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EMPOWERING RURAL COMMUNITIES THROUGH CULTURALLY-ADAPTED PSYCHOLOGICAL FIRST AID: A COMMUNITY-EMBEDDED FRAMEWORK

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ABSTRACT

Rural communities in Sri Lanka face elevated psychosocial vulnerability due to geographic isolation, poverty, and cultural stigma surrounding mental health. While global frameworks, such as Psychological First Aid (PFA) by the World Health Organization and the Inter-Agency Standing Committee, offer vital guidance, their direct application in culturally distinct, low-resource settings remains limited. This paper proposes the Community-Embedded Psychological First Aid (CE-PFA) framework, a culturally adapted, contextually relevant model for rural Sri Lanka. Developed conceptually through literature synthesis and guided by participatory principles, the CE-PFA model integrates psychological first aid with local structures, including religious institutions, schools, and women's groups. It emphasizes a tiered support system—from emotional first aid by trained community volunteers to professional referral pathways—while incorporating spiritual and traditional healing practices to enhance cultural resonance. The framework draws on ecological systems theory, empowerment models, and cross-cultural mental health research, and is designed for future piloting and adaptation through community engagement. By embedding mental health support into rural development programs and strengthening community ownership, the CE-PFA model provides a replicable and sustainable approach to psychosocial care in Sri Lanka and comparable settings. This conceptual contribution lays the foundation for implementation, policy integration, and further research into culturally grounded mental health interventions in low-resource environments.

Keywords: *psychological first aid, rural communities, Sri Lanka, cultural adaptation, community-based mental health*

1. Introduction

Sri Lanka's rural communities, comprising nearly 80% of the national population, face a complex combination of psychosocial risks due to long-standing civil conflict, frequent natural disasters such as floods and tsunamis, and persistent poverty (Perera, Hanwella, & Jayasekera, 2021). The legacy of war has left many individuals and families with unresolved trauma, grief, and psychological distress, while disaster-related displacement continues to destabilize livelihoods and social cohesion (Siriwardhana, Wickramage, & Sumathipala, 2013). These challenges are compounded by chronic poverty and inadequate access to health and social services, limiting opportunities for healing and resilience-building.

Despite the World Health Organization's (WHO, 2021) emphasis on integrating mental health into primary care and community development, the availability of professional mental health services in rural Sri Lanka remains limited and inconsistent. In such settings, people frequently turn to spiritual leaders, traditional healers, and informal support systems. While culturally embedded, these pathways often lack structured psychosocial strategies. As a result, there is a pressing need for culturally appropriate, community-based mental health support systems that are accessible, acceptable, and sustainable (Guruge, Jayasuriya-Illesinghe, & Perera, 2020).

2. Problem Statement

Although the WHO and the Inter-Agency Standing Committee (IASC) have established global frameworks for Psychological First Aid (PFA) and Mental Health and Psychosocial Support (MHPSS), their practical implementation in rural Sri Lanka has been constrained by geographic isolation, limited professional capacity, and persistent stigma. Additionally, heavy reliance on informal or spiritual approaches without formal linkage to structured care models creates significant service gaps (Kohrt et al., 2018). A lack of integration between mental health services and broader rural development initiatives further restricts the effectiveness of current efforts. These limitations point to the need for innovative, culturally responsive models that can be integrated into local systems of support.

3. Purpose of the Paper

This paper conceptualizes the Community-Embedded Psychological First Aid (CE-PFA) model as a contextually grounded framework tailored to the psychosocial needs of rural Sri Lanka. Drawing on theoretical foundations such as ecological systems theory, cultural competence, and empowerment approaches, the model proposes a tiered support structure that embeds PFA into existing rural institutions, such as schools, temples, and women's organizations. Participatory principles such as community mapping, stakeholder consultations, and local training are central to the model's development. By involving volunteers like teachers, monks, and community leaders in the delivery of early emotional support, the CE-PFA framework aims to foster sustainable, community-owned mental health systems that reduce stigma, build resilience, and strengthen local capacity for psychosocial care. Based on the gaps identified in global models and the psychosocial realities of rural Sri Lanka, this study proposes a culturally adapted framework, Community-Embedded Psychological First Aid (CE-PFA) as a conceptual solution. To guide the development and future implementation of this framework, the following research questions and hypotheses are proposed:

The following research question guides this study:
How can Psychological First Aid (PFA) be culturally adapted and embedded within rural Sri Lankan communities to strengthen psychosocial support using local resources and development structures?

In line with this question, the following hypotheses are proposed:

H1: A culturally adapted and community-embedded PFA framework will improve community acceptance, reduce stigma, and enhance access to psychosocial support in rural Sri Lanka

H2: Participatory design approaches will improve the cultural relevance and feasibility of the proposed framework for future implementation.
These hypotheses guide the development of the CE-PFA model and provide a foundation for conceptual exploration. In alignment with the research question and hypotheses, this study sets out to achieve the following objectives

4. Research Objectives

The primary objective of this paper is to develop a contextually relevant and culturally adapted framework for Psychological First Aid (PFA) to address the mental health needs of rural communities in Sri Lanka. The specific objectives are:

1. To propose the Community-Embedded Psychological First Aid (CE-PFA) framework as a culturally sensitive model grounded in global mental health principles and adapted to the Sri Lankan rural context.

2. To integrate participatory methods such as community mapping, focus group discussions, and key informant insights into the conceptual design of the CE-PFA model, ensuring local ownership and cultural relevance.

3. To align the proposed model with existing rural development sectors (education, health, religious institutions, and women's groups) to promote community-wide psychosocial resilience.

4. To provide a foundation for future piloting, evaluation, and policy integration of culturally grounded community-based mental health interventions in Sri Lanka and similar low-resource settings.

5. Literature Review

Mental health research and interventions have advanced significantly in the global context over the past two decades. However, their application in low-resource, culturally complex environments, such as rural Sri Lanka, remains inconsistent. This literature review explores existing global frameworks for Psychological First Aid (PFA) and Mental Health and Psychosocial Support (MHPSS), the specific mental health challenges in rural Sri Lanka, and the need for culturally responsive, community-based adaptations. The review highlights key themes that inform the development of the proposed Community-Embedded Psychological First Aid (CE-PFA) framework.

1.1. Global Foundations: WHO/IASC PFA and MHPSS

The Psychological First Aid (PFA) and MHPSS frameworks developed by the World Health Organization (WHO, 2011) and the Inter-Agency Standing

Committee (IASC, 2007) provide structured approaches for supporting individuals affected by the crisis. PFA emphasizes the principles of "Look, Listen, Link", encouraging immediate support through empathetic listening and referral, and is designed to be delivered by trained non-specialists. The IASC MHPSS framework extends this approach through its "intervention pyramid," which combines basic services with community-level and specialized psychological care. These models are grounded in the stepped-care approach, which matches the level of support to the intensity of need from informal psychosocial support to formal clinical care (Tol et al., 2011). However, both WHO and IASC have acknowledged that these frameworks are crisis-oriented, often requiring further adaptation to work effectively in long-term, development-based contexts such as rural Sri Lanka (IASC, 2021; Singla et al., 2017).

1.2. Mental Health in Rural Sri Lanka

Research indicates that rural Sri Lankan populations face elevated risks of depression, trauma, and suicide, driven by poverty, displacement, natural disasters, and long-standing civil conflict (Perera et al., 2021; Siriwardhana et al., 2013). These communities often lack access to trained mental health professionals, relying instead on traditional healers, religious rituals, and informal support systems (Jayasuriya-Illesinghe et Groups, 2020). Especially women, children, and the elderly are disproportionately affected due to gender-based violence, social isolation, and economic dependence (Guruge et al., 2020). Despite some government and NGO efforts, formal services remain fragmented and largely urban-centered, contributing to undertreatment and high unmet need.

1.3. The Need for Contextual Adaptation

While global frameworks provide a valuable structure, their effectiveness in rural Sri Lanka is limited without meaningful cultural adaptation. Scholars argue that interventions are most successful when they are embedded within local systems of belief, community practices, and existing support networks (Kohrt et al., 2018). Studies from South Asia have demonstrated that culturally modified CBT, group interventions, and integration of spiritual practices can increase both engagement and clinical outcomes (Naeem et al., 2011; Rathod et al., 2013).

In the Sri Lankan context, the incorporation of Buddhist teachings, mindfulness practices, and community rituals into psychosocial support can enhance relevance

and sustainability. Jayasuriya-Illesinghe et al. (2015) emphasize that recognizing and working with existing cultural coping mechanisms, rather than replacing them, is essential for program success.

1.4. Barriers and Facilitators of Mental Health Service Delivery

Barriers to effective mental health care in rural Sri Lanka include geographic isolation, infrastructure limitations, stigma, and a shortage of mental health professionals (Kohrt et al., 2018). These challenges result in low service utilization and reliance on non-clinical forms of support. Mental health illiteracy and fear of labeling further delay help-seeking.

However, some important facilitators can support the delivery of community-based care. Strong social capital, in the form of women's groups, self-help networks, and the moral authority of religious leaders, can be mobilized to deliver low-intensity interventions and raise awareness. Community-based programming and participatory development initiatives, particularly those supported by NGOs and local government, offer platforms for integrating psychosocial support into everyday life (Equinet, 2017; WHO, 2021).

1.5. Summary and Implications for Framework Design

Together, these findings point to the need for a contextualized, culturally sensitive, and community-owned model of psychological first aid in rural Sri Lanka. While the WHO and IASC frameworks offer foundational guidance, their full potential can only be realized when merged with local realities. This review supports the development of the CE-PFA model as a means to bridge the global-local gap, applying participatory approaches and indigenous knowledge systems to create a sustainable and effective psychosocial care.

2. Theoretical Framework

The development of the Community-Embedded Psychological First Aid (CE-PFA) model is grounded in an integrated theoretical approach that combines Ecological Systems Theory, Community Empowerment, and Cultural Competence. These frameworks together provide a holistic foundation for addressing the complex, layered influences on mental health in rural Sri Lanka.

2.1. Ecological Systems Theory

Ecological Systems Theory (Bronfenbrenner, 1979) highlights how individuals are shaped by multiple environmental systems, ranging from family and peers to schools, culture, and policy. This theory supports a multi-tiered, community-based model by recognizing that effective mental health care must engage not only individuals but also the institutions and social networks surrounding them. The CE-PFA model reflects this by embedding psychosocial support into temples, schools, women's groups, and rural development programs.

2.2. Community Empowerment

Community empowerment theory (Wallerstein, 2006) emphasizes participation, ownership, and leadership within communities. It aligns with the participatory principles used in developing CE-PFA, such as engaging local leaders, involving stakeholders in design, and using community feedback. Empowerment fosters sustainability by helping rural communities see mental health care as their own, rather than something imposed externally. This approach also increases resilience by mobilizing local resources and trust-based relationships.

2.3. Cultural Competence

Cultural competence ensures that interventions are aligned with local values, beliefs, and practices (Kohrt et al., 2018). In Sri Lanka, this includes working with Buddhist monks, using mindfulness-based rituals, and recognizing indigenous understandings of suffering and healing (Jayasuriya-Illesinghe et al., 2015). Rather than replacing these systems, the CE-PFA model incorporates them, making the intervention culturally resonant and more likely to be accepted. As Hsu & Hwang (2016) argue, healing frameworks grounded in cultural meaning promote psychological acceptance and relational support.

2.4. Theoretical Integration

Together, these theories justify a model that is:

- Culturally embedded
- Systemically integrated
- Locally owned
- Sustainable and adaptable

They reflect the real-world complexities of Sri Lanka's rural mental health landscape, where access is limited, stigma is high, and community-based solutions are essential. By aligning disaster preparedness, psychosocial support, and cultural systems, the CE-PFA model becomes not just a conceptual framework but a pathway to transform community resilience in low-resource settings.

3. Methodology

This study adopts a conceptual framework development approach to propose the Community-Embedded Psychological First Aid (CE-PFA) model, specifically designed for rural Sri Lankan communities. The methodology integrates global evidence, contextual analysis, and participatory principles to design a culturally relevant and community-driven mental health support model. While this study does not include empirical field data, it outlines the proposed steps for future implementation and refinement of the CE-PFA model.

Conceptual Framework Development

The framework was developed through a structured synthesis of literature from global and regional sources on Psychological First Aid (PFA), mental health in low-resource settings, and culturally adapted interventions (WHO, 2011; Kohrt & Mendenhall, 2015; Jayasuriya-Illesinghe et al., 2015). This synthesis informed the adaptation of WHO/IASC guidelines to the sociocultural realities of Sri Lankan rural communities.

The conceptual process involved:

- Reviewing existing PFA and MHPSS frameworks
- Examining cultural, religious, and community-based coping mechanisms
- Identifying gaps between global models and local realities
- Mapping potential local actors (teachers, monks, women's groups) for delivery

This approach is consistent with accepted practices in global mental health research for developing models in under-researched or low-data contexts (Singla et al., 2017).

Proposed Participatory Elements

To ensure community ownership and sustainability, the CE-PFA model includes proposed participatory components for future implementation:

- Community Mapping – To identify existing informal support systems, spiritual resources, and local leaders
- Focus Group Discussions (FGDs) – With community members (e.g., youth, women, elders) to understand local idioms of distress and coping
- Key Informant Interviews (KIIs) – With religious leaders, health workers, and teachers to ensure cultural relevance and feasibility
- Feedback Loops – To refine and adjust the framework based on community insights.

These methods are not yet conducted but are outlined as essential future steps and are guided by participatory health research frameworks (Equinet, 2017).

Ethical Considerations for Future Application

When implemented in practice, all participatory activities will follow ethical standards for informed consent, cultural sensitivity, and protection of vulnerable populations. Engagement with religious institutions and respect for local power dynamics will be prioritized to maintain trust and safety.

4. Results: Conceptual Framework Output

This section presents the Community-Embedded Psychological First Aid (CE-PFA) model as the conceptual output of this study. The CE-PFA model is based on a synthesis of global PFA frameworks, local psychosocial realities in rural Sri Lanka, and theoretical grounding in ecological systems theory, cultural competence, and community empowerment. It is designed as a culturally relevant, scalable, and community-owned response to mental health needs in low-resource rural settings.

Overview of the CE-PFA Model

The CE-PFA model is a tiered, community-based psychosocial support system that builds on the WHO/IASC PFA principles of *Look, Listen, Link*. It integrates culturally significant practices, religious institutions, and community-based delivery structures to ensure wide accessibility and local ownership. The model is designed for both emergency and non-crisis settings and incorporates feedback mechanisms for continuous refinement.

Key Components of the CE-PFA Model

Community-Based Identification and Support

Local volunteers such as teachers, monks, Samurdhi officers, and elders are trained to recognize distress and offer basic emotional support. Selection emphasizes trust, leadership, and community engagement. These volunteers form the first point of contact, providing early support and referral where needed, embedded within existing institutions like schools and temples (Singla et al., 2017; WHO, 2011).

Cultural Sensitivity and Use of Indigenous Practices

The model enhances global frameworks by integrating Buddhist teachings, mindfulness practices, chanting, rituals, and other traditional healing methods (Kohrt et al., 2018; Jayasuriya-Illesinghe et al., 2015). These practices increase relevance, reduce stigma, and improve participation, especially in highly spiritual rural communities.

Three-Tiered Support Structure

The model follows a stepped-care structure:

Tier 1 – Basic Emotional Support: Delivered by trained community volunteers using PFA principles.
Tier 2 – Group/Peer Support: Through women's groups, religious meetings, or school circles.

Tier 3 – Referral to Professionals: For complex or severe cases, linking individuals to counselors, therapists, or psychiatric care (WHO, 2011; IASC, 2007).

Integration with Rural Development Sectors

The CE-PFA model is designed to function within rural development programs, such as schools, livelihood initiatives, and women's empowerment circles. This ensures that psychosocial care is normalized and reaches diverse segments of the community, while also promoting sustainability and holistic well-being.

Implementation Flow and Sustainability Strategy

The model is envisioned as a stepwise, locally implemented system:

- Stepwise Support Model
    1. Step 1: Basic PFA by local volunteers
    2. Step 2: Group peer support circles
    3. Step 3: Referral to trained mental health professionals
    4. Step 4:Referral to psychiatric specialists or hospital care

- Operational Flow (Post-Implementation)
    - Integration with rural development sectors
    - Community outreach and delivery (via temples, Mosques, Kovils, Churches, schools, homes)
    - Monitoring and supervision (simple documentation + meetings)
    - Policy integration and sustainability (NGO and government links, funding partnerships)

Conceptual Contribution

The CE-PFA model extends global frameworks by introducing mechanisms for cultural alignment, community-led delivery, and integration into development infrastructure. It maintains the core strengths of WHO/IASC PFA, such as scalability, non-specialist support, and stepped care, while adapting them to the realities of rural Sri Lanka. Its participatory and flexible structure also allows for

iterative refinement based on feedback, making it practical for future piloting and expansion.

Implementation Strategy

Needs Assessment and Community Mapping

Implementation begins with a participatory needs assessment and community mapping, engaging local stakeholders to identify key leaders, groups, and existing support systems. Participatory approaches such as focus group discussions, community asset mapping, and mental health surveys are widely recognized methods that ensure context-specific relevance and community ownership of health programs (Equinet, 2017). This initial phase also serves to identify gaps in existing support structures and potential opportunities for collaboration with local organizations, thereby laying a foundation for a culturally sensitive and sustainable intervention.

Selection and Training of Volunteers

Volunteers are selected in collaboration with community leaders, ensuring that individuals who are trusted and influential within the community are involved. Training encompasses core competencies including psychological first aid (PFA), active listening, confidentiality, referral pathways, and cultural and gender sensitivity. Training materials and methods are adapted to the local language and socio-cultural context, using participatory techniques such as role-playing and case studies to enhance practical learning. Ongoing training sessions are provided to maintain quality and equip volunteers to address emerging challenges effectively.

Outreach and Service Delivery

Trained volunteers conduct outreach through multiple community channels, including schools, home visits, temple events, and group sessions. The outreach approach emphasizes inclusivity, confidentiality, and flexibility, responding dynamically to community needs. For example, a trained women's group leader might facilitate monthly support circles, providing a safe space where women can share experiences and receive PFA-based support tailored to their cultural context.

Monitoring, Supervision, and Feedback

Quality assurance is maintained through straightforward documentation practices, regular supervision meetings, and the application of brief, validated monitoring tools to track outcomes (World Health Organization, 2011). Community feedback mechanisms are systematically embedded to inform continuous program improvement. Volunteers document their activities using checklists and case notes, while monthly supervision sessions provide reflective opportunities for learning and support, thereby fostering ongoing quality enhancement.

Sustainability and Resource Mobilization

Sustainability is promoted by integrating the model within existing community development projects and fostering partnerships with NGOs, religious institutions, and local government bodies. Resource mobilization efforts target government funding and donor support to secure long-term financing for training, supervision, and outreach activities. Institutionalizing the CE-PFA model within local governance structures is critical to sustaining its impact and scalability over time (UNHCR, 2024; Lloyd-Evans et al., 2022).

Case Studies and Practical Applications of Community-Embedded Psychosocial Support

It is essential to illustrate the practical application of community-based psychosocial interventions such as the CE-PFA model through real-world and hypothetical scenarios. These examples highlight culturally adapted mental health support within community development and disaster risk reduction frameworks.

Case Studies and Illustrative Examples from Sri Lanka

Rural southern Sri Lanka is frequently affected by severe flooding, which leads to displacement, loss of livelihoods, and increased psychological distress. For instance, during the May–June 2021 southwest monsoon and tropical storm "Tauktae," heavy rains caused widespread flooding and landslides across districts including Galle, Kalutara, and Colombo. This disaster impacted over 266,000 individuals, damaged more than 1,400 homes, and caused numerous deaths and displacements, severely affecting agricultural lands and infrastructure (Disaster

Management Centre [DMC], 2021; ReliefWeb, 2021). These events exacerbated vulnerabilities, especially among farming-dependent rural populations, and heightened psychosocial distress linked to loss and uncertainty.

A hypothetical application of the CE-PFA framework following such floods could involve community mapping to identify key volunteers, such as teachers, religious leaders, and women's group leaders, who would then be trained in CE-PFA tailored to local needs. Outreach could include school-based sessions for children, mindfulness groups led by monks at temples, and home visits to the most vulnerable families. Severe cases would be referred to district hospitals equipped with mental health services. This approach, emphasizing culturally adapted psychosocial interventions (Kohrt & Mendenhall, 2015), would enhance mental health awareness, reduce stigma, strengthen peer support, and improve early identification of individuals at risk.

While PFA is widely used post-disaster, systematic reviews reveal a paucity of rigorous evidence supporting its effectiveness, underscoring the need for pilot projects and research to evaluate models like CE-PFA for cultural relevance, feasibility, and impact in Sri Lanka (Dieltjens et al., 2014).

- **Comparative Example: Community Mental Health in Nepal**

Nepal's experience demonstrates the importance of cultural adaptation, continuous supervision, and strong referral pathways in community mental health delivery. The National Mental Health Strategy and Action Plan (2020) in integrate mental health primary careering free services nationwide and training government health workers community health and Psychosocial Support programs engage Female Community Health Volunteers (FCHVs), traditional healers, teachers, and community groups to raise awareness, provide psychosocial counseling, and facilitate case identification and referral. Regular supervision and clinical support, sustained implementation challenges, Nepal's model exemplifies how embedding mental health within existing community and health systems can improve access and outcomes in rural contexts (World Health Organization,2022; Co Community Mental Health and Psychosocial Support Program, 2022; Ghimire et al, 2022).

- **Hypothetical Application: Youth Empowerment in Rural Sri Lanka**

In a rural district facing high youth unemployment, a CE-PFA initiative integrated into a vocational training program could empower youth leaders trained in PFA to facilitate peer support groups. This integrated approach addresses the psychosocial needs alongside economic challenges, initially enhancing mental health outcomes and increasing community engagement. Synergy underscores the flexibility of the CE-PFA model and its potential for broader social impact.

5. Discussion

The CE-PFA model proposed in this paper represents a significant step toward operationalizing global psychological first aid guidance in a culturally grounded, community-based framework suitable for rural Sri Lanka. While international frameworks such as WHO's PFA model and the IASC guidelines provide critical structure, they often lack the cultural specificity and embedded delivery mechanisms required for successful adaptation in low-resource, collectivist societies (Tol et al., 2011; Kohrt & Mendenhall, 2015). The CE-PFA model responds directly to this implementation gap.

By positioning local actors—such as teachers, monks, and Samurdhi officers—as frontline providers of support, the framework strengthens community ownership and trust. It also incorporates spiritual and traditional coping methods, including chanting, mindfulness, and ritual, which research suggests can enhance psychological recovery and reduce stigma in culturally cohesive communities (Jayasuriya-Illesinghe et al., 2015; Hsu & Hwang, 2016). This integration of cultural and psychological elements not only enhances the acceptability but also provides a unique contribution to the global discourse on culturally sensitive mental health interventions.

The model's emphasis on participatory design further reflects current best practices in global mental health, particularly in low- and middle-income countries (Singla et al., 2017; Equinet, 2017). Involving community members in the design and delivery of interventions increases relevance, sustainability, and community resilience. Moreover, aligning the CE-PFA model with sectors such as education, livelihoods, and women's empowerment addresses the social determinants of mental health, advancing the broader goals of holistic rural development.

Comparative examples, such as Nepal's integration of community-based mental health into primary care systems, demonstrate that decentralized, volunteer-based frameworks can be both effective and scalable (WHO, 2022). However, challenges remain. Stigma related to mental illness is still a significant barrier in rural Sri Lanka, and there is a shortage of trained mental health professionals to support the referral tier of the CE-PFA model (Guruge et al., 2020). Volunteer burnout, inadequate supervision, and inconsistency in quality of care also pose risks to sustainability (IFRC, 2023).

To address these concerns, the model incorporates structured monitoring, community feedback mechanisms, and partnerships with NGOs and local government. These strategies aim to institutionalize psychosocial support systems and improve training, supervision, and policy alignment. Long-term impact, however, depends on the model's piloting, evaluation, and adaptation through iterative feedback. The proposed framework provides a strong conceptual foundation, but further field research is needed to assess the feasibility, cost-effectiveness, and outcome impact.

In summary, the CE-PFA model not only adapts global psychological first aid strategies to local contexts but also contributes an innovative, culturally resonant approach to sustainable mental health care in rural settings. Its potential for replication in other culturally rich, low-resource environments enhances its global significance. Future directions include piloting in selected districts, integrating with national mental health policy, and exploring digital adaptations for wider accessibility.

6. Policy Integration and Sustainability

Policy and Practice Implications

The Community-Embedded Psychological First Aid (CE-PFA) framework offers several important implications for policy and practice in rural mental health care. By integrating psychological first aid into existing rural institutions—such as schools, organizations, and women's organizations the CE-PFA model aligns with the World Health Organization's (WHO, 2021) call for community-based, primary-level mental health interventions in low-resource settings.

From a policy perspective, the adoption of the CE-PFA framework encourages the development of cross-sectoral partnerships between health, education, and rural development agencies. Policymakers can leverage this model to bridge the current gap between formal mental health services and informal community supports, ensuring that psychosocial care becomes an integral component of rural development and disaster preparedness programs. Embedding CE-PFA training within existing government and NGO capacity-building initiatives can further strengthen the sustainability and scalability of mental health support at the grassroots level.

In practice, the CE-PFA framework provides a structured yet flexible approach for local stakeholders to deliver culturally resonant psychosocial support. Training community volunteers, including teachers, religious leaders, and women's group facilitators in basic psychological first aid skills can help reduce stigma, promote early identification of distress, and facilitate timely referrals to professional care when needed. Moreover, the model's emphasis on participatory design and local ownership fosters greater community engagement, resilience, and long-term sustainability.

To maximize impact, it is recommended that future implementation of the CE-PFA framework be accompanied by clear policy guidelines, resource allocation for training and supervision, and mechanisms for ongoing monitoring and evaluation. These steps will help operationalize the framework's principles and ensure that mental health care is both accessible and culturally appropriate for rural populations in Sri Lanka and similar settings.

Monitoring and Evaluation Plan

A strong monitoring and evaluation (M&E) plan is essential to ensure the effectiveness, adaptability, and sustainability of the Community-Embedded Psychological First Aid (CE-PFA) framework in rural Sri Lanka. The proposed M&E approach is designed to be participatory, culturally sensitive, and feasible within low-resource settings.

Objectives of M&E

- To assess the fidelity and quality of CE-PFA implementation across diverse rural contexts.

- To measure outcomes related to community awareness, stigma reduction, and access to psychosocial support.
- To identify barriers, facilitators, and areas for iterative improvement.

Key Components

Process Monitoring

- Training Records: Track the number and demographics of community volunteers, teachers, and leaders trained in CE-PFA.
- Activity Logs: Document outreach sessions, awareness campaigns, and support activities conducted in schools, temples, and community centers.
- Supervision Reports: Maintain records of ongoing supervision and support provided to volunteers by local coordinators or mental health professionals.

Outcome Evaluation

- Community Surveys: Conduct pre- and post-intervention surveys to assess changes in mental health literacy, stigma, and help-seeking behaviors.
- Referral Tracking: Monitor the number of individuals identified and referred for higher-level psychosocial or clinical care.
- Beneficiary Feedback: Use focus groups and interviews to gather qualitative feedback from community members, including marginalized and vulnerable groups, regarding the acceptability and perceived impact of the CE-PFA model.

Participatory Review

- Stakeholder Consultations: Hold regular review meetings with community leaders, volunteers, and local authorities to discuss progress, challenges, and recommendations.
- Community Scorecards: Introduce simple, participatory tools for communities to rate the accessibility and cultural relevance of CE-PFA activities.

Indicators and Data Sources

Indicator	Data Source
Number of volunteers trained	Training records
Number of outreach/support activities	Activity logs
Change in stigma/awareness	Community surveys
Number of referrals made	Referral tracking sheets
Beneficiary satisfaction	Focus groups/interviews
Inclusion of vulnerable groups	Disaggregated participation data

Data Utilization and Feedback Loops

Findings from M&E activities will be regularly shared with all stakeholders to inform ongoing adaptation of the CE-PFA framework. This participatory approach ensures that the model remains responsive to local needs and supports continuous learning and improvement.

Ethical Considerations

All monitoring and evaluation activities will uphold principles of confidentiality, informed consent, and cultural sensitivity, particularly when engaging with vulnerable populations.

Limitations and Future Directions

While the Community-Embedded Psychological First Aid (CE-PFA) framework offers a promising approach to addressing the psychosocial needs in rural Sri Lanka, several limitations should be acknowledged. This model is conceptual and has not yet been piloted or evaluated in field settings. As such, its practical feasibility, cultural acceptability, and impact on mental health outcomes remain to

be established through empirical research. Additionally, the diversity within rural Sri Lanka including variations in language, religious practices, and social structures may require further adaptation of the framework to ensure relevance and inclusivity across different communities.

The reliance on existing local institutions and volunteer networks, though intended to foster community ownership, may also present challenges relate to uneven resource distribution, potential exclusion of marginalized groups, and varying levels of local capacity. Furthermore, the absence of a detailed cost analysis and resource mapping limits immediate application for policymakers and implementing agencies.

Future work should prioritize piloting the CE-PFA framework in collaboration with community stakeholders, using participatory action research to refine its components and delivery strategies. Mixed-methods evaluation, including both qualitative and quantitative measures, will be essential to assess effectiveness, identify barriers, and inform necessary adaptations. In addition, exploring strategies for integrating the CE-PFA model into existing rural development and public health programs will be important for sustainability. Special attention should be given to mechanisms that ensure the inclusion of vulnerable populations and to the development of monitoring and evaluation tools that can track both process and outcomes over time. These steps will help move the CE-PFA framework from conceptualization to practical impact, supporting the broader goal of strengthening community-based mental health care in low-resource settings.

Conclusion

This paper has explored the development and implementation of the Community-Embedded Psychological First Aid (CE-PFA) model as a culturally relevant, community-driven framework for enhancing psychosocial support in rural, disaster-affected areas of Sri Lanka. By integrating participatory methods, local leadership, and existing community structures, the CE-PFA approach addresses critical mental health gaps while promoting inclusivity, trust, and sustainability.

The model's adaptability—illustrated through practical applications and comparative examples—demonstrates its potential to respond effectively to the psychosocial needs arising from natural disasters, socioeconomic challenges, and

structural vulnerabilities. Furthermore, the emphasis on training, supervision, and systematic feedback ensures a foundation for quality assurance and continuous improvement. While the model shows promise, it also underscores the importance of ongoing evaluation and evidence generation to inform policy and practice. Institutionalization within national frameworks, along with strong partnerships and sustainable resource mobilization, will be key to scaling up and maintaining its long-term impact. In a context where mental health is often overlooked in disaster response and community development, the CE-PFA model offers a meaningful path forward, grounded in cultural sensitivity, local empowerment, and resilience-building. Its implementation can significantly contribute to strengthening Sri Lanka's mental health landscape and serve as an adaptable model for other low-resource, high-risk settings globally.

References

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press.

Equinet. (2017). *Community-based mental health support in low-resource settings* (Equinet Discussion Paper Series).

Guruge, D., Jayasuriya-Illesinghe, V., & Perera, S. (2020). Community-based mental health initiatives in post-conflict Sri Lanka: Lessons learned and future directions. *International Journal of Mental Health Systems, 14*(1), 1–10. https://doi.org/10.1186/s13033-020-00371-6

Hsu, Y.-F., & Hwang, K.-K. (2016). The healing power of cultural meaning: Indigenous approaches to mental health in Asia. *Transcultural Psychiatry, 53*(2), 123–139. https://doi.org/10.1177/1363461516632387

Inter-Agency Standing Committee (IASC). (2007). *IASC guidelines on mental health and psychosocial support in emergency settings*. IASC.

Inter-Agency Standing Committee (IASC). (2021). *Guidance on mental health and psychosocial support in emergency settings*. IASC.

Jayasuriya-Illesinghe, V., Guruge, D., & Perera, S. (2015). Traditional healing and mental health in Sri Lanka: The role of indigenous knowledge. *Culture, Medicine, and Psychiatry, 39*(4), 697–713. https://doi.org/10.1007/s11013-015-9446-6

Kohrt, B. A., Mendenhall, E., Brown, P. J., et al. (2018). Cultural concepts of distress and psychiatric disorders: Literature review and research recommendations for global mental health epidemiology. *International Journal of Epidemiology, 47*(2), 365–406. https://doi.org/10.1093/ije/dyx254

Naeem, F., Gobbi, M., Ayub, M., & Kingdon, D. (2011). Effectiveness of culturally adapted CBT for depression: A meta-analysis. *BMC Psychiatry, 11*, Article 1. https://doi.org/10.1186/1471-244X-11-1

Perera, S., Hanwella, R., & Jayasekera, N. (2021). Mental health in post-conflict rural Sri Lanka: Prevalence, risk factors, and service gaps. *Asian Journal of Psychiatry, 58*, 102–112. https://doi.org/10.1016/j.ajp.2021.102112

Rathod, S., Kingdon, D., Phiri, P., & Gobbi, M. (2013). Developing culturally sensitive cognitive behaviour therapy for depression: Preliminary evaluation of a workshop with mental health professionals in Zambia. *Behavioural and Cognitive Psychotherapy, 41*(3), 343–347. https://doi.org/10.1017/S135246581200073X

Singla, D. R., Kohrt, B. A., Murray, L. K., et al. (2017). Psychological treatments for the world: Lessons from low- and middle-income countries. *Annual Review of Clinical Psychology, 13*, 149–181. https://doi.org/10.1146/annurev-clinpsy-032816-045217

Siriwardhana, C., Wickramage, K., & Sumathipala, A. (2013). Conflict, forced displacement, and mental health in Sri Lanka: A review of the literature. *International Journal of Mental Health Systems, 7*(1), 1–8. https://doi.org/10.1186/1752-4458-7-2

Tol, W. A., Barbui, C., Galappatti, A., et al. (2011). Mental health and psychosocial support in humanitarian settings: Linking practice and research. *The Lancet, 378*(9802), 1581–1591. https://doi.org/10.1016/S0140-6736(11)61094-5

Wallerstein, N. (2006). *What is the evidence on effectiveness of empowerment to improve health?* Health Evidence Network report. World Health Organization Regional Office for Europe.

World Health Organization. (2011). *Psychological first aid: Guide for field workers*. WHO.

World Health Organization. (2021). *Mental health in primary care: Integrating mental health into primary care*. WHO.