Community mobilization after an earthquake: case study of the use of the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings on mental health and psychosocial support in Peru*

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This article describes and analyzes the first comprehensive case study of the application of the IASC Guidelines on Mental Health and Psychosocial Support by Medicos del Mundo-Spain after the August 2007 earthquake in Peru. The methodology and core principles of the intervention are briefly summarized. The article explains strategies and key messages that were transmitted at each level. It proposes a multilevel approach that combines lobbying, sensitization, and training with key decision makers and grass roots work with leaders and community organizations. The experience in Peru provides important lessons for future implementation of the guidelines in other disasters.

Keywords: Inter-Agency Standing Committee (IASC), mental health and psychosocial support (MHPSS), Peru earthquake, community intervention, Medicos del Mundo, coordination, guidelines

The IASC Task Force on Mental Health and Psychosocial Support in Emergency Settings was formed in June 2005. After completing its mandate to develop guidelines in December 2007, the Task Force became a Reference Group to develop case studies of applications. Preliminary trials of application were done in Sri Lanka (2007). This article describes and analyzes the first comprehensive case study of application of the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* after the August 2007 earthquake in Peru. At the time of writing this article, training of trainers' processes has been completed in West Africa, Kenya, Lebanon, Haiti; and training processes are planned in Ethiopia and southern Africa. A comprehensive case study is being carried out in Colombia, and possible future case studies under consideration are Nepal and Iran. In the Peruvian case, the guidelines were an important tool for facilitating a coordinated action between the government and most humanitarian actors.

The earthquake in Peru

On 15 August 2007, at 6.41 pm, a 7.9° earthquake occurred in Peru. The epicentre was located in the sea, 64 kilometres from the coast, and affected not only the entire country, but the neighbouring countries as well. The most affected areas were Pisco

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and Chincha, where 80% of housing was destroyed. The earthquake also affected wide areas of Huancavelica and Lima, including some of the poorest areas of the country, where people displaced by political violence were living in already precarious conditions. According to official figures, 568 persons died, 2200 were injured, and more than 100 000 lost their home or job. Communication systems, electricity and water services immediately collapsed, and it took a long time to reestablish them. Thousands of people were evacuated to shelters built in stadiums, schools, and parks.

The impact of the earthquake could be seen in the landscape and in the people. In less than three minutes, people saw their lives change dramatically. Testimonies showed that the earthquake not only took away their family and belongings, but also left them with feelings of hopelessness, uncertainty, and anguish, especially in people that were the poorest of the poor before the earthquake. Life projects, barely reconstructed in the aftermath of past political violence, were lost again. People were overwhelmed by the idea of starting all over again. The Peruvian Army and the National Institute of Civil Defence (INDECI) took immediate action. However, people were shocked about the way aid was given:

> '*We have been brought here like animals. We have been put in plastic tents, four or five families in a single tent, no one knowing who is sleeping besides you. If you fell deeply asleep, others in your tent would steal your last belongings... There were people urinating at the door of the tent, and they insulted you if you complained... If someone had asked us, we could have looked for our surviving relatives, or our friends and neighbours, and try to gather in the tent, but this was not allowed*'. *(Agosto, 2007).*

This situation increased people's anguish and discomfort. The team found that many professionals, whether Peruvians or foreigners, considered this as a sign of abnormal emotional distress and prescribed medication. People coming from Lima judged, for instance, two weeks after the earthquake, that inhabitants of Pisco are *'lazy'* because they found people lying down in the tents *'doing nothing'* instead of moving the bricks or adobes from the road, or considered them *'dirty'* when authorities ordered the killing of all domestic pets for *'epidemiological reasons'* and people confronted the authorities.

After the initial hours, the response was slow and disorganized, mostly relying on churches and nongovernmental organizations (NGOs). The government created FORSUR (Fondo de Reconstrucción del Sur), an institution aimed to coordinate public and private sectors for rebuilding. However, even six months after its creation, FORSUR had no consistent plan of action.

Not surprisingly, and due to all these pitfalls, in a survey performed by the IASC external evaluator among refugees in shelters (338 surveys), there was a general disapproval of the actions taken after the earthquake at all levels of government authorities (district: 79% rejection; provincial: 61.9%; regional: 66%; and national: 71%) (Bazan & Gianella, 2008). There were also exceptions. In Pisco, there was a large self managed shelter, organized spontaneously by a man who lived in the neighbourhood who became a spontaneous leader. He managed to set up a system of 19 leaders who coordinated more than 3000 refugees. The Peruvian Army and the NGOs respected and supported his work. They managed to organize, not only shelter, food and cooking tasks, water supply,

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medical attention, and sanitation, but even religious and sporting activities. Four weeks after the earthquake, this shelter even had sewing and carpentry workshops with voluntary instructors. They also managed to set up leisure and commercial activities for the affected population.

Medicos del Mundo-Spain after the earthquake

Medicos del Mundo-Spain (MdM-Spain) has been one of the agencies involved in the IASC Task Force (TF). The organization made an assessment after the catastrophe, and included among its activities a facilitator to introduce and implement the guidelines on MHPSS in Peru. Two teams were set up. The MdM-Spain team consisted of a psychologist, a field coordinator and a community worker, supported by a person in Lima and a member of the TF in Spain. One of the members devoted most of their time to lobby work with government institutions, and national and international organizations. The other worked with community leaders and grass root organizations in shelters and *ollas comunes* (popular self organized spaces for community sharing of food and cooking). On the other hand, the Reference Group contacted the Columbia University which provided funds (from the Displaced Children and Orphans Fund of USAID) for an external observer who would assess and document the process from an outside, independent view point.

Methodology of Implementation of the Guidelines in Peru MdM-Spain structured an intervention based on three *strategies* listed below.

Level 1: National and International Institutions (headquarters and key policy makers); this included the Peruvian Ministry of Health (MoH) (at national level) and Civil Defense (national and regional levels).

Level 2: Local instances (regional and local authorities, social services, national and international cooperation agencies with working teams present in the affected area).

Level 3: Community instances (leaders and the affected population); the team developed meetings at the three levels with different key messages targeted for each context, as briefly summarized in Table 1.

The MdM-Spain team shared three *core principles* for introducing the guidelines, listed below.

(1) Every action to be developed should *strengthen the national public health system* of the country. This means acknowledging and reinforcing the role of the MoH (national, regional, and district) and other public sector agencies in the catastrophe.
(2) Favouring inter institutional coordination in mental health. This meant doing permanent lobby work for the implementation of *local, regional, and national mental health policies* that went further than the emergency alone and meant a permanent change for the people.
(3) Meetings and lobby work should not displace front line work with leaders and affected populations, *promoting in practice* the spirit of the guidelines.

To achieve these objectives, during the six months of implementation of the programme the team attended: (a) 47 Emergency Operational Coordinations (COE) meetings in the health, education, shelter, water and sanitation, and mental health areas, so as to have a multi sectorial approach and get involved all the sectors in the intervention;

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Table 1. Key messages transmitted at lobby meetings

1. Open discussion on observed/expected mental health reactions to the earthquake. The need for a focus that normalizes symptoms. Prevention of an indiscriminate use of diagnostic categories or a potentially damaging medicalising framework of work. Institutions in the area that were systematically prescribing anxiolitics, antidepressant, and neuroleptic medications to the affected population. The position and recommendations of WHO and other international agencies on the issue.
2. The need for an articulated framework of action of all key actors in the emergency. The need for sharing information for the prevention of rumours. The need for shared and coordinated actions in mental health and psychosocial work under the Peruvian Ministry of Health guidance.
3. The need to foster organization, cooperation, and self management from the affected populations. Prevention of hopelessness and victim hood and stimulation to empowerment and agency. Key actions related to this are:
   - Considering dignity issues in all actions related to the catastrophe;
   - Avoiding dependency and victim-hood;
   - Favouring mobilization and community support that gives individual and community sense of control over one's life.
4. Introducing the IASC, the guidelines, the team and the purpose of introducing the guidelines as a shared tool for action.

(b) 25 technical meetings with individual organizations working in the area (Médecins Sans Frontières (MSF), United Nations Children's Fund (UNICEF), Paz y Esperanza, Pan American Health Organization-World Health Organization (PAHO-WHO), the Argentinian electricity company-EDESUR, Mercy Corps, Christian Action Research and Education (CARE), United Nations Population Fund (UNFPA), Comision Episcopal de Accion Social (CEAS), Red Cross, Terre des Hommes, and Everychild); and (c) 24 workshops coordinated by the health authorities where the team managed to get 1 to 3 hours for each workshop, to introduce the guidelines to health personnel and community leaders (with more than 700 persons participating in total).

Additionally, the team developed systematic training and follow up for local organizations. Training included seven weekly meetings around the guidelines. Fourteen community groups in Pisco and Chincha were involved at this level. The selection criteria for an invitation to the training and follow up process are listed below:

(1) Organizations that were newly created by people affected by the earthquake;
(2) Organizations that had a wide social basis and were socially legitimate;
(3) Those who were eager to participate in a shared training process and exchange of experiences;
(4) Those who were already in contact with the health system and had some kind of coordination or mutual knowledge (*a criterion of sustainability);*
(5) Informal Community Health Promoters from the affected communities.

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Table 2. Key messages at field level

Emergency Operational Coordinating Meetings (COE)

1. Need for the participation of the affected population at all levels of emergency actions. Practical actions.
2. How to involve local stakeholders.
3. Redefinition of roles and functions so as not to weaken the public services.
4. Insisting on the need for reinforcing the leadership of local institutions.
5. Need to have an emotional support for workers, and supervision.

Technical meetings and Training Workshops

1. Exchange of experiences and learning.
2. Normalization of symptoms and the need of a non medical model. Avoiding prescribing medication.
3. Strategies for identifying strengths and resources from the affected populations. The need to mobilize individuals and communities.
4. Networking and coordination.
5. Not scheduled, but people felt often the need to be recognized not only as leaders but also as victims (*'we have also lost everything. . . Now we are expected to work for others as volunteers. . . this is difficult and demanding . . .*')

Workshops with local organizations

1. Mutual knowledge. Open spaces for listening and sharing.
2. Identifying actions and resources already going on from the affected populations. Strengths and weaknesses. Mutual commitment for action.
3. Historical memory of the community; from before the earthquake to the present moment.
4. Participatory assessment. Vulnerability and capacity analysis.
5. Vision of future. Possibilities of coordinated actions / projects.
6. Visiting other shelters/communities to exchange ideas and learn from others.

The workshops were aimed at community action (see Table 2).

To support the fieldwork, the team developed some *facilitating tools* that are listed below.

(a) A folder on *Do's and Don'ts* based on the guidelines.

(b) A poster with a summary of the 25 Minimal Actions targeted at all actors involved.

(c) A popular education leaflet based on the pyramid of the multilevel framework of work in mental health. The figure of the pyramid (pg 12 of the English version of the guidelines) was the most useful tool in lobby work. It allowed key stakeholders to understand the philosophy and purpose of the intervention in a single view, and to compare it with what was being actually implemented. It would be advisable to make it a poster in the future.

(d) An adapted and abridged version of the guidelines in Spanish with pictures and drawings taken from the Peruvian context that is widely known and used by many NGOs.

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Results

Knowledge of the Guide As a result of these efforts, 57.2% of the workers and authorities knew about the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* according to the interviews with key stakeholders done by the external assessment team (Bazan & Gianella, 2008). However, from this group, only 22.2% recognized having read and used it. Most of the people interviewed, identified with the way mental health is worked out in the guidelines. Regarding preferred contents, they mentioned the importance of community participation, the pyramid of interventions for mental health and psychosocial support, the groups that should be especially noted in an emergency, the emphasis on the '*do no harm*' approach, and the need to visualize the topic of sustainability as a key element in the interviews (Bazan & Gianella, 2008).

In terms of the Action Sheets, the people interviewed considered those related to community organization the most useful ones, especially in relation to the identification of leaders, strengthening community capacities, the importance of historical memory, and the need to build a reconstruction plan based on previous existing organizations, among others (Bazan & Gianella, 2008). People also stressed the emphasis on human rights, dignity, and respect for others, and the emphasis on coordination between authorities and the affected population as positive aspects.

Application: impact at the short, middle, and long term

Level 1: Short term The Ministry of Health has adopted the guidelines as an official text for working during emergencies. They are also included in regular disseminating activities and training processes. Aid organizations, such as PAHO and UNICEF, and various universities are, at the moment, concerned with the dissemination and training around the guidelines.

Level 2: Middle term The guidelines have been adopted and adapted by the Ica Regional Direction of Health (DIRESA). There was no public mental health service in either Pisco or Chincha before the earthquake. In Ica, the DIRESA detected, as a result of this intervention, the need for a model of Primary Care in Mental Health that went further than the present emergency. The DIRESA proposed a structure not based on hospital care. This finally turned into a regional mental health plan. PAHO and UNICEF are providing support. In Huancavelica, the poorest region in the country, the DIRESA asked for technical support to MdM-Spain for designing and implementing a three-year regional mental health plan. MdM-Spain has already developed two participative workshops; the project is under formulation and needs to find donors for implementation in 2009.

Level 3: Long term Results were ambiguous. On the one hand, and not directly attributable to the implementation of the guidelines, new leaders came up from the emergency. The survey showed that for 64% of the population in shelters, leaders did a good job of representing the interest of all community members (Bazan & Gianella, 2008). On the other hand, the impact on organizations was low; 56% of leaders complained of not being consulted at all by international nongovernmental organizations (INGOs) or NGOs when taking key decisions. While most organizations sent donations mainly to shelters and *ollas communes*, 39% of survivors would have preferred a house by house distribution, and 26% through their local organizations. Most people (76%) felt uninformed (Bazan & Gianella, 2008). Finally, 44.8% of people considered that people's

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dignity was not respected (mosquitoes, fleas, rats, plagues: 44.4%; access to bathroom: 41.4%; access to water: 20.7%; uncomfortable sleeping conditions: 17.2%; lack of security: 17.2%; conflicts between neighbours: 17.2%). A majority of the population (50.9%) considered that most of the population became united and was supportive, something also not directly attributable to the intervention or the guidelines.

According to the external assessment by the consultant team (Bazan & Gianella, 2008), a major positive result from MdM-Spain intervention were the plans created and proposed by the leaders. Noticeably, some of them have begun, after MdM-S closed the intervention, following the methodologies proposed at the workshops.

In brief, the implementation of the guidelines was successful at the level of national and regional authorities and for community mobilizing at shelters and *ollas comunes*. Its impact was lower in terms of changing practices of NGOs working in the zone and in helping all the hidden populations not living in shelters or in the *ollas comunes*.

Recommendations and lessons from the case study

1. Empowering public institutions requires a lot of energy. For NGOs, it is easier to ignore public institutions and act '*independently*'. In our experience, working '*independently*' in emergencies is a recurrent failure. When the political context allows it, it should be the golden rule to work in coordination with public institutions.
2. Emergencies become a chance to train workers from public health services. In Peru, as in many countries, the health system does not have any plan for continuous training for its personnel; tools for mental health interventions after emergencies are not an exception.
3. In spite of a top-down and bottom-up combined approach, for many of the institutions contacted by the team, the guidelines were often felt to be a burden and as something coming from abroad. Each institution and, we dare to say, everyone in an emergency has, somehow, their own '*guide*' and wants to share it and have it adopted by others. It was difficult to make people feel emotionally tied to the guidelines even for people linked to the UN system. It is necessary to make permanent ongoing efforts to make the guidelines known at all levels among governmental, NGOs, and INGOs headquarters so as to facilitate a natural and smooth implementation at field level in future emergencies. It is difficult to engage institutions *in the middle of an emergency* when, sometimes, issues of media coverage and distrust among competing institutions become relevant.
4. The road we walked with public institutions was full of meetings, informal conversations, shared workshops and activities in the field, but there was also plenty of open dialogue between peers. In the assessment, the health authorities of Ica explained that the most valued aspect of the programme was that MdM never acted as specialist, or in a vertical way, but responded by listening. Authorities were asking for better ways to give quick answers to peoples' needs and found someone who mainly listened.
5. One of the successes was that every action began with spaces for sharing ongoing experiences. When working with leaders and communities, we confirmed the need to not only introduce the guidelines, but also having regular meetings to follow up the advances and shortcomings. This meant *being part* of the process.

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6. Sometimes, workshops around the guidelines became groups of emotional support for community workers and leaders. We did not stop this, and accepted this intervention as a necessary function of implementing the guidelines (as called for by Action Sheet 4.4), and as a way to recognize the efforts and sufferings of voluntary people and workers.

Finally, we want to stress some aspects of daily work at the shelters that are not in the headlines, but might be important for future implementation, and have listed them below.

- In our experience women were more involved (80%), although this might be because some of the tasks in shelters are culturally associated in Peru with women.
- Words like dignity, participation, and empowerment are easily accepted and adopted by most stakeholders. However, the practice might be the opposite. So, it is important to agree on *actions* more than *principles*.
- Community workers are usually overloaded with tasks and try to answer to every NGO's agenda. So, '*lack of time*' was one of the main barriers for field implementation of the guidelines. In our experience, some awareness and coordination on this fact seemed mandatory.
- After an emergency, tasks tend to be concentrated on temporary shelters. The survey done by the external assessment team showed that, in the first two weeks, 45% of the population chose to stay in front of the ruins of their house. Only 7% of the population became part of a temporary shelter, a figure that remained stable for the next months. In other words, 93% of the affected population *was not* in a shelter. Although many of them approached the *ollas communes*, it is important to consider that there is always a hidden population not easily accessible for MHPSS work. This is probably the major challenge to be faced in emergencies in the future. Community activities in neighbourhoods might be a way of gaining access to hidden survivors.
- We found it especially useful working on community memory activities. This helped in strengthening the cohesion of the community and provided a good framework for a common envisioning of future and developing community plans.

In one of the closing meetings in Chincha, the group concluded:

> '*after the training process, besides the positive effect found in our community organizations, we can also identify personal changes that motivate us to continue working in our communities.*'

The list included changes like being more confident in community organizations, to be able to listen to others, the possibility to express their feelings, expressing their own ideas or proposals, and writing or explaining problems in sequences (detected problems, proposed causes, foreseen consequences, plan of activities, and possible results and scenarios). All this made coordinated actions, under their view, an enriching activity in personal terms.

This is the last lesson learnt in the experience, and who knows if not the more important: the process itself became enriching for those voluntary people involved in it. It was not only in keeping control over one's life, but also in feeling somehow stronger, in spite of the disaster.

There are still many obstacles ahead for building participatory, layered, ethically sensitive systems for emergency relief in

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political violence and catastrophes, and a strong need for collective efforts to address them. The *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* seem a significant step forward in this complex task.

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Reference

Bazan, M. & Gianella, C. (2008). Implementation of the IASC Mental Health Guidelines after August 15th Earthquake Emergency in Peru: Evaluation Report.

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