

Psychological First Aid: Five Year Retrospective (2011-2016)

Commissioned and supported by Church of Sweden
Peer reviewed by members of the Inter-Agency Standing Committee Reference
Group on Mental Health and Psychosocial Support in Emergency Settings



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Table of Contents

INTRODUCTION	4
Rationale and Purpose of the five-year PFA Retrospective	4
Purpose and Methodology of the Retrospective	5
Audience and Format for the Retrospective	5
CHAPTER 1. BACKGROUND AND DEVELOPMENT	8
Background	8
Development of the WHO Guidance	14
CHAPTER 2. ONLINE SURVEY RESULTS	18
Section 1. Demographics	19
Section 2. Experience with PFA Resources	24
Section 3. Experience with PFA Orientations and Trainings	32
Section 4. Perceptions of PFA	42
Section 5. Open-Ended Questions	52
CHAPTER 3. INTERVIEW FINDINGS AND CASE EXAMPLES	58
Interviewee Affiliations and Roles	58
Interface with PFA	58
Importance of PFA to Your Work	62
Main strengths of PFA Materials	69
Main Weaknesses of PFA Materials	70
Recommendations to Improve PFA Material	72
Potential Dangers of PFA	73
Priority Focus Areas for the Future	74
Thoughts on the Evidence Base for PFA	75
How the IASC MHPSS RG or PFA Guide Authors Could Improve Use of PFA	76
CHAPTER 4. LESSONS LEARNED AND FUTURE RECOMMENDATIONS	80
Overview	80
Specific Findings and Recommendations	81
Summary Recommendations	83
Conclusion	85
ANNEXES	
Annex A. Systematic Reviews of the Literature	88
Annex B. Invitation to the PFA Retrospective Survey	90
Annex C. Organisational Affiliations of Respondents	91
Annex D. Perception of the Term “PFA”	92

Introduction

“When terrible things happen, we want to reach out a helping hand to those who have been affected. Psychological First Aid is a humane, supportive and practical response to people suffering exposure to serious stressors and who may need support. It is an approach to help people recover by responding to their basic needs and showing them concern and care, in a way that respects their wishes, culture, dignity and capabilities.”

– Psychological First Aid Brief, World Health Organisation for World Mental Health Day 2016.

Psychological First Aid (PFA) has become a widely recognized and utilised frontline approach to mental health and psychosocial support (MHPSS) for affected people in emergencies over the last several years. This was influenced by recommendations in the consensus-based *Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergencies* (2007) and, in large part, by the publication of PFA guidance by the World Health Organisation and partners in 2011. The *PFA: Guide for Field Workers* (WHO, 2011) was developed in a 2-year collaborative process of international experts and practitioners working in various crisis contexts, and received endorsement by 24 UN and NGO agencies. Since then, a facilitation manual, over 20 translations to date and various adaptations (e.g., for Ebola virus disease outbreaks, for children) have been developed and disseminated. Various aid organisations orient staff and volunteers as standard practice in recent humanitarian emergencies, and PFA is increasingly applied in a variety of crisis contexts – from individual crisis events such as fire or interpersonal violence to mass events such as the Nepal earthquake or European refugee crisis.

That the PFA guidance has become so widely used in such a short time span is likely due to its accessibility. It is written in direct, simple language that is easily translated and adapted to different contexts. As part of the spectrum of MHPSS approaches in emergencies, PFA is easy for non-professional actors to understand and apply within their own work and daily life, and recommends

concrete skills that anyone can learn. Capacity building has extended to a wide variety of helpers – from health and mental health professionals, to firefighters, school counselors, staff in other humanitarian sectors and lay people in communities. One potential danger of its widespread use and acceptance is a misunderstanding about its place within the spectrum of MHPSS supports. For example, it has at times been used to represent all MHPSS interventions as a stand-alone approach, rather than being a component of a spectrum of approaches and multi-layered supports. Other pitfalls include inappropriate adaptations that attempt to extend PFA to counseling interventions beyond the scope of its intended use.

RATIONALE AND PURPOSE OF THE FIVE-YEAR PFA RETROSPECTIVE

Given the interest in and widespread use of PFA since the launch of the WHO guidance, the IASC Reference Group on MHPSS in Emergencies has continually reflected on how PFA is understood and applied in various contexts. A five-year retrospective of its application was proposed by the Reference Group in 2015 and taken up by member organisations Church of Sweden and World Vision International in 2016.

This retrospective has been conducted to explore how PFA has been understood and adapted by different stakeholders, including how it has been framed within the

evolving field of MHPSS in emergencies. In recent years, the field of MHPSS in low-middle income countries and emergency responses has benefitted from a burgeoning evidence base and development of innovative MHPSS approaches. PFA plays an important role in these response strategies, and understanding the appropriate use of PFA in a multi-layered, integrated support system is essential. The retrospective also aimed to elucidate the myriad applications of PFA in different contexts and with various stakeholders over the five years since its launch, drawing lessons learned for improving future, frontline MHPSS response in emergencies.

PURPOSE AND METHODOLOGY OF THE RETROSPECTIVE

The PFA Retrospective provides a look back at the journey of the PFA Guide's development and application since its launch, drawing lessons learned about:

- Processes of translation and adaptation for different cultures and languages
- Applications in different types of crisis contexts (including misunderstandings of its use)
- Use by different types of helpers (first responders, humanitarian actors, lay people)
- Place of PFA in the overall scheme of MHPSS in emergencies
- Recommendations for the future

The retrospective has utilised several methodologies, including a desk review of existing peer-reviewed literature, PFA adaptations and publications, and agency reports about its application from years 2011 through 2016. An online survey was conducted to provide a snapshot of how PFA has been understood and applied around the world. Furthermore, interviews and case studies provide a more in-depth picture of the application of PFA from key stakeholders in specific socio-cultural and crisis contexts.

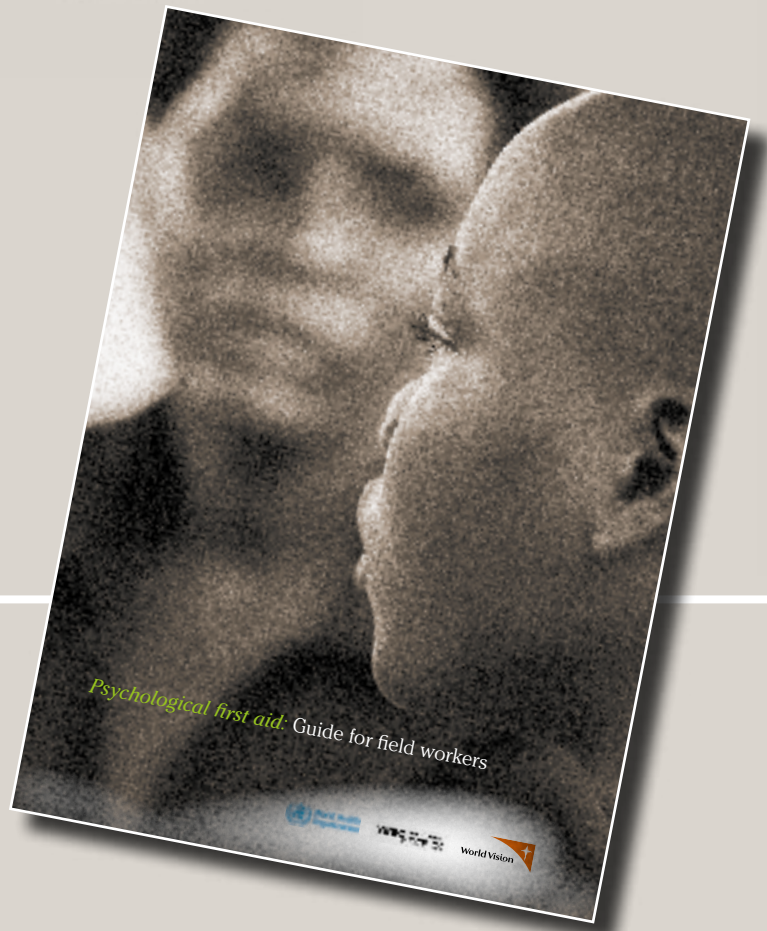
AUDIENCE AND FORMAT FOR THE RETROSPECTIVE

The PFA five-year retrospective is intended for field-level practitioners, frontline emergency responders and governmental and NGO stakeholders who provide various types of services and support to people affected by crisis events – not only those providing MHPSS services. PFA may be used by organisations as a frontline intervention or as a skill set to improve the work of responders in various sectors who interface with distressed people. It may also be used as an entry point to further MHPSS and related services (e.g., health and social services) over the course of response and recovery programming.

The retrospective is organized into the following chapters:

- Chapter 1. Background and applications
- Chapter 2. Online survey results
- Chapter 3. Interview findings and case studies
- Chapter 4. Lessons Learned and Future Recommendations

By clarifying the perceptions and applications of PFA by various individuals and organisations over the five years, this retrospective provides key lessons learned that can inform future PFA applications in ways that are most effective for the field and retain fidelity to the *Do No Harm* approach.



Chapter 1. Background and Development



Chapter 1. Background and Development

“Psychological first aid involves humane, supportive and practical help to fellow human beings who have suffered a serious crisis event.”

(WHO, 2011)¹

The need for evidence-informed, early psychosocial support following critical events has gained a growing recognition and interest in the last decades. Based on expert consensus, international agencies – including WHO, the Sphere Project, and the Inter-Agency Standing Committee (IASC) – recommend PFA as the frontline approach for helping people who have recently suffered a crisis event.^{2,3,4} But PFA is not a new concept. The term was originally coined at the end of World War II,⁵ and PFA has been written about and applied in various ways for decades as an approach to help affected people.⁶

This chapter covers the history of PFA, evidence and expert consensus that informs its use, the rationale for new guidance on PFA and the process of development of the WHO PFA model.

Background

HISTORY OF PFA

The first recorded mention of the term “Psychological First Aid” was in 1944 during the centenary meeting of the American Psychiatric Association (APA) in a paper later published in 1945 in the American Journal of Psychiatry.⁷ This early mention of PFA was in the context of a curriculum developed for the United States Merchant Marines during World War II that acknowledged the dangers of psychological distress at sea – “war nerves” – and aimed to help mitigate its impact in the short and long term through awareness, stress management and self and team care. In the 1950’s, the notion of PFA was expanded as a way for mental health practitioners to generally support acutely distressed individuals⁸ and to help affected people during disaster response. The 1954 APA monograph *PFA in Community Disasters*⁹ emphasized the importance for all disaster responders – not just mental health professionals – to be able to recognize common post-disaster distress reactions and to help affected people cope with stress:

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- 1 Psychological First Aid: Guide for Field Workers (2011). World Health Organisation (WHO), War Trauma Foundation and World Vision International. WHO: Geneva.
 - 2 Bisson JI, Lewis C., Systematic Review of Psychological First Aid, Commissioned by the World Health Organisation, 2009.
 - 3 The Sphere Project. Humanitarian Charter and Minimum Standards in Disaster Response. Geneva: The Sphere Project, 2011. <http://www.sphereproject.org>.
 - 4 Inter-Agency Standing Committee (IASC) IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC, 2007.
 - 5 Blain D, Hoch P, Ryan VG. A Course in Psychological First Aid and Prevention: A Preliminary Report. American Journal of Psychiatry.,1945, 101:629-634.
 - 6 Schultz J, Forbes D. Psychological First Aid: Rapid proliferation and the search for evidence. Disaster Health, 2013, 1:2, 1-10.
 - 7 Blain, Hoch and Ryan, 1945
 - 8 Thorne, 1952
 - 9 APA monograph, 1954

“...It is vital for all disaster workers to have some familiarity with common patterns of reaction to unusual emotional stress and strain. These workers must also know the fundamental principles of coping most effectively with disturbed people. Although [these suggestions have] been stimulated by the current needs for civil defense against possible enemy action... These principles are essential for those who are to help the victims of floods, fires, tornadoes and other natural catastrophes (APA, 1954, page 5).”¹⁰

The concept of PFA gained further attention among disaster mental health experts in the 1980s and 1990s. In the publication *When Disaster Strikes*, Beverly Raphael advocated for PFA and triage in the first hours after a disaster for at least “25% of the population...who may be suffering from the disaster syndrome”.¹¹ PFA was also important in the work of the Critical Incident Stress Management Foundation and the American Red Cross as they developed an integrated continuum of mental health care for disaster survivors¹². At this time in the early 1990s, “critical incident stress management”¹³ encompassed a range of psychosocial response components – another of which was critical incident stress debriefing (CISD) also known as psychological debriefing.

CISD is a semi-structured group intervention following a crisis event originally designed for use with professional emergency responders, but more widely applied with civilian disaster survivors as it gained increasingly popularity. However, debates emerged about its claim to benefit long-term recovery – including concern about worse outcomes for some people¹⁴. A Cochrane review in 2002¹⁵ unequivocally cautioned against its use:

“Psychological debriefing is either equivalent to, or worse than, control or educational interventions in preventing or reducing the severity of PTSD, depression, anxiety and general psychological morbidity. There is some suggestion that it may increase the risk of PTSD and depression. The routine use of single session debriefing given to non-selected trauma victims is not supported. No evidence has been found that this procedure is effective.”

PFA emerged as the ‘*do no harm*’ alternative by retaining elements of other models most likely to assist recovery, while avoiding potentially harmful elements such as a detailed review of the incident.¹⁶ Various other early psychosocial support models were developed after 9/11, but these do not necessarily represent the same concept of PFA as described by the WHO model. For example, “Mental Health First Aid” is “the help offered to a person developing a mental health problem, experiencing the worsening of an existing mental health problem or in a mental health crisis.”¹⁷ Training in mental health first aid focuses upon what the authors term *mental health literacy*¹⁸

10 Quoted in: The Johns Hopkins Guide to Psychological First Aid (). Everly, G.,

11 Raphael, 1986, page 257

12 google book

13 Everly and Mitchell, 1992

14 McNally RJ, Bryant RA, Ehlers A. Does early psychological intervention promote recovery from traumatic stress? *Psychol Sci Public Interest* 2003; 4:45-79

15 Rose SC, Bisson J, Churchill R, Wessely S. (2002) Psychological debriefing for preventing post traumatic stress disorder. *Cochrane Database of Systematic Reviews* 2002. Issue 2. Art. No.: CD000560. DOI: 10.1002/14651858.CD000560

16 Shultz J. and Forbes D. (2013) Psychological First Aid: Rapid proliferation and the search for evidence. *Disaster Health* 1:2, 1-10.

17 *Dignity in Mental Health: Psychological and Mental Health First Aid for All*. Report of the World Federation for Mental Health for World Mental Health Day, 10th Oct 2016. <http://wfmh.com/reports/2016-07%20WFMH%20DIGNITY%20IN%20MENTAL%20HEALTH.pdf>

18 Kitchener BA, Jorm AF (2002) Mental health first aid training for the public: evaluation of the effects of knowledge, attitudes and helping behaviour. *BMC Psychiatry*. 2:10

among family and community members in supporting people with mental disorders – whether or not they have recently experienced a crisis event.

It is important, therefore, that the distinction of PFA from other types of early psychosocial responses is understood, both in terms of implementation as well as in evaluating efficacy. In particular, PFA is not a clinical intervention, nor is it delivered primarily or solely by mental health professionals (although they may use the approach within the course of their work). Therefore, clinical study models currently in use to evaluate therapeutic interventions are likely not appropriate for studying the impact of PFA.¹⁹

EVIDENCE AND PROFESSIONAL CONSENSUS INFORMING PFA

With PFA's increasing popularity and the development of various models, there has been a trend to more clearly articulate the PFA approach and its components. Behavioral science research in post-disaster settings provides the empirical evidence basis for PFA.²⁰ This includes research on factors influencing 1) individual and community risk and resilience, and 2) the restoration of social and behavioral functioning.^{21 22 23} For example, a review by Bisson and Lewis (2009) found that certain factors are associated with increased rates of PTSD following exposure to traumatic events – in particular, perceived poor social support and feeling out of touch with reality (what is termed “dissociation”). Linking people with social support is a key element of PFA, and guidance is also offered in helping people to feel calm and grounded if they seem out of touch with reality, or to keep them safe until they can be referred to higher level support.

In addition, PFA models are generally underpinned by five intervention principles that were identified by disaster mental health experts in 2004 and articulated by Stephen Hobfoll and colleagues in 2007.²⁴ According to the authors, these five principles “have empirical support to guide evolving intervention practices and programs following disaster and mass violence...[and] should be contained within intervention and prevention efforts at the early to mid-term stages”. They include promoting: 1) a sense of safety, 2) calming, 3) sense of self and community efficacy, 4) connectedness and 5) hope. PFA enjoys broad professional consensus as one such early social care response promoting these five principles. It is the approach recommended by several international expert groups – including WHO²⁵, the

19 Schafer A, Snider L, Sammour R. A reflective learning report about the implementation and impacts of Psychological First Aid (PFA) in Gaza. *Disaster Health* 3:1-13, 2016. DOI: 10.1080/21665044.2015.1110292

20 Snider, L., Chehil, S, Walker, D. “Psychological First Aid.” In *Mental Health and Psychosocial Support in Disaster Situations in the Caribbean: Core Knowledge for Emergency Preparedness and Response*. Pan American Health Organisation/WHO: Washington, D.C. (2012).

21 The Sphere Project (2011)

22 Ruzek JI, Brymer MJ, Jacobs AJ, Layne CM, Vernberg E, Watson PJ. (2007) Psychological first aid. *Journal of Mental Health Counselling*. 29:17–49.

23 Cochrane Database of Systematic Reviews (2002)

24 Hobfoll SE, Watson PJ, Bell CC, Bryant RA, Brymer MJ, Friedman MJ, Friedman M, Gersons BPR, de Jong, JT Layne CM, et al. (2007) Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence. *Psychiatry*, 70:283-315; PMID:18181708. <http://dx.doi.org/10.1521/psyc.2007.70.4.283>

25 World Health Organisation. mhGAP intervention guide for mental health, neurological and substance use disorders in non-specialized health settings. Geneva: WHO Mental Health Gap Action Programme, 2010. Available at: http://www.who.int/mental_health/mhgap.

Sphere Project²⁶, the TENTS project²⁷, NATO²⁸, and the Inter-Agency Standing Committee on Mental Health and Psychosocial Support in Emergencies.²⁹ Examples from various expert guidelines that support the usefulness of PFA are listed in the table below:

Table 1. Expert Consensus Guidelines Supporting PFA

Consensus Group	Findings
TENTS Guidelines	TENTS Guidelines recommend social care responses following emergencies that promote a sense of safety, self- and community-efficacy and empowerment, connectedness, calm and hope. TENTS Delphi study found strong consensus for provision of general support, access to social support, physical and psychological support.
NATO Guidelines	NATO Guidelines promote PFA as part of psychosocial emergency plans because “the abilities of people to accept and use social support and the availability of it are two of the key features of resilience.”
SPHERE Guidelines and IASC Guidelines for MH-PSS in Emergency Settings	IASC and Sphere Guidelines recommend that PFA is made available to acutely distressed persons following extreme events and that some forms of psychological support should be easily taught to and provided by lay persons.

SYSTEMATIC REVIEW FINDINGS

The “evidence” for PFA is a topic of much debate. The broad expert consensus outlined above describes PFA as “evidence-informed”. In addition, a few systematic reviews of the literature have been conducted to evaluate the “evidence for PFA’s effectiveness”. An overview of the findings of three systematic reviews are summarised in Annex A. The reviews ultimately come to the conclusion that there is “no direct evidence of PFA’s effectiveness” measured in terms of impact for beneficiaries or clinical effectiveness. However, the findings point to evidence for the validity, feasibility and usefulness of PFA when appropriately applied in crisis contexts.

The authors of these reviews offer various explanations for the challenges in documenting direct evidence of PFA. Firstly, “PFA” is a blanket term that has been used to describe a range of approaches – there is really no uniform definition in the field. Different models exist and, although they generally all relate to the five Hobfoll principles, they emphasize different components and areas of focus and some may be more geared toward professional helpers. Achieving a uniform definition

26 Sphere Project. Humanitarian charter and minimum standards in disaster response. Geneva: The Sphere Project, 2011. Available at: <http://www.sphereproject.org>.

27 TENTS Project Partners. The TENTS guidelines for psychosocial care following disasters and major incidents. 2009. Available at: <http://www.tentsproject.eu>.

28 North Atlantic Treaty Organisation (NATO). Annex 1 to EAPC(JMC)N(2008)0038 Psychosocial care for people affected by disasters and major incidents: a model for designing, delivering and managing psychosocial services for people involved in major incidents, conflict, disasters and terrorism. Brussels: NATO (2009).

29 Inter-Agency Standing Committee (IASC). IASC guidelines on mental health and psychosocial support in emergency settings. Geneva: IASC, 2007. Available at: http://www.who.int/mental_health_psychosocial_june_2007.pdf.

and approach across the different models is unlikely, and separating out components (e.g., making contact, listening) to test the effectiveness of each may be impractical in practice.³⁰

Secondly, unlike clinical interventions for specific psychological disorders that have been the subject of randomised controlled trials, PFA is a psychosocial approach flexible to the needs of the person being helped. This flexibility means that one person offered PFA may only require a brief, supportive interaction that helps them to feel calm and provides information on specific services, while another person may need and receive much more extensive, focused support. This could include focused support to an unaccompanied child in ensuring they are safe, providing basic comfort and linking them with a trustworthy child protection agency; or perhaps support to an adult who is severely distressed and requires the helper to spend more time listening, helping them to feel calm and cope with problems, and ensuring they are linked directly with loved ones and/or higher level mental health or social support services. Furthermore, PFA may be offered in varied ways depending upon the professional skills of the provider. A provider with an MHPSS background may be able to offer more advanced psychosocial support or psychological care during the interaction.

Thirdly, not only do the goals of PFA tend to be vague, but the nature of interactions in post-crisis settings also present myriad challenges for evaluation³¹. Questions such as how to document what is delivered to whom, how to find adequate control or comparison groups, and how to follow-up with mobile populations in unstable settings pose serious methodological hurdles. Schultz and Forbes (2013) suggest trying pre-post designs in places susceptible to disasters or where there could be advance warning of crisis events, or using comparison groups of disaster-affected communities that have not received PFA. However, these suggestions are also based on the idea that PFA is designed as a discrete intervention. Given its flexibility, another view is that PFA can be considered an “intervention” when offered specifically by helpers who have a dedicated role in MHPSS for emergency-affected people. Or it can be considered a “skill set” that promotes safety, coping, social support, practical problem-solving and service connection by anyone in a position to offer help and support. It has even been suggested that it may be conceptualized as “documenting and operationalizing good common sense – those activities that sensible, caring human beings would do for each other anyway.”³²

This is perhaps one reason that PFA orientation is popular not only among MHPSS personnel, but also among firefighters, police officers, teachers, community members and humanitarian response staff working in various sectors. The guidance is simply written, with lists of do’s and don’ts that provide lay people with immediate, clear direction on how best to help without causing further harm. Orientations also offer the opportunity for practicing good communication and appropriate helping skills in different crisis scenarios. An emergency responder who previously felt intimidated by dealing with someone in emotional distress and therefore may have avoided the interaction often feels more confident to interact with distressed people after a PFA orientation. For example, firefighters who were part of a large-scale PFA capacity building initiative in the Dominican Republic reported that PFA “changes how we do our jobs.”³³

30 Schultz and Forbes (2013), page 6.

31 Schultz and Forbes (2013), page 4.

32 Forbes D, Lewis V, Varker T, Phelps A, O’Donnell M, Wade DJ, Ruzek JI, Watson P, Bryant RA, Creamer M. (2009) Psychological first aid following trauma: implementation and evaluation framework for high-risk organisations. *Psychiatry*; 74:224-39; PMID:21916629. Quoted in Schultz and Forbes (2013).

33 Personal communication, Devora Kestel, PAHO, 2012.

Approaches to broadening the evidence base may require a shift in how PFA is conceptualized (e.g., common sense skills) and in the outcomes selected for measurement. For example, a qualitative evaluation of a unique “whole of family” approach to PFA in Gaza found positive effects on the 5 elements as expected, but the authors also advocate for expanding attention to a range of psychosocial outcomes, such as strengthening healthy, functional family and community relationships. They also note that PFA may serve as “a ‘key to the door’ or gateway for establishing what additional psychosocial skills, knowledge, care and access to services are necessary in a given context”.³⁴ In the Ebola crisis, PFA orientations opened the door for health workers, burial teams and community outreach workers to express the severe stress they were experiencing and to intensify the focus on staff care strategies.³⁵

Thus, in addition to direct impacts of PFA on individual beneficiaries, useful areas of focus for future evaluation strategies could include:

- Impacts on systems: For example, in what ways do PFA orientations change awareness of the importance of MHPSS services in general for beneficiaries among different stakeholders (governmental policy makers, international donors, managers of aid organisations)? How does it influence the development of coordinated MHPSS and protection referral systems? How does it impact stigma around mental health issues and potentially change staff care policies and strategies?
- Impacts on participants of PFA orientations: How does receiving a PFA orientation change participants’ view of psychological distress in beneficiaries or themselves? How does it influence their approach to distressed people in their work and lives, and their sense of competence and confidence to offer support?
- Quality control in large-scale capacity building: Where PFA is rolled out broadly for national or organisational capacity building, how is fidelity to the model ensured in cascade training models? What kind and intensity of follow-up training or supervision is needed? What adaptations are necessary in the guidance for different socio-cultural and crisis contexts?

In summary, PFA enjoys broad professional consensus and can be appropriately considered to be “evidence-informed”. Various challenges exist to research on the effectiveness of PFA, beyond just the methodological challenges. Future efforts toward evaluating PFA must carefully consider, for example:

- what components or aspects of PFA should be measured;
- what outcomes are relevant to measure (etc., etc.) depending upon the PFA components provided to different individuals or within different systems of support;
- which target audience(s) should be included, such as beneficiaries, responders or trainees in PFA orientations; and
- the meta-level impacts on MHPSS systems.

³⁴ Schafer, Snider and Sammour (2016)

³⁵ Snider L and Valle C. Reaching out a helping hand during Ebola: Adaptation of the *Psychological First Aid* Guide. *Intervention Journal*, Vol. 13 (1): 85-87, 2015.

Development of the WHO Guidance

RATIONALE FOR NEW GUIDANCE

The IASC MHPSS Guidelines specifically state in their list of *Don'ts*: “Do not provide one-off, single-session psychological debriefing for people in the general population as an early intervention after exposure to conflict or natural disaster.” Rather, they recommend organising “access to a range of supports, including PFA, to people in acute distress after exposure to an extreme stressor.”³⁶ However, the IASC MHPSS Guidelines do not provide detailed guidance about how to offer PFA, and field practitioners began requesting more information and resources.³⁷

WHO and World Vision International responded to these requests in 2008 with an environmental scan to better understand the utility and accessibility of existing resources. Through an online survey of diverse international experts and practitioners, the scan revealed that few field practitioners knew of existing PFA resources. Those who were aware of existing resources found them to be difficult to translate and adapt to lower resourced settings. They felt the existing resources were geared more toward (mental health) professionals in their language and instruction, and that these resources assumed the existence of referral resources that simply were not available in many humanitarian settings. Across the board, respondents requested simple materials that could be easily translated into different languages, and applicable to diverse socio-cultural and crisis contexts. Another key finding of the scan was that many respondents did not have a clear idea of what “PFA” actually was. Simple and easily adaptable guidance was clearly needed.

PROCESS OF DEVELOPING THE WHO PFA GUIDE

In 2009, based upon the findings of the environmental scan, WHO, WVI and War Trauma Foundation began a joint project to develop PFA guidance. The project sought to review and gather the lessons and key elements of PFA from existing approaches – particularly those developed in or for low and middle-income settings – into a basic guide. In order to draw from diverse experience and perspectives, various stakeholders were engaged, such as humanitarian agency representatives, local community and staff impacted by or working in emergency contexts, and other international psychosocial experts from around the world. Existing literature and guidance documents were reviewed and compiled into an anthology³⁸ and included not only high profile PFA guidance developed by international experts, but also locally developed guidance from different crisis contexts. All of the existing guidance was valuable, but the direct and simple language and use of illustrations in locally developed resources from low- and middle-income settings were especially informative in drafting the WHO PFA guide.

A first draft of the PFA Guide was released in 2010 just as the Haiti earthquake response was being launched. Lessons from that pilot provided important feedback about how PFA would be used in practice in the immediate aftermath of a major crisis event in a low resource setting. For example, staff and volunteers responding to the earthquake could spare only two hours for orientation, and the lack of electricity and printing facilities meant that any materials provided needed to be simple and brief. Together with reviews of an initial framework that comprised five elements for PFA, it was clear that revisions to simplify and make the approach more concise and concrete were needed. Also, understanding that PFA

36 IASC Guidelines for MHPSS in Emergencies (2007), page 15.

37 Personal communication, Mark van Ommeren, WHO 2009.

38 PFA Anthology of Resources can be accessed at: <http://mhps.net/resource/anthology-of-resources-wvi-wtf/>

orientation needed to be delivered in just half a day, the pilot further informed the development of the subsequent PFA facilitation manual. Importantly, the Haiti pilot also demonstrated the value of PFA to frontline responders, who found even a two-hour orientation in the early response phases of the emergency useful to their work and their own awareness of self and team care issues.³⁹

Table 3. Timeline of development of the PFA Guide for Field Workers

2008	2009	2010	2011	2012	2013	2014
Environmental scan is conducted to determine the usefulness and accessibility of existing PFA resources	WHO, WVI and WTF launch a joint project of development of PFA Guidance for low and middle income settings. An anthology of resources is compiled and international stakeholders engaged	Draft PFA guide piloted during the Haiti earthquake response. Feedback from the pilot informs revisions	Second draft of reviewed by 60 international stakeholders, the IASC MHPSS RG, child protection experts and plain English. It is illustrated and launched on World Humanitarian Day	Multiple language versions published; Translation guidance developed by WHO	PFA facilitation manual is launched	Adaptation of the PFA Guide and Facilitation Manual for the Ebola Virus Disease outbreak is launched

The *Psychological First Aid: Guide for Field Workers* was launched in August 2011 by the World Health Organisation (WHO) and partners. Developed over a two-year collaborative process, the WHO PFA guide was reviewed by 60 international peer reviewers, reviewed by the IASC MHPSS Reference Group⁴⁰ and endorsed by 24 UN and NGO agencies. A subsequent Facilitation Manual (including power point slides) was released in 2013⁴¹. In response to the Ebola virus disease outbreak in West Africa in 2014-2015, the WHO PFA guide was officially adapted to fit the particular needs of helpers working in the crisis, and included an adapted facilitation manual.

The WHO PFA guide has been translated into over twenty languages (some translations also exist for the facilitation manual and adapted Ebola PFA materials). Using these materials as a basis, PFA has been rolled out in various humanitarian emergencies by governmental entities, UN and NGO actors. Capacity building initiatives have also been undertaken in various parts of the world (e.g., Latin America and the Caribbean, Southeast Asia, Middle East, Japan) by consortia of regional actors and by governments. Furthermore, various organisations have participated in capacity building for their own staff, including PFA orientations for first responders, humanitarian teams representing various sectors, and staff care personnel and managers, and PFA training-of-trainers (ToT).

39 Schafer, A., Snider, L., Van Ommeren, M. Psychological first aid pilot: Haiti emergency response. *Intervention Journal* (2010), Volume 8, Number 3, Pages 245 – 254.

40 Inter-Agency Standing Committee Reference Group for Mental Health and Psychosocial Support in Emergencies.

41 Psychological first aid: Facilitator's manual for orienting field workers (2013). World Health Organisation, War Trauma Foundation and World Vision International. WHO: Geneva.

Chapter 2. Online Survey Results



Chapter 2. Online Survey Results

This chapter provides an overview of the findings of the online survey. It was created in Survey Monkey and disseminated widely through various networks, including the IASC MHPSS Reference Group mail outs, MHPSS.net postings, twitter and LinkedIn, as well as cascade dissemination through organisations and networks. (See Annex B for the invitation to the survey.) The survey remained open from August 29th to October 20th, 2017.

The survey consisted of four sections:

- Section 1 – Information about you and your organisation
- Section 2 – Experience with PFA resources
- Section 3 – Experience with PFA orientation and training
- Section 4 – Perceptions of PFA

A variety of question formats were utilised: multiple choice, scaled responses, rank order, and open questions for qualitative responses. Although demographic data was requested, name and organisation were optional responses, and participants were advised that no identifying details about individual respondents or their organisations would be published without their permission. Participants could also contact the consultant for a follow-on interview or to provide further input related to the survey or the retrospective study itself.

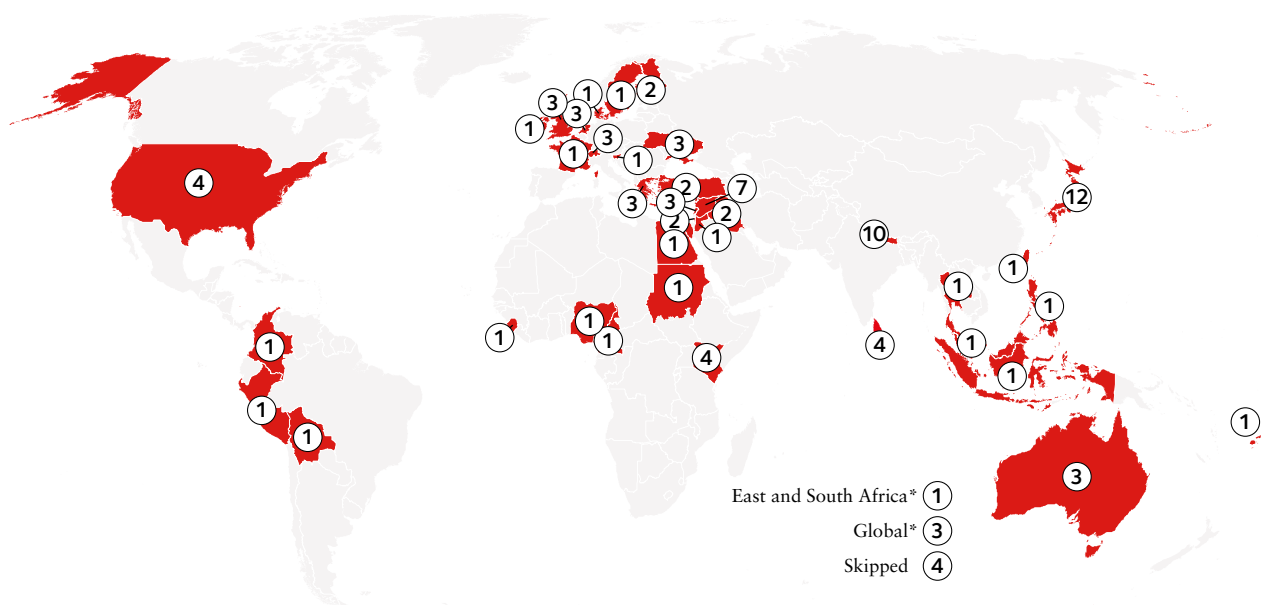
Survey results are summarised below.



Section 1. Demographics

COUNTRY/REGIONS

A total of 105 respondents took the survey⁴², hailing from 37 countries, as well as 1 respondent indicating the region of east and south Africa and 3 respondents indicating “global”. Countries and regions represented are detailed below.



* These respondents were not more specific

Japan, Nepal and Syria were selected by the most respondents, likely representative of the large-scale PFA capacity building efforts in Japan (detailed elsewhere in this report), as well as engagement of the MHPSS actors in emergencies in Nepal and Syria. Diverse countries and regions are represented, including both higher and lower income settings. However, as the survey was only administered in English, this could have limited its reach to non-English speaking stakeholders.

42 Note that not all respondents answered every survey question, so the N for some questions is lower. This is indicated where applicable in this report.

ORGANISATIONAL AFFILIATION

Organisational affiliations described by the respondents included a wide range of international and local NGOs, UN agencies, IFRC, universities, national governmental organisations and independent consultants. Four respondents listed two organisational affiliations (e.g., a university and NGO affiliation). Each affiliation is listed separately in the table in Annex C.

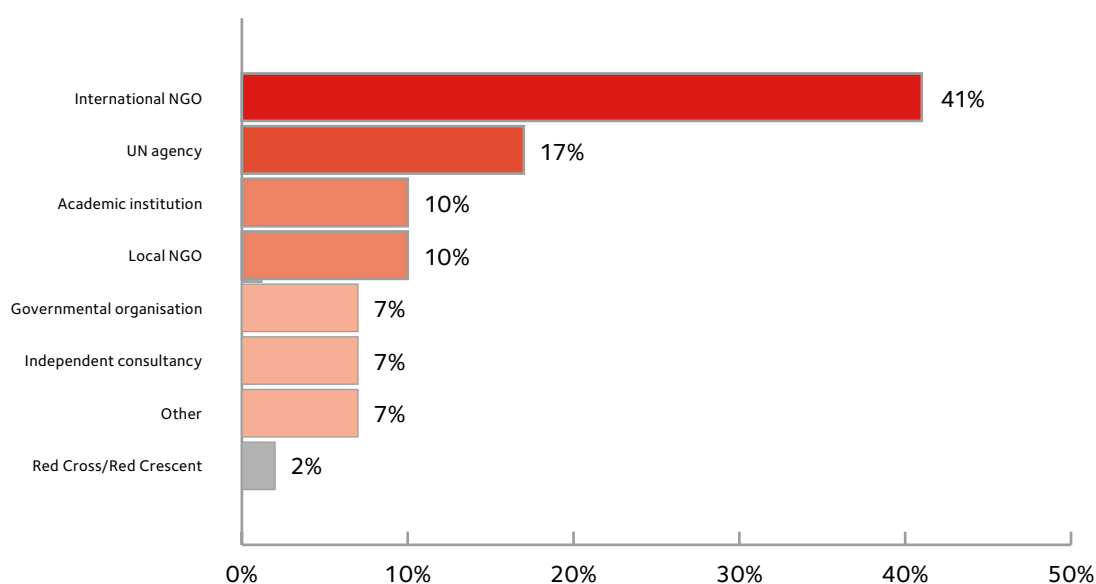
Organisations most highly represented in the survey include:

- International Organisation for Migration, 11 respondents
- International Medical Corps, 11 respondents
- Save the Children, 10 respondents
- World Health Organisation, 7 respondents

TYPE OF ORGANISATION

Respondents were asked to select one response that best describes their organisations. The majority (41%) work in international NGOs. Other organisations significantly represented include UN agencies (17%), various academic institutions (10%), and local NGOs (10%).

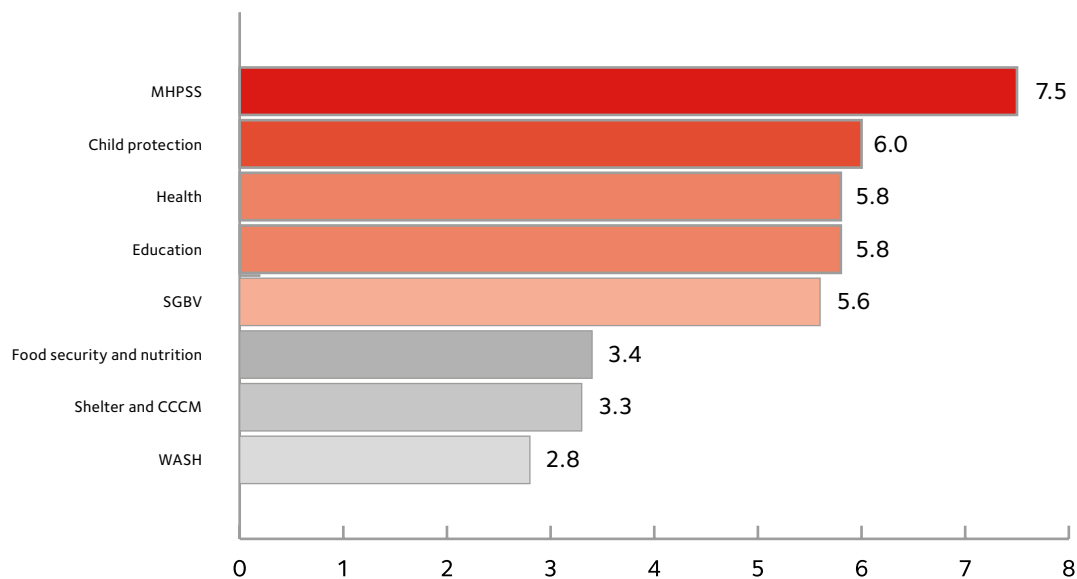
Type of Organisation: please select the response that best describes your organisation.



THEME/SECTOR

Participants were asked in which theme/sector(s) they primarily work, ranking their primary theme/sector highest and others in decreasing order. (Overall results per sector are detailed in the figure below.) Although the majority of respondents worked primarily in MHPSS, respondents indicated that they work across a variety of humanitarian sectors: 91 respondents (87%) ranked MHPSS within their top three choices; however, 10% of respondents indicated that MHPSS was “not applicable” to them. The next highest theme/sector selected by respondents was child protection, with 14 respondents (13%) ranking this sector as primary and 22 respondents (21%) as secondary. Overall, 55 respondents (52%) ranked child protection within their top three choices.

In which theme/sector(s) do you primarily work?



Health, education and SGBV (sexual and gender based violence) were nearly equally represented as the next highest themes/sectors (see table below).

Theme/Sector	Ranked in top 3	Ranked in top 5	N/A
Health	43 respondents (41%)	75 respondents (71%)	26 respondents (25%)
Education	40 respondents (38%)	67 respondents (64%)	35 respondents (33%)
SGBV	47 respondents (45%)	72 respondents (69%)	30 respondents (29%)

Other humanitarian sectors - food security and nutrition; shelter and camp coordination and camp management (CCCM); and water, sanitation and hygiene (WASH) – were also ranked by about a third of respondents, but were ranked lower overall than the other sectors described above.

Theme/Sector	Ranked 5-6	Ranked 6-7	N/A
Food security and nutrition	22 respondents (21%)	9 respondents (9%)	68 respondents (65%)
Shelter and CCCM ⁱ	15 respondents (14%)	12 respondents (11%)	70 respondents (67%)
WASH ⁱⁱⁱ	12 respondents (11%)	20 respondents (19%)	66 respondents (63%)

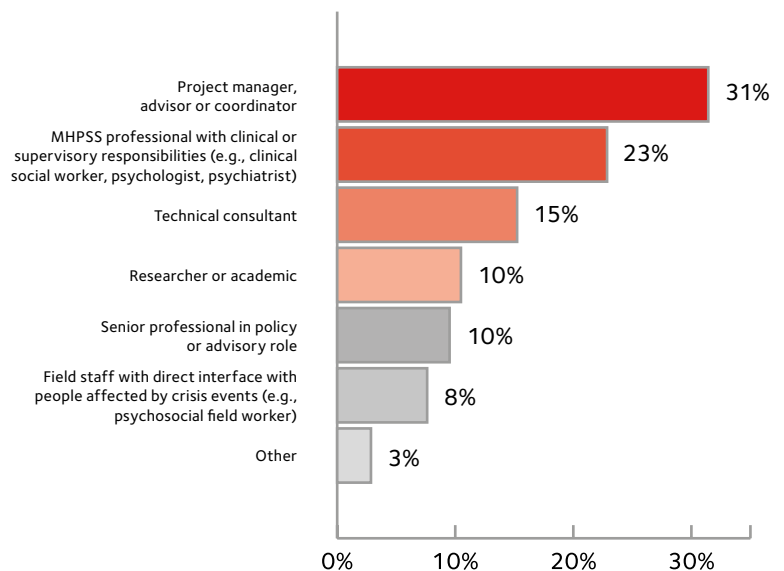
ⁱ camp coordination and camp management

ⁱⁱⁱ water, sanitation and hygiene

WORK ROLE

Participants were asked to select the response that best reflects their **primary** work role. The majority (31%) selected their primary role as project manager, advisor or coordinator. Twenty-three percent (23%) of respondents worked as MHPSS professionals either with clinical or supervisory responsibilities. “Technical consultant” was selected by 15% of respondents; “researcher or academic” by 11% and “senior professional in policy or advisory role” by 10%. Only 8 respondents (8%) selected the response “field staff with direct interface with people affected by crisis events (e.g., psychosocial field worker)”.

Your Work Role



DEMOGRAPHICS SUMMARY

The response rate was fairly low at 105 respondents, given the popularity of PFA and the various means of global dissemination used to advertise the survey. In addition, only certain questions were compulsory, and some respondents skipped questions resulting in a lower response rate for specific questions in the survey.

Despite the relatively small numbers, respondents were a representative group in terms of geographic spread, a variety of organisational affiliations (primarily iNGOs, but also including UN agencies, academic institutions, governmental entities, consultants and Red Cross/Red Crescent Societies), and across themes/sectors. Although MHPSS was most highly selected as the primary theme/sector in which participants work, the diversity of sectors represented may point to the integration and/or mainstreaming of PFA (and perhaps MHPSS in general) across sectors, and the usefulness of PFA to a range of actors. In terms of work role, the findings suggest that the survey results are more reflective of senior and programmatic management staff than field workers at the frontline.

Section 2. Experience with PFA Resources

FAMILIARITY WITH AND USE OF PFA RESOURCES

Participants were asked to rate their familiarity with and use of PFA resources published by WHO and partners, as well as the PFA Training Manual for Child Practitioners (an adaptation of the PFA Guide published by Save the Children, 2013) and other PFA resources published by entities other than WHO or Save the Children. (See charts below for summary data.)

Nearly all respondents (N=94) were familiar – 85% being very familiar – with the WHO PFA guide (only one respondent was not familiar with the guide). Most respondents (95%) used the resource, with 59% having used it often. A majority respondents (93%) also reported being familiar with the accompanying facilitation manual, although fewer reported being very familiar (54%) with this resource. It was also used less often than the WHO PFA Guide itself, and 20% of respondents reported that they have never used this resource.

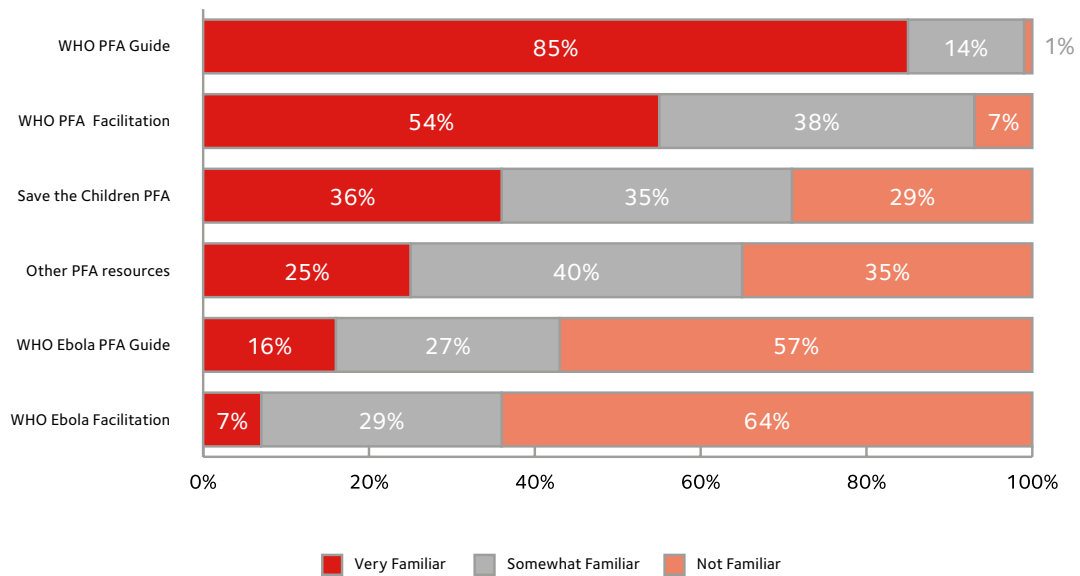
The Save the Children PFA resource was familiar to just over 70% of respondents, with 36% being very familiar with this resource. Half of respondents used the resource often or sometimes.

Similarly, 65% of respondents were familiar with PFA resources published by entities other than WHO or Save the Children, although fewer respondents (25%) reported being very familiar with other resources and over 1/3 of respondents (35%) were unfamiliar with other resources. Just over half of respondents used other resources, with 15% having used them often and 37% having used them sometimes. Other PFA resources mentioned by respondents in the comments section included:

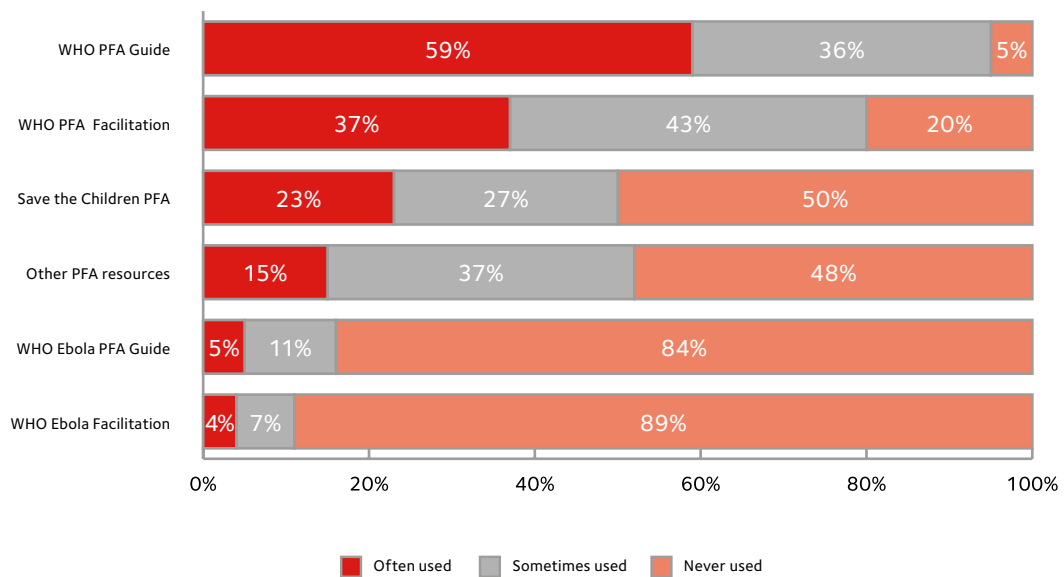
- PFA materials published by the International Federation of Red Cross/Red Crescent Societies (IFRC) Psychosocial Reference Centre, Johns Hopkins University (including an online course), the U.S. National Child Traumatic Stress Network (NCTSN) and National Center for PTSD (NCPTSD), and Save the Children;
- Other PFA materials published in specific countries (e.g., Japan, Nepal);
- Adaptations of the WHO PFA materials, such as that developed by the government of Sierra Leone during the Ebola crisis;
- IASC materials developed for health and CCCM as well as the GBVIMS (gender-based violence incident management system) resources.

Respondents were least familiar with the WHO PFA resources adapted for the Ebola crisis. Nearly 60% were unfamiliar with the Ebola PA guide and 64% were unfamiliar with its accompanying facilitation manual. This is not surprising, as the Ebola adaptation of materials are probably only familiar to those respondents who were involved in that specific crisis response. Most respondents have not used the Ebola PFA resources.

My familiarity with this resource



My use of this resource

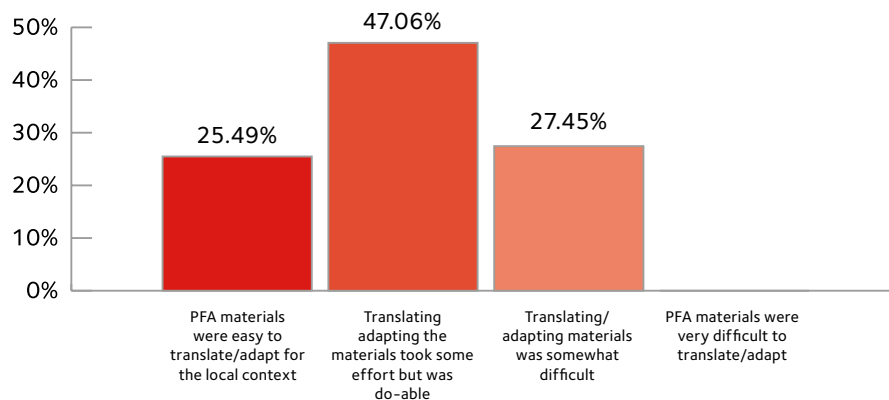


LANGUAGE TRANSLATIONS OF PFA RESOURCES

The majority of respondents (80%, N=94) have used PFA resources in a language other than English, with 44% using a translated resource often, and 31% sometimes. Nearly all of those who have used a PFA resource in a language other than English report that this has been important to their work or the work of their colleagues, with 88% reporting the language translation as “very important”.

Over half of respondents (55%) reported having been involved with translation and/or adaptation of PFA materials to a local language/culture. Those respondents (N=51) were then asked how easy or difficult it was to adapt or translate the materials with four response categories: very easy, somewhat easy, somewhat difficult, and very difficult. (See responses in the chart below.)

How easy or difficult was your experience in translating/adapting the materials?



No respondents found it very difficult to adapt or translate the materials, and the majority (47%) found it somewhat easy. The remainder were nearly equally divided in finding it very easy or somewhat difficult.

Nearly half (45%) of people who responded to this question provided comments:

- Several mentioned the ease of translation/adaptation, for example: “PFA materials were developed paying attention to various cultures, and that made our translation process very smooth. Thank you!”
- One third of comments mentioned difficulty translating specific terms: “Some of the words and terms used are difficult to translate, even how to describe ‘psychological first aid’” and “Sometimes, explanation of concepts was needed to capture the meaning”.
- One respondent noted that they did not translate the whole material into the local language, but “[we] utilised the parts that we found most useful regarding our work” and another comment describes translation as an ongoing process.

- Other comments highlighted challenges in “incorporating cultural practice and sociological issues of the particular community and individual.” Another respondent noted, “It is very [important? difficult?] for me to consider the culture differences; how we should talk, how we should act and how we should cope.”

AWARENESS AND USE OF ONLINE PFA RESOURCES

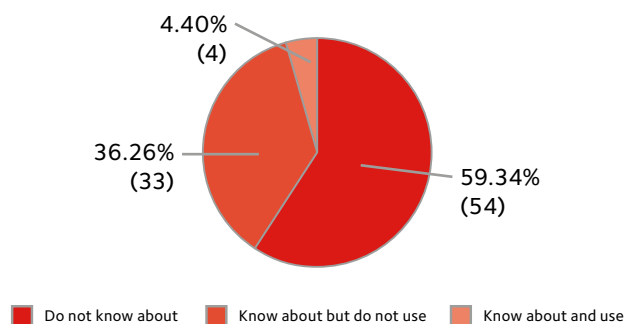
ONLINE PFA E-LEARNING COURSES

Online PFA e-learning courses have been accessible on the Plan International website since 2015, one based upon the PFA Guide and the other based upon the PFA adaptation for the Ebola crisis (the latter course is available in both English and French). These courses are password protected, but access was granted for anyone who requested it, and organisational passwords were offered to ensure accessibility. No organisations requested an organisational password.⁴³

The majority of respondents (59% out of N=91) did not know about these courses, and 36% reported they are aware of the courses but do not use them. Only 4 respondents (4% of those who answered this question) reported that they know about and use the online courses.

All 4 respondents who used the online courses felt they were useful, with 3 of the 4 finding them very useful. Of the respondents who did not know about the online PFA courses (N=54), nearly all felt online learning would be useful to themselves or their organisation, with 57% reporting this would be “very useful”.

Please indicate your awareness and use of the online courses hosted by Plan International: PFA and PFA for Ebola Virus Disease e-learning courses?



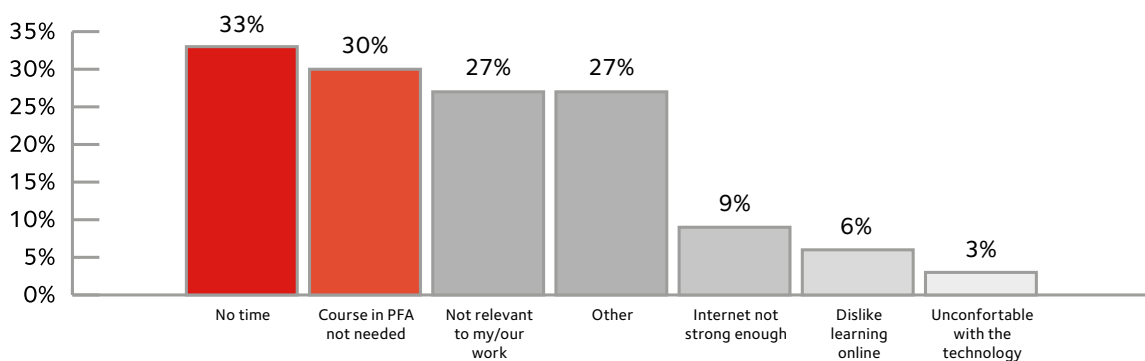
Thus, despite the very small percentage of respondents using the online courses, the courses were generally perceived as very useful for existing and potential users. Comments provided to this question highlight that online learning increases people’s accessibility to learn about PFA – especially those who cannot participate in an orientation. However, other comments emphasised again the importance of making e-learning courses available in the local language of users. In addition, several comments highlighted that although online learning would be useful, practical training in PFA is essential:

- “A large part of PFA is practical learning; so, while online learning is useful to review the concepts and steps of PFA, an actual training session will be needed for simulations, role plays, communication skills practice, which are essential to delivering PFA.”
- “I think [online learning] is useful to improve the knowledge, but not skills.”

⁴³ Personal communication, Marco Casavecchia, Plan International

Those respondents who knew about the online course(s), but do not use them (N=33) personally or within their organisation were asked their reasons (they could check all responses that apply). See responses in the table below:

If you know about the online course(s) but do not use either personally or within your organisation, please indicate your reason(s).



“No time” was the reason selected by most respondents, and nearly a similar percentage indicated that an online course was not necessary as they and their colleagues were already sufficiently familiar with PFA, or an online course was not relevant to their work. A similar percentage selected “other”, with 1/4 of comments mentioning language as a barrier to online learning, and 1/4 reporting the online courses were not relevant to them (in particular, the Ebola course was noted by those not involved in the Ebola response). Other comments noted the difficulty in prioritising online courses, and one comment noted using a different online course developed by the NCTSN.

Nearly 10% of respondents reported their internet connection wasn’t strong enough for online learning, but only 2 of the 33 respondents reported that they dislike online learning and only one felt uncomfortable with the technology.

MHPSS.NET PFA TRAINING AND ADAPTATION GROUP

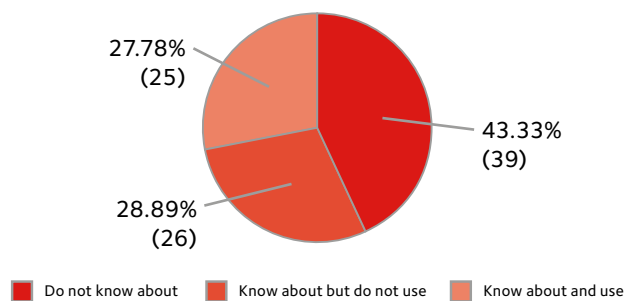
Respondents were also asked about their awareness and use of the online PFA Training and Adaptation Group on the MHPSS.net website (see screen shot of the web interface to the right). The group was established in 2011 and currently has 220 members, 64 posted resources, and 4 subgroups. The four subgroups are moderated voluntarily by local hosts in Japan, Sri Lanka, Saudi Arabia and Taiwan, respectively, and were formed in order for members to share information and resources relevant to their language and culture.



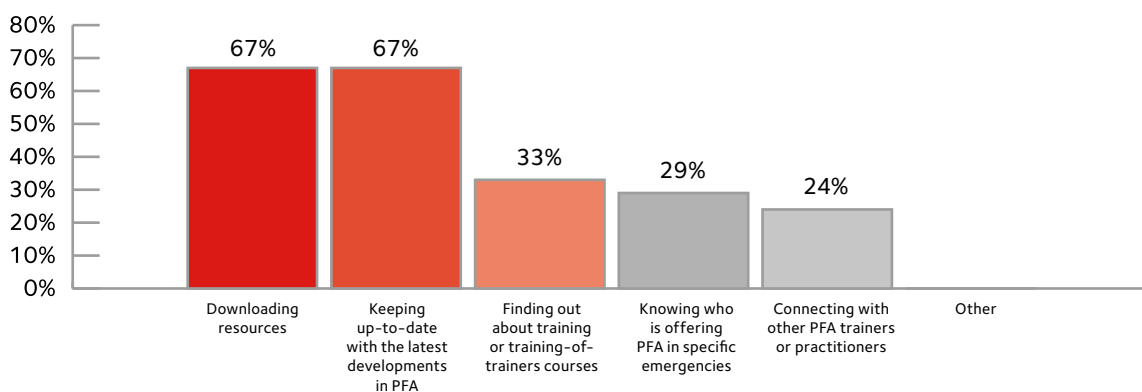
Fifty-seven percent (N=90) of respondents knew about the online group. Of those who knew about the group, half used it and half did not. The other 43% of respondents reported they did not know about the group.

Of those who use the online group (N=21), 1/3 each reported using it “every 2-3 months”, “every 4-6 months” or “once a year or less”. No respondents reported using the group more than once a month. Respondents were then asked to select from a list of reasons they use the group, checking all responses that apply. (See responses in the chart below.)

Please indicate your awareness and use of the online PFA Training and Adaptation Group on MHPSS.net.



If you know about the online course(s) but do not use either personally or within your organisation, please indicate your reason(s).



The most common reasons for having used the online group was for downloading resources and keeping up-to-date with the latest developments in PFA. One third of respondents also used it to find out about training or training-of-trainers (ToT) courses. Other respondents used the online group to know who is offering PFA in specific emergencies (29%) and to connect with other PFA trainers or practitioners (24%).

Nineteen of the 21 respondents who used the online group rated it as being either very useful (58%) or somewhat useful (42%), noting that “it gives the possibility to always be close to any change, improvement, etc.” However, another

respondent commented that the group goes through periods of inactivity and is not up-to-date on PFA activity in the field – perhaps partly due to a lack of engagement of group members.

Participants were further asked in what ways the online group could be improved or made more useful to their work. There were eleven responses to this question, several stating they were unsure how the group could be improved and one highlighting that the group is very useful and should be made “very accessible to newcomers”. But a few comments highlighted the need for sharing more of the translations and contextual adaptations of resources that people are using:

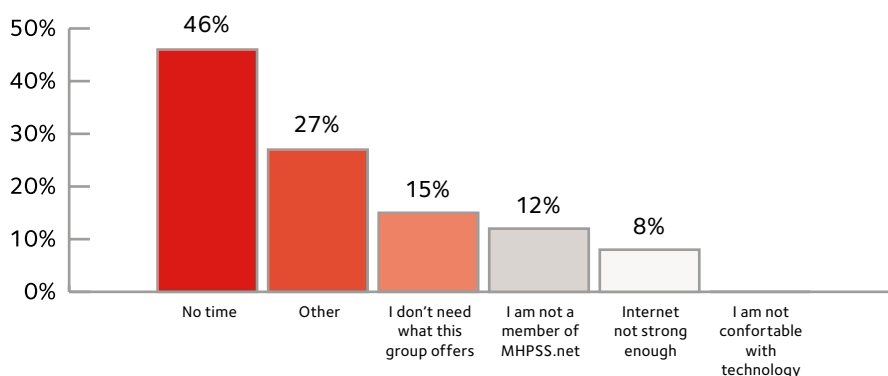
- “The resources I use are mostly the older original ones. It would be good if people uploaded more of their adaptations, or perhaps report on how they had adapted the PFA training in various contexts.”

Another comment provided specific recommendations for bolstering group activity, including:

- “1. [Make] a more lively forum - discussion topics that can be introduced to engage members, 2. targeted invites to members who are actively using PFA in the field, and 3. ensuring the group includes up-to-date information about PFA use, and adaptation in the field.”

Nearly half of respondents who knew about the online group, but did not use it (N=26) reported “no time” as a reason they do not use it (similar to the online learning). See the table below for other reasons selected (respondents could select all responses that apply).

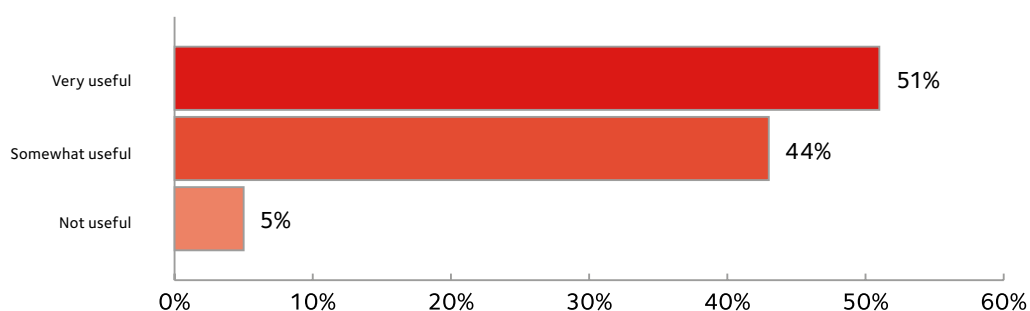
If you know about the online PFA Training and Adaptation Group on MHPSS.net but do not use it, please state your reasons(s).



For those who selected ‘other’, reasons given included a lack of internet access during emergencies, and lack of information in their local language (however, one respondent was unaware of the subgroup available in their language).

Respondents who did not know about the online PFA group (N=39) were asked how useful they felt an online group for sharing PFA resources, updates and connecting with other practitioners would be to them or their organisation. The majority felt an online group would be useful, with over half reporting it would be very useful. (See chart below.)

How useful do you feel an online group for sharing PFA resources, updates and connecting with other practitioners would be for you/your organization?



Several comments provided for this question again mentioned the importance of information in local languages in an online group. Comments also emphasised the usefulness of an online group for sharing experiences about PFA with others around the world, acquiring new knowledge and helping to design better tools in the future:

- “This would be good for national staff after they have completed a training or a ToT in order to keep up with PFA developments – especially if this was supported in other languages.”

However, another comment noted that although the idea of an online forum is useful, since the immediate disaster in which they worked had passed, they did not want to deal with “a flood of information, particularly in a foreign language.”

EXPERIENCE WITH PFA RESOURCES SUMMARY

In terms of familiarity with PFA resources, it is not surprising that most respondents were very familiar with and used the WHO PFA guide – but, in comparison, fewer were “very familiar” with the accompanying facilitation manual and fewer used it regularly, with 1 in 5 respondents saying they have never used it. This raises a question of ‘fidelity to the model’ in PFA orientations and can result in a wide variety of interpretations and approaches to PFA. The facilitation manual closely reflects the principles and guidance in the PFA guide and the way in which it was envisioned to be applied through simulations and case scenarios – therefore, greater emphasis and promotion of the facilitation materials may help to ensure a common approach to PFA as it was originally intended.

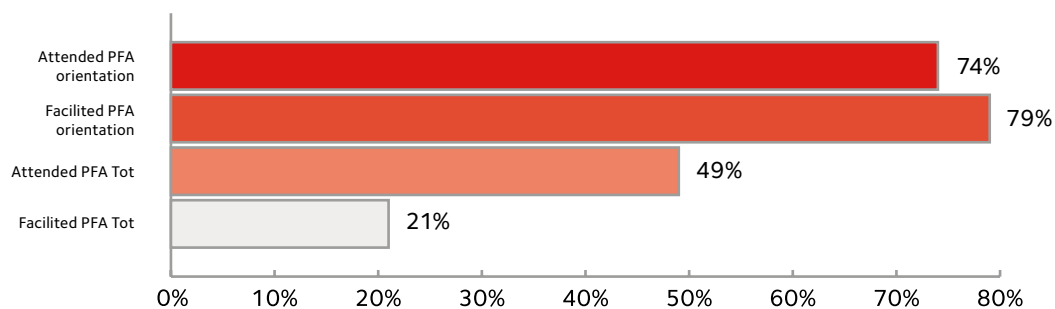
In addition to the original WHO PFA guide, the adaptation for child practitioners by Save the Children is a popular resource among respondents. There were also a variety of other resources that respondents use, although some of those mentioned are not actually PFA materials but more general MHPSS materials. This may indicate some confusion about what “PFA” actually is.

An important theme emerging from this part of the survey is the importance of having PFA materials in local languages – both the guidance as well as online resources and forums. Although few respondents were aware of the existence of online courses, they were very useful to those who did use them and desired by many respondents – with the caveat that practical skills training is necessary in addition to e-learning. Most respondents were both comfortable with and have access to technologies for online learning and sharing forums. A more active forum to connect practitioners and share adaptations of the material for varied contexts would be particularly valuable to respondents.

Section 3. Experience with PFA Orientations and Trainings

In this section, respondents were asked their experience with attending and/or facilitating PFA orientations and training-of-trainers (ToT). The following shows the percentage of respondents per each category (N=87):

Have you ever received an orientation in PFA?



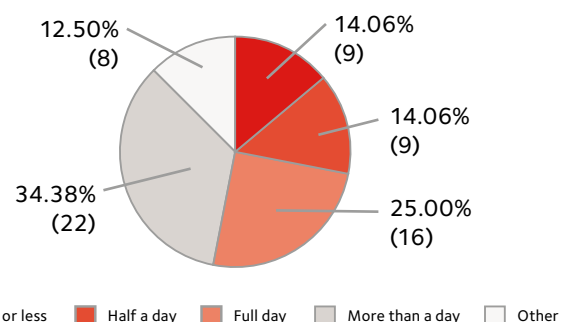
Respondents were then asked a series of questions about the orientation or ToT with which they had experience, including its purpose, length, teaching methodologies used, usefulness, and so on. Responses are detailed below for each category.

ATTENDED A PFA ORIENTATION

The 65 respondents who attended a PFA orientation described its purpose as, for example, orienting staff (e.g., health staff) and community volunteers for response in a specific emergency, scaling PFA for emergency preparedness in a country or region, as part of training of IASC Guidelines advocates, or becoming familiar with the approach in order to train others.

The majority of respondents (59%) attended a PFA orientation that was at least one day, and most of these reported the orientation was longer than one day. The remainder received orientations of 2 hours or less, or half a day, or “other” such as PFA incorporated into other MHPSS training courses. (See chart below.)

How long was the orientation?



Most respondents (78%) reported that the PFA orientation they attended utilised a combination of lecture, group discussion and practical exercises such as role play and simulation. The remainder utilised only lecture/powerpoint, lecture plus group discussion, or “other” such as online learning. The vast majority of respondents (85%) found the orientation very useful in building their confidence to offer PFA to others. In particular, one respondent commented that the opportunity to practice many simulations and role plays helped them to feel more psychologically and physically prepared for emergency response. Only 1 respondent did not find the orientation useful. Notably, the orientation this respondent attended was 2 hours or less, did not utilise any practical exercises, and the respondent noted that the facilitator was not actually familiar with PFA.

Many comments provided for this question emphasised the usefulness of the orientation for respondents’ profession and practice. Some comments also emphasised the importance of being involved in multiple trainings or in training others as a way to build their own confidence in PFA. For example,

- “It is quite useful. However, as a TOT-trained personnel, the best way to memorize contents is to conduct a training. If not, I forget the details.”

Another respondent noted the usefulness of having a culturally-informed, international trainer:

- “The resource person was Filipino and trained in USA. She could describe Asian as well as international practices.”

One respondent commented on the challenges of applying PFA in a protracted crisis situation, even after receiving a PFA orientation:

- “It was nice to have the training with colleagues, especially with role play and discussion, but again we did not discuss how to deal with the chronic violence context that we were facing. For example, a man told me he felt nothing when he is insulted every day at the checkpoint. In this case should I...push him to talk about real emotions that he may not want to talk about?”

This comment demonstrates the limitations of PFA and potential misconceptions about what PFA is and is not – and indicates the need for additional skills training to ensure PFA is not misapplied as a panacea for more complex MHPSS problems.

FACILITATED PFA ORIENTATIONS

Sixty-nine respondents facilitated PFA orientations, and described their purpose in various ways. An overview of their responses is provided below:

- Training MHPSS professionals, key health officials, community volunteers and others to assist in an immediate crisis response;
- Providing information and simple techniques for child caregivers, community volunteers (especially in the local language) and others to offer basic, psychosocial support to survivors, to support one another and to know when to refer;
- Preparedness efforts for a variety of emergency contexts (e.g., Kenya general election, natural disaster preparedness such as floods and landslides, refugee migration);
- Giving field workers skills and knowledge for both response and self-care;
- Mainstreaming PFA into other service sectors and promoting the “soft skills” (e.g., ambulance drivers, nurses, paramedical and rehabilitation staff)
- Encouraging humane, culturally appropriate and practical support to survivors that reduces further harm and promotes dignity and respect in the response.
- To raise awareness of and promote quality MHPSS programming;

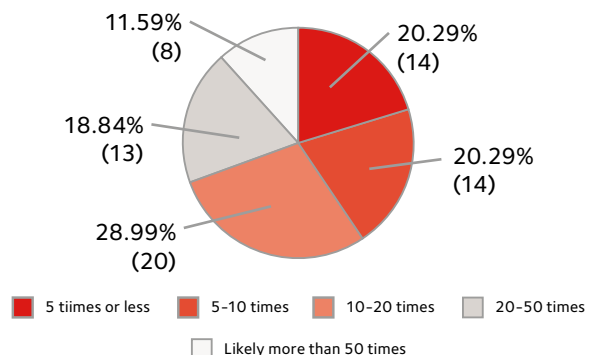
In addition, a few respondents described the purpose of their PFA orientation in terms of mental health aims: “to improve general mental health”, “to promote initial mental health response”, and “to orient health care workers about mental health and mental disorders.”

Respondents reported on the number of PFA orientations they had facilitated from 2011 to 2016. Although the majority of respondents (29%) gave PFA orientations 10-20 times, a fair percentage reported giving a large number of PFA orientations: 19% gave PFA orientations 20-50 times, and 12% gave likely over 50 orientations during the time frame. (See chart below.)

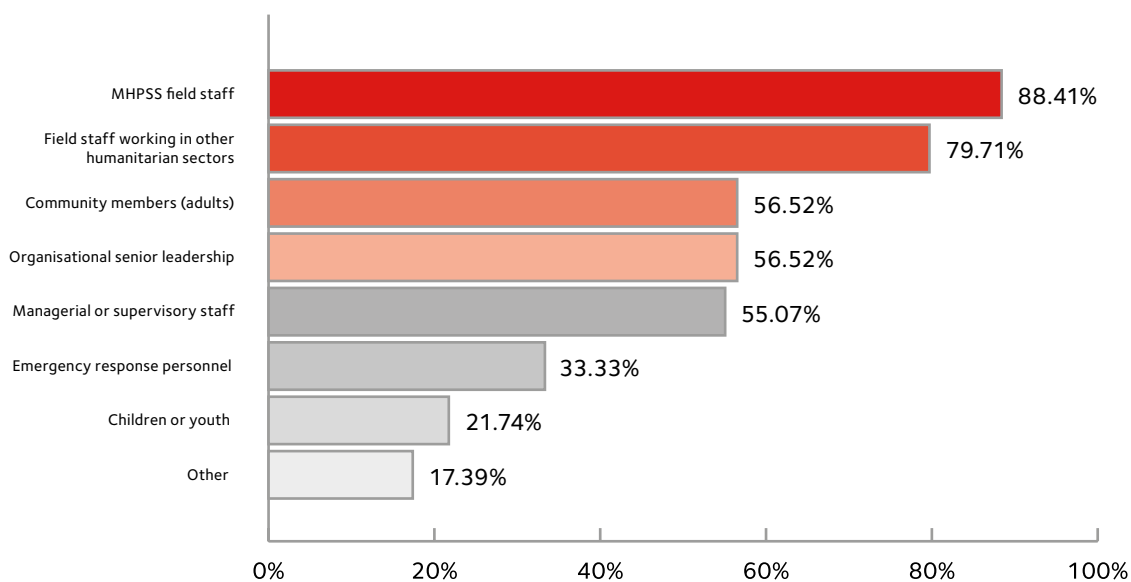
PFA facilitators noted that a wide variety of participants attended their orientations. (See chart below – respondents could select all categories that apply.) The majority of respondents oriented MHPSS field staff (88%), and field staff working in other humanitarian sectors (80%).

Over half of respondents oriented managerial or supervisory staff, adult community members, and emergency response personnel (e.g., firefighters, defense forces, police). A third of respondents oriented senior leadership of organisations, and 22% oriented children or youth.

Approximately how many times have you given PFA orientation to others over the five year span from 2011 to 2016?



Who has attended your PFA orientation(s)?



“Other groups” that respondents oriented included health care workers, university students, students at schools of social work, government officials, child friendly space facilitators, staff of the Ministry of Foreign Affairs, airline staff, radio and television announcers, protection cluster, indigenous people and people with disabilities, and various people who work in disaster-affected areas (e.g., barbers, emergency response personnel and volunteers).

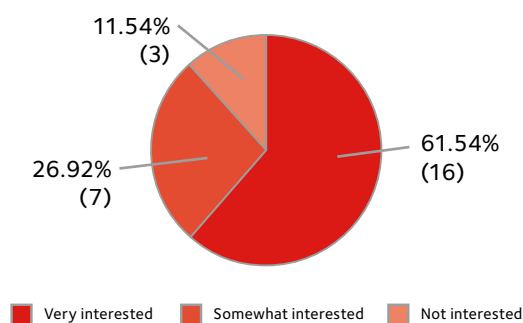
In terms of teaching methods, the vast majority of respondents (94% of N=69) utilised a combination of lecture, group discussion and practical exercises. No respondents utilised only lecture/powerpoint.

EXPERIENCE WITH TRAINING OF TRAINERS (TOT) FOR PFA FACILITATORS

The following details respondents' experiences with ToT for PFA facilitators – both attending and facilitating ToT.

Twenty-six respondents (30%) had neither attended nor facilitated a PFA ToT – however, the majority (89%) of those were interested to attend a ToT in the future, with 62% “very interested”. (See chart below.) One respondent commented: “I already have good training skills and the PFA training materials are self-explanatory. The part I would like to learn to do better is the simulation/role plays.”

How interested are you to attend a ToT in PFA (to learn skills in conducting PFA orientations)?



PURPOSE OF PFA TOT

Attended: The 18 respondents who have attended a ToT described their purpose as, for example, to improve their knowledge in offering PFA, to become a “PFA trainer”, to be able to orient staff and volunteers in PFA in emergency situations. For some respondents, the PFA ToT was part of a larger package of training, such as in community-based psychosocial support or the Child Protection in Emergencies (CPiE) training. One respondent described the purpose of the ToT as “to create a core group in countries that are able to train on IASC Guidelines and PFA.”

Facilitated: The 43 respondents who have facilitated a ToT describe the purpose as, for example:

- Building capacity within their own organisations to offer PFA;
- Scaling up national or regional capacity (e.g., Japan, Syria, Middle East and Eastern Africa region, Greece);
- Building capacity of communities and other local actors (e.g., health workers, emergency responders, workers in asylum centers) in disaster response;
- As part of national mental health and emergency preparedness plans;
- One respondent mentioned reducing the stigma of trafficking survivors.

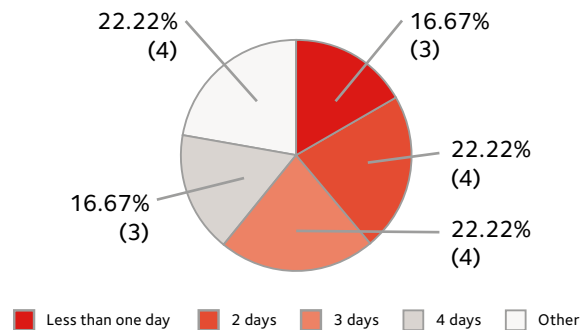
LENGTH OF PFA TOT

Attended: The length of ToT attended varied from one to four days or “other” time frames. Other time frames included “one and a half days”, “almost five days”, “within a 5-day training”, and “training was extended and lasted for about 10 months.”

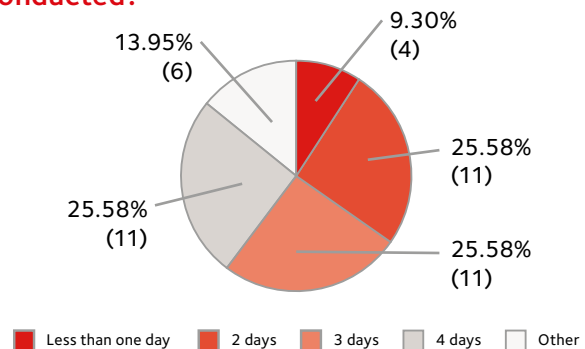
Facilitated: ToT facilitated by respondents showed similar variation in length from 1 to 4 days, or “other” time frames as those attended by respondents above. For example, ToT of 1-2 days were reported by 39% of respondents attending, and 35% facilitating. However, more of the ToT facilitated by respondents tended to be at least 3-4 days (52%), compared to those attended by respondents (39%). Furthermore, descriptions of other time frames all included coaching, supervision and/or training over time that would increase the overall length of ToT, for example:

- One day theoretical orientation, co-facilitation of 1-2 trainings, and supervision of 1-2 trainings along with one-on-one feedback and support;
- Conducting four training sessions of three days each;
- Five days with follow-up training to address problems faced by participants after conducting their own PFA training.

Approximately how long was the PFA ToT you attended?



Approximately how long was the PFA ToT you conducted?

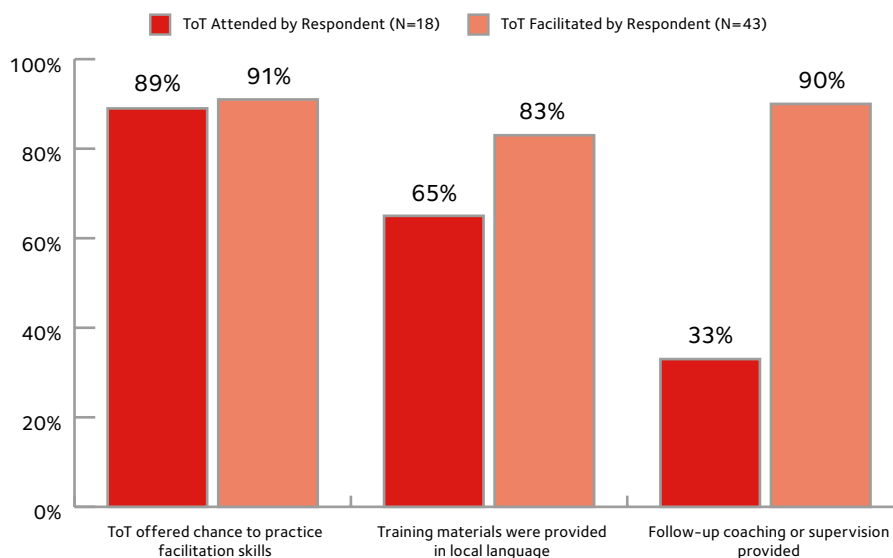


PFA TOT TEACHING METHODS, MATERIALS AND SUPERVISION

See the chart below for comparison of those who attended ToT and those who facilitated ToT with regards to teaching methods, materials and supervision.

Both the vast majority of those who attended and those who facilitated ToT reported that opportunities to practice facilitation skills were given (e.g., giving a practice training, practicing facilitation of some aspects of a PFA orientation.) However, more ToT facilitators reported that materials were provided in the local language (83%) than those who attended a ToT (65%). But the largest difference was in supervision or follow-up coaching provided as part of the ToT – 82% reported by ToT facilitators, and just 33% reported by ToT attendees.

Teaching Methods, Materials and Supervision Offered in PFA Training of Trainers



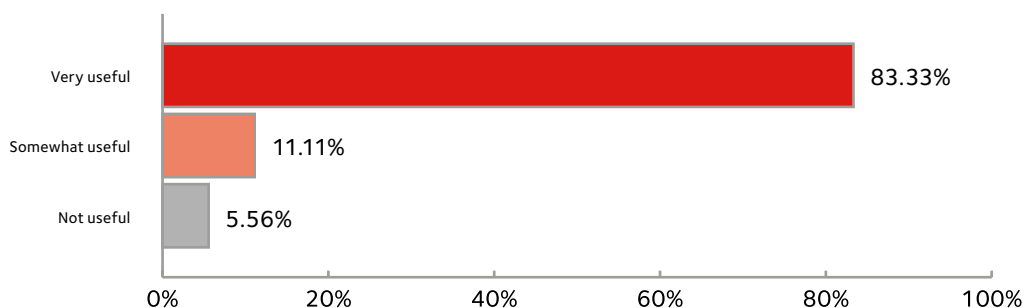
USEFULNESS OF PFA TOT TO THOSE WHO ATTENDED

Those who attended ToT were also asked its usefulness in building confidence and skills to orient others in PFA. The 83% respondents (15 of 18) reported that the ToT was very useful. Of note, 67% received an orientation of at least 3 days and 64% received training materials in the local language. Nearly all reported the opportunity to practice facilitation skills during the training, and 40% received follow-up supervision and coaching.

The 2 respondents who described the ToT as “somewhat useful” each reported different lengths of ToT (4 days versus 1 day), and differed in whether or not training materials were provided in the local language. Both had the opportunity to practice facilitation skills during the ToT, but neither received any follow-up supervision or coaching.

Only 1 respondent reported the ToT was not useful, but notably the ToT they attended lasted less than one day with no opportunity to practice facilitation and no follow-up or supervision.

How useful was the ToT in building your confidence and skills to orient others in PFA?



OPINIONS ABOUT PFA ORIENTATIONS AND TOT

Respondents were then asked a series of questions to gauge their opinion about PFA orientations and ToT on a five-point scale from strongly agree to strongly disagree. An overview of responses is provided in the table below (N=83 respondents).

In terms of PFA orientation for helpers, the vast majority (90%) of respondents felt that an orientation is necessary for helpers to be able to appropriately support someone who is distressed. Sixty-three percent strongly agreed with this statement, while 27% agreed.

A majority of respondents (83%) felt that a PFA orientation requires at least one day for participants to effectively learn PFA skills; however, 7% of respondents disagreed or strongly disagreed with this statement, and 9% were equivocal (neither agreed nor disagreed). Nearly all respondents (96%) felt that an effective PFA orientation must include opportunities for participants to practice skills, with 83% strongly agreeing to this statement.

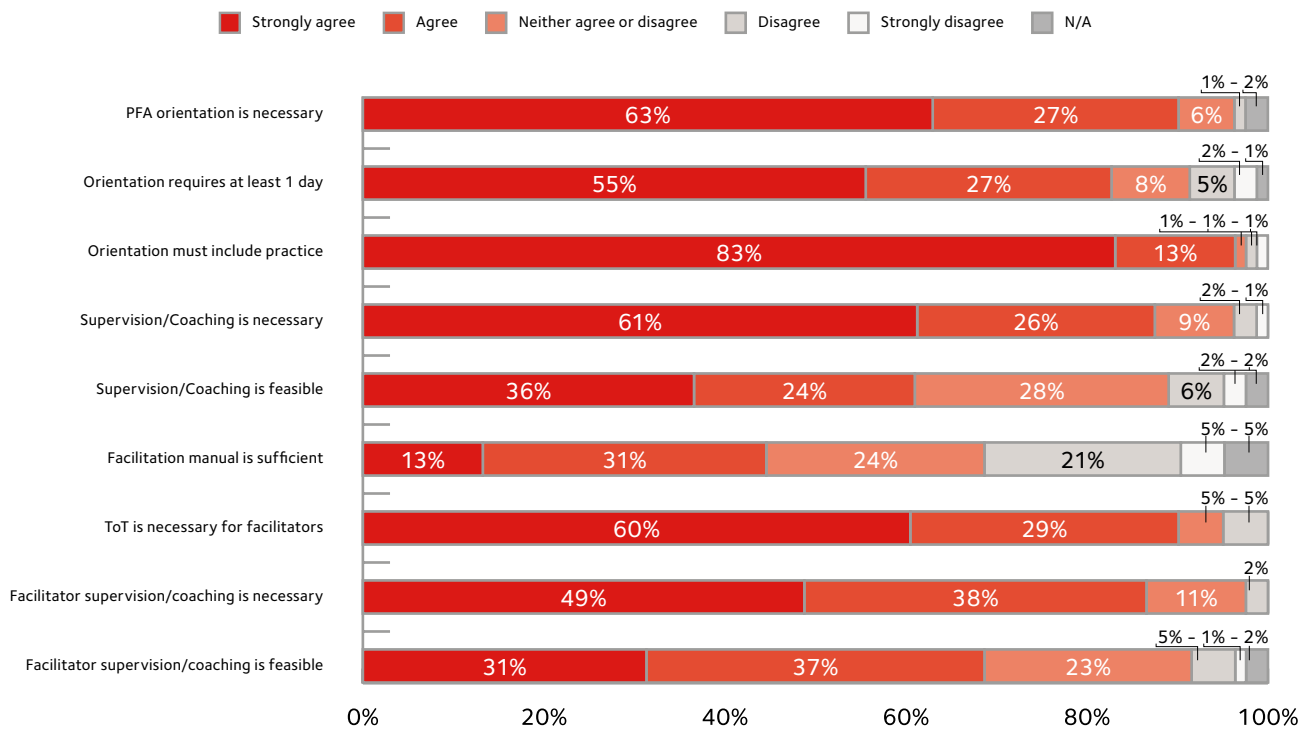
A majority of respondents (87%) felt supervision and coaching following a PFA orientation is necessary in order to ensure the quality of PFA provided by helpers (37% strongly agreed and 26% agreed). However, only 61% of respondents felt that offering such supervision or coaching for trained PFA providers was feasible to implement in the areas where they work (37% strongly agreed and 24% agreed). Twenty-eight percent of respondents neither agreed nor disagreed that supervision/coaching was feasible to implement, and 8% disagreed or strongly disagreed with this statement.

In response to the statement that the PFA facilitation manual on its own provides sufficient information for anyone to provide a PFA orientation, 22% of respondents disagreed and 5% strongly disagreed. Less than half of respondents (44%) agreed with this statement (only 13% strongly agreed) and ¼ of respondents neither agreed nor disagreed.

The vast majority of respondents (90%) felt that a ToT is necessary for facilitators to learn how to give PFA orientations to others (60% strongly agree and 30% agree). Five percent of respondents disagreed, but none strongly disagreed.

The majority of respondents (87%) felt that supervision and coaching is necessary in order for trained facilitators to appropriately offer PFA orientation to others (49% strongly agree, 38% agree). However, 11% of respondents were equivocal about this statement, and 2% disagreed. As to whether supervision and coaching of trained PFA facilitators is feasible to implement in the areas where respondents work, only 68% strongly agreed or agreed; while 6% disagreed or strongly disagreed.

Please select the answer that best corresponds to your opinion about PFA orientations and training-of-trainers.



EXPERIENCE WITH PFA ORIENTATION AND TRAINING SUMMARY

The 87 (of total 105) respondents who answered the questions in this section of the survey may have self-selected for their prior experience with PFA orientation and trainings. Three quarters had attended a PFA orientation and half of respondents had attended a ToT. Likewise, respondents appeared to be experienced PFA facilitators, with 4/5 of respondents having facilitated PFA orientations – a fair number facilitating from 20-50 and even over 50 orientations in the time frame – and 1/5 having facilitated ToT.

Furthermore, PFA orientations facilitated by the respondents have reached a wide variety of people across sectors and disciplines, including various types of emergency responders (police, firefighters, ambulance drivers), staff in various humanitarian sectors, radio and TV announcers, embassy staff and various community members – even including barbers and hairdressers. This demonstrates the wide applicability of PFA to diverse audiences and how PFA is increasingly being mainstreamed across humanitarian sectors.

For a PFA orientation to be useful for participants, the data shows the importance of having materials available in the local language, adapting to the culture and context, and devoting sufficient time (e.g., at least one day). Particularly important appeared to be teaching methodologies that offer the opportunity to practice skills. Most orientations provided were at least one day in length, and utilised participatory and practice methodologies – and the majority of participants found them useful in building their confidence to offer PFA.

Likewise, ToT models that provided participants the opportunity to practice facilitation skills – as well as models that included training over time with supervision and coaching – seemed to be most useful for PFA facilitators to learn the knowledge and skills to orient others. When PFA is incorporated into other ToT packages, it is important to ensure that sufficient time is devoted to the subject, as well as opportunities for practicing facilitation and coaching/supervision where possible.

These findings speak to the need for careful training to ensure fidelity to the model, and are corroborated by the large percentage of respondents who felt PFA orientation and ToT are essential for helpers and facilitators, respectively. For example, less than half of respondents felt the PFA facilitation manual provides sufficient information on its own for those who will offer an orientation to others. Furthermore, follow-up supervision and coaching were not always offered in PFA orientations and ToT, but were felt by the majority of respondents to be important. In most situations, respondents felt this would also be feasible to implement – but likely not in every situation given the nature of emergency contexts.

Another reason for training to ensure fidelity of the model was demonstrated by comments that showed a lack of clarity about the limitations of PFA. For example, some orientations were conducted with mental health aims beyond the scope of PFA and respondents who attended orientation mention it was insufficient to know how to provide targeted psychosocial support to distressed people in chronically stressful situations. It is important therefore to emphasise that PFA orientation is not sufficient to address all MHPSS problems that arise in complex emergency situations – nor is it intended to do so.

Section 4. Perceptions of PFA

In this section, respondents (N=76) were asked their perceptions of PFA and how it is used in practice.

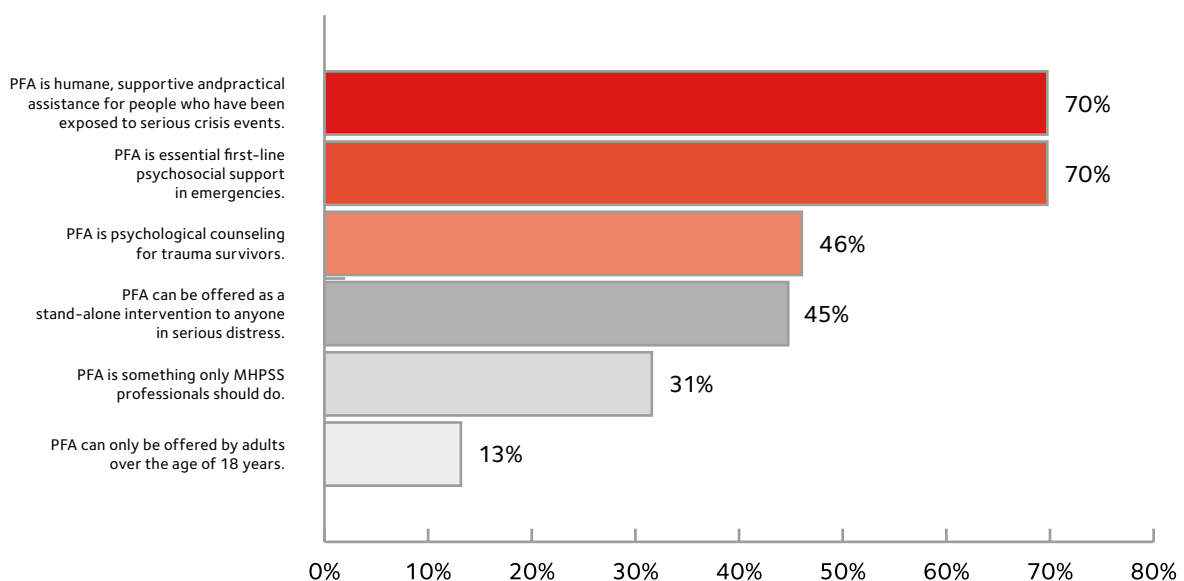
MISCONCEPTIONS OR MISUNDERSTANDINGS

Respondents selected from a series of statements that they felt best characterized people’s understanding of PFA. Note that this was not their own perception, but what they felt perceptions of PFA are in general in the field. A summary of results is provided in the chart below for each statement.

The first two statements listed were accurate statements about PFA as described in the WHO guide. The majority of respondents (70%) felt that these statements correctly characterize people’s understanding of PFA. However, it is interesting that 30% of respondents did not feel that people understood PFA in the way it is intended.

Other misconceptions or misunderstandings were also felt to be frequent, as nearly half of respondents felt that people wrongly perceive PFA as “psychological counseling for trauma survivors” and that it can be “offered as a stand-alone intervention to someone in serious distress”. Furthermore, respondents felt that nearly 1/3 of people wrongly see PFA as something only professionals should do, and 13% wrongly perceive that PFA can only be offered to adults.

Misconceptions or misunderstandings about PFA can occur. What statement(s) do you feel best characterize people’s understanding of PFA? (Check all that apply.)



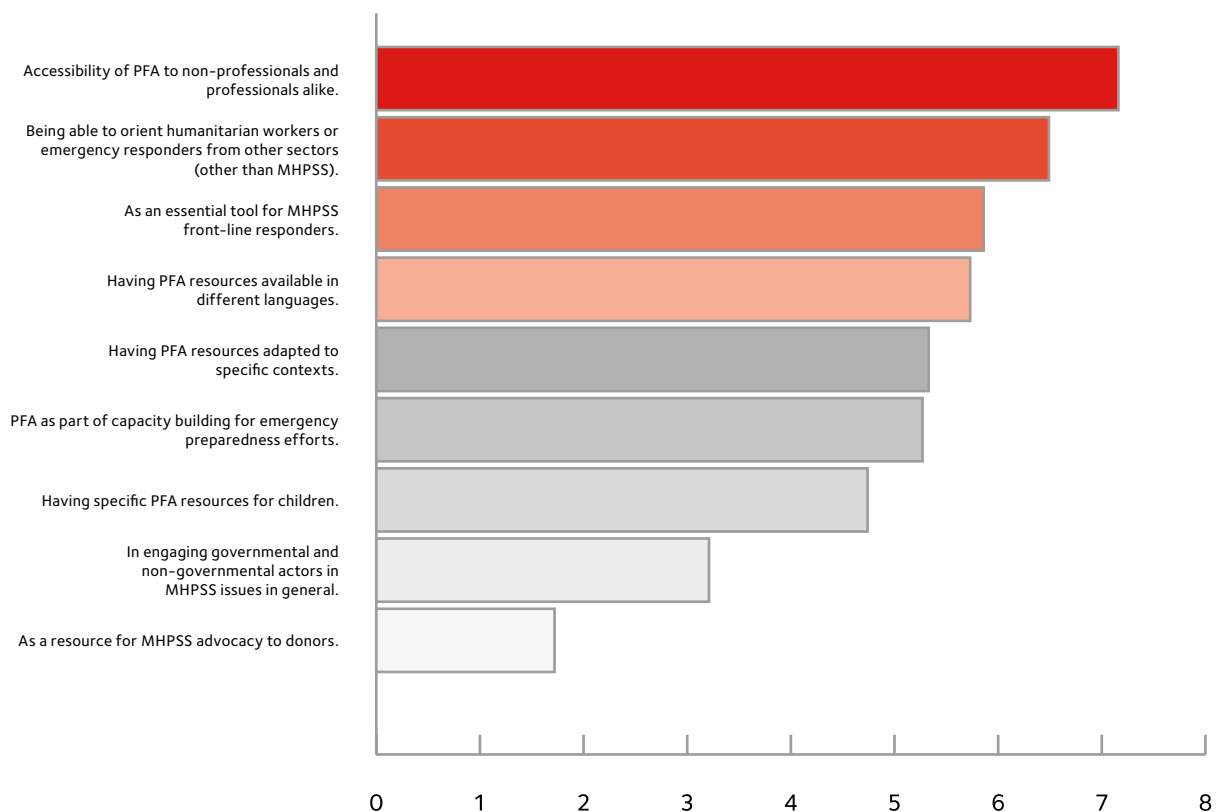
MOST USEFUL ASPECTS OF PFA

Participants were asked to rank order the aspects of PFA that they felt are most useful according to 9 statements. (See chart below for weighted averages of responses.)

By far, the most useful aspects of PFA from the statements listed were the accessibility of PFA to professionals and non-professionals alike, as well as to responders in other sectors (other than MHPSS). The next most useful aspects were the use of PFA as an essential tool for MHPSS front-line responders and having the PFA resources available in different languages.

Having PFA resources adapted to different contexts and PFA's use in capacity building for emergency preparedness ranked higher than specific children's PFA resources. Least useful aspects from the statements listed were the use of PFA to engage government or NGO actors in MHPSS issues in general, and its use in MHPSS advocacy to donors.

In order of importance, what aspects of PFA do you feel are most useful? (rank order score)

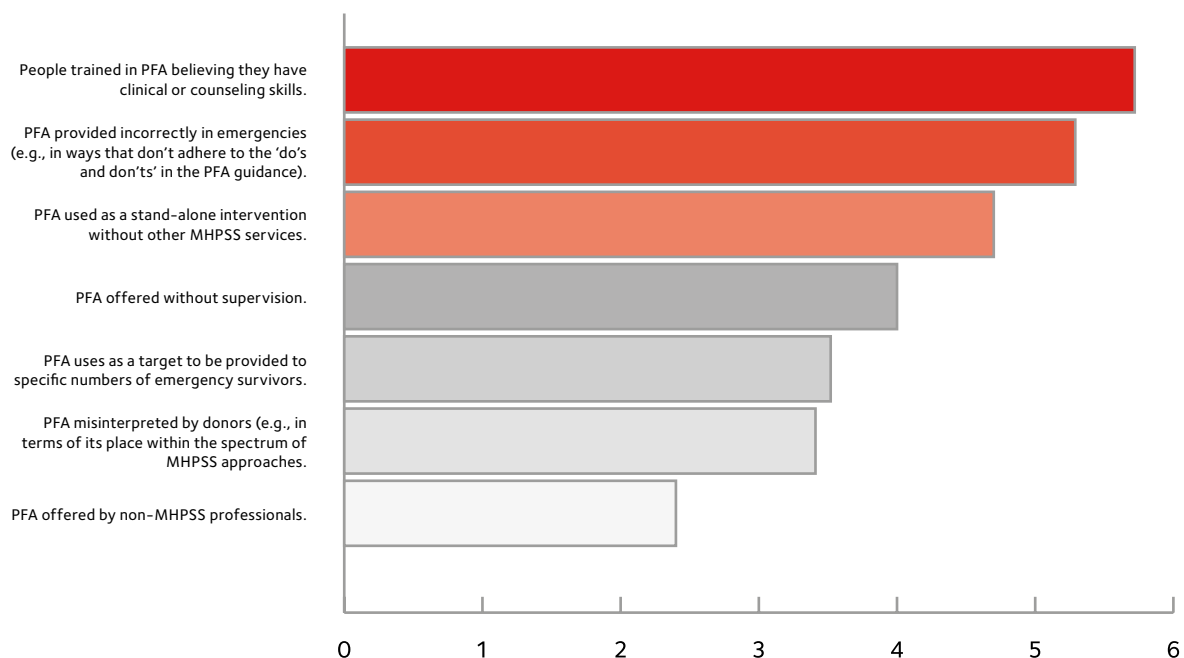


POTENTIAL DANGERS OF PFA

Respondents were next asked to rank order what they believe are the greatest potential dangers of PFA according to seven statements. (See chart below for weighted averages of responses.)

The most highly ranked potential danger of PFA was the belief that training in PFA gives participants clinical or counseling skills – even though this is explicitly refuted in the guidance. Next in rank order was PFA provided incorrectly in emergencies –in terms of non-adherence to the guidance and being used as a stand-alone intervention. PFA being offered without supervision was of some concern, but of less concern were PFA being used as a “target” in programme M&E and PFA being misinterpreted by donors. Lastly, PFA being offered by non-MHPSS professionals was ranked least, and this is consistent with the intended aim of PFA as an approach that both professionals and non-professionals can offer to people in distress.

Rank what you believe to be the greatest potential dangers of PFA. (rank order score)



PERCEPTIONS OF THE TERM “PFA”

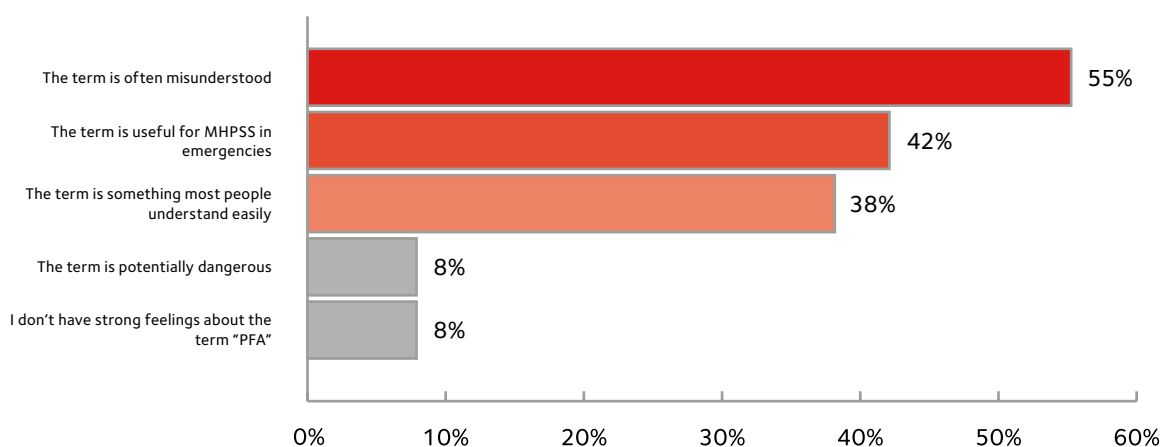
The term “Psychological First Aid” is often debated in terms of its usefulness in cross-cultural contexts. Respondents were asked their perceptions of the term itself, and could select all responses that apply. (See chart below for weighted averages of responses.)

More than half of respondents (55%) felt the term “PFA” is misunderstood, and some (8%) even felt the term is potentially dangerous. Less than half (42%) felt the term is useful for the field of MHPSS in emergencies, and just 38% of respondents felt that most people understand it easily.

However, despite the concerns about the term “PFA” being misunderstood or even dangerous, the majority (63%) of respondents do not ever use another term to describe the approach. Thirty percent of respondents sometimes use other terms and 7% always use other terms to describe the approach. Other terms used include: “psychosocial first aid”, “active listening skills”, “listening and helping”, “auto-socio-cuidado” in Spanish, “how we care in our culture”, “peer support”, “first humanitarian response” and “emotional first aid”. A couple of respondents mentioned using the term “mental health first aid”, but it is important to note that this term is also used to describe an approach to support people who are developing or experiencing a worsening of a mental health problem, or in a mental health crisis⁴⁴.

Some respondents used terms in the local language, or asked participants what term they prefer. A couple of respondents related PFA to physical first aid during orientations – particularly for health professionals, one respondent likened PFA to ‘basic life support’.

How do you feel about the term “Psychological First Aid”?



⁴⁴ Kitchener BA, Jorm AF, Kelly CM. Mental Health First Aid International Manual. Melbourne: Mental Health First Aid International, 2015: <https://mhfa.com.au/shop/international-mhfa-manual-2015>

Eighteen respondents provided comments to this question that demonstrate the diversity of opinions about the term. (See Annex E for the full list of comments.) Some respondents felt the term is well-known, even within non-MHPSS sectors, and helps to link MHPSS to emergencies. One respondent felt that although the term may be misunderstood and needs to be defined, this was not a significant issue.

Several respondents noted that it is often called “Psychosocial First Aid”. This adaptation of the term may help to avoid what many respondents felt are difficulties with the word “psychological” – that this makes the approach sound too clinical or technical contributing to the misperception that PFA is counseling or psychotherapy; that participants in PFA orientation may overestimate their skill level; and that it is potentially stigmatizing in certain cultural contexts. In addition, some respondents commented that the term “psychological” may be off-putting to potential PFA orientation participants who come from a non-MHPSS field, and may think the approach doesn’t apply to them. One respondent further commented that “psychological” misses the strong social component in PFA (e.g., linking to social support) – a problem that may also be addressed by use of the term “psychosocial first aid” instead.

A couple of respondents felt the term PFA has become too ubiquitous in the MHPSS field – representing all psychosocial support approaches – and that “quite varied practices are provided under the same umbrella”. Another felt that everything is being called PFA – giving food, shelter and non-food items, as well as “any talking one does with someone.”

THE PLACE OF PFA ON THE IASC MHPSS PYRAMID

The IASC MHPSS intervention pyramid⁴⁵ (see figure below) provides a framework for multi-layered, integrated MHPSS interventions on each of four layers. Respondents were asked upon which layer they felt PFA best fits, including a response for “none of the above.” Respondents could check all that apply but were not given a separate option to select “all of the layers”. The layers were defined in the survey as follows:

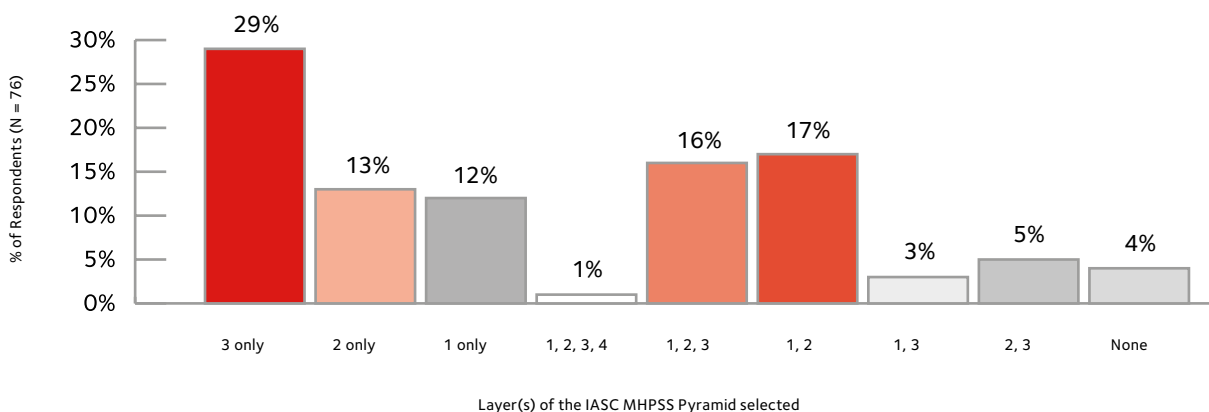


45 IASC Guidelines for MHPSS in Emergencies (2007)

Respondents showed wide variety in response to this question, as shown in the chart below. The majority of respondents placed PFA at layer 3, which reflects the placement of PFA described in the facilitation manual (WHO, 2013). The combination of layers 1 and 2, followed by a combination of the layers 1, 2 and 3 were next most common. Next were participants who selected only layer 2, then only layer 1.

Only one respondent selected all four layers of the pyramid, and thus was the only respondent to select layer 4 from the menu of choices; however, comments provided by other respondents also noted that PFA can be applied on layer 4. For example, of the three respondents who selected “none of the above”, two commented that PFA is actually cross-cutting across layers. The other respondent who checked “none of the above” felt PFA should not be on the pyramid, but that “orienting people to PFA” could be considered a layer 1 intervention as it helps to create a supportive environment for people who are distressed.

Respondent Selections: PFA Corresponding to Layer(s) of the IASC MHPSS Pyramid



Other comments provided for this question reflected the diversity of views about where – and if – PFA should be placed on the pyramid. In their commentaries, some respondents were firm in the rationale for their selection, while several others noted other layers in which they felt PFA could be placed in addition to the layer(s) they selected. For example, one respondent commented: “I think that PFA is cross-cutting all layers when helpers meet people in distress. Sometimes PFA is used as a more structured way and when it is done so, it might best belong to the third layer.” Some respondents noted that they have changed their mind over time and with experience applying PFA in the field as to its place (or not) on the pyramid.

One respondent commented that placement of PFA on the pyramid depends upon who is providing the PFA and the context in which it is provided. Another commented that it is confusing for people in orientations (especially non-MHPSS participants) to understand the rationale for placing PFA on layer 3, as described in the facilitation manual:

- “...it is usually easier to explain PFA in relation to other MHPSS programmatic activities as a general (not linked to a particular layer) or as a layer 1 intervention...PFA is more related to ‘stabilizing’ and referring/linking a person

in distress to the needed focused or specialised intervention, rather than the provision of the focused intervention itself. I understand that it is a ‘focused action’ requiring good communication skills, but I’m not sure it is a ‘focused intervention’ per se. It is also easier to explain why an intervention provided by frontliners who are sometimes unrelated to MHPSS or relevant fields (e.g., security, WASH) are providing an intervention at layer 1.”

WAYS THAT PFA IS MOSTLY USED IN THE FIELD

Respondents were next asked how they have mostly used PFA (or believe PFA is mostly used) in the field, selecting “often, sometimes and never” for each statement. Responses are summarised in the table below (N=76).

The vast majority of respondents perceive that PFA has been most often used as a basic psychosocial support skill set for frontline workers, consistent with its aims. More than half of respondents perceive that PFA has also often used as a complement to mainstreaming MHPSS into other sectors, and a further 41% felt it has sometimes been used in this way. PFA was also perceived by a majority of respondents as having been used as part of staff care. One respondent commented that PFA has been used “to increase awareness at the manager level to protect staff mental health and psychosocial wellness.”

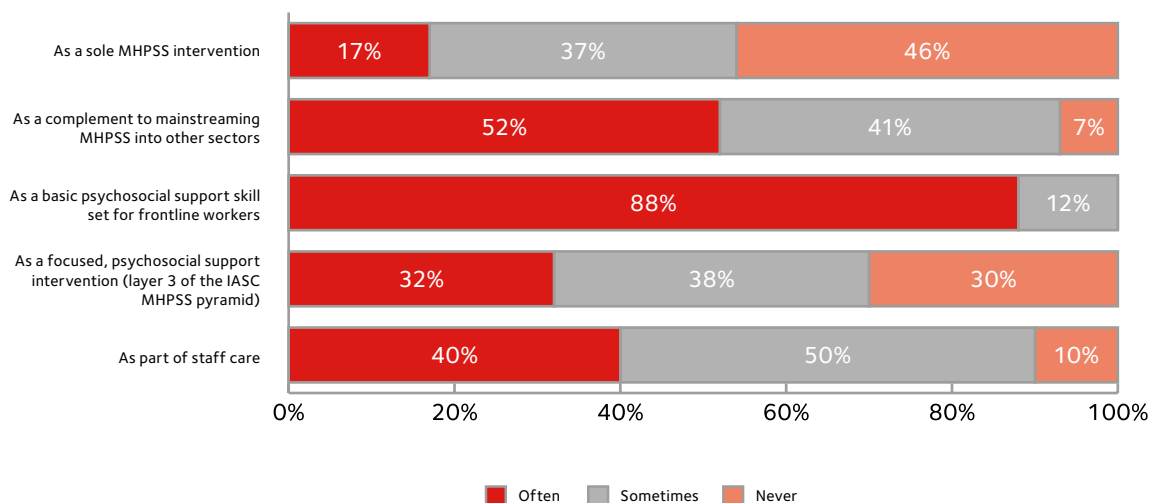
Respondents gave a mixed response to the statement that PFA has been used as a focused psychosocial support intervention at layer 3 of the IASC MHPSS intervention pyramid – further reflecting the diversity of views about PFA’s placement on the pyramid.

Nearly half of respondents felt that PFA has been used as a sole MHPSS intervention – an incorrect application of PFA – with 17% perceiving it has been often used this way.

Thirteen respondents also selected the “other” category and commented that PFA has been mostly used:

- “To introduce concepts of mental health and mental disorder, and psychosocial disorder, for populations where this knowledge is very low, then we segue into the understanding of stress reactions and how to help responsibly, then staff care...”
- “As part of disaster preparedness training.”

How have you mostly used PFA (or believe PFA is mostly used) in the field?



PRIORITY NEXT STEPS FOR PFA

Participants were asked to rank the most important next steps for PFA according to nine statements. Weighted averages for the responses are illustrated in the chart below.

Responses indicate that respondents' top three priorities were: "mainstreaming PFA into all sectors of humanitarian response", "strengthening the evidence base for PFA" and "ensuring quality in PFA training." (See table below for details of the top three ranked priorities.) "Clarifying the place of PFA within the larger scope of MHPSS approaches" was also a priority for many respondents.

Statement	% Respondents ranked in top 3 priorities	% Respondents ranked first
Mainstreaming PFA across humanitarian sectors	75%	28%
Strengthening evidence base	68%	32%
Ensuring quality in PFA training	61%	20%

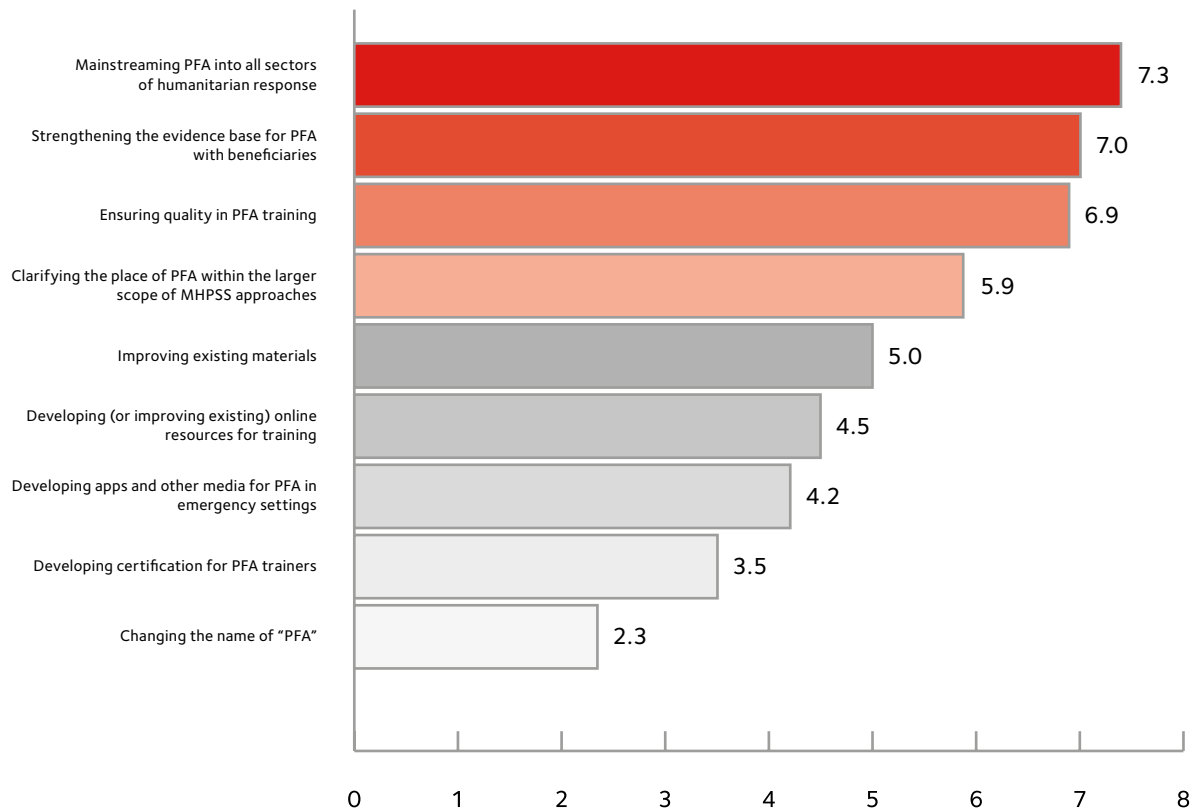
“Improving existing materials” and “Developing (or improving existing) online resources for training”, were higher priorities than the development of apps or other media innovations for PFA in emergency settings.

“Developing PFA certification for PFA trainers” and “changing the name of PFA” are the least priorities for respondents among the 9 statements. (See table below for details of the lowest three ranked priorities.)

Statement	% Respondents ranked lowest 3 priorities	% Respondents ranked last
Developing online training resources, apps or other media innovations	33%	11%
Developing certification for PFA trainers	46%	21%
Changing the name of PFA	84%	45%



Respondent Priorities for PFA Next Steps (weighted averages)



PERCEPTIONS OF PFA SUMMARY

Striking findings in this section of the survey are the large percentage of respondents who report misconceptions or misunderstandings of PFA among people in general. Although 70% felt that PFA is actually correctly understood and applied, this is not a very strong majority, and nearly half of respondents felt that people believe PFA is “psychological counseling for trauma survivors” or can be used as a stand-alone intervention. These findings were further reflected in the priorities participants ranked in terms of potential dangers of PFA. Respondents are most concerned that people who are trained in PFA believe they have clinical or counseling skills – far beyond the scope of PFA and in direct contrast to the way PFA is explained in the guide and facilitation manual. Many respondents were also concerned that it is incorrectly applied in emergencies. These concerns further reflect on the challenges to maintaining fidelity to the model described in the PFA Orientation and Training section.

Although the term “PFA” was also felt by most respondents to be misunderstood, and a few respondents found it potentially dangerous or stigmatising for some cultures, changing the name is not a priority for respondents. The name has recognition among MHPSS practitioners and within the emergencies field in general, given the mainstreaming of PFA among other sectors. It appears that respondents use the term flexibly, many adapting the name in order to make it more accessible to a variety of helpers (especially those not in the MHPSS field), more easily understood or more culturally acceptable.

There was also a wide variety of opinions on PFA’s placement on the IASC MHPSS intervention pyramid. This could be related to the background of the respondent themselves (e.g., MHPSS clinician, emergency worker in another sector), or to their experience of applying PFA in different contexts. Confusion about this issue may be a reflection of – and perhaps contributing to – the concerns about how PFA may be misapplied in the field, and clarification may help people’s understanding of PFA and its role in the spectrum of MHPSS supports.

Despite the concerns about misapplication of PFA, the vast majority of respondents felt that is used as intended – as a basic psychosocial support skill set for frontline workers – and most also noted its use in mainstreaming MHPSS into other sectors and as part of staff care. Thus, PFA seems to have value in supporting both people affected by emergencies and emergency response staff. Mainstreaming is also the top priority among respondents for next steps. Still, half of respondents felt that PFA is incorrectly applied as a stand-alone intervention, and ensuring quality in PFA training is among the top 3 priorities of next steps for respondents, in addition to strengthening the evidence base.

Section 5. Open-Ended Questions

Participants were invited at the end of the survey to further share reflections on their experiences with PFA in their own words on the three following questions:

1. In what ways has PFA been most important to your work over the last five years (from 2011 to 2016)?
2. Where do you feel we need to go from here with PFA? What would be most important to focus on in the coming years?
3. Is there anything specific you felt the IASC MHPSS Reference Group, or the authors of the PFA Guide for Field Workers, could do to improve the use of PFA in emergency settings?

A summary of responses is provided below.

QUESTION 1: MOST IMPORTANT TO YOUR WORK

Many respondents noted that PFA has been most useful within training and capacity building both for frontline MHPSS responders and actors in other sectors. The way PFA is articulated has been helpful in boosting the confidence of helpers of all kinds in supporting people who are distressed. It has been a useful approach for many respondents in engaging emergency responders in other sectors with MHPSS, improving their understanding of MHPSS and the role they can play in offering this type of support. It also has helped to support a “do no harm” approach by sensitising various emergency responders and humanitarian workers to the principles of PFA, and supporting staff codes of conduct.

Sample comments include:

- “PFA gave us the chance to highlight that not everybody needs to go through speaking, that some people would not like to talk and we need to respect their silence.”
- “For me, it has been most useful when used in training frontline workers from non-MHPSS sectors; in my experience, they benefit the most from PFA, because a lot of it is new information. For these groups, I often carry out training on the IASC guidelines, covering actions sheets relevant to their sector, and describe where PFA falls within the pyramid of intervention, and get into the specifics of PFA.”
- “It was an essential part of any capacity building module; whatever the training is, it should start with PFA.”

Some respondents noted how PFA has been used to build a “community of practice” at local, national or regional levels in MHPSS, and using PFA as the entry point to further MHPSS programming. Its wide acceptance by the field – and its applicability for a variety of emergency situations (both mass and individual events) – was also important for respondents in mainstreaming MHPSS and as an entry point to further MHPSS programming. Some respondents also used PFA as the starting point to developing other resources, such as resources for child caregivers, in their context. In addition, it has helped in raising awareness of the need for staff care, as this is included within the training package. One respondent noted that PFA orientation helps non-professionals to be more psychologically prepared for work in emergencies.

Some respondents noted that the PFA materials have been useful as an “easy-to-use” tool or package in training a variety of MHPSS and non-MHPSS staff. Some respondents specifically mention exercises and guidance given in the facilitation manual as particularly useful and easy to implement. One respondent felt it has been most useful as a basic package of skills training for social workers in emergency settings. Another respondent highlighted that the tools were very valuable in contexts with limited resources and in helping staff to feel equipped for their work. Another respondent specifically mentioned how the “link” function of PFA helped to improve the way various agencies in his/her country were connected for a functional referral system in emergencies: “it helped to connect agencies that had not been connected before.”

A few respondents mentioned the way PFA has been used by governments and international organisations for advocacy and raising awareness of MHPSS in general. One respondent commented that they used PFA to help them to guide interventions done by governments in forced displacement situations. One respondent commented that PFA was the only MHPSS tool available, and so was a crucial intervention. However, PFA may have been used as a sole MHPSS intervention in this context beyond the scope of how it is intended.

Other respondents, who may be more reflective of frontline staff, commented more personally about the usefulness of PFA: “PFA helped me to adopt a more humane approach during crisis, understand the importance of the context and provide better services.” These respondents noted how PFA boosted their confidence to provide support in ways that didn’t further harm affected people, and also facilitated their collaboration with other emergency sectors.

A few respondents mentioned the usefulness of PFA during their work in the Ebola crisis, in particular:

- “PFA has been most important as a way of introducing field staff to basic and key MHPSS topics including psychosocial support, humane service provision, consent, do no harm, active listening, good communication skills, and self-care. This is especially useful for staff with limited training in psychosocial work but may be first responders or work in the field. This was incredibly useful in the Ebola response for both our psychosocial workers and the

ambulance teams who were both trained and used PFA in the field when picking up patients in communities as a way of keeping themselves safe, and those they were providing services to.”

Finally, one respondent noted that they felt PFA reduced the tension in the discussion about psychological debriefing in emergencies, and moved practitioners away from this practice.

QUESTION 2. WHERE TO GO WITH PFA FROM HERE – A FOCUS FOR THE COMING YEARS?

Answers to this question reflected the survey results from section 4, and provided a variety of recommendations for future next steps. For example, some respondents felt it was important to improve monitoring and evaluation approaches for PFA, and to improve and standardise data collection tools for building the evidence base for PFA. One respondent was interested to see more publications about how PFA can best be applied in different cultural contexts of types of emergencies, and potentially to know more about the implications of PFA on survivors’ quality of life in the longer term. Another commented that continuing to popularize and improve PFA would be important to convincing donors to fund monitoring and evaluation, as well as supervision and translation, of PFA in different contexts.

In addition to developing the evidence base, some respondents also felt it would be important to ensure standardisation of training models and possibly certification in order to keep fidelity to the model. One respondent shared their concern that a vast amount of PFA training is conducted for frontline workers, but that is unclear what this actually means on the ground in terms of quality and actual capacity. The respondent recommends focusing on better operationalising PFA capacity building and including systematic follow-up to assess what happens after training and to provide guidance for how PFA is implemented. Guidance on supervision or a “supervision package” was recommended.

Another respondent underscored the importance of not only explaining the limits of PFA, but also developing other MHPSS materials for situations beyond the scope of PFA. This was emphasised by another respondent: “We need to make sure that PFA is not seen as the only MHPSS intervention in emergencies.” Another commented:

- “Donors/decision makers/ programme managers [need] to understand that PFA is a first step (and a good one) but cannot solve magically all mental suffering during an emergency. That PFA should be an entry point to strengthening existing mental health systems/ low intensity interventions.”

Some commented on the need to better include PFA in contingency planning and disaster preparedness; to show how PFA is an integral component to building MHPSS systems in affected communities, and to better integrate and mainstream PFA in all sectors through coordinating inter-agency responses. One respondent noted both the need for training and for formalising the approach in public policies:

- “We have the tool but its -still- not used properly. We need to have more trainings; to formalize it also with health workers. In my country, more health workers are getting involved in responding to emergencies but they are not trained. Public policies need to be part of our perspective for the following years.”

Others focused upon the need for more models of adaptation of PFA to different cultural settings and emergencies, as well as more language translations of materials. A few respondents mentioned that developing more materials would be helpful, including more online resources – including e-learning courses in different languages – and apps. Others were more interested in materials related to ToT, such as field checklists for field staff and trainers/supervisors that could be

used in follow-on support and supervision following a ToT. The importance of providing more information and case studies about the “link” function in different contexts was noted by a few respondents – particularly in contexts where few MHPSS resources exist, or where there is little cooperation between different mental health and social service agencies. Although several respondents mentioned the need for better training and supervision, one respondent cautioned against professionalising PFA training, such as by providing certificates for training.⁴⁶

One respondent mentioned that changing the name “PFA” is likely to add confusion, given that the term is now so well known in the field. However, he/she recommends ensuring that PFA is “well understood and well defined by donors, program managers and field workers.” The need for this type of clarification of PFA was echoed by other respondents, also for lay workers and non-MHPSS professionals. One respondent noted that clarification is needed as to “what it is about, why it is important, when to conduct it, and to whom.” Another respondent felt that “broadening the cross-sectoral outreach and positioning it as a life-skill in preparedness” would be a useful focus for next steps.

QUESTION 3. HOW CAN THE AUTHORS OF THE PFA GUIDE OR IASC MHPSS RG IMPROVE THE USE OF PFA IN EMERGENCIES?

Responses to this question included some concrete suggestions, for example:

- Focus on quality strengthening of PFA and develop other approaches to respond to the gaps
- Creating compliance checklists for training and supervision
- Developing key indicators of supervision and outcomes of PFA (not just numbers of beneficiaries)
- Link PFA with the UN SDGs (sustainable development goals)
- Clarify how PFA links with and complements other emergency preparedness and response interventions (e.g., security measures, medical first aid)
- Advocate its use within the member organisations of the IASC RG, as part of a required set of skills
- Work with governments and donors to include PFA as a mandatory tool, and follow-up with training and collecting data for the evidence base
- Closer partnership with UN Cluster System and its subsidiary working groups (e.g., child protection) to ensure complementary training and PFA roll-out so that PFA is embedded within protection
- Acknowledge other useful approaches such as self-help and mutual efforts of local communities, with or without PFA
- Facilitate exchange of professionals and field practitioners around the applications of PFA in varied contexts
- Better contextualise PFA and develop additional materials and visuals for specific contexts
- Clearer guidance on how to apply PFA in complex situations (e.g., case studies for displacement from conflict, natural disasters and children on the move)
- Share modalities of work, availability of online courses and any useful information on what is going on with the use of PFA globally
- Case studies and examples of PFA effectively applied in the field across various sectors and responses
- Research to build the evidence of how PFA is applied in different cultural settings
 - “Regular annual conferences to discuss findings and create the action plan to improve PFA capacity building plans, contextualization and practices in all countries. Follow-up of action plan with different focal points in each country, regional advisory and global advisor.”

⁴⁶ Note that the authors of the PFA guide and related materials have cautioned against professionalising PFA or the training from the outset.



Chapter 3. Interview Findings and Case Examples



Chapter 3. Interview Findings and Case Examples

In this chapter, interviews with various stakeholders and case examples are presented to gain a more in-depth understanding of how PFA has been applied in the world. Interviews were conducted with select individuals who have had extensive experience in applying PFA in various contexts, and in orientation and ToT. The majority of interviews were conducted individually and in small groups over Skype. One interview was conducted face-to-face in a small group, and two stakeholders contributed written answers to interview questions. Responses to each of the questions posed to interviewees are detailed below, along with quotations from the interviews.

Case examples illustrating how PFA was applied in different contexts and by different organisations were also contributed by interviewees and other stakeholders, and are presented through the chapter.

INTERVIEWEE AFFILIATIONS AND ROLES

Twenty-five individuals participated in interviews, and provided both their current affiliations as well as their affiliation during 2011-2016 (the time frame of the retrospective). Ten interviewees were senior MHPSS leaders within international NGOs (iNGOs), UN agencies, or governmental entities, and one interviewee was co-chair of the IASC MHPSS Reference Group. Three interviewees served as field staff in iNGOs and another three were consultants with extensive international field experience in MHPSS. There were five interviewees from Japan representing a governmental entity for mental health in disaster preparedness. Three interviewees also had academic affiliations in addition to their work with UN agencies or iNGOs. The interviewees represented diverse regions of the world, some working globally, and others working in particular regions or countries (e.g., southeast Asia, Japan, Latin America and the Caribbean, Peru, Egypt). One interviewee currently represents a donor agency.

INTERFACE WITH PFA

“WHAT IS YOUR RELATIONSHIP / INTERFACE WITH PFA?”

In terms of their interface with PFA, two interviewees were co-developers of the WHO guidance and therefore part of its global dissemination. Several described their interface with PFA through capacity building efforts within different emergency settings, including PFA orientations and ToT in acute and protracted humanitarian crises – including earthquakes in Haiti (2014) and Nepal (2015), the Syrian refugee crisis and the Ebola Virus Disease Outbreak in 2014 in West Africa. In the Ebola outbreak, interviewees trained health workers, burial teams, ambulance teams and community support staff and volunteers.

“I interface with it nearly every day in one form or another. It’s because the basics of PFA are the foundation of what we do in MHPSS.”

“PFA is a basic building block of the work we do globally.”

Several interviewees view their main interface with PFA as bringing capacity building efforts to scale in targeted countries or regions (including large-scale roll out of PFA in Japan, Sri Lanka and the South Asia region, among others). These efforts have included translation and adaptation for the cultural and crisis context (often with a local group of stakeholders), and ToT efforts with follow-up support and supervision in order to form a cadre of PFA trainers within a local/regional community of practice. One interviewee used PFA as the entry point for an MHPSS disaster preparedness project in Latin America and the Caribbean. (See case examples below from Japan and Latin America and the Caribbean.)

National Scaling of PFA Capacity Throughout Japan

Over the five years since the launch of the PFA guide, a coordinated, large-scale PFA capacity building and dissemination effort has been coordinated by the National Information Centre for Disaster Mental Health (NICDMH), a subsection of the National center for Neurology and Psychiatry (NCNP) established in 2012, directed by Dr. Yoshiharu Kim. In addition to publishing the official Japanese version of the PFA Guide, Dr. Kim and his staff describe their ongoing work:

“The first official ToT by NCNP was held in August 2012 with collaboration of the UN University and international trainers. Drawing from lessons in the past where outside manuals and guidance were rejected by Japanese care providers, in that first ToT we developed our own Japanese ethical code for disseminating PFA in order to increase the cultural acceptance of PFA in the country. When the NICDMH was established in 2012, PFA capacity building was adopted as its official activity. The NICDMH undertook a coordinated effort to raise awareness of PFA and reach out to various stakeholders. We held a number of ToT workshops but also appealed to local government officers and colleagues in related facilities to adopt PFA. Gradually more PFA workshops came to be organised by local governments and colleagues in other ministries – including foreign affairs, self-defense, police and education. In 2012, 6 workshops were held with 154 participants, but by 2015 this number increased to 47 workshops with 1,015 participants. From 2012 to 2017, workshops have been held with 3,904 participants. The Ministry of Self Defense held the biggest workshop in Japan, gathering 99 psychologists that work directly with the troops. The Ministry of Foreign Affairs now holds annual workshops in Japan or in southeast Asia and has gathered more than 200 participants, including consuls, secretaries, doctors and staff. The center has also conducted 95 lectures about PFA with 5,489 attendees, raising awareness of PFA throughout the country and reaching out to professionals and paraprofessionals in many disciplines – as well as community members.

We credit the success of our initiative – engaging diverse stakeholders, scaling PFA through the country – with the careful support and monitoring of PFA facilitators from a key staff member at our headquarters in order to keep the quality of PFA orientation and training high. She is in charge of selecting facilitators and pairs experienced and novice facilitators together in PFA workshops. In this way, novice facilitators receive on-the-spot coaching and their skills can be evaluated and improved. Only when facilitators meet certain criteria are they issued a PFA trainer certificate by NICDMH. The cadre of PFA trainers formed are therefore well known and respected among Japanese mental care providers, and provide workshops throughout Japan.

The future task is to develop an effective way to disseminate PFA to people who are not able to attend the workshops. Together with key long-standing partners, we have received a grant from the Japanese government to develop PFA e-learning for Asian countries.”

– Yoshiharu Kim and Asami Ohnuma

Addendum: One interesting measure of success of the Japan initiative in scaling PFA through the country was a recent request they received from the community – hairdressers who go to affected areas to cut hair for affected people requested a PFA workshop!

PFA as an Entry Point for MHPSS Disaster Preparedness in Latin America/Caribbean

"We were implementing a disaster preparedness project in Latin America and the Caribbean that included a component to strengthen capacity in MHPSS in selected countries. At some point, PFA became the strategy to facilitate the work in MHPSS in those countries because it generated interest from first responders and other partners from different sectors. Through PFA orientations, we met health professionals as well as colleagues from education, police, firefighters, etc., and worked on the elaboration of a MHPSS plan in ten Caribbean countries. The project consisted of three components – one component was to help countries develop an MHPSS plan for emergencies, the second was training and capacity building, and the third was developing a Caribbean manual for MHPSS disaster response in the region in which PFA is one chapter.ⁱ

Now, over the years, we have been involved in the translation of the manual in Spanish and in Dutch, and we use it every time there's an emergency in the region [Latin America or the Caribbean]. We have also regular requests from a few national emergency response bodies to facilitate PFA training as part of their preparedness initiatives. In my opinion, PFA facilitates access to those partners who usually wouldn't be interested in MHPSS."

– Devora Kestel, PAHO

i Pan American Health Organization (PAHO). Mental Health and Psychosocial Support in Disaster Situations in the Caribbean: Core knowledge for emergency preparedness and response. Washington, D.C.: PAHO, 2012.

Another interviewee worked with emergency preparedness and response teams in a Scandinavian country and provides PFA orientation for staff in a variety of emergency-related jobs – firefighters, police, ambulance workers and hospital staff – both for capacity to help affected people and for supporting their own staff injured in the response. Other interviewees were involved with PFA capacity building in the Asia region through multi-country, distance learning webinars, described in the case example below.

Multi-Country, PFA Distance Learning Webinars in Asia

Videoconference technologies provided the vehicle for multi-country, distance learning PFA orientations in Asia. Led by the World Bank Tokyo Development Learning Center (TDLC), and in cooperation with the United Nations University and the Japan National Information Center for Disaster Mental Health (NICDHM), PFA distance learning was instituted in 2013 and 2014. Drawing upon an existing network called the Global Distance Learning Community, groups of practitioners in several countries – including the Philippines, Thailand, China, Mongolia, Vietnam, Indonesia, Nepal and Sri Lanka – participated in the 3-hour PFA distance orientations. A brief introduction video was also developed in cooperation with WHO and can be accessed here: <http://www.jointokyo.org/en/pfa>

The participants included more than one hundred practitioners from the fields of psychology, disaster risk reduction and inter-sectoral crisis response. The distance orientations utilised participatory methodologies with practice opportunities for role plays, similar to face-to-face PFA orientation. Participants would practice their role plays in their own country site, and then come back together to demonstrate, receive feedback and to discuss the experience among the larger group.

The distance orientations provided the unique opportunity to provide PFA orientation in some typically underserved areas, and to connect practitioners from the different countries in sharing their experiences, lessons learned, challenges, ideas and resources. Participants particularly appreciated this aspect of the distance orientation, and provided positive feedback overall about the format and technology. Since then, various types of distance learning and knowledge sharing (e.g., recent PFA webinars) are becoming increasingly more common, but at the time this was a novel application for PFA orientation that expanded access of participants to an international network for learning and mutual support.

– Takashi Izutzu and Atsuro Tsutsumi

Capacity building efforts have also included providing orientations to lay people (e.g., community leaders, teachers, volunteers, church groups), in addition to broader outreach and advocacy. Several interviewees were involved in advocacy efforts, including PFA as part of general MHPSS in emergencies advocacy efforts, (e.g., advocacy in Japan after the Great Earthquake of 2011). PFA has also been a part of mental health advocacy for World Health Day, and various campaigns for World Mental Health Day in 2016 which had PFA as its main theme. (See case example below.)

“PFA 4 Sri Lanka”

“For World Mental Health Day in Sri Lanka 2016, we promoted PFA through running a “training of trainers” programme and organising a seminar that brought together PFA trainers and practitioners to reflect upon how the approach had been applied in Sri Lanka since 2012. For World Health Day, we launched a campaign on “Psychological First Aid 4 Sri Lanka” at a WHO-led national event where we distributed the guides, as well as #PFA4SriLanka calling cards that helped people to access PFA materials in local languages, and got people to interact through self-assessment quizzes. We now have a Facebook pageⁱⁱ for public engagement and a WhatsApp group for our growing community of trainers.”

– Ananda Galappatti

ii The PFA 4 Sri Lanka Facebook page can be accessed here: <https://www.facebook.com/PFA4SriLanka/>

Others described PFA as an integral component of the global MHPSS work that they implement and supervise within their agencies, including sharing materials, coordinating translations and adaptations in different countries and cultural contexts, and training national and regional counterparts and programme implementers. Sometimes PFA has been used as a complement for skills training of varied MHPSS actors, and other times it has been mainstreamed within other sectors within large humanitarian organisations. PFA is also incorporated as an integral component in several international MHPSS training courses that reach a large global audience, university courses and degree programmes (such as, in social work and psychology) and even a course for donors through USIP (United States Institute of Peace).

Interviewees also describe efforts to adapt and integrate PFA principles into other themes and processes, such as orienting personnel who were conducting consultations for the post-war reconciliation process in Sri Lanka, or into UN inclusion campaigns for people with mental and intellectual disabilities. Interviewees report that PFA seems to integrate fairly easily with other themes and processes because it is practical and concrete, and is related more to a social rather than a medical model.

“In every ToT [in community-based PSS] we use the PFA material and really work with them on how to do the PFA orientation. We use the [PFA materials] to teach some of the basic mental health-related skills like active listening and to care for yourself, basic empathy, etc. PFA is the tool I use to teach those skills that they use in other areas also.”

“As head of a large operation – 60 programmes around the world – from the very beginning, I was a peer reviewer on the manual, endorsed it, and have tried to mainstream it everywhere – in all the programmes of the organisation (where people are in direct touch with beneficiaries) – such as, camp coordination, programmes for demobilized soldiers, voluntary returnees, survivors of trafficking.”

IMPORTANCE OF PFA TO YOUR WORK

IN WHAT WAYS HAS PFA BEEN MOST IMPORTANT TO YOUR WORK OVER THE LAST FIVE YEARS?

One way PFA has been most important to the work of many interviewees includes the packaging of PFA in the WHO guidance into an accessible approach for engaging a variety of actors MHPSS in emergencies – including those who are not traditional humanitarian actors (e.g., border police, embassy staff). PFA was perceived as “an interdisciplinary, common denominator” and an entrée for engaging other sectors in MHPSS and understanding their role in providing this type of support. Thus, it helped to broaden MHPSS efforts beyond the roles of just psychologists and social workers and created a useful bridge to other sectors and a basis upon which to build other integrated programming. (See case examples below.) In addition, interviewees noted that the PFA materials made the job of training in emergency settings easier as the message was consistent and did not have to be developed from scratch for each emergency.

PFA Integrated within the work of Handicap International

“Handicap International is an iNGO that works with the most vulnerable people affected by conflict and disaster. In 2013, we started to explore how PFA could be adapted to support those not just affected by crisis, but also injured by it – a population with a particularly high need of appropriate support, not only due to the life changing nature of many injuries but because they often correlate with a loss of family, friends, home or livelihood. We started with an initial PFA ToT for our humanitarian advisors, adapted for our work. The team felt the PFA model as a whole provided an excellent framework, not only to enable our staff and partners to explore common themes affecting people in crisis, but also to help them think about the scope of their role.

The key target for our PFA training is health professionals, all of whom were already familiar with supporting individuals in crisis. As such, we reduced some of the content, and added in new scenarios that helped participants to explore how supporting people with injuries in an emergency context was different from supporting people in their normal jobs. We developed new role plays with a focus on typical injuries we see, such as spinal injuries, amputations and burns, with the unique psychosocial challenges that each present. We also adapted scenario contexts to those in which our teams commonly work – in hospitals, camps or communities.

“Having it neatly packaged changed how I interfaced with it – could more easily communicate what I knew from clinical training to lay people in the field. Made the whole skill set more accessible and took it away from the realm of counseling. It also increased the importance of these types of skills and this approach for frontline responders.”

“It’s great to have PFA in your toolkit like a little gift you give people. It’s something they can hold, that they can do...”

“It makes MHPSS everybody’s business. We’re all human beings with the capacity to be supportive to one another. It increases the number of people that can be helpful in an emergency.”



Since the initial adaptation, the training has been used in a variety of contexts – the initial focus was on rehabilitation professionals working as part of the UK Emergency Medical Team (UKEMT). This has been expanded to include all team members of the UKEMT clinical team. In addition to this, we have trained a number of our country teams. For example, following the Nepal earthquake we undertook a rapid training with our clinical teams, discarding some of the early simulation elements (due to the recent lived experience of a disaster) and emphasising the basic principles of PFA, and the self and team care components. Feedback has always been excellent, and participants value the interactive, active nature of the training.”

- Peter Skelton

PFA Applied in the Work of Faith Leaders

“It’s an excellent tool for working directly at community level. Recently, it’s one of a number of tools I’ve brought to religious leaders, in helping them to strengthen their skills in working with people who are distressed, and expanding their resources. They’ve been very grateful and use it in a variety of ways – they talked about using it in congregations and that this is a way their congregation can reach out to the wider community. So, it’s been very useful to encourage religious leaders not to tell people what to do but to listen! And to link [religious leaders] to other professionals and other places. That’s been very important. Now, we’re working to bring the link back in the other direction – for mental health workers to refer back to religious leaders.”

- Kathy Angi

One interviewee noted that PFA was particularly helpful in breaking down the various components of support processes for MHPSS field teams so that they could be more easily applied in their work. She describes how she and her field team used the elements of PFA in preparing, responding and reflecting during mobile outreach work in the Ebola crisis in the case example below.

Breaking down the Components of Helping in Liberia

“We trained our psychosocial workers to help in responding to potential outbreaks in the field using PFA. We always accompanied the ambulance, so our field workers trained the ambulance team in PFA too. That was one of the most useful applications of PFA I ever experienced – both the PS workers and ambulance team trained. The training was so much fun! We would see the actual use of PFA principles in the field, and then regroup as a team and break it down step-by-step when we came back.

For example, they were responding to a call for a suspected case with the ambulance team and the whole village came around. So, the ambulance personnel were very strategic in terms of how they would park so they could get out easily (safety first). Immediately it was obvious that the wife of the patient was becoming increasingly distressed, hovering over her husband and startling her children. The teams decided to move the wife away from the husband so the ambulance team could screen the patient and the woman could receive support from the psychosocial worker. The psychosocial worker listened to the concerns of the wife and helped her care for her children who were also fearful of the situation. They were able to give her information about Ebola, the Ebola Treatment Unit (ETU), and telephone number so she could call and check on her husband. She was also invited to come visit and stay at the unit while her husband received treatment. Eventually the wife was calmed and the husband was moved into the ambulance and taken to the ETU.

Afterward we debriefed with the questions: 1) how did you Prepare well? (e.g., learn about the village and previous responses, parked in a strategic way for safety and access), 2) what did you Look for? (saw immediately people gathering – noted for their safety and ours, or to mobilise bystanders for support) and 3) when you got out of the car what did you do? (saw hysterical wife, Listened to hear and Linked her to resources she needed when her husband was taken to ETU). And then would ask what would you do differently? They might say; I got too close to the wife, I forgot to respond to the children who were witnessing and could have had some stress.”

– Katie Mullins

For some respondents, PFA has been important as a Do No Harm approach, such as providing an alternative that helped shift the professional discourse from psychological debriefing, provided clear guidance to counter an over-focus on post-traumatic stress disorder, and helped to curb some harmful practices by MHPSS professionals and lay people alike. For example, interviewees stressed that some professionals and paraprofessionals have not received training on frontline support for distressed people in crisis situations. PFA was felt to provide parameters and guidance to curb the tendency of these practitioners to go too deeply in frontline supportive responses – i.e., to remind them that this is not the moment to engage in counseling or trauma treatment, but rather to provide practical support and linking with loved ones, needs and services.

“It helps us prevent harm where we see that people [on the frontline] overstep their roles and end up doing things that are not helpful in the end. For example, there’s a common misconception among counselors in the field that they have to get people to talk and extract information from them. So, they need to know that just their physical presence is valuable.”

“It fits into this little space of people not knowing what to do/not doing anything – and the space where things are so difficult and complex that you need a professional.”

Also described as most important by many interviewees were the humane principles upon which PFA is based – its “humanising approach”. Interviewees felt this is what makes PFA applicable to a variety of settings, as generally good skills to have, even in dealing with life crises such as family illness, death of loved ones and “other small personal tragedies” – particularly the elements of good listening skills, practical assistance and social support. PFA also helped to legitimise the use of the “softer skills” of psychosocial support among male helpers in some cultures – both for staff and beneficiaries.

Other interviewees mentioned that PFA has helped to highlight the importance of staff care within organisations and among emergency responders, particularly in the Ebola crisis as shown in the case examples below.

“PFA taps into that common humanity that every culture and language shares – the common human experience.”

“A moment of listening with care in the midst of humanitarian crisis can be so supportive and transforming. It’s not the do’s and don’ts that will make it supportive – it’s the level of empathy one human being to another.”

“PFA can be a humanising approach in a de-humanising situation. It’s a ‘quality of presence’.”

PFA and Staff Care in the Ebola Crisis

“For me, PFA was most important in Liberia during the Ebola crisis. We recognized that people in the ETUs (emergency treatment units) and ambulance workers were seeing a lot of things and experiencing a lot of things, as well as their own colleagues falling sick and dying. PFA was the first thing I thought of doing that was easy to deliver. It was an easy module to roll out quickly to mental health clinicians who had not used it previously, who could then offer orientations to health workers, ambulance workers and others. They found PFA really useful to voice what they were going through and their own experiences and fears. It was really useful.”

– Florence Baingana

“After arriving in Liberia, we saw teams before they had experience in an ETU and the fear of the anticipation was quite strong. The self-care component was quite useful because both national staff and expatriates were under great amounts of stress. Most people had their normal coping mechanisms removed...therefore reminding them of their coping mechanisms, learning new ones in their unfamiliar environment, and reiterating the importance of positive coping was always useful.”

– Katie Mullins

Because of the importance of staff care and the way it is integrated within and essential to the PFA materials, several interviewees suggested that it would be important to expand this portion of the guidance and include specific stress management techniques (e.g., breathing techniques, muscle relaxation). (Some of these techniques are included in the PFA facilitation manual and online e-learning courses for PFA.) The case example below from Greece highlights how PFA orientation was used not only for skills training, but also as a vehicle for supporting participants.



PFA Orientation as a Vehicle for Staff Support in Greece

"I've been working since 2007 with the Babel Day Centre, a mental health unit for migrants and refugees. In 2014, there started the huge influx of people coming from Turkey to the Greek island – people from war-torn countries such as Syria, Afghanistan, Iraq, Iran, etc. We were asked to facilitate PFA trainings for those who were receiving refugees on the islands – on our own together with iNGOs such as War Trauma Foundation and International Medical Corps.

Trainees belonged to different professional categories such as health and psychosocial staff, police officers, coast guard, volunteers. All people were keen to participate, to acquire skills that would allow them to help those who were coming. They had much good will, very good intentions and were motivated – but most of them lacked previous experience, the proper skills and attitudes.

I learned many things while adapting the guidance [in this situation] in Greece: particularly to be sensitive to training needs of participants as they were expressed by them, to understand that training is a form of support, and that it can be used also for team building and in order to bring people working in different organisations together – to facilitate their learning from each other and exchanging experiences and know-how. PFA had a large impact as it allowed them to get organised as individuals and as teams, and to understand that good intentions are necessary but not enough. Especially it helped them to trust themselves and to pay attention to their own and their team's care. What I will take away from this experience is a profound respect for people working on the front line – and a sense of responsibility for their wellbeing."

– Nikos Gionakis

Several interviewees felt that PFA orientation and training had been most important in helping to give community psychosocial workers a legitimate place within the emergency response and within multi-disciplinary teams. For example, in the Ebola crisis, a couple of interviewees reported that following PFA orientation, mobile medical teams of doctors and nurses had a better understanding of the skill set that community psychosocial workers were bringing, giving these workers space and legitimacy on their teams. It has also been a fundamental skill set within training for MHPSS staff, such as case managers and counselors, in emergency settings. In addition, one interviewee noted that it has been useful as a concrete tool for lay people that they can use to help people in meaningful ways, and that also values their contribution in emergencies. It helped them to address the common challenges they encounter as lay people helping in emergencies, as described in the case example below.

PFA as a Practical Tool for Community Workers in Peru

"During PFA orientations, it's easy to draw the MEC on the board "Mirar-Escuchar-Conectar" in Spanish, or "Look-Listen-Link". For Look, participants often say they don't have to look that much because there's so much to do in the emergency, and usually it is affected people that look for them to be helped. Because of the overwhelming demands, they have to prioritise, for example, the children, elderly or sick people [as described in the guidance]. Addressing basic needs as part of MHPSS also gives them the feeling of working with a ground-level approach. The way PFA is written allows me to emphasise that they need to Listen not just to emotional concerns but also to everyday concerns of people in the midst of the emergency – as well as listening to people's capabilities! When arriving to Link, we can see that participants really felt relief to hear that they don't have to have the answers for all demands people are posting. That they have to connect, to inform people about better ways to find help. But they also realise that before going to the field to work in emergencies, they have the ethical principle of being Prepared."

– Miryam Rivera Holguín

For some interviewees PFA has been most important as a tool for advocacy for MHPSS in emergencies in general – particularly because it is a WHO publication and therefore carries legitimacy and weight with governments and donors. Having a consensus approach endorsed by so many international agencies was also felt to be important for MHPSS actors in the field to be able to present and promote their work. It also has provided a useful entry point to policy makers for some interviewees. One notes that the Do No Harm principle was easy to use at high levels in the UN system, and that the approach was something that policy makers and ambassadors could imagine as being useful and do-able: “mental health, on the other hand, is too complicated”. Another interviewee noted that the popularity and global take-up of PFA has helped to lay the foundation for MHPSS work at high levels both within her organisation and within the various regions of the world where the organisation works. (See case example below.)

“PFA gave a wonderful entry point for policy people to look at mental health. Especially in a way that was not affected by too much stigma. The content and title were helpful to mainstream into development and human rights.”

PFA Laying the Foundation for MHPSS Scaling in the Middle East and North Africa

“In our Gaza programme, PFA was taken up enormously and used as a basis for providing psychosocial support. The success of integrating PFA into Gaza MHPSS programmes led to much bigger interest in other Middle East responses. So, our MENA programmes are now offering PFA, mhGAP and [a range of other MHPSS interventions]. And we’re working with remote partners in Syria on a multi-million-dollar grant incorporating MHPSS, protection and other interventions. What started out as a simple PFA and IASC MHPSS guidelines training in Gaza with communities has expanded into an entire regional interest in MHPSS. It brought in money and supplemented, health, humanitarian protection and other programmes in the region. Now we’re doing many programmes from the MHPSS lens. It blew open the door! PFA made people think – people must be psychologically affected by the conflict – what can we do?”

– Alison Schafer



Finally, some interviewees note that national capacity building efforts in PFA provided the vehicle for stronger engagement with local government and other organisations – and for building bridges between various entities (including community members) for coordinated emergency MHPSS responses. For example, engaging different organisations and entities in ToT efforts in Japan – including local community members and organisations – enhanced the dissemination of PFA throughout the country as well as cooperation among different entities in order to be more relevant and responsive in different situations. The contribution of PFA capacity building to enhanced coordination and coverage of MHPSS for recently-affected survivors is also highlighted in the case example below from Sweden.

Enhanced Coordination for Frontline Psychosocial Support in Sweden

“As part of emergency preparedness and response for 11 municipalities in southern Sweden, we train people in all emergency-related jobs – firefighters, police, ambulance workers, hospital staff, as well as the psychosocial support groups (e.g., social workers, teachers, nurses, coaches, church people). Once we had a very big car accident in the winter – 100 vehicles affected, 50 autos and 50 trucks on slippery bridges. Each discipline did their work with PFA teams. For example, firefighters rescued people in trapped cars, and engaged others from the vehicle who were not stuck using PFA principles. Emergency staff were on the scene and worked very carefully to get people moved on to the right place. The non-injured were put in buses with PFA trained staff and later moved to support centres where a special psychosocial team offered PFA. PFA was also provided in hospitals as people arrived there, with helpers listening to people’s needs and requests and linking them to appropriate services. PFA was also used with professional staff to support them as they decompressed after the intensity of the work, and with firefighters and ambulance staff injured in the response.

It was orchestrated like a ballet in the whole province! Each discipline also had a command centre, and the provincial governor was also involved and in contact. We could follow where people were, where they went, who was caring for them. We coordinated with tow trucks, media, relatives, and on and on. In retrospect, we were prepared, trained, organised and we are proud of the work we did. We trained and practiced over and over again for these events, and everyone had the same training so it was easy to communicate with each other. Each discipline had PFA in common with the others. We could talk to each other and understand what was needed. People needed charging cables for mobile phones, and we anticipated food and shelter. We had psychosocial resources. But the highest priority for people was to communicate with friends, family, employers and so on. We made sure they had clothes, toothbrushes, hotel rooms, but these were not as important as the connectivity.

We learned that we must be trained and keep up to standards – and have common standards such as PFA – among all branches of emergency services. We have developed more networking among the services.”

– Göran Tesfai Skoglund

Two interviewees, both of whom are very experienced MHPSS practitioners, noted that the WHO approach has not been important to their work. One has deliberately avoided using both the term and the manualised PFA approach because she fears this undermines people's natural empathic, coping abilities and leaves them feeling they cannot act without training. She favours starting directly with what people are already doing, and building on what they already know about appropriate helping responses without the use of any technical language. The other interviewee felt that the framework articulated in the guide was useful, but was not necessary for her as an experienced trainer and field practitioner. She agreed that PFA is really about what is practical and natural for people to do for others in crisis situations, and it is crucial to retain this.

“We're a bunch of older trainers, we need to be ready for the modern world. Humanitarian aid is not what it was when we began. Thousands of humanitarian aid workers are out there now, and people are using their phones. They like manuals, structure and to pick up their phone and say, 'what do we do?' PFA has been timely in that. It fit a need. We need to help make sure it doesn't make people lose the natural helping mechanisms that people do.”

MAIN STRENGTHS OF PFA MATERIALS

WHAT ARE THE MAIN STRENGTHS OF THE PFA MATERIALS?

Nearly all respondents felt the main strength of the WHO PFA materials was the simple language used, that has lent itself easily to various translations and cultural and contextual adaptations. Having multiple translations is also felt to be a major strength, facilitating its implementation and uptake across various regions of the world. Furthermore, the illustrations (artwork used in the guide) were felt to reflect the content well, to be engaging, and to transcend language and culture. One interviewee has used only the illustrations in orientation with non-literate groups with great success.

“Look, listen and link just sort of rolls off the tongue – 3 catchy words!”

“A lot of the time the guidelines we write in the field are very technical, even though we try our level best to make them relatable. To have something like PFA that is a simple, good product is really great. That's what makes it a common denominator – you don't have to be a specialist to understand it.”

One interviewee particularly mentioned the usefulness of the two-page pocket guide at the end of the PFA Guide, and another that the guide can be read in about 40 minutes cover to cover, increasing its accessibility to non-MHPSS people. In addition, interviewees mentioned that PFA being able to be offered also by non-professionals is a significant strength.

In addition, interviewees mentioned the free accessibility of the materials on the WHO website, and the consistent web address for those materials over time as strengths. The consensus-based process of development of the materials was also considered a strength, as well as the extensive review that ensured concepts were widely acceptable. One interviewee noted that the approach described in the materials has held up over time, and remains relevant and necessary in emergency settings to promote a Do No Harm approach. Further, it was noted that the quality control that WHO provides as copyright holder has helped to ensure fidelity to the model in the various translations.

Many interviewees felt the training materials were a strength – “an attractive package” and easy to train from – and that provide a do-able framework for a one-day PFA orientation. Interviewees particularly appreciated the experiential, “hands-on” process of training described in the facilitation manual, which is a new approach in many contexts where lecture is the mainstay of training. The PFA facilitation materials were therefore felt to be revolutionary for their capacity building efforts. In particular, one interviewee mentioned the usefulness of the simulation exercise in the beginning of the training manual, as this demonstrates what really happens in emergency settings. Nearly all interviewees adapted the training materials to their context and organisational needs. For example, case studies were adapted to the local context (as is recommended in the facilitation manual). One interviewee mentioned that one strength of the online PFA training course on the Plan International website is that it is true to the content and spirit of the WHO PFA guidance and other materials.

MAIN WEAKNESSES OF PFA MATERIALS

WHAT ARE THE MAIN WEAKNESSES OF THE PFA MATERIALS?

Several interviewees felt the PFA guide itself has no inherent weaknesses. It seems to be a solid product that remains useful and flexible to apply over the years in various crisis contexts. Interviewees also commented on the fact that simple tools are needed in the field for programme managers and others to use and disseminate – and PFA has filled a gap in this regard.

Some interviewees felt the simplicity of the guidance, while being its greatest strength, may also be its weakness. One interviewee stated that the danger of simplicity and accessibility is that PFA has morphed into something it was not intended to be, and the core of the guidance had been lost in the process. One interviewee felt there was a tendency for people to “take the headlines but not the content and the basis of empathy”. Its simplicity may also lead to the misconception that MHPSS programming in complex environments is also simple. An example provided was the challenging situation of the lack of resources in many settings to which people can Link affected people for additional help when needed.

“I’ve known a PFA orientation to last 2 hours and talk about Look, Listen, Link – but not talk about communication, empathy, the extent of links and supports that people need to be provided with, or the needs of special populations groups. That’s concerning.”

Others felt that its popularity has also caused other difficulties. For example, one interviewee felt the materials were so simple and easy to train on that people in the field became lazy in planning what to do 2-3 months post-emergency. She stated that this is when people are beginning to experience adjustment difficulty and more enduring or complex problems, but the next steps and approaches were not clear. One interviewee noted that where other services don’t exist or staff have not been trained in further approaches, some field programme staff continue “to do PFA” over time inappropriately in chronic stress situations.

“[MHPSS] is a spectrum. PFA at one end, with skills shifting along the continuum with case management and counseling at the other end of the spectrum. You can’t call everything PFA. It does an injustice to [the skills required for] case management and lay / barefoot counseling.”

In terms of weaknesses in the PFA facilitation materials, some interviewees felt they were too heavily dependent upon powerpoints and gave too much detailed information for inexperienced trainers. One interviewee stated that inexperienced trainers therefore tend to run through the powerpoints in a didactic way, since they don't know what to keep in and what to take out. One interviewee found the powerpoints useful, but felt the manual itself was too long to be practical. Although several stated there is value in this for initiating the roll-out of capacity building efforts, they felt more attention to experiential processes and how to adapt case scenarios to the culture and context may be more useful. Several interviewees admitted that over time, their experience with PFA orientation and training has made it easier for them to focus on adaptation in new contexts and less dependent upon the manual and powerpoints. However, supervision of how newly trained ToT participants use the materials is needed. One interviewee noted that newly trained PFA trainers sometimes add new slides that are not relevant to PFA or that are incorrect.

“I used to have over 100 slides, now I have 20. I did a workshop in Uganda that was very experiential. If I have limited time, I want participants to discuss and role play, and not read slides”.

“The number of slides can be daunting, especially in an emergency. A slide set for ‘PFA-lite’ might be helpful.”

A few interviewees also mentioned that the most important part of training is actually related to how the principles of PFA (safety, dignity and rights) can be upheld in challenging contexts and what this means in practice for participants. They suggested that the facilitation manual could focus more upon how to relate the principles to participants' contexts. Similar to this, one interviewee mentioned that the training manual needs to be more explicit about how values of care get interpreted and expressed. He gave the example that some values related to the ethics of care (e.g., interpersonal relations, boundaries, respect) may not be universal values, but are values related to autonomy, dignity and rights that can be upheld regardless of cultural relativism.

It was also noted by one interviewee that some of the training material contains information that is not in the PFA guide itself. This is information that provides some larger context for MHPSS in humanitarian emergencies, but some less experienced trainers struggle to be credible because they are unable to answer questions about this larger sphere. It was felt that combining the PFA ToT with other training can be very useful, particularly training in the IASC MHPSS Guidelines. In fact, some interviewees only provide PFA orientation as part of a larger training package, so that its place within the spectrum of MHPSS supports is clearer.

A couple of interviewees felt the Ebola adaptation of PFA materials did not add value beyond the original materials, and an entirely new manual was perhaps unnecessary. Rather, they suggested that adaptation guidance could have been developed for applying PFA in this context characterised by stigma and with the barriers of helpers needing to wear protective body equipment that separated them from affected people. This interviewee also felt an opportunity may have been missed to develop adaptation guidance of the original materials for any infectious disease outbreak. The other interviewee worked in the Zika virus outbreak in Brazil and felt that, although PFA was well regarded as a WHO publication and therefore helped to open doors with authorities, they were able to avoid some of the pitfalls of PFA (see below) by incorporating the approach more anonymously within a general guidance document called “Psychosocial Support for Pregnant Women and Families”⁴⁷. This approach contained guidance that was consistent with the PFA guide but avoided labeling or referencing it explicitly, and allowed for inclusion of more holistic and integrated MHPSS interventions in the response.

47 World Health Organization (WHO). Psychosocial support for pregnant women and for families with microcephaly and other neurological complications in the context of Zika virus. WHO, Geneva; 2016. <http://www.who.int/csr/resources/publications/zika/psychosocial-support/en/>

Few interviewees were familiar with the online course, and this was mentioned as one of the limitations of this resource. One interviewee felt that the course being housed on a particular iNGO platform may be a weakness, and a more neutral online home may help people to better know about and access it.

RECOMMENDATIONS TO IMPROVE PFA MATERIAL

WHAT DO YOU RECOMMEND FOR IMPROVING PFA MATERIALS/RESOURCES IN THE FUTURE (E.G., REVISING EXISTING GUIDES, ONLINE FORMATS)?

A couple of interviewees warned against changing the content, and potentially losing the good balance of what currently exists in the materials. Others provided the following suggestions for improving PFA materials and resources:

- More attention to how to contextualise the PFA materials in different cultural and crisis contexts (rather than adaptations of the guide itself for different crises), such as developing an adaptation tool
- A collection of case scenarios from different parts of the world to demonstrate adaptations of training materials
- The use of video or interactive technologies (e.g., video clips of interactions between helpers and affected people scripted and acted by professional actors) to enhance training in PFA helping skills
- A quality, online PFA e-learning course that is housed on a popular and easily accessible online platform for MHPSS practitioners, and that uses voice overs, high-level animation and/or video for communication skills training (with the potential to add translation from existing translated guides). It was also suggested that an online course, rather than being completely self-learning, could be accompanied by tutors who follow a group of participants and facilitate group discussions on various topics, exercises and cases.
- An evaluation of the facilitation materials now that they have been field tested – and potential revision with the inclusion of more training aids, streamlined powerpoints, and a shortened version for quicker orientation in acute emergencies where needed.
- ToT guidance that includes follow-up coaching and supervision to ensure fidelity to the model, and possible certification for trainers. (But with certain cautions – being clear that one does not have to be an MHPSS professional to offer training, and that certifications are not given for people oriented in PFA so as not to professionalise it.)
- An online training module for PFA ToT in order to give brief guidance to trainers who don't necessarily need a full ToT but could use some pointers and a chance to go through the material in an interactive way (e.g., a 10-minute video explaining ToT, where it's been implemented and case studies to go along with it).
- A collection of brief case studies to illustrate how PFA was used in different countries (e.g., who was trained, how it was used, how it helped) and to stimulate creativity in how it can be applied in other contexts.
- More creative materials (e.g., scenarios, picture-only versions of the guidance, stories and images) for use with populations who are not text-based in their learning.
- Self-directed learning formats, such as a PFA workbook that contain

“If there’s a basic tool for a self-help strategy based on PFA that has the do’s and don’ts and exercises related to targeted skills – something like a workbook to go along with “PFA lite”- it would be so helpful for local people to reinforce what they learn in orientation, or for peer facilitators who can’t return for follow-up training or supervision.”

- more examples, checklists and space for self-reflection on how to apply PFA in one's own context
- Moving up the information on staff care to earlier in the guidance and facilitation materials, given its importance, and including more stress management techniques.
 - Assembling the interesting applications and adaptation of PFA for various care providers, such as dentists, police officers, firefighters and others.
 - Developing guidance on PFA for infectious disease outbreaks as a stimulus for more MHPSS attention in this area.

POTENTIAL DANGERS OF PFA

WHAT DO YOU FEEL ARE THE POTENTIAL DANGERS OR PROBLEMS WITH PFA?

Several interviewees felt that PFA itself is not dangerous – and that the point of PFA was to avoid or minimise harm. One interviewee was actually surprised to hear that anyone thought there were dangers associated with the PFA approach. Other interviewees also expressed that “problems with PFA” are actually not with PFA itself, but with how people are communicating about PFA and about MHPSS as a whole. One interviewee saw this as a problem for the MHPSS field as a whole that is not specific to PFA – a general misunderstanding amongst donors and others about what it means to truly “cover MHPSS programming”. She gave the example that people with pre-existing mental illness are frequently left out of various MHPSS plans and interventions.

However, many interviewees expressed various problems with how PFA is being applied in the field. For example, in protracted crisis situations where distress is due to the long-term stressful situation, they felt PFA is being inappropriately carried on as the sole “intervention” where other tools and approaches are needed. In addition, the term PFA has become ubiquitous and synonymous with “MHPSS”, rendering it meaningless in some situations. For some interviewees, this is a result of the “business” of the humanitarian system where low-cost, widely scalable interventions are valued over other interventions that are more resource intensive, but necessary to appropriately care for people in the situation. As part of the “humanitarian business”, they also felt that there is a perception that PFA must always be done in all crisis situations, but upon closer look, it is not clear what people are really doing when they “do PFA”. One interviewee gave the example of stand-alone “PFA providers” being trained to go to affected areas after a crisis to talk to people, but divorced from other training, supports or programming.

“What’s the damage really if anyone takes it and runs with it? What damage can it do to listen to people, link them with help, etc.?”

“Saying PFA gives the message that it’s the only MHPSS response is like saying that physical first aid is the only health response. It’s silly.”

“We’ve gained ground in the fact this PFA is a legitimate area in skill sets responders should have. But we’ve lost ground in others understanding the breadth of experience that is needed for MHPSS in emergencies.”

“The problem now is that a lot of people in my work use it to mean everything that has to do with first-line psychosocial assistance in emergencies. I often find proposals where they talk about PFA, but they are doing the full range of things. So, it’s not understood semantically and is increasingly used incorrectly.”

“In the spectrum of ‘offering a cup of tea’ to ‘psychological intervention’ do people really know what it is? It can become everything and nothing.”

This reminded him of previous negative experiences with psychological debriefing teams and the potential danger of inappropriate counseling efforts happening as frontline interventions.

Another danger expressed by many interviewees was that many participants in PFA orientations over-estimate their capabilities believing that they have gained counseling or therapy skills – even though this is clearly stated in the guidance as something PFA “is NOT”.

A few interviewees mentioned that the initial placement of PFA as a layer 3 “intervention” on the IASC MHPSS pyramid in the facilitation materials may have fueled some of the misapplications of PFA. In part, it was felt that this is because the pyramid itself can be contentious and has different interpretations. One suggestion to counter this problem was to see PFA as a skill set and not an intervention, and therefore not relevant for any particular layer of the pyramid but rather across various interventions. Other interviewees alternatively suggested layer 1 (social considerations in basic services and security) is more appropriate as it relates to improving the recovery environment. In this case, “orientation in PFA” would be the layer 1 intervention (PFA itself being likened to communication and helping skills). In addition, one interviewee felt that where or whether PFA fits on the pyramid was not actually a danger, but it did reflect how agencies conduct their training and report on their activities to donors. Therefore, having consistency on this would be useful across the field.

PRIORITY FOCUS AREAS FOR THE FUTURE

WHERE DO YOU THINK WE NEED TO GO WITH PFA FROM HERE? WHAT WOULD BE IMPORTANT TO FOCUS ON?

Interviewees provided a range of suggestions in response to this question, including:

- Quality control in terms of how PFA is being implemented and how orientation and training is being conducted. Some interviewees felt there should be more control on who is training and whether or not they are keeping fidelity to the model in the guidance and facilitation manual.
- Clarify what PFA is and is not, and the boundaries about how it should be applied within integrated, multi-layered MHPSS services in complex situations – particularly with the donor community, IASC MHPSS RG member organisations at local level.
- Emphasise PFA less in general, as it already has sufficient “push”, and instead “develop an MHPSS package for emergencies with 20-30 options that include sensible, evidence-based and adaptable interventions in the social and medical fields (including interventions for children)”.
- Link PFA with other types of MHPSS programmes and approaches, such as child friendly spaces, case management, and lay/barefoot counseling to help ensure that organisations are providing it as part of a range of interventions.



- Tease out how people perceive the name “PFA”, and people’s expectations of the name.
- Develop a monitoring tool to ensure that PFA is implemented in ways that Do No Harm.
- Consider making PFA a mandatory, pre-requisite for training for all health staff, including as a pre-requisite for training in mhGAP (Mental Health Gap Action Programme by WHO). This would help to ensure both that respectful, active listening occurs when evaluating people with a mental disorder, and that health professionals are linked up with humanitarian actors for referral to MHPSS interventions outside of the health system (with child friendly spaces, etc.)
- Better articulate PFA within disaster preparedness efforts, which will help to communicate its place as a “first response” measure and build skills for what comes next in MHPSS interventions.
- Better understand how PFA is being used both with children in child-to-child PFA approaches.
- Articulate a basis for studying PFA on its own terms, related to its core aims. Consider ready-made protocols and tools for evaluating PFA in emergencies that would be useful to small groups of local responders and research teams in different settings – as well as researching the impact of PFA at the grassroots level with community members.

THOUGHTS ON THE EVIDENCE BASE FOR PFA

WHAT ARE YOUR THOUGHTS ON THE EVIDENCE BASE FOR PFA?

Some interviewees felt that it is neither necessary nor actually possible, to measure the outcomes of PFA for beneficiaries for a variety of reasons. For example, one interviewee noted that the key skills within PFA already have a solid body of evidence over the long time that PFA has existed (prior to the 2011 WHO publication). Interviewees also felt that, at its core, it is about respectful relationships and a humane approach reflecting what people should already be doing from an ethical point of view – and evidence was not needed for this. In this sense, one interviewee noted that PFA relates to over-arching humanitarian principles, accountability frameworks and human rights – and that there are no calls to “do an RCT to know if it’s important to talk about dignity”. It was also distinguished by interviewees from clinical interventions with discrete inputs in each case, so they felt it clearly does not lend itself to evaluation in terms of clinical/symptomatic outcomes.

“When you understand the essence of PFA, then it’s a bit silly to say there needs to be an evidence base for natural human things that we do.”

“We don’t need a randomized control trial to show that being nice to people is a good thing.”

Despite this, other interviewees felt that building an evidence base for the effectiveness of PFA is important for the field, as having evidence and numbers would better help to engage policy makers. They emphasised that it would first be essential to define what kind of effectiveness is of interest. In other words, it would be important to clarify what outcomes are expected from PFA that are clear and that reflect what PFA is intended to do – e.g., to promote dignified, supportive, frontline care. Systems level outcomes were mentioned as being of interest, such as documenting how the application of PFA has changed over time, and how its use has evolved. It may also be important to have an agreed clarity about whether or not PFA can help in the prevention of mental health problems following an emergency.

“It’s pretty bad that people ask us, does it work? And we can’t say anything. But we need to be very clear what we think PFA will do before doing any study. Don’t go on a fishing expedition. Find a crisp research methodology and test something we really want to know and could find out.”

One interviewee advocated for more implementation science to evaluate PFA –mixed methods studies to evaluate outcomes for those who receive orientation and provide PFA. For example, three objectives she uses are for those oriented to: 1. Be able to recognise distress in themselves and their colleagues; 2. Know what to do for themselves and their colleagues; and 3. To know when and where to do referral. She feels that if we have clearly articulated objectives for PFA orientations and ToT, then we should be able to measure outcomes, and it is important to do so.

HOW THE IASC MHPSS RG OR PFA GUIDE AUTHORS COULD IMPROVE USE OF PFA

IS THERE ANYTHING SPECIFIC YOU FELT THE IASC MHPSS RG, OR THE AUTHORS OF THE PFA GUIDE, COULD DO TO IMPROVE THE USE OF PFA IN EMERGENCY SETTINGS?

Suggestions from interviewees to this question included:

- Prepare and publish a guidance document about the top ten mistakes that people make with PFA and how to avoid those mistakes (clarifying its place within the scope of MHPSS interventions).
- Give advice on how to include PFA appropriately in proposals, and develop common indicators and approach to M&E of interventions that utilise PFA – including a way to report on deeper outcomes (such as skills development and promoting understanding of the need to support survivors of emergencies among local people).
- Conduct more implementation science research to evaluate PFA, utilising mixed methods and with a focus on outcomes related to clear and pragmatic objectives for those who receive orientation and provide PFA (including those at grassroots community level).
- Develop a guidance note on how the foundations of PFA (i.e., the skill set) can be incorporated appropriately as an integrated component of all MHPSS programmes, not just used solely in emergency response.
- Link PFA to the newly emerging scalable interventions, in order to demonstrate where PFA sits within a comprehensive system of care.
- Continue to spread and scale PFA to different regions of the world, such as ASEAN countries with disaster-prone islands, and fund distance learning webinars for countries in these regions.
- Strengthen the linkages of PFA capacity building to other IASC member groups, such as the protection cluster, as part of mainstreaming efforts.
- Strengthen the human rights /values perspective within PFA approaches to contribute to approaches such as safe and secure environments.
- Publish a new advocacy or reference document to update the range of new MHPSS interventions and approaches available, and include PFA with guidance about its place in the spectrum of support and services.
- Keep it alive within the IASC MHPSS RG and keep engaged with it – keep sharing experiences with it and keep it going through processes of reflection, new applications and research, as it is a common denominator among all the RG members.

“If you put something out there, you have to tend it.”





Chapter 4. Lessons Learned and Future Recommendations



Chapter 4. Lessons Learned and Future Recommendations

Overview

The PFA 5-year retrospective has provided both quantitative and qualitative data about the ways PFA has been applied in different contexts around the world and by a variety of actors; the ways in which PFA is perceived, and its strengths as well as pitfalls. Combining information from the desk review, online survey, and key informant interviews and case examples provides the opportunity to draw upon common threads to articulate lessons learned and future recommendations.

Various practitioners have adapted the PFA resources and applied PFA appropriately for their particular cultures and contexts. The simplicity and accessibility of PFA has helped to capitalize on existing human resources in emergency settings – from community members to multi-sectoral actors and MHPSS professionals – in order to expand the reach of frontline support to those who are distressed. It has also captured the attention of the international community and donors, helping to demystify MHPSS and serving as one of the vehicles moving the field forward in recent years.

However, PFA has also been used as a panacea where other MHPSS responses don't exist or in the absence of other accessible, clear guidance for next steps after PFA. There appear to be many misconceptions about what PFA is – including its limitations – and, as PFA has been widely and freely disseminated, fidelity to the original model was not always guaranteed. A particular concern of stakeholders in this retrospective was how best to retain the core spirit of PFA as a humane, *Do No Harm* approach in frontline responses in emergencies as it is scaled and mainstreamed.

The concerted effort of various local and international actors in the MHPSS field is required to best meet the emerging global challenges for “integrated and multi-layered” MHPSS that provide a comprehensive and coherent *system* of supports. From the lessons learned in this retrospective, PFA is a useful complement within this larger framework of skills, tools, approaches and interventions. But it cannot cover the range of complex and longer-term issues of distress and mental disorder in emergency settings – including complicated grief, exposure to extreme loss, the perils of displacement and migration and exposure to serious adversity and human rights violations.

However, despite its pitfalls, PFA has opened the field to various actors who previously did not engage with MHPSS and provided an entry point for expanding the range of actors who can provide critical, frontline support and referral. By engaging a wider audience and raising awareness of MHPSS needs among donors and multi-sectoral actors, PFA helped to open the door for other MHPSS approaches and interventions necessary for the recovery and wellbeing of people affected by crisis events. The recent emergence of accessible, scalable interventions is beginning to fill the gap of “what comes next”, along with existing models of case management and the engagement of governments in “building back better” MHPSS systems.

“PFA at one level has really benefitted from being distilled into this little package. At the same time, it is just one representation of the principles that underly it. The danger is that people focus too much on the little package and don't see how it can be adapted to other settings, how to transform it, and how it resonates with broader programming principles. Being able to explain PFA in a broader sense will ultimately be a useful thing for PFA and as a bridge/gateway to thinking about larger structural and process reforms in humanitarian service provision and intervention.” – Interview respondent

Specific Findings and Recommendations

Contributors to both the online survey and the interviews provided recommendations detailed in this report about: 1) how the PFA materials can be improved, 2) where to go from here with PFA (a focus for the coming years), and 3) how the IASC MHPSS RG, or authors of the PFA Guide, could improve the use of PFA in emergency settings. An overview of those recommendations is provided below.

1. HOW THE PFA MATERIALS CAN BE IMPROVED:

Contributors valued the simplicity of the PFA materials and their free accessibility on a stable web platform through WHO, and they particularly emphasised the importance of having materials available in local languages – both the guidance itself as well as online resources and forums. Overall, contributors felt the content of the guidance has withstood the test of time, and they advised not to lose “the good balance of what currently exists” in the materials through revision.

Suggestions to improve the materials therefore were focused around its practical application and contextualisation, online resources, and guidance for facilitators and ToT trainers to ensure fidelity to the model. The following is a sample of specific recommendations provided in this report:

- Develop an adaptation tool for contextualising the PFA materials for different cultural and crisis contexts, and for different care providers (across various sectors). Also develop a general adaptation for infectious disease outbreaks.
- Collect brief case studies to illustrate how PFA has been used in different countries and contexts to stimulate creativity in its application in other settings, including case scenarios to demonstrate adaptations of facilitation materials.
- Evaluate the facilitation materials for potential revision, including: additional training aids, streamlined powerpoints, and a short version for quick orientation in acute emergencies. Promote the facilitation materials to enhance fidelity to the model.
- Develop a quality, online PFA e-learning course housed on a well-known and easily accessible web platform utilising voice-overs, animation, video or interactive technologies for communication skills training (with potential for translation) as a complement to face-to-face orientations and trainings.
- Develop ToT guidance (including a brief online module) to help ensure fidelity to the model, and that includes pointers for interactive trainings, case studies from around the world, and follow-up coaching and supervision guidance.
- Develop self-directed learning formats (e.g., PFA workbook) for applying PFA in one’s own context, as well as creative and non-text based materials (e.g., picture-only version).
- Enhance the dissemination of the materials and their application through the online forum, promoting a global community of practice for PFA.

2. PRIORITY NEXT STEPS FOR PFA:

In addition to the recommendations for improving the materials, contributors had a variety of suggestions for priority next steps for PFA, including: clarifying what PFA is and is not, mainstreaming PFA across humanitarian sectors, strengthening the evidence base and developing practical tools for monitoring and evaluation, and ensuring quality in PFA orientation and training (ToT). The following is a sample of specific recommendations provided in this report:

- Develop and standardise data collection tools for monitoring and evaluation of PFA relevant to its practical applications (including Do No Harm), including ready-made protocols for local implementers to evaluate PFA in emergencies.
- Build the evidence base for the practical application of PFA through implementation science that utilises mixed methods to evaluate clearly defined outcomes for those who are oriented and providing PFA.
- Provide quality control by better operationalising PFA capacity building, including a mechanism to monitor orientation and training (i.e., in terms of fidelity to the model), systematic follow-up of how it is implemented, and guidance for follow-up supervision.
- Ensure PFA is not seen as the “only MHPSS intervention” in emergencies by emphasising an MHPSS package in emergencies that links and integrates PFA with a range of other MHPSS interventions, such as child friendly spaces and case management, and consider mandating PFA orientation as a pre-requisite for training for all health staff (including training in mhGAP).
- Continue and broaden mainstreaming efforts within a range of humanitarian sectors.
- Include PFA in disaster preparedness plans as a frontline response, and formalise the approach in public policies.

3. HOW THE IASC MHPSS RG OR AUTHORS OF THE PFA GUIDE CAN IMPROVE ITS USE IN EMERGENCY SETTINGS:

Contributors advised the IASC MHPSS RG and authors of the PFA guide to continue to keep it “alive” in inter-agency discussions within the RG as a foundational approach in MHPSS, and to tend to its application through ongoing reflection, new applications and research. This would include strengthening linkages to other IASC member groups, such as embedding PFA within the protection cluster through complementary training and roll-out. Several recommendations related to forming an active PFA community of practice that could facilitate exchange of professionals and field practitioners, provide examples of contextualisation of PFA in varied settings, develop additional materials and visuals for specific contexts, and keep everyone updated on new materials, adaptations, availability of online resources.

To clarify its place within the spectrum of MHPSS supports, a sample of the recommendations given in this report to the IASC MHPSS RG and authors include:

- Develop an overall guidance note/advocacy document for MHPSS in emergencies that can update the field on available (and some newly developed) tools and approaches, and how to incorporate PFA appropriately within a comprehensive system of care.
- Link PFA to the scalable approaches (e.g., mhGAP).
- Clarify how PFA relates to the IASC MHPSS intervention pyramid.
- Give advice on how to include PFA in proposals, including developing a common approach to indicators and monitoring and evaluation of interventions that utilise PFA.

Building the evidence base for PFA through implementation science in varied cultural settings was recommended by advocating for increased donor support for research, as well as regular annual forums to discuss findings of studies, create an action plan to improve capacity building efforts, and staff a community of practice with national focal points, regional and global advisors.

Summary Recommendations

In summary, several key recommendations have emerged from the 5-year PFA retrospective that encompass the main findings and reflect common themes in the data. They include:

- **Provide an updated overview of the MHPSS field that clarifies the place of PFA within the spectrum of supports**
The MHPSS field has grown and evolved rapidly in the last 10 years. There are increasing numbers of practitioners, programmes and coordination with other sectors, and increased funding for MHPSS interventions and research. Practical and innovative tools and approaches are being continually added to the repertoire of practitioners, and online forums have connected the global community of MHPSS practitioners. Within this new environment, it would be timely to provide updated information about the range of approaches, tools and forums available in the MHPSS field, and to appropriately place PFA within this spectrum of supports in terms of when and how it can be most appropriately applied. Related to this, it would be useful to clarify how PFA relates to the IASC MHPSS intervention pyramid, given experiences with its application since the launch of the PFA guide.
- **Keep attention to PFA as a foundational component of MHPSS approaches and tend to its applications in the world**
The skill set of PFA has been described in the retrospective as a foundation for the MHPSS work of many organisations and practitioners, and its simplicity and accessibility to diverse actors has been a unique strength and facilitated its mainstreaming across sectors. As other priorities emerge in the MHPSS field, it will be important to keep attention to PFA and support its appropriate application within ongoing and new initiatives. Concrete recommendations from the retrospective are to ensure its incorporation within the new scalable interventions in ways that can help to clarify its place within the spectrum of MHPSS interventions, and to promote PFA within disaster preparedness initiatives.

- **Continue to develop innovative PFA resources and technologies**

Innovative technologies, such as apps, online learning and web-based forums are valuable for practitioners across the globe and increasingly more accessible in lower resource settings. Participants in this retrospective value existing, innovative resources and are eager for additional resources not only to expand access to PFA skills and knowledge, but also to clarify how PFA can best be used by practitioners, other sectoral partners and trainers. Lessons learned from the use of these technologies with other MHPSS approaches can inform and guide the revision, development and housing of e-learning modules for PFA, video clips for use in demonstrating skills, webinars and online forums to connect practitioners, and other innovative media applications.

- **Promote fidelity to the model with support to capacity building initiatives and dialogue among communities of practice**

There is a clear need to support various capacity building initiatives and frontline emergency responses that utilise PFA. One way to do this is through facilitation of dialogue and sharing of information among local, national and regional communities of practice. Several successful models exist from which to draw lessons that can be shared in peer to peer forums and adapted to new contexts. A reinvigoration of existing forums (such as the MHPSS.net PFA group) would be an important first step.

- **Develop common approaches and tools for monitoring, evaluation and research of the relevant aspects of PFA**

Wherever one falls on the issue of the need for strengthening the evidence base for PFA, there is a clear need for common, practical approaches to its measurement and reporting for field practitioners. The field would benefit from the development of practical and relevant indicators, a systems level perspective, and simple tools for emergency responders and researchers to begin relevant data collection to inform its use in crisis response.

Conclusion

The five-year PFA Retrospective explored how PFA has been perceived, understood, adapted and applied by various actors in a wide variety of cultural and crisis contexts. It provided information about how PFA has been framed within the evolving field of MHPSS in emergencies, and elucidated recommendations for priority next steps to ensure fidelity to PFA model as an effective, frontline MHPSS approach that does no harm. These recommendations provide a starting point for various actors in the field, including the IASC MHPSS RG, to improve how PFA is mainstreamed across sectors, applied within disaster preparedness efforts, and effectively integrated within a system of multi-layered MHPSS interventions that continue to evolve as new approaches are developed and tested. The findings from the five-year PFA Retrospective can inspire and provide a basis for further exploration and research to inform future PFA applications that are appropriate, scalable and add value within the larger MHPSS field.



Annexes



Annex A. Systematic Reviews of the Literature

The following table summarises the findings of three systematic review of the literature related to the effectiveness of PFA.

Review	Findings
Bisson and Lewis (2009) ⁱⁱⁱ	<p>Given the lack of any randomized controlled trials of PFA, the authors considered any study that contained data regarding its effectiveness. They also conducted a systematic review of predictors of PTSD and depression to determine if other sources of research could inform its potential effectiveness.</p> <p>“The absence of quantitative data containing evidence to support PFA makes it impossible to determine whether it is effective or not following traumatic events. It is apparent, however, that certain factors, in particular peri-traumatic dissociation and perceived poor social support, are associated with raised rates of PTSD. This provides support for the argument that effective interventions should address these two factors.”</p> <p>They also caution, that despite a lack of evidence for PFA, the option of doing nothing risks leaving affected people with the sense of a lack of social support that has been associated with the development of PTSD following traumatic events: “Many guidelines caution against doing nothing shortly after traumatic events, arguing for the delivery of supportive, practical and pragmatic input in a supportive and empathic manner but avoidance of formal clinical interventions. Such approaches do not resemble psychological treatments, in contrast to most of the early interventions that have been subjected to randomised, controlled trials. They are psychosocial with key social elements that address people’s basic needs, such as housing, finances and nutrition.”</p>
Fox, Burkle, Bass, Pia, Epstein and Markenson (2012) ^{iv}	<p>The Advisory Council of the American Red Cross requested an independent study of whether “first-aid providers without professional mental health training, when confronted with people who have experienced a traumatic event, offer a “safe, effective and feasible intervention.” Using the keyword phrase “PFA”, an expert panel searched databases from 1990 to September 2010 for care provided only after mass casualty or disaster events. Results revealed the lack of adequate scientific evidence (including no controlled studies) for PFA, although it is widely supported by “expert opinion and rational conjecture.” There was therefore insufficient evidence to support a treatment standard or treatment guideline.</p> <p>The panel reached the following conclusion:</p> <p>“Sufficient evidence for PFA is widely supported by available objective observations and expert opinion and best fits the category of “evidence informed” but without proof of effectiveness. An intervention provided by volunteers without professional mental health training for people who have experienced a traumatic event offers an acceptable option. Further outcome research is recommended.”</p>

Review	Findings
<p>Dieltjens, Moonen, van Praet, de Buck and Vandekerckhove (2014)^v</p>	<p>Members of the Belgian Red Cross Flanders reviewed the literature on PFA in order to use the best available scientific evidence as the basis for courses and educational materials in training their emergency volunteers. In their detailed analysis of 5 published PFA guidelines, as well as two systematic reviews of the literature on PFA, they found no intervention studies to document the effectiveness of PFA.</p> <p>Among the reasons for the lack of studies, they suggest that: “Studies during the aftermath of a disaster or adversity are considered difficult to perform. Practical issues such as unpredictability of timing and context are some of the challenges typically invoked, as are ethical issues claiming that research could impede the capacity to respond in this critical time of need. The third explanation for the evidence gap can be found in the particular domain of PFA, as PFA is a multifactorial intervention based on five key principles as outlined by Hobfoll, et al. PFA interventions therefore can take on many different forms depending on the contexts and cultures in which disasters or adversities occur. Each of these interventions should be evaluated separately in experimental studies to gain knowledge on their effectiveness.”</p> <p>However, they also state: “The lack of evidence for PFA interventions obviously does not prove evidence of absence of a useful effect of PFA, but it does reveal the need for future studies on the effectiveness of early PFA interventions to support the relatively new concept of PFA... Research is needed to determine the most effective, efficient, and acceptable interventions before evidence-based PFA guidelines on how to train laypeople and professionals can be developed.”</p>

ⁱⁱⁱ Bisson JI, Lewis C (2009) Systematic Review of Psychological First Aid. Commissioned by the World Health Organisation. 2009. Available: <http://mhps.net/?get5178/1350270188-PFASystematicReviewBissonCatrin.pdf> .

^{iv} Fox JH, Burkle FM Jr., Bass J, Pia FA, Epstein JL, Markenson D. The effectiveness of psychological first aid as a disaster intervention tool: research analysis of peer-reviewed literature from 1990-2010. *Disaster Med Public Health Prep* 2012; 6:247-52; PMID:23077267; <http://dx.doi.org/10.1001/dmp.2012.39>

^v Dieltjens T, Moonens I, Van Praet K, De Buck E, Vandekerckhove P (2014) A Systematic Literature Search on Psychological First Aid: Lack of Evidence to Develop Guidelines. *PLoS ONE* 9(12): e114714. doi:10.1371/journal.pone.0114714

Annex B. Invitation to the PFA Retrospective Survey

PFA Retrospective Online Survey

Since the launch of the Psychological First Aid (PFA): Guide for Field Workers (WHO, 2011), PFA has been widely utilised as a frontline MHPSS response in emergencies. This survey is part of a larger Five-Year Retrospective on how PFA has been understood, adapted and applied by various organisations and in diverse emergency contexts. We appreciate you taking the time to share with us the experience of your organisation with PFA and your reflections about PFA within the larger context of multi-layered, integrated MHPSS interventions. This survey should take about 15-30 minutes of your time: https://www.surveymonkey.co.uk/r/PFA_retro_survey.

The survey contains multiple choice responses as well as space for sharing written reflections. If you have any questions about the survey, or would like to follow-on with an interview to provide further input, please contact Dr. Leslie Snider at leslie@peaceinpractice.org. You can also choose at the end of the survey if you are willing to be contacted to answer further questions.

This survey will be open from August 29th to [October 20th], 2017. Please disseminate the survey within your organisations and networks, including people you may have trained, frontline workers and others who may be interested: https://www.surveymonkey.co.uk/r/PFA_retro_survey.

On behalf of Church of Sweden and World Vision International, we thank you kindly for your time and reflections!

Annex C. Organisational Affiliations of Respondents

Organisational Affiliation	#	Organisational Affiliation	#
Action Against Hunger	1	Naya Health Nepal (Bayalpata Hospital, Achham)	1
Ahfad Trauma Centre, Sudan	1	Nivel, Netherlands	1
Babel Day Centre, Greece	1	OSCE	1
Care Miyagi, Japan		The London School of Hygiene & Tropical Medicine (LSHTM)	1
CBM	1	PAHO	1
Church of Sweden	1	Plan International, HQ	1
Doctors of the World	2	Prelomi - Inštitut za družinsko terapijo, svetovanje in izobraževanje, (Institute for Family Therapy, Counseling and Education) Slovenia	1
Dorcas, Lebanon	1	Psychosocial Support and Children's Rights Resource Center, Philippines	1
Good Practice Group, Sri Lanka	3		
Handicap International	2	Red Cross, East and South Africa	1
Health Works, Netherlands	1	Save The Children	11
Himalayan Children's Charities Nepal	1	<i>Save country offices: Australia – 1; Denmark – 1; Egypt – 1; Finland-1; Japan – 1; Egypt – 1; UK – 3)</i>	
IFRC (International Federation of the Red Cross and Red Crescent Societies)	1	School, Sri Lanka	1
Independent	3	Secours Islamique France	1
Imagine Nepal	1	Transcultural Psychosocial Organisation, Nepal	1
Impact-Arq, Netherlands	1	Universities:	
International Organisation for Migration (IOM/ OIM)	11	- Kanazawa University, Japan	1
International Medical Corps (IMC)	11	- Middle East Technical University, Turkey	1
IsraAID	1	- Pontifica Universidad Catolica del Peru, Peru	1
Jiwan Ship Bikash Kendra, Nepal	1	- Tri Chandra Campus of Tribhuvan University, Nepal	1
Medecins du Monde, France	2	- University of Miyazaki, Japan	1
Mental Health and Psychosocial Support (MHPSS)	3	- University of Tokyo, Japan	2
Ministry of Health, Fiji	1	- University Tunku Abdul Rahman, Malaysia	1
Miyagi Disaster Mental Health Care Center, Japan	1	- Yamagata University, Japan	1
Mvogo, Cameroon	1	UNRWA (UN Reliefs and Works Agency for Palestinian Refugees in the Near East)	1
National Center for Disaster Psychiatry, Sweden	1	Uzima Mental Health Services, Kenya	1
National Center for Neurology and Psychiatry, National Information Center for Disaster Mental Health, Japan	3	World Health Organisation (WHO)	7
National Disaster Medical Center, Japan	1	World Vision	3

Annex D.

Perception of the Term “PFA”

The following are the comments provided to the question about perceptions of the term “PFA”.

1. I am having real difficulty with this questionnaire as I strongly disapprove of the term.
2. Everyone who has gone through a crisis situation needs this assistance, it is the starting point of resilience.
3. Unfortunately, quite varied practices are provided under the same umbrella.
4. I felt the term is useful in linking MHPSS to emergencies, however it is somewhat misunderstood and needs to be defined – yet this is not a significant issue.
5. I felt it is not useful for the context I came from. I think it is a great approach for people exposed to one trauma or risky situation ever, making someone talk about his feelings while being under the risk since he was born, or for ten years, doesn't make sense in many situations.
6. It is useful, but is now being used as if it is PSS, i.e., interchangeably. Giving food, shelter, non-food items – all this is now PFA. Any talking one does with someone is also called PFA – is it?
7. It is a term people know, even within non-MHPSS sectors.
8. Much better than MHPSS or PSS!
9. It is currently used after earthquake disaster in Nepal.
10. I have heard it referred to as “Psychosocial First Aid” a lot too.
11. Need to use local terms in context if and when necessary. PFA still too technical because of the word “psychological”.
12. People often got intimidated to practice because the title contains disaster and emergencies which make people think this tool is not for me – e.g., I am not a disaster worker.
13. It misses the strong social component (linking to social support) and can create the impression that PFA providers provide counseling/psychotherapy.
14. There are two types of risk if we conduct PFA for children, not PFA WHO version training. Risk or Misunderstanding is No. 1. Some participants think he/she can get a kind of expert skills for a one day training. Participants understand the contents gradually through training. Risk or Misunderstanding No. 2. As the title is “Psychological”, some may consider they come from a different field.
15. “Psychological” is stigmatizing in some cultures and also sometimes disingenuously represents the intervention causing trained individuals to misunderstand their skills after being trained, or to believe it's not suitable for them if they come from a different field.
16. The “Psychological” part isn't helpful – it makes people think of counseling.
17. The term may be misunderstood, but it became a well-known term in Japan, especially among the emergency responders and MHPSS professionals. I find people often prefer to use psychosocial first aid to help differentiate from a clinical intervention.
18. I find people often prefer to use the term psychosocial first aid to differentiate from a clinical intervention.

Psychological First Aid: Five Year Retrospective (2011-2016)

Commissioned and supported by Church of Sweden
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Group on Mental Health and Psychosocial Support in Emergency Settings

Translations of the PFA Guide for Field Workers to Date

