

Kelly O'Donnell

Developing Member Care Affiliations

One of the recent developments in the care of missionary personnel has been the formation of "regional interagency member care affiliations" (RIMAs). These groups help to identify and develop needed resources (e.g., team building workshops, crisis care networks, attrition research) on behalf of mission personnel in a specific region (e.g., West Africa, South Asia, German-speaking Europe). RIMAs reflect the growing cooperative efforts within both the international health care and mission communities. This article explores several characteristics of these strategic new affiliations, interspersing the discussion with some personal reflections from the author along with suggestions for their formation and maintenance. Helpful concepts from the field of community psychology are also discussed, such as identifying groups/areas at risk and empowering missionaries/member care personnel with additional skills.

It is encouraging to observe the continuous expansion of the global missions movement, with current estimates being over 400,000 personnel in cross-cultural ministries (Barrett, 1997). A majority of these come from the Older Sending Countries (e.g., United States, United Kingdom, Australia, Canada) with the movement growing rapidly in the Newer Sending Countries (e.g., Nigeria, India, Brazil, Korea). Interfacing with this growing movement is the maturing domain of member care, an interdisciplinary field whose overall purpose is to nurture and develop mission personnel, from their recruitment through their retirement (O'Donnell and O'Donnell, 1992). The need to sustain missionaries over the long haul is seen in the recent figures on missionary attrition, in which each year an estimated 3.1% (possibly 12,000 people) depart prematurely, permanently, and for preventable reasons (Brierly 1997). Such undesirable attrition also spills over onto others, as its ripple effects negatively impact thousands of family members and friends in the home and host communities.

How can mission organizations, sending churches, and member care groups work together to help provide the necessary "flow of care" (Pollock, 1997) for the increasing numbers of mission personnel? One important way is to form affiliations of experienced member care practitioners who are familiar with missions, who band together to intentionally develop important member care resources within a specific geographic region (e.g., North Africa), people group (e.g., tribal groups in North India), or type of ministry (e.g., trauma management). These affiliations, when set up and maintained properly, help complement the supportive resources that sending agencies are already providing

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(e.g., team building, crisis care, and pastoral field visits), and in many cases fill in significant member care gaps.

This article takes a closer look at a specific type of affiliation referred to by the acronym *RIMA*—regional interagency member-care affiliations. I have had the good and challenging fortune of being involved with seven RIMAs over the past several years. Some are working well and some are still getting off the ground. My background in community psychology has been especially helpful for me, as several core principles from this field have shaped my involvement with these affiliations.

The main thrust of this article is to explore some of the characteristics of RIMAs, relating these to community psychology principles. Community psychology's relevance is found in the similarity and compatibility of many of its concepts with those of the member care field (O'Donnell, 1986). Examples include the emphasis on working with at-risk groups (e.g., focusing on missionaries in isolated, unstable settings), assessing felt needs in order to develop supportive resources (e.g., doing a needs assessment for Latin American field personnel), and empowering missionary personnel with additional skills for personal adjustment and work effectiveness (e.g., offering workshops on stress management and contingency planning). Interspersed with the discussion are some personal comments about my involvement with RIMAs along with suggestions for their formation and maintenance. What types of personnel are needed? What types of projects are prioritized? What are some of the pitfalls? In short, how can these affiliations become relevant for the missions community? I also report on the work of some current member care affiliations, and review similar cooperative efforts which have been occurring within the international health care and the global missions communities.

Some Historical Perspectives

In the early 1990's I began to explore the viability of developing more coordinated member care efforts at both the international and interagency levels. I became convinced that the time had come to deliberately pursue a consensually-derived "macro model" of member care in order to further support the Church's mission efforts, especially among unreached people groups. My initial ideas were published in an article "An Agenda for Member Care", whereby I encouraged leaders in the member care field to "step forward and help steer this field in response to the Lord's direction" (O'Donnell, 1992, p. 112).

These aspirations for a more global and coordinated member care approach were neither unrealistic nor without precedent. Cooperative endeavors were being seen in the rise of national and international missionary associations, and in the formation of partnerships of ministries/organizations focusing on specific unreached people groups (Taylor, 1995). Likewise in the area of missionary care, there had been some encouraging cooperative developments via the three previous International Conferences on Missionary Kids (ICMK, in 1984, 1987, 1989). These historic gatherings, in retrospect, have served as the main interagency, international forums for member care workers to come together (not just for MK care personnel). ICMK eventually evolved into three regional groups for the Americas, Asia, and Europe/Africa, and also several local chapters (Wilcox, 1998).

Member care, like missions, was rapidly growing in the 1980s, and by the early 1990s had developed into its own specialized field (O'Donnell, 1997). The next step was to see various streams of this field come together (psychologists, residential care centers, crisis care specialists, mission pastors, etc.) not just for mutual support and additional training, but to more systematically provide and develop additional resources on behalf

of the mission community (e.g., counseling, training, crisis care, screening tools, MK reentry programs).

Several joint member care projects were launched in the 1990s. Examples include the MK-CART/CORE group's research on missionary kids and school personnel; the 1992 book *Missionary Care* which was the collaborative effort of six consulting editors and 23 authors, and the 1997 WEF book on missionary attrition called *Too Valuable To Lose*, a landmark book in that it included authors from all over the world; special gatherings that have brought together member care workers, like the three European Member Care Consultation held in 1997, 1999, 2001, and smaller, informal day consultations in Singapore to address member care topics via case studies; and, as this article describes, the formation of separate interagency member care groups for the regions of the Middle East (1993), North Africa (1994), Europe (1997), and most recently for Asia (1998) and hopefully for Latin America in 1999.

Similar developments were making and continue to make their mark on the health sciences, where the increased emphasis on international, interdisciplinary cooperation has been called upon to tackle human problems. Currently, for example, there are over 60 international psychological associations and related organizations (APA Office of International Affairs, 1998). International psychology, seen as both a vast network and a social movement, is actively involved as a health care partner around the globe. Pawlik and d'Ydewale (1996) comment:

The role of international cooperation and exchange (of persons, knowledge, and experience) may seem all too obvious in the interest of developing cross-national understanding and good will among people of different nationality, ethnic, or other background. Psychology has been opening up to and has become a partner in many such initiatives, too numerous to be cited in detail... A more recent example is the initiative (through the [International Union of Psychological Science] Committee for the Psychological Study of Peace...) to help mitigate postwar stress disorders in war stricken Rwanda and Burundi. Other examples are psychology's contributions to international educational programs (Gelman & Lee, 1995) or to world-wide health education initiatives under the aegis of the World Health Organization (WHO) (p. 489).

Another example of coordinated efforts is seen in the People in Aid's *Code of Best Practice* (1997). This document, formulated by several humanitarian aid organizations from the United Kingdom and Ireland, discusses seven core principles for the management and support of aid personnel. Recognizing the draining realities of this labor-intensive profession, guidelines were drawn up to help ensure the security and well-being of staff (see Table 1). Organizations, both religious and non-religious, as well as those outside of the United Kingdom/Ireland, have been encouraged to discuss these principles, weave them into their ethos, and hold themselves accountable for their implementation. Outside funding for projects will likely be increasingly contingent on the degree to which aid and mission organizations are putting this or similar codes into practice.

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Table 1. People In Aid—Principles for the Care/Management of Aid Personnel

- Principle 1: The people who work for us are integral to our effectiveness and success... Human resource issues are integral to our strategic plans.
- Principle 2: Our human resource policies aim for best practice...We do not aim to respond solely to minimum legal, professional, or donor requirements.
- Principle 3: Our human resource policies aim to be effective, efficient, fair, and transparent...Our policies must enable us to achieve both effectiveness in our work and good quality of working life for our staff...and to promote equal opportunity.
- Principle 4: We consult our field staff when we develop human resource policy. We recognize that we must implement, monitor, and continuously develop our human resource policies in consultation with the people who work for us.
- Principle 5: Plans and budgets reflect our responsibilities towards our field staff...for staff management, support, development, security, and well-being.
- Principle 6: We provide appropriate training...professional support and development before, during, and after [staff] field assignments.
- Principle 7: We take all reasonable steps to ensure staff security and well-being. We recognize that the work of relief and development agencies often places great demands on staff in conditions of complexity and risk.

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Characteristics of RIMAs

RIMA Personnel

RIMAs, in community psychology terms, are strategies for meeting a community's felt needs by creating new or alternative "settings" (Sarason, 1972). These settings can be health care task forces, support groups, and so on. At times such settings are birthed out of a sense of frustration that the existing health service structures and social programs are inadequately serving groups within their catchment areas, while at other times it is done as an amicable way to complement existing resources. For RIMAs, the latter is by far the case. Nonetheless, there is a motivating conviction among most RIMA members that much more needs to be done. A prime example of this is seen in the organization of various regional and national member care consultations whereby member care practitioners (e.g., mental health professionals, physicians specializing in tropical medicine, personnel directors, pastors) and church/mission leaders have met each other, exchanged information/updates, and in many instances have decided to work more closely together (Ritschard, 1992).

Most RIMAs are inclusive in their membership. They have a good representation of people from different organizations and nations, who have diverse mission and member care experience. Such diversity is welcomed and encouraged among community and organizational psychologists working in international contexts, as it helps assure that various groups' needs are understood, and culturally-relevant approaches to meeting such needs are developed (Adler, 1991). Initially though, North Americans have often been in the majority. An example of some criteria that have been used to invite colleagues to participate in RIMAs is presented in Table 2, taken from the Member Care Task Force of the World Evangelical Fellowship's Mission Commission.

Table 2. Guidelines for RIMA Members—Selection and Ongoing Involvement

- Spiritually and emotionally mature, with good family life if married and a support group for personal growth and accountability.
 - Actively involved in member care, having specific member care skills and working with different missions/member care networks.
 - Growing or broad international experience and a respected leader (via position and/or sphere of influence).
 - Has a call/desire to further develop member care in broader arenas than one's usual work setting.
 - One's organization supports his/her involvement in this Task Force—it is part of the job description in many cases.
 - Has access to electronic mail to communicate regularly with other members; meets together at least once every two years.
 - Term of service is three years; works on at least one Task Force project at any given time.
 - Has adequate clerical and financial support to participate.
 - Is a team player, committed to work in unity of purpose and objectives.
 - Understands and agrees with these guidelines, and the WEF Statement of Faith.
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Not surprisingly, I have found that RIMAs work best when a number of their members have had a prior, trusting relationship. In fact, group diversity without group trust, is quite difficult to manage. It often seems that *function* (working on strategic joint tasks) usually brings friends and colleagues together, but *friendship* and Christian *fellowship* keep them together. From this foundation of friendship and function eventually emerges a more definite *form* (structure) to help support the affiliation's efforts. With time, many other colleagues usually connect with this core group, forming a broad network of affiliates who relate to it for information, joint projects, and encouragement.

RIMA members need to cultivate at least four different dimensions, or roles, within their group. The challenge is similar to that of community psychologists and others involved in community work, where the issue is not just what one can do or what one is good at, but also what really needs to be done. In other words, how does one adjust their usual roles in order to meet the felt needs of underserved groups? For RIMAs, this means that members must be willing to stretch their role parameters at times on behalf of the mission communities they serve. Moderating an email forum for member care workers within a given region, is a good example. It may be tedious, but it is quite valuable. I see four types of roles as being basic to those who want to develop member care in general and RIMAs in particular.

- *Scouts*—to monitor what is happening (trends, events, needs) and report back to others in the affiliation and the mission/member care community.
- *Scribes*—to make accurate notes and write/disseminate material about what is happening.
- *Bards*—to inspire others, point out future directions, and eloquently retell what is happening via discussions, presentations, and training.
- *Brokers*—to connect the right information about regional needs with the right resources (especially people) which can help.

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RIMA Projects

Member care affiliations, whether they focus on regions (e.g., South Asia), people groups (e.g., unreached groups in Indonesia, China), or specific ministries (e.g., trauma care), identify a number of projects in keeping with the group's goals. Each joint project usually has a coordinator, a written plan with an estimate of costs and funding sources, and an evaluation at the end. None of the RIMAs I have worked on have offered remuneration for our efforts, as we work as volunteers. However funds have been periodically available to cover many expenses, made possible through contributions from one's organization and outside sources.

At the heart of RIMA projects is the goal to really make a difference on behalf of mission personnel. At the task level, this means developing relevant resources that fill in significant regional member care gaps. At the relationship level, this means demonstrating the love Christians have for one another as described in John 13-17, by supporting missionaries with member care resources, and encouraging them to support each other (Pollock, 1997). RIMAs can benefit from community psychology's emphasis on working with groups whose well-being is "at risk", due to the inadequate development and distribution of available and potentially available resources (e.g., immunization programs, transportation to schools, single parent support groups). In the member care context, at-risk groups would include missionaries serving in isolated, potentially traumatic, and/or politically unstable areas, with limited access to important supportive resources (e.g., fellowship, recreation opportunities, safe and consistent sources for food, desirable educational options for missionary children).

For Collins and Porras (1994), organizational consultants who write about the successful practices of visionary companies, going after large and at times audacious goals is a necessary means to stay on the cutting edge in the marketplace, provided that such goals stem from the company's core vision—its *raison d'être*. In terms of RIMAs, this means that members must not be content with just discussing issues, sharing updates, providing mutual support, or helping each other with their organizational-related work. Rather, it means that members want to deliberately and ambitiously go after larger-scale projects that will strategically impact the mission community.

Here are three broad categories of projects—member care gaps—which RIMAs can address. Each gap heading represents a major community psychology principle and practice. Getting missionaries themselves and other member care colleagues involved in these projects, which is not unlike the community psychology practice of "citizen participation" (Heller, 1990), is key to creating a sense of ownership in the projects, and making sure that they are relevant. Using electronic mail to create "virtual offices/teams" is a promising way to accomplish many of these projects (Koster, 1994).

Gap One—Going into the Community to Provide Acceptable/Accessible Services

- Develop an interagency team/network/center of care givers within the region (e.g., Southeast Asia, West Africa, Commonwealth of Independent States).
- Provide services via short-term field visits and also for the participants at strategic conferences (e.g., workshops, counseling, team building, consultation).
- Consult with regional and national mission associations concerning member care; maintain close working relationships with mission leaders.

- Set up regional consultations where people actively involved in member care can meet each other, pray together, exchange information/updates, and receive additional training.

Gap Two—Developing a "Sense of Community" via Communication and Writing

- Oversee an email forum for people within the region to communicate about member care issues, needs, and news.
- Send out an email newsletter and hard copy twice a year, with updates about past and future member care-related events, commentaries/perspectives.
- Set up Web sites to share and disseminate member care-related materials—an electronic "clearing house" for information, current events, referral listing, and useful publications.
- Translate and write member care materials in different languages, not just in English. Submit articles to regional journals and magazines (e.g., *Asian Mission*, *Africa Journal of Evangelical Theology*, *Ellos Y Nosotros* in Latin America.)

Gap Three—Empowering Mission Personnel and Member Care Workers

- Organize a network of trainers that can give workshops for national Christians, member care workers, missionaries, and mission leaders at key locations such as at graduate/Bible schools, training centers, special regional gatherings, and in field settings. Important topics include:

a. Crisis and contingency management	b. Interpersonal skills/peer counseling
c. Team building skills	d. Spiritual life/retreats
e. Family life/MK seminars; child safety	f. Member care overview course
g. Grief/depression/transition	h. Addictions/unwanted habits
i. MK personnel orientation	j. Stress management
- Develop practicum and training opportunities in missionary care for graduate students and other member care workers (e.g., inviting colleagues to work at an overseas mission conference or to do a field visit; offering a three month practicum for graduate students).
- Train missionaries and national Christian workers with member care skills in order to provide needed services to nationals (e.g., training for counseling, debriefing; and running support and recovery groups).

RIMAs in the Broader Context

RIMAs do not exist on their own. They are part of and dependent upon the missions and member care communities. RIMAs are not merely special interest groups, lobbying for some cause. Rather, they are fundamentally *mission* groups, specializing in member care but intricately woven into the missions movement. In most cases RIMAs would not exist without the backing and involvement of concerned mission leaders who function as "gate keepers" to help member care workers access mission communities. In some ways they may embody the vibrant spirit of the grassroots groups and movements which have historically been part of the community psychology landscape. At the same time, though,

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RIMAs are relationally linked to leadership structures in missions along with other related member care groups.

Metaphorically, RIMAs function like a thumb on the member care hand, in that they are able to touch, influence, and complement the movements of the four fingers—i.e., other member care resources. Members of the European RIMA called Member Care-Europe, for instance, have helped organize two interagency teams of mental health and education specialists to provide consultation services to missionaries in Central Asia, and have sponsored two intensive member care courses in Germany to further train European mission personnel who have member care responsibilities.

RIMAs also represent a key component envisioned in PACTS, a further development of the macro model of member care mentioned previously (O'Donnell, 1997). This model summarizes five future directions for this field, with the "A" standing for affiliations. Again, if PACTS were a hand, the "A" would function like the thumb, inasmuch as it works alongside to help support the work of the other four appendages, or member care directions.

- Pioneering member care for at-risk groups who have limited access to supportive resources.
- Affiliating together for mutual support and joint work, such as via RIMAs.
- Continuing education/personal growth for member care workers.
- Training others in member care via key workshops and courses.
- Specializing in strategic projects to provide and develop important member care resources.

Pulling It Together

In summary, RIMAs need three things to be relevant. First, they need the *right platform* upon which to solidly base themselves. For many this means being part of (and often emerging from) an existing mission structure, such as the Association of Evangelicals in Africa, the World Evangelical Fellowship, or COMIBAM (Iberoamerican Missions Cooperation), plus having connections with mission leaders. Such relationships provide more credibility and access to resources. Second, they require the *right personnel*: members with good relationships with health care/mission networks, respect (for godly character, competence, contributions), and resources (time, skills, funding). And third, they must pursue the *right projects* on behalf of different groups or "levels" of mission personnel: agencies, nations, regions, and also globally. Table 3 summarizes these factors via a member care "relevance grid" and includes relevant concepts from community psychology.

Table 3. RIMA Relevance Grid for Developing Member Care

4. LEVEL OF FOCUS			
Agency	National	Regional	Global
	^	^	
	^	^	
	*Coordinating groups (task forces, member care affiliations)		
	*Consultations (training, joint projects, sense of community)		
	*Centers (facilities, geographic service hubs, and groups providing member care)		
	*Compilation of resources (written materials, service organizations, referrals)		
	*Courses/workshops (prevention of problems, empowerment for ministry)		
	*Comprehensive study and information (research, web sites)		
	*Coalitions/networks (tropical medicine, MK ministries, crisis care teams)		

3. PROJECTS—the right tasks:

Developing resources for groups of mission personnel, especially "at risk"

^ ^ ^

2. PERSONNEL—the right relationships, respect, resources:

Encouraging diversity/new roles for RIMA members
and "citizen participation"

^ ^ ^

1. PLATFORM—the right organizational backing:

Working with mission associations/influential leaders to create new "settings"

[Note from Kelly on Table 3, May 2005: Since originally writing this article in 1997, I and others are learning, sometimes the hard way, about the need for clearer protocols in RIMAs. Protocols are agreed-upon, basic guidelines for things like managing conflicts, decision making, roles/responsibilities etc. Developing such protocols is a normal and essential process for healthy affiliations, and parallels the processes outlined in Figure 3. To quote Charles Handy in *Understanding Voluntary Organisations* (1988, p. 9): "Virtue does not have to be so painful, if it is sensibly organised." And simple recognised protocols are a sensible way to avoid unnecessary pain as well as to help guide and protect RIMAs. See also point 10 in Table 4 below.]

RIMAS—Practicalities and Pitfalls

It takes a lot of work for RIMAs to reach a point of viability. In my experience, it is a three to five year process to "knit the net"—to help organize a network of basic resources within a region. It is similar to the process of building a house, described in Proverbs 24:3-4, in which wisdom, knowledge, and skill are needed to establish it and fill it with precious goods.

Some people and projects start off with much enthusiasm, but then eventually fade largely due to time constraints. At times there can be relational differences and cultural misunderstandings which drain energy from projects. Different agendas and personalities can clash. There can also be different commitments to look at or go after "the bigger regional picture". A coordinator may not keep the communication flowing over time and over large geographic distances, both of which are so necessary when people live in different countries and their work is done in cyber space via electronic mail. Sometimes the coordinator gets stuck with most of the work, or there is no true accountability for the timely completion of projects, or funds are not available to do projects. The possible hindrances to RIMA viability, frankly, are legion.

But the potential gains are worth the trouble. What has helped me persevere is the support and involvement of close friends, plus a basic road map to help guide my involvement in affiliations. With regards to the latter, I am indebted to the work of Phill Butler and the staff of Interdev, and have mingled several of his ideas on forming ministry partnerships with my own thoughts for member care affiliations (summarized in Table 4).



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Table 4. Guidelines for effective member care affiliations

- 1. Affiliations are built on friendship, trust, and mutual concerns. Function (tasks) usually bring people together but friendship keeps them together. Affiliations are spiritual entities as well as working groups, so both dimensions require attention. Prayer, worship, and sharing from Scripture are encouraged.
- 2. Affiliations need at least one coordinator who functions by consensus to bring the affiliation together and keep the fires burning. Coordinators are like roving ambassadors that can articulate the purposes of the affiliation, while helping to bring people and resources together. They champion the group's cause.
- 3. Affiliations exist in order to accomplish a specific vision and tasks. Partnership for partnership sake is a sure recipe for failure. Consensus is always involved in identifying tasks. Working together successfully on "demanding performance challenges" also helps to rally and hold the group together.
- 4. Affiliations have limited, achievable objectives in the beginning, and become more expansive with time. They start by identifying the most important needs and member care gaps among the people/region being served. Members endeavor to get behind not in front of the mission community in a given region (emphasizing felt needs rather than one's own agenda).
- 5. Affiliations are a process, not an event. They may be birthed via a conference/special gathering, but they take time to form and reach viability. Lots of behind the scenes relationship-building, exploratory meetings, and trust development occur before the groups are launched. They are even more challenging to maintain than to start. Making sure the vision stays alive, the focus clear, communications good, and outcomes relevant takes effort and long-term commitment—and not just from the coordinator!
- 6. Affiliations are made up of members with different backgrounds and skills. They have relationships with mission leaders and networks, are respected, and have access to important resources. Inclusion, interdependency, and cooperation are core values, hence other groups and individuals are invited to participate on projects.
- 7. Affiliations acknowledge, even celebrate, the differences in their members' backgrounds. They focus on a common vision and values to help fulfill the group's objectives. Members feel that they truly belong and can influence the group. People and groups participate because they want to be there and want to work together—there is a high level of ownership and participation.
- 8. Affiliations remain focused on their ultimate goals or vision and are not overly distracted by day to day operational demands. Practical jobs are needed to be done, and members often function in clerical roles. But nonetheless, the end product is kept in mind to guide and inspire. Mutual accountability is essential to make sure that plans are carried out in a timely fashion.
- 9. Affiliations do not come free. Personal finances at first may be needed as well as funds from one's mission organization/church. Ultimately, outside funding, especially for larger projects, is needed.
- 10. Affiliations expect problems and plan ahead for them. They have an agreed-upon protocol for handling differing expectations, disappointments, and friction.

(Adapted from "16 Key Partnership Principles", by Phill Butler, *Evangelical Missions Quarterly*, 31, 409,410.)

Current Examples of RIMAs

The 1990's has been a decade for member care affiliations, especially RIMAs. Most RIMAs were established as a result of an international mission conference (e.g., Asia Mission Congress II and COMIBAM in 1997) or an international member care consulta-

tion (e.g., European Member Care Consultation in 1997, Middle East Member Care Consultation in 1993). Participants got together, identified needs and resources, and then formed the beginning of some type of a group, which then developed into a RIMA.

In 1992 I became involved in my first two RIMAs. One was for mission personnel in the Middle East and the other for personnel in North Africa. These groups came into being as member care workers and mission leaders within these regions met to discuss regional needs and resources. For the Middle East, the group took shape following a three-day workshop which overviewed member care. For North Africa, a group emerged at the end of an 18-month process of discussion with leaders and member care workers involved in this region. In both cases it was not always certain what would practically materialize as a result from our efforts to talk with people from such diverse backgrounds.

Several other RIMAs now exist, and continue to be developed at the time of this writing. On one end of the task continuum, some tend to function more like discussion groups which occasionally do some joint projects. On the other end of the continuum, others are wanting to be more like cohesive teams, which intentionally go after "demanding performance challenges" to develop member care, while prioritizing mutual accountability/support (Katzenbach and Smith, 1993). Here is a brief description of the main RIMAs.

World Evangelical Fellowship, Mission Commission Member Care Task Force (MemCa)

Following the International Attrition/Pastoral Care Consultation in England in 1996, plans were made to develop a Member Care Task Force that would help stimulate missionary care around the world. After much planning and interaction, eleven individuals met in England in September 1998 to refine and launch this strategic coordinating body. MemCa functions like a global interagency affiliation, and could potentially be a good structure to help catalyze and pull together several RIMAs around the world. The focus is on developing resources on behalf of mission personnel from the "Triple A" (Asia, Africa, and América-latina), and on those working among unreached people groups. MemCa also maintains a WEB site (www.membercare.org) which includes an updated, global list of member care resources (books, counselors, events, training, important articles, etc.). MemCa regrouped during a special consultation in Malaysia in May 2001, and now has 25 members.

Evangelical Fellowship of Asia, Mission Commission Member Care-Asia Task Force

This RIMA is the joint effort of MK and other member care specialists. It was discussed at the Asia Missions Congress II in Thailand in October, 1997 and then birthed in May 1998 as its 10 members met for the first time. Asia is an incredibly diverse continent, and so the strategy is to help develop member care resources at the national level. Prime examples of this are encouraging missions and member care workers to convene national member care consultations, increase awareness of the needs of Asian MKs, and publish materials in English and Asian languages.

Iberoamerican Missionary Cooperation (COMIBAM)

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Pastoral Care Working Group

This group continues to develop and is part of the COMIBAM structure for Latin America, Spain, and Portugal. It officially was set up at COMIBAM II in Acapulco, Mexico in November 1997, never really materialized, and then was reorganized in the summer of 1998 and then again in November 2001 during a small continental pastoral care consultation held in Lima, Peru. Some of the goals are to publish member care materials in Spanish/Portuguese, develop a network of Christian mental health professionals who can provide consultation services (e.g., screening, assessment, counseling), maintain an email forum for member care, and organize Latin American member care consultations in different regions.

Middle East Member Care Team

Based in Europe, this interagency group was set up in 1992 to help care for Christian workers and their families in the Middle East. A special focus is resourcing support personnel based in Cyprus. Some members travel to the field to provide services. They also sponsor retreats and member care workshops at various locations. A main goal is to set up a member care center in proximity to the Middle East.

North Africa Member Care Group

Based in Europe, this is one of the working groups of a larger regional partnership. It meets four to six times a year to help coordinate and provide member care services in North Africa and in Spain including retreats for MKs, workshops, and some field visits.

Member Care-Europe

This group of 20 people developed as a result of the First European Member Care Consultation, held near Geneva in 1997. Two other successful member care consultations have been held since then, in France (1999) and in Hungary (2001). Examples of projects include organizing the bi-annual European consultation; linking more with member care personnel from Eastern Europe; providing field services together; maintain an email forum; teaching in seminaries and institutions; and encouraging the formation of other national member care affiliations. The overall goal is to help develop member care within and from Europe.

Central Asia Member Care Working Group

This group is currently reforming with five active members and pursuing these goals: helping to place and resource member care workers in Central Asia, helping to monitor and exchange member care-related information with mission leaders working into this area, supporting a daily radio program going into the region to encourage workers, and providing referrals for professional care.

Other Types of Member Care Affiliations

- **Mobile Member Care Team**—This is an interagency group of member care specialists which is developing a network of consultants who can provide crisis response training and crisis intervention on the field. The first team is located in West Africa and described in chapter 12 of this book.

- **YWAM Frontier Missions Member Care Group**—An affiliation of consultants in Youth With A Mission (YWAM—an agency with over 15,000 staff) which provides and develops member care resources to frontier mission personnel in YWAM. The main function is to provide professional consultation to each other via email, and to provide counseling/workshops at regional YWAM conferences.
- **National Affiliations**—Other regional/national member care affiliations continue to emerge, such as for Malaysia, The Philippines, and Brazil. The national member care group for the Netherlands is focusing on such items as the medical, material, career, and counseling needs of Dutch missionaries, and the one for Germany on training and network building.
- **Additional Groups**—There are other groupings of member care personnel, such as national gatherings of personnel directors, regional meetings of MK personnel and cross-cultural trainers, research groups, health care/tropical medicine groups, and Internet member care forums.

For Everything There is a Season—And a Summons

The reality of living in a global society calls each of us to seriously look beyond our own national, organizational, and disciplinary borders. As Ray Fowler, the CEO of the American Psychological Association puts it, "To limit our information to developments in the United States now makes no more sense for psychologists than it does for economists, chemists, or political scientists. More than ever we are citizens of the world (1998, p. 3)". The same charge holds true for mental health professionals from other countries.

Member care likewise continues to mature and internationalize. We in this field have the dual responsibility of providing for those in our own cultures/organizations, as well as promoting cross-cultural understanding and cross-cultural cooperation to help fill in important member care gaps. This is no small task. People from other countries can see things very differently, whether it be how best to conceptualize and resolve human problems (e.g., Zaman, 1998), or how best to form and maintain member care affiliations.

Member care workers, be they mission pastors, psychologists, or personnel directors, are encouraged "to capitalize on those aspects of their current professional life which are their greatest strengths, and to find some ways to translate those strengths into an effective contribution to the missionary endeavor (Richardson, 1988, p.6)." For some, these contributions will take the form of working as part of RIMAs and other strategic member care groups, stretching themselves to develop additional strengths to further support missions.

I have sometimes wondered if RIMAs will become a passing trend, slated to go the way of many well-intentioned aspirations. But I really do not think so. It would seem that the season for member care affiliations is just beginning. If the way forward to reach the unreached is to work cooperatively across organizational, cultural, and disciplinary lines, pulling our strengths, skills, and prayers together, then RIMAs are right on target. RIMAs, when carefully formed and maintained, have already played, and will continue to play an important role in world evangelization.

Reflection and Discussion

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1. How could a RIMA be developed for your region? Who could be involved? How could you share about the need for these affiliations?
2. Review the 10 summary principles at the end of the article. Which ones seem to be the most important for RIMA cohesion and effectiveness?
3. What are some of the main hindrances that can prevent RIMAs from achieving viability?
4. Comment on the author's optimistic perspective on the role and future of RIMAs.
5. Some member care people are better gifted for providing services within a specific setting, and others are more oriented towards developing resources at broader, regional levels. What are some ways that these two types of people could work together to better care for mission personnel?

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Kelly O'Donnell is a member care/mental health working with Youth With A Mission and Member Care Associates-Geneva, based in Europe. He co-ordinates Global Member Care Resources (MemCa), part of the World Evangelical Alliance's Missions Commission. Kelly studied clinical psychology and theology at Rosemead School of Psychology, Biola University, in the United States. Specialties include personnel development, setting up member care affiliations, team building, and crisis care. Together with his wife, Michèle, he has published several articles in the member care field, along with editing **Helping Missionaries Grow** (1988), **Missionary Care** (1992), and **Doing Member Care Well** (2002). They have two daughters: Erin, aged 15 and Ashling, aged 11. email: 102172.170@compuserve.com

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