A post disaster capacity building model in Peru

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This paper presents a model of a capacity building intervention, which encompasses two phases: reception and familiarity (a process of getting to know people to beyond their problems) and community mobilisation. This intervention was conducted with 65 participants from Chincha (Peru) urban and rural areas after the earthquake of 15 August 2007, highlighting a community intervention that was based on the content and methodology generated during the sessions. It is grounded in the recognition of local capacities and putting collective action into practice, through workshops and art to enhance culture and identity and empower participants. The 65 participants were able to mobilise their communities to design and create 17 murals and signboards. The main achievements of this model of intervention were the progressive withdrawal of external professionals involved, the development of personal skills of community leaders (e.g. self-efficacy, organisation), and the systematic increase of leadership and community participation.

Key implications for practice
- This methodology is useful for working with communities affected by disasters.
- It empower communities to organise and mobilise, on a culturally sensitive way, in order to set their own priorities.
- Art based projects can enhance cultural identities, acknowledge past and hopes for future and empower communities.

Keywords: capacity building, community mobilisation, earthquake, Peru, post disaster

Introduction: background

On 15 August 2007, an earthquake measuring 7.9 on the Richter scale occurred in Ica and other southern regions of Peru, Ica is a coastal region with approximately 722,321 inhabitants (Instituto Nacional de Estadística e Informática (INEI), 2007). As a result of the earthquake, 596 people died, 1292 were injured and approximately 500,000 people were reported to be homeless. At an infrastructure level, more than 70,000 homes and four hospitals were destroyed, with a further eight hospitals severely damaged (Organización Panamericana de la Salud/Organización Mundial de la Salud (OPS/OMS), 2010). The severity of the consequent infrastructure collapse clearly shows the economic and material vulnerability of the area before the earthquake, with a prior precariousness transforming a natural phenomenon into a disaster with long-term consequences (Velázquez, Rivera, & Morote, 2016).

The earthquake impacted both individuals and social relations, with the majority of the population expressing emotional pain, fear, hopelessness, anxiety and uncertainty about the future. Not only had working capital been impacted, but also—and more importantly—social capital had been lost. So, not only material possessions, but also jobs, churches, schools, beaches and public areas had gone. As a result, this was expressed as a loss of their dreams and the population as a whole could no longer imagine their futures or the future lives of their children (Rivera, Pérez-Sales, Aparcana, Bazan, Gianella, & Lozano, 2008; Rivera, Velázquez, & Morote, 2014).
Post disaster poverty increased severely, as did insecurity and mistrust, robberies and looting. Immediate post disaster interventions focused on security, humanitarian support, education, health and civil construction programmes. However, one year after the earthquake, most humanitarian organisations working in mental health care and psychosocial support had withdrawn from the area. Public institutions, with few resources and personnel, resumed regular operational plans that did not acknowledge the populations’ needs in the aftermath of the disaster.

As a result, social unrest continued to grow and was expressed in mass violence, civil strikes and blocking of national highways (Zapata, 2009). There were no democratic spaces for participation, and clashes between public institutions and civil organisations were observed. Representatives of national, regional and local governments were accused of misusing public funds meant to aid the affected population (Zapata, 2009; Elhawary & Castillo, 2008). It is within this context that a community intervention was designed for the material, social and political reconstruction of communities affected by the earthquake.

This intervention, described here, is based on a capacity building model that promoted participation and collective action in emergency contexts (Custodio, Rivera-Holguín, Seminario, Arenas & Urruchi, 2015). It consisted of two main phases (reception and familiarity, and community mobilisation) that were carried out over the course of three workshops (basic, participatory, community action). Both phases demanded consistent accompaniment and personal supervision. It is also important to note, that although eight years have passed since the earthquake in southern Peru, there remain two fundamental reasons for presenting this article now. First, the world is constantly faced with major disasters that diminish the wellbeing of people. The authors believe that this ‘capacity building model’ may well contribute to the strengthening of personal and social resources required to cope with the consequences of disasters elsewhere. Secondly, the work with some of the community leaders described in this article is still ongoing. Finally, over the intervening years, the objective of implementing a mental health public policy within the community during emergencies and reconstruction has remained. This year, there are signs this is finally being achieved, and therefore this article is also presented as academic support for the implementation of a community based, mental health public policy.

**A capacity building model**

Community intervention within post disaster contexts is an appropriate model to respond in a timely manner, comprehensively, and with the participation of a variety of stakeholders (Rodriguez, 2009). Moreover, it is a relevant approach for processes of social reconstruction (Velázquez et al., 2016; Pérez-Sales, 2002), using them as opportunities for social development and change (World Health Organization (WHO), 2013; Kohan et al., 2011). For these reasons, one year after the earthquake, a new community mental health project was proposed. Its objective was to create forums for dialogue, to promote participation and to enhance resources and creativity within the community, while avoiding unsustainable welfare/aid based initiatives. The intervention was conducted as an initiative of the American Red Cross and the project was based on a capacity building and community mobilisation model (Montero, 2009; Inter-Agency Standing Committee (IASC), 2007).

It should also be noted that, during the project, art was used as a strategy for community mobilisation and healing. The use of art allowed an acknowledgement that there are different ways to heal. From a psychosocial perspective, ‘art’ can be utilised as a means to strengthen both personal and
social welfare. This process also revealed that art enables communication of ideas and emotions without the use of words, as well as strengthening networks and collective (re)construction.

The project
Participants and facilitators
The project took place in the province of Chincha, located about three hours from Lima, the capital of Peru. The duration of the project was one year, including designing, implementation and monitoring of results.

The model developed (see below) targeted both male and female community leaders who had an interest in the psychosocial well-being and mental health of their community. In the end, 65 community leaders from 17 different communities in Chincha (50 women and 15 men) participated. The age of participants ranged from 18 to 60 years old, and most had graduated from high school. They included: teachers, health and social development promoters, neighborhood leaders, administrators of children’s services (e.g. educational playgrounds, libraries, and leaders in Child Friendly spaces), housewives and volunteers (Rivera et al., 2014).

In terms of the facilitators, the project was overseen by two people who retained responsibility for the process: a psychologist who specialised in community mental health care, and a public health specialist from Chincha with experience of working with local governments and social organisations.

Intervention objectives and development of model
The intervention objectives were: (1) to consolidate a group of participants with the capacity to initiate, organise and lead actions for their own wellbeing, as well as the welfare of their communities; (2) to design a collective action based on needs identified within the communities; (3) to implement a community action with the participation of communities; and (4) to develop interpersonal bonds in order to sustain trust and mutual support.

To achieve these objectives, a capacity building intervention model was designed. Capacity building was grounded on the recognition of local capacities, the elaboration of a common language and putting a collective process into action. Therefore, it was also expected that there would be a progressive withdrawal of external professionals, and a systematic increase of community leadership. This model was comprised of two main phases (reception and familiarity, and community mobilisation) that were carried out over the course of three workshops (basic, participatory, community action) and a concurrent strategy: accompaniment. In reception and familiarity we aimed to form a cohesive group that could hold the groups’ emotions regarding the earthquake, with empathy, trust, and confidentiality bonds as key elements. In community mobilisation we aimed to aid communities to identify issues to address as a community, with their own resources and capabilities (see Table 1).

Accompaniment includes being close, listening and comforting people, protecting, offering support, reinforcing community bonds and monitoring actions within the communities. To achieve this, the group met for four hours, on a weekly basis, in the office of the nongovernmental organisation (NGO), the American Red Cross in Chincha city. In order to avoid adding any financial burden, the project included paid transportation and a small meal. Later in the project, facilitators visited communities in order to accompany participants in the engagement of community actions. Table 1 presents the main objectives of the workshops and some of the contents of the sessions. In the following sections, the content and methodology of each of these workshops will be described.
<table>
<thead>
<tr>
<th>Phases</th>
<th>Workshops</th>
<th>Objective</th>
<th>Sessions</th>
</tr>
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<tbody>
<tr>
<td>Reception and</td>
<td>Basic (3 months)</td>
<td>To consolidate a group of participants with capacity to initiate, organise, and lead actions for their wellbeing and the welfare of their communities.</td>
<td>14 sessions (4 hours each). There is a special time to share experiences. Empathic listening is encouraged among the participants when memories about the earthquake are evoked. The empathic listening fosters the construction of a group and from the group emerge the possibility of developing collective actions.</td>
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<tr>
<td>familiarity</td>
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<tr>
<td>Participatory</td>
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<td>To design a collective action according to the needs identified within the communities.</td>
<td>7 sessions (6 hours each). Information is exchanged regarding disasters, their impact, people's resources, mental health and community welfare. Participants are encouraged to suggest different solutions to specific problems</td>
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<td>(2 months)</td>
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<td>Community mobilisation</td>
<td>Community action</td>
<td>To implement a community action with the participation of the communities.</td>
<td>16 sessions (6 hours each). Capacity strengthening: organisation and activities planning, psychosocial diagnostic, and motivation for participation. Monitoring of the implementation of the workshops of community action in the communities (murals).</td>
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<td>(4 months)</td>
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<tr>
<td>Accompaniment</td>
<td></td>
<td>To develop interpersonal bonds to maintain trust and mutual support.</td>
<td>Concurrent strategy. It promotes a constant reflection about the experiences during the disaster, and the challenges of the community mobilisation.</td>
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<td>(9 months)</td>
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Source: Author.
Reception and familiarity

The basic workshops focused on problematic situations that had been generated by the disaster (e.g. recognition of people's feelings, their reactions post earthquake, identification of signs of trauma, etc.), as well as strategies for community mobilisation, personal and family wellbeing, and how to participate in collective actions.

The workshops were held once a week for four months. Initially, the participation rate was inconsistent. There were sessions with more than 90 participants, while others had less than 30. There was an open call for the first few workshops, to enable participants to join in at any time. In the end, a group of 65 people, coming from 17 different communities, became regular participants and continued with the process of capacity building.

The sessions also provided a form of emotional support to participants; there had been an intense emotional response connected to the disaster, aftershocks, and incomplete reconstruction. During the sessions, participants were able to express feelings of instability, insecurity, fears and conflicts arising in the community. In this way, the group incorporated the strategy of personal accompaniment in the field in the sessions, in order to raise awareness of the emotional suffering of the inhabitants of Chincha. One volunteer described her feelings:

'I cannot even hold my casual jobs, there is not enough money and my daughters won't let me go anywhere, they just want to hold on to me. My husband does not want me to go anywhere, I'm in the house (...) I cannot stand anything, everybody asks me for everything, but nobody knows how I feel, I cannot, I just want to cry at everything' (volunteer, 36 years old, Chincha) (Rivera, 2010, p. 43).

This participant clearly shows the impact of stress generated by the constant demands of her family responsibilities. The disaster often increased stress and pressure on women, as it is considered a social norm that women will respond and care for the emotional demands of their families.

The methodology used in the workshops facilitated sharing based on exchange of personal experiences, for example, during the workshops an hour was designated to assess work completed over the week. All participants were given a space to speak about major problems within their communities, so it also became a support encounter. Additionally, during this time, potential strategies to face difficulties they might encounter as potential community leaders were explored.

Training began in the second part of the workshop. Since the disaster and during the project, participants had developed new ways to care about and interact with their families, for example, relying on the support of neighbours to help to take care of the children, and how to organise economic and social enterprises. These new strategies were shared and formed a toolkit of practical experiences.

After finishing the basic sessions, and once the group was consolidated, the participatory workshops began. First, the participants who would lead the community mobilisations were identified. Then, the goal was to define a strategy for community action through connecting topics developed in the first sessions to the psychosocial problems identified in each community (e.g. violence, social stigma, alcoholism and drugs). A housewife acknowledged her role in this diagnostic stage:

‘What I liked most is that we all had to identify the needs of our neighbourhoods (...) and [that] the ideas to address the problems came from there’ (housewife, 27, Chincha) (Rivera, 2010, p. 49).

Each community identified difficulties to resolve for the common welfare. People
could speak about common behaviours present after the earthquake, and about the lack of commitment to a common wellbeing:

‘We are ‘walking back’ like a crab. Some time ago, we succeeded in stopping people from throwing garbage in front of the school. Now, as there is no school, people throw their rubbish everywhere. There are rats where the kids play, the drug addicts urinate everywhere, and nobody says anything, nobody cares’ (housewife, 42, Chincha) (Rivera, 2010, p.50).

In addition, difficulties in social organisation were identified. There were needs previously met through solidarity within the community, however, after the earthquake people no longer responded to these needs:

‘Before the earthquake, we organised care of two ladies with AIDS, and another lady with tuberculosis who has young children (...) now who knows how they are, nobody brings them food, or helps them, not even the elderly, who knows how are they doing?’ (health promoter, 52, Chincha) (Rivera, 2010, p.50).

These training workshops utilised a methodology developed for adult education, a multidisciplinary process oriented to favour lifelong education for all, as well as efficient learning throughout life. It aims to provide the knowledge that improves professional qualifications and to achieve civic, social, moral and cultural attitudes and skills for performing responsibilities and for progress in all spheres of life. Each week the workshop focused on a topic that had been established in the previous session, so the group would have ample preparation for the role of co-facilitators. This role of co-facilitator was accepted by all participants and included thematic and methodological aspects regarding the use of time, presentation skills and their own body language. The topics that aroused the most interest within the group were: community participation, services for vulnerable populations, ethical aspects of working with communities and culture, and traditional healing.

**Community mobilisation**

Disaster response is managed most effectively by the people affected, through local efforts, organising and with the support of local governments. Community mobilisation refers to the efforts made by all internal and external stakeholders for engaging community members in actions, decisions and other processes that affect them during reconstruction (Inter-Agency Steering Committee (IASC), 2007).

The participatory workshops promoted community mobilisation and joint action in order to improve the living conditions of the population. In these workshops, which focused on community mobilisation, the highest level of participation was achieved as each community involved approximately 250 people in collective actions. At this stage in the project, 16 sessions (once a week) were conducted to organise, distribute tasks and to plan actions that would take place in 17 separate communities throughout the area. During the workshops, the leadership of the participants was evident. They suggested the themes, and designed and led the sessions. Consequently, participants led community mobilisation through the organisation and facilitation of training sessions and workshops:

‘It was something very nice and also very important in my life, because I could see that we could do many things, I did not even know that I had these [skills]. When we talk [in the community], I felt great because I had never done anything like talk in front of people (...) It changed my life because I learned things from my friends, I learned things from here (American Red Cross), now when someone asks me something, I proudly speak and explain’ (social volunteer, 32 years old, Chincha) (Rivera, 2010, p. 55).
The participants, acting as social promoters, put into practice their abilities to convene community gatherings, to communicate knowledge and information related to disasters and psychosocial wellbeing. They were also able to promote and motivate collective action in their communities, support achievement and implement collective action for the common good. Through weekly practical tasks they could connect the content of face-to-face sessions with their daily, community lives.

'We have to be trained in order to reach out to the community. The training gives you a better perspective (...) I have tried to involve the community, so they will learn. This has helped many to improve, to learn how to express themselves, how to succeed (...) I have learned how to listen, to be impartial (...) I have learned to understand them’ (teacher, 40 years, Chincha).

Community mobilisation demanded dialogue and organisation within each community. The participants implemented and valued the skills that had been strengthened in prior training sessions, such as team work, democratic dialogue, participatory leadership, fostering commitments, delegating responsibilities and joint action planning. What the participants had learned in previous workshops enabled them, particularly the women, to feel more secure with their personal capacities. This positive self evaluation was reinforced by the social and institutional recognition the participants received in each of their communities as a result of their performance and contribution.

**Community actions: murals and signboards** Collective actions that were implemented were defined by consensus within each community. After that, participants encouraged and motivated communities to implement the collective actions defined. Some of these actions included the design and creation of murals and signs for their communities. These murals and signs included diverse references to traditional practices and cultural elements inherent in their communities. For example, villagers chose elements from their basic identity, such as the origin of the community’s name, elements of a shared past or common history that enabled them to understand the present and to imagine a shared future. In this way, the mural depicted a narrative that bound them both socially and culturally, transforming them into agents of their own history.

In the murals, the population portrayed an image of the future including improvements in public spaces, such as green areas and management of solid waste, among others. In addition, the realisation of the mural required creativity and the employment of local forms of organisation and work. To design and to paint murals demanded long hours of work, often under the intense sun. This was a collective experience as food, humour and stories were shared among the community. In many communities, no public walls remained standing after the earthquake to be used as murals. In these cases, participants took the initiative, for example, to donate a private home’s wall or to find a wall in a cemetery. The process of construction of the murals had deep meaning as a symbolic appropriation of public space and a revitalisation of community ties. The places where the murals were painted created a new axis of social life.

In summary, this collective experience contributed to strengthening ties, raising the level of social cohesion, and expressing affection and social recognition. These are all key aspects in community mental health and psychosocial wellbeing.

**Accompaniment workshops** The accompaniment workshops ran concurrently with the capacity building process. The objectives were to generate an emotional connection, to acknowledge the skills of the participants and to promote mutual care. There were
weekly practice sessions to talk about their role as social facilitators of community mobilisation, and to share their experiences, even in situations involving tension and frustration generated by community action. The affective link and care among participants allowed them to support each other and listen to the difficulties each was recounting, as well as to find better strategies to respond.

The accompaniment workshops were designed to be a constant source of support from the beginning of the training through to the end. This accompaniment generated other meetings within each community. The respect for each person's differences was recognised as a key aspect in the quality of the relationships and collective work.

‘An aspect needed is respect for persons, of any social level, that is to respect each person because of his human condition, that’s priceless’ (mother, 39 years old, Chincha) (Rivera, 2010, p. 49).

These workshops were central to achieving sustainability of the participants, as they found the necessary support in their own community groups. This allowed them to continue community mobilisation and to undertake new projects. Now, they are often economically rewarded by public institutions:

‘Now we have another community project (...) it is to clean up the streets, they certainly give us something, we get paid, but we formed a committee, and twice a week we work on the maintenance of our main square, our health centre, our school and our main gateways (...) we will paint all over this wall (...) “take care of your community”, “do not throw garbage”’ (housewife, 28 years, Chincha) (Rivera, 2010, p. 68).

Finally, the female participants were strengthened, and became more proactive and autonomous.

‘[Young people] say “Lady, you have drawn the mural, you can make other drawings there”; and I told them, “now I won’t be able to because I’m going to have another training, so now you do it.” They are now thinking about doing so; they will draw a sign of “welcome” at the gateway of the community. We must encourage them’ (mother, 32 years, Chincha) (Rivera, 2010, p. 69).

These workshops constitute a model of capacity building based on the active participation of the population and their communities, in the affective bond developed between the different actors, and in the commitment and hope of the participants to rebuild their communities – despite the material impact and psychosocial suffering post earthquake.

Achievements and challenges of capacity building model

Supervision was conducted at the end of the capacity building process and community action. In the last session of the project, a participatory evaluation was conducted, in which approximately 40 people from 11 communities participated. The evaluation was intended to understand the project’s contribution to both the personal and community life of the participants. It began with the question: what results they believed had been achieved by the community? In addition to that, one year later, individual interviews were conducted with some of the participants. It was also possible to interview six local leaders from six different communities.

In both scenarios, it showed the main achievements recognised by the participants. During the self evaluation sessions, they mentioned capacities related to self efficacy (goal orientation), community effectiveness (efficacy grounded on relationship and shared work) (Hobfoll, Schröder, Wells, & Malek, 2002), social mobilisation, reconstruction of community bonds and promotion of community mental health.
<table>
<thead>
<tr>
<th>Category</th>
<th>Participant's vignettes</th>
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</thead>
<tbody>
<tr>
<td>Self efficacy</td>
<td>‘When we do something, we feel very good being promoters, to achieve something for the community’&lt;br&gt;‘I manage to organise my community’&lt;br&gt;‘I am able to convene the people for our meetings’&lt;br&gt;‘To be able to make signboards for the community’</td>
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<tr>
<td>Community efficacy</td>
<td>‘I manage to get a very organised community committee, and to support each other’&lt;br&gt;‘To work with other institutions and request trainings (…) we have achieved that in our community’&lt;br&gt;‘We succeeded in painting a mural that people from the community supported. We had also the support of the children and adults to paint the signboards’</td>
</tr>
<tr>
<td>Organisation for community mobilisation</td>
<td>‘That people organise themselves’&lt;br&gt;‘To know how to organise the people of my community’&lt;br&gt;‘To exchange ideas with people from diverse communities’&lt;br&gt;‘To know how to deal with my community and how to be more responsible in my work’</td>
</tr>
<tr>
<td>Community bonds and trust reconstruction</td>
<td>‘To join friendship bonds, to raise trust between everybody’&lt;br&gt;‘To share our experience in the community’&lt;br&gt;‘To communicate better with the people of my community’&lt;br&gt;‘I get to know the needs of all the neighbours on my block’&lt;br&gt;‘We appeal for the participation of four people, we finish it with 25, among them friends and enemies, now we all are friends’</td>
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<tr>
<td>Category</td>
<td>Participant’s vignettes</td>
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<tr>
<td>Abilities to promote mental health</td>
<td>‘I invite them to my meetings to express how do they feel’</td>
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<td></td>
<td>‘Now I know how to help a person who is stressed or is struggling with a crisis’</td>
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<td></td>
<td>‘I succeed in making them to listen to each other with calm’</td>
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<td></td>
<td>‘[I learnt that] what happened has had an impact on us’</td>
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<td></td>
<td>‘To give psychosocial first aid (…) in the context of disaster’</td>
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<td></td>
<td>‘I learnt to respect each person, to be more empathetic’</td>
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<td></td>
<td>‘I am more fair and empathetic’</td>
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<td></td>
<td>‘I feel more sensitive to all human suffering, I feel more able to help, and I feel I have tools to do it’</td>
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<tr>
<td>Personal skills and development</td>
<td>‘To express myself and how I feel, losing fear and shyness’</td>
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<td></td>
<td>‘I have learnt to listen to people and to be patient, not to get mad, and to find solutions if it is in my hands’</td>
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<tr>
<td></td>
<td>‘I manage to get out of my house, I never did it before coming to the Red Cross’</td>
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<td></td>
<td>‘I have learnt to speak naturally. I am not ashamed to speak in front of a group anymore, to talk with the people, or to exchange ideas for everybody’s wellbeing’</td>
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<td></td>
<td>‘I have learnt to organise my time’</td>
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<td></td>
<td>‘I have learnt how to control myself in the moment of a crisis, or when I am worry’</td>
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Source: Rivera, Velizquez, & Morote (2014).
Table 2 summarises several personal and community skills achieved.

The impact of the capacity building approach occurred not only on a personal level, but also at community level. This change translates into concrete actions, such as the improvement of public space. Four years after the training, a community agent continued to seek opportunities for the promotion of the mental health in her community, through the networks that were established in this experience. Currently, she is part of community mental health actions, in coordination with the local health centre and the university. Three years after the project, Lima de Andrade (2012) found...
that the murals made by the community were used as a model and that the local government had built a park with benches and green areas. Thanks to community mobilisation and action, it is now possible to improve public spaces post earthquake with collective initiatives from the community (see Figures 1 and 2).

The author and other facilitators all agreed with the model of 'building back better', as stated by WHO (2013), because as well as needs arising as a consequence of disaster, it is also important to consider the effects of structural poverty and exclusion. These conditions create double vulnerability for the population, generate rights transgressions and impede people's access to social services (health, education, housing, etc.). The capacity building model cannot ignore these conditions in its proposal, either as a part of the analysis of the context, or in its methodology.

It is also important to mention some lessons that were crucial for project development and for designing and implementation of future projects. They all relate to the importance of understanding the participants' psychosocial processes.

Firstly, the training programme focuses on minimising potential risk situations, and conflicting mental health problems, while promoting good community mental health. However, participants also demanded individual attention in terms of mental health care. Therefore, an important challenge is to integrate the potentially conflicting mental health needs, whether the programme includes them or not, or connects participants with established networks and support systems.

Secondly, the workshops became mainly listening and containment spaces for those who attended. The aim was to establish dialogue, to have the possibility to listen to each other and to focus attention on emotional needs. As the emotional dynamics of the participants were incorporated, the project had to maintain a flexible programme. That is, it was important to be able to incorporate new issues, return to issues that had already been addressed, or seek more appropriate strategies for group needs.

Finally, it should be mentioned that the participants of the project were not considered community leaders within their communities before the process. In order to convene the first meetings, a broadcast was sent out to the entire population. Initially, more than 90 people responded and attended the first meeting, but in the end only 65 people remained throughout the entire process. As they had not been recognised as community leaders (either by their communities or themselves), it was necessary to strengthen personal and social characteristics to enable them to carry out assigned tasks. This meant incorporating topics such as speech and public speaking, human rights and citizenship, participation in public institutions, etc. Therefore, the process came from a psychoeducational perspective, seeking to integrate constant training with personal and social recognition.

Conclusions and recommendations

The intervention described in this paper is based on a capacity building model that promoted participation and collective action in emergency contexts (Custodio et al., 2015). It consisted of two main phases (reception and familiarity, and community mobilisation) that were carried out over the course of three workshops (basic, participatory, community action). Both phases demanded consistent accompaniment and personal supervision.

This capacity building model is based on the practical experience of the people who had been impacted by the disaster. As a result, the focus and contents of the intervention were debated and proposed by the participants themselves, thereby generating a valuable peer learning process. This intervention model also reinforces the identification and appreciation of local practices, knowledge, identity and culture. It locates the person
within the context in which they live, promoting a sense of community, belonging, and self projection in a positive future. Therefore, capacity building interventions contribute to the reconstruction of community wellbeing within a post disaster context. The model incorporated art as a mean to express and to process personal experiences related to the disruptive event of the earthquake. Following Soon and Quayle (2014), the use of artistic and culturally sensitive methods is instrumental and transformative because they support the community mobilisation while dealing with the social precariousness and vulnerability prior to the disaster. Art was an effective tool for recapturing community culture, meaning and values in the process of reconstruction.

In a capacity building intervention, participation promotes the transformation of established power relations. Therefore, within this intervention, local agents were encouraged to lead community actions and to strengthen their capacity of social organisation. This process was based on democratic dialogue between the participants and the team of professionals. As a consequence, the professionals also experienced personal transformation.

The capacity building model also intervenes in terms of vulnerable aspects of community cohesion, rooted in prior conditions of poverty and exclusion. The development of bonds based on trust requires both connecting with one’s own experiences as well as with the experiences of others in the community. The workshops promoted effective bonding and care through personalised relationships with the participants, as well as peer learning experiences. They encouraged the stability of bonds made and validated the intense emotional reactions as a normal response to an abnormal situation, such as a disaster. As a result, the process of making the murals was an opportunity to build a positive self representation and hope. These processes were cohesive, and were especially needed within these vulnerable and excluded communities.

Frequently, it is argued that psychosocial support should be offered once basic needs have been met. However, we observed a population willing to learn about community health, and with a great concern about the emotional condition and wellbeing of their family and neighbours. In this case, the population did not present a passive role (i.e. simply wait for donations), nor it was only focused on the material recovery of their communities. The people, their community promoters and leaders all sought to participate and get involved in projects that would serve the wellbeing of the community and relationships within it.

References


