults in evacuation centers, documenting psychophysiological impacts such as depression, anxiety, insomnia, chronic pain, and living-condition stressors highlighting a clear need for psychosocial and health system interventions. However, the study focused on immediate effects rather than long-term counseling program development or policy responses tailored to adult IDPs.

Humanitarian actors like Médecins Sans Frontières (MSF) provided mental health first aid and basic individual counseling during the siege, benefiting about 11,000 displaced persons, but these were short-term emergency interventions without post-conflict follow-up. In contrast, post-seige efforts by IOM, KOICA, and UNFPA established community safe spaces and Women-Friendly Spaces offering counseling and referral networks in various barangays, though Sagonsongan-specific adult counseling remains inadequately explored.

From a systemic policy perspective, the Philippine Commission on Human Rights (2018) critiqued the reliance on disaster management frameworks to address Marawi displacement, noting the lack of rights- and psychosocial-centered institutional approaches for IDPs. Meanwhile, ICRC has contributed to building Mindanao's mental health workforce through targeted training, but uptake remains limited and not tailored for community-based counseling in displaced settings like Sagonsongan.

Moreover, integrating mental health and psychosocial support (MHPSS) across disaster and conflict responses rather than siloed by trigger would better address the lived realities of complex displacement. Without such integration, humanitarian systems risk perpetuating cycles of displacement that are not only physically and economically damaging, but also psychologically devastating (See et.al., 2025; Miller & Rasmussen, 2010).

Community-based Mental Health and Sustainable Development Goals

Community-based mental health has been widely conceptualized as a holistic and decentralized approach that situate mental health promotion, prevention, care, and rehabilitation within the everyday contexts of people's lives rather than in institutional settings (Keet et.al., 2019). Espinosa (2022) illustrates this approach through a community-level assessment of older adults in Iloilo, Philippines, where mental health is closely linked to social functioning, family relationships, and community support systems, emphasizing promotion and prevention alongside access to local mental health services.

Similarly, policy-oriented frameworks described community-based mental health as an integrated, rights based system embedded in primary care and local governance structures, involving multi-sectoral collaboration and active participation of families and community members across the continuum of care, from early intervention to recovery and social reintegration (Ligot et.al., 2025). Moreover, Hechanova (2019) describes community-based mental health interventions as programs that are designed and delivered in community settings, mobilize local resources, and actively involve community members such as families, volunteers, and trained paraprofessionals in addressing mental health needs.

Together, these studies underscore that effective community-based mental health programs are characterized by accessibility, social inclusion, and the strengthening of community and family capacities to support mental well-being (Keet et.al., 2019; Espinosa 2022; Ligot et.al., 2025; Van Citters et.al., 2004; Hechanova, 2019).

Also, the community-based mental health program is fundamentally aligned with SDG 3, particularly Target 3.4, which emphasizes the promotion of mental health and well-being (United Nations, 2015). By focusing on healing

after crisis among internally displaced persons (IDPs) in the transitory shelters of Marawi City, the program responds to trauma, psychological distress, and barriers to accessing mental health services. Strengthening community-based, culturally appropriate mental health support contributes to improved psychosocial functioning, reduced stigma, and enhance overall well-being among conflict-affected populations (Wood et.al., 2021; Pluess et.al., 2025). Furthermore, SDG 11 particularly Target 11.1, which highlight inclusive, safe, resilient, and sustainable communities (United Nations, 2015), is supported by this study. Addressing mental health needs within transitory shelters promotes social cohesion, resilience, and recovery among displaced communities (Kola et.al., 2021; Posklinsky & Nouman, 2025). By integrating mental health services at the community level, the program contributed to rebuilding trust, strengthening social support systems, and fostering inclusive recovery processes in post-conflict urban settings such as Marawi City.

Given these contexts, there is an urgent need to assess and develop responsive programs that address not only physical infrastructure but also social welfare, sustainable development, and long-term recovery. This research seeks to provide empirical and evidence-based information for establishing community-based mental health and psychosocial support program for internally displaced adults in Barangay Sagonsongan, Marawi City.

MATERIALS AND METHODS

Study site

Through the NHA, the Task Force Bangon Marawi (TFBM) has already constructed 1,452 units in Sagonsongan, clustered into eight. Area 1 with 102 units, Area 2 with 217 units, Area 3 with 54 units, Area 4 with 150 units, Area 5 with 194 units, Area 6 with 335 units, Area 7 with 100 units, and Area 8 with 300 units (NHA, 2019).

Respondents

The participants of this study were internally displaced adults (aged 18 and above) residing in the seven designated areas of Barangay Sagonsongan. A total of 50 survey respondents were targeted across the seven areas, with an average of 12–15 respondents per area.

These areas are known clusters of transitional shelters established after the 2017 Marawi Siege. To ensure inclusive representation, the study used a stratified purposive sampling technique, selecting participants from each area based on the following criteria:

- Must be 18 years old or above
- Must have resided in Sagonsongan for at least one year
- Must be willing and able to give informed consent
- Preferably diversified in gender, age, marital status, occupation, and length of displacement

Data Collection

The study is quantitative-descriptive. It investigated dimensions related to psychosocial wellness and access to counseling services among internally displaced adults in Sagonsongan. All participants received a briefing on the purpose and voluntary nature of the study. Informed consent was obtained prior to any data collection with ethical considerations. A structured survey questionnaire was utilized.

Quantitative variables included demographic characteristics (such as age, gender, civil status, religion, education, occupation, income, and length of stay), levels of emotional wellness and perceived support, awareness and usage of mental health services, attitudes toward counseling, and perceived barriers to access.

Data Analysis

Quantitative data from the survey were encoded and analyzed using descriptive statistical tools. Frequencies and percentages were used to describe nominal and ordinal variables. Mean scores and standard deviations were



computed for Likert-scale responses. Cross-tabulations were also considered to explore relationships between variables such as age, gender, and willingness to participate in counseling.

RESULTS AND DISCUSSION

Social Demographic Profile

Table 1 shows the personal profile of the internally displaced adult respondents includes age, sex, civil status, religion, occupation, average monthly household income, and current area of residence within the Sagonsongan Transitory Shelter. Findings revealed that majority of the respondents are female, married, and in their early to mid-adulthood, with a mean age of 34.52 years. All respondents identified as Muslims, reflecting the religious homogeneity of the population in the area. Religious homogeneity can strengthen social cohesion, trust, and collective identify, shared beliefs, values, and moral frameworks often facilitate cooperation, mutual support, and collective action within a community especially in small or resource-dependent communities (Harraka, 2002; Clarke & Jennings, 2008; Hamza et.al., 2024; Nizam & Ikaputra, 2025). However, religious homogeneity has limitations. In the context of development and sustainability initiatives, overly uniform social structures may reduce openness to alternative livelihood strategies or externally introduced policies that are perceived as misaligned with prevailing religious or cultural values (Bebbington et.al., 2014; Alesina et.al., 2016; Wimmer, 2023; Asori et.al., 2023).

In terms of livelihood, most respondents are engaged in informal or small-scale occupations. A significant number of them reported having an average monthly household income of below ₱5,000, indicating a high level of economic vulnerability. Dependence on informal or small-scale occupations often entails irregular income. Lack of job security, and minimal access to social protection mechanisms, which exacerbates household vulnerability to economic and environmental shocks (Israel & Briones, 2014; World Bank, 2020). Specifically, 56% earned less than ₱5,000 per month, while only 4% earned ₱20,000 and above. According to the 2023 Family Income and Expenditure Survey (FIES) by the Philippine Statistics Authority (PSA), a family of five needs at least ₱13, 873 monthly to meet its minimum basic needs. The very small proportion of respondents earning 20,000 highlights pronounced income inequality within the community and suggests limited opportunities for upward economic, health, and nutrition mobility (Coulthard et.al., 2011; Warren et.al., 2021 Brunori et.al., 2013; Albert & Vizmanos, 2018; Salvaña, 2022).

As to place of residence, respondents were distributed across the eight zones of the Sagonsongan Transitory Shelter, with Area 2 having the highest concentration of respondents at 20.5%. The rest of the areas ranged between 11.4% to 15.9%, suggesting a relatively even distribution across the shelter zones. These data reflect the demographic and socioeconomic diversity of adult IDPs residing in Sagonsongan, shaped by shared experiences of displacement and post-conflict recovery. Such diversity has important implications for recovery interventions, as uniform or one-size-fits-all programs may fail to address specific needs, older adults and those with limited education often face greater barriers to livelihood reintegration, while younger or more educated IDPs may adapt more easily to new economic opportunities (Cernea, 2021; Ajibade, 2022). However, prolonged displacement and limited livelihood opportunities may strain these social bonds over time, increasing dependency on aid and heightening risks of chronic poverty (Salvaña, 2022; Ignacio, 2024).

Table 1. Socio-Demographic Profile of the Respondents (n = 50)

| Variable | Category | Frequency (f) | Percentage (%) |
|---------------|-----------------|---------------|----------------|
| Age (Grouped) | 17–24 years old | 9 | 18% |
| | 25–34 years old | 18 | 36% |
| | 35–44 years old | 10 | 20% |
| | 45–54 years old | 7 | 14% |
| | 55–65 years old | 6 | 12% |
| Mean Age | — | — | 34.52 |

| | | | |
|-------------------------------|-------------------|----------------------|-----------------------|
| Standard Deviation | — | — | 12.04 |
| Gender | Male | 16 | 32% |
| Variable | Category | Frequency (f) | Percentage (%) |
| | Female | 34 | 68% |
| Civil Status | Single | 17 | 34% |
| | Married | 28 | 56% |
| | Widow | 5 | 10% |
| Religion | Islam | 50 | 100% |
| Average Monthly Income | Below ₦5,000 | 28 | 56% |
| | ₦5,000–₦10,000 | 16 | 32% |
| | ₦10,001–₦15,000 | 3 | 6% |
| | ₦15,001–₦20,000 | 2 | 4% |
| | ₦20,001 and above | 2 | 4% |
| Sagosongan Area | Area 1 | — | 13.6% |
| | Area 2 | — | 20.5% |
| | Area 3 | — | 11.4% |
| | Area 4 | — | 13.6% |
| | Area 5 | — | 15.9% |
| | Area 6 | — | 11.4% |
| | Area 7 | — | 13.6% |
| | Area 8 | — | 13.6% |

Psychosocial Conditions of the Respondents

Table 2 shows the psychosocial condition of the internally displaced adult respondents was assessed using four key indicators: emotional wellness, presence of stress or sadness, availability of emotional support, and perception of safety within the community.

In terms of emotional well-being, nearly half of the respondents (48%) rated themselves a “3” on a 5 point scale, indicating moderate emotional wellness. A combined 46% rated themselves positively (22% rated “5” and 24% rated “4”), while a small portion (6%) rated themselves “2,” reflecting lower emotional health. This suggests a population that is largely functioning but psychologically vulnerable. Mental health research, moderate level indicates that many individuals can cope with daily demands but may experience emotional strain, uncertainty, or unresolved stressors. These often reflect adaptive coping in the presence of adversity, rather than optimal well-being, particularly among populations exposed to displacement, poverty, or prolonged instability (Keyes, 2002; Miller & Rasmussen, 2010; Bryant et.al., 2023 Sugara, 2025). Significantly, combined 46% reflects a significant degree of psychological resilience and suggests the presence of protective factors such as social support, religious or spiritual coping, community cohesion, and meaning-making, which are commonly documented as buffers



against psychological distress in vulnerable and post-conflict populations (Tol et.al., 2011; Bürgin et.al., 2022; Hou et.al., 2020; Ungar, 2013; Elshahat et.al., 2022).

When asked whether they often feel stressed, sad, or hopeless, the responses were also centered around the moderate rating: 46% selected “3” and 24% selected “4.” A noticeable 14% rated “2” and 12% rated “5,” with only 1% reporting extreme distress (“1”). This suggests that while emotional challenges are present, most respondents fall within a moderate range of emotional struggles. Viewed through a community mental health lens, these findings imply a population experiencing widespread but mostly moderate psychological distress, rather than acute or severe mental health crises. Such patterns are common in communities exposed to chronic stressors such as poverty, displacement, livelihood insecurity, or social marginalization, where stress, sadness, or hopelessness become normalized experiences rather than exceptional conditions (Patel et.al., 2018; Kang et.al., 2020; McGorry et.al., 2024).

Regarding social support, 38% of respondents chose “3” while a significant 36% rated “5,” indicating that more than one-third strongly agreed that they have someone to talk to when feeling down. However, a smaller portion reported limited support: 8% rated “2” and 4% rated “1.” Strong perceived social support is a well-established protective factor in community mental health, as it buffers the effects of stress, reduces the risk of depression and anxiety, and enhances coping capacities, particularly in communities exposed to socioeconomic hardship or displacement (Thoits et.al., 2011; Marroquín et.al., 2020; Lee et.al., 2023). Moreover, community mental health emphasizes strengthening social support networks, peer-based coping mechanisms, and access to culturally appropriate psychosocial services to prevent moderate distress from escalating into severe mental health disorders (Kola et.al., 2021; Posklinsky & Nouman, 2025).

Table 2. Summary of Respondents’ Psychosocial Condition

| Statement | Total Frequency | Mean | Interpretation |
|---|-----------------|------|----------------|
| I feel emotionally well most days | 50 | 3.62 | Agree |
| I often feel stressed, sad, or hopeless | 49 | 3.31 | Neutral |
| I have someone to talk to when I feel down | 50 | 3.70 | Agree |
| I feel safe and supported in my current community | 50 | 3.94 | Agree |

Finally, in terms of perceived safety and community support, the data reveal a generally positive outlook. A combined 68% gave high ratings (44% rated “5” and 24% rated “4”), suggesting that a majority feel secure and supported in their current community. Only 2% reported feeling the least safe (rated “1”), which indicates that while challenges exist, the Sagonsongan community provides a relatively stable and supportive environment for most respondents. Community-based mental health emphasizes that mental well-being is not only shaped by individual factors but also by the social environment, including perception of safety, belonging, and mutual support (WHO, 2013; Bangpan et.al., 2019; Bolton et.al., 2023). This underscores that mental well-being is collectively produced; that perceived safety, belonging and mutual support are not peripheral factors but core determinants of psychological health. And to strengthen these social dimensions can enhance resilience, reduce distress, and promote sustainable mental well-being at both individual and community levels (IASC, 2006; Hobfoll et.al., 2007; Wang et.al., 2024).

Awareness, Utilization, and Perceptions of Mental Health Services

The table 3 shows the respondents’ awareness, experience, and perceptions regarding mental health services available in their community. A significant portion (60%) of the respondents are aware of the existence of counseling or mental health services within their area, while 40% indicated otherwise. However, only 40% have used such services, suggesting that access or willingness to utilize mental health resources may still be limited despite awareness. Notably, among those who have used the services, a majority (82%) stated that the services were culturally respectful—honoring their language, beliefs, and customs—while 18% felt otherwise. This

reflects a relatively positive alignment between available services and the cultural values of the community. Moreover, a large majority (84%) of the respondents believe that more adults in their community need counseling.

From a community-based mental health perspective, these disparities may be attributed to several interrelated barriers. First, structural and access-related factors such as limited-service capacity, distance to facilities, financial constraints, or lack of culturally appropriate providers often prevent individuals from seeking help even when services are available (WHO, 2013; Patel et.al., 2018; Bolton et.al., 2023; McGorry et.al., 2024). In low-resource or post-crisis settings, mental health services are frequently underfunded and overstretched, which can discourage utilization despite awareness. Second, stigma and cultural perceptions of mental illness remain significant deterrents. Individuals may fear social adjustment, discrimination, or being labeled as weak or unstable, which reduces willingness to seek formal psychological support (Corrigan & Watson, 2002; Misra et.al., 2021; Javed et.al., 2021; Thornicroft et.al., 2016; Thornicroft et.al., 2022). In many collectivist communities, emotional distress is often managed through family, religious leaders, or informal social networks rather than professional services, further limiting further use of the service. Third, mental health literacy plays an important role. Awareness of service existence does not necessarily imply understanding of when, how, or why to use these services. People may normalize psychological distress or perceive their symptoms as not severe enough to warrant professional help, leading to delayed or avoided utilization (Jorm, 2012; Byrow et.al., 2020; Carvalho et.al., 2022; Yang et.al., 2024).

The 40% who have accessed services, however, represent an important foundation for strengthening community-based mental health systems. Their utilization suggests that when barriers are reduced through trust, accessibility, or perceived relevance, community members are willing to engage with mental health support. Expanding outreach, integrating mental health services into primary care, and leveraging community leaders can help bridge the gap between awareness and utilization (Patel, 2022; Patel et.al., 2023; Islam, 2022; WHO & UNICEF, 2021).

Table 3. Respondents' Awareness and Experience with Mental Health Services

| Indicators | Yes | % | No | % | Total (n) |
|---|-----|-----|----|-----|-----------|
| Are you aware of the counseling or mental health service in your community? | 30 | 60% | 20 | 40% | 50 |
| Have you ever used any of these services? | 20 | 40% | 30 | 60% | 50 |
| Was the service culturally respectful (language, beliefs, customs)? | 41 | 82% | 9 | 18% | 50 |
| Do you think more adults in your community need counseling? | 42 | 84% | 8 | 16% | 50 |

The data shows in table 4 that most of the respondents (74%) hold either a positive or very positive perception of counseling, while 26% remain neutral. This suggests a generally favorable attitude towards mental health support in the community. Moreover, when asked about the likelihood of participating in community-based counseling, 48% indicated they are very likely (rated 5), followed by 30% selecting a moderate likelihood (rating 3), and 20% choosing 4. These results imply that nearly half of the community members are open and ready to engage in localized mental health services, signaling potential success for programs that are accessible and culturally grounded.

This is particularly important in community settings where cultural beliefs, social norms, and past experiences often shape attitudes toward mental health services. Positive perceptions are known to be critical enabling factor for help-seeking behavior, as individuals are more likely to engage with services they perceive as trustworthy, relevant, and respectful of their values (Corrigan & Watson, 2002; Misra et.al., 2021; Javed et.al., 2021; Gulliver et.al., 2010; Aguirre et.al., 2025)

Table 4. Respondents' Perceptions and Preferences Toward Counseling

| Statement | Response | Frequency | Percentage (%) |
|--|---------------|-----------|----------------|
| What is your perception of counseling? | Very Positive | 20 | 40% |



| | | | |
|---|-----------------|----|-----|
| | Positive | 17 | 34% |
| | Neutral | 13 | 26% |
| How likely are you to participate in community-based counseling if offered? | 5 (Very Likely) | 24 | 48% |
| | 4 (Likely) | 10 | 20% |
| | 3 (Neutral) | 15 | 30% |

Access and Barriers to Mental Health Services

Table 5 shows the barriers affecting access to mental health services. The most identified barrier is lack of awareness (60%), followed by stigma or shame (34%) and lack of trained counselors (32%). Other notable factors include distance or transportation issues (24%) and religious or cultural beliefs (22%). The least cited barrier was services not being culturally sensitive (4%).

The barriers identified in Table 5 can be succinctly explained through the combined perspectives of Yang et.al. (2024), Carvalho et.al. (2022), and Byrow, et.al., (2020). The predominance of lack of awareness reflects low mental health literacy, which limits problem recognition and delays help-seeking, as emphasized by Yang, while also indicating weak positive mental health literacy that undermines autonomy and self-efficacy, as outlined by Carvalho. Stigma or shame and religious or cultural beliefs further shape negative attitudes and subjective norms, reinforcing avoidance of formal services, a pattern consistently noted across all three authors. Structural constraints, including lack of trained counselors and distance or transportation issues, align with Byrow's argument that systemic and navigational barriers interact with literacy deficits to restrict service use. The minimal concern about cultural insensitivity suggests that the core challenges lie not in cultural mismatch but in insufficient awareness, persistent stigma, and limited-service capacity, underscoring the need for integrated strategies that strengthen mental health literacy while addressing structural access barriers (Thornicroft et.al., 2022; Javed et.al., 2021; Misra et.al., 2021; Byrow et.al., 2020; Carvalho et.al., 2022; Yang et.al., 2024).

Table 5. Barriers Affecting Access to Mental Health Services

| Barrier Identified | Frequency | Percentage (%) |
|--|-----------|--|
| Lack of awareness | 30 | 60% |
| Stigma or shame | 17 | 34% |
| Lack of trained counselors | 16 | 32% |
| Services are not culturally sensitive | 2 | 4% |
| Religious or cultural beliefs | 11 | 22% |
| Distance / Transportation | 12 | 24% |
| Lack of trust in outside professionals | 8 | 16% |
| Total Respondents | 50 | 100% (multiple answers allowed) |

CONCLUSION

The findings indicate that internally displaced adults in Sagonsongan Transitory Shelters experience moderate psychosocial vulnerability shaped by prolonged displacement, economic insecurity, and limited livelihood opportunities, alongside notable strengths in social cohesion, perceived safety, and positive attitudes toward counseling. While awareness of mental health services is relatively high, actual utilization remains constrained

by low mental health literacy, stigma and limited-service capacity rather than cultural mismatch. The generally favorable perceptions of counseling and the expressed belief that more community members need psychosocial support suggest a readiness for engagement if services are accessible, trusted, and community-centered. Collectively, these results provide a strong empirical basis for a community-based mental health program that prioritizes mental health literacy, leveraged existing social and religious support networks, reduces stigma through culturally grounded engagement, and integrates psychosocial services into everyday community settings to enhance resilience, prevent escalation of distress, and promote sustainable well-being among displaced populations.

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