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Barriers to Mental Health Service Accessibility Among University Students in Malawi: A Qualitative Multi-Stakeholder Study

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ABSTRACT

Background: Mental health challenges among university students represent a growing public health concern across sub-Saharan Africa. Despite documented high rates of depression, anxiety, and psychological distress in this population, the accessibility of mental health services within Malawian higher education institutions remains largely uninvestigated. Objectives: This study explored barriers to mental health service accessibility among university students at Emmanuel University in Lilongwe, Malawi. Methods: A qualitative research design was employed, guided by Andersen's Behavioral Model of Health Service Utilization (BMHSU) and the Framework for Access to Mental Health Services (FAMS). Purposive sampling was used to recruit 12 participants: eight students, two lecturers, one university administrator, and one mental health professional. Data were collected through semi-structured interviews and a focus group discussion and analysed using Braun and Clarke's (2006) thematic analysis, producing 42 initial codes consolidated into five overarching themes. Results: Five themes emerged: (1) a visibility-utilisation gap in service accessibility; (2) multilayered mental health stigma rooted in cultural, religious, and institutional dynamics; (3) academic pressure operating as a structural stressor tied to financial and social consequences; (4) informal support systems that were well-intentioned but clinically inadequate; and (5) a policy-practice gap in mental health awareness and communication. A marked divergence was identified between administrators' confidence in existing provision and the persistent inaccessibility reported by students and lecturers. Conclusions: Structural, psychosocial, and institutional barriers collectively constrain mental health service accessibility. Addressing them requires targeted anti-stigma interventions, strengthened professional counselling systems, formal institutional policies, and active communication strategies that close the gap between policy existence and lived student experience.

INTRODUCTION

University students navigate a complex and often overwhelming array of psychosocial, academic, and financial pressures during a critical period of personal development. The demands of academic performance, financial insecurity, social adjustment, and the transition to adulthood combine to create conditions of chronic stress that significantly elevate vulnerability to mental health conditions including depression, anxiety, emotional distress, and burnout. Globally, these conditions affect a substantial proportion of university students and are associated with poor academic outcomes, absenteeism, social isolation, and diminished quality of life (Hunt & Eisenberg, 2010; WHO, 2018).

Mental health accessibility is a multidimensional construct extending beyond the physical presence of counselling facilities. It encompasses students' awareness of services, the affordability of care, the cultural acceptability of help-seeking, institutional responsiveness, and the social safety required to disclose psychological difficulties without fear of stigma or judgment. This study sought to address these gaps by qualitatively exploring barriers to mental health service accessibility among university students at Emmanuel University in Malawi. By incorporating perspectives from students, lecturers, a university administrator, and a mental health professional, the study offers a multi-stakeholder analysis of the institutional, psychosocial, and structural barriers shaping mental health support utilisation in a Malawian higher education context.

Background Of The Study

University students worldwide encounter a distinctive convergence of pressures: academic demands, social expectations, financial anxieties, and the developmental passage into adulthood (Hunt & Eisenberg, 2010). Approximately one in three university students' experiences symptoms of mental health disorder at some point during their studies (WHO, 2018). Universities occupy a critical position in promoting student well-being and facilitating access to mental health resources (ACHA, 2022); however, research specifically examining mental health service accessibility on Malawian campuses remains scarce.

In many African university contexts, cultural beliefs that associate mental illness with spiritual failure, personal weakness, or moral inadequacy actively discourage professional help-seeking, creating a substantial gap between need and utilisation (Mofatteh, 2020; Khesht-Masjedi *et al.*, 2017). In sub-Saharan Africa, escalating mental health challenges among university students are compounded by the chronic underdevelopment

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of institutional mental health infrastructure. Studies conducted in low- and middle-income countries (LMICs) document high prevalence rates of depression and anxiety in this population, frequently between 20% and 40%, yet access to psychological support services remains severely limited across most African university settings (Akhtar *et al.*, 2020; Cui *et al.*, 2022; Julius *et al.*, 2024).

In Malawi, despite growing recognition of mental health challenges, access to appropriate services remains severely limited within university settings (Chipeta, 2016). Existing research has focussed almost exclusively on mental health prevalence among adolescents and secondary school learners, leaving university students' experiences of service accessibility virtually unexamined (Chipeta, 2016; Slekiene *et al.*, 2024). Recent systematic reviews confirm that university student mental health remains substantially under-researched within the Sub-Saharan African higher education settings (Julius *et al.*, 2024).

This study examined service accessibility across four core dimensions: availability (whether services exist on campus); affordability (whether services are financially accessible to students); awareness (whether students know about available services and how to access them); and acceptability (whether services are culturally appropriate and responsive to students' needs). Understanding these dimensions is essential for identifying service gaps and informing evidence-based strategies to improve accessibility and utilisation.

Statement of the Problem

Despite increasing global and regional recognition of mental health challenges among university students, access to mental health services within Malawian higher education institutions remains limited and insufficiently investigated. Students continue to experience psychological distress arising from academic pressure, financial hardship, social adjustment difficulties, and the stigma associated with mental illness, yet limited institutional support systems, inadequate service awareness, and fear of social judgment further impede appropriate help-seeking.

Existing Malawian research has focussed primarily on prevalence rates and psychosocial determinants of mental health among adolescents and secondary school learners, with minimal attention given to accessibility barriers within university environments (Slekiene *et al.*, 2024; Julius *et al.*, 2024). This study addressed that gap by qualitatively exploring barriers to mental health service accessibility among university students in Malawi.

Research Objectives

The study was guided by the following objectives:

- **General Objective:** To explore barriers affecting mental health service accessibility among university students in Malawi.
- **Specific Objective 1**: To identify the types of mental health services available in Universities in Malawi and the structural and psychosocial barriers preventing student access.
- **Specific Objective 2:** To examine the roles of university lecturers, counsellors, and administrators in promoting mental health awareness and facilitating student access to support.

LITERATURE REVIEW

University students globally face intersecting academic, financial, and developmental stressors that elevate vulnerability to depression, anxiety, and burnout (Hunt & Eisenberg, 2010; WHO, 2018). In LMICs, prevalence rates of clinically significant symptoms frequently range between 20% and 40% (Akhtar *et al.*, 2020; Cui *et al.*, 2022), yet prevalence alone does not dictate help-seeking. Instead, structural invisibility, cultural stigma, and academic-financial pressures intersect to suppress service utilisation even where services nominally exist (Julius *et al.*, 2024; Mofatteh, 2020). Academic stress consistently predicts adverse educational outcomes, including reduced grades, absenteeism, and course withdrawal, through mechanisms such as impaired concentration, motivational deficits, and emotional dysregulation (Pascoe *et al.*, 2020; Awadalla *et al.*, 2020; Allen *et al.*, 2018). Gender and socioeconomic status further moderate these effects: female students and those from lower-income backgrounds report disproportionately higher rates of distress and greater academic disruption (Rentala *et al.*, 2019; Fréchette-Simard *et al.*, 2022). Evidence-based interventions including mindfulness programmes, structured counselling, and stress management workshops have demonstrated effectiveness in reducing symptoms, but their reach is constrained by stigma and low mental health literacy that suppress help-seeking irrespective of service availability (Galante *et al.*, 2018; Hsu & Goldsmith, 2021; Khesht-Masjedi *et al.*, 2017).

In sub-Saharan Africa, mental health infrastructure remains chronically under-resourced, with university counselling systems often relegated to informal pastoral or spiritual support networks (Chipeta, 2016; Julius *et al.*, 2024). Stigma operates as both a cultural and institutional barrier: mental distress is frequently interpreted through moral or spiritual lenses, discouraging clinical engagement and reinforcing concealment (Khesht-Masjedi *et al.*, 2017). Academic pressure further compounds this, particularly where performance determines financial aid, scholarship retention, or postgraduate opportunity. The resulting stress-performance nexus transforms psychological vulnerability into a high-stakes survival issue, deterring help-seeking that might signal academic instability (Pascoe *et al.*, 2020; Anniko *et al.*, 2017).

In Malawi, scholarly attention has predominantly focussed on adolescent and secondary school populations, leaving university student mental health largely unexamined (Slekiene *et al.*, 2024). Systematic reviews confirm this gap, noting minimal qualitative evidence on institutional accessibility, stigma dynamics, or help-seeking behaviours within Malawian higher education (Julius *et al.*, 2024). This study addresses that gap by qualitatively mapping multi-stakeholder perceptions of mental health accessibility,

revealing how policy existence, cultural stigma, and academic pressure converge to constrain effective service utilisation.

Theoretical Framework

Andersen's Behavioural Model of Health Service Utilisation (BMHSU).

Andersen's model identifies three categories of determinants of health service use: predisposing factors (demographic attributes, health beliefs, and attitudes towards mental health); enabling factors (resources facilitating or constraining access, including financial capacity, geographical proximity, and service awareness); and need factors (perceived or actual health needs motivating care-seeking, including symptom severity and recognition of the value of professional help). In this study, the BMHSU guided identification of the individual-level determinants shaping students' mental health service utilisation and informed the development of research questions and data collection instruments.

Framework for Access to Mental Health Services (FAMS).

FAMS offers a multidimensional conceptualisation of access designed specifically for mental health service delivery contexts. Its five domains (availability, accessibility, acceptability, utilisation, and quality) structured the investigation of how each dimension contributes to the barriers experienced by university students at Emmanuel University. FAMS was particularly valuable in surfacing the distinction between service availability (services exist institutionally) and effective accessibility (students can locate, navigate, and use them safely).

The two frameworks operated complementarily: FAMS structured the institutional and service-level analysis, while the BMHSU foregrounded the individual-level predisposing, enabling, and need factors that shaped students' propensity and capacity to seek support.

MATERIALS AND METHODS

Research Design

This study adopted an interpretivist qualitative research design. Qualitative methodology was selected because the study aimed to generate rich, contextualised understandings of participants' lived experiences, perceptions, and meanings regarding mental health service accessibility, an inquiry goal that quantitative approaches cannot adequately serve.

Study Site and Population

The study was conducted at one university, private higher education institution in Lilongwe, Malawi. The primary participant group comprised university students. Secondary groups (lecturers, a university administrator, and a campus-affiliated mental health professional) were purposively included to capture institutional and clinical perspectives.

Sampling and Sample Size

Purposive sampling was employed to recruit participants with direct experience of, or responsibility for, mental health service provision and utilisation on campus. A total of 12 participants were recruited: eight students (one male and one female from each academic year), two lecturers, one university administrator (registrar), and one mental health professional. Participant selection prioritised diversity across gender, year of study, and institutional role to ensure a breadth of perspectives. Data collection continued until thematic saturation was achieved, defined as the point at which additional interviews yielded no new codes or conceptual insights (Guest *et al.*, 2006).

Table 1: Participant Profile

Code	Role	Gender	Academic Position	Data Collection Method
S1	Student	Female	Year 1	Focus Group Discussion
S2	Student	Male	Year 1	Focus Group Discussion
S3	Student	Female	Year 2	Focus Group Discussion
S4	Student	Male	Year 2	Focus Group Discussion
S5	Student	Female	Year 3	Semi-structured Interview
S6	Student	Male	Year 3	Semi-structured Interview
S7	Student	Female	Year 4	Semi-structured Interview
S8	Student	Male	Year 4	Semi-structured Interview
L1	Lecturer	Male	Senior Lecturer	Semi-structured Interview
L2	Lecturer	Female	Lecturer	Semi-structured Interview
A1	Administrator	Male	Registrar	Semi-structured Interview
MH1	Mental Health Professional	Female	University Counsellor	Semi-structured Interview

Data Collection Instruments

Data were collected using two instruments: semi-structured interview guides and a focus group discussion guide, both developed in alignment with BMHSU and FAMS. Focus group discussions were conducted with Year 1 and 2 students (S1 to S4) to elicit shared accounts of experiences and perceived barriers. Individual semi-structured interviews were conducted with Year 3 and 4 students, lecturers, the administrator, and the mental health professional to generate deeper, personally situated accounts. Using both instruments enabled triangulation across individual and group data sources. All sessions were audio-recorded with participants' consent and transcribed verbatim.

Pilot Testing

All instruments were piloted with a small group of participants not included in the main study. The pilot process assessed the clarity, appropriateness, and comprehensibility of questions, enabling revision prior to full data collection.

Trustworthiness

To ensure credibility, dependability, and confirmability of the findings, four strategies were employed. Credibility was enhanced through member checking, whereby interview participants reviewed and provided feedback on the researcher's interpretations of their responses. Dependability was addressed through standardised interview and focus group protocols, ensuring consistency across all sessions. Confirmability was maintained through reflexive journaling, in which the researcher documented assumptions and analytical decisions throughout the study. Peer debriefing with a colleague experienced in qualitative research provided an additional layer of analytical scrutiny

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Data Collection Procedure

Prior to data collection, permission was obtained from relevant university authorities. Participants were informed in advance of the study's purpose, academic nature, and voluntary basis. Ethical principles including informed consent, confidentiality, voluntary participation, and psychological sensitivity were observed throughout. Participants were made aware of their right to withdraw at any stage without consequence.

Data Analysis

Data were analysed using Braun and Clarke's (2006) six-phase thematic analysis framework. Following verbatim transcription, all data were read repeatedly to develop deep familiarity with the dataset. Initial open coding generated 42 descriptive codes, which were iteratively clustered into 12 subcategories and refined into five overarching themes. A coding tree was maintained in NVivo 14 to track analytical progression from raw data to conceptual themes, providing an auditable record of analytical decisions.

Ethical Considerations

The study adhered to established ethical principles throughout all stages. Informed consent was obtained from all participants prior to data collection, with full explanation of the study's purpose, procedures, potential risks, and the unconditional right to withdraw. Confidentiality and anonymity were maintained through coded participant identifiers and secure, encrypted digital storage. Particular care was taken to respond sensitively to the potential vulnerability of participants experiencing mental health difficulties, with campus support information made available at the close of all sessions. Data were accessible only to authorised members of the research team.

RESULTS AND DISCUSSION

Thematic analysis of semi-structured interviews and focus group data yielded five major themes. Table 2 presents a summary of themes across stakeholder groups, including convergent and contrasting perspectives. Each theme is presented below with direct participant quotations,

Table 2: Summary of Themes Across Stakeholder Groups

Theme	Student Views	Lecturer Views	Administrator Views	Converging Perspectives	Diverging Perspectives
1. Accessibility Barriers	Unaware of services; limited practical access	Observed access gaps; used informal referral	Mental health partner institution; Matron oversight	All groups: limited access identified as a concern	Admins: services are available and functional
2. Mental Health Stigma	Fear of judgment; shame; social labelling	Students reluctant to seek help; concealment observed	Not raised	Students & Lecturers: stigma as a primary barrier	Admins: stigma absent from discourse
3. Academic Pressure	Chronic stress; pressure linked to funding and future	Observed withdrawal, absenteeism, disengagement	Not raised	Students & Lecturers: pressure-distress link confirmed	Admins: academic pressure not acknowledged

4. Support Systems	Peer support as default; professional help hard to access	Informal one-on-one support; no clinical training	Chaplain, Matron, Mental health partner institution -referral	All groups: formal support needs unmet	Admins: existing systems described as adequate
5. Mental Health Awareness	Policy unknown to students; services invisible	Informal integration into teaching	Policies developed and implemented	Students & Lecturers: awareness deficit	Admins: policy existence equated with awareness

identified by participant code, gender, and role.

Theme 1: Accessibility Barriers, The visibility-utilisation Gap

Accessibility to mental health services emerged as the most consistently identified concern across all stakeholder groups. Although university administrators highlighted existing institutional support structures, including a referral partnership with St. John of God Hospital and oversight by the university matron, students and lecturers consistently described mental health services as difficult to identify, poorly communicated, and procedurally inaccessible. Many students described support systems as effectively hidden, discovered only through informal peer conversations rather than through institutional promotion.

"I didn't even know the university had a counselling service until a friend mentioned it in passing. When I tried to find it, even staff at the front desk couldn't direct me." (S4, Female Student, Year 2)

Lecturers similarly reported relying on informal referral mechanisms after observing behavioural and emotional changes among students, in the absence of clearly structured institutional pathways.

"When I notice something is wrong; a student goes quiet, stops engaging, misses assessments. I try to refer them to the matron informally. But there is nothing written down, no formal process for me to follow." (L1, Male Lecturer)

These findings reflect the FAMS distinction between availability and accessibility: services may be institutionally present, yet remain functionally inaccessible when communication systems, referral clarity, and service visibility are inadequate. The primary barrier was not the absolute absence of services, but a significant institutional communication and utilisation gap.

"There is a partnership with a mental health specialist hospital. If a student needs specialised support, we refer them through the matron. The system exists." (A1, University Registrar)

The divergence between this administrative confidence and students' persistent unawareness constitutes a critical implementation failure that cannot be resolved by the mere existence of referral agreements.

Theme 2: Mental Health Stigma, Fear, Labelling, and Social Consequences

Mental health stigma emerged as a critical and pervasive barrier to help-seeking. Participants consistently described stigma as both a cultural and academic deterrent that discouraged students from openly discussing psychological difficulties or accessing professional support. Students expressed strong fears of social judgment, shame, and negative labelling, perceiving mental distress as something that must remain hidden to avoid social exclusion or academic discrimination.

"If you walk into the counselling office, everyone will know. Lecturers might think you can't handle the coursework, and friends will distance themselves. It's safer to suffer in silence." (S2, Male Student, Year 1)

Lecturers observed that many students were reluctant to seek professional support because of fear of being perceived as weak, unstable, or academically incapable. Institutional silence surrounding mental health status of most affected students was itself identified as reinforcing stigma, normalising concealment over care-seeking.

"Students come to me because they trust me personally, but they always ask me to keep it between us. They are afraid it will follow them academically or socially. The stigma is very real." (L2, Female Lecturer)

Within the Malawian collectivist and religious-cultural context, mental distress was frequently interpreted through moral, spiritual, or character-based frameworks, intensifying shame and discouraging clinical help-seeking.

"In our culture, if you are struggling emotionally, people say you need to pray more or that you are weak. Seeking counselling would mean admitting something is wrong with you spiritually. That is the last thing students want." (S7, Female Student, Year 4)

Critically, university administrators did not address stigma in any of their accounts, a significant institutional blind spot that effectively removes stigma from the policy agenda and limits the institution's capacity to design targeted responses.

Theme 3: Academic Pressure, The stress-performance Nexus

Academic pressure emerged as a significant contributor to psychological distress across both student and lecturer accounts. Participants described chronic stress associated with the pressure to achieve high academic performance, meet institutional expectations, and maintain future educational and financial opportunities. Students reported experiencing overwhelming anxiety linked not only to coursework demands, but to the broader consequences of academic failure.

"We are expected to pass with distinctions, but if you fail one module, your funding drops or disappears. The pressure is suffocating, and there's no room to ask for help without risking your future." (S6, Female Student, Year 3)

"I come from a village. My family sacrificed everything for me to be here. I cannot fail. That pressure never leaves me. I am stressed every single day." (S2, Male Student, Year 1)

Lecturers observed behavioural changes among students during peak assessment periods, including absenteeism, emotional withdrawal, and declining classroom engagement, while acknowledging limited institutional mechanisms to respond to severe psychological distress.

"I see it in every exam season. Students who were fine suddenly look exhausted, disappear from class, or break down. I try to talk to them, but I have no formal route to get them real help quickly." (L1, Male Lecturer)

The above explanations detail that academic pressure in higher learning institutions operated not merely as a pedagogical stressor, but as a structural one: students perceived academic success as directly tied to scholarship retention, family expectations, and long-term socioeconomic opportunity, thereby intensifying emotional strain and discouraging any form of help-seeking that might be interpreted as academic instability.

Theme 4: Support Systems: Well-Intentioned but Clinically Inadequate

Participants across all stakeholder groups recognised the importance of robust support systems, yet described existing arrangements as fragmented, reactive, and clinically insufficient. Students reported relying primarily on peer support networks and informal lecturer relationships as substitutes for professional mental health care, in the absence of accessible formal alternatives.

"My friends are the ones I go to. But we are students, not counsellors. Sometimes we end up worrying about each other more than helping. We need someone qualified." (S3, Female Student, Year 2)

"The chaplain tries, but he is not trained for clinical distress. We need someone who understands trauma and depression, not just spiritual advice. Good intentions are not enough when you are having a panic attack before exams." (S8, Male Student, Year 4)

Lecturers described providing informal one-on-one support despite lacking formal mental health training or any institutional guidance framework.

"Students come to me and I do my best. But I am not equipped for this. I worry, I sometimes say the wrong thing. There should be training, or at least guidelines for what to do." (L2, Female Lecturer)

The mental health professional corroborated the structural inadequacy directly.

"The need is real and significant, but the system is not built to meet it. Students are struggling and have nowhere to go that feels safe, professional, and easy to reach." (MH1, University Counsellor)

While administrators described the chaplain, matron, and external referral pathway as components of an adequate support structure, students and lecturers perceived these arrangements as informal, poorly publicised, and insufficient for complex psychological distress. In terms of BMHSU, these limitations reflect critical weaknesses in enabling factors that constrain students' capacity to access and utilise effective mental health support.

Theme 5: Mental Health Awareness: Policy on Paper, Practice in Silence

Limited mental health awareness emerged as a cross-cutting barrier operating at student, lecturer, and institutional levels. Students consistently reported low awareness of available counselling services and described the absence of formal mental health orientation programmes, awareness campaigns, or visible institutional communication. Services were perceived to exist as policy statements rather than as practically visible or accessible campus resources.

"They talk about mental health in policy documents, but we never see posters, emails, or workshops. It feels like it exists only on paper. If you don't know it's there, you can't use it." (S1, Female Student, Year 1)

"I did not know what depression was until my third year. I thought I was just tired and unmotivated. Looking back, I think I was really struggling, but I had no words for it and no idea there was anywhere to go." (S5, Female Student, Year 3)

Lecturers acknowledged attempting to incorporate mental health discussions into teaching and student interactions on an individual basis, in the absence of any institutionally coordinated awareness programme.

"I try to raise mental health when it comes up naturally in my subject. But it is entirely my own initiative. There is no policy asking us to do it, and I am sure most of my colleagues do not." (L1, Male Lecturer)

Administrators confirmed that mental health policies and support structures had been developed, yet students and lecturers described a persistent disconnect between policy existence and practical implementation. Awareness of available services relied almost entirely on informal peer communication, producing inequitable and crisis-dependent access patterns. This policy-practice gap is among the most consequential findings of the study.

Discussions

This study reveals that mental health service accessibility in university level students in Malawi, is constrained not by absolute service absence, but by a convergence of informational opacity, cultural stigma, academic-financial stressors, and fragmented support infrastructure. Framed through Andersen's BMHSU and FAMS, these barriers operate across predisposing, enabling, and need-level dimensions and interact in ways that compound their individual effects.

Predisposing Factors: Stigma as Cultural, Religious, and Institutional Barrier

Predisposing factors include deeply entrenched stigma and cultural interpretations of mental distress. In Malawi, where collectivist values and religious frameworks shape social identity, psychological vulnerability is frequently conflated with moral failing or spiritual deficiency

(Chipeta, 2016; Khesht-Masjedi *et al.*, 2017). This cultural script discourages clinical help-seeking and normalises silent endurance as the socially acceptable response to psychological difficulty. The multilayered architecture of stigma documented in this study, operating simultaneously at interpersonal, cultural, religious, and institutional levels, is consistent with sub-Saharan African evidence more broadly (Mofatteh, 2020) and represents a qualitatively distinct challenge from the attitudinal stigma, typically addressed by awareness campaigns in high-income settings.

Several student accounts indicated that mental illness was interpreted spiritually, positioning professional counselling as not only unnecessary, but as indicative of insufficient faith. This framing creates a barrier that biomedical or psychological messaging alone cannot address. Effective stigma reduction in higher learning institutions in Malawi will require engagement with religious leadership and the development of messaging that integrates theological and clinical perspectives. The complete absence of stigma from administrative narratives represents not merely an oversight, but a governance failure: when institutional actors do not name stigma as a problem, it cannot enter the institutional agenda and those experiencing it cannot access systemic support.

Enabling Factors: The visibility-utilisation Gap

Enabling factors are severely compromised by poor service visibility and procedural opacity. While administrators highlighted referral partnerships and matron oversight, students experienced these structures as hidden or functionally inaccessible. This aligns with FAMS' distinction between availability and accessibility: services may exist institutionally, but without proactive communication, clear referral pathways, and normalised help-seeking cultures, they remain functionally absent from students' experience. The policy-practice gap documented in Theme 5 underscores a broader LMIC challenge in which mental health infrastructure is developed at the administrative level but fails to reach end-users (Julius *et al.*, 2024). Participatory service design, student feedback mechanisms, and active outreach are required to close this gap.

Need Factors: Academic Pressure as Structural Stressor

Need factors are amplified by academic-financial interdependence. Academic pressure at Emmanuel University is not merely pedagogical; it is economically and socially determinative. Students internalise performance anxiety because academic failure directly threatens funding, residency, family expectations, and future mobility. This structural stressor transforms psychological distress into a high-stakes survival issue, further discouraging help-seeking that might signal academic instability. Lecturers' observations of behavioural withdrawal during assessment periods corroborate global evidence linking assessment pressure to absenteeism and emotional dysregulation (Anniko *et al.*, 2017; Pascoe *et al.*, 2020). Addressing academic pressure therefore requires not only structural interventions, workload review and assessment reform, but cultural ones that actively legitimise the expression of difficulty within the academic environment.

The Stakeholder Divergence: Systemic Implementation Failure

The divergence between administrative and student/lecturer perspectives is not merely perceptual; it reflects systemic implementation failure. Bureaucratic markers of provision, policy documents, partnership agreements and staff roles, are mistakenly equated with functional accessibility. Without participatory monitoring, student feedback loops, and culturally attuned outreach, institutional mechanisms remain decoupled from lived experience. This divergence is the most diagnostically important finding of the study: it reveals that a higher learning institution's mental health challenge is not primarily one of resource absence, but of institutional communication, governance accountability, and participatory service design. The findings extend evidence from Julius *et al.* (2024) and Slekiene *et al.* (2024) by revealing the specific campus-level mechanisms through which this divergence is produced and sustained.

CONCLUSION

This study explored barriers to mental health service accessibility among university students at one of the higher learning institutions in Malawi. The findings demonstrate that accessibility is constrained by a convergence of structural, psychosocial, cultural, and institutional factors: low service visibility, multilayered stigma rooted in cultural and religious frameworks, academic pressure operating as a structural stressor tied to financial and social consequences, clinically inadequate informal support systems, and a pervasive gap between the policies institutions document and the realities students encounter. This study contributes to the limited but growing body of qualitative evidence on university mental health service accessibility in Malawi and sub-Saharan Africa.

Limitations

- The small sample size (n = 12) and single-site design limit the transferability of findings to other Malawian or sub-Saharan African university contexts.
- Purposive sampling, while appropriate for qualitative inquiry, may not capture the full diversity of student experiences across demographic subgroups.
- Thematic analysis is inherently interpretive and subject to researcher subjectivity, notwithstanding the trustworthiness measures employed.

Recommendations

Institutional Policy and Governance

- Develop and formally document a comprehensive

mental health policy specifying clear protocols for student referral, crisis response, confidentiality, and periodic service review.

- Establish a dedicated, adequately resourced campus mental health unit staffed by qualified mental health professionals in order to provide a safe environment for students.

- Ensure that referral partnerships are formally documented, communicated in writing to students at enrolment, and independently accessible without requiring a lecturer or matron as intermediary.

Stigma Reduction and Cultural Engagement

- Design and implement targeted anti-stigma campaigns addressing interpersonal, cultural, and religious dimensions of stigma, engaging university chaplains and religious leaders as strategic partners.

- Train student leaders in mental health first aid to extend non-stigmatising peer support within the student community.

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