



HEALING LIVES




medical ambassadors
INTERNATIONAL

Healing Lives: Post-Crisis

Medical Ambassadors International
Community Health Evangelism/Education

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Dedication

This book is dedicated to all the communities that God has given us the privilege to serve around the world, but especially the ones where disaster has left broken lives.



MAI Disaster Response Team

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Introduction



Medical Ambassadors International (MAI) began publishing the 'Healing Lives' magazine in the 1980's. Since then, our readership has grown and expanded as we have covered a wide variety of topics. As we celebrated 40 years of MAI's service in 2020, I began to reflect on the amazing stories of disaster relief along with the connected

issues we have encountered. In an effort to gather as many stories and experiences as possible, I reached out to MAI staff and volunteers around the globe, inviting each to share their experiences. As the responses started coming in, it was evident this was not to be another magazine publication, but a more permanent document that can serve as a long-term reference for staff and supporters.

The strategy of Community Health Evangelism/Education (CHE) operates on a principle of maximizing available resources within the community to enable it to move towards a sustainable and empowering outcome. Disasters in a community, depending on their intensity, often leave the community with depleted resources to work together in building a viable survival strategy. An external intervention in such circumstances therefore becomes essential. Relief must be less of a 'hand out' and more a 'hand up'.

The story Jesus told about the good Samaritan (Luke 10:25-37) is a beautiful example of a relief response. The wounded man lying on the road was helpless and deprived of resources. He had no capability of getting up and putting his life together again. He needed an immediate external intervention. The

story goes on to talk about the next steps of follow up that not only have helped him to recover, but also move on towards rehabilitation. The story ends abruptly in verse 35, because Jesus had achieved his point – compassion and a continuum of care display how to love one’s neighbor as oneself.

This book is a collection of articles related to multiple disasters our teams around the globe have encountered, with information related to what they did in response and a post-disaster analysis of the lessons we learned. Some articles also focus on the macro profile of disasters and provide principles that determine the best way to respond, so that the post-disaster transition to rehabilitation and on to transformational development can be done in a smooth continuum.

An important role of this book is to enable our well-wishers and supporters to join us in becoming partners in the development process. We are creating a ‘disaster response reserve fund’ so we can respond immediately when a community reaches out to us for help. Please feel free to contact me if you wish to become a disaster response support partner.

Paul admonishes us in Ephesians 3:20-21 (NIV): “Now to him who is able to do immeasurably more than all we ask or imagine, according to his power that is at work within us, to him be glory in the church and in Christ Jesus throughout all generations, for ever and ever! Amen.”

We pray that this book will accomplish this purpose, for which it was compiled.

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1

Why Worry About Foreign Disasters?

By Dr. John Payne

“Don’t we have enough disasters of our own?” That sounds like a reasonable question to me. The number of hurricanes hitting North America broke a record in 2020! Also in 2020, California saw over 4.3 million acres of land burn in wildfires, more than double the record since these fires have been documented. That does not mention the COVID-19 pandemic, the earthquakes, the floods, and the disasters originating with human decisions. Surely, we in the United States have had enough disasters. How can we worry about other people’s trouble too?

Part of the answer came to me when my extended family and I were evacuated under threat of the CZU wildfire south of the San Francisco Bay Area in August 2020. The fire was started by a severe dry lightning storm, striking dozens of locations at nearly the same time.



Our decision to evacuate did not take a lot of convincing from the policeman knocking on our door, since smoke was dimming the daylight. The wind was blowing our direction from the fire,

and the air was getting hard to breathe. Along with ourselves, we stuffed as many irreplaceable things as possible into two cars and fled 50 miles away to the refuge of friends who offered us a place to stay.

Our story could have been vastly different. If we had been normal people in the developing world who needed to flee, we would have had to walk, carrying what we could on carts, bicycles, and our backs. There would not have been enough food, and we would have slept on the ground. Protecting even the little we had taken with us would have been hard, because everyone around us would have been desperate too. And how would we have cared for the young or the very elderly, like my 96-year-old mom?

In the developing world, things would have been different in other ways as well. In our situation, planes and helicopters



dropped hundreds of loads of water and fire retardant on the fire. Two thousand brave, well-equipped firefighters kept the fire from crossing the road two miles from our home.

Therefore, when we returned, there was an undamaged home for us to reclaim. Here, the fire burned about 900 homes. The

same fire, fought by poorly equipped firefighters in the same kind of steep forest terrain in a developing country, would have destroyed most of the 30,000 homes in the vicinity.

There would be other differences. When we returned home, fire trucks lined the road. Hundreds of utility vehicles, under the control of well-organized command centers, had crews busily repairing power lines. Easily available technology reported air quality indexes, advising residents when it was safe to exercise outside. In the developing world, help would likely be sparse or poorly organized. Discouraged people without hope would be milling around wondering what would happen next. Instead



of life returning to mostly normal in four weeks, it would more likely take four years. In Port au Prince, Haiti, eleven years after their big earthquake, many of the buildings destroyed in the earthquake are still in rubble.

The problem of local people in developing countries is not that they are lazy or shortsighted. Their problems are ones they are eager to solve. However, preparation takes time and forethought, and their resources are chronically overstretched.

When disaster does strike, well-intentioned outsiders often come with resources they imagine local people need. Plans for recovery made without any input from the community often stay unfinished after the outsiders leave. The helpers may have unintentionally created dependency, rather than empowerment. Disasters do require outside help, but local people need to manage everything they can, starting from the beginning of their recovery.

The beauty of the strategy of Community Health Evangelism/Education (CHE) is that local ownership and control is at the core of its DNA, right there with recognizing God's rightful part in everything that happens. Interestingly, the more the local people allow the Holy Spirit to be part of their decision-making, the more they are empowered to trust each other. Trust is the basis of the cooperation for which all relief experts long. Cooperation is an essential element of the "Relief Development Continuum" that Dr. Jayakaran discusses in Chapter 4 of this book.

This is why Medical Ambassadors International (MAI) is uniquely positioned to organize disaster relief in places that have already succeeded with CHE. These are places where locally managed and controlled development strategies are what local people know and expect. Here, many people already trust each other because they have experienced the love and empowerment of the Holy Spirit in their lives. When communities receive the relief assistance they themselves have requested, there is a sense of control and empowerment in place of the helplessness. Best of all, God gets the glory!

So, why should North Americans cooperate in disaster relief in the rest of the world? Perhaps a desire to help is a mark of the Holy Spirit living in us. The Holy Spirit prompts us to cooperate in meeting the needs of people He loves everywhere. Doing anything else would be a mark of our selfishness, not of His love.

2

Providing Relief with a Development Mindset

By Dr. Bibiana MacLeod

As a student enrolled in the Wheaton College Graduate Program on Humanitarian Disaster Leadership, I heard lecture upon lecture, and read book after book on the topic of Emergency Management. With my missionary history of Community Health Evangelism (CHE), where development and local ownership are emphasized, I was happy to recognize that engaging the locals in relief activities was frequently mentioned as an important component of appropriately implemented aid. However, I quickly learned that theory and reality do not always align.

In my experience, when involved in responses to disasters, the outsiders bringing the resources are the ones who determine the assessments, priorities, procedures and evaluation of their plans. They decide when to begin and when to end their interventions. Community participation is considered adequate if members of the affected area are hired, consulted, or met at some point of the journey, so the “box can be checked”. There are lives to be saved. Time is an essential resource. “We are the experts”, you can almost hear them say. Even the language spoken in clusters rarely corresponds to the country of intervention.

But community involvement is not an item to be checked on the list of relief best practices. It is the way to begin, it is a road map, and it is also the end of a successful relief effort.

Through the eyes of one who has seen substantial transformation take place in both urban and rural environments, I present a list of considerations that if followed, will result in local ownership and ongoing development amid a crisis that requires immediate response.

1 - Relationships of trust are cultivated, nurtured, promoted and pursued.

Providing relief is not about a mere job that needs to be done. We must be sincerely concerned about fellow human beings that, in the midst of their dismay and stress, need to be reminded that someone cares at the deepest level, mirroring God's sacrificial love for the world by walking alongside them.

2 - Partner with local community groups.

Local groups that have previously been involved with community efforts to solve their challenges should be invited to the table as partners the moment we step into their own area. Out of respect for their area of influence, we acknowledge the need for their moral approval also, even if we have authorities' permission to come in.

3 - Proactive training of local leaders in disaster preparedness and risk management.

Initiating training before a disaster occurs equips leaders to respond with more understanding at the time of crisis. Medical Ambassadors International (MAI) invests in areas of the disaster cycle that may not seem as impressive as immediate response efforts, but in the long term, build capacity for local response in multiple circumstances where outside resources are not available.

4 - View the crisis event holistically.

We need to have an integral mindset, even if our intervention is single-focused. If we do not have a holistic view of an event and its causes and consequences while considering the necessary

responses to it, we may miss the opportunity to link with others responding to the different aspects of complex emergencies. Only when we replace an attitude of self-sufficiency with a deep understanding of being a small part of God's response to the need, will we be able to contribute without claiming ownership and can relinquish all credit to the One who sees the whole picture.

5 - Care for the most vulnerable remains non-partisan, respects dignity, and values the ideas of others.

Though these are well-promoted recommendations from recognized actors in the disaster response arena, organizations must be intentional in their approach, as these things can be easily engulfed by the stress of the moment.

When COVID-19 affected our planet, response was no different. Communities who acted with intention also succeeded in the fight against the spread of the virus. Those that relied on the latest information from the outside world, or their own magic solutions had an uphill struggle. Out of their practical actions expressing creativity, care and confidence, intentional communities found resilience.

In summary, there is always room to improve crisis response. But without communities' own initiative being considered, we are in Paul's words, "beating the air".

Therefore, I do not run like
someone running aimlessly;
I do not fight like a boxer
beating the air.

1 Corinthians 9:26

3

Guidelines for Relief with a CHE Mindset

CHE – Community Health Evangelism/Education

By Dr. Bibiana MacLeod

Medical Ambassadors International (MAI) follows a set of core values for community development that will also be key principles for the way we assist in case of emergencies. Additionally, we adhere to the Code of Conduct that has been established by The Sphere Project, Red Cross, and other international leaders in disaster relief¹.

Ideally, MAI would like to train all partners in Disaster Mitigation and Disaster Preparedness. In situations where MAI received many requests, it would preferably interact with those Community Health Evangelism / Education (CHE) communities that have received previous training. We want to promote local ownership, multiplication, sustainable/long-term development, and integration of spiritual and physical ministry during a situation causing much distress and desperate needs.

PHASE A: RESPONSE

When disaster hits CHE communities or partners that have been trained and are entering areas that have been affected by disaster, the steps below are followed.

1. Situation Summary – Survivors, along with local CHE Trainers will:

- Conduct a simple assessment of damage.
- Detail losses and areas that need external aid, with names of communities, lists of structural damage and

people who have been injured or died as a result of the disaster.

- List the location of people that may be in need.
- Conduct an inventory of available resources.

2. Prioritize and Budget – Survivors, along with local CHE Trainers will:

- List priorities and goals for the short term, (first week) and mid-term (next two months), so donors can have a better idea of the overall picture and what needs to be done in response to the event.
- Create a plan to keep local ownership and long-term development in mind as a part of crisis response.
- Report additional organizations that have been contacted for assistance in order to maintain transparency and accountability.

3. Organize – A local response team will be formed to:

- Manage communications, resources, and activities in response to the crisis.
- Report directly to MAI.
- Sign an agreement for the duration of the help if there is no previous cooperation agreement signed between them and MAI.

4. Monitoring and Evaluation – Local Partners will be also asked to:

- Provide monthly updates of deliveries and accounting.
- Conduct a 6-month post-response assessment with long term plan to accompany communities.

PHASE B: REHABILITATION

Rehabilitation follow-up takes different forms, based on the previous community relationships, champions leading the local response, and their specific CHE previous situation, as well as

funding availability. Medical Ambassadors Canada (MACA) will be intervening mainly in this phase, after signing a Cooperation Agreement with the implementing partner. Funding for shelter, food security, WASH (water, sanitation, and hygiene), care for those most vulnerable, survivor's safety and security, and partnership with other agencies will be promoted. MAI can be part of specific training activities and focus on areas of specialty, but in view of organizational capacity, MAI will not focus on this nor phase A, unless more resources are made available.

PHASE C: MITIGATION

This is where larger funding should be provided, allowing focus groups identified as vulnerable to be strengthened through the CHE structure. As relationship with local actors is strengthened through immediate response and ongoing communication in following phases, MAI can offer training in this phase based on resources we already have or will develop in the future. CHE lessons such as “Theory of Change”, “10 Seed Technique Assessments”, along with developmental lessons on fish farming, agriculture, internal saving groups and others will be customized for specific situations, including CHE basic training if needed.

PHASE D: PREPAREDNESS

MAI will make preparations both at headquarters and in the field.

Headquarters:

1. Recruit potential donors, asking to commit a certain amount, and set it aside in case of disaster, at which time field personnel will contact headquarters to release funding.
2. Build relationships with partners to create a coordinated response, identifying capacities and areas of influence.

(World Challenge, Samaritan's Purse in some countries where they support CHE, local partners, Global CHE Network, Global Health partners, etc.)

3. This framework and follow-up interaction with Regional Coordinators (RCs) are part of the MAI Headquarter Preparedness Plan. Disaster Continuum Regional Teams will focus on a person from each region to be trained in the process of Disaster Ministry, equipping them to be the key leaders in MAI response and service.

Field MAI Teams and Partners:

1. Train CHE communities in specifics of disaster preparedness, such as creating a "go bag", and how to provide first aid or trauma care. Also, training in dealing with specific hazards, like flooding, fire, mud slides, cyclones, etc.
2. Put in place mechanisms for further interaction between the field and MAI Headquarters.
3. Build relationships with local government responders and help field partners, (local teams and communities) to understand the dynamics of disaster response, with different players. This includes teaching them how they can integrate the external interventions in a coordinated way.
4. Establish a communication plan in case of emergencies.

4

The Relief to Development Continuum

By Dr. Ravi I Jayakaran

“Now to him who is able to do immeasurably more than all we ask or imagine, according to his power that is at work within us, to him be glory in the church and in Christ Jesus throughout all generations, for ever and ever! Amen.” Ephesians 3:20-21 (NIV)

In the nineties and early 2000s, I was actively involved with relief & rehabilitation programs. As Director of Operations for the World Vision International (WVI) projects that I supervised, there were specific seasons in the year when we keenly listened to weather reports and cyclone warnings to track disasters along the coastal regions. The pattern for these rapid impact disasters could easily be mapped on a seasonality chart, as could the slower impact disasters such as droughts and famines. Earthquakes, ethnic clashes, and slum fires were a little less predictable, but over the years our team developed a relief response strategy that allowed us to effectively deploy relief response while continuing to maintain other projects not impacted by the disaster.

Several members of the leadership team wore two hats. We were responsible for overseeing our slew of multiple programs and projects when there were no disasters; but as soon as a disaster occurred, we stepped into the role of Director of Relief. Over time, with more experience and a lot of training in relief and rehabilitation programming, I became part of the National Rapid Response team for WVI as well as the Regional Rapid Response Team for the Asia Pacific Region. This led to more research

into community-based disaster responses, community-based disaster mitigation, food security issues and community coping mechanisms. During my stint as the Regional Advisor for food security and Disaster Mitigation for the Asia Pacific Region, I had some interesting experiences of studying community resilience and coping patterns during and post disasters along the Mekong River as it passes through five countries. Larger organizations with heavy staffing resources can have teams dedicated to relief and rehabilitation. But, for a small organization such as Medical Ambassadors International (MAI), a separate team for relief is too big a luxury. Our regional and area teams must develop the capabilities of responding to disasters that occur in their area and move them back on to the development track as soon as possible. The basic principle should be to respond to the smaller disasters that occur in the areas where there are Community Health Evangelism/ Education (CHE) programs and where MAI partners are affected.

I have found that a useful way to classify the level of a disaster is to base the assessment on the extent to which the community is impacted. This is referred to as the 'D5 classification' – named as such because all the levels can be defined by the following words: Delay, Disturb, Disrupt, Destroy, Devastate.

D-1 describes a low impact disaster, such as a storm or heavy rain which delays the normal functioning of life processes (social infrastructure) in the village. As the waters recede or dry, life returns to normal. In D-2, the intensity of the disaster increases, affecting not just the social infrastructure, but regular economic activity is also affected. At this stage, the normal life is not only delayed but gets disturbed. Further intensity of the disaster results in being moved up the scale from D-1 to D-5, as damage impacts not only the social and economic activity, but also the physical infrastructure. The following chart shows this progression from D1-D5:

LEVELS	IMPACT	REMARKS
D-1: Delay	Normal Life gets delayed	Social infrastructure affected
D-2: Disrupt	Normal life gets disturbed	Social infrastructure affected/ some economic activity affected
D-3: Disrupt	Normal life gets disrupted	Social infrastructure and economic infrastructure temporarily affected
D-4: Destroy	Physical infrastructure affected	Social infrastructure, economic infrastructure damaged with minor damage to Physical infrastructure
D-5: Devastate	Physical structures permanently damaged	Social infrastructure, economic infrastructure, with serious dam- age to physical infrastructure

When the economic and physical infrastructure are damaged, recovery becomes a slower process. Communities in the developing world do not have reserve capital or well-developed response mechanisms to address major damage to physical infrastructure. Hence, recovery time is long, and vulnerable members of the community are the worst affected with some falling off the grid by migrating away. Situations like this make them vulnerable to trafficking. In most cases, we will find that a disaster beyond D-3 is outside the scope of MAI to respond. However, there are many larger Christian non-governmental organizations (NGOs), such as World Vision, World Relief and Samaritan's Purse – to name a few, that have the capacity to respond to larger disasters. MAI Regional Coordinators and Area Coordinators must maintain connection with the leaders of these Christian organizations as this makes it easier for the NGOs to be invited to step in with the resources of their organizations. MAI teams can then help with 'needs assessment', 'situation summaries', and 'mobilizing affected communities for the response'.

MAI home office leadership can assist the field teams in making these connections with the country office teams of

the larger Christian relief and development organizations. It is important to note that these connections and relationships must be established prior to the occurrence of a disaster!

Local government institutions related to relief and social welfare also have provisions for supporting responses when the disasters are widespread, therefore, local leaders should explore this possibility. As an example, during the COVID-19 pandemic some of the leaders in South Asia were able to access the relief related provisions of the local government and became distribution centers for the relief support.

There is an interesting similarity in the process of inflammation that takes place in the body and disasters of different levels. In the body, as the cause of an inflammation intensifies, the affected area passes through the five stages of inflammation, namely (in Latin):

Stage 1: Rubor-Affected area becomes red

Stage 2: Calor- Affected area becomes warm

Stage 3: Tumor- Affected area becomes swollen

Stage 4: Dolor- Affected area experiences pain

Stage 5: Functio Laesa- Affected area becomes 'function less' (or a scar tissue)

The task of the health care provider is to arrest advancement by removing the patient away from the cause of inflammation before it reaches the worst stage, namely, 'Function Laesa'. If this happens, the trauma results in the creation of a scar tissue. Applying this principle to disasters, means that we must strive to restore things back to normal as soon as possible.

When people are in traumatic situations, we can move them out of the circumstances that caused the trauma, however the impact of the disaster (flood, storm, fire, etc.) remains in the area for some time. Our strategy is to move affected people

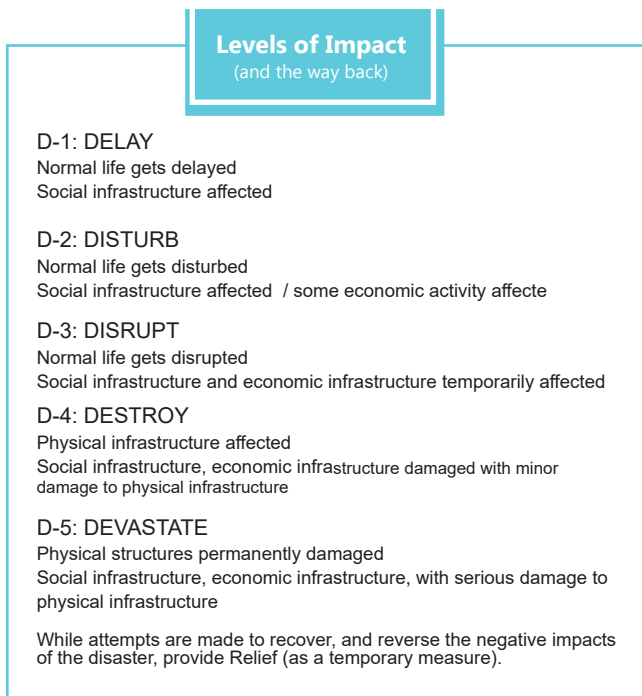
(if possible) to a safer place, await the recession of the cause of the disaster, and meanwhile do what we can to sustain life during that process. This may involve arranging temporary shelter in a community building or church while providing food, safe drinking water, and medicines. These temporary measures can easily go away as soon as the community is able to get back into their homes.



In the photo shown here, the flood that took place in Central America made it unsafe for the people to remain in their homes. The people were moved into a local church where they were provided food, shelter, safe drinking water and medical care. The church pastor and elders consoled and encouraged them. After the hurricane passed, the waters started receding and within a few days the affected families were able to return to their homes to begin cleaning up and getting things back to normal. The stronger houses sustained less damage, but some of the poorer shelters experienced structural damage. As often happens in such cases, the community pitched in to help restore the houses. MAI's CHE partner, who had served as the relief coordinator for this disaster, had previously developed good relationships with other Christian organizations, therefore she was able to get assistance for construction materials for the damaged homes and seeds for planting to replace the crops damaged by the floods.

Rural families in developing countries make investments on their homes as well as assets when their food security status leads to surplus. The house and the assets then become their reserve capital that can be liquified for bidding them through a “rainy day”. *That is the theory!* However, when that “rainy day” turns out to be a disaster, the family can suffer a serious setback as the disaster actually damages their investment (their house or assets). The journey of “returning back to normal” can then take a much longer time than expected, and they may end up becoming vulnerable to local loan sharks in the community. Over the years I have realized that a *single disaster can be a setback for decades of development*. In the story of the Good Samaritan (Luke 10:25-37) that I mentioned in the introduction, there is a point in a crisis when the victim needs external assistance. If this does not happen, the setback can be permanent!

How do we reverse the damage caused by a disaster, and get the community to make the journey back to normalcy? Let us address this for disasters that fall into the categories of D1-D3 because those are the ones that are within the scope of MAI’s



response. D4 and D5 types of disasters need a lot of resources, lots of training and professional relief response capabilities and as suggested earlier, are best addressed through partnerships with larger relief organizations.

Starting with the D-3 level, the strategy is to provide relief support to the people most impacted by the disaster and then work towards restoring the economic activity in the area. This may involve studying what aspect of the economic activity was disrupted, such as the supply of raw material, production of a value-added product or helping with the marketing. Much of this will be in the area of transportation or restoring production. Assuming that the product that was being produced already had a market, this aspect of restoration of the enterprise will be the easiest to manage. This strategy requires engaging with the people involved in the enterprise and identifying where the supply chain was disrupted.

RESPONSE:

- ◆ Identify the level of impact (D1-D5) using participatory tools.
- ◆ Identify those who are worst affected and ensure that the right people are being supported.
- ◆ Engage the local people in the response process.

DISASTER MITIGATION:

- ◆ Ask what disasters happened there in the past?
- ◆ What did they do to response?
- ◆ Break it up into steps.
- ◆ Develop a disaster mitigation strategy/plan.
- ◆ Plan to mitigate the negative impacts of future disasters.

In the case of the D-2 level, the only relief response required is waiting for the cause of disturbance of the social and economic infrastructure to recede. During the wait time, we can provide food, shelter and basic supplies typically for a few days or at the most a week.

For the D-1 level, unless a large number of people are affected, no action may be required. In planning a relief response, care has to be taken not to do what the community is able to do by itself. This will enable returning to normal in the shortest possible time.

There are principles to follow when assessing the intensity of a disaster, identifying the people impacted, and planning a response. While working in a community, it is best to involve the people in the plan in order to identify the type of disasters they encounter and plan in advance.

Some developing communities in South Asia and Southeast Asia believe it is bad luck to plan in advance to deal with a disaster. It is still worth working with the leadership of the community to show them that 'being prepared' is a wise strategy. Sometimes, depending on how good the relationship with them is, they will listen to counsel; but in other cases, it is only after the disaster that people will wake up to reality and want to be prepared for the future.

The Ten Seed Technique (TST) has been used extensively for rapid assessment of groups of people most affected by disasters to identify the level of impact. This CHE tool can also be used to specifically identify the worst affected families so that they can be prioritized for receiving relief.

The relief to development continuum consists of the following steps that follow a disaster:



Relief leads to **Rehabilitation** which leads to **Restoration** which aims at bringing things back to the **Regular** status. When

things return to **Regular** status, the development continuum can take place by getting the community back on track with CHE.

The goal of **Relief** in the first days after a disaster is aimed at saving lives. Then attention is turned to clearing debris and laying the groundwork for rebuilding; this is the process of **Rehabilitation**. Eventual rebuilding brings **Restoration**, which aims at getting things back to the **Regular** status. However, the continuum does not have to stop there. In the process of working together, communities can be prepared to look around and ask, "What else can we do to make things even better here?" CHE committees can re-group and new improvements (**Development**) can begin again in that place.

When a disaster strikes, depending upon the extent of media attention the event gets, there is a reasonable response from people who are willing to fund the response. As MAI builds up its relief response capability, the first step is to develop a Central Relief Response Fund so that we are able to respond within 48-72 hours after a disaster with immediate funding support for the area. To learn how MAI plans to mobilize this Central Relief Response Fund (CRRF) contact me at Ravi@med-amb-org. MAI also encourages all the Regional Coordinators and Area Coordinators to receive training in Basic Relief by registering for the course available to all MAI staff and partners through MAI-Academy.

A valuable guideline when planning a larger relief response is to plan to have at least 50% of the total funding for long term follow up after the initial relief response is over. This amount can be put to use for mobilizing a CHE program in the affected communities so that the community can continue its transformational journey. This is important since most traditional relief agencies leave the site as soon as the community returns close to or at its pre-disaster status.

MAI is not per se a relief organization, but we do not want to be like the negative examples of neighbors from Jesus' powerful story about relief response in Luke 10:30-36:

³⁰ In reply Jesus said: "A man was going down from Jerusalem to Jericho, when he was attacked by robbers. They stripped him of his clothes, beat him and went away, leaving him half dead. ³¹ A priest happened to be going down the same road, and when he saw the man, he passed by on the other side. ³² So too, a Levite, when he came to the place and saw him, passed by on the other side. ³³ But a Samaritan, as he traveled, came where the man was; and when he saw him, he took pity on him. ³⁴ He went to him and bandaged his wounds, pouring on oil and wine. Then he put the man on his own donkey, brought him to an inn and took care of him. ³⁵ The next day he took out two denarii and gave them to the innkeeper. 'Look after him,' he said, 'and when I return, I will reimburse you for any extra expense you may have.'³⁶ "Which of these three do you think was a neighbor to the man who fell into the hands of robbers?"

The lessons that we, as a mission, can draw from this story can be applied to our response to disasters.

Below are the guidelines we seek to implement:

- MAI will establish a Crisis Relief Fund (U020) that will enable rapid (within 48-72 hours) deployment of funds to the local team in the event of a disaster.
- When a disaster strikes in a community where MAI has established CHE programs, we will respond. This also applies to communities where we work through partnerships.
- We will generally respond to disasters in the D1-D3 levels and seek to partner with other Christian relief organizations for D4 and D5 level disasters. MAI can offer support in the aspects of needs assessment and community mobilization.
- The International Relief Response Coordinator will be the

point of contact and provide advice on the way forward, including the level and type of engagement.

- Similarly, if the intervention is likely to continue for an extended period of time, at least 50% of the budget should be earmarked for continuing CHE programs after the community has returned to its pre-disaster status.
- MAI has a network of prayer partners who faithfully pray for our ministry and we have a special 'Crisis Prayer Team' that can be contacted in emergencies. In the event of a disaster clear information on the disaster situation, such as the summary/type of disaster/photographs, etc. help in sharing the prayer needs on the website also.
- The MAI Academy will provide a training program on disaster response that all MAI field leaders are encouraged to take.
- The following chart is a quick checklist of information MAI will need when a request for relief is received from you. See also Addendum #1 for further detail.

Proposal Components

- Name of the project
- Situation summary
- Area affected
- Area of focus for the proposal
- Plan for response
- Which "D(s)" will be responded to
- Names of personnel available
- Main contact & contact details
- Budget
- Timeline for action
- Expected start date
- Expected completion date

It is our prayer that our teams on the field will become excellent, qualified and responsive neighbors when crises come to the communities where they work.

5

Beauty Instead of Ashes: Stories of Recovery

“The Spirit of the Sovereign LORD is on me, because the LORD has anointed me to preach good news to the poor. He has sent me to bind up the broken-hearted, to proclaim freedom for the captives and release from darkness for the prisoners, to proclaim the year of the LORD’s favor and the day of vengeance of our God, to comfort all who mourn, and provide for those who grieve in Zion... to bestow on them a crown of beauty instead of ashes, the oil of gladness instead of mourning, and a garment of praise instead of a spirit of despair. They will be called oaks of righteousness, a planting of the LORD for the display of his splendor.” Isaiah 61:1-3 NIV

New Opportunities

by Dr. Bibiana MacLeod

Guarani Community in Argentina

Orfa Gómez Parra is a Guarani Community Health Evangelism/ Education (CHE) trainer that serves in South America’s oral tradition cultures as an associate with Medical Ambassadors International. In 2017, she moved from her homeland in the southeast of Bolivia to work as a missionary with the Guarani in Argentina.

In December 2019, Orfa’s dad fell ill. He was part of a Bible translation team bringing God’s word to one of the Guarani dialects, the Aba. Orfa went to be with him and her family. He was diagnosed with hemorrhagic dengue, and regretfully,

passed away right after Christmas. The family was devastated, and Orfa's mother needed her daughter with her for few months.

As she was getting ready to go back to the field, COVID-19 infections in both countries had increased and borders were closed. But out of this "inconvenience" came many requests for Orfa to share CHE principles with church leaders in two key areas where the Guarani live near her hometown, Charagua. There were also German missionaries working with aboriginal groups in Paraguay that had interest in learning how to apply the strategy with their health agents going to remote communities from a local clinic. Out of the pain of loss and the grief, God opened new opportunities to serve people.

A CHE Community in Nicaragua

In early November 2020, Hurricane ETA caused devastation across parts of Central America. At this time, the Nicaragua Community Health Evangelism/Education Association asked me if I could give them direction on how to find help for CHE communities on the east coast that had suffered severe damage. People needed basic subsistence provisions and building materials to repair their homes.

While plans for help were being made, the second hurricane, Lota, hit the area again! Flooding and high winds knocked down what was still standing. Thirty families that had sought shelter in a local church had to leave when the building lost its roof from the heavy winds. Eight people were



reported missing in the twelve villages for which this group was caring.

In the wake of the second storm, this small CHE committee responded to God's call to care for their neighbors, as they opened their homes and shared resources with the people affected. Here, the beauty of community was in full display.

The CHE Team in Haiti

The Haiti team had been working in rural areas throughout Haiti, promoting a healthy and holistic approach to the first 1000 days of life. Peri-natal care, training of birth attendants, and health monitoring of babies and infants are some of the regular activities that have taken place since 2017. Communications during the COVID-19 pandemic were interrupted. My intentions to visit the most vulnerable villages in the mountains of Mombin Crochu came to a halt when we had to return home in the middle of March due to the rapid spread of the pandemic.

The local team immediately responded to the risk of food insecurity with locally made flours rich in proteins and mixed with powdered moringa leaves and seeds. The babies growth remained consistent during the second trimester, but the third trimester showed a big change. Acute malnutrition cases had dropped significantly, showing that their intervention was appropriate and timely.

This team made many plans for their ministry during 2021: home visits, additional teaching of agricultural practices, spiritual formation of their families, water purification, breastfeeding, family gardens and printed booklets to be left with mothers that teach them how to care for their children with local resources.

The crisis, instead of paralyzing them, gave them new ideas and desire to learn more.

Working Together in A Time of Disaster

by Shelly Zadina

The earthquake in Albania on November 26th, 2019, measured 6.4 magnitude and lasted for 50 seconds. This would be the strongest earthquake in Albania in 40 years and the deadliest in 99 years!

Fifty-one people lost their lives, and the European Union office estimated that 14,000 people became homeless, as 14,000 buildings were damaged with 2,500 being uninhabitable.



In the cities, the government arranged to temporarily house the homeless in hotels or tent camps. In the affected villages, many people felt they could not relocate to the temporary state housing because they had livestock and fields that need attending to, so they continued to sleep in unstable structures, such as tents, courtyards or greenhouses. To add to the troubles, Albanians do not typically have home insurance, so rebuilding would prove extremely difficult for these families.

Medical Ambassadors International (MAI) had previously established Community Health Evangelism/Education (CHE) in several Muslim villages in the Korça area, resulting in three villages with church plants and a group of growing believers. While the earthquake was felt in this area, it did not cause significant damage. The believers' immediate response to the disaster was that they wanted to help. In spite of many of them being needy themselves, they collected special offerings in each of their churches and added to the offerings from their church finance accounts to bring their gift to about \$1000. Also, some of the people donated items from their own homes.

When everything was collected, Patriot, the CHE team leader, connected with the CHE ministry partner in the area affected by the earthquake. Next, he and some representatives from the churches went to the ministry partner's CHE community. They were able to visit with three families who they helped with some immediate needs. Their gifts were very much appreciated.

The Albanian Evangelical Alliance, of which Medical Ambassadors Albania is a member, set up a disaster response to help organize the efforts of churches and organizations that were wanting to help out in this time of great need. Their desire was to not only provide resources, but to be an example and a testimony as a community of believers. Hope was brought into a desperate situation by meeting the physical, emotional and spiritual needs of the disaster victims.

Medical Ambassadors' CHE team in Korça also wanted to help with the disaster response and to support the Alliance in their effort to be the hands and feet of Jesus to so many in need. With the help of their generous supporters, almost \$5,000 was contributed to the effort.

Many people were ministered to through the efforts of all of the churches and organizations who worked together in this time of disaster.

A Community Comes Together

by Marco Aurelio Quispe Trinidad

In Peru, the community Los Libertadores and Jesus Is The Way Church took the Community Health Evangelism / Education (CHE) training “Community Awareness”. As a result of this training, participants decided to take action by forming a committee to identify problems in their community.



The problems identified were:

- Delinquency
- Rubbish and garbage in the streets
- Lack of transportation
- Malnutrition
- Poor education
- Poor hygiene

The committee decided to first focus on cleaning the streets, as this would greatly benefit the health of the children. Realizing the importance of local resources, they visited their neighbors to organize a community cleaning day.



As a result, the community's streets were clean, but the question was, "How do we prevent the streets from getting dirty again?" The committee spoke to area food vendors and a transport company to ask for help with the cleaning. Also, they hung posters on the poles that said, "Our streets are not garbage cans!"

The results were seen immediately. Some sellers took the initiative and started to keep the streets clean. Upon seeing this, the committee decided to reward the seller who swept his part of the street more often than others. He was given a special award lunch in celebration of his efforts.



It has not been easy, but today we see the results! Below are the before and after photos showing the difference on just one of the streets.



6

Food Security During Pandemics

By Tirus and Winnie Githaka

Nairobi (CNN), Jan 25th, 2020: The Horn of Africa has been hit by the worst invasion of desert locusts in 25 years, the UN's Food and Agriculture Organization (FAO) said Friday. The invasion poses an unprecedented threat to food security in the entire sub region, where more than 19 million people in East Africa are already experiencing a high degree of food insecurity.

A swarm of locusts was quickly spreading throughout the East African region, vastly destroying both crops and animal pasture, leaving millions of people at high risk of food insecurity. And then, in Kenya and some parts of Ethiopia, floods destroyed what the locusts left. Many people in these areas depend on farming as a source of income and to feed their own families. In the past, some people supplemented the farming income with an additional job outside of the home. Now, because of the COVID-19 pandemic, the jobs are lost due to preventive measures that include restriction on travel.



In one community in eastern Kenya, most people lost their crops. With supplemental jobs also lost, they feared their children would go hungry. Even with their meager savings, the price of available food in the market was out of reach.

But the situation was a bit different for Ndeko's family. Through Community Health Evangelism/Education (CHE), Ndeko learned to cultivate his land to prevent soil erosion, retain moisture in the soil and therefore, produced more food. He also learned how to store his harvested food in a hygienic way, keeping it secure from destruction by pests and weevils through natural methods. Ndeko's wife, Kendi, kept a few chickens and some goats, using the eggs and milk to supplement the family nutrition. So, when other members of the community struggled with malnutrition and other nutritionally related diseases, Ndeko's children were healthy and rarely got sick. Sometimes they would even have a few extra eggs and milk to sell. Through CHE, Kendi learned how to use the manure from the chickens and the goats to improve the soil on their small farm.

Kendi also learned how to use a small portion of her land behind her kitchen for planting vegetables, such as sukuma wiki (kale), spinach and other traditional nutrition-packed vegetables. When there was no rain, Kendi would use wastewater from her kitchen to water the garden. She was thankful she could help her frail mother-in-law with the diet that was recommended for her by the doctors.



When the neighbors were receiving food donations, the helping churches were happy to learn that they could purchase

some of the local food from the community. Ndeko and his wife were among the few who had stored food that the churches bought for distribution to those most vulnerable. Because there was so little food in the market, they received a higher amount than they would have gotten during normal times.



Ndeko and Kendi enjoy teaching others the valuable lessons they learned from CHE. They are highly regarded by fellow community members since they are willing to invest their time to teach their neighbors farming methods for better yields. They also teach simple food storage techniques so that their neighbors will be prepared with extra food to use or to sell for extra income during difficult times. Ndeko and Kendi are changing their economy for the better as the people begin diversifying their food sources. Besides farming, they are keeping animals and growing vegetable gardens. People are encouraged to use some fruit trees for reforestation so they will have a good source of fruits while still taking care of their environment.

Ndeko and Kendi are a fictitious family, however, they are representative of many typical CHE families in rural communities.

Many African communities are dependent on their small farms as their main food source. When disasters such as locust

invasion or flooding occur, or even a pandemic like COVID-19 that affects production and food prices, these communities are left at the mercy of relief agencies to feed them, which is not always forthcoming nor enough for their nutritional needs. In addition, the dignity of the vulnerable is affected. We have realized that in most CHE communities the people are more resilient than in non-CHE communities regarding food security. We have found that the simple lessons given by the CHE volunteers provide a significant foundation toward building food security in these communities. CHE lessons teach people how to grow more food despite small portions of land, better storage methods, diversification of the crops, and keeping small animals as a source of protein and extra income. They show people how to have kitchen gardens for a continuous supply of fresh vegetables, as well as how to plant fruit trees for reforestation.

These simple lessons have increased the resilience of CHE communities. Of greater significance are the spiritual and moral value lessons. The changed behaviors in people's lives because of their relationship with Christ, translate to more productivity in the community, especially for the men and youth who invest more time in farming and caring for the animals rather than idling at the local marketplaces. It also means that the small family incomes are spent for the wellbeing of the family, as opposed to being spent on alcohol and other social vices.

One Kenyan man put it well. He said, "So much has changed for the better since this CHE strategy came among us!"

7

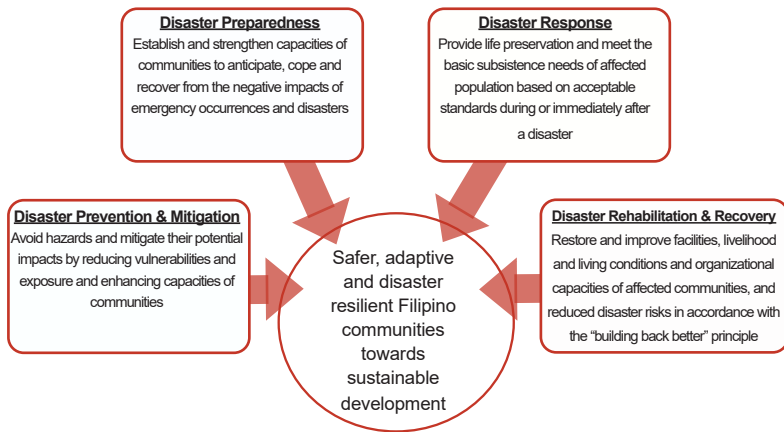
Engaging the Church and Community

By Dr. Bill and Sharon Bieber

Technology today allows us to view the devastation of natural disasters taking place around the world. But what if it happens in my own place, my own neighborhood? Well, now it has. The COVID-19 pandemic has taught us that we are all vulnerable, and there seems to be no place on the entire planet untouched in some way. We are a world community, sharing daily accounts of a common tragedy.

We have also had to re-think our personal role in times of disaster, asking ourselves a key question, “How does our Community Health Evangelism/Education (CHE) training apply to a Canadian community and to churches struggling with a pandemic response?” If we want to help our community and not just merely cope, how do we expand our prevention thinking to include relief right here on our home front?

When our church asked if we would coordinate their pandemic response, we were delighted to put our international CHE experience to work in our own community. We knew the benefits of a good plan. The disaster cycle we have used from the Philippines moves from Disaster Preparedness to Response (relief), to Rehabilitation and Recovery, to Prevention and Mitigation.



In this model all stages of the cycle point to the center of the circle, Resilient Communities, an important CHE goal.

This means that the community is left functioning at a higher-level post-disaster than before, because of learning to work together to identify and help the vulnerable.

We took our lead from the 6-step plan already researched by the Humanitarian Disaster Institute of Wheaton Seminary. Here is the summary of their steps and our adaptations:

1 - Get Organized

We looked for existing expertise within our church family, such as those already working in health or first responder fields, community volunteers with the food bank, existing ministries within the church like the compassion team, senior care and home groups. While urgency was required as we saw the pandemic was already upon us, we knew that fear and panic are counteracted by presenting a thoughtful plan and accuracy of information.

2 - Create a health team

Ten portfolios or tasks were identified and someone with expertise, as we had identified above, invited to lead that team. Examples of the tasks include health care and personal fitness, community organizing, emergency response, transportation and practical help, family resources, assistance to vulnerable and prayer support.

3 - Develop a communication strategy

Initially, the church secretary and website were vehicles for communication, but then a separate website was created, and a part time coordinator appointed. The local town offered ways to help inform, and brochures were created. Sources for accurate information and key messaging were important as social media began circulating much false information. Our goal was to maintain positive hope, credible information, and calm preparation for lockdowns.

4 - Focus on Reach

Knowing how to contact all the underserved or vulnerable in our communities was difficult. We had to find people who would be liaisons with community and government groups, as well as organizing church volunteers to be the 'connectors' within their own communities. Many volunteers found it was hard to overcome that the fear of being rejected or the fear of speaking with strangers. But without these connector people, most of the 'vulnerable' would remain hidden.

The first line of defense in disaster preparations is that someone needs to know the names and contacts of individuals who live in each house. Our goal, still not achieved, would be to have someone responsible to connect within each block in a town or a defined rural area. With churches working together, this could be done with efficiency.

5 - Strength Through Collaborations

Inter-church collaboration does not come easily unless it has previously been established through prayer networks or ministerial associations. Theological differences and church-focused goals are hard to give up. Even in our small community the churches were suspicious of working together. This became a major hurdle for us, but cooperation is so essential as each has strengths and special resources. Collaborations with health, community and emergency response groups were much easier. We are fortunate to have a Youth with a Mission (YWAM) center in our community, with staff that have an outreach mentality, as well as a health-approved kitchen for meals that could be frozen and ready as needed.

6 - Adapt to changing needs

As the pandemic grew, protocols for church gatherings changed, working from home became normal, visitation became difficult and channels for communication were limited to internet or phone. It has been important to keep reinforcing the guidelines set by health authorities, while at the same time continuing to look for ways to reach out to the elderly and vulnerable. This is a time for churches to emphasize the vital role of a small group structure in keeping members connected in order to provide essential spiritual, emotional, and physical care for each other and those around them.

In all of this, our messaging must be love-filled. We are good at blame-games when it comes to disasters—finding fault with how the outbreak started, or our government’s slow response or WHO’s changing advice. This gets us nowhere. From churches, we have listened while Christians dwell on irrelevant and unproductive theological theories to the ‘why’ of the pandemic. We hear glib comments like, “these are signs of the Lord’s soon return.” Or “the Lord is judging the world and we must call for repentance,” and “people are willing to

listen when they are vulnerable so we must take advantage to evangelize.” None of these messages reflect the command to love our neighbor as ourselves, instead creating more anxiety and hurt to a broken world.

Churches will no doubt look back on the COVID-19 days with the hindsight that magnifies many glaring mistakes and missed opportunities. But we also pray that Christians around the world will have learned important lessons about our true calling: to pray and to serve. After all, it is love in action that demonstrates what it means to be salt and light during times like this – ‘that they may see your good deeds and glorify your Father in heaven.’ (Matthew 5:16)

Leaving theological pride and dualistic mindset behind in order to cooperate in love with other church groups would be a powerful voice of unity which Christ said would demonstrate Him to the world. May churches be found to be relevant in our society’s time of need as they have during great pandemics of past centuries, leaving good footprints for others to follow.

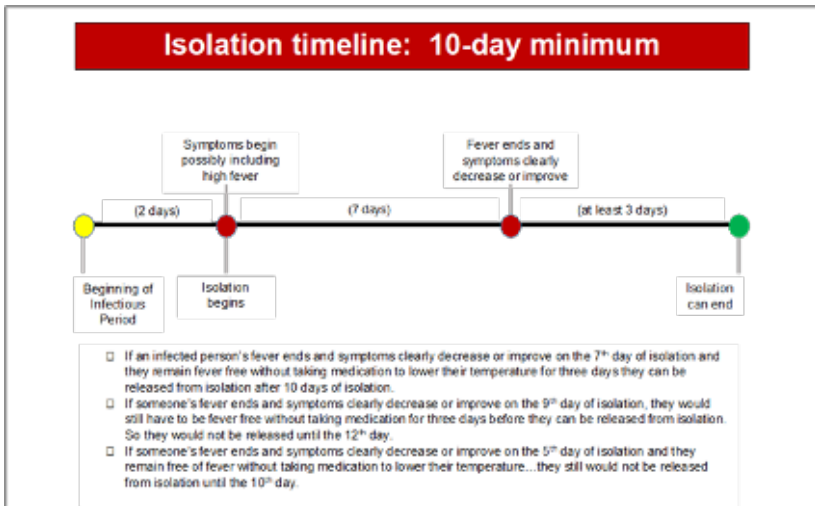
Community Care in the Midst of a Pandemic

By Dr. Bibiana MacLeod

As I tracked World Health Organization’s briefings twice a week during the early months of the COVID-19 pandemic, one statement kept coming back to me, given by Dr. Van Kerkhof and Dr. Ryan: “Communities have an essential role in the control of the pandemic”. My experience with Community Health Evangelism/Education (CHE) in Haiti and other countries in South America and the Caribbean immediately resonated with their recommendations. Neighbors helping neighbors, teaching each other, encouraging best practices, and demystifying rumors.

In those early weeks of the pandemic, I was tasked with the job of creating lessons to be used at the community level.

In preparation, I attended an online training in Contact Tracing provided by Johns Hopkins Bloomberg School of Public Health and adapted it to simple lessons that could be communicated by local trainers to villagers in ways that would reinforce the teachings of their local health authorities. In areas where contact tracing was unattainable by the government, well-trained neighbors would be able to provide guidelines and accurate information. This could help to prevent infection from those infected to people exposed, taking all the necessary precautions to stop the spread. Below is the timeline we used to explain WHO recommendations that would be more likely to be adopted in countries where we serve rather than Johns Hopkins or CDC.



Shelly Zadina, RN missionary to Albania and Dr. Victor Chen, MPH and our Global Coordinator, graciously agreed to help provide the first online training to leaders from Ghana, Togo, India, Bangladesh, Latin and North America. Dr. Hugo Gómez, from Global CHE Enterprises helped me to prepare the Spanish version for Latin America delivered last March. I have had the opportunity to teach the course in different contexts from practitioners experienced in Community Development to church leaders and lay people.

We learned that everyone faced similar challenges:

- Neighbors are not well informed once they are infected, not knowing how long they should stay home.
- Health systems are overwhelmed.
- Many countries are not able to do contact tracing due to the volume of sick people.
- Most people shared experiences of fear, misinformation, and the lack of orientation on what needs to be done once someone has been exposed or has a family member with symptoms of COVID-19.

We start the training with a story of a young schoolteacher that comes back from a family gathering where his uncle, who works

at a meat packing plant, was present. The next day his uncle becomes ill, and this young teacher feels safe, because this is happening only after they were together at the family party. He goes to school, meets with other teachers and his students, and after few days, he begins having symptoms. As we continue the story, we discuss the timeline of events, to describe who is contagious, for how long and the window of opportunity to determine who needs to be contacted and in quarantine to prevent further spread.

This story brings the facts closer to home and becomes an excellent opportunity to do role plays of interviews, what to say and what not to say, ending with simulation of conversations that participants will certainly have with family or church members and neighbors, informally, or as part of a collaboration with the health authorities. We advise to give orientation and information regarding quarantine recommendations, but also to face fears on vaccination - from micro-chip theories, Bible studies on the beast of Revelation and explanation of the phases of development of new vaccines. As fears are addressed, participants are ready to go into their communities and share what they have learned, online or in person when possible.

We teach how to interview with compassion, care and respect, making sure they understand the importance of recognizing who were they in contact with as soon as they are diagnosed. This will prepare community members to face the challenges and provide them with the power to control the spread of the virus in their own backyard.

Simple solutions can make a big difference. I sincerely believe that the health of the community is in the hands of the community; therefore, we need to recognize and validate the role of the community in a pandemic. To keep them in the dark or ignore their confusion, will lead us to frustration and lead them to indifference. When given the tools, community members are not only allies, but key actors in the efforts to stop the pandemic.

Psychological First Aid

By Dr. Bibiana MacLeod

My husband, Alexander, and I were training senior leaders in Haiti in early March of 2020. We had arrived the week before, taking time to visit some communities that were implementing the First 1000 Days program.

Proud moms were showing their back yard gardens and the progress in monitoring the growth of their children. We

accompanied the local teams in their monthly gatherings, where they take time to weigh infants and introduce new teachings on nutrition, spiritual formation, and water



purification. We were planning to stay in Haiti for a month, using the time to meet with key trainers, preparing them for eventual disasters, with lessons I had learned during my studies at Wheaton College, then the plan was to go to the mountains of the Northeast to visit the hospital in Mombin Crochu and Bois de Laurence, meeting with birth attendants trained in the past three years, as part of the same First 1000 Days program.

Unfortunately, all the planning came to a halt by the end of our second week. As we visited missionary friends, we were able to connect to Wi-Fi where Alexander heard the Canadian

news: our Prime minister was calling all Canadians back home. COVID-19 was declared a pandemic, and we were unsure of when flights would be suspended.

The journey home was quite adventurous, but we made it by the middle of March. I immediately felt the need to adapt lessons on Psychological First Aid that I had written the previous year, this time to respond to the pandemic and to present them, not in person but virtually, via Zoom, a platform I was used to, thanks to our monthly meetings with our team at Medical Ambassadors International.

The five sessions cover eight different practical actions that can make a difference in the life of people going through a crisis, a loss, or the anxiety of facing unexpected trauma: Contact and Engagement, Safety and Comfort, Stabilization Exercises, Gathering Information, Practical Assistance, Discovering Natural Networks, Information on Coping Mechanisms and Connection with Other Services. The last day we talked about Spiritual Ministry and Self-care.

Following the first round of training, people from South Korea, Bangladesh, Egypt, Ghana, Europe and North America began registering for the classes. Team members from Latin America requested the training in Spanish, and teaching started to multiply, done by those that had received it. By the time we reached 300 participants I stopped counting, since it was hard to find numbers among others doing the training in their areas of influence.

Mental Health became one of the key interventions we used to make a difference among our brothers and sisters around the world.

What seemed to be an interruption in ministry, back in the mountains of Haiti, became an opportunity to serve with the skills and tools that God had equipped us with for such a time like this.

Spiritual First Aid

By Dr. Jamie Aten

When Hurricane Katrina struck my community just six days after I moved to South Mississippi for my first professorship position, I saw firsthand how faith seemed to help people in my community make sense of and navigate life as they picked up the pieces of what was left.

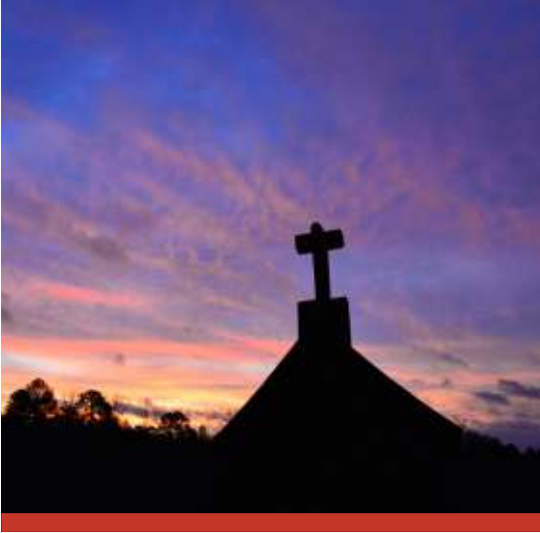
As a psychologist, I felt compelled to empirically test my observations about faith and resilience in the aftermath of the storm. Since my early involvement in helping after Hurricane Katrina and studying the storm's impact on faith and resilience, I have gone on to do the same around the globe over the last 15 years.

Following are spiritual and psychological insights my colleagues and I at the Humanitarian Disaster Institute at Wheaton College have learned along the way.

How Faith Helps

Our findings help give insight into valuable lessons about how personal faith can help survivors recuperate after a disaster—lessons that can inform how survivors and helpers respond to disasters with practical, positive mental, emotional, and spiritual support.

Local churches are one of the first places both congregation and community members turn to for help in the aftermath of a disaster. We found many people turn to local congregations



or clergy for help before professional helpers, first responders or the government. Even if the congregation was also suffering from the disaster or seemed ill-equipped to serve, people still sought help from local faith communities, especially among

underserved populations. This means that congregations cleaning up or dealing with the effects of disasters should be prepared to have open arms, as they are able, to those hurting from the storm.

Our research also shows that helping survivors make spiritual meaning of their experience can have a significant positive impact. Following Katrina, we found that spiritual meaning can be a buffer against negative mental health consequences like posttraumatic stress symptoms. Thus, it may be helpful for those encountering disasters to try and frame their experience in a meaningful spiritual context as a strategy for reducing negative mental health consequences. For example, a survivor who is able to find hope and purpose through their faith in the aftermath of a disaster is likely to experience fewer negatively intrusive thoughts, severe anxiety, and fear.

After a disaster, many people struggle psychologically with a perceived loss of a sense of control over their lives. But in the aftermath of disasters, we have found survivors who reported surrendering their disaster experience to God actually reported having a greater sense of control amidst the catastrophe. Others impacted by disasters might similarly be able to find



a deeper sense of peace believing that something bigger than themselves has command over their circumstances. Paradoxically, relinquishing one's need to gain mastery over the destruction and chaos could be in part what disaster survivors need in order to face the daunting task of recovery ahead.

Our findings further demonstrated that even when disasters lead to loss of basic survival needs, drawing on spiritual resources (e.g., religious coping, spiritual social support) helps protect survivors' psychological resources like hope and optimism. While food and water might become scarce for some survivors, those who are still able to find comfort in their faith may find that their sense of safety does not feel as threatened. An additional study revealed this not only improved emotional well-being but also health-related quality of life among survivors.

BLESS Needs

Overall, our findings suggest faith generally leads to positive outcomes among disaster survivors—but there is more to it than just being 'religious'. Resilience comes from a survivor's actively engaged faith. Further our research has shown that

helping people address 5 core unmet needs in the wake of disasters, including COVID-19, can help them gain a sense of meaning, feel connected, and improve resilience:

1. **B**elonging Needs (relationships)
2. **L**ivelihood Needs (health, finances, resources, employment)
3. **E**motional Needs (mental health)
4. **S**afety Needs (suicide, harm to self, threat to others, domestic violence)
5. **S**piritual Needs (faith, spiritual struggles, meaning-making, purpose)

This may sound like an overwhelming task, but the goal is to work within constraints and challenges caused by COVID-19 as best as you can to provide practical solutions for addressing unmet core needs. Helping to make even small improvements now can lead to big improvements later. Doing so helps keep problems from “snowballing” and getting worse in the long run. Likewise, our longitudinal studies have shown that addressing unmet core needs early on can improve a person’s trajectory for being able to positively cope over time.

Similarly, our research suggests that it is important to recognize these five needs are interconnected. Although only one of these needs is listed as “spiritual,” all of them have a spiritual component.

These psychological comforts must also be cared for alongside real physical needs. As might be expected, there is a significant relationship between resource loss (e.g., home is destroyed) and mental health. For example, in one of our studies we found financial loss was a significant predictor of depression. Thus, a good rule of thumb to remember when helping is: “aid occurs when assistance and needs meet”. Do not assume you know

exactly what survivors' physical needs are; inquire about how you can help. Start by focusing on attending to basic needs like shelter, safety, and medical issues first. Know that by attending to physical needs through what some veteran faith-based responders call "water bottle ministry", you are caring for spiritual and emotional needs simultaneously.

Spiritual First Aid

Based on this research I have shared above and countless other studies we have conducted, we developed Spiritual First Aid as a way to put this research into practice.

*Spiritual First Aid: A Step-by-Step Disaster Spiritual and Emotional Care Manual (COVID-19 Edition)*¹ is designed so people like you can step up to respond to help individuals or small groups (like couples, families, or roommates living together). We also specifically designed it for helping remotely (e.g., online or by phone) and while staying at home. Our Spiritual First Aid is not a counseling approach. Instead, it teaches basic helping skills and interventions that address common disaster needs—which in turn reduces distress—and promotes better mental health. Though it can be used by mental health professionals, we have designed it so that almost anyone can provide basic spiritual and emotional care.

Spiritual First Aid is an evidence-informed, peer-to-peer, disaster spiritual and emotional care intervention, designed to be delivered virtually. It is the first intervention of its kind to have been built from the ground up using evidence-informed spiritual and psychological insights from years of scientific study. Spiritual First Aid is based on 15 years of our team's faith and resilience research that we have conducted around the globe after disasters, mass traumas, civil conflicts, humanitarian crises, and public health emergencies, such as the Ebola outbreak. We have also spent the last four years refining and field-testing Spiritual First Aid after numerous disasters across the United

States. Now we have adapted this method to specifically focus on equipping you to provide spiritual and emotional care amidst the COVID-19 pandemic.

The BLESS Method

The BLESS Method is Spiritual First Aid's way to understand and respond to people's needs. Its simple design will enable you to remember what and how to help others struggling because of COVID-19. Following the steps below will help you address, with humility and practical presence, what people need help with the most amidst COVID-19.

This straightforward and intuitive four-step approach (Attend, Ask, Act, And Repeat) will help you maximize your natural helping skills to provide effective peer-to-peer support.

- ◆ **Step 1: Attend.** Start by taking a posture of humility so you avoid assuming you know what the other person needs most. Begin the conversation as you might normally while also being intentional about creating space for the other person to share her/his story. As the person shares, attend to details shared or observed, particularly listening for what could be an unmet core need. Be cautious not to interrupt; save your questions until the conversation arrives at a natural pause.
- ◆ **Step 2: Ask.** Once the other person has had some time to talk about their COVID-19 experience, use open-ended questions to clarify anything that may have been confusing, unclear, or that may warrant further conversation. Do not accidentally interrogate the person or "push" to talk about things the person isn't ready to share. Spiritual First Aid does not try to uncover deeper issues. A good rule of thumb is to ask questions that will help you identify unmet core needs as well as strengths and resources that can help the person cope.

- ◆ **Step 3: Act.** After you and the person you are assisting have identified what the most pressing unmet core need is in that moment, respond with the recommended intervention we have paired with each need. See Addendum #2: Spiritual First Aid Tip Sheet.

Keep in mind that because of the nature of helping amidst COVID-19, you may only have the time or opportunity to address a single unmet core need or be limited in interaction. If circumstances permit, it may be possible to address multiple unmet needs in one interaction or over multiple interactions by making contact by phone calls, video conferencing, or texts for example.

- ◆ **Step 4: And Repeat.** Address other unmet core needs if warranted and possible. If more help is warranted but either is not possible in the time you have available, exceeds your ability, or requires necessary resources you lack, explore helping another time, connect the person to another helper, direct them to a faith-based or community organization, or link them to resources.

Although physical distancing does not allow us to be present in all the ways we are used to, amidst other forms of disasters, you can still provide spiritual and emotional care from your home by using these principles to walk through the BLESS Method. The challenges presented by COVID-19 create an opportunity for the church to think more creatively than ever about what it means to be the hands and feet of Jesus as we seek to faithfully respond to the great needs all around us.

Official Spiritual First Aid Online Certificate Course & Discount Code

Through readings, online lectures, and additional resources, this online certificate course will equip individuals to use Spiritual First Aid's easy-to-use BLESS method, which takes the "guesswork" out of providing disaster spiritual and emotional care remotely and while staying at home. The course will take approximately 10 hours to complete, with content including:

- 8 unique training videos with accompanying readings
- 5 role-play scenario videos and 5 expert commentary videos to see Spiritual First Aid in action
- Final assessment
- Certificate of completion

Also included is access to a curated selection of free HDI resources, including:

- 7+ hours of videos with speakers such as N.T. Wright, Eugene Cho, and Rev. Dr. Brenda Salter McNeil,
- 3 manuals regarding Spiritual First Aid and COVID-19 mental health
- 10+ additional tip sheets and resources
- Access to 4 extra mini courses.

Learn more about course offerings, pricing, and group discounts at spiritualfirstaid.teachable.com.

Use the special Medical Ambassadors International member's code MAI30 at time of checkout to receive a \$30 discount off the course cost.

Man-Made Disasters: Ethnic Clashes and Persecution

By Dayo Obaweya

God created man in His image and instructed him to have domination over all other creation. However, man sinned by disobeying God's instruction, and this culminated in suffering. One manifestation of such was greed as written in the scriptural case of Cain and Abel. This was the beginning of disasters, some of which include curses, unhealthy competition, enmity between man and neighbors, and man and nature.

As a missionary in Africa, we have come to see that many people groups are engaged in tribal conflicts, such as religious, lordship over territories, leadership, resource control, and others. To investigate the challenges, several visits have been made to communities engaged in transformation activities like Community Health Evangelism / Education (CHE).



As we enter these places of conflict, the following questions are asked:

1. What is the cause of disunity and distrust between the neighboring communities?

2. What is the immediate and the remote cause?
3. How long had this issue persisted?
4. How was it passed down through the generations?
5. How can we mediate in the crisis to have peace?

We arrived at several conclusions as a result of asking these questions, some of which I would like to share with you.

1. Historical happenings like slavery, forceful acquisition of land and properties, and supremacy struggles were perceived to cause division among the affected people.

To be deeply involved in mitigating these challenges, we should first work on the worldview of the people by engaging them directly. Causes of conflict are deeply rooted. In proffering solutions, we should delve into the root cause of the issues.

Our approach to finding solutions to conflict is to build trust when engaging the people affected. Building trust involves visitation, sharing things in common, listening and sometimes being deliberately vulnerable. Outside solutions that we previously thought would work in solving ethnic problems have failed. Some people among those affected have ideas for solutions, but because nobody was listening to them, they keep these ideas to themselves.

Community residents need to be encouraged to talk about challenges they face individually and collectively. They need to feel safe to go into history on the cause of the problem.

An African proverb says, “a problem known is half solved”. The Scriptures in the book of John, chapter 5 speak of a disabled man who would wait at the pool in Bethesda hoping to get healing. He knew he needed to be healed, but his disability made it difficult for him to get into the pool. When Jesus met him, he told Jesus what he wanted because he knew his problem. In this same manner, the affected people know what is needed

in dealing with conflicts, they just cannot “get there”. This is where we can help.

I was requested to adjudicate in a land dispute in an African community. We started reconciliation by first inviting the two groups involved to a round table discussion. In trying to understand the issue in contention, I asked them some questions.

One of the questions was “Who owned the said land 1000 years ago?” Nobody could give an answer. I then asked, “Who will own it in 1000 years from now?” Same silence. Now, both parties began to see the futility of fighting over what would not last.

I encouraged them to realize that everything being done is adding value to land, but it remains where it is presently located and



would never be taken away. This was the beginning of the end of the contention. The necessity of creating awareness on the futility of the issue in contention reduced the possibility of hostility escalation.

2. Peacemakers should be people of prayer since the source of conflict is sometimes spiritual. Human effort without divine intervention is futile. We have come to see the need for both individual and corporate prayers when we are involved with conflict resolution.

On one occasion, we had a meeting with a community committee in Nigeria to settle a misunderstanding between the elders and youths of the community. The CHE team facilitated a lesson about forgiveness in the community meeting. We did not know there was present in the meeting a divorced couple sitting apart from each other. They had been separated for 8 years. As we were about to come to the end of the lesson, we saw a lady standing up from her seat crying. She went to the husband and knelt before him asking him for forgiveness. Understanding the cultural implication of such action, some women joined her to plead with the man to accept her back. They were reunited, prayed for, and now they are happily married again.

The Lord has a plan and purpose for every one of His creation. However, each person has a unique path He has charted for us. Many conflicts happen because a man desires to be like another man. Such mindset could result in conflicts. A question I always ask myself when entering zones of conflict is “what uniqueness do we have as individuals and as a community and how can that be galvanized to make life better for all?” I discovered that in the process of communicating, many listeners begin to appreciate the availability of local resources – both human and material so that there was no need for ethnic clashes.

3. In some cases, we learn that time is needed to bring healing in a conflict.

At times, we must research the resources that we have identified to better understand how we can use them to offer local solutions to the needs of the people in the community. Researching requires time. Going back to the scripture story of the man by the pool, we see another lesson. He was patiently waiting for an opportunity to get into the pool for 38 years! Just when he must have felt hopeless, Jesus showed up! This is a good lesson to say that it is never too late to resolve a conflict. An opportunity will always come to resolve conflicts peacefully.

The following steps should be followed in conflict resolution:

1. Talk about the issue(s).
2. Discuss/brainstorm with affected people about possible solutions to the situation.
3. Take positive steps to mitigate the effect of the crisis.
4. Engage the opinion leaders in the affected community.
5. Finally, make an effort to preach peace to people affected. Most ethnic clashes are rooted in misunderstanding of a situation.

In summary, every person is called to reconcile one to another, each to God and each to oneself and to one's environment. The disaster that befell the human race in the Garden of Eden will live with us if we do not avoid ethnic crisis and resolve conflicts in communities using a holistic strategy.

Health Disparities, Disasters and the Church

By Dr. Jason Paltzer

As God's people who belong to His Church, we care about advancing the Great Commission and the Great Commandment of Jesus. Yet how do we balance His call to engage the poor with the personal risk involved? When natural disasters hit, the existing instabilities and vulnerabilities of a community will be exposed and accentuated. In most situations, a natural and human disaster creates an acute-on-chronic event exacerbating the ability of the poor to navigate the immediate needs of shelter, food, and water. Do we work to protect ourselves from these situations? For individual Christians and churches, disasters can cause division, frustration, and anger as we work for self-protection while serving our neighbors and communities with the love of Christ.

Navigating this balance can cause moral conflict and injury as we try to do for others what we know we should do yet fail to implement protection for ourselves. The objective of this chapter is to show, from a public health framework, how we can better prepare our churches to respond to disasters. In this way, we can better serve communities to become more resilient and can minimize the disparities that may result while taking precautions to protect ourselves. The idea is to do both rather than having to choose one or the other.

From a public health perspective, the Sendai Framework is a helpful tool to orientate how we think about a disaster. These concepts include:

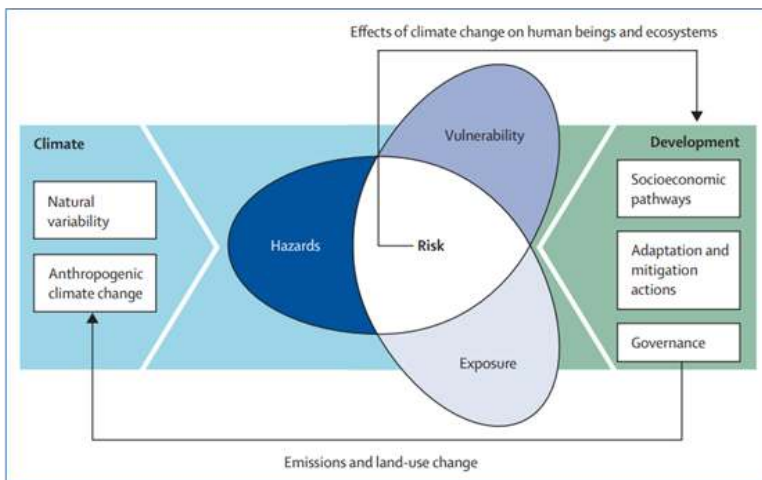
1. Understanding disaster risk.
2. Managing the risk by strengthening disaster risk governance.
3. Investing in disaster risk reduction for resilience.
4. Enhancing disaster preparedness for effective response and to “Build Back Better” in recovery, rehabilitation, and reconstruction.

The last point mirrors the relief to development theme of this issue moving from recovery to reconstruction. The opportunity within a disaster is to engage a community to recover, rehabilitate, and reconstruct systems that are better than the ones that existed prior to the disaster. Understanding the disaster risk (point #1) is essential to being effective churches commissioned to radically love people and share with everyone the ultimate hope amidst any human crisis – hope in Jesus.

Health determinants include individual (biologic, behavior, and beliefs), social, economic, environmental, and spiritual determinants influencing health disparities and worse health outcomes in a disaster situation. Health disparities are often associated with aspects outside of one’s individual control such as gender, physical disability, race or ethnicity, mental health, social status, or geographic location. The Social Ecologic Model is often used to help us understand that disparities and inequities in health result from intersecting levels and systems within a society as the intrapersonal, interpersonal, community, institutional, and policy all converge on an individual’s opportunity to be healthy. This model aligns with Bryant Myer’s¹ model of poverty based on our relationship with God, self, others, and the environment. Integrating our understanding of public health, health determinants, and health systems with our identities in Jesus can help us serve impoverished communities and minimize health disparities.

The COVID-19 pandemic has offered a unique opportunity to wrestle with our risk tolerance to love others at the expense of not only our personal health but possibly the health and lives of those in our families and community. What is the balance in loving others as Jesus loved the outcasts and lepers of society, while ensuring our own safety and health? I would like to present two examples from public health that will help us navigate disasters as a church, especially churches serving lower-resource communities where such acute-on-chronic events can lead to even greater disparities.

Whitmee et al. (2015)² developed a graphic to help us understand disaster risk. Three components are important to consider: the hazard itself, the vulnerability of the community, and level of exposure.



- Hazard: climate conditions, biological, chemical, air quality, violence, and other man-made and natural disasters can create hazardous events.
- Vulnerability: understanding current gaps in the community and systems that individuals would otherwise rely on such as communication systems, transportation network, healthcare systems and referrals, evacuation protocols,

building infrastructure and housing, agriculture and flood zones, and, of course, public health and other social services.

Exposure relates to identifying those individuals that will experience the highest level of exposure relative to others impacted by the same disaster. This could be related to high-flood areas, extreme weather events, or higher levels of interaction with people. Combining these factors help us determine differences in risk.

The second resource is from the United Nations Office for Disaster Risk Reduction (UNDRR). The UNDRR program has created tools to assess both a public system³ and a city or community⁴ prior to an event. The same tools and scorecards can be used by churches to strengthen their planned responses. The results of the assessment or scorecard can then be used to address specific gaps in creating more resilient communities, thus improving health and security in the moment as well as for future mitigation in the likelihood of such an event.

As a church or Christian health leader, you might consider asking questions such as:

1. To what extent do our risk management policies integrate with local public health considerations (infectious diseases, trauma, environmental health, epidemiology, water and sanitation, mental health, chemical contaminants, etc.)?
2. To what extent are we prepared for disease outbreaks in our neighborhood, village, or city?
3. Are there sources of funding we should identify and leverage to help prepare for disaster-related impacts?
4. To what extent are we familiar with and connected to the local health authorities for quick mobilization of health services through our church?

5. To what extent do we encourage neighbors and community members protect the ecosystem that is important for their livelihoods?
6. To what extent can we provide resources to the neighborhood, village, or city during a disaster (space, stuff, staff/volunteers)?
7. To what extent do our church members understand the role of public health and its impacts to prevent and mitigate during a disaster?
8. Is there an early warning system we can be a part of to initiate an early response?
9. What is our plan to care for church, neighborhood, and community members after an event?
(transportation, financial support, healthcare partnerships, mental health support)

Why invest to understand poverty and potential health disparities at this time? God calls all of us to care for the poor and to be a voice for the oppressed. We must use all of the resources available to us to be obedient to the calling of compassion and thus be all things to all people so that we fill heaven and help others experience the comfort of God's grace now and into eternity.

Worldview Clashes, Myths, Confusing Rhetoric and Misinformation During Pandemics

By Dr. Victor Chen

Early in the COVID-19 pandemic, Ed Stetzer, the executive director of the Billy Graham Center and a dean at Wheaton College, wrote an article in *Christianity Today*¹ to address concerns that Christians seemed to be “disproportionately fooled by conspiracy theories”. Believing that Christians were damaging not only their individual witnesses but also that of the global church by perpetuating falsehoods and misinformation, Stetzer strongly called on Christians to repent for bearing false witness. He reported on something a man named Austin Jones



had tweeted: “Last week my Facebook feed was full of people posting crazy COVID-19 conspiracy theories, followed by posts about evidence for the resurrection. I

don’t think they realize the message they are actually sending.” Think about that. Now pause and sense if any emotion is welling up inside you. If you have even remotely been engaged in COVID-19 and political news in the past year, you would have likely felt some emotional reaction. Depending on your perspective and understanding of COVID-19, the role of the church, the intersection of faith and science, the role of government, the teachings of Jesus, and even your own personality, you may find yourself on either end of declaring

“Amen – preach it!” to “If Stetzer really valued truth, he would know COVID-19 is the real conspiracy”, or somewhere in between.

We certainly have experienced contentious times during the COVID-19 pandemic. Multiple articles have discussed factors contributing to this. The proliferation of social media and alternative news sources, disagreement and skepticism regarding experts, and the erosion of general trust and good will in society have created confusion about what to believe, whom to believe, and why. For followers of Jesus, this has been a time to lament the tremendous pain and loss many have experienced in every dimension. It is also a time to lament the church’s confusion and struggle to live out the ministry of reconciliation with grace, truth, and love. I do share Ed Stetzer’s concern about the witness of the church to the unchurched.

In the Genesis account of creation, we see that creation as God intended it to be is one of harmony, fruitfulness, and right relationship between the Creator and his creation. It only took until the 3rd chapter where we learn of creation’s fall and the shattering blow to shalom. Satan’s attack on truth was seemingly the first conspiracy theory in history: *He said to the woman, “Did God really say, ‘You must not eat from any tree in the garden’?” . . . “You will not certainly die,” the serpent said to the woman. “For God knows that when you eat from it your eyes will be opened, and you will be like God, knowing good and evil.”* Genesis 3:1,4 NIV



There is a reason Jesus called Satan a “liar and the father of lies,” and the struggle for truth reverberates to this day. As Christians, we need to first remember that there are spiritual

“principalities and powers” at work and to pray regularly for wisdom, sensitivity, and discernment for ourselves and for those we seek to engage.

The Oxford Dictionaries declared “post-truth” as its 2016 international word of the year². Although Oxford Dictionaries traced the first usage of “post-truth” to 1992, its usage exploded by 2000% in 2016 over the previous year. Many articles discussed whether we were indeed living in a “post-truth era” where objective facts and standards for truth have become supplanted by appeals to emotional needs and personal opinions in influencing beliefs. In our current climate in the United States, many demographic groups live with a constant sense of being under assault. Whether it is a deep fear about government overreach and control, the fear of riots and mob rule, the loss of religious freedom, the fear of socialism or capitalism, or anxiety about systemic injustice and racism, some group believes some other group is out to get them for something. This collective siege mentality can affect the church as well if it acts out of fear and defensiveness. Moral outrage generally distorts judgement and objectivity while heightening our suspicions about the motives of others.

The challenges we encountered in pursuing truthful and accurate information this past year of 2020 will only grow. Have we learned lessons that will motivate us to become more responsible with our tweets, Facebook postings, and rhetoric? Are we any more capable at evaluating our sources of information for credibility and accuracy? Do we feel more confident in our ability to identify bias and recognize when news is opinion or factual reporting? After a year, do we see others who are different than we are with more common ground, or even more as an “other” or “one of them”? These are difficult questions to answer. But I am certain if our only approach to combat misinformation is with information, we will be falling far short of equipping our organizations and ministry partners. And

we will not make much progress. Words have consequences that can impact lives. We have to be careful how we use them or share messages!

In the space of this article, I will share tools and resources that can help us become more aware in how we utilize information, more cognizant of our own biases and blind spots, and more discerning in the sources we consult and trust. Ultimately, this is an encouragement for all followers of Jesus to embrace humility, empathy, curiosity, and true listening as we pursue being people of grace and truth.

1. Value the individual and the relationship.

We discovered early in the pandemic that many of our ministry partners and regional networks were facing the same struggles to keep up with the rapidly changing information about SARS-CoV-2 and COVID-19. Identifying trusted sources of information was difficult when there was no clear criteria or filter to apply. But even for health professionals, understanding the information was confusing as it evolved. Some of our regional network WhatsApp groups were exploding with memes, anecdotal stories, and unsolicited advice as partners with good intentions shared what they thought was important for everyone to read. In areas where our coordinators had strong, long-term relationships with local partners, Medical Ambassadors International (MAI) was often viewed as the most accurate source of information and a trusted partner who could help guide our partners in wading through the information.

Sometimes, we worked with network leaders to establish guidelines on what information partners should or should not share on the group messaging apps to encourage thoughtfulness and vetting before information got passed on. We agreed on which sources we would consider trustworthy for community health guidelines (World Health Organization or Johns Hopkins,

for example), but to also align our information with what local or national health departments were communicating. We understood that not all partners trusted the WHO or CDC. Some held perspectives that were quite skeptical of COVID-19, vaccinations in general, and any government mandates.

In one regional meeting where we had a session to discuss concerns about the COVID-19 vaccine, the facilitator did an excellent job, sharing factual information in a very humble, yet confident way while respecting and giving space to those who thought differently. This contributed to a comfortable, inclusive group dynamic where people could still disagree while seeking to learn from one another. Sometimes, dialogue that turns political can get overly contentious, and perhaps there are times when two people can agree to disagree and choose to avoid certain topics to maintain the relationship and peace.

2. Exercise humility, empathy, and curiosity in our desire to understand why others believe what they believe. What are some of the deeper concerns that influence their perspectives?

It was easy to feel disappointment and concern when a February 2021 Pew Research Center survey³ revealed that 49% of white evangelicals stated that they would “definitely/probably NOT get a vaccine for COVID-19”. With an estimated 41 million



white evangelical adults in the US, this represents the largest demographic group unlikely to get vaccinated and a major potential barrier to the national, state, and community goals reaching the herd immunity threshold

of 70%. Even though 25% of Americans said they have had COVID-19 infection, and 67% of Americans knew of someone who had been hospitalized or died, it was surprising to see such significant vaccine hesitancy in this group. In a virtual town hall to discuss evangelicals and the vaccine (Humanitarian Disaster Institute, 4/27/21), Tim Dalrymple, the president of Christianity Today cautioned people not to scapegoat this group of white evangelical adults because there were other groups that were also highly hesitant to get the vaccine like young mothers and African Americans. We need to avoid quickly labeling groups and thinking the worst about them and must recognize that there are often valid underlying concerns that give people pause. A friend of ours has hesitated to get the COVID-19 vaccine because the husband developed significant paralysis from Guillain-Barre syndrome following a childhood vaccine. Although there have, up to this point, been no documented cases of Guillain-Barre Syndrome following an mRNA COVID-19 vaccine, we can definitely understand the roots of this family's concern. Perhaps there are other underlying influences driving vaccine hesitancy – fear of government control, isolation, confusion about the science and necessity of the vaccine, or theological concerns. If we engage each other with humility and curiosity, we form a starting point for dialogue. As the facilitator of my pre-marital communications class once said, “true listening is when you care more to understand than be understood.”

3. Understand and recognize the different ways we are prone to bias.

Every individual is shaped by beliefs, values, and experiences. Our particular worldviews, perspectives on the world and philosophies of life, color the way we see things on a daily basis. When these influences distort our critical thinking, lock us into skewed preconceptions, or limit our ability to objectively seek out and process information, they can become cognitive biases. Cognitive biases are a large category of systematic

errors in thought processes that adversely affect our ability to make fair assessments and thoughtful, nuanced decisions. One of my MAI colleagues likes to say “snake head; dove heart” as he simultaneously points to the corresponding body parts. He says this as a reminder for Christians to not only serve out of compassion, grace, and selflessness but to also serve with a sharp, alert, and discerning mind. When it comes to critically judging the validity and accuracy of information, this is an area where Christians could definitely use more head and heart in developing self-awareness, analytical skills, logic, and discernment.

During the pandemic one of the most commonly highlighted cognitive biases has been confirmation bias. Confirmation bias is the tendency we have to seek out, recognize, and give greater weight to information that confirms our pre-existing beliefs. Someone who is skeptical about the safety of mRNA COVID-19 vaccines and believes these vaccines can change our cellular DNA, may look at every article that mentions cancer in someone who was vaccinated as strong evidence proving why the vaccine is dangerous. Someone who can mitigate that particular bias regarding COVID-19 vaccines may read the same news report but intentionally look for other explanations that may contribute to cancer risk, unrelated to COVID-19. This person may then seek out a video that discusses how mRNA vaccine works to see if there is validity to the fear of DNA altering (there is not, because the mRNA never enters the nucleus of the cell that contains DNA). For regular users of Facebook and other social media, confirmation bias can be compounded by the algorithms developed by social media platforms that increase clicks and advertising revenue by exposing users to more things that align with their common interests, values, and beliefs while decreasing exposure to things that do not align.

Unless people intentionally seek to diversify their access and exposure to other perspectives, users can quickly find

themselves in an echo chamber of other like-minded people who validate the same beliefs in each other. Slowing down our thought processes before we make conclusions, seeking out a diverse sampling of information and perspectives, and intentionally considering information that challenges or disproves your own position can decrease confirmation bias and its impact.

Availability bias is the tendency to think of and give more weight to recent examples or to information we can more quickly recall. Before becoming pervasive in the US, COVID-19 hit certain geographic areas (coastal and metropolitan) and demographic groups (elderly and those with co-morbid conditions) early and hard. For those who lived in communities or social circles where the virus had not yet penetrated, it was easier to wonder whether COVID-19 was actually real because their personal realities did not match up with what they were seeing in news from New York City. Availability bias is exacerbated when the individual extrapolates his or her personal recall and reality to an assumed understanding of other people or situations. To mitigate availability bias, it is helpful to examine the evidence on which we base our conclusions and determine whether our information is sufficiently representative.

The Decision Lab (thedecisionlab.com/biases/) has an extensive list of cognitive biases with in-depth explanations and examples of each. The Catalog of Bias (catalogofbias.org) discusses biases and how they affect health evidence.

4. Recognize logical fallacies in your own reasoning and that of others. Respectfully engage in dialogue to mutually sharpen arguments and raise the level of accountability.

In contrast to cognitive biases, which are systematic errors in thought processes that arise from distortions caused by our own ingrained perspectives or philosophies, logical fallacies are

errors in reasoning that result in weakened or invalid arguments. Fallacies may sound convincing at first but do not hold up to scrutiny.

Causal fallacy

This is an umbrella term for a group of fallacies involving an illogical conclusion about the cause of some effect. Two types of causal fallacies are: false cause fallacy, when one assumes a cause for an effect when there is not justifiable evidence to do so, and post hoc fallacy, when a cause is mistakenly assumed because it immediately preceded a visible event. If a man is newly diagnosed with type 2 diabetes at a clinic check one day after he received a COVID-19 vaccine, he may mistakenly believe that the vaccine caused his diabetes because of the timing of his vaccine shot, despite no known evidence of diabetes causation by the vaccine. This is an example of post hoc fallacy.

Circular argument fallacy

This fallacy involves taking an initial assumption and then rephrasing the same assumption as evidence to support itself. A mother who believes that the measles-mumps-rubella shot causes autism, and then states her child developed autism after receiving the MMR vaccine, is an example of a circular argument fallacy. (Several quality, large-scale studies have found no link between autism and the MMR vaccine.)

False dichotomy

These fallacies illegitimately narrow all possible options to two, black-or-white choices when more than two exist. If an older man accuses a younger man of lacking faith and not trusting in God if he wears a face mask, he is creating a false dichotomy fallacy because there are more than two possible options. The underlying assumption is that you can only demonstrate faith in God by not wearing a mask. However, one could wear a face mask and have faith and trust in God. One could also not wear a face mask and not have faith or trust in God.

There is a long list of other types of logical fallacies. Some of the ones you may recognize are the straw man, slippery slope argument, red herring, and false equivalence. The more you can learn different examples, the better you will be able to recognize a logical fallacy in use.



Children's Hospital of Philadelphia⁴ put together two documents that use examples of COVID-19 and vaccine fallacies to help you practice your recognition and understanding of them.

Developing News and Media Literacy

With the explosion in information, it is vital that we learn to equip ourselves, our families, friends, church members, and ministry partners in news literacy. The News Literacy Project is a nonpartisan national education nonprofit organization that provides resources and independent programs to equip educators, students, and the general public with critical thinking skills to better discern the reliability and credibility of information. They define news literacy as “the ability to determine the credibility of news and other content, to identify different types of information, and to use the standards of authoritative, fact-based journalism to determine what to trust, share and act on.” Their website (newsliit.org) has an excellent online learning platform called Checkology where professional journalists and academics facilitate video lessons on topics such as “Arguments and Evidence”, “Understanding Bias”, and “Conspiratorial Thinking”.

5. Be aware of news blind spots and seek a balanced diet of news sources.

Because we often gravitate to news sources that we generally agree with (thereby reinforcing availability and confirmation bias), we can easily develop blind spots to other news sources and perspectives. When major events occurred over the course of 2020, it was enlightening to see how differently major networks covered the same events. It was even more enlightening to see an event highlighted by one source as the major event of the day buried in secondary headlines or not mentioned at all in the other source.

To help bring awareness to our own news consumption patterns and biases, platforms like Ground News (ground.news) and AllSides (allsides.com) provide a valuable service. Both platforms aggregate stories around global headlines from media sources with left-, centrist, and right-leaning perspectives so that articles representing a diversity of viewpoints can be readily available in one place. They also provide valuable information on which news events are covered (or not) by media across the bias spectrum while highlighting personal blind spots depending on which media sources are typically frequented by an individual. Most people do not have time to skim through Fox News, CNN, the Financial Times, the BBC, and our community newspaper every day, but it's a helpful practice to diversify news consumption regularly

6. Fact-check information and stories we read and receive from others. Be discerning about whether we should pass it on if we cannot verify the credibility and accuracy of the information.

Fact-checking and media bias rating sites are certainly open to bias themselves, but they provide a useful reference to cross check media claims, stories, and bias. Examples of helpful websites include:

- Fact Check (factcheck.org) - a nonpartisan project of the Annenberg Public Policy Center of the University of Pennsylvania
- Snopes (snopes.com) - an independent website that

researches and checks urban legends, anecdotal stories, and media claims

- Politifact (politifact.com) - run by the Tampa Bay Times and checks the accuracy and truthfulness of people in public office.
- Media Bias/Fact Check (mediabiasfactcheck.com)- rates over 3700 media sources according to liberal or conservative bias.
- Poynter Institute's International Fact-Checking Network (poynter.org/ifcn)- promotes standards and a code of principles for fact-checking organizations.

When the COVID conspiracy video Plandemic caused an uproar in 2020, it was helpful to consult fact-checking sites to review the research and critiques on the video as claim after claim was debunked with citations and references. Fact-checking can be a double-edged sword, however, when trying to engage strong adherents to conspiracy theories. Any opposition to the conspiracy theory can be re-framed as validation that there is a conspiracy. As entities like Facebook and Twitter began labeling statements by public and political figures, transparency concerns about their criteria, process, and fairness raised the question of "who fact checks the fact checker?". That is where groups like the International Fact-Checking Network (ifcn.codeofprinciples.poynter.org) serve a necessary role in establishing and promoting standards of ethics and transparency.

7. Learn about the intersection of faith and science from organizations with a Christian worldview who can help you navigate through complex questions with nuance.

These are a few great sites to help address specific concerns and fears common among Christians:

Christians and the Vaccine (christiansandthevaccine.com) is a collaborative project by theologian and former pastor

Curtis Chang and several organizations, including the National Association of Evangelicals, to help Christians apply biblical principles and scientific evidence to address common concerns and questions Christians have regarding the vaccine. There is a downloadable toolkit and several videos addressing some of the complex, hot topics regarding the COVID-19 vaccine.

Biologos (biologos.org) is an organization of Christian scientists who uphold the authority and inspiration of the Bible while advocating for gracious dialogue, the pursuit of truth and excellence, and discovering the harmony between science and biblical faith. Several articles, podcasts, and videos are available on a broad list of topics, including COVID. Biologos was founded in 2007 by Dr. Francis Collins, a devout evangelical Christian who serves as the current director of the National Institute of Health and former leader of the Human Genome Project.

Science for the Church (scienceforthechurch.org) is an organization whose mission is “to strengthen the church by engaging science.” Articles, podcasts, and videos on understanding COVID, concerns about the vaccine, and helping churches process grief and trauma are available. The organization also has resources on other topics such as creation care, race and science, and theology and the Bible.

Wheaton College Humanitarian and Disaster Institute (wheaton.edu/academics/academic-centers/humanitarian-disaster-institute/covid-19/). The Humanitarian Disaster Institute has excellent resources on equipping the church to respond during disaster and pandemic. The HDI has developed several manuals and guidelines to help churches prepare and transition during the pandemic and to continue to serve their congregations and communities with a holistic approach.

Spiritual First Aid and the COVID-19 Mental Health Handbook (spiritualfirstaidhub.com) are useful tools to help churches

address spiritual and mental care during difficult times.

Cristianity Today (christianitytoday.com) has thoughtfully engaged complex issues on faith, society, culture, science, politics, and health during the COVID pandemic. There is a treasure of articles written from many perspectives and diverse authors.

Trauma Healing Institute (traumahealinginstitute.org) is supported by the American Bible Society and the Trauma Healing Alliance, a global collaboration of nearly 700 Christian ministries and organizations. The THI champions a simple yet powerful method of trauma healing using stories, the Bible, prayer, and sound mental health principles in the context of safe healing groups. There are some COVID-19 specific materials, but the Trauma Healing method and training is relevant to Christians and non-Christians alike for any times of pain, suffering, and loss.

There are many excellent resources and organizations to help equip Christians in addressing concerns about faith and science in the face of the COVID pandemic, so this is not intended to be an exclusive list.

8. Identify and consult credible resources to learn up-to-date information regarding SARs-CoV-2 and COVID-19 from a medical and public health perspective.

World Health Organization (who.int) and US Centers for Disease Control and Prevention (cdc.gov) have been recognized for years as among the leading and reputable international and domestic public health agencies in the world. Both organizations have endured criticism regarding institutional credibility, inconsistent messaging, and accusations of political influence and compromise during the COVID-19 pandemic. Despite these setbacks, the WHO and CDC still remain recognized by the majority of public health professionals as credible

authorities on health research, guidelines, and public health practice. Medical Ambassadors International and the Global CHE Network currently and historically strive to align CHE health lessons according to WHO guidelines and best practices and to, a lesser extent, those of the CDC.

Johns Hopkins Bloomberg School of Public Health (jhsph.edu) is perhaps the top school of public health in the US. Johns Hopkins has several excellent resources on COVID-19.

Their COVID-19 School of Public Health Expert Insights section⁵ houses podcasts, articles, videos from some of the top scientists in their fields.

Harvard Medical School (health.harvard.edu) has a coronavirus resource center containing up-to-date medical information regarding SARS-CoV-2 and COVID-19.

Global CHE Network (chenetwork.org/coronavirus), of which MAI is a founding partner and network member, is a collaborative of nearly 1000 organizations who have been trained in the Community Health Evangelism/Education strategy for holistic discipleship, church planting, and transformational community development. GCN has a useful COVID/coronavirus resource page of individual lesson plans and manuals developed by CHE practitioners to equip communities and churches during the COVID-19 pandemic. Materials on this resource page are open-source and available for free download.

Conclusion

In conclusion, the struggle for truth requires a holistic approach that addresses worldview, strengthens thought processes and logical reasoning, builds relationships of trust and good communication, increases media and science literacy, equips people with online accountability and fact checking tools and websites, and emphasizes curiosity, empathy, and humility.

In the early 1930s, Herbert J. Taylor was tasked with saving the Club Aluminum Products Distribution Company from bankruptcy. His first priority was to set policies that would “reflect the high ethics and morals God would want in any business.” Taylor believed “if the people who worked for Club Aluminum were to think right, they would do right.”

After reading through books and searching for inspiration, Taylor paused to pray at his desk. When he finished, he took out a card and wrote down the following twenty-four words:

1. Is it the TRUTH?
2. Is it FAIR to all concerned?
3. Will it build GOODWILL and BETTER FRIENDSHIPS?
4. Will it be BENEFICIAL to all concerned?

When he made a personal commitment to live out what he named the “Four-Way Test of the things we think, say or do,” Taylor was quickly convicted by personally not being able to move past the first question in the day-to-day operations of the business. As he gradually made policy changes, he revised the company’s literature and even its attitude and approach to competitors to align with the principles that he was leading the company to embrace. This process transformed the company and eventually was adopted verbatim by the Rotary when Taylor became an international director.

Today the Four-Way Test remains an integral part of Rotary around the world. There was power in the simple, yet profound truths that transformed an entire company and organization. What if the church took this to heart as Taylor did?

May God continue to guide us with wisdom and discernment as his agents of shalom in the ministry of reconciliation.

Innovations in Crisis-Use of Technologies in West Africa

By Dayo Obaweya & Dr. Nzuzi Mukawa

A common saying in West Africa is “necessity is the mother of invention”. Equally, the dictionary defines crisis as an unpleasant state where man finds himself grappling with issues created by nature, God, others, and self. Many times, the effect is out of control, requiring complex solutions. In most cases, these four sources of conflict must be altered to provide appropriate solutions to the crisis.

In our journey of mediating crisis situations, we have witnessed complexities that forced our team of professionals, such as doctors, healthcare workers, teachers, agriculturists, and engineers, to brainstorm the remote and immediate cause of the crisis. In this chapter, we wish to discuss how we leveraged technology during time of disaster in the lives of the people living in West African communities.

During the Ebola and COVID-19 pandemics, we were compelled to think about how affected and vulnerable people will be able to mitigate and manage a crisis.

To determine the needed innovations, we asked ourselves these questions.

1. How did the crisis start?
2. What is the remote and immediate cause?
3. What are the short and long-term effects?
4. What barriers need to be removed?

These questions led our teams to consider appropriate response and technologies. Normal crisis resolution practice in this region includes:

- Use of government legislation.
- Persuading affected people to accept offered solutions.
- Teaching affected people about the cause and effect of the crisis.
- Training personnel to be deployed to affected communities.
- Direct person to person discussions with affected people.

All these activities required the following innovations to function in the COVID-19 and Ebola “new normal”:

1. Internet
2. Phones
3. Radio
4. Existing local community leadership structures
5. Picture booklets
6. Handbills
7. Leveraging youth within the community to deliver change messages



Due to social distancing requirements during the pandemics, we used projectors to present our messages by video. The projectors with films giving messages or solutions relevant to the crisis at hand were deployed to community trainers. Our training materials came from Animations Without Borders (SAWBO), The Great Commission Movement and other organizations.

Use of social media was another tool we used. Messages designed in local languages were sent to the community

residents in affected areas. Trainers encouraged people who had access to social media to share the messages with their neighbors who did not have access during CHE Home Visits.

We were able to reach some remote areas via the phone. We inquired regarding their health, family and communities. Phones were helpful in reaching people despite the lockdown.

At first, we did not consider it important to use radio resources thinking it might be too expensive or out of reach to the local trainers. We were wrong! Since everybody was forced to stay



in their houses, radio became a suitable means to reach many people. We were on the air for 5 days a week covering all subjects relating to COVID-19: prevention, care, and spiritual needs. We also hosted radio programs where people could phone in and ask questions. The response was overwhelming. A larger audience was reached, and people responded

by asking questions in areas that were not clear to them during the presentations. Many people began to ask how they could be a part of this team. Others asked to be trained and many volunteers showed up at our offices.

We observed that many residents were no longer patient to listen to long teachings but quickly responded to drama and skits done in the communities. Drama was an excellent tool that led people to accept our responses and messages. There is a community in Ghana where we presented a drama on the

effect of disunity among people. We saw broken families and friendship restored. In another community in Nigeria, we had communities coming together to enforce the COVID-19 protocol after a drama on the effect of non-observance of protocol.

Zoom and other online meeting apps were another innovation we used, especially in reaching out to our trainers and partners who were unable to be physically available for training. Teams and network partners were invited to an online meeting at a specific and agreeable time. Online meetings helped reduce physical contact and save travel time. The people who receive messages from these forums would then take the messages to proximal community trainers and CHE community workers, who would then teach individuals and families. This worked well, as in many localities, outsiders are not welcome because of the possibility of infections in case of disease outbreaks or were suspected as mercenaries in cases of conflicts with outsiders. Such situations include Boko Haram, cattle rustling and kidnapping in Nigeria and some other countries in West Africa.

Picture booklets became more acceptable to use in training especially when translated to local languages. In one instance, our team could not find a translated picture booklet in the Hausa language. We decided to remove the words entirely. To our surprise, many residents understood the COVID-19 message we were presenting through the pictures alone, and we began to see a change in attitude of the people which caused a reduction in the incidence of COVID-19 in the community.

Truly, necessity is the mother of invention! As a result of technology innovations, our communities and CHE leaders stayed healthy. Over 5 million people were impacted by our programs and many of our partners are inquiring about CHE training.

Stewarding Relief Resources

By Suzette Montez

Jesus' teaching about good stewardship is a prevailing topic in the Gospels of Matthew, Mark, and Luke, and can be summarized in I Corinthians 4:2 *"Now it is required that those who have been given a trust must prove faithful."*

What does that say to us today? Paul instructed the early church in I Timothy and Titus to follow in his steps and exhibit characteristics that were "above reproach" and "blameless". Guidelines, policies, and processes allow a ministry to incorporate the means for each staff member, partner, or recipient of funds to report adequately any and all funds expended in performing ministry.

Medical Ambassadors International (MAI) also has excellent reasons to follow strict guidelines for financial integrity and good stewardship. These include, but are not limited to:

1. Membership requirements to various Christian agencies. Management reporting for budgeting, planning, and special needs.
2. Federal, state and other regulatory reporting for exempt purposes.
3. Various donor-oriented publications that communicate our financial stewardship.

Standards are used to ensure that the ministry can be relied on, that financial information reporting has the needed control

procedures in place, and these are adequately employed. Poor stewardship in one relief project can impact all of MAI's ministry.

This guide is to provide the assurance of proper stewardship of God-provided resources and accountability. The result is MAI can disclose that it has followed the intent and purpose of the giver and that any communication restricting or directing the use of a donation was interpreted adequately.

Recipient Requirements

All documents need to be clear, concise, and complete for the reader to understand and follow easily. And second, all need to have signed approval from the supervisor or leader when submitted to the accounting department.

An understanding between the mission and the program leader must be in place or a memorandum of understanding (MOU) signed between the two authorities to outline requirements. This



will prevent any misunderstanding. MAI relies on documents and reliable reports to answer to those who trust in our published information.

Timing of submitted reports and approval signatures is extremely important. Both entities need to comply with substantiated expense information within required deadlines and return unused funds on a timely basis. This will ensure trust and cooperation in future program partnerships.

Below is an example of a relief program with income distributed to a specific Ministry Program A of \$4000.

Project Name: _____						
Project #: _____ Year: _____						
#	Funds received for the relief response- Income	Date Received	Total Amount spent - Expense (per summary of expenses 0.2.)		Amount left over - Excess (Fund Balance)	
			In Local Currency	Equivalent in US\$	In Local Currency	Equivalent in US\$
1	a) 4000	Feb 22, 2021		b) 3980		c) 20

A fund statement or ledger needs to provide posting of \$4k as acceptance of income and date received by the recipient.

Below is an example of an expense sheet.

#	Name of item Expense Description	Category (food material, safe drinking water, medicine, logistics, temporary shelter materials, misc.)	Receipt #	Amount in local currency	Equivalent amount in US\$
1	Rice bags	Food material	1,5,9		1500
2	Lentils	Food material	2		420
3	Bottled Water	Safe drinking water	3		300
4	Bread	Food material	4		200
5	Cooking Oil	Food material	6		300
6	Condiments/spices	Food material	7		80
7	Vegetables	Food material	8		80
8	Cookies	Food material	10		50
9	Electrolytes	Medicines	11		50
10	Anti-diarrhea pills	Medicines	11		40
11	Topical applicants	Medicines	11		70
12	Tylenol	Medicines	12		50
13	Local Transportation expenses	Logistics			200
14	Torches	Miscellaneous	13		40
15	Temp. shelter sheets	Temp. shelter	14		500
16	Binding material	Miscellaneous	15		100
					b) 3980

The expense sheet should include at the least, these items: Description of expense, Category of expense, Receipt number, Amount in local currency, and Amount in U.S. dollars.

Original receipts are to be kept with program office manager. All receipts should include Date, Amount, Description of item, and Ministry purpose.

After Program A manager reports relief income of A) \$4000 in USD from MAI, expenses need to be added to line 1 on this statement to report B) \$3980 in U.S. dollars. This is transferred over from Expense Sheet for total items spent. This Ministry Program A has a fund balance (excess) of C) \$20. The MOU will indicate when this fund balance is to be returned to MAI.



Relief programs and categories of expenses will vary; therefore, it is important to use good judgment on selecting categories of expenses related to your ministry program.

Diligent and responsible account keeping is the best way to assure donors that we are good stewards of the money they send us for relief programs.

Introduction to MAI Academy

By Galen Dalrymple

On February 10, 2021, we announced the “soft launch” of MAI Academy for those working directly with Medical Ambassadors International (MAI). Approximately three months later, we announced the full grand opening of the academy.



What is MAI Academy and why did Medical Ambassadors create it? We are glad you asked!

MAI Academy is an on-line learning platform created to strengthen and equip our team members and others so that their work and ministries can flourish and be more efficient and effective. The platform utilizes Thinkific Learning Management System to deliver this training.

We began the academy with courses ranging on topics as diverse as the various Microsoft tools we use (Word, PowerPoint, Excel, OneDrive, Teams, etc.) to how to conduct virtual trainings, how to better tell stories through photography and videography (so our people can better share what is happening in their area of the world), interpersonal skills, writing/editing/proofreading skills and even a very fascinating 8-part podcast about the history of the city of Jerusalem.

Over time we expect to add many, many more topics including, but not limited to:

- Relief response and disaster mitigation – how to properly respond to urgent crises such as famine, storms, earthquakes, etc. so as to not create dependency
- Bible education and Bible studies
- What CHE is and how it works in communities
- Project management
- Time management
- Personnel management
- Virtual mission trips
- How to promote missions via social media
- Donor follow-up and care
- Fundraising
- Virtual Vision Seminar (primarily for north American audiences)
- Partner training
- Virtual internships (for in-house personnel)
- Photo editing
- Video editing
- Proposal writing and various other funding options
- Written communication – becoming proficient in telling stories of what God is doing
- Creating and maintaining a YouTube channel

In addition to these and many other topics, we plan to adopt some of the specialty areas of CHE (such as disabilities, human trafficking, etc.) to make those materials available for training of partners or individuals who have interest in improving their knowledge and skills in those special ministry fields.

We have the option of charging individuals and partner organizations to access lessons which will help offset the costs of the online learning platform itself. It is our prayer that MAI Academy becomes totally self-funded in the long run and may

even be able to contribute some funding toward ongoing field work.

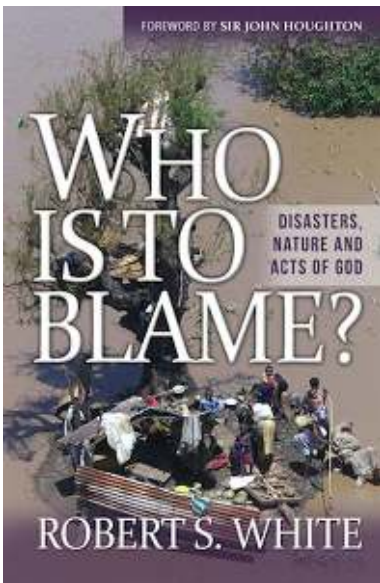
Some of the content of MAI Academy is original material created entirely by MAI while other content will leverage already existing training materials readily available, but curated, from YouTube, TED Talks, Udemy and other sources of educational material.

We believe that both the MAI team and others serving in the mission field can benefit significantly from what MAI Academy offers and we thank you for your support and donations towards this vital resource.

Book Review: Who is to Blame? Disasters, Nature and Acts of God¹

By Dr. Bibiana MacLeod

Disasters have been increasing in number as well as volume of people affected since the 1900s. White examines where in the world disasters are occurring and who are being affected, focusing on those most vulnerable - the poor and the migrants - that enlarge already weakly-prepared cities.



After a review of the most common natural events, White describes disasters mentioned in the Bible. The third section of the book focuses on biblical reflections on disaster. He points to the fact that we need all of nature to thrive - including volcanoes, earthquakes, rains and floods.

He reminds readers of the ongoing care by God of His creation. Then he addresses the effect of broken relationships on nature, as humankind no longer adequately representing God's interests in creation and theodicies, the explanations of God's reasons for allowing man's suffering.

The book ends with the images given in Revelation, and the message of hope in the coming of the kingdom.

This book confronts us with our own role in restoration and stewardship and uses all the arguments described above to bring the reader to reflect on the responsibility for a scientific understanding of disasters, to building community resilience against disasters, to fight unjust disparities in wealth and to enable God's creation to reflect His glory as He intended it to do.

I found the book inspiring and challenging, bringing the centrality of the cross to the topic of disasters in a refreshing approach.

From Victims to Entrepreneurs¹

By Sharon Bieber

The prophet replied to the widow, “How can I help you? Tell me, what do you have in your house?”
2 Kings 4:2

The widow in this story had two sons and large debts. She had no way to repay and now the creditors demanded her two sons as bonded servants. This is a story from ancient Israel and the prophet was Elisha, but it has a hauntingly modern ring to it. Any number of countries in South or Southeast



Asia might be the setting for this same scenario. Vast numbers of young sons and daughters are sent away to work in near-slavery with hopes of releasing their family from debt.

The widow-prophet interaction, however, has a very enlightening twist to it. Instead of providing money or even a job, neither of which he had, Elisha recognized her need then asked her to identify her resources: “What do you have in your house?” Only after she looked at her own resources, meagre as they were, did he offer a solution.

For years conventional wisdom in development started with a needs assessment. The goal was to help communities discover

their 'felt needs' and set priorities for action. We have finally seen that by focusing on needs we may imply or reinforce a sense of poverty and helplessness. It does not take much understanding of human nature to know that if we are told things look bad, they suddenly look even worse!

The widow in the ancient Middle East story did not have to sell her sons. By discovering that she did have something in her own house, a jar of oil, the poverty cycle was broken. With a willingness to risk following the prophet's absurd instructions, she borrowed jars and then started pouring oil. A miracle happened; the oil jar was bottomless! She lived among neighbours who were willing to help her and buy from her, turning her from a victim to an entrepreneur. Taking people who feel hopeless and helpless and changing the poverty mentality that is crippling their mind, frees them to notice the abundance around them. This is amazingly liberating.

There are, of course, times when the jar really is almost empty and short-term relief is necessary for survival. This is the reality in situations of war or physical disasters. The hardest part of outside relief is to know when is enough or when it becomes a hindrance to future development. Whole countries have gone backward rather than forward after natural disasters.

Shia (not her real name) is a Southeast Asian CHE colleague who looks for better solutions. She has seen the devastation of tsunamis and earthquakes, living among the people who have suffered through more than one disaster. While many of us do our small part and leave, she stays and helps them find their assets. What remaining resources are there after the disaster, she asks, and what is needed to restore healthy homes?

Shia masterfully takes the community members from being victims of the disaster to producing their own building materials for their homes, making their own concrete pillars, sun dried bricks and bamboo. Builders gain skill and experience by

helping themselves and their neighbours re-build homes, and then launch their own construction business. Now they have moved from victims to entrepreneurs as they learn to market their skills to other communities and run their own businesses. Even the school children in one place got involved in helping to build their own schools!

Along with business training, in this area where teaching Christianity is illegal, Shia includes classes in moral values such as integrity, truthfulness, consideration and family harmony. Often Bible stories are used to illustrate the topics. This approach will go a long way towards peacefulness in communities where other elements seek to put wedges of intolerance between people. Peacemaking is taking place at the same time as place making.

MAI Response During the 2020 Outbreak of COVID-19

By Dr. Bibiana MacLeod

Medical Ambassadors' Technical Advisor in Disaster Response conducted an internal evaluation of the organizational response to the COVID-19 pandemic, through interviews at headquarters and at the field level. The dual purposes of the study were to collect information regarding their response during the COVID-19 pandemic's initial stages and to listen to concerns and ideas on coping with the challenges that this new situation brought to their lives.

Methodology

Personal, individual interviews were set up virtually, between a Technical Advisor and team member. Field staff that participated in the interview were regional leaders, who covered one or more countries where Community Health Evangelism/Education (CHE) is implemented, representing all areas of Medical Ambassadors International's (MAI) intervention. Office-based staff from MAI's headquarters in California selected for the interview represented the following roles: Administration, Human Resources, Secretarial, Printing, Curriculum Development and Management/Executive Leadership. Two sets of questions were prepared, one for office staff and another for the field practitioners. Survey questions focused on MAI's priority, their perception of the response to COVID-19 and what they would like to improve for the future.

Results

1. Field leaders reported MAI's response to COVID-19 as quick and appropriate.

Based on the reports from field leaders, it was found that response was not limited to training on COVID-19, but also multiple actions focused on teams' well-being and rapid recovery from the impact of lock down and emerging challenges. Serving communities in the midst of the crisis continued to move forward. Approximately 7000 people received direct training from MAI personnel during the first 6 months of the pandemic. Many more benefited from the provided resources of hygiene supplies, food, equipment, and counseling.

2. When asked about MAI's priorities, responses from the home office focused on their own location, not on the global role of MAI and its response overseas.

Most home-office based participants mentioned the here and now. It is probable that this reaction came from being overwhelmed with the local situation, as the pandemic affected their own lives, bringing challenges both at work and home.

Answers about the local response of MAI in the US concentrated on compliance to county guidelines, showing that MAI is not seen by the home office as having a major role in intervention as a partner with local churches or communities, except for one participant that mentioned their work with homeless at the Vine House in Modesto. In the same way, field leaders' responses were focused on their personal situation, and home office was only considered in the last question. In retrospect, answers may have been biased by the way questions were formulated.

These observations brought us to consider alternative ways of increased communication between office and field leaders,

apart from reports by the Global Coordinator, to personalize and create an environment and sense of belonging to each other. Ideas to accomplish this:

- Ask everyone to adopt a prayer partner from the other group.
- Include all home office staff in mailing list from the field leaders.
- Facilitate virtual face-to-face participation in Zoom calls on a regular basis.
- Encourage field leaders to be intentional in communication beyond “business”.
- Share reports
- Urge home office personal to engage with field leaders by writing frequent personal notes of encouragement.

3. Gaps in COVID-19 response which were addressed by MAI in the first 6 months:

- Mental health, through training in Psychological First Aid online to over 300 participants.
- Food security, through provision of staple food in multiple countries.
- Member care, intensifying communication and making sure families were cared for.

These aspects have been highlighted in different regions, depending on interest of Regional Coordinators, needs identified in their areas of influence, local capacity and available resources, such as internet connectivity, funding and community engagement.

4. Gaps in pandemic response that MAI needs to consider:

MAI is developing a set of principles and philosophy of aid and development, that may be used in future responses. Disaster

prevention and response protocols should be in place from Headquarters to the last neighborhood where CHE is being implemented by MAI direct partners. We have clear parameters for development, but the lines are blurry when coming to disaster response. The need for a strategy with steps clearly defined and guidelines in response to any emergency in the field or home office has been expressed by survey participants.

It has been suggested that MAI should sign adherence to the Red Cross and Sphere standards found at <https://spherestandards.org/>. These standards would require that field personnel would take online training in their local language. Disaster response guidelines should be formulated once leaders have taken the training, following our participatory and community-owned philosophy of work.

Additional areas of focus emerged from the survey that will be researched as suggestions for improvement:

- Find useful forms of communication, with regular feedback from all team members, including communities and other stakeholders.
- Avoid centralization of relationships and encourage internal multi-channel communication. This could occur among smaller single-country areas and larger multi-country regions, and between field and home office, making relationships more personal during times of calm, so when crises happen, people connect naturally, and everyone cares for everybody.
- MAI will need to explore suitable equipment, communication tools, offer training in new available resources, and be able to rapidly identify unaddressed emerging issues. As one participant puts it, “Be the first and the best in its kind, find the gap, that thing that nobody else is talking about”.
- Evidence in this survey showed that teaching materials produced by well-intentioned outsiders were hardly used or were not efficient when the input from local leaders

was missing. Examples were COVID-19 videos or initial lessons that were distributed but not widely adopted or used. Regional leaders applauded radio spots, locally produced videos on WhatsApp and other local sources of information which were contextual and more appropriate. This is a lesson learned. In the case of global disasters, local solutions need to be supported and encouraged, taking time to listen to their proposals, and facilitate their execution. The worldview realities which influence response to misinformation and to guidelines should be strongly and intentionally addressed. Though briefly mentioned in the survey, we recognize that there has been confusing news, later worsened by loss of trust in scientific evidence and authorities in the global arena. This led to an infodemic (an overwhelming deluge of information and misinformation difficult for even trained professionals to filter and process). MAI teams were not immune to the viral spread of wrong information, house remedies, and discrediting of traditionally reliable sources. Two words MAI needs to explore with field leaders in their approach should be “worldview” and “trust” when facing emergency situations in the future. Cognitive Behavioral Therapy in the context of mental health should also be explored to increase understanding of people’s compliance or non-compliance to Public Health guidelines.

Topics that need attention and deeper understanding, based on responses given:

- Mental Health Care at community level. We will need to deepen our understanding of different ways to promote mental health on a peer level neighbor to neighbor.
- Biblical Justice. Disasters offer evidence that the most vulnerable members of society are disproportionately impacted and at greatest risk for failing to cope. Their conditions diminish their chances of survival or recovery.

Participants recognized the need to address more directly these justice issues because communities are usually blind to them and cannot proactively recognize them as a need. MAI should explore ways to bring these issues to the surface among those people it serves. It needs to ask how the community can focus on the weakest in each context.

- Prayer and fasting: Intentional and corporate prayer and fasting are crucial as we seek God's will and leading, asking if He still wants us to continue doing things the same way or whether there are new things that MAI should be doing. We seldom think of spiritual resources as one of MAI's strengths in the fight against the pandemic. However, we count on a vast network of intercessors that hold the ministry and people serving with MAI before God's throne. Without prayer our efforts are in vain. For this reason, one of the outcomes of this evaluation has been a weekly time of prayer on Sundays. Leaders around the world are committed to continue to ask for guidance from the Holy Spirit and to encourage team members to do likewise.
- Daily Prayer Support Team: Though MAI has traditionally started every year with a World-Wide Day of Prayer, and we continue to do so, we realize how much we depend on God's grace and support daily. We invite people from around the world to join our monthly prayer guide and invest time and resources in advancing His Kingdom.

In summary, MAI is committed to continue to learn from God and His word, from the circumstances, and from each other, so that we may serve the world better for God's glory.

Addendum 1

Relief Response Request

Following the Code of Conduct of the Red Cross and other international relief organizations, MedicalAmbassadors commits to humanitarian help in times of disasters, independent of race, creed, nationality or any other difference, to respect culture and work together with local actors, reducing future vulnerabilities, respecting dignity and being mutually accountable. We have developed a partnership request form to guide local leaders in their application for specific aid from our organization. On the following page is a sample of this partnership request.

PARTNERSHIP REQUEST

1. SITUATION SUMMARY

- a) Location of damage (names of villages, or neighborhoods)
- b) Description of Damage
How many people have been hurt? _____
Died? _____
What other losses? _____
Please give an approximate number of people affected by the damage or losses: _____

2. PRIORITIES AND BUDGET

- a) What are the immediate priorities that need to be addressed in the first week? How are vulnerable groups, in particular women and children will be considered in your response?
- b) What would be the cost? (Give us as many details as you can, write on another page if needed)
- c) What will be the needs anticipated for the next 2 months?
- d) What other groups, government institutions or Non-Government Organizations are being contacted to help?

3. LOCAL ORGANIZATION

Please, give names of local residents and training team members that will form a response team and be responsible for:

1. Communicating with MAI (Name, email contact, Whatsapp)
2. Accountability of funds received and expenses
3. Reporting activities, monitoring and evaluation of progress
4. If you or your organization do not have a signed agreement with MAI, after presentation of this Situation summary MAI will assess availability of funds and offer to sign an agreement before delivering assistance.

Addendum 2

Spiritual First Aid Tip Sheet



COVID-19 SPIRITUAL FIRST AID:

Faithful Preparedness, not Fearful Panic

BLESS Method: Meeting Core Needs

ABOUT: *Spiritual First Aid (SFA)*

Spiritual First Aid (SFA) is an evidence-informed, peer-to-peer, disaster spiritual and emotional care intervention. SFA was developed to take the “guess work” out of providing disaster spiritual and emotional care by turning research findings into practical helping methods. Each of the principles and practices below are based on scientific research and spiritual insights.

GOALS: *identify and respond to unmet core needs*

The goal of SFA is to reduce distress by identifying and responding to unmet core needs (Belonging, Livelihood, Emotional, Spiritual, and Safety needs) that are caused or heightened by COVID-19.

BLESS METHOD: *match needs with interventions*

SFA helps by using the *BLESS Method*. The BLESS Method is designed to help spiritual care providers identify peoples’ needs and then match them with appropriate interventions. BLESS is an acronym that is easy to remember and intended to assist helpers in remembering *what* and *how* to help.

IMPLEMENTATION: *observe, prioritize needs, provide support*

First, assess core needs through observations (i.e., “What to Observe”) and open questions (i.e., “What to Ask”). Second, work with the person you are helping to prioritize the person’s most pressing needs. Third, provide practical and tangible support using spiritually oriented interventions (“What to Do”). Keep in mind that because of the nature of helping in a disaster zone, you may only have the time or opportunity to address a single unmet core need. If circumstances permit, it may be possible to address multiple unmet needs in one interaction or over multiple interactions.

CONTACTS & UPDATES

HDI’s website and social media accounts provide ongoing updates and resources for preparing your church for COVID-19.

Email: hdi@wheaton.edu

Facebook: [facebook.com/WheatonHDI](https://www.facebook.com/WheatonHDI)

Twitter: twitter.com/WheatonHDI

Instagram: [@wheaton_hdi](https://www.instagram.com/wheaton_hdi)

HELPING PROCESSING



COVID-19 SPIRITUAL FIRST AID:

Faithful Preparedness, not Fearful Panic

BLESS Method: *Meeting Core Needs*

The BLESS Method			
Needs	Assessments		Interventions
	<i>What to Observe</i>	<i>What to Ask</i>	<i>What to Do</i>
B = Belonging	Interpersonal Interactions	Relationship Questions	Provide Social and Spiritual Support
L = Livelihood	Losses	Resource Questions	Connect to Faith-based and Community Resources
E = Emotional	Distress	Mental Health Questions	Listen and Facilitate Lament
S = Spiritual	Indicators of Faith	Religious and Spiritual Sensitive Questions	Attend to Ultimate Questions and Spiritual Meaning
S = Safety	Behavioral “red flags” (e.g., acts frightened, giving away belongings)	Threat and Harm Assessment Questions	Refer and Report

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Acknowledgements

Medical Ambassadors International is not a typical “relief response organization”, and yet, God has drawn us into that role repeatedly as we encountered disasters in our mission field in the recent past. The lesson we draw from the story of the Good Samaritan is that when a disaster strikes in our mission field, we do not have the option of ignoring the call to respond.

The authors who have contributed to this book have responded beautifully as “Good Samaritans” and I am eternally grateful to each one who took time from extremely busy schedules to put their stories on paper. Collectively, we pray that our experiences will be of benefit to others.

A special thanks to Dr. Bibiana MacLeod, who wrote the most chapters in this book.

If you wish to communicate with an author reach out to me at the address below and I will be happy to make a connection.



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About the Authors



Dr. John C. Payne

Dr. John Payne served as a field staff member in East Africa and a Medical Ambassadors International (MAI) Region Coordinator between 2005 and 2009. In 2009, he moved into the role of MAI President, where he remained until his retirement in 2017. Since retiring, he has continued to serve MAI as an Advancement Facilitator.

Prior to becoming a missionary, Dr. Payne was a family physician and Family Medicine Residency Director in Modesto, CA as part of the University of California Davis Residency Network for 19 years. Before this, he taught doctors at Cook County Hospital part time, while also staffing a Christian Community Clinic in Chicago, IL.

Dr. Payne is a graduate of Wheaton College (BS 1969), the University of Illinois Medical School (MD 1975), the University of California, Davis Family Practice Residency (1978), the Cook County Hospital Faculty Development Fellowship (1984), and the Medical Ambassadors International CHE Internship (2005).

John and his wife, Madelle, describe themselves as ‘followers of Christ’. They have two married children and four grandchildren scattered around the world, all serving the Lord. Madelle has worked hand-in-hand with John in all his roles at MAI.



Dr. Bibiana and Alexander MacLeod

Dr Bibiana MacLeod was born in Argentina, where she completed her studies and residency as a medical doctor, with a specialty in Internal Medicine. After a deep spiritual experience while practicing in Brazil, Bibiana dedicated her life to serve God with her profession as a missionary. She moved to Haiti in 1989, first practicing medicine in partnership with the local Ministry of Health.

Bibiana and her husband Alexander, joined Medical Ambassadors International (MAI) as full-time workers to implement Community Health Evangelism/Education (CHE), first in Haiti, and some years later, in Cuba and Dominican Republic, where they lived for 3 years. They then served as coordinators in South America and the Caribbean from 2005 to 2018, when new local leaders took over the task.

Bibiana obtained a Masters' Degree in Disaster Leadership from Wheaton College in 2020 and is now the Technical Advisor for Disaster Preparedness, Human Trafficking prevention, CHE in Oral cultures, and the 1000 days programs in Haiti. Bibiana is also part of the World Evangelical Alliance task force against Human trafficking and co-leads a regional network of Christian leaders serving in this field in Spain, Portugal and Latin America.

Alexander and Bibiana live in Atlantic, Canada, where they are actively involved with Medical Ambassadors Canada Association, (MACA), the sister organization of MAI based in Edmonton, Alberta.



Dr. Ravi & Vimla Jayakaran

Dr. Ravi Jayakaran joined Medical Ambassadors International (MAI) as the President/CEO in 2017, working out of the Home Office in Salida, CA. In addition to his work at MAI, Dr. Jayakaran is also the Catalyst for Integral Mission for the Lausanne Movement.

His background includes long-term leadership experience in international poverty reduction and strategic programming. In the 90s and early 2000s, he was actively involved with relief response programs in the Asia-Pacific region, including a role as Food Security & Disaster Mitigation Advisor for the region.

He has also held senior management positions in the corporate sector and International NGOs - including World Vision International, the Asian Development Bank and the United Nations Development Programme (UNDP). He has lived and worked long term in India, Cambodia, China and the US, providing technical support in more than 23 countries.

Dr. Ravi and his wife, Vimla, recently celebrated their 43rd wedding anniversary. They came to know the Lord Jesus Christ as their personal Savior while they were in university. Besides their engagement with integral mission, they are actively involved with their local church, small group and Christian counselling. They have 2 sons, Amit and Rohit, who are married and have their own families and live in California and Dubai, respectively. Ravi and Vimla live in Ripon, CA, USA.



Shelly Zadina

Shelly Zadina is a Community Health Evangelism/Education (CHE) Facilitator who has been serving in Albania since 1999. She grew up in a Christian family and made the decision to follow the Lord early in her life. She felt called to cross-cultural ministry in junior high school. After having obtained her Bachelor of Science in Nursing from Pensacola Christian College she returned home and worked in the ICU at the local hospital. While seeking the Lord's direction for future service, Shelly worked 5 ½ years in ICU and 3 ½ years as a nursing instructor in the nursing program at the local community college.

When Shelly first heard about the concept of CHE, she joined Medical Ambassadors International (MAI). Her first assignment in June 1999 was in Albania, working under the leadership of an Albanian leader.

Shelly has continued to serve in Albania for the last 21 years. She is currently working with an Albanian team in villages in the southeastern portion of the country where there are now three CHE communities. They are using the CHE strategy locally and also training and mentoring other teams throughout the country and in neighboring countries.

She enjoys teaching the local women, children and youth. She also encourages and mentors youth that are actively reaching their peers, works with literature and curriculum development, translation and editing of CHE lessons, and is involved with the team in establishing and strengthening the communities in which they work.



Marco Aurelio Quispe Trinidad

Marco Aurelio Quispe Trinidad is a Coordinator for Medical Ambassadors (MAI) programs in South America. He is responsible to promote, multiply and develop the Community Health Evangelism/ Education (CHE) programs in this region. Marco was discipled for this role by his former supervisor and mentor, Dr. Bibiana MacLeod.

Marco has visited many countries in South America and the Caribbean, such as Argentina, Ecuador, Bolivia, Brazil, the Dominican Republic, Haiti and Cuba, facilitating trainings on the CHE program and gaining experience from existing programs in these countries. He received training in appropriate technology, agriculture, animal husbandry, the environment, storytelling for oral cultures, and human trafficking prevention.

He was born in Lima, the capital of Peru. He worked for 8 years as a computer programmer before receiving the call of God to become a full-time missionary in 2006. Marco and his family then relocated to the city of Trujillo in northern Peru. Two years later while involved with outreach missions, he learned about the CHE Program and put what he learned into practice in the community where he worked. As a result of the program, a church was established, and the community developed holistically. The rest of his journey is one of expansion, increased responsibility and seeing God's plan gently unfold.

Marco and his wife, Vilma have three children, Abigail (20), Katherine (17) and Jeremy (03). All of Marco's family is involved in the mission. They continue to live in Trujillo Peru, from there Marco travels to different parts of the region he serves.



Tirus Karunga and Winnie Ndaru Githaka

Tirus and Winnie Githaka serve with Medical Ambassadors International (MAI), as Co-Regional Coordinators in the East Africa and Horn of Africa region. Both Tirus and Winnie have been involved in establishing community development programs for over fifteen years. They have extensive experience in strategy development and evaluation of transformational community programs. Through their office, they coordinate learning labs for indigenous mission organizations. Their goal is to build their capacity to network with those working in the hard-to-reach areas, for integral mission.

Over the years of ministry, they have learned to be open to the Lord's leading and be ready to engage in the best way possible to address the struggles they find in the community. This is what led them to develop and use household food security ventures during the COVID-19 lockdown, when villagers struggled a great deal to meet their families' daily food needs.

Tirus has a biochemistry background and a master's degree in Medical Microbiology, while Winnie has a social work background with a master's degree in International Development, as well as a diploma in Organization Leadership. Both serve as advisors for two separate NGOS through serving on their boards.

Tirus and Winnie love Christ passionately. They are parents to two teenage boys, Toria and Tugi, and live in Nairobi, Kenya.



Dr. Bill and Sharon Bieber

Since their introduction to Community Health Evangelism/Education (CHE) in 2000, Canadians Sharon and Dr. Bill Bieber have served together as volunteer trainers and then Regional Coordinators for Medical Ambassadors International (MAI) and Medical Ambassadors Canada (MACA) in the Pacific and SE Asia. They look for potential collaborations between government, NGOs and community churches in initiating CHE. Their goal is to see thriving families and community ownership of biblically holistic programs that will impact large population groups.

Sharon, who has a master's degree in Education, has taught in public school in Canada, in a mission school in Papua New Guinea, and adult education in various business settings. Sharon published a book in 2020, 'Outside the Margins: Lessons from walking with communities of the world.'

Dr. William Bieber practiced family medicine in Canada for a total of 25 years, in Papua New Guinea for 8 years, as well as other international consulting and extensive travel. Returning to Canada in 1986, Bill and Sharon helped to start an inter-disciplinary medical clinic in Calgary and also a 'street clinic' ministry called Calgary Urban Project Society (CUPS). For this they were honored with medals from the Governor General of Canada in 2016.

Bill and Sharon have two married children and five grandchildren and live on a small farm in the foothills south of Calgary where they continue to be involved in church and community work during the times they are at home.



Dr. Jamie D. Aten

Jamie D. Aten, Ph.D. is a disaster psychologist and disaster ministry expert. He is also a Hurricane Katrina and late-stage cancer survivor and the founder and co-director of the Humanitarian Disaster Institute at Wheaton College, where he serves as the Blanchard Chair for the MA in Humanitarian & Disaster Leadership and Co-Director of the Graduate Certificate in Trauma.

Jamie has been awarded over \$6 million in external funding for research and programs to help others cultivate faith and resilience amidst mass disasters and humanitarian crises. He has published over 100 peer-reviewed articles and book chapters, made over 200 conference presentations, coedited or authored 7 books including the Disaster Ministry Handbook (IVP), and is currently co-editing Refugee Mental Health (APA Books). Jamie is an award-winning author, recipient of an APA Early Career Award, and recipient of the 2016 FEMA Community Preparedness Champion Award at the White House. He is a disaster ministry columnist and is frequently cited or interviewed in media outlets like The Washington Post, USA Today, Christianity Today, Moody Radio, and CBS. He has also written widely for a general audience with over 100 bylines in outlets like TIME, The Washington Post, Preaching Today, Religion News Service, Psychology Today, and Christianity Today.

Dr. Aten resides in Wheaton, Illinois with his wife and three children.



Williams Adedayo “Dayo” Obaweya

Williams Adedayo Obaweya has been a disciple of Christ for 33 years. He has worked with Medical Ambassadors International (MAI) for 19 years, currently serving as MAI’s Regional Coordinator for West Africa and Chairman of the Global CHE Network.

Dayo also serves as the Africa Internship Center Coordinator in Ghana, and as a Co-catalyst for Integral Missions with the Lausanne Movement. In addition, he is an Evangelism coordinator and resource person for Appropriate Technology (AT) and Business Management to many organizations serving in Africa.

Although he is a Nigerian, Dayo lives in Ghana as his second home, where he has established a center to train missionaries in holistic development strategies.

Dayo has travelled across many continents, training people in business and missions. He speaks multiple languages including English, Yoruba, Hausa, and Tagalog. He is an agriculturist and holistic development consultant.

Dayo’s wife, Tope recently retired after 35 years in the ministry of education where she was a school principal. Dayo and Tope are blessed with two sons. Their older son is a computer engineer in Nigeria, while their younger son is a medical doctor in England.



Dr. Jason Paltzer

Jason Paltzer is Assistant Professor of Epidemiology at Baylor University, Robbins College of Health and Human Services. His work is in the area of alcohol epidemiology and substance abuse prevention in low-income populations. He also does research focused on adapting behavioral screening and intervention for use in community-based settings with specific interest in leveraging community health and faith-based partnerships to develop effective peer support recovery programs.

Dr. Paltzer received his MPH from the University of Minnesota and his PhD in Population Health Sciences from the University of Wisconsin. He has worked in sub-Saharan Africa, Southeast Asia, the Caribbean, and Latin America with various community and church-based health initiatives.

He sits on the board of directors for Esperanca, a global health organization based in Phoenix, Arizona, serves as a global health and development consultant for faith-based organizations, and coordinates the 'Public Health as Mission initiative' for the Global CHE Network.

Jason and his wife, Amanda have two children—a 12-year-old son and a 10-year-old daughter. They enjoy biking, hiking, spending time in the mountains and exploring food from around the world.



Dr. Victor Chen

Dr. Victor Chen currently serves as Global Coordinator for Medical Ambassadors International (MAI) and has been involved in transformational development and community health work for 14 years. He and his family lived in Central Asia for 4 years where he served as the Director of Community Development and Health for an NGO working in the sectors of community development, preventive health, and disability.

Prior to joining MAI, Victor worked as a family physician in a community health center and served on the teaching faculty of a family medicine residency program in California. He received his MPH from the University of California, Berkeley School of Public Health and his MD from the University of Southern California Keck School of Medicine. Victor also serves on the board for Vine House Ministries in Modesto, CA; The Refuge Retreat Center in Shingletown, CA; and on the representative council for the Global CHE Network.

Victor is married with two daughters, ages 9 and 11. They enjoy traveling, road trips, and being outdoors.



Dr. Nzuzi Mukawa Feliciano

Nzuzi Mukawa Feliciano was born to a pastoral couple of the Mennonite Brethren churches in Congo and was raised and educated in Congo. After finishing his studies, Nzuzi came to the United States to continue his higher studies at the Trinity International University in Deerfield, IL. He completed his PhD in Missiology and then returned to Kinshasa, Democratic Republic of Congo, to serve the Lord as the Medical Ambassador International (MAI) Regional Coordinator for Central Africa, where he continues to promote Community Health Evangelism/ Education (CHE) programs for facilitating holistic transformation.

Dr. Feliciano has been leading this movement since 2004 and currently there are 945 communities in his region that have been impacted through CHE. These communities are not only empowered and able to run successful CHE programs, but during the COVID-19 crisis, Nzuzi and his senior leaders were able to reach out to the communities using cell phone communication and introduced a special radio program designed to bring awareness about COVID-19. The result of this effort was a radio program that over 5 million people tuned in to and learned from. The CHE leaders, and the CHE communities stayed healthy and safe from COVID-19.

Nzuzi has been married to Chantal Mukawa since 1991, and they have three children: Hosanna (25), Jireh (24) and Trego (22). All three of their children live in the USA.



Suzette Montez

Suzette was born and raised in Stanislaus County, CA where she completed a Bachelor of Science degree in Business Administration with specialization in Accounting. She continued her studies for a Master of Science degree in Taxation after moving to the Bay area.

Raised in a pastoral family home in the small town of Salida, California, Suzette chose to study business administration and accounting after prayerfully reflecting on a need for financial and accounting advice by the many leaders of small community churches and non-profits. After living and studying in the Bay Area, she chose to return to a quieter, slower-paced life, and moved back home where she acquired a job at a local cooperative egg processing plant, performed the accounting for her local church, and was nominated into its board. Later, she obtained a managerial position at Medical Ambassadors International (MAI), and under the mentorship of the then CFO, Michael Carroll, she became proficient at fund accounting and non-profit reporting including the federal 990 tax returns.

In 2006, she became Controller, and fills the position of Chief Financial Officer. Suzette assists national church leaders, bishops, pastors, accounting managers, and administrative assistants in setting up church policies and procedures for applying for tax exemption. She is a knowledgeable Board treasurer for her local church, the Apostolic Temple.



Galen Dalrymple

Galen Dalrymple is the Dean of MAI Academy and also serves as the field education coordinator for Medical Ambassadors International (MAI). He lives and works from home in Wheaton, IL. Galen has been with MAI since January of 2013.

Galen spent 25 years working in various management and operations roles in the high-tech world. His last position was Director of Operations for a group of 220 people responsible for a \$55 million revenue stream. He left the high-tech world after being led to become a church planting pastor in northern California, prior to joining MAI.

In addition to curating and creating training materials for MAI Academy, Galen facilitates Community Health Evangelism (CHE) trainings in the United States for MAI and has been involved with the necessary transition in 2020 from in-person TOT trainings to virtual TOT trainings.

Galen grew up in a Christian home and holds a bachelor's degree in biblical studies and a master's degree in theology. He and his wife, Laurel, have been married 50 years and have three children and six amazing grandchildren. In addition to Galen's work with MAI, Galen is a Stephen Ministry leader and Laurel is a Stephen Minister serving in their local church in Wheaton. He has written a daily Christian email devotion called "DayBreaks" that is released Monday – Friday since 1997.

Glossary

CDC-Centers for Disease Control
CHE-Community Health Evangelism
CHE-Community Health Education
CRRF-Central Relief Response Fund
GCN-Global CHE Network
HDI-Humanitarian Disaster Institute, (Wheaton)
MACA-Medical Ambassadors Canada
MAI-Medical Ambassadors International
MAI-A-Medical Ambassadors International – Academy
MOU-Memorandum of Understanding
NGOs-Non-Government Organizations
RC-Regional Coordinator
THI-Trauma Healing Institute
TST-The Ten Seed Technique
WASH-Water, Sanitation, and Hygiene
WHO- World Health Organization
YWAM-Youth with A Mission

Bibliography

Chapter 3:

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<https://media.chop.edu/data/files/pdfs/vaccine-education-center-logical-fallacies.pdf>

-⁵ The COVID-19 School of Public Health Expert Insights section
<https://www.jhsph.edu/covid-19/articles/covid19-vaccines-verifying-safety-and-identifying-misinformation.html>

-Other resources will be found in the body of the article.

Chapter 17:

-¹ Who is to Blame? Disasters, Nature and Acts of God, by Robert S. White, 2014, Lion Hudson place. Wilkinson House, Oxford, England.

Chapter 18:

-¹ This chapter is an excerpt from Sharon Bieber's recent book, *Outside the Margins: Lessons from Walking with Communities of the World*. Read more of the back stories of transformational development taking place through CHE around the world. All profits go to MAI. Available on Amazon.com

Chapter 19:

-Red Cross and Sphere standards
<https://spherestandards.org/>

About the Authors:

-Connecting to the artist – Steven Lester, who made the authors' portraits: <https://www.stevenlesterartstudio.com/>

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About this book



Community volunteers from CHE communities in the DRC sharing Covid-19 prevention information

This issue of Healing Lives is entirely focused on the subject of Disaster Relief response and covers a range of topics from understanding the different types of disasters one may encounter on the field based on their intensity. It also addresses the principles that need to be considered while responding to them. It is a practical reference guide with stories of transformation related to the post recovery process, and also captures MAI's response to the pandemic and lessons learned from it.

It's our desire that this publication will help readers learn how to respond in a way that brings communities back into 'a continuum of transformation'. We also want to inspire those who cannot be directly involved in going to the field, to become Relief Response Support Partners with Medical Ambassadors International.

-MAI Relief Response Team